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System-wide Recovery Guidelines

Team: Ambulatory Specialty Care

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III. Guidelines for Clinic Visits & Virtual Care Opportunities

a. Patient Scheduling:

- The number of in-person clinical appointments and/or tests should be calibrated so as not to exceed the defined capacity.
- There is an opportunity to leverage the system tools which instruct schedulers how to manage the appointment deferral process (e.g., call ordering physician vs. simple rescheduling)
  - Ambiguous cases should be primarily managed by involvement of the ordering physician.
  - Physician-to-physician communication is strongly encouraged in this process, if the support teams cannot easily arrive at a compromise regarding an appropriate deferral of care. Clerical and support teams are not trained to weigh the relevant considerations.
- Services/Clinics must ensure that a clear process is in place for (1) deferring/rebooking care and (2) identification of previous cancellations that have been performed without putting an alternative subsequent care event into place at the time of cancellation. This issue potentially has important patient safety implications and practice leaders and operations teams need to carefully consider current and recent past practice in this regard.
- Local medical and operational leaders should work collaboratively to ensure that patient visits are not scheduled until prioritization of orders is complete, as applicable. If schedules are revised as a function of the prioritization exercise, adequate communication to patients and/or ordering providers needs to be implemented.
- Operations teams should continually strive to recognize and address gaps in the process or tools for ensuring adherence to process steps at a local level. EHR/Access teams are commonly recording reasons for cancellations or deferrals, although that approach may not be consistently applied. It is the responsibility of the local operations team to evaluate retrospectively how care has been postponed and which gaps in patient care this may have created. They should also proactively engage in closing those gaps going forward as operational capacity ramps up and can increasingly accommodate deferred patients.
- Population health lists, grouped by disease, may be useful to identify high-risk patients who may suffer adverse outcomes from deferred care.

b. Patient Screening:

- Defining a process for screening of patients for potential COVID-19 infection is critical for the resumption of activities and the administration of care in the specialty clinics in a manner that limits risk of exposure to patients and staff. The screening process is complex and evolving with changing technology and understanding of disease characteristics/presentation, kinetics, transmissibility, and resolution. The opportunities afforded by rapid turnaround of test results for active infection as well as antibody testing to

define prior exposure and potential immunity will have significant impact on the pattern of patient evaluation and flow. These areas are under ongoing development and the screening program will require ongoing input and guidance from Infection Control and the BILH Recovery Incident Command or a similar operational leadership group.

- The primary principles of screening involve the need to define categories of potential risk of infection and transmissibility including patients with active infection, recent exposure, and symptoms potentially consistent with active infection, post-infection with resolved symptoms and/or resolution of positive testing. The nature of screening is complicated by the presence of asymptomatic disease and atypical presentations in a subset of patients as well as different patterns of disease course particularly in patients with compromised immunity.
- A process of screening should be defined for each clinic. This may need to be tailored to the specific needs of the population. For example, clinics with a high proportion of immune compromised patients at high risk from infection may need a more rigorous or overlapping process of screening. In addition, patients coming from a setting of high-risk exposure such as a nursing home facility may require a more rigorous screening process. Each clinic must have a defined process of patient and visitor screening prior to resumption of activities.

  Critical components of screening prior to the visit include:

  1) Screening prior to the visit. This may be accomplished via electronic interface such as texting a prescribed list of questions including symptoms, COVID-19 diagnosis, and exposure history, optimally within 48-72 hours prior to the visit
  2) Phone screening from medical staff such as a resource nurse. This approach may be more effective in finding patients with a more atypical presentation and may be preferable in higher-risk settings
  3) Pre-visit COVID-19 testing. This approach may be most indicated for patients undergoing procedures or therapies that pose a significant risk of COVID-19 infection to patients and staff. It may also include patients at particularly high risk due to past exposure without symptoms or arrival from a facility at risk for endemic exposure such as nursing home facilities. Testing should also be considered for any patients with a positive symptom screen.
  4) Patient escorts will be limited to a maximum of 1. In certain high-risk patient populations, escorts may be limited further to certain types of visits (e.g., new patients, new treatment discussion, and end of life discussion). All clinic visitors must undergo a similar screening process
  5) An additional screening will be performed at time of patient check in
- Staff working in the clinic will be similarly screened using the automated BILH system for identification of symptoms or exposures that may require testing and quarantine. Any staff with a positive symptom screen should follow up with institutional Employee Health.

c. Patient Visit Instructions:

- Symptom screening should be integrated into the scheduling and visit process, potentially at multiple points (e.g., at the time of scheduling, within 48 hours of the visit, on arrival).
- Workflows need to be established which specify actions depending on outcome of screening/failure of screening.

- Pre-visit instructions (including building entry, arrival time, visitor policies) should be communicated well in advance so patients and their supporters can adequately plan their visit.
  - These instructions should include clear expectations about escort screening, PPE expectations, and necessary precautions if an escort fails screening.
  - In clinics with a higher percentage of patients at greater risk of complications from COVID-19 infection (e.g., oncology), a more restrictive policy towards visitors/escorts may be required. Transit of the patient from the entrance to the facility to the clinic area may need to be facilitated by designated institutional transporters and support personnel.
  - Clinics should strive to electronically collect as much information ahead of the visit as possible to reduce contact time of clerical/front desk staff with patients.
- Avoid exchanging physical items as part of the registration/information gathering process if possible (clipboard, electronic devices such as iPads). Consider completing full registration and financial clearance activities as part of the pre-visit workflow.
- Consider leveraging cloud-based technology or other patient-facing technology (portal) to collect visit-related information (examples: MRI safety screening, clinical risk assessment questionnaire for breast cancer screening, etc.)
- Check-out process should be moved out of the clinic if possible (attempt to leverage hands free methods for co-pay collection)
- Actual signage at the clinics to provide instructions and reinforce key messages should be made available to clinic managers. Template signage is available from your institutions and on the BILH COVID-19 resource page. [BILH COVID-19 Materials]

d. Clinic Design & Patient Flow

Overarching Principles:

The following section contains some very specific examples of measures that need to be considered or are recommended to achieve practice that is safe for patients and staff. The higher level of specificity in the following sections is provided partly to illustrate what can be done, as well as to provide some best practice examples. This document is not meant to be overly prescriptive. Rather, they are included to inspire considerations by the local teams how to optimize for safe practice and to signal to patients what specifically we are doing to address their very real concerns about returning to BILH for care.

Local operations leaders need to be vigilant about monitoring compliance with the augmented guidelines of safe practice. “Secret Shopper” and open approaches of continuous surveillance may be used to detect opportunities for improvement. This guideline references the simultaneous change of a lot of process for and by many providers, staff and patients. Good performance cannot be expected without continuous nurture, communication, monitoring, learning from mistakes, and rapid implementation of iterative improvements. Meanwhile everyone involved in this journey is encouraged to treat each other with respect and dignity, taking into consideration that these are very stressful times for everyone.

Arrival:

- Provide clear instructions to your patients prior to visit, especially if non-traditional workflows are employed. Additional staff may be needed to help patients adjust to the new way of interacting with the clinic. Volunteer services may be a resource to consider for additional wayfinding and process adherence support.
- Signage will guide patients. Some template signage is available on the BILH COVID-19 Resource Page under the "Signage" section. [BILH COVID-19 Materials]
- To the extent possible, consider non-traditional approaches to the conventional waiting room concept: Consider using the parking lot as a potential staging/waiting area, keeping patients in the safety and comfort of their cars until they are called into the facility for the appointment "just-in-time".
- Evaluate whether check in/registration can be done virtually.
- In settings where patients are being asked to use an alternative check-in process, patients who utilize public transport (Uber, etc.) should be accommodated.
- Consider collecting updated patient information ahead of the visit, to support a process of "rapid rooming"
- One mask will be provided to each patient that arrives without an adequate face covering or mask. Ideally, a medical assistant can escort patient directly to exam room.
- Consider the need for additional dedicated phone lines to handle increased phone call volume.
- Allow essential escorts / family members in the clinic only when need outweighs risk. Number of supporting escorts/family members should be kept to one per patient. Escorts should be symptom and exposure screened and required to wear a mask. Special precautions may be instituted in clinics caring for high risk patients.
- Restrictions regarding escorts and visitors need to be communicated to patients ahead of time to manage expectations and avoid challenging situations where entry needs to be refused based on the current restrictions.
- Staff are trained how to inform the patient of practice changes to enhance safety (masks, escort to room and possibility of remote history taking through the door if needed).
- Clinics should minimize and reduce the need for patients to touch surfaces in practice (doors should be push open or automatic, elevators should automatically be brought to main/lobby level, etc.).
- When feasible, a one-way patient flow from check-in to check-out should be implemented.

Front desk:

- Face shields are recommended for all staff and providers who are patient facing. However, local infection control policies must be adhered to. Physical space for interaction with patients should be optimized to reduce infection risk: consider apartition/Plexiglass divider in reception/front desk areas.
- Markings/lines on the floor are helpful to encourage social distancing and guide patient flow
- Ideally, design of front desk area must be optimized to accommodate 6' separation
- Workflows should be implemented which help to minimize time spent by patient at front desk pre & post evaluation including the use of electronic check in and check out by testing.

- Ensure availability of masks for reception staff
- Establish schedule for disinfection of frequently touched surfaces

Waiting Room:

- Ensure availability of hand hygiene products & hospital-approved disinfectant wipes. Replenishment frequency may have to be changed with expected increase in burn rate of these products
- Evaluate physical layout of waiting room area & consider removing chairs and ensuring chairs are 6 feet apart. Consider alternatives to conventional waiting rooms which could serve as holding or staging areas: cafeteria, car, underutilized corridors, and outdoor spaces (if available and suitable, and subject to weather conditions). Consider impact of scheduling changes (extended hours, weekend service) on "load" to waiting areas.
- If the waiting room does not permit establishment of 6 feet of available space, then a barrier (curtain) may need to be set up between chairs.
- Reading materials and other non-essential, non-cleanable movable items should be removed

Exam & Break Rooms:

- Consider chronologic or spatial separation of exam/treatment rooms for confirmed COVID-19 and suspect-COVID-19 patients from remainder of exam/treatment rooms
- Explore feasibility of outfitting exam rooms with portable, hospital-grade HEPA filters.
- Consider using visual aids to establish a "flag" system to help indicate current state of exam room: "clean"/"occupied"/"dirty".
- In general, try to avoid performing aerosol-generating procedures (see BILH list or procedures). If an aerosol-generating procedure is performed, allow sufficient downtime of exam room to ensure adequate room air turnover. Infection Control in conjunction with the Facilities department for each site can advise as to what constitutes sufficient downtime. Expect to have more room downtime than usual for this reason (e.g., 30 minutes prior to staff entering to clean). Remember to follow all PPE and room and equipment cleaning protocols for these types of procedures per institutional policy
- Ensure that appropriate staff is trained on appropriate room cleaning procedures.
- Evaluate size of staff break room to ascertain safe occupancy limit (6 feet apart). Establish PPE guidance, occupancy limit & disinfecting/cleaning schedule.

Cleaning Protocols:

- Clinics will follow new and enhanced cleaning protocols with cleaning crews. Consider appropriate use of recommended cleaning materials to maximize protective effects.
- Exam rooms, elevators, common spaces, bathrooms, but also staff-facing infrastructure such as computers, keyboards, storage, etc. should be cleaned more frequently. Staff may play a role in keeping their working equipment sanitized and should not solely rely on the assistance of housekeeping staff. Rather, this is a shared responsibility for all who are working together in clinical and administrative spaces.

Assignment of care for COVID-19 suspected or COVID-19 positive patients

- Patients with suspected COVID-19 infection will be evaluated in dedicated areas that allow for rapid assessment and testing. When medically appropriate, outpatients with COVID-19 will be managed remotely until they are no longer at risk for transmission. Symptomatic patients with suspect or confirmed COVID-19 who require outpatient services or subspecialty care will be assigned to designated sites segregated from the non-COVID-19 clinic population.
- In managing the care of COVID-19-confirmed or suspected COVID patients, clinics could consider identifying a dedicated space, dedicated day, and/or dedicated hours during the day for such patients.
- In creating a separate COVID care space for screening, clinics should be mindful of the need to move equipment that is co-located. PPE and cleaning procedures will be in place following standard guidelines. Consideration will be given for the need for additional PPE for office-based invasive procedures. Efforts to develop standards of care for patients with suspect or confirmed COVID-19 with concomitant medical issues will be addressed in each discipline and may require the establishment of formal guidelines and consultative programs to address these questions. Guidelines for when patients no longer require precautions upon return to the regular clinic are available on the BILH website.

e. Clinical Evaluations & Virtual Care Opportunities

Changes to Evaluations

- While protocols for patient visits have been modified to limit exposure risk, the goal should be to engender meaningful, high-value interactions between physicians and patients with deference to the physician's judgment.
- To build patient confidence and trust, physicians are encouraged to pursue meaningful interactions with patients and not feel the need to rush patient encounters while practicing safe social distancing measures.
- Clinics should consider signage to inform patients of steps taken to optimize exam time and minimize non-value added time for their safety and the safety of our caregiver teams. (e.g., a laminated checklist that precautions have been completed on the exam room door)
- In pursuit of this goal, clinics are encouraged to streamline the overall visit and the focus should be on the preparation of getting patients in the room

Virtual Care Visits & Follow-up

- In addition to routine visits, telehealth and virtual care should be offered for follow-up visits.
- Given a majority of care will be offered via telehealth, pro-active follow up with patients to check in with them should be encouraged.
- Clinics should continue to increase and enhance use of existing modalities such as in-basket messages, portal messages, email, text messages, etc. to stay in touch with patients.
- Clinics should feel empowered to rethink how we deliver specialty care by utilizing virtual solutions to more effectively treat and connect with patients. In this era of uncertainty, we actively encourage clinics to explore, test, and share innovative pilots.

- In supporting a culture of technology innovation, clinics should consider offering formal training on best practices and development of telemedicine guidelines.
- Clinics should continue to refine telemedicine workflows customized to EHRs and other legacy nuances.
- As we build a portfolio of innovation pilots across the network, the goal of system leadership will be to inventory, catalogue, and cross-fertilize a broad portfolio of successful pilots.

Load Balancing Clinic & Virtual Care Volumes [Staffing]

- Clinics should continue to offer telemedicine and virtual care while carefully relaxing guidelines to bring high-risk patients in for in-person care.
- The volume of in-person visits will be informed by the prioritization criteria and high-risk patient list.
- Clinics should link daily/weekly patient schedules with a phased approach to reopening (overarching clinic capacity targets), safe patient throughput, and staffing.
- In promoting video visits, clinics should account for workload related to virtual visits including training, infrastructure, etc.
- Clinics should consider scheduling changes that create two teams with the goal of offering extended hours.
- Clinics should build local virtual care expertise by identifying a virtual care “owner” on staff.