



System-wide Recovery Guidelines

Team: Ambulatory Specialty Care

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Executive Summary:

This document provides a set of guidelines and tools to help BILH clinics plan for the resumption of the full spectrum of ambulatory specialty care (referred to from hereon as “clinics”) in the context of the evolving COVID-19 epidemic.

Recognizing the diverse nature of the BILH network, the guidelines offer a broad discussion of the critical issues and foundational principles associated with resumption of clinical activities during the next phase of the pandemic. The document leverages the significant existing resources that address many of the areas of discussion offered by federal and state authorities, subspecialty societies, policy platforms of the individual hospitals, and an ever-growing experience of best practices.

Formulation of policies strives to help caregivers effectively resume activities in a safe environment for patients and staff, provide necessary medical care across disciplines in a manner that recognizes urgency and the need to reengage with longitudinal care, and to foster confidence among our patients about returning to our facilities.

The challenge of phased recovery and transformation of operations is dependent on external factors created by the pace of the epidemic and associated risks as well as operational readiness and infrastructural support required to meet these demands. The creation of broad principles for prioritization based on patient urgency and medical need are paramount to appropriately stage resumption of activities across the diverse areas of care within the network. Processes are established to effectively screen patients and staff to minimize the risk of transmission of infection. This includes providing separation of care for patients with COVID-19 infection from those seeking medical care for other issues. Those patients at the highest level of risk, including the elderly and those with compromised immunity, warrant special consideration. A goal of the screening process is to triage patients into relevant groups: symptomatic COVID-19-suspect, COVID-19-positive requiring precautions (either improving not yet reaching Recovered Status and/or Discontinue Precautions on Return to Healthcare Status) and fully recovered/no longer requiring precautions. Such triage will need to be integrated in this effort in the context of a changing landscape of testing and understanding of the COVID-19 manifestations and disease course.

The arc of the visit to the specialty clinic will need to embrace these measures resulting in care which allows for appropriate staff and patient protective equipment, spacing, cleaning procedures, and encounters with staff that minimize opportunities for exposure. All of these principles must be pursued while maintaining the bedrock of our approach to patient care - recognizing the distinct humanity of each patient and providing empathic, patient-centered, competent care that is the driver for patients to come to BILH member organizations.

Outlook:

In crafting this response to the challenges posed by the COVID-19 pandemic, our BILH system has a unique opportunity to further strengthen the collaborative spirit and operational synergy within its community. The response to the crisis also affords the chance to think broadly about how new approaches to health care delivery may enhance patient experience and outcomes beyond the transient issues posed by the pandemic. The thoughtful incorporation of telehealth strategies into the care model offers just one powerful example of potentially lasting care transformation.



The Ambulatory Specialty guidelines are organized into the following categories:

I. Guidelines for Operational Readiness & Capacity Management

- a. Clinic Capacity based on a Phased Reopening
This section outlines a variety of recovery frameworks, including a recommended approach, for clinics to consider when resuming ambulatory activity in a step-wise, phased manner.
- b. Operational Readiness Criteria
This section includes clinic footprint guidelines and options for scheduling modifications to limit patient density. PPE guidelines and disinfection protocols are also outlined.
- c. Operationalizing of Infection Control Guidelines
This section covers staff testing and guidelines to promote a safe work environment. Staff training and coordination (e.g., policies, team meetings, and local expertise) are also included.
- d. Optimizing Clinic & Network Capacity
This section outlines operational leadership structures that can help optimize network capacity and patient prioritization while recognizing limitations (e.g., specialized expertise).

II. Guidelines for Patient Prioritization

- a. Prioritization Criteria
This section outlines two prioritization criteria, specifically patient prioritization (i.e., patient risk vs. medical need) and operational prioritization (i.e., "visit footprint").
- b. Prioritization Process & Virtual Care Considerations
This section outlines how clinics can support a physician-led, local prioritization process, including guidelines for prioritizing virtual and in-person visits in parallel.

III. Guidelines for Clinic Visits & Virtual Care Opportunities

- a. Patient Scheduling
This section outlines scheduling considerations in the context of an iterative patient prioritization process, including rebooking and monitoring patients with deferred care.
- b. Patient Screening
This section outlines the critical components of a screening process that is tailored to a clinic's population, including phone screening by medical staff and pre-visit COVID-19 testing.
- c. Patient Visit Instructions
This section outlines instruction content, technology to collect information, and clinic signage.
- d. Clinic Design & Patient Flow
This section includes recommendations on clinic flow, including arrival/front-desk, waiting room, exam rooms, and areas for symptomatic patients with suspect or confirmed COVID-19
- e. Clinical Evaluations & Virtual Care Opportunities
This section outlines changes to evaluations to promote high-value interactions while limiting exposure risk. Opportunities for transforming care through virtual health are also included.

IV. Guidelines for Enhancing Patient Awareness & Communication

- a. Awareness of Patient Perception
This section covers how clinics can maintain awareness of patient apprehension about visits.
- b. Patient Communication Principles
This section outlines how to improve patient communication by focusing on patients with deferred care, scripting outreach language, and conveying a safe clinic environment.



I. Guidelines for Operational Readiness & Capacity Management

a. Clinic Capacity based on a Phased Reopening:

- Prior to resuming activities, each discipline will review with administration and the appropriate Supply Chain personnel the current availability of staffing and resources, respectively, that will be needed to meet the required conditions for clinic opening (outlined below). Once these conditions are satisfied, reopening ambulatory activity in a step-wise, phased approach is recommended.
- Many frameworks are available to organize a staged increase in clinical activity to confirm that patient volume does not outstrip available resources. This staging will be dependent on the current activity during the acute phase of the pandemic as some clinics have remained partially operational while others have paused all activity. Physician leads and operations managers may find it useful to review the following frameworks to aid and structure their decision making: BIDMC phasing (Phase 1: Urgent, Phase 2: Semi-Urgent, Phase 3: Routine, Phase 4: 100%+ of budgeted visits), ACS approach (acute phase, early recovery, late recovery)¹, and BILH staged reopening of capacity (25%, 50%, 75%). The appropriate mode of engagement with the patient (telehealth versus in-person visit) is an important additional consideration.
- Integration of clinical urgency with operational readiness may be addressed with a prescribed staged opening and network capacity/space (e.g., shared clinics as an interim step) in phases: For example:
 1. Phase 1 (at the height of the pandemic) – Emergent cases
 2. Phase 2 (with expansion of clinic services, including non-emergent care) – Patients with medical urgency or needed longitudinal care or visits with a low-visit footprint (e.g., telehealth, blood work, screenings)
 - i. A plan to include standard patient evaluations in high-risk patients
 - ii. Routine screening for serious medical conditions (e.g., lung cancer screening)
 3. Phase 3 (with operations at full capacity modified for the new environment) – Routine (e.g., bariatric patient, annual “well” patient)
- A process of staged resumption of activity is anticipated for the network that recognizes the external factors associated with the pandemic, the need for patients to undergo in-person evaluation or treatment based on medical necessity, the relative requirements for delivery of care, and the infrastructure of the individual clinic areas to provide necessary safeguards as outlined below. Clinics should open in a phased approach based on Operational Readiness, meeting defined operational criteria (below) before increasing clinic capacity. Medical and operations leaders of clinics will be guided by system and institutional guidance about permissible levels of activity, which in turn will depend on local and state orders reflective of the state of the pandemic environment.
- The Commonwealth is providing up-to-date metrics on the state of the pandemic. Examples of key indicators of reduction of the external threat posed by the pandemic are:
 - (1) Downward trend in 14 day hospitalization rate of patients affected by COVID-19 and

¹ ACS Guidelines for Triage and Management of Elective Cancer Surgery Cases During the Acute and Recovery Phases of Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.facs.org/-/media/files/covid19/acs_triage_and_management_elective_cancer_surgery_during_acute_and_recovery_phases.ashx



(2) Decreasing percent positive PCR tests among all daily new COVID-19 PCR tests reported [[Massachusetts Department of Public Health COVID-19 Response Reporting](#)]

- Principles of medical prioritization are outlined later in this document and are not germane to this section which considers operational readiness. Please keep in mind that medical prioritization is a critical process to cut overall patient volume back to a level that can be accommodated while minimizing adverse effects of deferring other care.

b. Operational Readiness Criteria:

Spacing and Geographic Footprints in the Clinic

- Social distancing should be maintained in the waiting room and patient care areas
- Geographic layout of the clinic will need to be modified to limit patient density in the waiting room, evaluation, and treatment areas
- Patients may be asked to wait remotely until called in for evaluation
- Creative use of and modification of conventional scheduling practice may offers clinics several tactics to optimize safety by reducing the number of patients that are on premises at one time. Clinics should select the appropriate mix of these example practices:
 - Consider ratio of providers to rooms, and number of providers seeing patients in a given space at one time. Example: scheduling no more than 2 providers seeing patients at one time with 3 rooms available per provider. No more than 3 visits per hour.
 - Consider offering designated service hours for high-risk populations: for instance, symptomatic patients with fever, cough, influenza-like illness (ILI) symptoms or suspected COVID-19 positive patients at the end of the day (to achieve some separation from other patients, and afford more thorough room air turnover overnight and terminal cleaning at the end of the day).
 - Clinics should consider operating expanded weekly schedules, e.g., operating 6 days/week and/or offering expanded hours. This will require careful assessment matching availability of staff and support services.
 - Consider offering more exam rooms per care team/provider per session to allow for appropriate cleaning between patients.
 - Consider multidisciplinary care in COVID-19 care areas versus non-COVID-19 care areas, with providers from multiple specialties seeing the same patients in the same space.
 - Consider creating dedicated COVID-19 rooms within a clinic, COVID-19 clinic sessions, or COVID-19 days to consolidate care, reduce PPE usage under extended use protocols, and more efficiently handle cleaning needs.

PPE (Availability, Burn Rate, Preservation, Redundancy)

- Clinics should adhere to appropriate PPE usage for staff and patients in line with BILH policies.
- The current recommendation is that staff maintain the basic principle of Standard precautions with all patient encounters as well as staff interactions. This involves the wearing of surgical masks in the clinic at all times, with the use of eye protection for all



patient care, and the addition of gloves and a gown for care of patients with suspected or confirmed COVID-19. If aerosol-generating procedures are performed, a N95 respirator should be used. The specific recommendations are likely to undergo evolution.

- Patients and essential escorts will be asked to wear cloth face coverings or masks during the visit. During the reminder call and symptom and exposure screen 48 hours prior to the appointment, patients will be asked to bring a face covering or mask with them, if possible. For patients and escorts who arrive without masks, one will be provided to them.
- PPE preservation through extended use and reuse per current recommendations is an important pillar of ensuring that adequate levels of PPE remain available
- Clinics should anticipate PPE usage/burn rate based on staffing and anticipated in-person visit volume & report usage via manager/local leadership up to local incident command
- Clinics should stock adequate PPE supply on-site for staff, patients, and escorts
- All care team members should be trained on proper donning and doffing techniques
- Clinics operations teams should define adequate and safe levels of PPE inventory based on burn rate
- If resumption of care results in an unsustainable increase in the burn rate of PPE, clinic operators may receive feedback that operations may need to be held steady or throttled back. This dialog will ensure that clinical activity can be aligned with the prevailing reality of the PPE supply situation. Supply Chain and operations leaders should regularly monitor availability metrics (e.g., 30 days on hand) and redundancy metrics (e.g., percentage of staff using N95s that have been fit-tested to a 2nd brand)
- Adapt preservation measures (and contingency plans) in coordination with leads overseeing the local supply situation.
- It cannot be overemphasized that safe care is of paramount importance. If patients and/or staff cannot be adequately protected from infection as a result of inadequate PPE supplies, operations need to be adapted to ensure that this premise is kept.

Protocols for Disinfection

- Protocols for cleaning and disinfection of clinic areas is a requirement for resuming operations. Frequency and process of cleaning the clinic spaces should adhere to BILH protocols.
- Daily general cleaning may involve daily cleaning of all patient care, staff, and public spaces by Environmental Services (EVS) and appropriate disinfection of each room and treatment space between each patient encounter by the clinic staff.
- EVS support, clinic staffing, and availability of cleaning materials should be confirmed prior to resumption of clinic operations.

Protocols for Patient and Essential Escort Symptom Screening

- Patients should undergo symptom and exposure screening, as outlined in the BILH policy, by phone or electronically 48-72 hours prior to their appointment
 - Patients who have a positive symptom or exposure screen should be considered for testing and/or delay of their appointment
 - Patients will be screened again upon arrival at the point of care



- Patients with a positive screen who come to clinic should be seen using Droplet and Contact Precautions
- Essential escorts should undergo symptom and exposure screening, per BILH policy, upon entry to the facility
 - Escorts who have a positive symptom or exposure screen should be asked to leave the facility and recommended for evaluation
 - Escorts who leave the facility should provide a phone number where they can be reached to pick up the patient
 - Clinic or facility staff should assist the patient when their escort is unable to accompany them to their clinic visit

c. Operationalizing of Infection Control Guidelines:

Staff Testing & Safety

- Continue employee symptom screening and monitoring system per existing policies and procedures
 - Adhere to BILH policies regarding working when symptomatic
 - Develop redundancy in staffing model in the event of employee illness
 - Educate staff about how to keep their families safe
- Adhere to current BILH return to work policy
- Continue to use remote work where possible (e.g., providers working shifts/days of telehealth remotely), and leverage ability of clerical and scheduling staff to tele-commute in accordance with applicable institutional and system policy
- Optimize infection prevention practices in break room, lunch room, conference rooms, and at clinic front desk
 - Maintain proper social distancing in these areas
 - If not possible due to space constraints, implement a sign-up rotation
 - Attention to thorough hand hygiene
 - Disinfect countertops, microwave, etc after use
- Implement standardized team huddles twice per day to foster situational awareness and solidarity

Staff Training, Coordination, & Readiness

- Ensure education of staff as to optimal infection control practices. Dissemination of BILH published guidelines for masking, patient screening, staff symptom attestations, hand hygiene, disinfection of shared medical equipment, donning and doffing PPE, and PPE extended use and reuse protocols [[BILH COVID-19 Materials](#)]
- Foster situational awareness, training and solidarity via regular team meetings. Create opportunities for regular review of clinic practice, review of experience, and opportunity for systems improvements.



- Clinics should consider identifying team members for three key tasks:
 1. “Flow buster” (should raise a flag if patient or staff safety becomes compromised due to increased volume)
 2. Infection Control Liaison/PPE expert (hand hygiene, equipment disinfection, donning & doffing, inventory monitor)
 3. Telemedicine (in-clinic subject matter expert for all matters pertaining to telemedicine)
- Environmental Services training for use of signage for equipment/exam rooms to designate “clean/not yet cleaned” services.

d. Optimizing Clinic & Network Capacity:

- Clinics across the health system will likely return to (new) normal operations at different paces. Clinics should leverage local operational leadership and incident command structures to help manage prioritization and sites of care across clinics and across hospitals.
 - Identification of specialized expertise needed to meet a patient’s needs is a key input to leverage network capacity.
 - In case of inability of local recovery incident commands or medical directors to find capacity in their facility, they should consider escalating the issue to an operational leadership group (e.g., BILH Recovery Incident Command) or medical director to evaluate whether system-wide capacity exists for high-priority cases.
- The BILH will endeavour to facilitate the flow of patients into off-site locations if they cannot be accommodated within the primary hospital, will promote use of shared physical clinic space and infrastructure by multiple provider teams as feasible, and will leverage underutilized clinics/spaces (if applicable). A designated network-based committee should support these efforts.
 - Example: A time-critical, specialized interventional radiology treatment can’t be provided in a specific service location care due to workforce and facility constraints. The local subject matter experts/clinicians are likely to have knowledge about potential alternative sites of care. They are encouraged to assist with arranging a transfer of such care, after consulting with their counterparts at the alternative site. This will often be done on a patient-by-patient basis, since complex medical, skillset, and logistical considerations are likely to arise.
 - Local clinics by design have a limited situational awareness of what is going on at other locations and in other service lines. This requires an integration function at the system level and/or coordination between institutional/site leaders. They are in a position to identify and connect clinical/ops leaders of similar or complementary clinics and services to facilitate coordination and patient load balancing.
- Progress of recovery may be tracked by reporting system-wide metrics. While this is challenging to accomplish across diverse electronic health records and business intelligence systems, there are some potential key metrics such as recovery volume vs. weekly historical run rate. Taking into consideration that clinics will not be able to reach pre-COVID-19 capacity right away, it may also be useful to report the gap between utilization and actual current capacity since historic capacity may not presently be achievable.



II. Guidelines for Patient Prioritization

a. Prioritization Criteria:

- Ambulatory clinics and services should consider prioritization along two main dimensions:

- (1) **Patient (medical) prioritization** based on criteria of patient risk vs. medical need
Patient medical stratification: Consideration should be given to the clinical urgency, including prognosis of a particular patient's condition, and impact thereof on the patient's quality of life. Risk-benefit analysis plays an important role when considering individual cases. The following guiding principle is offered for consideration by the ACR: "If the risk of illness or death to a healthcare worker or patient from healthcare-acquired COVID-19 is greater than the risk of illness or death from delaying [...] care, then care should be delayed; however, if the opposite is true, the [...] care should proceed in a timely fashion. The risk from healthcare-acquired COVID-19 can be made very low for most [...] examinations and [...] procedures if appropriate safety measures are in place (screening, testing, infection control processes, PPE, etc.). Decision-making will be guided by attempts to estimate these risks.

In the initial phase of resumption of activities, patient medical conditions that require urgent evaluation and treatment should be prioritized. Those patients who require in person longitudinal assessments for complex medical conditions for which delays in assessment pose significant risk should also be prioritized. The relative risk of delay in treatment or evaluation as compared to the risks from outside exposures will need to be carefully considered for each patient disease category and situation reflecting on the disease process and risk from COVID-19 infection. Each discipline should consider creating a schema to define prioritization within their disease specialty and a forum for discussion and evaluation within the specialty to address the issues posed by individual patients. Practices should do their best to determine the risk to healthcare workers and patients of developing illness or death from healthcare-acquired COVID-19 in their local environment, as well as the patient-specific risk of illness or death from postponing an examination or procedure, and then use that information to guide the re-engagement of non-urgent [...] care. In this determination, the probability of negative outcomes (from COVID-19 and non-COVID-19 disease) should take precedence. Patient-specific risk is best determined through collaboration between [...] providers."²

- (2) **Operational prioritization**: As outlined above, determination of appropriate clinic volume will be dependent on the hierarchy of medical urgency and evaluation as determined by the conditions of the pandemic and the need to provide care within the specific discipline. As outlined below, clinic volume will also be dependent on the needed infrastructure and conditions to care for patients in a setting that minimizes risk of exposure to COVID-19 infection. These two guiding principles will be used to determine the assignment of patients to in-person as compared to remote (telehealth) visits. Clinics should consider the "visit footprint": which visits/treatments can be done sooner than later, and at scale, versus other activities which have remaining operational interdependencies that cannot be met at scale. In the setting of clinical need that is not able to be met due to operational constraints, a process for referral to other sites within BILH will be provided.

² Davenport MS, Bruno MA, Iyer RS, Johnson AM, Herrera R, Nicola GN, Ortiz D, Pedrosa I, Policeni B, Recht MP, Willis M, Zuley ML, Weinstein S, ACR Statement on Safe Resumption of Routine Radiology Care During the COVID-19 Pandemic, Journal of the American College of Radiology (2020), doi: <https://doi.org/10.1016/j.jacr.2020.05.001>.



b. Prioritization Process & Virtual Care Considerations:

In providing these principles, we are mindful of the heterogeneity across specialty practices (in current operation, capacity, etc.) and the wide range of patient needs. We encourage each clinic to prioritize patients locally and to collaborate with the local incident command, medical directors, and complementary service line leaders in optimizing network capacity and off-site space.

(1) Virtual Care Considerations during Prioritization: Before prioritizing in-person visits, clinics should develop processes to review patient master lists and orders within EMRs for determination of appropriateness of visits to be conducted at the facility as compared to remotely via telehealth.

- a. Since telehealth and in-person visits will both require clinic staff/resources, both types of visits need to be considered in parallel. While the “footprint” of a telehealth visit (on-site resource utilization, infection risk) is smaller, significant support may be needed to provide patient education and other requirements via telehealth visits. The medical appropriateness and ability and preference of patients to engage with the provider team in this way should be assessed.
- b. The appropriate leveraging of telehealth evaluations is encouraged when feasible and appropriate. Examples may include cases that haven’t been previously managed virtually (e.g., nutrition, chronic pain), as well as those which require only a very focused and simple interaction.
- c. Telehealth visits will need to be integrated into the larger process of patient evaluation and follow up as patients will likely require a combination of in-person and remote assessments. A process to manage longitudinal care in this setting should be established to avoid disruption on continuity.

(2) Prioritization Process: The prioritization process requires the establishment of a defined algorithm within each discipline along with a process for regular review of pending clinical items/patients while fitting in net new work that arises from referrals and initial patient presentation. Providers may need to decide on a case-by-case basis how long some visits and treatments can be postponed before becoming urgent or emergent. The order of appointments and care may need to be re-arranged accordingly. The optimization of these processes will require an iterative process as experience may direct best practices. Clinics are encouraged to foster a continuous improvement mind-set. Sharing of best practices across BILH is welcome and will be supported. In managing this process, clinics are encouraged to consider:

- a. The clinic’s provider team and operations team need to work collaboratively to achieve optimal prioritization within a clinic.
- b. Challenging situations arbitrating resource allocation between individual patients or groups of patients (e.g., biopsies, cancer patients) may arise. Member clinics and institutions should establish an escalation process for input and adjudication (e.g., through the local medical director or incident command).
- c. In prioritizing patients, clinics should also consider coordination with ancillary services (e.g., imaging, labs) that may be needed to support a complete encounter. This represents an opportunity to recognize bottlenecks in required support, allowing clinics to manage expectations of patients and to schedule accordingly. If clinics are unable to secure necessary services at a required level, local medical directors or incident command may need to assist in synchronizing priorities across service lines. Ideally, this



would happen before patient care is scheduled and negatively impacted by lack of coordination or availability of required resources.

- d. Lead providers act as liaisons between individual clinics and the local medical director in these instances.

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 a partition/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.

IV. Guidelines for Enhancing Patient Awareness & Communication

a. Awareness of Patient Perception

- Clinics should be made aware of patient perception and apprehension about resumption of care after many weeks of social distancing, and other infection control measures. BILH leaders will regularly review consumer sentiment metrics (e.g., BILH patient surveys); these data should be disseminated to clinic leaders if possible for their consideration and to enable them to optimize their own efforts to connect with and engage their patients.
 - Several BILH member organizations have very active patient and family advisory groups, which can be used to inform and engage our patient communities.

b. Patient Communication Principles

- Providers should be provided with template language to explain our phased approach to re-opening to patients who may need to be deferred. This will be an important tool to help explain why an appointment must be postponed. It should signal to patients that consideration has gone into assessing the associated risks and benefits, individually and collectively.
- Outreach to patients that are deferred is a way to double check that no one is missed and an opportunity to reengage and assess care needs.
- Providers should be encouraged to convey to patients the establishment of defined practices and procedures to establish a safe environment of care for our patients and staff.
- Standardization of messaging and support for clinics can be achieved through provision of standard communication materials by BILH communications/operations team.
- Different communication may be needed for different types of patients (e.g., deferred appointments, high-risk, immunocompromised).