Beth Israel Lahey Health

System-wide Recovery Guidelines

Team: **BILH Primary Care (BILHPC)**
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II. Primary Care Operations

a. Patient prioritization

Careful consideration of the prioritization of clinical conditions for which patients could/should be seen in-person is essential to a gradual and safe re-opening of primary care practices. Below is suggested guidance for the prioritization of clinical conditions for in-person visits:

- Any condition in which telemedicine was attempted but found to be inadequate for evaluation and management of the condition
- Chronic medical issues that are overdue and no longer appropriately managed via telemedicine, e.g., complex chronic disease management
- Any condition where anxiety/behavioral health issues of the patient outweighs the risk of an in-person visit
- High-risk patients who may suffer adverse outcomes from deferred care and need to be prioritized (e.g., high-risk patients identified by population health lists, grouped by disease, well infant visits)
- All required pre-operative evaluations

A list of other medical conditions that can be prioritized for in-person care is also included below.

We understand that there are differences in medical practice across BILHPC, including our triage and telemedicine capabilities, and referral processes. Some providers may choose to refer directly to specialists based on availability and prior referral practices. Please refer to the below list of conditions as guidelines when evaluating the appropriateness of an in-person visit. Visit conditions where telemedicine is required will be clearly stated below.

1. Gynecology:
    a. Any urgent condition requiring breast or pelvic exam (telemedicine not required)
2. Ophthalmology:
    a. Pink eye not adequately evaluated by telemedicine
    b. Corneal abrasion
    c. Concerning visual symptoms

    d. Eye swelling not adequately evaluated by telemedicine
3. Neurology: (telemedicine recommended)
    a. New-onset neurological symptoms not thought to require urgent ER evaluation that cannot be diagnosed via telemedicine
        i. ***acute stroke symptoms not included
    b. Worsening headaches with additional concerning/red flag symptom
4. Orthopedics:
    a. Injury concerning for fracture/dislocation (telemedicine not required)
    b. Back pain with high risk features/history (IV drug use/cancer history)
    c. Musculoskeletal issue not improving with conservative management
    d. Conditions requiring joint injections to be performed by primary care practice
5. Cardiology: (telemedicine recommended)
    a. Worsening leg swelling
    b. CHF exacerbation
    c. Elevated home BP
    d. Chest pain/anginal equivalent
        i. ***suspected acute MI not included
    e. Palpitations with concerning features
6. Endocrine: (telemedicine recommended)
    a. Diabetes with need for injection training
    b. Evaluation of thyroid nodule/neck mass
    c. New onset thyroid symptoms
7. Men's Health: (telemedicine not required)
    a. Any condition requiring prostate or genital exam
8. Gastroenterology: (telemedicine not required)
    a. New or worsening abdominal pain requiring exam
    b. Abdominal complaint not improving with home management
    c. Any condition requiring rectal examination
9. Dermatology:
    a. Rash or acute skin condition unable to be fully evaluated using telemedicine and remote images
10. Pulmonary: (**TELEMEDICINE REQUIRED** in an effort to reduce exposure of possible COVID-19)
    a. Shortness of breath from a non-COVID-19 condition requiring evaluation
        i. COPD
        ii. Asthma
11. Ear, Nose, Throat: (telemedicine recommended)
    a. Acute ear complaint, not improving on initial treatment
    b. Severe sinus pain, not improving on antibiotics
    c. Severe throat pain, not improving on treatment

12. ***Annual wellness visits and Transition of Care visits should be done by telemedicine unless the condition requires an in-person evaluation***

Pediatrics

- Expand scope of pediatric care at designated BILHPC sites where pediatric patients may be seen in-person for the following:
  - Well infant checks and immunizations for any infant 18 months or younger, including newborn visits
  - Well child/adolescent visits and immunizations for ages where immunizations are more significant/crucial based on CDC immunization guidance and/or where developmental monitoring and screening are important for providing safe care: 0-6 years, 12 years, and 16 years
  - Any pediatric sick visit that cannot be adequately managed via telemedicine/telehealth at the discretion of the primary care provider
- When possible, morning sessions will be dedicated specifically to pediatric well checks and immunizations
- When possible, afternoon sessions will be dedicated specifically to pediatric sick visits
- All visits will be limited to 1 parent/guardian/caretaker with a negative symptom/exposure screen accompanying the pediatric patient, if possible
- Sites will be staffed by one family medicine physician per session when there are pediatric patients scheduled
- During Phase I, every effort will be made to separate pediatric patients being seen from adult patients either by location and/or by time, while maintaining the above guidelines

In the future of primary care, telemedicine will be a mainstay of patient access, and we will continue to advance and promote the utilization of telemedicine. During Phase 1, telemedicine evaluations are preferred, including prior to some in-person visits, and may include patients who haven't been previously managed virtually as well as those patients who require only a very focused and simple interaction. As practices prioritize patients for in-person visits, they should also consider coordination with ancillary services (e.g., imaging, labs) as these services may be needed to support a full patient evaluation.

Practice Operations

This section contains specific examples of measures that should be considered when applicable or are recommended to maintain a safe practice environment for patients and staff. These measures may be adapted and optimized by local staff to meet the safety needs of their practice. The number of in-person appointments and/or tests should not exceed the modified practice capacity due to safety protocols.

b. Pre-arrival and screening

The pre-arrival and screening guidance for both staff and patients may change as technology and our understanding of the disease evolves, including the potential future possibility of widespread testing of asymptomatic patients.

- Each practice must define screening processes for their patient population prior to resuming in-person visits. These processes may be tailored to specific patient needs. For example, patients coming from a setting with high risk of exposure, such as a nursing home, may require a more rigorous screening process
- Critical components of pre-visit screening include:
  - **Symptom and exposure screening prior to the visit**. This may be accomplished electronically the day before or day of the visit, such as texting a prescribed list of questions
  - **Phone screening from medical staff such as a nurse**. This approach may be more effective in patients with an atypical presentation and may be preferable for higher risk settings; perform day of or day before the visit
  - **Patients and escorts should be instructed to arrive wearing a mask or cloth face covering**; one will be provided if the patient does not have one upon arrival
  - **Patients are limited to 1 asymptomatic, essential escort**. For certain high-risk patient populations, practices may further limit escorts to certain types of visits (e.g., new patients, new treatment discussion, end-of-life discussion). All practice visitors must undergo a symptom and exposure screening process on the day of or day prior to the visit. Exceptions to this recommendation will be made by the patient's care team for extenuating circumstances
  - **An additional screening will be performed of all patients and escorts at time of patient check-in**

- Symptom screening should be integrated into the scheduling and visit process, possibly at multiple time points (e.g., at the time of scheduling, on the day of or day prior to the visit, on arrival) at all points of care
- Workflows that specify actions depending on the outcome of screening will be established
- Pre-visit instructions (including building entry, arrival time, visitor policies) should be communicated well in advance so patients and their escorts can adequately plan for the visit
  - These instructions should include clear expectations about escort screening, mask/face covering expectations, and necessary actions if an escort fails screening
  - In high-risk clinics, no visitors/escorts may be allowed and transit of the patient from the entrance to the facility to the clinic area may need to be facilitated by designated staff
  - Practices should electronically collect as much information ahead of the visit as possible to reduce contact time of clerical/front desk staff with patients

- Practice staff should avoid exchanging physical items (e.g., clipboard, electronic devices such as iPads) as part of the registration/information gathering process if possible. Instead, practices should consider completing full registration and financial clearance activities as part of the pre-visit workflow
- Check-out processes should be moved out of the clinic and practices should attempt to leverage hands-free methods for co-pay collection, if possible
- Managers should have signage available at the practices to provide instructions and reinforce key messages. Template signage is available from your local institutions and on the BILH COVID-19 recovery resource website.

c. Arrival

- Practices should provide clear instructions to patients prior to their visit, especially if non-traditional workflows are employed. Additional staff may be needed to help patients and volunteer services may be a resource to consider for process adherence support
- Signage must be present to guide patients. Some template signage is available on the BILH COVID-19 recovery resource website under the "Signage" section
- 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 by keeping patients in their cars until they are called into the facility for their appointment
- Evaluate whether check-in/registration can be done virtually
- Process flows for patients who utilize public transport (subway, ride-sharing services, etc.) should be developed
- Consider collecting updated patient information ahead of the visit, to support a process of "rapid rooming"
- All patients will be given a surgical mask upon entrance to BILH facilities, if they do not arrive wearing a mask or cloth face covering, as instructed in the pre-visit call, subject to BILH policies
- Ideally, a medical assistant would escort the patient directly to the exam room
- Practices should consider the need for additional dedicated phone lines to handle increased phone call volume
- Escorts/visitors are allowed in the practice only when need outweighs risk. Patients should have only 1 essential escort at their visit. Practice staff will screen escorts for symptoms and require escorts to wear a mask. Special precautions may be instituted in clinics caring for high-risk patients
- Staff are trained on informing patients of practice changes (masks, escort to room, and possibility of remote history taking through the door if needed)
- Practices should minimize and reduce the need for patients to touch surfaces on the way to their visit (doors should be pushed open or automatic, elevators should automatically be brought to the main/lobby level, etc.)

d. Front desk

- Physical space for interaction with patients should be optimized to reduce infection risk:

  - Practices may consider a partition/plexiglass divider in reception/front desk areas
  - Ideally, the design of the front desk area should be optimized to accommodate 6 feet of separation between persons
- Markings/lines on the floor are helpful to encourage social distancing and guide patient flow
- Practices should implement workflows to minimize the time spent by patients at the front desk pre- and post-evaluation, including the use of electronic check-in and check-out. IPads or other electronic means should be cleaned between uses.
- Ensure availability of surgical masks for reception staff
- Establish schedule for cleaning and disinfection of high-touch surfaces

e. Waiting room

- Ensure availability of hand hygiene products and disinfectant wipes or sprays. Expected increases in the usage rate of these products may increase replenishment frequency
- Develop designated COVID-19 positive (as indicated by PCR test) or suspected COVID-19 positive care areas by time (e.g., specific clinic sessions/day)
  - Where feasible, develop designated COVID-19 positive (as indicated by PCR test) or suspected COVID-19 positive care areas (e.g., side of waiting room, specific clinic rooms)
- Practices should evaluate the physical layout of the waiting room area and consider removing chairs to ensure seating is 6 feet apart. Consider alternatives to conventional waiting rooms which could serve as holding or staging areas, e.g. a cafeteria, car, underutilized corridors, 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 practice may need to set up a barrier (curtain) between chairs
- Practice staff should remove reading materials and other non-essential movable items from waiting rooms

f. Exam and break rooms

- Consider chronologic or spatial separation of exam/treatment rooms for COVID-19-positive or suspect patients from non-COVID-19 exam/treatment rooms
- Consider using visual aids to establish a “flag” system to help indicate the current state of the exam room: “clean”/“occupied”/“dirty”
- Ensure that appropriate staff is trained on room cleaning procedures.
- Evaluate size of the staff break room to ascertain safe occupancy limit (6 feet apart) and stagger meal breaks (time when staff are not wearing masks), if possible. Establish PPE guidance, occupancy limit, and a disinfecting/cleaning schedule

g. PPE

- Clinics should adhere to appropriate PPE usage for staff in accordance with BILH policies.
- Staff should provide all patient care following Standard precautions for all patient encounters. This involves the wearing of surgical masks in the clinic at all times, with the addition of eye protection for all patient care, as well as the use of gloves and a gown for care of patients with suspect or confirmed COVID-19.

h. Cleaning and disinfection protocols

- Clinics will follow new and enhanced cleaning protocols. Consider frequency and appropriate use of recommended cleaning products to
- Exam rooms, elevators, common spaces, bathrooms, and staff-facing infrastructure such as computers, keyboards, storage, etc., should be disinfected more frequently. Staff may play a role in keeping their work equipment clean and should not solely rely on the assistance of housekeeping staff. This is a shared responsibility for all who are working together in clinical and administrative spaces
- Clinics should follow standard procedures for cleaning shared medical equipment before and after each use.
- If available, establish locations for staff to take a shower, if desired
- Establish protocols for changing room locker use and cleaning

i. 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 providers and patients with deference to the provider's judgment
- To build patient confidence and trust, providers are encouraged to pursue meaningful interactions with patients and not feel the need to rush patient encounters while practicing safe social-distancing measures
- Practices should consider signage to inform patients of the 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)