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System-wide Recovery Guidelines

Team: **BILH Primary Care (BILHPC)**
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Introduction

In March 2020, the SARS-CoV-2 (COVID-19) global pandemic arrived in full force in Massachusetts resulting in a stay-at-home advisory from Governor Baker on March 24, 2020 with the closure of non-essential businesses. BILH responded swiftly to assure safe access to care for our patients and safe working environments for our care teams. Similarly, BILH Primary Care (BILHPC) rapidly set up a limited number of safe-cohort and high-acuity care sites for in-person care while immediately ramping up robust telemedicine capabilities. Currently, BILH is planning for our recovery as the COVID-19 pandemic begins to stabilize with decreasing new cases. In close partnership with the Governor's orders and BILH, BILHPC has developed six strategic priorities and initiatives to guide our recovery planning process, four of which are addressed in this document as part of the initial recovery (Phase I).

BILHPC's Recovery Plan includes a three-phased approach:

- Phase I: Staged re-opening post-surge
- Phase II: Transitioning from immediate reopening to the future
- Phase III: Envisioning and implementing Primary Care 2.0 post-COVID-19

This document provides a set of guidelines to help BILHPC practices plan for the resumption of in-person care as the COVID-19 pandemic evolves. The following guiding principles serve as the foundation for BILHPC's strategic priorities and initiatives:

- Resume **safe in-person** care **while optimizing remote care in a phased approach,** leveraging emerging best practices
- Engage BILHPC **key stakeholders and patients** in plans to reopen
- Envision, plan for, and implement Primary Care 2.0 **while fostering innovation and joy i**n the practice of medicine
- Advance **team-based patient-centered** care
- Support **patient and care team member health, wellness, and engagement**
- Ensure the creation of **a financially sustainable** model for care delivery
- Maintain situational awareness and be **nimble and flexible** in our response as circumstances evolve, including the potential for a future surge

The guidelines are organized into the following six strategic priorities and initiatives:

I. **Safety and Quality for our Patients and Care Team Members**
II. **Primary Care Operations**
III. **Care Team Experience**

IV. Communication
V. Patient Experience (addressed further in Phases II and III)
VI. Innovation (addressed further in Phases II and III)

With safety and quality for patients and caregivers as the number one guiding principle, this document outlines the details of Phase I reopening, acknowledging the complexity and vital importance of working in concert with the BILH Recovery Steering Committee and assuring a coordinated, effective patient-centered approach inclusive of care team members' needs. This opportunity allows for BILHPC and its legacy entities to continue to come together as a cohesive, coordinated primary care system for BILH. As the BILH mission statement says, "*Together, we can do more than we could do alone. There is far more strength in collaboration than there is in competition. We'll solve more problems. Help more people. Make more breakthroughs. Make a difference. Together, we have the ability to make the world healthier."*

Please note that the end of this document includes several appendices that provide further information on BILHPC's immediate next steps for re-opening, metrics for success, and framework for evaluating site re-opening.

Outlook

BILHPC is intentionally referring to our recovery plan as "Creating the Future of Primary Care". We view the challenges of the COVID-19 pandemic as an opportunity to accelerate our efforts to coalesce our legacy groups into a cohesive, integrated primary care enterprise. We view this period as a once-in-a-lifetime opportunity to reimagine the delivery of primary care and create what we are referring to as Primary Care 2.0, the care delivery model we and our patients have

always wanted – a model that allows us to consistently provide an outstanding experience for our patients and care team. We will do this in part by embracing the remarkable gains we've experienced in telemedicine to improve access for our patients and work-life balance for our providers.

The BILHPC guidelines for Phase 1 are organized into the following categories:

I. Safety and Quality for our Patients and Care Team Members
   a. Ensure adequate PPE supply and proper PPE use
   b. Standardize cleaning and disinfection protocols
   c. Mitigate exposure risk for patients and staff
   d. Communicate safety and patient triage protocols effectively
   e. Provide appropriate COVID-19 testing for patients in a timely manner
   f. Optimize workforce physical and psychological safety
   g. Maintain contingency plans to create capacity for potential surge
II. Primary Care Operations
   a. Patient prioritization
   b. Pre-arrival and screening
   c. Arrival
   d. Front desk
   e. Waiting room
   f. Exam and break rooms
   g. PPE
   h. Cleaning and disinfection protocols
   i. Changes to evaluations
III. Care Team Experience
   a. Identification of affected BILHPC care team members
   b. Modified debrief model
   c. Translation of findings into action items and recommendations
   d. Opportunities for care team member involvement and input
   e. Support and resources for care team members
   f. Promotion of organization-wide alignment
   g. Collaboration with Safety and Quality Taskforce on safety coach role
IV. Communication
   a. Goals and objectives
   b. Next steps
   c. Timeline

I. Safety and Quality for our Patients and Care Team Members

a. Ensure adequate PPE supply and proper PPE use

The provision of safe care is of paramount importance. Operations must be modified if patients and/or staff cannot be adequately protected from infection as a result of inadequate PPE supplies.

- Practices should adhere to appropriate PPE usage for staff and patients in line with BILH system policies
- Practices should:
  - **Project PPE usage** based on staffing and anticipated in-person visit volume
  - **Track PPE inventory and report PPE levels** via manager/local leadership up to BILHPC Incident Command
  - **Stock adequate PPE** supply on-site for staff, patients, and their escorts in order to maintain a safe environment
  - **Preserve PPE** by following current extended use and reuse recommendations
  - All care team members should be trained on proper donning and doffing techniques

If resumption of care results in an unsustainable increase in PPE usage, practice operations may need to be adjusted or held steady. In this scenario, practices should adapt preservation measures (and contingency plans) in coordination with leads overseeing the local supply situation.

b. Standardize cleaning and disinfection protocols

Standardized protocols for cleaning and disinfection of practice areas are a requirement for resuming in-person practice operations. Cleaning will involve daily cleaning by our staff and/or a sub-contracted cleaning company paired with appropriate surface disinfection of each room and treatment space, including patient equipment, between each patient encounter by the clinic staff.

- Practices should follow standard clinic space cleaning processes and frequency as specified by BILH protocols
  - Disinfect all desktops, counters, doorknobs and computer keyboards
  - Use approved germicidal wipes or sprays that are effective against human coronaviruses
- Use proper supplies and implement protocols for disinfecting exam rooms and equipment
  - Use approved disinfectants
  - Disinfect all shared medical equipment before and after each use (e.g., stethoscope, thermometer, pulse oximeter)
- Train MAs on proper cleaning and disinfection protocols

c. Mitigate exposure risk for patients and staff

- Universal precautions will be utilized at all times
- Designate specific hours for high-risk patient visits (e.g., infants <2yo, elderly, immunocompromised)
- 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)
- Reach out to scheduled patients on day of visit (day prior for next day AM visits) to screen for Influenza-like Illness (ILI) and COVID-19 symptoms as well as recent COVID-19 diagnosis and exposures
- Perform symptom and history screen of all patients and essential escorts by phone, including temperature, prior to all visits
    - Continue to enforce escort policy, as specified by BILH guidance
- Manage practice flow and facility set up to adhere to social distancing guidelines
- Manage patient schedule to allow time for cleaning and disinfection of exam rooms
    - 30-minute visit slots
    - 3 exam rooms per provider/care team, if possible
    - For patients with positive symptom/exposure screens in whom an aerosol-generating procedure (AGP) must be performed,
        - If negative pressure isolation room or portable HEPA are used, room should be vacant for 30 minutes before cleaning
        - If neither are available, wait 60 minutes after AGP prior to cleaning
    - For patients with negative symptom/exposure screens in whom an AGP must be performed, no wait time is necessary before cleaning
    - Patient roomed in each room every 60 minutes (unless need for 30 to 60-minute vacancy due to AGP in screen-positive patient)
- Minimize time spent in physical proximity with patients by maximizing history taking by telephone
    - Whenever possible, start the check-in process by phone regardless of whether patients are still in their cars or whether patients are arriving without a car and proceeding to the exam room immediately
    - MA escorts patient directly from car/practice entrance to exam room
    - MA and provider take history via phone outside of exam room
- Avoid bringing laptop computers into exam rooms

d. Communicate safety and patient triage protocols effectively

- Implement clear phone tree algorithms for each care team and set communication expectations (e.g., if using the trigger word tool and the patient has a red category symptom, keep the patient on phone while calling a clinical team member immediately)
- Implement daily safety briefings to discuss staffing, flow busters, safety issues, etc.

e. Provide appropriate COVID-19 testing for patients in a timely manner

- Educate providers and care team members about testing options and indications
- Maintain updated database of testing capacity and operational details
- Establish a reliable mechanism for closing the loop on test results

f. Optimize workforce physical and psychological safety

- Continue daily employee symptom screening and monitoring system
  - Adhere to BILH Employee Health policies, including policies for evaluation and work restriction, when symptomatic
  - Develop redundancy in staffing model in the event of employee illness
- Adhere to current BILH return to work 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
- Identify a care team member who will be the safety coach for each "re-opened" practice. The safety coach will support safety on the front lines by facilitating regular team safety briefings and sharing learnings/best practices with other safety coaches across BILHPC
- Implement standardized team safety briefings twice per day to foster situational awareness and solidarity

g. Maintain contingency plans to create capacity for potential surge

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)

III. Care Team Experience

BILHPC will optimize the experience, wellness, and engagement of all BILHPC care team members as we exit crisis mode, phase into recovery, and transition to a

new/future care model. The initial focus will be to gain a thorough understanding and assessment of the care team's experience in the recovery period.

a. **Identify all care team members of BILHPC whose experience is affected by the crisis, starting with direct care team members, followed by indirect care team members**

b. **Understand the current experience of our care team members as we come through the COVID-19 crisis through a modified debrief model approach**
   - Survey assessment adapted to all care team members (satisfaction, burnout, recovery, etc.)
   - Focus groups and huddles to gather additional data
   - Anecdotal collection of trends from leadership

c. **Translate trends, themes, findings, and data into clear action items and recommendations to guide the BILHPC's recovery team**
   - Emphasis on safety
   - Reconnecting with patients
   - Re-igniting care "team" and sense of community

d. **Create opportunities for involvement, input, and feedback for care team members in the recovery process and align recovery and future care models with optimal care team member experience**

e. **Provide care team members with an opportunity to participate in programmatic support and resources throughout legacy systems that are most specific and effective to COVID-19, including:**
   - Peer support programs
   - Huddles/focus groups
   - Self-care resources
   - EAP
   - Coaching
   - Learning collaborative
   - Others

f. **Sustain organization-wide communication avenues that promote alignment between care teams and leadership, including the weekly BILHPC COVID-19 Forum**

g. **Collaborate with Recovery Safety Task Force to add wellness and engagement to the safety coach's goals and responsibilities**

IV. Communication

Timely and effective communication to the community, patients, and care team members is essential for a successful Recovery Plan that imbues attention to safety,

radiates empathy and concern, and outlines details of recovery planning. The enormity of the impact COVID-19, social distancing, illness, deaths and a global pandemic have had on each individual's daily life must be taken into consideration as a comprehensive communication strategy is developed and implemented. BILHPC will communicate primary care recovery plans, including guidance, workflows, and processes, to patients, BILHPC care team members, and BILH leadership. The following outlines BILHPC's approach:

a. Goals and objectives

- Goal: Effectively communicate primary care recovery phase 1 plans to patients, BILHPC care team members, and BILH leadership, and the broader community
- Objectives:
    - Establish effective/reliable communication channels with multiple stakeholders
    - Be situationally responsive and agile
    - Signal to patients what we are specifically doing to address their concerns about returning to BILHPC for care
    - Continue to gather patient experience data and patient feedback (including from the Patient and Family Advisory Council) to improve future communications

b. Next steps

Immediate next steps during Phase I will include the development of tactics and messaging to communicate with patients, BILHPC care team members, and BILH leadership and broader community

- Acknowledgement of urgency for timely communication and plan for execution
- Develop communication plan with distribution dates that align with Phase I planning
- Development of the following:
    - Maintenance of internal distribution lists
    - Patient communication:
        - Create a process for patient communication development and approval
        - Distribution timeline
    - Care Team communication:
        - Create a process for care team communication development and approval
        - Distribution timeline
    - Messaging from:
        - BILH Marketing & Communication
        - BILHPC
        - Local and regional dyads
    - Scripting:
        - Develop and distribute scripting for practice phone calls (incoming and outgoing)

- Signage:
  - Consider patient-facing signage needs for offices/elevators/parking lots/facilities that communicates safety plans and guidance for accessing care
- Primary care page on BILH.org

c. Timeline

Completion of steps listed above by end of phase 1

Appendix A: Phase 1 - Immediate Next Steps and Metrics by Strategic Priority/Initiative

Safety and Quality for Patients and Care Team Members

Next Steps	Due Date	Metrics
Establish current PPE inventory and ensure adequate PPE stocked at all re-opened sites	5/15	PPE inventory data, burn rate
Distribute PPE use guidelines by email, post in re-opened sites	5/15	Report out by safety coaches at regular safety coach briefings
Develop or select and existing brief training video that staff working in re-opening sites should view re: proper donning and doffing techniques	5/15	Number of employees who have viewed the video
Develop and implement telephone scripting for front desk staff to use with patients when scheduling visit (scripting would include expectations about safe operations – e.g., wear mask, stay in car upon arrival)	5/15	
Ensure approved hospital-approved disinfectants with activity against human coronaviruses in stock at re-opening sites	5/15	
Develop training materials for MAs on proper cleaning and disinfection protocols	5/15	Number of employees who review the materials
Ensure trigger word tool exists in each re-opening site		
Develop/identify scripting for Outreach to scheduled patients on day of visit (day prior for next day AM visits) to screen for ILI symptoms	5/15	
Develop/identify protocol to Screen all patients again for COVID-19 and ILI symptoms (including temperature) upon arrival to practice	5/15	
Develop staffing schedule and phone trees for each site: Implement clear phone tree algorithms for each care team and set communication expectations (e.g., if red category symptom, keep patient on phone while calling clinical team member immediately)	5/15	
Develop a written safety briefing framework or video of how to conduct a safety briefing; implement safety briefings in re-opening sites by 5/18; to be led by designated safety coach	5/15	
Educate providers and care team members about testing options and clinical indications per current BILH guidance	Ongoing	
Maintain updated database of testing capacity and operational details	Ongoing	
Continue daily employee electronic symptom screening and monitoring system	Ongoing	
Develop redundancy in staffing model in the event of employee illness, in conjunction with operations team and regional leadership as needed	5/15	
Practice managers for re-opening sites should modify these common areas, based on space, to adhere to social distancing guidelines	5/15	
Documents posted to PC intranet, continue to present at various clinician forums	Ongoing	
Develop and implement additional telemedicine guidance re: privacy and security, prescribing, medical documentation	5/29	
Continue to gather patient experience data related to telemedicine visits and share these data regularly with clinicians and other care team members across BILHPC	Ongoing	

Next Steps	Due Date	Metrics
In conjunction with RIC clinical operations team and regional leadership as needed, determine location of re-opening sites to ensure equitable access	5/15	
Determine capabilities in re-opening sites implement any necessary improvements (e.g., phones in exam rooms) to support this capability	5/15 6/12	
Develop scripting and determine which care team member will perform the outreach	5/15	Track rate of successful outreach attempts (per attempted outreaches)
Develop and implement patient-facing communication to be distributed broadly via various modalities in conjunction with BILH Communications	Ongoing	
Continue to share feedback with PC community and develop/implement improvements across BILHPC based on this feedback	Ongoing	
Draft role description and training materials, identify care team member at each re-opening practice who will serve as safety coach	5/15	
Develop framework/outline for these briefings, implement safety coach briefings	5/15 5/22	
Stock sites with appropriate PPE per BILH guidelines	5/18	

Primary Care Operations

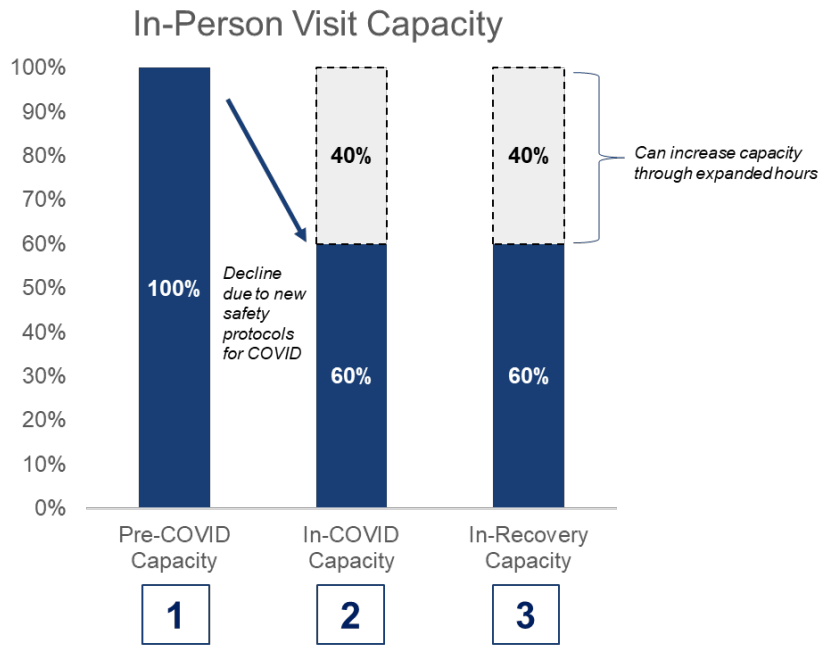
Next Steps	Metrics
Ensure adequate PPE supply and proper use	PPE usage rate PPE supplies on hand Feedback on in-person and televisits HCW acquisition of infection in health care settings
Implement new practice workflows to ensure safety for patients and caregivers	Current available capacity and expanded volume by cohort sites Volume at additional sites opened and volume type (in-person vs. telemedicine/telehealth) and type of patients evaluated in-person
Track patient/consumer sentiment	Proportion of in-person visits and televisits proportions System marketing survey to track consumer sentiment Reasons for in-person visits
Re-open additional sites as necessary	
Track percentage of providers doing in-person care	Staffing schedules to judge progress on % of providers doing in-person care

Care Team Experience

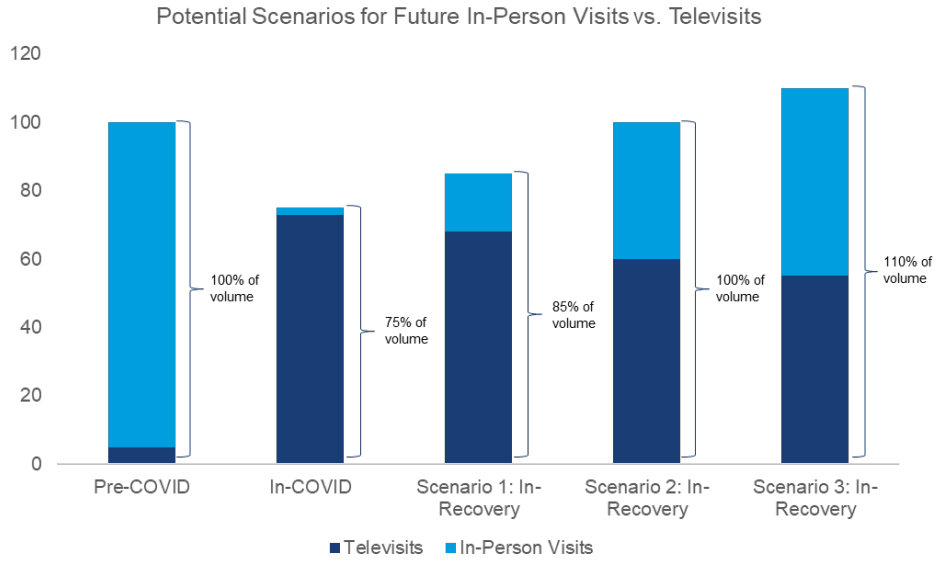
Next Steps	Due Date
Collect accurate data on current care team experience during early recovery	Survey 5/11/2020
Create tangible opportunities for involvement, input, and feedback for care team members in the recovery process	Forum 5/14/2020
Provide Recovery Steering Committee with tactical report/recommendations on how to develop a recovery care model that aligns with care team experience	5/18/2020
Expand peer support, focus groups, and team huddles	5-10 focus groups 5/15/2020

Appendix B: Framework for Re-Opening Additional Sites – Optimizing Cohort Capacity

The BILHPC Recovery Operations Team's framework for re-opening additional sites recognizes two key variables: safe in-person visit capacity and future proportion of in-person visits vs. televisits. Both of these factors will drive BILHPC's decision to open additional sites and in which geographies. The graph below illustrates how practices should consider capacity analyses.



1. Pre-COVID, we were operating at 100% of our in-person visit capacity
2. During the COVID crisis, in-person visit capacity is significantly reduced because it is defined by the safety parameters of the physical space and limitations on schedule to allow for safe patient flow
3. During COVID recovery, extended hours and weekend coverage can increase our in-person visit capacity but will be determined by factors such as staffing and provider / patient willingness



The future proportion of in-person visits vs. telemedicine will be defined by:

a) Patient sentiment and demand
b) Provider sentiment and experience
c) Regulatory agency and payer payment policies

Example Scorecard for Additional Sites

Rate 1-5

5 = Best Meets Criteria

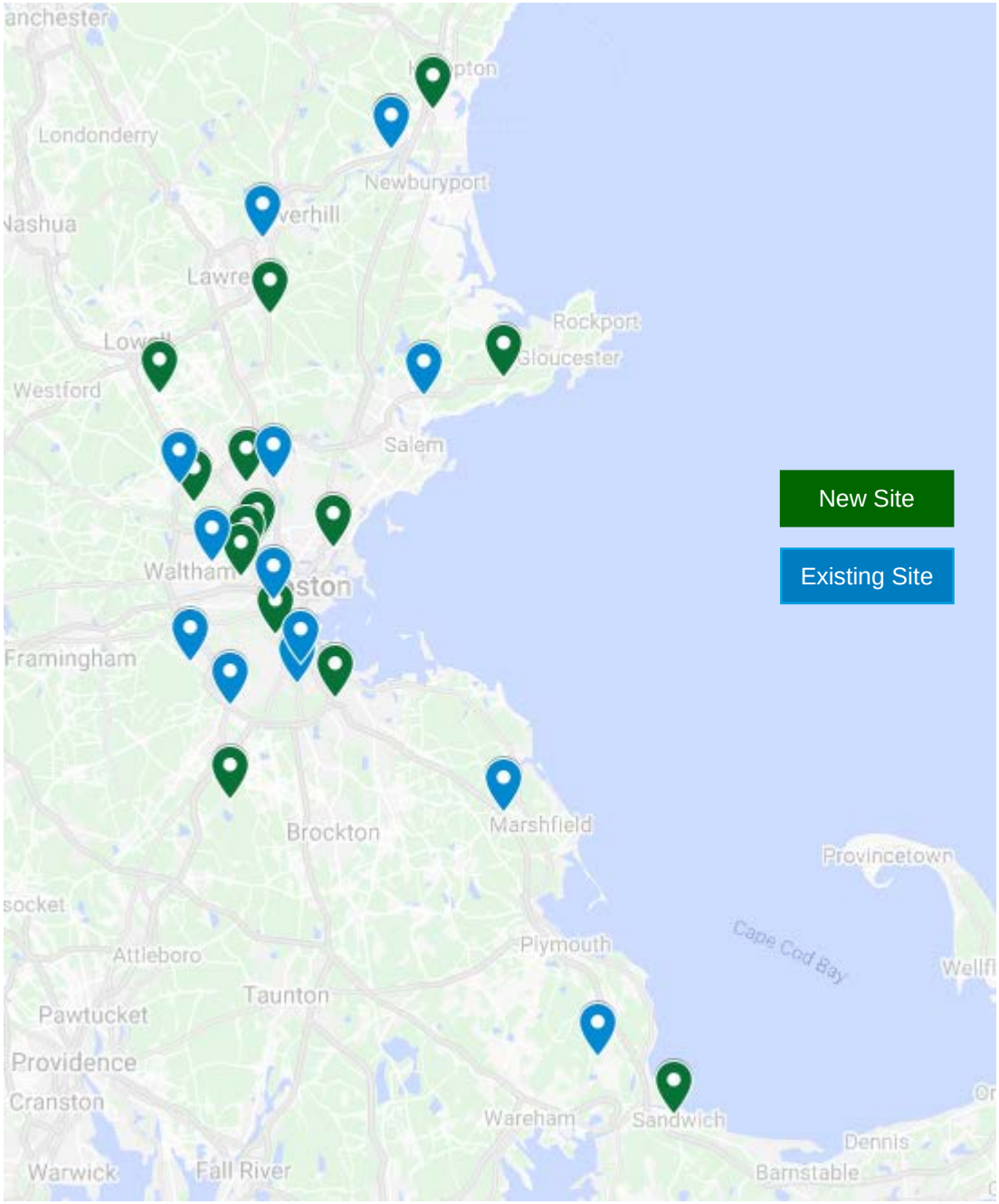
Practice Legacy Name **Practice Address**	**CGP Billerica** **267 Boston Post Road, Billerica MA**			
Access from Outside				
Private vs. Shared vs. Public Parking Lot	3			
Steps to Entrance (steps and corridor access)	5			
Separate/Multiple Entrances	5			
Handicap Access	5			
Size of Practice				
Available Exam Rooms	5			
Facilitate more than one "Team"	5			
Distancing for MAs	5			
Distancing for Medical Secretaries	3			
Private Provider Offices	5			
Location				
Proximity to Major Highways	5			
Central to other Sites/Patient Base	4			
Public Transportation	5			
Distance from Other Cohorts	4			
Ancillary Services				
Lab/Radiology Access	4			
Specialty Access	3			
Total Points	**66/75**			

Final Recommendation:	**Site**	**Points**	**Comment**
Existing Cohort Expansion			
New Access	CGP Billerica		

Appendix C: New and Existing Sites

Site Type	Site Name	Site Address	Notes
New Site	Lahey - Woburn Medical	23 Warren Avenue, Suite 100, Woburn, MA 01801	
New Site	Lahey - BILH Pediatrics (ABC)	29 Massachusetts Ave, Arlington, MA 02474	Pediatrics WC only
New Site	Lahey - LPCO FMA Manchester	195 School St., Manchester, MA 01944	
New Site	Lahey - CGP Billerica	267 Boston Post Rd., Billerica, MA 01862	
New Site	Lahey – MVFP	100 Bypass Road, N. Andover, MA 01845	
New Site	Lahey – Arlington	37 Broadway, Arlington, MA 02474	Internal medicine only
New Site	MAPS – Belmont Medical Associates	725 Concord Ave., Cambridge MA 02138	
New Site	MAPS – Lexington	57 Bedford St # 130, Lexington, MA 02420	
New Site	MAPS – MAMA	521 Mt Auburn St # 202, Watertown, MA 02472	
New Site	BIDHC – Seabrook	570 Lafayette Rd. Suite 901; Seabrook, NH	
New Site	BIDHC – Chelsea	1000 Broadway St. Chelsea, MA	
New Site	BIDHC - Jamaica Plain	3525 Washington St. Jamaica Plain, MA	Peds in AM; Adults in PM
New Site	BIDHC – Sharon	93 Pond St. Sharon, MA	
New Site	BIDHC - Crown Colony	700 Congress Street, Quincy, MA	
New Site	BIDHC - Sandwich	74 Route 6A, Sandwich, MA	

Type of Site	Site Name	Site Address	Notes
Non-ILI	Lahey - Stoneham	88 Montvale Avenue, Stoneham, MA 02180	
Non-ILI	Lahey - Amesbury	24 Morrill Place, Amesbury, MA 01913	
Non-ILI	Lahey - Beverly	30 Tozer Road, Beverly, MA 01915	
High-Acuity/Non-ILI	MAPS - Waltham	355 Waverly Oaks Road, Waltham, MA 02452	
High-Acuity	BIDHC – Needham	310 Chestnut Street, Needham, MA 02492	Original site located in Wellesley
High-Acuity	BIDHC - Lexington	24 Hartwell Avenue, Suite 204, Lexington, MA 02421	
High-Acuity	BIDHC - Milton	100 Highland Street, BID-Milton, Suite 105, Milton, MA 02186	
High-Acuity	BIDHC - Methuen	386 Merrimack Street, Methuen, MA 01844	
High-Acuity	BIDHC - Pembroke	295 Old Oak Street, Pembroke, MA 02359	
Infant Immunization	BIDHC - Dorchester	1100 Washington St., Suite 100, Dorchester, MA 02124	Will cover peds care
Infant Immunization	BIDHC - Family Medicine Dedham/Westwood	333 Elm St., Suite 220, Dedham, MA 02026	Will cover peds care
Infant Immunization	BIDHC - Family Medicine of Brookline	1101 Beacon St., Suite 4 East, Brookline, MA 02446	Will cover peds care
Infant Immunization	BIDHC - Redbrook	6 Greenside Way South, Suite 1, Plymouth, MA 02360	Will cover peds care
Infant Immunization	BIDHC - Amesbury	2 Goddard Ave., Amesbury, MA 01913	Will cover peds care


New Site
Existing Site
Londonderry
Newburyport
Lawrence
Rockport
Gloucester
Westford
Salem
Framingham
Brockton
Marshfield
Provincetown
Attleboro
Plymouth
Taunton
Pawtucket
Providence
Cranston
Wareham
Sandwich
Dennis
Barnstable
Warwick
Fall River