Massachusetts Department of Public Health Guidance Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) Phase 2: Cautious

NOTE: This further guidance incorporates the capacity criteria and public health and safety standards required for Phase 1: Start and outlines additional requirements for health care providers in Phase 2: Cautious, effective June 8, 2020.

I. Preamble and Purpose

As the Commonwealth continues to monitor trends to support its reopening strategy, recent data show that the impact of COVID-19 on the state's health care system is beginning to abate. Recognizing a need to begin to provide care deferred during the public health emergency[1], and that telehealth may not be feasible or clinically appropriate for all patients, the Department of Public Health (DPH) issued guidance on May 18 (updated on May 25) on the **Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals** ("Phase 1 Guidance"). The Phase 1 Guidance describes the scope of in-person services and attestation requirements for health care providers during Phase 1:Start of the Commonwealth's broader reopening strategy.

Building off of the Phase 1 Guidance, DPH issues this further guidance for how health care providers that are not acute care hospitals[2] can resume in-person provision of additional services and procedures in Phase 2: Cautious without jeopardizing health system capacity or the public health standards that are essential to protecting health care workers, patients, families, and the general public. This guidance does not apply to emergency care, which has been ongoing and will continue without limitation. DPH recognizes the importance of ensuring that this guidance promote equitable access to care, including high-priority preventative care, across all communities and patient populations, including low-income communities, communities of color, children, and individuals with disabilities.

The initial and ongoing implementation of this guidance is contingent on Massachusetts meeting a range of relevant capacity and public health metrics. Ongoing performance on these measures will inform additional reopening decisions for future phases.

[1] Elective Procedures Order. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/doc/march-15-2020-elective-procedures-order. Memorandum: Nonessential, Elective Invasive Procedures in Hospitals and Ambulatory Surgical Centers during the COVID-19 Outbreak. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/info-details/covid-19-state-of-emergency

[2] As used in this document, "hospital" means an acute care hospital, unless otherwise specified. For the purposes of this guidance, acute care hospitals shall not include comprehensive cancer centers, as defined in G.L. c. 118E, § 8A, or freestanding pediatric hospitals, as defined in 105 CMR 130.

II. Statewide and Hospital-Specific or Hospital System-Specific Capacity Criteria and Required Public Health and Safety Standards and for Entering Phase 2: Cautious

Beginning June 8, 2020, health care providers may be eligible to move into Phase 2 if the following capacity criteria, more fully described in Section II of the Phase 1 Guidance, continue to be met:

1.) **Statewide Intensive Care Unit (ICU) Bed Capacity:** The 7-day average of the number of available, staffed adult ICU beds statewide must be at least 30% of total staffed adult ICU beds (including staffed surge ICU beds).

2.) **Statewide Inpatient Bed Capacity:** The 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) statewide must be at least 30% of total staffed adult inpatient beds (including staffed surge beds).

In addition, health care providers must continue to be in compliance with the public health and safety standards described in Section IV of the Phase 1 Guidance, including specific criteria related to: a) personal protective equipment (PPE); b) workforce safety; c) patient safety; and d) infection control (see additional standards in Section III. B. below).

DPH will continue to monitor bed capacity at the statewide level and may suspend or limit provision of any of the procedures and services described in Section III of the Phase 1 Guidance or Section III of this guidance based on its determination that the available bed capacity is deemed to jeopardize overall health system's ability to respond to patient demand.

III. Guidance on Recommended Procedures and Services for Phase 2: Cautious

If the statewide criteria and public health and safety standards have been met in accordance with the Phase 1 Guidance, a health care provider may incrementally begin in-person delivery of in-person elective, non-urgent procedures and services, including routine office visits, subject to the following requirements and limitations.

A. Prioritization of Services in Phase 2

Health care providers must establish and adhere to a written prioritization policy for Phase 2 non-urgent care and scheduling. Health care providers must use their clinical judgment and their prioritization policy to determine which in-person services meet the criteria outlined below for in-person services in Phase 2. The prioritization policy should promote equitable access to care for all populations, without regard for patient's insurance type.

The health care provider's prioritization policy for scheduling and delivery of Phase 2 services must include the following six requirements:

1) Health care providers should continue to prioritize the use of telehealth services where clinically appropriate and feasible for a given patient.

2) For in-person services and procedures, health care providers should prioritize high-priority preventative services, pediatric care and immunizations, and urgent procedures that would lead to high risk or significant worsening of the patient's condition if deferred, as described in Phase 1 Guidance.

3) Health care providers should then identify and prioritize the patients and services that, based on the clinical determination of the hospital or hospital system and its providers, are most critical and time sensitive. In identifying patients and services and making its clinical determination, the health care provider should prioritize patients and services that meet the following criteria:

    a) Patients with acute illnesses that cannot be addressed through telehealth
    b) Patients with chronic illness, including but not limited to those that put patients at higher risk for complications from COVID-19
    c) Patients with behavioral health conditions, disability, and/or risk factors related to social determinants of health, without regard for patient's insurance type
    d) Adult preventive care clinically necessary to be performed in-person (including screening/diagnostic procedures)
    e) Patients with progressive conditions that will worsen without surgery or other intervention, or whose symptoms negatively affect their quality of life or ability to perform daily activities
    f) Patients needing in-person visits to monitor health status or assess progression of illness

4) Health care providers should consider deferring certain non-essential, elective procedures and services such as those that do not meet the prioritization criteria above and which are likely to produce high concentrations of respiratory droplets (aerosolization) and/or that could require or result in the use of a significant level of certain health care system resources (e.g., PPE and pharmaceutical supplies in short supply; transfusions; general hospital, ICU, and/or post-acute admissions).

5) Health care providers may provide in-person group treatment for behavioral health within the following parameters:

    a. Telehealth and/or in-person one-on-one treatment should be prioritized in lieu of group therapy when clinically appropriate
    b. In-person group treatment should only be utilized when, in the clinical judgment of the provider, the benefit significantly outweighs the risks for the participants, taking into account each individual's circumstances and medical and social risk factors
    c. No more than 6 people may be present in a single group treatment session or room, including participants, facilitators and/or treatment providers
    d. Rooms must be configured to ensure social distancing of at least 6 feet
    e. No food or drink may be served
    f. No physical contact or sharing of materials during a session

g. In-person group treatment sessions should be limited to the minimum amount of time that the provider determines is clinically effective (e.g., 60-90 minutes or less)
h. Providers must adhere to all other public health and safety standards described in this guidance and any other relevant guidance from CDC and DPH

6) Health care providers should not deliver the following services in Phase 2 and should postpone scheduling to future phases: 1) elective cosmetic procedures, and 2) day programs.

B. Safety Standards for Invasive Procedures and Services

In order to manage statewide PPE consumption rates, reduce COVID-19 transmission, ensure compliance with public health and safety standards, and maintain hospital capacity in case of further peaks in prevalence during Phase 2, health care providers should take steps to cautiously and incrementally resume non-essential, elective invasive procedures and services[3].

Specifically, for all non-essential, elective invasive procedures and services, providers must attest to monitoring patient volume in each facility, clinic, or office setting where such procedures and services are performed and must schedule patient visits in order to ensure:

1) Ongoing compliance with the public health and safety guidelines in Phase 1 Guidance (Section IV.) including, but not limited to, standards related to PPE supply and use, restricting the number of health care workers in the treatment space to those individuals necessary to complete the service or procedure for the patient, screening patients in advance of a service or procedure, administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas and minimizing contact between patients through scheduling modifications; and

2) Ongoing compliance with CDC requirements[4] and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated

[3] DPH defines nonessential, elective invasive procedures as procedures that are scheduled in advance because the procedure does not involve a medical emergency; provided, however, that terminating a pregnancy is not considered a nonessential, elective invasive procedure for the purpose of this guidance. However, the ultimate decision is based on clinical judgement by the caring physician.
Examples of nonessential, elective invasive procedures may include but are not limited to: any procedures involving skin incision; injections of any substance into a joint space or body cavity; orthopedic procedures (e.g. hip or knee replacement); endoscopy (e.g., colonoscopy, bronchoscopy, esophagogastric endoscopy, cystoscopy, percutaneous endoscopic gastronomy, J-tube placements, nephrostomy tube placements); invasive radiologic procedures; dermatology procedures (e.g. excision and deep cryotherapy for malignant lesions- excluding cryotherapy for benign lesions); invasive ophthalmic procedures including miscellaneous procedures involving implants; oral procedures (e.g. tooth extraction); podiatric invasive procedures (e.g., removal of ingrown toenail); skin or wound debridement; kidney stone lithotripsy; or colposcopy and/or endometrial biopsy
[4] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

timeframe necessary for sufficient air changes to remove air-borne contaminants[5], prior to the thorough cleaning and disinfection of the room and equipment, as required in the Phase 1 Guidance.

Providers should postpone any non-essential, elective procedure or service if these safety standards cannot be met.

IV. Compliance and Reporting

Attestation Form
Before delivering the services described in Section III of this guidance, health care providers must first attest, on a form prescribed by DPH [LINK], to continuing to meet all Phase 1 criteria and standards, and three additional conditions for Phase 2: Cautious:

1) The health care provider has established a prioritization policy for scheduling and delivery of Phase 2 non-urgent care in accordance with this guidance and is making clinical determinations about service provision in a manner consistent with health equity principles in such policy and this guidance.

2) The health care provider is monitoring patient volume for non-essential, elective invasive procedures and services, in each facility, clinic, or office setting where such procedures and services are performed and is scheduling patient visits in a manner consistent with this guidance.

3) The health care provider is in compliance with CDC requirements and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove air-borne contaminants, prior to the thorough cleaning and disinfection of the room and equipment, as required in the Phase 1 Guidance.

The attestation must be signed by the chief executive officer of a community health center[6] (CHC) and for other health care providers by the compliance leader responsible for internal compliance with these criteria. CHCs and other health care providers must maintain the signed attestation and make it available upon request of DPH at any time. Health care providers with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance leader has clinical and operational control over the other locations. Health care providers must prominently post a copy of the signed attestation form at each of its facilities, clinics, and office locations. Submission of the Phase 2 attestation form to DPH is not required.

[5] https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1
[6] For purposes of this guidance, the term "community health center" shall include Federally Qualified Health Centers and hospital-licensed community health centers.

Written Policies and Protocols
Health care providers must update and maintain written policies and protocols that meet or exceed the standards outlined in this guidance including the prioritization policy required in Section III of this guidance. Such policies, protocols, and documentation must be regularly updated and made available to DPH upon request at any time.

Compliance
DPH will monitor and assess compliance and may require remedial action or suspension of Phase 2: Cautious procedures and services as warranted.