CMG COMMUNITY MEDICAL GROUP

POST-COVID-19

PRACTICE RECOVERY TOOLKIT

June 2020 | 1st Edition

CMG COMMUNITY MEDICAL GROUP

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Introduction

Dear CMG Member,

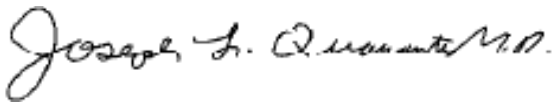
We have compiled a number of resources designed to help your practice begin to reopen and recover from the many challenges posed by the COVID-19 pandemic and resultant shelter-in-place orders.

Within this toolkit, you will find valuable information and resources that address the following:

- Practice Operations – including ways to implement safety measures for patients, clinicians, and employees and customer service recommendations.
- Clinical Operations – including guidance on personal protective equipment (PPE) and aerosol-generating procedures (AGPs).
- Business Operations and Legal Considerations – including malpractice/risk considerations and best practices for revenue cycle management (RCM).
- Human Resource (HR) Operations – including guidance for employers with workers at high risk for severe illness from COVID-19 and return-to-work criteria.
- Ways that the "new normal" will require a shift in strategy.

Our hope is that some or all of these tools may become a valuable resource for your practice, and support you as you strive to provide the best care for your patients.

Sincerely,



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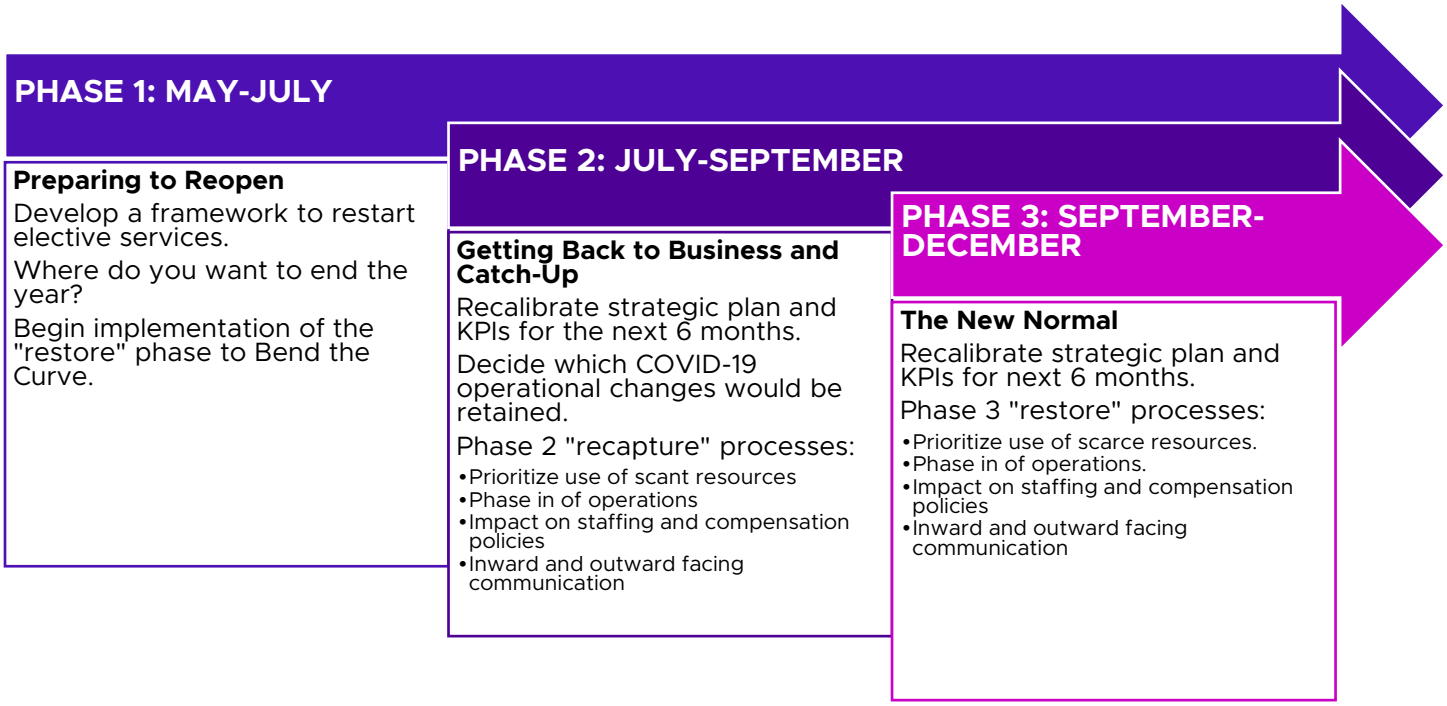
CMG President

Note: The COVID-19 guidance has continued to change frequently, even as this toolkit has been developed. It can be anticipated that the guidance will continue to be modified as the COVID-19 situation evolves. Please continue to monitor official sources—such as the CDC, OSHA, and your affiliated medical association—for the most up-to-date information.

Using the Ctrl-F Function to Locate Guidance: This toolkit provides a large amount of information about a wide range of relevant topics and navigating to specific guidance may be difficult at times. Please remember to use the **Ctrl-F function** on your keyboard, which allows you to type in keywords to help you quickly identify the resource you are looking for.

Returning to the New Normal: A Timeline



The timeline above summarizes how practices may choose to approach their reopening and recovery strategies through the remainder of 2020.

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PRACTICE OPERATIONS

Make a Plan | Preparation | Safety in the Workplace
Communication | Customer Service

As public health experts determine that it is safe to see patients and stay-at-home restrictions are relaxed, physician practices should strategically plan when and how best to provide face-to-face, non-emergent, non-COVID care**.** Communication, preparation, and policy review are necessary for patients to safely reestablish in-office care.

As a reminder, healthcare is an essential service; thus, the phase-in approach adopted by the State of Connecticut does not apply to physician practices.

MAKE A PLAN

Pre-opening planning will be vitally important to the success of your practice reopening. Sit down with a calendar and chart out your expected reopening day and, ideally, a period of "soft reopening" where you can reopen incrementally. This guide provides published checklists to help with the reopening process.

PREPARATION

Consider a step-wise approach to reopening so that the practice may quickly identify and address any practical challenges presented. Begin with a few in-person visits a day, working on a modified schedule. Administrative staff who do not need to be physically present in the office should be advised to work remotely when possible. Consider bringing employees back in phases, or working on alternating days or different parts of the day to reduce contact.

SAFETY IN THE WORKPLACE

Safety encompasses patients, clinicians and office employees. Here are recommendations to provide a safe physical environment.

Building Ventilation Systems:

- Ensure building ventilation systems are working properly and appropriately maintained.
- For offices with central HVAC systems, ensure that the system is adjusted in such a way that dilution and filtration are maximized and that dampers are fully open to bring as much fresh, outdoor air into the system as possible.
- Change system filters according to the manufacturers' specifications and utilize the highest-rated filter possible (MERV rating) that is compatible with your system.
- For offices without central HVAC systems, ensure that standalone units (e.g., window air conditioning units) are maximizing outdoor air brought into the space.
- Be careful to ensure that examination rooms are not becoming pressurized and pushing room air into common areas (i.e., neutral airflow).

Institute Safety Measures for Patients:

- If practice has multiple clinical sites, consider designating one as a "well" clinic for preventative care.
- To ensure that patients are not coming into close contact with one another, utilize a modified schedule to avoid high volume or density.

- Switch between in-person evaluations and telemedicine encounters to allow for less patient-to-patient contact.
- When possible, designate separate waiting areas for "well" and "sick" patients in practices where sick patients need to continue to be seen.
- If separate waiting rooms are not an option, consider dividing the appointment schedule to see "well" patients in the morning clinic, and "sick" patients in the afternoon clinic.
- Consider waiving cancellation policies so patients are not compelled to keep appointments to avoid charges.
- Use pre-appointment triage calls to assess patient symptoms.
- Place signs outside of your office asking patients to call before coming inside if they have symptoms of fever, cough, or shortness of breath.
    - **Best practice:** Instruct all patients to call upon arrival to the office; use signage on door as a reminder.
- Advise patients to wait in their vehicle or outdoors until exam room available.
- Advise against arriving 15 minutes early to appointment.
- Remind patients to bring their own mask and to wear it while in the medical office; provide masks to patients if they do not have them.
- Screen patients for fever and other symptoms of COVID-19 before entering office.
- Provide tissues, alcohol-based cleansers, soap and paper towels at sinks and no touch trash receptacles.
- Hang posters or signs with COVID-19 safety instructions (e.g., safe hand washing, how to put on a mask, cough etiquette, etc.)

Institute Safety Measures for Clinicians and Employees:

- Require all staff wear personal protective equipment (PPE) (e.g. , surgical facemasks or N95 respirator masks for aerosolizing procedures such as nebulizer administration)
    - Know PPE requirements for patient care.
    - Require staff to be trained on indications for and proper donning and doffing of PPE.
        - See CDC poster on donning and doffing PPE in Resources section.
    - Implement a strategy to optimize use of PPE following CDC guidance for extended use and reuse of PPE.
- Require staff be trained on respiratory and hand hygiene, the proper techniques for using alcohol- based hand sanitizers and washing hands with soap and water.
- Limit patient companions to individuals whose participation in the appointment is necessary based on the patient's situation (e.g., parents of children, offspring, spouse).
- Post all patient forms online and have patients complete before arrival.
- Install physical barriers between patients and staff, e.g., plexiglass.
- Evaluate patient flow, assess whether separate points of entry and exit from clinical areas are available.
- Schedule after visit follow up appointments and referrals by phone.
- Plan in advance how you will handle staffing and cleaning if an employee or patient or visitor is diagnosed with COVID-19 after being in the clinic.

- Evaluate CDC recommendations for determining when and how long employees who interacted with a diagnosed patient should be out of the clinic.
- Communicate personnel health requirements clearly to clinicians and staff. Employees should not present to work with a fever or other symptoms of COVID-19, or if recently in direct contact with a person who has tested positive for COVID-19.
- Screen employees for fever and other symptoms of COVID-19. Minimize contact as much as possible. This includes during the employee screening process, as employees conducting temperature checks have been the potential sources of spread in some workplaces.
- Consider rearranging open work areas to increase physical distance between employees.
- Consider having dedicated workstations and patient rooms to minimize the number of people touching the same equipment.
- Establish open communication with facilities management regarding cleaning schedules and protocols regarding shared spaces (e.g. kitchens, bathrooms), as well as reporting of COVID-19 positive employees in the office building.
- Ensure that any other businesses and employers sharing the same workspace also follow this guidance.
- Perform an inventory of needed supplies and have these delivered in advance before you reopen so that sporadic deliveries and other visitors do not disrupt the order of your daily plan.

Institute Safety Measures for the Waiting Room:

- Provide patients with a mask if they need one.
- Remove amenities non-essential to businesses' main function, including all customer-facing water and coffee machines, toys, plants, magazines/reading materials, remote controls, tables and flat surfaces. Patients should take coats and other belongings with them into exam rooms.
- Physically distance chairs in the waiting room (minimum of six feet apart) or close waiting room and repurpose the space.
- Limit seating or label chairs to maintain social distancing. Supply only enough seating to support social distancing or, ideally, ask patients to remain in their cars if staff is not ready to see them immediately.
- Place visible markers in front of check in desk, etc., to maintain social distancing.
- Request credit card information to be kept on file to eliminate transaction with plastic cards or paper checks and cash.

Institute Safety Measures for the Rest Rooms:

- When possible, designate bathrooms for staff use or patient use.
- When urine specimen is needed, recommend patients collect urine at home.
- Eliminate use of air dryers and provide paper towels and no touch waste receptacles.
- Post signage in bathrooms regarding hand hygiene.

Institute Safety Measures for the Exam Room:

- Create separate, non-COVID care zones to reduce risk of COVID-19 exposure and transmission.
- Remove all but essential equipment. Remove contents of storage cabinets, clipboards, pens, anatomical models, etc.
- Keep disposable equipment and supplies outside of exam rooms to prevent theft and contamination.
- Keep computer equipment outside of exam rooms.
- Clean frequently used surfaces and equipment in-between patient visits with approved disinfectants for use against COVID-19.

Keep Disinfection Checklist and Log:

- To ensure that items are disinfected regularly, it can be helpful to create a protocol or checklist.
- Include details such as frequency, which cleaning product to use, and how often the tasks should be performed.
- Create and maintain a written log to keep track of your disinfection activities.
- The log should have a separate line item for each area that has a documented disinfection process.
- Add a section for the date and time the disinfection took place, and the name of the person responsible for the task.
- Include a space for the responsible person to add their initials, indicating the processes were completed.

Room Turnover Workflow Recommendations:

- Keep all clinic area surfaces clear from clutter to facilitate cleaning. Limit presence of fomites within the room.
- The person cleaning the room should wear gloves.
- Change paper on exam table. Wipe exam table and all touch surfaces (countertops, door knobs, cabinet handles, tables, EKG machine and leads, keyboards, etc.) and patient equipment with approved disinfectant wipes (2 minute wet time) or any standard brand disinfectant.
- At end of day, complete enhanced patient care area cleaning, including:
    - Disinfect any soiled areas using approved cleaning product.
    - Clean the floor.
    - Wipe exam table and all touch surfaces (countertops, cabinetry, doorknobs, cabinet handles, tables, EKG machine and leads, keyboards, etc.).
    - Wipe patient equipment with approved cleaning product (2 minutes' wet time).
- Staff are to clean all rooms between patients with disinfectant, as if each patient is COVID+.

COMMUNICATION

The most important intervention in the post COVID-19 recovery period is communication.
Communication needs to occur with patients, employees, other clinical personnel and the public. Communication takes many forms, including verbally through voicemail messages, conversation and audiovisual means; and in writing through portals, text messaging, letters, social media and website updates.

- **As you begin to resume operations in your "new normal", it is imperative to communicate with your staff, covering physicians and answering service.** Be sure to openly address sensitive issues like missing staff members, increased or decreased hours, and other changes.
- **Share important information with patients regarding the state of your practice, including scheduled days or hours of operation and how to get their appointments back on the schedule.** Publish this information everywhere, including in targeted emails to patients, on social media, and on your website.
- **Ensure that your online practice information is correct and up-to-date.** Not just on your website, but also in payor profiles or directories – add telemedicine as a service if you are now offering it.
- **Check review sites like Yelp, Vitals.com, and healthgrades.com for profiles that were made without your knowledge and permission.** Search for and claim listings for both your name and the practice's name; you may have more than one listing per site. Once claimed, you can make the appropriate updates.
- **Consider recording a video of your practice showing all the precautions you have undertaken for your patients' and staff's safety.** Show staff wearing masks and gloves or in PPE gear. Capture them in action disinfecting door handles, light switches, work surfaces, and so on. Upload the video to your practice website and share it across social media platforms.
- **Reactivate/update any automated messaging**—including those in your telephone tree, voicemail messages, email autoreplies, within software for text messaging and appointment reminders, and in marketing communications.
- **Engage your team in the design of new office policies and procedures**–including back up staffing plans for illness or quarantine.
- **Update emergency contact list for staff and key business partners**—including DPH, vendors and suppliers, payers, billing support.

CUSTOMER SERVICE

Great customer service experiences leave lasting impressions on patients. The better the service, the more likely patients will return as well as tell their family and friends about their experience.

Rekindle your relationship with patients by telling them they have been missed. Ask how they have been faring, not just feeling. Patients have been dealing with a prolonged time of uncertainty, financial strain, and social isolation, so take the opportunity to screen for behavioral health issues such as sleep disturbance, anxiety, and substance abuse. You may be able to assist them with more than their presenting problem.

Create a process for returning patient calls, pointing out the changes from pre-COVID-19 procedures. Assess reasons for any excessive patient wait times. Studies show that patient wait times play a key role in satisfaction ratings. Allow staff to interrupt you in the exam room if delays become longer than expected to help move things along. Using an agreed upon verbal signal, such as, "I'm so sorry to interrupt, but Dr. Wait is on the phone for you." This would allow you to leave the room gracefully without making patients feeling robbed of their time with you.

Other customer service best practices include:

- Acknowledge and welcome patients by name.
- Pick up incoming telephone calls within three rings.
- When placing callers on hold, ask first, and let them answer. It may be an emergency!
- Create and distribute a welcome packet that informs new patients of policies and services.
- If wait times are longer than expected, keep patients informed and provide an updated timeframe, if possible.
- Keep personal cell phones and food out of patients' sight.
- Tell patients what to expect during their appointment or procedure.
- Show your appreciation – thank patients for coming in.
- Ask patients to submit their reviews on social media.

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CLINICAL OPERATIONS

Patient Management in Office | PPE | Prioritizing Patient Scheduling People Who Are at Higher Risk for Severe Illness | Screen Patients before In-Person Visits | Pre-Visit Screening Script Template Maximize the Value of the In-Person Visit | COVID-19 Testing Strategy for Practices | Clinical Decompensation and the ED Adult/Pediatric Treatment Guidelines

PERSONAL PROTECTIVE EQUIPMENT (PPE) AND OTHER EQUIPMENT CONSIDERATIONS

Given the scarcity of PPE resources, office-based procedures must be evaluated based on availability of supplies and patient need.

- ✓ Require all staff to wear PPE, minimally a facemask.
- ✓ Require staff to be trained on respiratory and hand hygiene, including the correct use of using alcohol-based hand sanitizer and washing hands with soap and water.
- ✓ Confirm that staff members know the proper way to don/doff and dispose of used/soiled PPE. (See CDC poster on donning and doffing PPE in Resources section.)
- ✓ Implement a strategy to optimize the use of PPE following CDC guidance for extended use and reuse of PPE.
- ✓ Reconsider any procedure that increases aerosol transmission. Nebulizer treatments, pulmonary function tests, and throat swabs are common procedures that increase risk of large-droplet transmission.
- ✓ Patients living in congregate living settings may be at higher risk of COVID transmission and should be treated accordingly.
- ✓ Follow CDC guidelines for handling of clinical specimens and medical waste.
- ✓ Clean equipment that is utilized between patients or patient rooms. Consider phones, pens, clipboards, scales, blood pressure cuffs, otoscopes, stethoscopes, thermometers, and non-disposable PPE— such as face shields and goggles.
- ✓ Refer to Tables I-V on the following pages for ambulatory recommendations for PPE and infection control.

Information about Respirators:

- ✓ Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard. HCP should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- ✓ Under certain circumstances, extended use and reuse of N95 respirators can be managed in the clinical environment. CDC guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances.
- ✓ Decontamination and Reuse of Filtering Facepiece Respirators
- ✓ Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings
- ✓ NIOSH - Information about Respirators
- ✓ OSHA Respiratory Protection

Filtering Facepiece Respirators (FFR) including N95 Respirators

- ✓ To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one. This is called “fit testing” and is usually done in a workplace where respirators are used.
- ✓ Three Key Factors for an N95 Respirator to Be Effective

- ✓ FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- ✓ Learn more about how to perform a user seal check.

For a listing of approved N95 manufacturers, go to:
https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html

Table I. Ambulatory Recommendations for PPE Use/Infection Prevention (5/13/20)

Category	Population	Location Examples	PPE Staff/Clinician	PPE Patient	Additional Notes
Routine Care (Negative Entrance Screen)	•Not an active COVID patient •Not a COVID suspect •COVID patient >14 days since symptom onset	•Infusion centers •Specialty offices •Pediatrics •Primary care/walk-in •Dialysis	•Face mask •Social distancing •Eye protection when clinically indicated	Provide face mask if not wearing one	•Deep clean office daily •See "room turnover recommendations"
Routine Care (Positive Entrance Screen)	Postpone visit and send for testing unless emergent. If emergent, refer to COVID Precautions.				
Office-based Procedures			•Non-AGP require face mask and eye protection •PPE for AGP can be found in Appendix A & B	Provide face mask if not wearing one	•Enhance cleaning per protocols
COVID Precautions	•COVID suspect •COVID confirmed (on isolation) •New respiratory symptoms •Recent travel •COHORTED SITES	•Designated radiology COVID precaution sites •Designated lab COVID precaution sites •Private infusion or negative pressure rooms, includes neutropenic fever evaluation	•Respirator, eye protection, gown, gloves •Social distancing	Provide face mask if not wearing one	•COHORT by location •COHORT within building and by appointment time (end of day) for alternative sites •Clean room, including wet wipe of all surfaces, knobs, handles, computers, or contact Environmental Health Services (EHS) •Rest the room for 1 hour (not necessary if subsequent patient is known COVID+)

Table II. Aerosol-Generating Procedures (AGP) For COVID Negative/Not Suspected Patients (5/13/20)

	HR[1]-AGP?	Negative Pressure	Regular Pressure	PPE	Comments
Devices/Treatments/Anesthesia					
Nasal cannula	No	No	In a room by themselves	Face mask and standard precautions	If not in a room by themselves, recommend COVID testing within 24 hours of INITIATION. Curtain should be drawn between 2 patients.
High flow nasal cannula	Yes	No			If not in a room by themselves, recommend COVID testing within 24 hrs of INITIATION (for intermittent treatments/device, only one time recommended). Curtain should be drawn between 2 patients.
Nebulized medications (use for strong clinical necessity)	No	No			
Aerosol mask, cold steam mask, or venture mask	No	No			
High flow mask	Yes	No			
Non-invasive ventilation (BIPAP/CPAP)	Yes	No			
Chest physiotherapy	Yes	No			
Chronic tracheostomy	Yes	No			Ask pt to wear paper mask over trach when HCP in room
Closed suctioning (closed in-line, oropharyngeal, trach provided via closed circuit device for spontaneously breathing patients)	Yes	No			If repeated suctioning is anticipated AND not in a room by themselves, recommend COVID testing within 24 hrs of INITATION and curtain drawn between 2 patients
Open suctioning	Yes	No			
Extubation	Yes	No		Respirator, eye protection, isolation[2] gown and gloves	If pt is not in a room by themselves, draw curtain.
Sputum induction	Yes	Strongly recommend	Not recommended		Usually r/o TB
Tracheostomy with trials off vent	Yes	No	In a room by themselves		Trials off the ventilator should be done by attaching the trach to a closed, filtered system and then deflating.
Tracheostomy inner cannula changes	Yes	No			
Nasopharyngeal specimen collection, aspiration, washing	Yes	No			If pt is not in a room by themselves, draw the curtain between 2 patients
Feeding tube placement	Yes	No			
CPR	Yes	No	Isolate as much as possible	Respirator, eye protection, bouffant/balaclava, procedure[3] gown, double gloves, foot cover	
Bag mask ventilation	Yes	No			
Intubation	Yes	No			
Cardiac rehabilitation	No	No	In a room by themselves	Face mask and standard precautions	
PT/OT/ST	No	No			

	HR[1]-AGP?	Negative Pressure	Regular Pressure	PPE	Comments
Interventions/Procedures/OR					
Bronchoscopy, including fiberoptic bronchoscopy	Yes	Strongly recommend	In a room by themselves	Respirator, eye protection, bouffant/balaclava, procedure[3] gown, double gloves, foot cover	COVID testing within 2 calendar days of procedure is recommended.
GI tract endoscopy	Yes	Not necessary			
Pain procedure	No	No		Face mask and standard precautions Respirator, eye protection, isolation[2] gown, and gloves	
Urologic procedure (prostate biopsy, cysto)	No	No			
Surgery entering the mouth, sinuses, or airways (e.g., some ENT/dental)	Yes	No			
Procedures that enter the lung or airways	Yes	Yes			
Laparoscopic surgeries	No	No		Face mask and standard precautions	
Other cardiac surgeries	No	No			

[1]High Risk, [2]Isolation Gowns = non-sterile, semi-fluid resistant, [3]Procedure gown = non-sterile, fluid resistant

For the aerosol-generating portions of anesthesia (e.g., intubation, extubation), limit presence in the room to essential staff. All staff in the room for the aerosol-generating portions of anesthesia must wear a Respirator and Eye Protection.

Table III. Aerosol-Generating Procedures (AGP) For COVID Positive and PUI Patients (5/13/20)

	HR[1]-AGP?	Negative Pressure	Regular Pressure	PPE	Comments
Devices/Treatments/Anesthesia					
Nasal cannula (≤6 liters)	No	Recommended if available	Permitted	Respirator, eye protection, isolation[2] gown, and gloves	
Nebulized medications (use only for strong clinical necessity)	No				Door is closed. PUI always in room by themselves (see neb notes)
Sputum induction	Yes				AVOID
High flow nasal cannula		Strongly recommended	Not recommended	Respirator, eye protection, isolation[2] gown, and gloves	Discouraged unless clinically necessary
High flow mask					AVOID
Non-invasive ventilation (BIPAP/CPAP)		Strongly recommended	Not recommended	Respirator, eye protection, isolation[2] gown, and gloves	Discouraged unless clinically necessary
Nasopharyngeal specimen collection, aspiration, washing		Recommended if available	Permitted		
Feeding tube placement					
Tracheostomy with trials off the ventilator		Strongly recommended			Trials off the ventilator should be done by attaching the trach to a closed, filtered system and then deflating the cuff. Door is closed.
Tracheostomy inner cannula changes					Door is closed.
Open suctioning		Recommended if available			
CPR				Respirator, eye protection, bouffant/balaclava, procedure[3] gown, double gloves, foot cover	
Bag mask ventilation					
Intubation		Strongly recommended			
Extubation		Recommended if available			
Bronchoscopy					AVOID
GI tract endoscopy		Strongly recommended	Not recommended	Respirator, eye protection, bouffant/balaclava, procedure[3] gown, double gloves, foot cover	
Chronic tracheostomy		Recommended if available	Permitted		RT to place closed, filtered system
Chest physiotherapy		Strongly recommended	Not recommended		Restricted to patients with strong clinical necessity.
Interventions/Procedures/OR					
Any COVID positive or PUI	Yes			Respirator, eye protection, isolation[2] gown, and gloves	

[1]High Risk, [2]Isolation Gowns = non-sterile, semi-fluid resistant, [3]Procedure gown = non-sterile, fluid resistant

Sterile Procedure Considerations:

- Sterile gowns should only be used for the sterile part of the procedure
- Refer to above for use of non-sterile fluid-resistant gowns for non-sterile procedures
- Surgical masks should be used by those at the sterile field
- Surgeon, Assistant(s) and Surgical Tech should wear double gloves per usual standard.
- Shoe coverings should be worn if they are indicated as part of standard precautions

Table IV. Aerosol-Generating Procedures Often Performed in the Primary Care Setting (Updated 5/26/20)

HIGH RISK OF GENERATING AEROSOLS	MEDIUM RISK OF GENERATING AEROSOLS	LOWEST RISK OF GENERATING AEROSOLS
N95/PAPR always required during procedure and for duration of room closure* after procedure performed.	**If there is strong clinical suspicion of COVID-19 (e.g., new fever/respiratory deterioration) or if patient is known COVID positive, follow high-risk guidelines (N95/PAPR always required). If there is no clinical suspicion of COVID-19, follow low-risk guidelines (N95/PAPR and room closure NOT recommended).**	**N95/PAPR and room closure NOT recommended.**
•Sputum induction •Pulmonary function testing •Breath alcohol testing •Bag mask ventilation •CPR (Cardiopulmonary resuscitation) •Airway procedures (e.g. nasopharyngeal endoscopy, surgical airway, tracheostomy) •Esophageal procedures (e.g. Upper GI endoscopy, TEE) in a non-intubated patient	•Positive airway pressure therapy (e.g. BPAP, CPAP) provided a viral filter is in place •High flow oxygen delivered >15 L/min (e.g. Simple mask, Non-rebreather, OxyMask, Venturi Mask, Cold mist) •High flow nasal cannula >6 L/min (e.g. OptiFlow, VapoTherm, Nasal Pendant) •Nebulizer treatment NOT delivered by breath actuated nebulizer (e.g., AEROEclipse) •AEROBIKA •Exhaled nitric oxide testing •Dysphagia evaluation •Insertion of a gastric tube (e.g. NG, OG) which could generate a strong cough •Transpleural procedures without significant risk of a pressurized air leak (e.g. CT guided lung biopsy, thoracentesis, pleural tube placement for pleural effusion, pleural catheter removal without positive pressure ventilation, pleural catheters to suction or water seal)	•Closed face mask (e.g. Simple mask, Non-rebreather, OxyMask, Venturi Mask, Cold mist) or trach collar with oxygen flow rates of <15L/min •Nasal cannula (<6L/min) •Nebulizer treatment delivered by metered dose inhaler (MDI) or breath actuated nebulizer (e.g. AEROEclipse) •Incentive spirometry provided a viral filter is in place (standard at Rochester) •Physiologic (non-induced) coughing •Nasopharyngeal swab collection •Oropharyngeal suctioning •Basic dental examinations and fluoride administration, panoramic radiographs, intraoral radiographs, cephalometric radiographs, Cone Beam radiographs and photographs •Wound care/lavage •Practices which induce or include physiologic heavy breathing (e. g. cardiac stress testing, induced exercise during PT/OT, pulmonary rehabilitation)

Table V. Aerosol-Generating Procedure Recommendations for COVID Negative/Non-PUI Patients (5/13/20)

AEROSOL-GENERATING PROCEDURES	
Require Respiratory/Eye Protection	**Respirators Not Recommended**
•Endotracheal intubation •Bronchoscopy, including fiberoptic bronchoscopy •Sputum induction •Pulmonary function testing •Bag mask ventilation •CPR (Cardiopulmonary resuscitation) •Procedures entering the lungs, sinuses, mouth, or airway (e.g. nasopharyngeal endoscopy, surgical airway, ENT) •Esophageal procedures (e.g. Upper GI endoscopy, TEE) •Dental procedures that are not listed in other column •Procedures where pressurized air from the pleural space or pulmonary parenchyma escapes into the environment •Tracheostomy with Inner Cannula Changes •Tracheostomy with Trials off the ventilator •GI Tract Endoscopy •Insertion of a gastric tube (e.g. NG, OG) •Nasopharyngeal swab collection •Extubation	•Closed circuit mechanical ventilation (includes patients' own device) with a viral filter in place without circuit disconnection, or with brief (<1 min) disconnection with the ventilator in standby •BiPAP, CPAP •Closed in-line tracheal suctioning •Insertion of a gastric tube (e.g. NG, OG) •Open tracheal suctioning •Oropharyngeal suctioning •Tracheostomy suctioning provided via closed circuit suction device for spontaneously breathing patients •Chronic tracheostomy •Nasal cannula (<6L/min), High Flow nasal cannula •Closed face mask (e.g. High Flow, Non-rebreather, OxyMask, Venturi Mask, Cold steam, aerosol) with oxygen flow rates of <15L/min •Nebulizer treatment or metered dose inhaler (MDI) •Incentive spirometry provided a viral filter is in place •Physiologic (non-induced) coughing, chest physiotherapy •Laparoscopic surgeries •Basic dental exams and fluoride administration, panoramic radiographs, intraoral radiographs, cephalometric radiographs, Cone Beam radiographs and photographs •Exhaled nitric oxide testing •AEROBIKA •Dysphagia evaluation •Transpleural procedures without significant risk of a pressurized air leak (e.g. CT guided lung biopsy, thoracentesis, pleural tube placement for pleural effusion, pleural catheter removal without positive pressure ventilation, pleural catheters to suction or water seal) •Second stage labor •Wound care/ lavage •Pain procedure •Urologic procedure (i.e. prostate biopsy, cystoscopy) •Cardiac rehabilitation, PT/OT/ST •Other Cardiac procedures not listed on the left

Note: A Fit Tested Respirator and eye protection is recommended for all aerosol generating procedures involving a COVID patient/PUI. Please refer to the appendix for detailed recommendations based on the availability of a negative pressure room. The following AGPs are to be avoided, if possible, in the COVID patient/PUI: sputum induction, use of a high flow mask and bronchoscopy.

Understanding the Difference

	 Surgical Mask	 N95 Respirator	 Elastomeric Half Facepiece Respirator
Testing and Approval	Cleared by the U.S. Food and Drug Administration (FDA)	Evaluated, tested, and approved by NIOSH as per the requirements in 42 CFR Part 84*	Evaluated, tested, and approved by NIOSH as per the requirements in 42 CFR Part 84
Intended Use and Purpose	Fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids. Protects the patient from the wearer's respiratory emissions.	Reduces wearer's exposure to particles including small particle aerosols and large droplets (only non-oil aerosols)	Reusable device made of synthetic or rubber material
Face Seal Fit	Loose-fitting	Tight-fitting	Tight-fitting
Fit Testing Requirement	No	Yes	Yes
Designed for Reuse	No	No	Yes
User Seal Check	No	Yes. Required each time the respirator is donned (put on)	Yes. Required each time the respirator is donned (put on)
Filtration	Does NOT provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection	Filters out at least 95% of airborne particles including large and small particles	May be equipped with filters that block 95%, 99%, or 100% of very small particulates. Also may be equipped to protect against vapors/gases.
Leakage	Leakage occurs around the edge of the mask when user inhales	When properly fitted and donned, minimal leakage occurs around edges of the respirator when user inhales	When properly fitted and donned, minimal leakage occurs around edges of the respirator when user inhales
Use Limitations	Disposable. Discard after each patient encounter.	Ideally should be discarded after each patient encounter and after aerosol-generating procedures. It should also be discarded when it becomes damaged or deformed; no longer forms an effective seal to the face; becomes wet or visibly dirty; breathing becomes difficult; or if it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids.	Reusable and must be cleaned/ disinfected and stored between each patient interaction

*As of July 2, 2018, NIOSH evaluates N95 FFRs intended for use in healthcare for biocompatibility, flammability, and fluid resistance to ensure conformity to relevant standards during the approval process. These tasks were previously performed by the FDA.

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Resources:
Hospital Respiratory Protection Program Toolkit
http://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117.pdf
Implementing Hospital Respiratory Protection Programs: Strategies from the Field
https://www.jointcommission.org/assets/1/18/Implementing_Hospital_RPP_2-19-15.pdf

What are Air-Purifying Respirators?

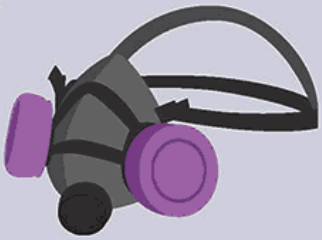
Air-purifying respirators (APRs) work by removing gases, vapors, aerosols (droplets and solid particles), or a combination of contaminants from the air through the use of filters, cartridges, or canisters. These respirators do not supply oxygen and therefore cannot be used in an atmosphere that is oxygen-deficient or immediately dangerous to life or health. The appropriate respirator for a particular situation will depend on the environmental contaminant(s).

Filtering Facepiece Respirator (FFR)

- Disposable
- Covers the nose and mouth
- Filters out particles such as dust, mist, and fumes
- Select from N, R, P series and 95, 99, 100 efficiency level
- Does NOT provide protection against gases and vapors
- Fit testing required

Elastomeric Half Facepiece Respirator

- Reusable facepiece and replaceable cartridges or filters
- Can be used to protect against gases, vapors, or particles, if equipped with the appropriate cartridge or filter
- Covers the nose and mouth
- Fit testing required



Elastomeric Full Facepiece Respirator

- Reusable facepiece and replaceable canisters, cartridges, or filters
- Can be used to protect against gases, vapors, or particles, if equipped with the appropriate cartridge, canister, or filter
- Provides eye protection
- More effective face seal than FFRs or elastomeric half-facepiece respirators
- Fit testing required

Powered Air-Purifying Respirator (PAPR)

- Reusable components and replaceable filters or cartridges
- Can be used to protect against gases, vapors, or particles, if equipped with the appropriate cartridge, canister, or filter
- Battery-powered with blower that pulls air through attached filters or cartridges
- Provides eye protection
- Low breathing resistance
- Loose-fitting PAPR does NOT require fit testing and can be used with facial hair
- Tight-fitting PAPR requires fit testing

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National Institute for Occupational Safety and Health

Prioritizing Patient Scheduling

- **Prior to scheduling an appointment,** practices may want to consider conducting an initial tele-triage visit to determine if an in-person visit is required. The triage process may include the following steps (adapted from CDC's COVID-19 Telephone Response Guide):
    - Collect patient's demographic information
    - Screen for life-threatening symptoms or conditions
    - Document chief complaint/reason for appointment request
    - Screen for COVID-19 symptoms
    - Assess ongoing high-risk medical conditions (e.g., chronic lung disease, congestive heart failure, diabetes with complications, neurological conditions that weaken ability to cough, weakened immune system, dialysis, cirrhosis of the liver, extreme obesity, pregnancy)
    - Screen for special circumstances (e.g., do they live in a nursing home or long-term care facility?)
    - Determine appropriate disposition (e.g., emergency, in-person visit, telemedicine visit, home care) and provide follow-up instructions to your patient
- **Consider incorporating these steps into a tele-triage template** in your electronic health record to minimize documentation burden
- **If your practice uses an online scheduling tool,** consider adding a screening questionnaire to help you prioritize scheduling or deploy the questionnaire through your patient portal
- **If possible, consider adding extended hours** (e.g., early-morning, evening, or weekend appointments) for vulnerable patients who are elderly or have high-risk medical conditions or for patients with respiratory complaints (r/o COVID)
- **Consider blocking out more time per patient visit:**
    - Initial visits for high-priority patients may require more time to address complex clinical issues
    - Allow time for cleaning procedures in-between patient visits
    - Consider making your cancellation policy more flexible for patients
- **Consider asking remote staff (MA, LPN, RN) to proactively identify patients** that need follow up by telemedicine or in-person visit.
- **Consider prioritizing scheduling in-person visits for patients with high priority needs—**see Table VI on the next page:

Table VI. Prioritizing Patient Scheduling

PRIORITY LEVEL	CONSIDERATIONS	SCHEDULE OPTIONS *Based on availability*
High Priority	•Acute, semi-emergent care •Delayed care: high-risk with previously cancelled appointments who are at high risk) •Complex chronic condition management •Post-COVID hospitalization •Perioperative care •Vulnerable patients (e.g., older patients or patients with high-risk conditions) •Patients with access issues	•Schedule immediately (within 1-2 weeks) during normal office hours •Schedule immediately during extended hours (reserved for vulnerable patients)
Medium Priority	•Routine care visit for patients with chronic conditions •Delayed care - medium risk (patients with previously cancelled appointments whose conditions are well managed)	•Schedule (within 2-4 weeks) during normal office hours •Schedule (within 2-4 weeks) during extended hours (reserved for vulnerable patients) •Recommend telemedicine visit
Lower Priority	•New patients •Preventive care •Wellness visit •Annual physical •Prescription refill	•Schedule {within 4-6 weeks) during normal office hours •Recommend telemedicine visit

People Who Are at Higher Risk for Severe Illness

COVID-19 is a new disease and there is limited information regarding risk factors for severe disease. Based on currently available information and clinical expertise, older adults and people of any age who have serious underlying medical conditions might be at higher risk for severe illness from COVID-19.

Based on what we know now, those at high-risk for severe illness from COVID-19 are:

- People 65 years and older
- People who live in a nursing home or long-term care facility
- People of all ages with underlying medical conditions, particularly if not well controlled, including:
    - People with chronic lung disease or moderate to severe asthma
    - People who have serious heart conditions
    - People who are immunocompromised
        - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Consider leveraging your EHR to track these patients—for example, pull a report of all male patients with a BMI >40. These are prime candidates for telemedicine visits. Confirm that they have been seen for a visit; avoid providing care in the office.

Screen Patients before In-Person Visits

BEFORE A PATIENT PRESENTS IN THE OFFICE

- **The practice should verify as best it can that the patient does not have symptoms of COVID-19.** Visits that may be conducted via telemedicine should be.
- **For visits that must take place in person, administrative staff should contact the patient via phone within 24-48 hours prior to the office visit to:**
    - Review the logistics of the reopening practice protocol; and
    - Screen the patient for COVID-19 symptoms. Utilize a script for your administrative staff to follow when conducting these calls.
        - See the sample script the AMA has developed on the next page.
- **If patients need to have forms completed, request documents be submitted electronically or by fax ahead of the appointment.** This can be easily done through smart phone apps such as pdf readers or faxing apps. Complete as much of the form as possible prior to appointment, or offer to complete form and return to patient after the visit.
- **Once the patient presents at the office, the patient should be screened prior to entering.** Some practices may utilize text messaging or another modality to do such screening, subject to patient consent and relevant federal and state regulations. Others may deploy staff in a designated part of the parking lot or an anteroom of the practice to screen patients before they enter the practice itself.
    - Supplementary materials:
        - AMA Pre-Visit Screening Script Template
        - In-Person Triage Sample: UCSF On-site Workflow for Adult NON-Respiratory Screening Clinics

LIMIT NON-PATIENT VISITORS:

- **The practice should strictly limit individuals accompanying patients**–but, in instances where an accompanying individual is necessary (e.g. a parent of a child), those individuals should be screened in the same manner as a patient.
- **Clearly post your policy for individuals who are not patients or employees to enter the practice**—including vendors, educators, service providers, etc.—outside the practice door and on your website. Reroute these visitors to virtual communications such as phone calls or videoconferences (for example, a physician may want to hold "office hours" to speak with suppliers, vendors or salespeople).
- **For visitors who must physically enter the practice (to do repair work, for example),** designate a window of time outside of the practice's normal office hours to minimize interactions with patients, clinicians or staff.
- **Temperature checks should be performed on all visitors entering the office.**

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Pre-Visit Screening Script Template

INTRODUCTION: *Given the recent COVID-19 outbreak, I'm calling to ask a few questions before your upcoming appointment. We are screening all patients to help ensure everyone's safety. So that we can ensure that you receive care at the appropriate time and setting, please answer these questions truthfully and accurately—all responses will remain confidential. As appropriate, the information you provide will be reviewed by one of our clinicians, who will provide additional guidance regarding whether any adjustments need to be made to your scheduled appointment.*

Question	Y/N	Details
Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, and when the symptoms stopped.)	☐ Yes ☐ No	
Have you or a member of your household been tested for COVID-19? (If yes, obtain the date of test, results of test, whether the person is currently in quarantine, and the status of the person's symptoms.)	☐ Yes ☐ No	
Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started/stopped, and the current health status of the person who was advised.)	☐ Yes ☐ No	
Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, whether the person quarantined, when any symptoms started/stopped, and the current health status of the person who was advised.)	☐ Yes ☐ No	
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other healthcare facility in the past 30 days? (If yes, obtain the facility name, location, reason for visit/treatment, and dates.)	☐ Yes ☐ No	
Have you or a member of your household traveled outside the U.S. in the past 30 days? (If yes, obtain the city, country, and dates.)	☐ Yes ☐ No	
Have you or a member of your household traveled elsewhere in the U.S. in the past 30 days? (If yes, obtain the city, state, and dates.)	☐ Yes ☐ No	
Have you or a member of your household traveled on a cruise ship in the last 30 days? (If yes, determine the name of the ship, ports of call, and dates.)	☐ Yes ☐ No	
Are you or a member of your household healthcare providers or emergency responders? (If yes, find out what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus furloughed firefighter.	☐ Yes ☐ No	
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, obtain the status of the person cared for, when the care occurred, and what the care was.)	☐ Yes ☐ No	
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)	☐ Yes ☐ No	
To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19? (If yes, obtain information about when the contact occurred, what the contact was, how long the people were in contact, and when the diagnosis occurred.)	☐ Yes ☐ No	

Thank you. I will share this information with a medical professional in our practice. Please note that our office requires that all patients and visitors follow CDC guidance regarding face coverings to prevent the spread of COVID-19. For that reason, we ask that you please wear a cloth face covering or mask to your appointment. Unless you hear otherwise from us, we look forward to seeing you at your appointment on [date/ time].

PRACTICE SELF-ACTION STEPS:

- If patient responds "Yes" to any of the above, questionnaire must be reviewed by designated medical leadership to assess whether the patient can keep the scheduled appointment. Patient will be contacted again after decision-making.
- If patient responds "No" to all of the above, do you believe any further inquiry with the patient is appropriate before the scheduled visit? If yes, what type of inquiry and why?
- If you have any questions, please contact (designated medical leadership] to discuss.

Note: This sample script is designed to collect information that can be used to inform decisions about whether it is advised for patients to receive care from the practice. This sample should be reviewed, modified as appropriate, and ultimately approved for use by practice medical leadership who have responsibility for remaining current on applicable COVID-19-related guidelines from the CDC and other appropriate resources.

Maximize the Value of the In-Person Visit

NEW PROCESSES TO CONSIDER

- **Implement a daily huddle before in-person visits.** Consider including remote tele-triage staff in the huddle as they may have important information about the needs of patients on the schedule.
- **Implement pre-visit planning protocols:**
  - Ask patients to complete a pre-appointment questionnaire to ensure you understand the goal(s) of the appointment.
    - Resource: CDC Self-Checker
  - Require patients to take temperature and report any respiratory symptoms to the office on the day of scheduled in-person visit.
  - Implement pre-visit lab testing to inform decision making and cut down on need for follow up communication.
  - Assure examination room is set up for specific procedures/examinations; joint injection, Pap smear, cryotherapy, etc.
- **Implement standing orders protocols for integrating preventive care—**e.g., flu vaccinations, mammograms—for in-person visits. While your practice may consider delaying non-urgent, in-person medical care during the COVID-19 outbreak, it is important to consider implementing protocols to provide critical preventive care services for patients who require an in-person visit.
  - Resource: Using Standing Orders for Administering Vaccines: What You Should Know
- **If possible, develop follow-up care plans that can be conducted remotely** (minimize the need for the patient to return to the office).

CHECK-IN AND ROOMING PROCEDURES CONSIDERATIONS

- **Temperature checks should be performed on all individuals entering the office.**
- **Adapt workflows to minimize contact between patients and clinical or office staff.**
  - Upon arrival, ask patients to call the front desk to check-in.
  - Instruct patients to wait outside (e.g., in their car) until time of their appointment.
  - Call or send text notification to patient when they are ready to be seen.
  - Reserve physically distanced waiting room seats for patients with special considerations (e.g., patients without a car, no cell phone, etc.).
- **Implement contactless check-in procedures and notification of rooming via mobile phone.**
- **If patient does not have a mask, provide one and instruct patient to keep for use at future visits.**
- **Alert patient to wear mask at all times, including entering the facility, during visit and after leaving.**
- **Bring patient to the room by the most direct path.** Accompany patient to exam room, watch carefully for areas where the patient may have touched walls, door handles or grab bars so these areas may be sanitized.

- **During visit, use triage and pre-visit notes and questionnaire to determine reason for visit and reduce face to face time.**
- **Close exam room doors once patient has been roomed.**
- **When possible, limit patient teaching during the in-person visit.** Offer a follow up telemedicine visit to review important guidance and instructions.
- **Offer to transmit patient education and care plan materials electronically or through USPS mailings.**

COVID-19 Testing Strategy for Practices

Developing a strategy for COVID-19 testing is critical to reopening your practice. While the availability of testing varies depending on your region, it is important for you to have a plan in place to safely resume care while managing potentially limited testing capability. The following tips are designed to help your practice develop an approach to COVID-19 testing.

COORDINATING COMMUNITY TESTING FOR COVID-19

If you have limited testing capability in your practice, or if you are concerned about the infection control challenges of offering testing in your practice, consider coordinating with local and community testing sites in your region.

- **Tips for coordinating testing outside of your practice:**
  - Assign a member of the team who will be responsible for contacting testing sites to ensure they are open and to keep track of their requirements.
  - Create a directory/contact list for available testing sites in your region.
  - Prior to sending a patient out for testing, contact the testing site to ensure availability of testing and site requirements (e.g., appointment only, drive through only, etc.).
  - Ask the testing site for anticipated timeline for receiving test results.
  - Provide patient with key information about testing site, including:
    - Address
    - Contact information
    - Expected timeline for receiving results
    - Any site-specific information or instructions (e.g., what to bring)
- **How to find local testing sites:**
  - Contact your state or local health department for testing options in your community or to coordinate testing with public health laboratories.
  - Refer to the COVID-19 Updates page on CMG's website.

COVID-19 TESTING IN YOUR PRACTICE

If you choose to administer COVID-19 tests in your practice, it is important to understand your practice's capability for testing (e.g., how many tests can you conduct per day) and develop a strategy for administering tests in your practice.

- **Tips for COVID-19 testing in your practice:**
  - Establish a plan for prioritizing administering tests in your practice versus coordinating with external testing sites (based on your state or local health department's guidance and your practice's infection control plan).
  - Follow CDC Guidelines for handling clinical specimen.
  - Educate patients on what to expect when they get tested (specimen collection, false negative rates, test turnaround time, self-isolation instructions and how they will be notified of results).
  - In consultation with state or local health department staff, identify alternatives to self-isolation at home for patients who are unable to do so safely while awaiting confirmation of diagnosis, or after diagnosis.

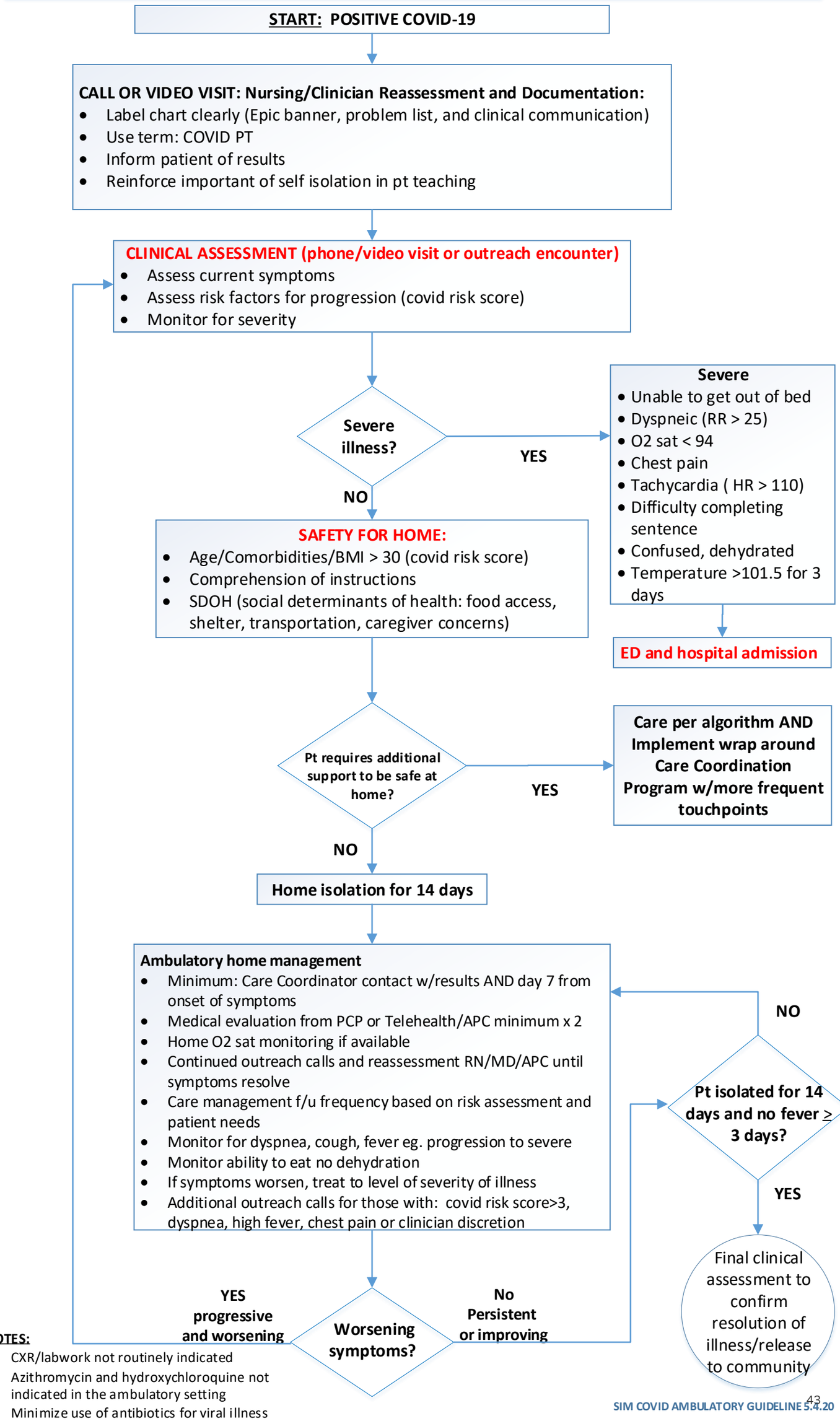
- Develop a communication plan for notifying patients of test results.
- Notify local or state public health department as appropriate:
  - Utilize ContaCT Connecticut Contact Tracing Platform.
- Use strict infection control protocols for testing—limit testing while non-COVID patients are in the office and use appropriate PPE for staff and patients.

COVID-19 TESTING CRITERIA

Stay abreast of the rapidly changing criteria for COVID-19 testing in your region. While national guidance from ACP and the CDC are available, your practice should coordinate with your local and state health departments and use your own clinical judgement to determine when it is appropriate to test patients for COVID-19.

- **ACP Recommendations:**
  - **Priority Level 1: Testing All Symptomatic Individuals and Close Contacts (Molecular Testing)** - test all symptomatic patients and close contacts of confirmed patients using a free, readily available, rapid, and reliable molecular (diagnostic) test with a high sensitivity and specificity for COVID-19 with a streamlined and easy sample collection. Special attention needs to be paid to communities with high health care disparities.
  - **Priority Level 2: Screening All Asymptomatic, High-Risk Population (Molecular Testing)** - screen high-risk asymptomatic populations with targeted approaches that are tailored to the community's specific demographics, economy, and infrastructure. High-risk populations should generally be defined as those with a high risk of transmission. Communities should roll out screening to more asymptomatic populations as resources allow, with the ultimate goal of gradually screening the general population.
  - **Priority Level 3: Surveillance (Antibody Testing)** - surveillance of communities using a reliable immunologic (antibody) or serologic tests to track the incidence, prevalence, and transmission of SARS-CoV2. This will help to track presumptive immunity and prevalence and to inform vaccine development.
- **Look up your state health department's website to understand local testing criteria in your community:**
  - Connecticut State Department of Public Health
  - Centers for Disease Control and Prevention

ADULT AMBULATORY HOME MANAGEMENT TREATMENT GUIDELINE



NOTES:

- CXR/labwork not routinely indicated
- Azithromycin and hydroxychloroquine not indicated in the ambulatory setting
- Minimize use of antibiotics for viral illness

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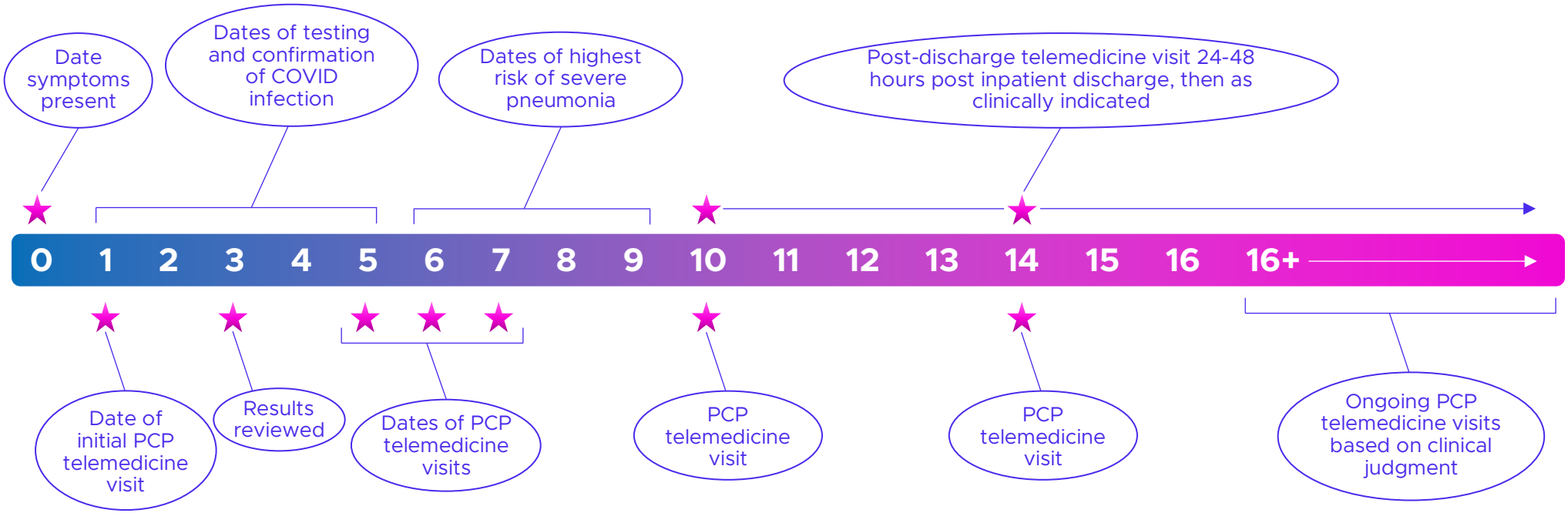
TIMELINE FOR FOLLOW-UP: Community-Based Patients



★ = DATE OF TELEMEDICINE VISIT

Ambulatory Negative Covid Test Algorithm—Symptomatic Pediatric Patient (< 18 years old)

Estimates of the sensitivity of covid 19 PCR testing vary widely but may be in the 70-90% range in ambulatory patients. Sensitivity highest within 3-5d after symptoms onset due to high viral loads.

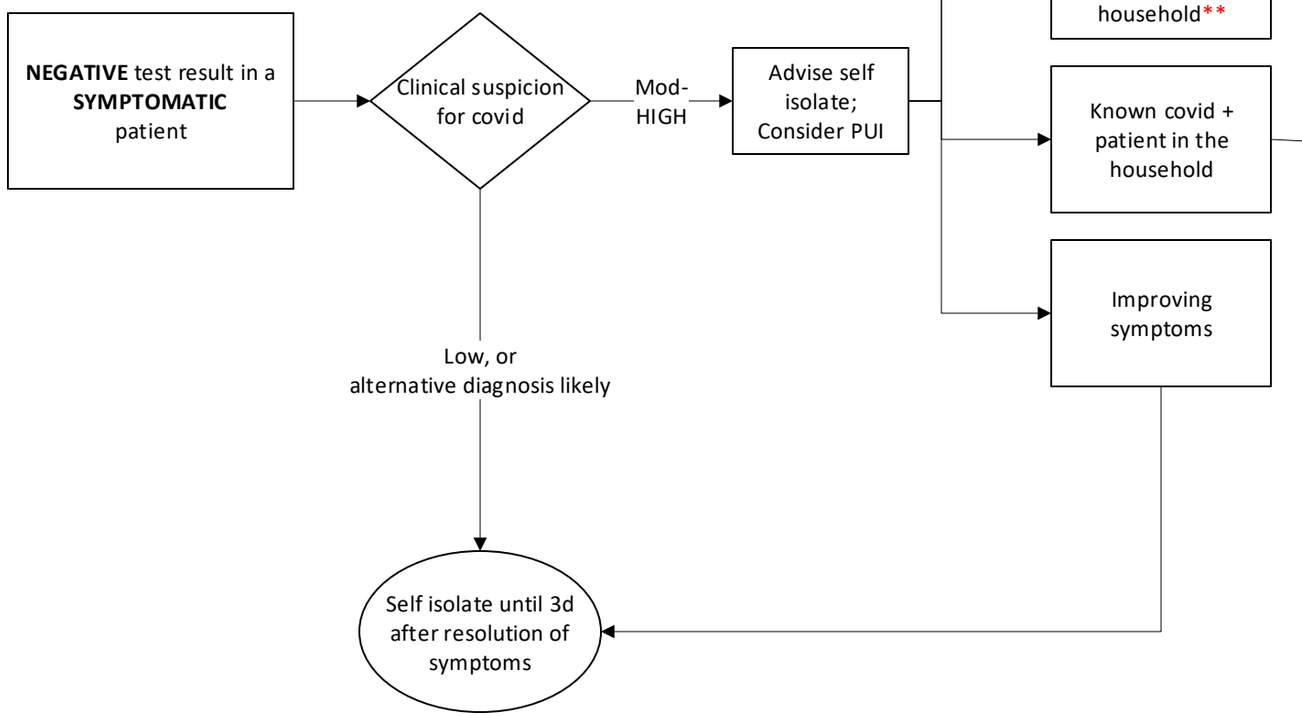
Factors that may increase false negatives:

Assay used:

- Lab-based PCR (e.g. YNHH, Mayo, Quest) estimated at 85-90% sensitive
- POC tests (e.g. Abbott ID now and others) predicted to be 10% lower (currently not being done in < 18 years old)

Other factors:

- Poor sample quality or sampling technique
- Advanced disease stage—viral loads are highest EARLY in disease
- Variable viral shedding, including patient-specific factors
- Disease severity



- **Retest for covid in 2-3d**
- Ensure high quality sample
- Consider additional diagnostic testing (e.g. labs, CXR) if can be done safely
- Consider home 02 sat monitoring if available
- **Refer to ED if clinically warranted**

Labs to consider: CBC, CRP, ferritin, procalcitonin, complete metabolic panel, D-Dimer, PT/PTT fibrinogen, , troponin, BNP

(Lymphopenia, elevated inflammatory markers, hepatitis, elevated D-dimer, PT/PTT examples of labs consistent with COVID-19)

- **Presume COVID positive** and self isolate for at least 14d from symptom onset with resolving symptoms and 72h fever free off antipyretics
- Repeat testing not needed unless progressive symptoms

***Pediatric patients with the following conditions/characteristics may be at increased risk for severe disease:**

- BMI > 95% for age
- Diabetes
- Congenital or chronic heart, kidney, liver or lung disease
- Asthma that requires daily medications
- Malignancy and undergoing treatment
- Immunosuppressive illness or medication
- Smoker (tobacco products, e-cigarettes vaping, marijuana)

****High risk household member with high risk condition**

- Age > 60
- BMI > 30
- Diabetes
- Chronic heart, kidney, liver or lung disease
- Asthma that requires daily medications
- Malignancy and undergoingtreatment
- Immunosuppressive illness or medication
- Smoker

COVID-19 Pediatric Task Force 5/5/20

PEDIATRIC OFFICE TRIAGE to evaluate for Multisystem Inflammatory Syndrome in Children (MIS-C)

This tool is a guide for the evaluation of children suspected of MIS-C, associated with COVID-19 infection. It does not replace clinical judgement or decision making.

START: RN/LPN triages patient
Fever >38.0°c x 24hr
and
New Rash
or
Abdominal Pain

YES → **Triage to MD /APRN / PA or Call Center if no clinician available to confirm severity of symptoms**

NO

Any Associated Symptoms
- Bilateral Conjunctivitis
- Peripheral edema
- Mild Myalgia
- Loss of taste and smell
- Mucosal Changes

YES

NO

Routine Triage
For Patients with no associated symptoms

Severe Symptoms
- Difficulty breathing
- Severe abdominal pain
- Altered mental status/light headed/ fainting

YES

ED and evaluation for hospital admission
- **Call before sending to inform COVID-19 suspect**
- **If ambulance needed must inform COVID-19 suspect**

No Confirmed Fever AND One Associated Symptom

No Confirmed Fever AND Multiple Associated Symptoms

Confirmed Fever +/- Minor Abdominal Pain Or New Rash

Confirmed Fever w/ Abdominal Pain Or New Rash AND Any associated symptoms

Home Care Instructions:
- Symptomatic tx
- Self monitor, advise pt to call as needed
- Educate Regarding MIS-C signs and symptoms
- Daily Follow Up Until Symptoms Resolve

mild ← **Office assessment**
Consider labs, telehealth or a Face to Face with PPE

If MIS-C Concern → ED and evaluation for hospital admission

RECOMMENDED INITIAL TESTING FOR ALL PATIENTS
- SARS-CoV-2 RT-PCR & COVID ELISA serology testing
- Blood Culture
- CBC w/ diff, CMP, Lactate, CRP, Procalcitonin, Ferritin, D-dimer
- EKG (evaluate for ST segment and T wave abnormalities, ectopy and/or arrhythmias, AV or bundle branch block, QTc prolongation)
- Troponin, pro-BNP
- Chest X-ray if concern for chest pain/dyspnea/respiratory symptoms

Characteristic Results of MIS-C include:
Lymphopenia, Elevated Inflammatory Markers

A negative COVID Test does not Rule Out MIS-C

Pediatric COVID Treatment Team, T.Murray MD
DRAFT 5.18.20 v6

Clinical Decompensation and the ED

When safe to do so, patients with suspected or confirmed COVID-19 should be managed at home with telemedicine support. Approximately 80 percent of patients have a mild disease course, which does not warrant medical intervention or hospitalization.

DETERMINE IF EMERGENCY DEPARTMENT (ED) EVALUATION IS WARRANTED

Patient activity, risk profile, and clinical assessment determine the need for emergent care. Note that rapid decompensation/deterioration has occurred with patients diagnosed with COVID-19. Patients should be educated on this disease characteristic and instructed to call 911 for emergent transportation to the ED if rapid decompensation occurs.

Patients with one or more of the following features should be referred to the ED for further management:

- Severe dyspnea (dyspnea at rest, and interfering with the inability to speak in complete sentences).
- Hypoxia or deteriorating oxygen saturation regardless of severity of dyspnea.
- Elevated respiratory rate and/or elevated heart rate.
- Concerning alterations in mentation (e.g., confusion, change in behavior, difficulty in rousing).
- Other signs and symptoms of hypoperfusion or hypoxia (e.g., falls, hypotension, cyanosis, anuria, chest pain suggestive of acute coronary syndrome).
- Patients identified with pneumonia in the outpatient setting.
- Patients identified with abnormal lab values in the outpatient setting, which are indicative of severe or critical illness (e.g., elevated CRP, PCT, Ferritin, D-dimers, immune dysregulation, lymphopenia).
- Patients requiring pronation interventions should be evaluated in the ED to assess safe home management.

CLEANING AND DISINFECTING PROCEDURES

Cleaning and disinfecting procedures are an extremely important component of infection control in medical practices, and their importance should be elevated in the face of the COVID-19 pandemic.

- ✓ **Appropriate PPE must be worn for all activities involving potential exposure to patient body fluids, contaminated surfaces and equipment, and hazardous chemicals (i.e. disinfectants).** Staff performing cleaning activities need to be adequately protected *simultaneously* from infectious and chemical hazards. Puncture resistant/utility gloves, masks, eye protection and gowns must be worn while handling contaminated instruments.
- ✓ **Schedule patient appointments in a manner that allows for complete disinfection** of procedure rooms prior to the first appointment of the day, in between each patient, and after the last patient of the day.
- ✓ **Clean and disinfect each room with an Environmental Protection Agency (EPA)-registered hospital disinfectant** on list N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program from use against SARS-CoV-2. Follow the manufacturers' instructions for use of all cleaning and disinfection products (i.e., concentration, application method and contact time).
    - o EPA: Disinfectants for Use Against SARS-CoV-2
- ✓ **Doorknobs and other common touch points need to be wiped down routinely** in addition to counters, chairs, cabinets, and other surfaces.
- ✓ **Designate clean and dirty areas in the sterilization area.** Autoclave all critical and heat-tolerant reusable instruments prior to use. Use chemical and biologic monitoring to ensure sterilization is effective and include the date and time of sterilization on all instrument packs. Keep all sterile instruments packaged until ready to be used for patient care.

OTHER CLEANING/DISINFECTION CONSIDERATIONS

- ✓ **Hand sanitizer should be made available at entrance points and common areas where possible.**
- ✓ **Cleaning or disinfecting products and/or disposable wipes should be available near commonly used surfaces where possible**—e.g., phones, computers, credit card machines, reception desk, light switches, and door handles.
- ✓ **Restrooms should be cleaned and disinfected frequently.** Implement use of cleaning log for tracking. Clean multiple times a day if restrooms are used frequently by patients and/or staff.
- ✓ **Ensure that any other businesses and employers sharing the same workspace also follow this guidance.**

COMMUNITY MEDICAL GROUP

BUSINESS OPERATIONS AND LEGAL CONSIDERATIONS

Notification of Enforcement Discretion for Telehealth
Malpractice/Risk Considerations | Review Legal Implications for Financial Assistance | Top 20 Best Practices for RCM Billing | Money-Saving Tips and Ideas

Notification of Enforcement Discretion ("Notice") for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency and HIPAA

During the COVID-19 public health emergency, covered health care providers may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) has exercised its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any ***non-public*** facing remote communication product that is available to communicate with patients. OCR's exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

Under this Notice, covered health care providers may use applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Under the Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products.

Please click here to review the Notice in its entirety.

IMPORTANT NOTE:

At the time of publication, the Notice does not have an expiration date. OCR will issue a public notice when it is no longer exercising its enforcement discretion based upon the latest facts and circumstances.

Additional information on telehealth and HIPAA during the COVID-19 nationwide public health emergency can be found here.

HIPAA PRIVACY AND COVID-19

In light of the COVID-19 outbreak, OCR provided a bulletin to ensure that HIPAA covered entities and their business associates are aware of the ways that patient information may be shared under the HIPAA Privacy Rule in an outbreak of infectious disease or other emergency situation, and to serve as a reminder that the protections of the Privacy Rule are not set aside during an emergency. The bulletin can be accessed here.

In response to the coronavirus disease 2019 (COVID-19) pandemic, many healthcare providers have temporarily closed their office practices or significantly reduced in-office services. In the weeks and months to come, as the pandemic begins to recede, providers will likely have questions about how best to reopen. The unprecedented nature of the COVID-19 outbreak might make navigating this process confusing and stressful.

We wish to offer guidance and important actions to consider as you develop your reopening strategy. Although this checklist is not all-inclusive, and practices vary, the information in this document provides a roadmap that you can use as you progress toward reopening and evaluating lessons learned as a result of the pandemic.

CONTACT YOUR MEDICAL MALPRACTICE INSURANCE CARRIER

- To ensure that clinicians on the front line of treating COVID-19 patients are protected from medical malpractice litigation, Congress has shielded clinicians from liability in certain instances. As the practice reopens, however, there may be heightened risks caused by the pandemic that do not fall under these protections.
- Contact your medical malpractice liability insurance carrier to discuss your current coverage and whether any additional coverage may be warranted.
- As much as is practicable, you should protect your practice and your clinicians from liability and lawsuits resulting from current and future unknowns related to the COVID-19 pandemic.
- The AMA is also advocating to governors that physicians be shielded from liability for both COVID treatment and delayed medical services due to the pandemic.

ESTABLISH CONFIDENTIALITY/PRIVACY

- Institute or update confidentiality, privacy and data security protocols. Results of any screenings of employees should be kept in employment records only (but separate from the personnel file).
- Remember that HIPAA authorizations are necessary for sharing information about patients for employment purposes. Similarly, coworkers and patients can be informed that they came into contact with an employee who tested positive for COVID-19, but the identity of the employee and details about an employees' symptoms cannot be shared with patients or co-workers without consent.
- While certain HIPAA requirements related to telemedicine are not being enforced during the COVID-19 public health emergency, generally, HIPAA privacy, security and breach notification requirements must continue to be followed. Answers to frequently asked questions are provided at the end of this document.

CONSIDER LEGAL IMPLICATIONS

- New legal issues and obligations may arise as the practice reopens. For example, some practices may not have had to make decisions about paid sick leave (per the "Families First Coronavirus Response Act") because they were on furlough; as the practice reopens, these sorts of employment obligations should be considered and decisions about opting out or procedures for requesting these leaves communicated to

employees. The AMA has additional resources for physician practices related to employees and COVID-19.

- ☐ Coordinate with your local health department as provided for by law. Provide them with the minimum necessary information regarding COVID-19 cases reported in your practice, and stay informed of local developments.
    - o ContaCT Connecticut Contact Tracing Platform

PREPARING TO REOPEN

- ☐ Offer condolences to families of patients and staff who died as a result of the COVID-19 pandemic.
- ☐ Confirm with local public health officials that permitting patient visits beyond emergencies is advisable.
- ☐ Assess local hospital, specialty care, home care, pharmacy, and durable medical equipment (DME) service readiness.
- ☐ Check for updated information from the Centers for Disease Control and Prevention (CDC), Occupational Health and Safety Administration (OSHA), Centers for Medicare & Medicaid Services (CMS), The Connecticut State Department of Public Health (CT DPH), and other authoritative and regulatory agencies on a daily basis for updated recommendations.
- ☐ Notify your professional liability carrier about changes to practice (e.g., resuming full-time service, returning to original scope of practice, or permanently adding telehealth services).
- ☐ Contact OSHA authorities for mandatory reporting of employee exposure to COVID-19 that results in a positive test. See OSHA's Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19) and ContaCT Connecticut Contact Tracing Platform.
- ☐ Consult with accountants and financial advisors in regards to loans, advance payments, and other healthcare practice financial programs.
- ☐ Review changes to billing procedures and billing codes for health insurance plans that the practice accepts.
- ☐ Confirm readiness of office support service providers (e.g., regular cleaning crew, laundry service, specimen collection, and lab analysis).
- ☐ Establish employee screening processes for COVID-19 (including guidance for self-monitoring for symptoms), and follow CDC guidelines regarding assessment of staff eligibility to return to work.
- ☐ Ensure that the office has sufficient personal protective equipment (PPE) to allow staff to perform their job functions in a safe manner.
- ☐ Establish one-way ingress/egress routes for office visits, if possible.
- ☐ Create a telephone triage process to prioritize patients' needs for office visits.
- ☐ Establish a triage system for patients who require office visits. Prioritize appointments for patients who have the lowest risk of COVID-19 and have the greatest clinical care needs.
- ☐ Establish patient screening processes for COVID-19. Plan to maintain telehealth appointments for any symptomatic patients until they are well for at least 2 weeks.
- ☐ Tailor your telehealth practice to evolving guidelines from the Office of Inspector General, U.S. Department of Health and Human Services.

PREPARING THE OFFICE FOR PATIENTS

Testing and Maintenance:

- ☐ Run tests on the office fire and security alarm systems prior to opening the office to ensure they are functioning normally. Notify your central station monitoring company prior to the tests.
- ☐ Ensure exit signs, smoke detectors, sprinklers, and fire extinguishers are in good working condition according to local fire codes.
- ☐ Ensure information technology (IT) systems are fully functional and that your electronic health record (EHR) system and office were secure during closure:
    - Be aware of increased cyberattacks because of hackers trying to take advantage of this crisis.
    - Run a scan on all electronic systems to ensure no breaches have taken place during this crisis.
- ☐ Consider upgrades or enhancements to your EHR system based on your experience during the closure.

Disaster Management:

- ☐ Review the practice's disaster/emergency plan in light of your pandemic response and revise as needed:
    - Perform a debrief/review of how the crisis was handled.
    - Document what went well and potential areas for improvement.
    - Consider adjustments to normal office processes based on lessons learned.
- ☐ Evaluate whether your office is prepared to handle a second wave of COVID-19 infections:
    - Determine whether the medications that the practice uses are available
    - Identify whether a patient prioritization and communication plan is in place.
    - Communicate pertinent plans with all staff members as soon as possible.
- ☐ Consider modifications to the office practice physical plan (e.g., adding a dirty utility room, second exit, or another restroom; evaluating sterilized vs. disposable tools/supplies; etc.) and develop a plan for updates.

Biomedical and Supply Management:

- ☐ Check for outdated supplies and medications (including sample medications), and discard as necessary.
- ☐ Verify that you have sufficient supplies and medications, either in the practice or readily available to care for your patients:
    - Be prepared for shortages and delays in supply deliveries.
    - Begin to create a stockpile of emergency supplies and establish a rotation schedule.
- ☐ Verify that all biomedical equipment inspections are up-to-date (e.g., automated external defibrillators, diagnostic equipment, radiological equipment, etc.)
- ☐ Verify the location of any loaned equipment and the expected date of return.
- ☐ Review settings on refrigerators used to store medications and testing supplies. Confirm the temperatures have not registered outside the normal recommended range for proper storage.

- ☐ Ensure sufficient supplies of soap, alcohol-based rub, and paper towels are available for reception, waiting areas, patient care areas, and restrooms.
- ☐ Be suspicious of any offers of PPE, testing, and medication discounts for bulk or group purchase due to fraudulent actors trying to take advantage of this crisis and its aftermath.

Insurance and Business Continuity:

- ☐ Reinstate any professional liability, general liability, or other relevant business insurance policies and programs that were suspended during the closure.
- ☐ Verify that clinical employees who have their own professional liability coverage have not let it lapse during the closure.
- ☐ With assistance of legal counsel, evaluate and update all contracts for appropriate changes based on lessons learned from pandemic-related issues.
- ☐ Evaluate your practice's tax return preparation status.
- ☐ Determine whether billing procedures for health insurance plans you accept have changed during your closure. These may be routine changes or changes associated with government mandates during the pandemic. Educate staff as needed.
- ☐ Consider completing a risk management self-assessment.

RESUMING PATIENT CARE

Communication/Continuity of Care:

- ☐ Update your patient portal, website, email, and other communication modes to alert patients that the practice has reopened. Have patients call for appointments to inform initial staffing needs and hours. Depending on need, consider:
  - o Shorter hours
  - o Longer appointment times
  - o Weekend hours
  - o Evening hours
- ☐ Verify with your answering service that all calls/messages have been communicated to the practice. Ensure outgoing messages reflect that the practice is open again and include any changes to office hours.
- ☐ Prioritize the backlog of patients based on the nature of their condition or need. For example, consider whether any patients:
  - o Were hospitalized during the pandemic (for any reason)
  - o Have high-risk conditions that make them a priority
  - o Had telehealth appointments during the closure that helped address their care needs
- ☐ Determine whether you need to reschedule patients for annual physicals or other routine care to help accommodate patients who have more urgent needs.
- ☐ Acknowledge patient deaths that occurred due to any cause (including COVID-19).
  - o Update all patient health records as needed.
  - o Understand the emotional impact on patients' families, especially if they were not able to see a loved one during his/her last days or attend the funeral.
- ☐ Consider a general screening process for patients coming to the office with potentially infectious conditions (e.g., those who have flu-like symptoms):

- Post signage in appropriate languages at the entrance of the office to instruct patients with respiratory symptoms and/or fever to notify staff immediately via telephone before entering the office.
- Consider how the practice will ensure social distancing.

- ☐ Follow up on labs, films, tests, and specialist referrals made prior to the closure, results received while office operations were suspended, or services provided via telehealth:
  - Ensure that patients completed, or are in the process of completing, studies.
  - Review lab work that arrived via EHR or other communication mode for critical or urgent follow-up issues.
  - Review patients for recent hospitalizations and discharge summaries that arrived via EHR, mail, or other communication mode.
- ☐ Determine how best to handle uninsured/previously insured patients. Create a plan to avoid abandonment:
  - If you plan to see them and bill them, consider at what rate.
  - If you do not plan to see them, ensure you are not violating any contractual or legal obligations by discharging patients. Consult legal counsel related to applicable federal and state laws.
  - Consider the patient's clinical status. Terminating a relationship at a critical junction in care is not advised.
  - Develop a process for providing written notification to patients regarding discharge from the practice.

Telehealth:

- ☐ If you used telehealth during the crisis, consider whether you should continue these services following the pandemic.
- ☐ Consider whether the practice should still offer telehealth in light of the anticipated return to stricter guidelines (e.g., requiring HIPAA-compliant platforms).
- ☐ If you plan to continue offering telehealth services on a new platform, determine whether a new patient agreement/consent is necessary. If yes, consider the terms of the agreement, including information about when a virtual visit is appropriate and when an in-person visit is required.
- ☐ Review state and federal telehealth laws and regulations, telehealth billing guidelines, and risk management considerations for telehealth.

Documentation:

- ☐ Thoroughly document your pandemic circumstances, decisions, and any actions taken to ensure patient care and patient/staff safety.
- ☐ If you had limited or no access to your EHR system during your office closure, add any notes to patients' records that were not entered. You may be able to accomplish this by scanning your handwritten notes or emailing those notes into your EHR system.
- ☐ In light of the pandemic, review health records to determine if patients have executed advanced directives. If not, encourage patients to do so.
- ☐ Reorient staff to your practice's documentation policies and privacy/confidentiality protocols.
- ☐ Resume your normal documentation practices, as any immunity associated with COVID-19 response is likely no longer in place.

SMALL BUSINESS ADMINISTRATIONS (SBA) LOANS/GRANTS

The SBA announced that borrowers might be asked to substantiate their need for Payroll Protection Program (PPP) relief funds. If you have not already, start compiling documentation validating your need for funds. Whatever the format of your documentation (e.g., written text, operating budget, cash flow analysis), consider including the:

- Impact upon your practice's revenue, and the uncertainty of future income;
- Decreased demand for services and appointments;
- Increased staff absenteeism, furloughs, and/or terminations;
- Increased supply expenses (e.g., PPE, disinfectants);
- Need to defer payments (e.g., rent, lease payments);
- Efforts expended trying to secure other financial assistance;
- Advice received from professional advisors, including business consultants, CPAs, and attorneys;
- Hardships experienced due to loan program restrictions that prohibit participation in other loan programs; and
- Intended use of funds for sustaining practice operations, and staff wages and benefits

As already advised, consult with your CPA as well as your attorney and other professional advisors in preparation of your documentation.

PROVIDER RELIEF FUND

In order to participate in the Provider Relief Fund program, you are required to attest to terms and conditions within 30 days of receipt of your payment at the CARES Provider Relief Fund portal. There are two criteria for your payment: your eligibility to receive it and the terms on which you may use it. These payments are grants, not loans, and do not have to be paid back unless CMS or another federal agency decides you are not entitled to the money or have spent it inappropriately. CMS is requiring that you attest that you are eligible and will use the funds the way they are meant to be spent.

According to the HHS fact sheet on the Fund, the recipient entity certifies that it:

- ✓ Billed Medicare in 2019.
- ✓ Provides or provided after Jan. 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. (Do not worry about tracking down your patients to see if any tested positive. HHS is interpreting "possible or actual cases of COVID-19" to mean pretty much anyone who came into your office after January 31 for treatment.)
- ✓ Is not currently terminated from participation in Medicare.
- ✓ Is not currently excluded from participation in Medicare, Medicaid and other federal health care programs.
- ✓ Does not currently have Medicare billing privileges revoked.

The Fund specifies that payments are to be "used to prevent, prepare for and respond to coronavirus." But it also covers "health care-related expenses or lost revenues that are attributable to coronavirus," HHS says. Conceivably, a cardiologist could find "patients didn't want to sit in my waiting room due to COVID-19, so I have lost [a certain amount of] revenue; therefore I am entitled to use [these funds) to pay for staff and expense [since Jan. 31), as those are things I would have otherwise have had revenue to pay for."

Be aware also that your payment could be audited down the road - and, if it amounts to more than $150,000, you are required by the terms and conditions to file a detailed quarterly report to HHS of where the money's going. In fact, HHS reserves the right to require a spending report of any recipient at any time, regardless of amount. To help avoid trouble, follow these rules:

- **No appearance of double-dipping.** Providers should make sure other sources of reimbursement that are used to cover expenses or losses do not cover the same things.
    - For example, a provider might be receiving funds from the Paycheck Protection Program (PPP), a low-interest SBA loan that is supposed to be spent on designated categories such as payroll costs, rent, mortgage interest or utilities. To the extent those PPP funds fully reimburse those categories of expenses, the funds received from provider relief fund should not be used for those expenses, but for other purposes - even if mixing and matching of different sources of funds to different expenses would result in essentially the same outcome.
- **Be reasonable in your interpretation of what's COVID-19-related.** If a physician left a practice just prior to January 31, 2020, for reasons unrelated to COVID-19, and the group closed its offices on February 6 due to COVID-19, it does not seem reasonable to utilize the grant received by the group to reimburse its lost revenues from this physician's departure. Overall, use very conservative estimates and steer the funds, if appropriate, toward healthcare expenses related to COVID-19.
- **Keep a separate account.** Keep the Provider Fund payments in a separate bank account to eliminate confusion - and auditor suspicion. Track expenses bit by bit, make note of every payment and demonstrate the need to use the funds for what you spent them on.

Be aware that another condition of payment is that you "not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient," according to HHS guidance. Patient responsibility sums can be very high out of network, and add up to significant revenue in large organizations. To be forced to accept an in-contract level of coinsurance for out-of-network patients could be a huge loss for your practice.

Also, if you are thinking of giving one of your executives a raise, make sure their salary does not exceed $197,300. While you can certainly use Fund payment for payroll, including executive salaries, the Further Consolidated Appropriations Act of 2020 restricts salaries paid out of federal grants to that amount. Note that there are many other statutory exclusions to the use of the funds, such as “Promotion of Legalization of Controlled Substances" and "Pornography," in the final pages of the fact sheet.

CMG COMMUNITY MEDICAL GROUP

Top 20 Best Practices for Revenue Cycle Management (RCM)

1. Collect patient responsible balances at the time of check-in.
- Establish payment arrangements for patients who cannot pay in full.
- Provide a private area for financial discussions.

2. Verify benefits, eligibility, and demographic data for all patients.
- Determine out of network benefits.

3. Provide staff a quick reference sheet with fee schedule information.
- Update the practice's fee schedule if it has not been updated within the last year.

4. Notify patients of any outstanding balances when scheduling appointments.

5. Post payments and charges at the time of service.

6. Establish billing expectations. The following standards should be expected:
- Claims submitted daily.
- Statements generated weekly.
- Payments posted within 24-48 hours.
- Denials reviewed and resolved within two working days.
- Delinquent patient balances followed up on after 45 days.
- Delinquent insurance balances followed up on after 30-45 days.
- Reports generated by the lst working day after the period close.

7. Monitor claims transmission and acceptance reports.

8. Track and work claim denials.
- Stay abreast of timely filing deadlines to avoid unnecessary denials.

9. Mail patient statements weekly.
- Provide a credit card payment option on statements.

10. Allow online payment through your portal.

11. Assign a direct phone number to billing staff for questions.

12. Prioritize accounts receivable (AR) follow-up.
- Begin with the oldest and largest balances.

13. Perform small balance write-offs.
- Adjust and write-off balances of $10.00 or less.

14. Load fee schedules into your practice management system.

15. Familiarize yourself with payor policies and where they can be found.
- Know the billing requirements for your most commonly reported codes.
- Subscribe to payor updates and newsletters (e.g., Cigna).

16. Monitor payer contracts, determine continued participation, and negotiate when possible.
- Maintain copies of all contracts and fee schedules.

17. Stay abreast of prior authorization requirements.

18. Monitor changes to payer policies.
- Watch for guidance about resubmitting claims in lieu of the health plan reprocessing them automatically.

19. Utilize health plan cost estimators (e.g., United Healthcare).

20. Ensure correct coding and know who is ultimately responsible.
- Understand modifier usage.
- Provide staff education on new or updated coding requirements specific to COVID-19.
- Ensure your EHR has been updated with the new COVID-19-specific codes.

REVIEW EVOLVING BILLING RULES

Review evolving billing rules to avoid telehealth denials. For example, if you are offering telehealth services as part of the PHE, those claims should be submitted with the POS from where the face-to-face service is normally performed (e.g., office POS 11, hospital POS 21) and include modifier 95 to identify this as a telehealth service during the PHE. In recent years, CMS had moved away from modifier 95 and had instructed providers to report the new telehealth POS 02. But during the COVID-19 emergency, you should return to using modifier 95 on your telehealth claims.

Medicare Advantage (MA) providers can now do risk adjustment by telehealth, but you are advised to tighten up on your documentation and not go further than good judgment allows. On April 10, CMS issued a brief memo: "Applicability of diagnoses from telehealth services for risk adjustment," stating MA organizations "that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter."

That policy applies as long as the visits involve an "interactive audio and video telecommunications system that permits real-time interactive communication." Risk adjustment uses a combination of demographic and "disease burden" information to determine future costs for patients on which provider payments under MA and other risk-based reimbursement plans are based.

ACCOUNTS RECEIVABLE MANAGEMENT

Although it is financially challenging to keep the business office running during this time, it is key that practices work on maintaining a streamlined revenue cycle that focuses on patient collections, tight denial management and follow-up automation. Massive layoffs, as we are seeing today and will continue to see during this pandemic, will bring a shift in most practices' payer mix and highlights the importance of checking eligibility every time the patients come in. It also highlights the need to have automated processes to facilitate the collection of outstanding balances: online and mobile payment capabilities, automated credit card deductions for payment plans, estimation tools, and automated collection letters and calls. These are a few examples of key processes organizations need to have in place in order to collect as much revenue as possible.

Every time practices start using new diagnosis and procedure codes, we should anticipate an influx of denials due to coding errors. Leverage your denial management tool to detect these denials as quickly as possible. The goal should be to implement processes to enhance documentation and to configure coding rules within your practice management system to capture and automatically correct possible errors before the claims are billed out.

Instruct staff to focus on old accounts receivable. This does not necessarily mean asking staff to make collections calls, but rather to verify that balances are truly outstanding. Determine if the balances are correct and if the patient really owes the money. Identify which patients might be placed on a payment schedule and offer them the option of making regular

monthly payments to ease their financial burden. Also, sort your aged accounts receivable (AR) report by payor and contact those from whom you are still awaiting payment. Verify that the claims have been received, or if necessary, resubmit. Finally, review your small balance write-off policy in your policies and procedures manual, and determine if any balances should be written off in accordance with that policy.

LEVERAGE ONLINE BILL PAY AND BILLING SYSTEM MESSAGES

Maximize and optimize technology in your practice to help streamline processes. Implement online bill pay and appointment scheduling, and fully activate the patient portal on your website.

Determine if and/or how telemedicine will continue in your practice. Initially you may have implemented telemedicine very quickly. Decide if it works well for you and your patients or if there are changes you should make to optimize the use.

Reactivate any automated messaging—including those in your telephone tree, voicemail messages, email auto- replies, within software for text messaging and appointment reminders, and in marketing communications.

During this time when practices have fewer resources to manage follow-up efforts, and now that many staff happen to be working from home for the first time, it is crucial to have the tools to:

- Automatically route outstanding claims to specific queues based on claim status and denial reasons.
- Automate 277 transaction messages back into the practice management system to easily identify the status of the claims.

Also, remember to:

- Collect all time-of-service payments and past-due balances;
- Manage rejected claims in a timely manner;
- Ensure correct coding and that all charges are captured;
- Promptly close encounter notes;
- Manage inventory levels; and
- Continually visit payors' websites to stay abreast of changes.
- Refer to the Monitor Payers section for detailed information.

Money-Saving Tips and Ideas

- ✓ **Negotiate your contracts** for better pricing and termination terms.
- ✓ **Buy office supplies in bulk when possible and if you have the storage space.** If you work in a professional building, enlist other practices to order supplies in bulk and share the cost.
- ✓ **Shop online.** Sometimes buying online is less expensive; often, when sales exceed a certain dollar amount, shipping is included.
- ✓ **Buy recycled printer cartridges.**
- ✓ **Purchase gently used equipment and office furniture** rather than new products.
- ✓ **Purchase inexpensive copy paper** for routine office copying and use both sides when feasible.
- ✓ **Use a third-party printer for bulk printing jobs** to save on toner and staff costs, rather than using the office laser printer.
- ✓ **Upload practice forms to your website** or email to patients.
- ✓ **Take advantage of free, branded prescription pads** from vendors, if not e-prescribing.
- ✓ **Shop around for better rates** on phone, credit card, overnight courier, biohazardous waste removal, and other services.
- ✓ **Use energy-efficient light bulbs** and install sensors that automatically turn the lights on and off when entering and leaving a room.
- ✓ **Install a digital thermostat** and program it to use less energy during closed hours.
- ✓ **Put only hazardous material in biohazard waste receptacles** to keep pick-ups to a minimum. Keep receptacles out of patients' site so they aren't used for general trash cans.
- ✓ **Replace costly magazine subscriptions** with free health literature in the waiting room.
- ✓ **Create a system for monitoring supplies** to prevent ordering items you already have or accumulating more than you need.
- ✓ **Don't reinvent the wheel.** Take advantage of already-developed forms, tools, and resources from CMG and specialty societies.
- ✓ **Consider online fax capabilities** and save paper wasted on printing.

COMMUNITY MEDICAL GROUP

HUMAN RESOURCE OPERATIONS

Screening, Vulnerable Staff, Return-to-Work, the ADA, and the EEOC | Leadership, Communication and Employee Care Needs | Phases of Disaster | Staffing/Payroll

GUIDANCE FOR EMPLOYERS WITH WORKERS AT HIGH RISK

As workplaces consider a gradual scale up of activities towards pre-COVID-19 operating practices, it is particularly important to keep in mind that some workers are at higher risk for severe illness from COVID-19. These workers include individuals over age 65 and those with underlying medical conditions. Such underlying conditions include, but are not limited to, chronic lung disease, moderate to severe asthma, hypertension, severe heart conditions, weakened immunity, severe obesity, diabetes, liver disease, and chronic kidney disease that requires dialysis.

Workers at higher risk for severe illness should be encouraged to self-identify, and employers should avoid making unnecessary medical inquiries. Employers should take particular care to reduce workers' risk of exposure to COVID-19, while making sure to be compliant with relevant Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) regulations.

Workers in vulnerable populations may be shifted to different roles that minimize their risk of exposure. This may include various duties, such as acting as the primary resource for updated COVID information, ordering medications and supplies for the clinic, working from home, phone triage of patients, helping with scheduling, billing, chronic care management or annual wellness visits as appropriate.

SCREENING

- Employees should self-monitor for symptoms of COVID-19. If they develop symptoms, they should notify their supervisor and stay home.
- Consider conducting routine, daily health checks (e.g., temperature and symptom screening) of all employees.
- If implementing health checks, conduct them safely and respectfully. To prevent stigma and discrimination in the workplace, make employee health screenings as private as possible. Do not make determinations of risk based on race or country of origin and be sure to maintain confidentiality of each individual's medical status and history.
- The ADA requires that all medical information about a particular employee be stored separately from the employee's personnel file, thus limiting access to this confidential information. An employer may store all medical information related to COVID-19 in existing medical files. This includes an employee's statement that he has the disease or suspects he has the disease, or the employer's notes or other documentation from questioning an employee about symptoms.
- Employers tracking employee temperature screenings in a log need to maintain the confidentiality of this information.
- Follow guidance from the Equal Employment Opportunity Commission regarding confidentiality of medical records from health checks.

PLAN FOR IF EMPLOYEES BECOME SICK

- Employees with symptoms (fever, cough, or shortness of breath) at work should immediately be separated and sent home.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Close off areas used by the sick person until after cleaning and disinfection. Wait 24 hours to clean and disinfect. If it is not possible to wait 24 hours, wait as long as possible before cleaning and disinfecting. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms, follow appropriate CDC guidance for home isolation.
- Sick employees should not return to work until they have met CDC's criteria to discontinue home isolation.
- Employers should notify the Connecticut Department of Public Health (CT DPH) when they become aware of any staff member who has been diagnosed with COVID-19, including whether that employee has provided direct patient care or not, so that appropriate contact tracing and monitoring can be performed.
- In addition, employers should keep themselves informed about continually updated requirements from CDC and CT DPH for employee symptom monitoring, provisions for continuing business activities, reporting requirements, and quarantine and isolation of healthcare workers and other staff potentially exposed to COVID-19 in their workplaces.

OSHA-RELATED GUIDANCE FOR COVID-19 CASES

On May 26, 2020, the Occupational Safety and Health Administration (OSHA) established a Memorandum providing new guidance on determining when COVID-19 cases must be recorded as work-related under OSHA recordkeeping obligations.

Employers with ten or fewer employees throughout the previous calendar year are exempt from routinely[+] keeping injury and illness records.

For purposes of OSHA's recordkeeping requirements, COVID-19 is a recordable[*+] illness if:

- The case is a confirmed case of COVID-19, as defined by the CDC.
- The case is work-related: A condition is considered work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment, unless an exception applies.

It is sufficient in most circumstances for the employer to: (1) ask the employee how he or she believes he or she contracted the disease; (2) while respecting employee privacy, discuss with the employee his or her work and out-of-work activities that may have led to the illness; and (3) review the employee's work environment for potential exposure.

COVID-19 illnesses are likely work-related:

- When several cases develop among workers who work closely together and there is no alternative explanation.
- If it was contracted shortly after lengthy, close exposure to someone encountered in the wok environment who has a confirmed case of COVID-19 and there is no alternative explanation.
- If their job duties include having frequent, close exposure to the general public in a locality with ongoing community transmission and there is no alternative explanation.

An employee's COVID-19 illness is likely not work-related:

- If they are the only worker to contract COVID-19.
- If the employee closely and frequently associates with someone (e.g., a family member, significant other, or close friend) who (1) has COVID-19; (2) is not a coworker, and (3) exposes the employee during the period in which the individual is likely infectious.

*OSHA "recordable" is a term for injuries and illnesses that must be reported to the Occupational Safety and Health Administration (OSHA) on a Form 300 (Log of Work-related Injuries and Illnesses). It includes a work-related injury or illness that results in any of the following:

- Medical treatment beyond first aid
- Loss of consciousness
- One or more days away from work following the date of the incident
- Restricted work or transfer to another job
- Any significant injury or illness diagnosed by a physician or other licensed health care professional
- Any work-related fatality

+Some work-related safety events also require employers to call OSHA within a certain number of hours: fatalities, serious injuries that result in in-patient hospitalization, amputations and eyeball loss are all considered an OSHA reportable injury. OSHA definitions come into play as the agency does not consider hospital admission for tests or observation to be in-patient hospitalization. See Standard 1904: Recording and Reporting Occupational Injuries and Illnesses.

In addition, please remember to refer COVID-positive employees to the ContaCT Connecticut Contact Tracing Platform.

RETURN TO WORK CRITERIA FOR HEALTH CARE PROVIDERS (HCP) WITH SUSPECTED OR CONFIRMED COVID-19

Per the CDC, decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. These recommendations have been amended a number of times, and employers are advised to seek out the latest guidance on the CDC website.

Employees should not return to work until they have met the criteria to discontinue home isolation and have consulted with a healthcare provider and state or local health department.

Employers should not require a COVID-19 test result or a healthcare provider's note for employees who are sick to validate their illness, qualify for sick leave, or to return to work.

Under the ADA, employers are permitted to require a doctor's note from your employees to verify that they are healthy and able to return to work. However, most people with COVID-19 have mild illness—they can recover at home without medical care and can follow CDC recommendations to determine when to discontinue home isolation and return to work.

PREVENT AND REDUCE EXPOSURE AND TRANSMISSION AMONG EMPLOYEES

- Most workplaces should follow the Public Health Recommendations for Community-Related Exposure.
- Critical infrastructure workplaces should follow the guidance Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19.
- In most cases, you do not need to shut down your facility. However, do close off any areas used for prolonged periods by the sick person.
- Wait 24 hours before cleaning and disinfecting to minimize potential for other employees being exposed to respiratory droplets. If waiting 24 hours is not feasible, wait as long as possible.
- During this waiting period, open outside doors and windows to increase air circulation in these areas.
- If it has been less than 7 days since the sick employee used the facility, clean and disinfect all areas used by the sick employee following the CDC cleaning and disinfection recommendations.
- If it has been 7 days or more since the sick employee used the facility, additional cleaning and disinfection is not necessary. Continue routinely cleaning and disinfecting all high-touch surfaces in the facility.
- Other employees may have been exposed to the virus if they were in "close contact" (within approximately 6 feet or 2 meters) of the sick employee for a prolonged period.
- In most workplaces, those potentially exposed but with no symptoms should remain at home or in a comparable setting and practice social distancing for 14 days.
- Employees not considered exposed should self-monitor for symptoms such as fever, cough, or shortness of breath. If they develop symptoms, they should notify their supervisor and stay home.
- Employees who are well, but who have a sick family member at home with COVID-19, should notify their supervisor and follow CDC recommended precautions.

Leadership, Communication, and Employee Care Needs

Effective team-based care and leadership support is critical to helping your practice manage the unprecedented challenges of the COVID-19 pandemic. It is important that leadership, clinical, and office teams work together and communicate effectively to keep up-to-date with new information related to COVID-19, implement new protocols to ensure safety of patients and practice staff, and work closely with local and state public health departments to manage the COVID-19 response.

COMMUNICATION IS KEY

As practices slowly reopen, COVID-19 remains an active threat to practice operations. Physicians and their employees will face copious amounts of questions, uncertainties, and fast-occurring changes.

Be empathetic and responsive to employee sensitivities. Practices will need to effectively communicate with employees to assure them that the workplace will be safe upon their return.

Once your plan to reopen has been communicated, employees may be still be hesitant to return to work--even when all reasonable precautions are taken. Some may be fearful, and many will have family obligations that interfere with their ability to return to work. You may also encounter employees who remain under quarantine due to exposure to COVID-19. Be prepared to respond to requests in a consistent way that addresses legitimate concerns from employees and ensures that productivity can be achieved.

ESTABLISH CLEAR LINES OF AUTHORITY AND ASSIGNMENTS

It is important for staff to have a clear, singular chain of authority to address daily challenges. Unclear lines of authority and performance expectations may lead to general staffing and/or operational problems.

- As staff return to work, make sure they understand who to go to for questions and issues that arise from implemented changes.
- Consider designating department leads if your practice does not have them already.
- Appoint a pandemic recovery team to assume responsibility for clinical operations, such as scheduling and rooming decisions and new cleaning and sanitizing routines.
- Consider making a member of the recovery team the liaison to monitor and report suspected or confirmed COVID-19 cases to local public health department and monitor public health advisories, and CMG, CDC and DPH and hospital websites. Utilize the ContaCT Connecticut Contact Tracing Platform.
- Establish regularly scheduled, transparent communication between the pandemic surge/recovery team and your clinical teams - mode will depend on the amount of overlap between teams (daily briefing, email update, voicemail, intranet post)
- Include updates from leadership and the pandemic surge/recovery team in daily huddles with clinical teams.

HOLD REGULAR STAFF MEETINGS

Staff meetings allow employee concerns to be acknowledged and addressed before concerns become serious problems. Staff will appreciate your attendance at the meetings - in addition to management. Your participation shows that you are engaged and interested in staff, and the operations of the practice.

Setting an agenda and distributing a copy prior to the meeting will be helpful in keeping the meeting on track and on time. Inform the team of evolving policy changes and relevant clinical updates. Address risk and safety concerns. Provide opportunity for reflection and feedback. Offer acknowledgment and appreciation to your staff for their dedication and support.

Psychological Responses to Phases of Disaster

PHASE 1 – THE PRE-DISASTER PHASE:

- Characterized by fear and uncertainty.
- Specific reactions a community experiences depend on the type of disaster:
    - Disasters with no warning can cause feelings of vulnerability and lack of security; fears of future, unpredicted tragedies; and a sense of loss of control or the loss of the ability to protect yourself and your family
    - Disasters with warning can cause guilt or self-blame for failure to heed the warnings
- May be as short as hours, or even minutes, such as during a terrorist attack, or it may be as long as several months, such as during a hurricane season.

PHASE 2 – THE IMPACT PHASE:

- Characterized by a range of intense emotional reactions—specific reactions also depend on the type of disaster that is occurring.
- Slow, low-threat disasters have psychological effects that are different from those of rapid, dangerous disasters.
- Reactions can range from shock to overt panic.
- Initial confusion and disbelief typically followed by a focus on self-preservation and family protection.
- Usually the shortest of the six phases of disaster.

PHASE 3 – THE HEROIC PHASE:

- Characterized by a high level of activity with a low level of productivity.
- Sense of altruism—many community members exhibit adrenaline-induced rescue behavior.
- Risk assessment may be impaired.
- Often passes quickly into phase 4.

PHASE 4 – THE HONEYMOON PHASE:

- Characterized by a dramatic shift in emotion.
- Disaster assistance readily available.
- Community bonding occurs.
- Optimism exists that everything will return to normal quickly.
- Numerous opportunities available for providers and organizations to establish and build rapport with affected people and groups, and for them to build relationships with stakeholders.
- Typically lasts only a few weeks.

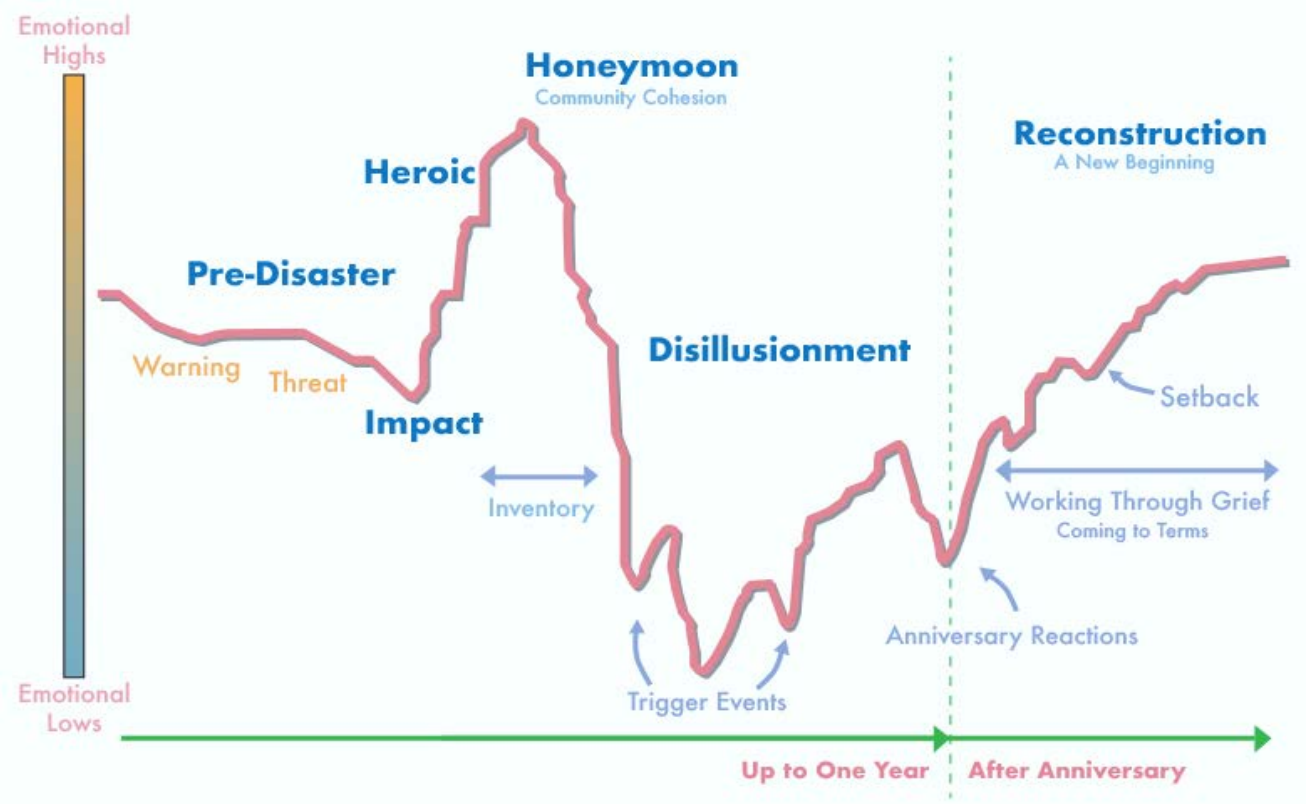
PHASE 5 – THE DISILLUSIONMENT PHASE:

- Stark contrast to the honeymoon phase.

- Communities and individuals realize the limits of disaster assistance.
- As optimism turns to discouragement and stress continues to take a toll, negative reactions, such as physical exhaustion or substance use, may begin to surface.
- Increasing gap between need and assistance leads to feelings of abandonment.
- Especially as the larger community returns to business as usual, there may be an increased demand for services, as individuals and communities become ready to accept support.
- Can last months and even years—often extended by one or more trigger events, usually including the anniversary of the disaster.

PHASE 6 – THE RECONSTRUCTION PHASE:

- Characterized by an overall feeling of recovery.
- Individuals and communities begin to assume responsibility for rebuilding their lives, and people adjust to a new "normal" while continuing to grieve losses.
- Often begins around the anniversary of the disaster and may continue for some time beyond that.
- Following catastrophic events, may last for years.



Adapted from Zunin & Myers as cited in DeWolfe, D. J., 2000. Training manual for mental health and human service workers in major disasters (2nd ed., HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

ASSESS YOUR STAFFING PLAN

Staffing is one of the largest—if not the largest—operating expenses for medical practices. Practice revenue and patient volume may come back slowly, in cycles and unevenly. To prepare for this, practices should consider staffing adjustments, which may include bringing staff and physicians back in different waves.

Engage your team in the design of new office policies and procedures (including back up staffing plans for illness/quarantine needs) and communicate new procedures with staff in advance of reopening practice with request for ongoing feedback and ideas.

- Update contact/emergency contact list for key staff members.
- Assess when and how furloughed staff return, based on ramp-up projections.
- Make a plan that details how and when employees will return to work. Asking all employees to return on the same day at the same time may be overwhelming and chaotic.
- Evaluate which staff can continue telecommuting and by what performance metrics they will be measured.

MANAGE STAFF ABSENTEEISM

Determine how you will operate if absenteeism spikes from increases in sick employees, those who stay home to care for sick family members, and those who must stay home to watch their children until childcare programs and K-12 schools resume.

Cross-train employees to perform essential functions so the workplace can operate even if key employees are absent.

Ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of and understand these policies.

Employers that do not currently offer sick leave to some or all of their employees should consider drafting non-punitive “emergency sick leave” policies.

EVALUATE WORK SCHEDULES

Implementing flextime and/or alternating schedules will help prevent accrual of overtime. Alternating with staff on a later shift rather than implementing a permanent shift change may be acceptable to staff. If overtime is needed, make sure it is pre-approved by you or management before staff work late. Also, review processes and staff work assignments to determine why the overtime is needed rather than routinely approving it after the fact. As an added benefit, mutually respecting each other's time and personal obligations will give a boost to staff morale during this challenging time.

REVIEW AND UPDATE JOB DESCRIPTIONS AND JOB DUTIES

Some staff members may be returning to work in a revised or completely different role than pre-COVID-19. Make sure that staff have a copy of their revised/new job description. This will help ensure that staff understand their role and responsibilities within the practice.

Make sure to update the practice's policies and procedures manual with the new descriptions, including detailed procedures for each job function. Moving forward, review and update all job descriptions annually or when staff change positions within the practice.

Perform background and employment history checks for any new employees hired as a result of staff turnover associated with the closure.

Verify that clinical employees still have active licenses, registrations, and/or certificates.

NOTIFY THE CT DEPARTMENT OF PUBLIC HEALTH

Employers should notify the Connecticut Department of Public Health (CT DPH) when they become aware of any staff member who has been diagnosed with COVID-19, including whether that employee has provided directed patient care, so that appropriate contact tracing and monitoring can be performed; utilize the ContaCT Connecticut Contact Tracing Platform. In addition, employers should keep themselves informed about continually updated requirements from CDC and CT DPH for employee symptom monitoring, provisions for continuing business activities, reporting requirements, and quarantine and isolation of healthcare workers and other staff potentially exposed to COVID-19 in their workplaces.

CMG COMMUNITY MEDICAL GROUP

TELEMEDICINE

Integrate Telemedicine into Your Practice Workflow
Implement a Tele-Triage Program | CMG Telemedicine Resources

INTEGRATE TELEMEDICINE INTO YOUR PRACTICE WORKFLOW

Telemedicine is critical to helping your practice continue or resume care of your patients during the COVID-19 outbreak. ACP's Telemedicine Guide provides practical guidance for incorporating telemedicine into your practice. The following menu of recommendations and resources from ACP's Telemedicine Guide are designed to help you in your COVID-19 recovery plans.

- **Ensure clinical team members have time blocked on their schedule to conduct telemedicine visits:**
  - You can set aside a portion of your day that you know from past experience is typically slow (e.g., Wednesday afternoons).
  - Intersperse telemedicine visits into your daily schedule.
  - Offer telemedicine visits in the evenings or weekends to patients who cannot come in during weekdays due to their work schedule limitations.
- **Train staff to use telehealth documentation templates and algorithms and solicit their ongoing feedback on how to improve them**
- **Train staff on how to appropriately code and bill for the visit:**
  - Telehealth Coding and Billing During COVID-19
- **Identify HIPAA-Compliant technology options to help your practice conduct telehealth visits:**
  - FAQs on Telehealth and HIPAA during the COVID-19 Nationwide Public Health Emergency

IMPLEMENT A TELE-TRIAGE PROGRAM

- **Depending on a patient's medical needs and health status,** a patient contacting the office to make an in- person appointment may need to be redirected to the practice's HIPAA compliant telemedicine platform, a COVID-19 testing site or to a hospital.
- **Utilize a tele-triage program to ensure that patients seeking appointments** are put on the right path by discussing the patient's condition and symptoms.
- **If the practice had already engaged a tele-triage service to handle after-hours calls pre-COVID,** contact this service to see if the service can be expanded to tele-triage daytime calls. You may also consider redeploying the practice's own clinicians or staff to manage this service.
- **Supplementary materials:**
  - CDC COVID-19 Phone Advice Line Tools and Triage Algorithms

Please refer to CMG's Annual Wellness Visit Telemedicine Toolkit and COVID-19 Telemedicine Toolkit for more information about caring for patients via telemedicine during this time.

CMG COMMUNITY MEDICAL GROUP

CONCLUSION: THE NEW NORMAL

Leverage Opportunities to Improve Operations and Patient Care | Prepare for a Second Wave | A Final Note

It is difficult to project how patients will reintegrate routine in-person appointments once stay-at-home orders are relaxed. Personnel are beginning to make plans for re-opening after the shutdown is over. Your individual practice may see a surge, or conversely, patients may be reluctant to enter medical practices due to the concern of COVID-10 exposure.

An important factor that will need to be considered as the stay-at-home orders are relaxed is the high likelihood that social distancing practices will remain in force until 2021, and your current COVID-19 mitigation practices may need to be maintained during this time.

LEVERAGE OPPORTUNITIES TO IMPROVE OPERATIONS AND PATIENT CARE

- Improve processes to share patient data. If your practice does not have access to online faxing capability, hospital EHR access or direct messaging, appoint a practice employee to explore these options to improve the flow of patient data between your practice and other health care entities.
- Encourage/refer patients to have elective procedures in dedicated ambulatory centers instead of hospital -based facilities.
- Plan for the future of providing necessary, routine care, such as vaccination clinics.
- Evaluate the viability of COVID-19 POC testing in office.
- Plan for an ongoing need for PPE and a supply chain. Continue established relationships with suppliers so if a surge occurs at a later date, your practice will have inventory on hand and can be considered a priority customer.

PREPARE FOR A SECOND WAVE

- Most scientists and researchers believe a second wave of COVID-19 is inevitable, and is likely to coincide with the cold and flu season. Keeping employees and patients healthy will help keep your practice a viable entity prepares to weather the next wave of illness.
- Mitigate a possible surge this fall or winter.
- Encourage every patient to get a flu shot. Increasing the number of people who are vaccinated for the flu is particularly important this year, since a normal flu season often taxes the resources of the health care system.
- Offer COVID-19 testing to larger patient populations as testing becomes increasingly available. Continue to monitor testing guidance from the CDC and State of Connecticut DPH.
- Counsel patients to take care of health needs now, while the curve is flattening. Unfortunately, people have stayed away from the health care system in ways that are unhealthy, out of fear of exposure, putting off chronic care visits and waiting too long to address symptoms.
- Proactively manage patients at higher risk for COVID-19 complications. This may be an opportune time to help patients control chronic illnesses such as heart disease, hypertension, diabetes and obesity.
- Promote medication adherence by prescribing cost-effective treatment, 90-day supplies and addressing reasons for non-compliance during patient visits.

- Evaluate patient interest in holding group-counseling sessions for patients with chronic conditions in order to mitigate isolation and provide a supportive environment.
- Consider providing free webinars for health-related topics on a regular basis, focus on uplifting viewers and guiding them toward healthier lifestyles.

A FINAL NOTE

The COVID-19 pandemic has rapidly changed how we live, work and learn.

The "new normal" of this public health emergency coupled with the guidance around physical distancing also makes this a trying time for clinicians, employees, health care systems and others who support patient care.

In the face of the current global pandemic, we will need to continue to collaborate and work creatively and proactively. Community Medical Group is here to help while you take the necessary actions to keep yourselves, your families, your colleagues and your patients safe and healthy.

Access your CMG resources, including Provider Relations, Care Management, Coding and Clinical Quality supports. We are all in this together.

COMMUNITY MEDICAL GROUP

OTHER RESOURCES AND REFERENCES

Checklist to Prepare Practices for COVID-19

COVID-19 EDUCATION

- ☐ Educate staff about coronavirus disease 2019 (COVID-19) and why it is important to contain the outbreak.
- ☐ Educate staff on facility policies and practices to minimize chance of exposure to respiratory pathogens, including SARS-CoV-2, the virus that causes COVID-19.
- ☐ Train and educate staff with job- or task-specific information on preventing transmission of infectious agents, including refresher training.
- ☐ Educate staff about COVID-19 evaluation and treatment.
- ☐ Educate staff about alternative office management plans.
- ☐ Educate staff on how to advise patients about changes in office procedures (e.g., calling prior to arrival if the patient has any signs of a respiratory infection and taking appropriate preventive actions) and developing family management plans if they are exposed to COVID-19.

OFFICE PREPAREDNESS

- ☐ Design a COVID-19 office management plan that includes patient flow, triage, treatment and design.
- ☐ Consider designing and installing engineering controls to reduce or eliminate exposures by shielding staff and other patients from infected individuals. (If applicable in your setting)
- ☐ Provide hand sanitizer, approved respirators (if applicable), face shields/goggles, surgical masks, gloves, and gowns for all caregivers and staff to use when within six feet of patients with suspected COVID-19 infection.
- ☐ Ensure adherence to standard precautions, including airborne precautions and use of eye protection. Assume that every patient is potentially infected or colonized with a pathogen that could be transmitted in a health care setting.
- ☐ Implement mechanisms and policies that promptly alert key facility staff, including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known suspected COVID-19 patients (i.e. PUJ).
- ☐ Keep updated lists of staff and patients to identify those at risk in the event of an exposure.
- ☐ Staff should follow the CDC guidelines on collecting, handling and testing clinical specimens.
- ☐ Prepare for office and clinical staff illness, absences, and/or quarantine.
    - o Develop guidance for staff monitoring for signs of illness (including self-reporting, self- quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
    - o Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
    - o Plan for staff access to medical care for them-selves and their families; determine whether illness will be handled as workers' compensation or personal insurance depending on situation/criteria and share best practices.
- ☐ Cross-train staff for all essential office and medical functions.

- ☐ Determine contingency plan for at-risk staff (e.g., pregnant, other defined risk groups) including job expectations and potential alternate roles and locations.
- ☐ Evaluate the need for family support to enable staff to work (e.g., childcare, pet care). Provide information for family care plans.
- ☐ Review proper office and medical cleaning routines.
- ☐ Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- ☐ Management of medical waste should also be performed in accordance with routine procedures.
- ☐ Plan for cross-coverage with other healthcare professionals in your community and participate in local hospital planning exercises. (If applicable)
- ☐ Identify materials and supplies required for care to be delivered during an outbreak or pandemic, and suppliers that can provide those materials. Order appropriate materials and supplies.
- ☐ Contact representatives at your office's waste-disposal service regarding plans for appropriate waste disposal so that they can prepare for an increased amount of waste materials. Currently, there is no evidence to support the need of different waste management protocols for facilities caring for patients with COVID-19.
- ☐ Create templated charts for COVID-19 patients including discharge instructions and prescriptions.
- ☐ Stay informed. Visit your state and local department of health's website often or develop a reliable method for routine epidemiologic monitoring. Make appropriate connections with local and state health department staff.
- ☐ Become knowledgeable about available testing and treatment as that information becomes available. This should include general recommendations on COVID-19 from the Centers for Disease Control and Prevention (CDC).
- ☐ Work with your state and local health departments on diagnostic testing protocols and procedures.
- ☐ Ensure that you and your staff are familiar with specific public health reporting practices legally required in your area. Familiarize staff with procedures on transporting patients from your office to the hospital or other facility if required.
    - o ContaCT Connecticut Contact Tracing Platform
- ☐ Post signage in appropriate languages at the entrance and inside the office to alert all patients with respiratory symptoms and fever to notify staff immediately.
- ☐ Post signage in appropriate languages with pictures to teach/remind all patients about correct respiratory hygiene and cough etiquette. Specifically, they should cough and sneeze into a tissue (which then should be properly discarded), or into the upper sleeve. Remind patients to use appropriate hand-washing technique.

TRIAGE AND PATIENT FLOW SYSTEMS

- ☐ Determine screening process and location (e.g., curbside screening prior to entry, supplemental screening at intake, separate well/ill clinics, etc.).
- ☐ Develop a triage protocol for your practice based on patient and community outbreak.

- Develop telemedicine service plan for use for patients with special needs or general population.
- Recommend that patients with respiratory symptoms and fever call the office before arrival.
- Implement alternative patient flow systems.
    - Attempt to isolate all patients with suspected symptoms of any respiratory infection using doors, remote office areas, or negative- pressure rooms, if available.
    - Evaluate patients with acute respiratory illness (ARI) promptly.
- After delivering care, exit the room as quickly and directly as possible {i.e., complete documentation in a clean area).
- Clean room and all medical equipment completely with appropriate cleaning solutions.
- When possible, reorganize waiting areas to keep patients with respiratory symptoms a minimum of 6 feet away from others and/or have a separate waiting area for patients with respiratory illness.
- Consider arranging a separate entrance for symptomatic patients.
- Schedule patients with ARI for the end of a day or at another designated time.
- Determine how suspect cases will be isolated from other patients in the clinic space.
- Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
- Provide no-touch waste containers with disposable liners in all reception, waiting, patient care and restroom areas.
- Provide alcohol-based hand rub and masks in all reception, waiting, patient care and restroom areas for patients with respiratory symptoms.
- Always keep soap dispensers stocked with hand-washing signs.
- Discontinue the use of toys, magazines, and other shared items in waiting areas, as well as office items shared among patients, such as pens, clipboards, phones, etc.
- Frequently wipe down public areas. Wipe down items such as pens and clip boards between uses by individuals.
- Dedicate equipment, such as stethoscopes and thermometers, to be used in ARI areas. This equipment should be cleaned with appropriate cleaning solutions for each patient. Consider the use of disposable equipment when possible. (e.g., blood pressure cuffs)

REFERRAL OR TRANSFER OF PATIENTS

- While the patient is waiting for diagnostic test results, home isolation may be required.
- Develop patient education materials to inform such patients of the reason for home isolation and the process to be followed.
- Transportation to a referral/transfer site should be handled by a previously exposed family member in a persona l vehicle, or by a health facility vehicle such as an ambulance, not via public transportation.
- Notify the recipient of a referred/transferred patient that a suspected COVID-19 case is being referred/transferred.
- Implement appropriate public health reporting procedures.
    - ContaCT Connecticut Contact Tracing Platform.

ADDITIONAL OPTIONS TO PREVENT COMMUNITY TRANSMISSION

Per the CDC, please consider the following options to prevent the spread of community transmission:

- ☐ Develop optional protocols and procedures for your practice based on patient and community outbreak.
- ☐ Explore alternatives to face-to-face triage and visits.
- ☐ Learn more about how healthcare facilities can prepare for Community Transmission. Designate an area at the facility (e.g., an ancillary building or temporary structure) or identify a location in the area to be a "respiratory virus evaluation center" where patients with fever or respiratory symptoms can seek evaluation and care. (If possible)
- ☐ Cancel group healthcare activities (e.g., group therapy, recreational activities).
- ☐ Postpone elective procedures, surgeries and non-urgent outpatient visits.
- ☐ Provide patients and families with information about stress responses, resilience and available professional mental health/ behavioral health resources.
- ☐ Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.

WASTE DISPOSAL

- ☐ No-touch methods should be used to dispose of waste materials with respiratory secretions.
- ☐ Arrange to use the currently recommended methods for disposal of dangerous waste.
- ☐ Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
- ☐ Products with emerging viral pathogens claims are recommended for use against SARS-CoV-2. Management of medical waste should also be performed in accordance with routine procedures.

CHECKLIST OF REQUIRED EQUIPMENT/SUPPLIES

- ☐ Healthcare facility should provide Personal Protective Equipment in accordance with current CDC guidance and OSHA's standards (29 CFR 1910).
- ☐ Clear signage with pictures recommending patients call first if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever).
- ☐ Signage in appropriate languages instructing patients to alert staff about respiratory symptoms and correct hygiene and cough etiquette. It's helpful to have signage with pictures.
- ☐ Alcohol-based hand sanitizer and masks placed at the front of office/practice.
- ☐ Boxes of disposable tissues.
- ☐ While the patient is waiting for diagnostic test results, home isolation may be required. Develop patient education materials to inform such patients of the reason for home isolation and the process to be followed.
- ☐ Transportation to a referral/transfer site should be handled by a previously exposed family member in a personal vehicle, or by a health facility vehicle.
- ☐ Single-use towels and tissues for use throughout the office.

- No-touch wastebaskets and disposable liners.
- Alcohol-based hand rub for reception, waiting, patient care and restroom areas.
- Single-use gloves.
- N95 respirators, face shields/goggles, surgical masks and gowns for providers and staff, as appropriate.
- Appropriate disinfectant for environmental cleaning. Train staff and assess that it is used correctly.
- Buckets and single-use mops.
- Adequate medical supplies (e.g., IV solutions, antivirals, antibiotics), as appropriate for location.
- Handouts made available prior to an outbreak or pandemic, and posters and patient education materials posted during an outbreak or pandemic.

KEY COVID-19 WEBSITES:

CDC for Health Departments

CDC Situation Summary

CDC for Healthcare Professionals

CDC Get Your Home Ready

CMS Coverage and Payment Related to COVID-19 Medicare

Connecticut Department of Public Health

Medical & Professional Associations

MEDICAL ASSOCIATIONS:

- American Medical Association [AMA] - http://www.ama-assn.org/:
- Administration on Aging - http://www.aoa.gov/
- American Academy of Allergy Asthma & Immunology - http://www.aaaai.org/
- American Academy of Child & Adolescent Psychiatry - http://www.aacap.org/
- American Academy of Dermatology - http://www.aad.org/
- American Academy of Family Physicians - http://www.aafp.org/
- American Academy of Neurology - http://www.aan.com/
- American Academy of Ophthalmology - http://www.aao.org/
- American Academy of Orthopaedic Surgeons - http://www.aaos.org/
- American Academy of Pain Medicine - http://www.painmed.org/
- American Academy of Pediatrics - http://www.aap.org/
- American Academy of Physical Medicine & Rehabilitation - http://www.aapmr.org/
- American Association of Clinical Endocrinologists - http://www.aace.com/
- American Association of Colleges of Osteopathic Medicine - http://www.aacom.org/Pages/default.aspx
- American Association of Electrodiagnostic Medicine - http://www.aaem.net/
- American Association of Neurological Surgeons - http://www.aans.org/
- American Board of Allergy & Immunology - http://www.abai.org/
- American Board of Emergency Medicine - http://www.abem.org/public/
- American Board of Family Medicine - https://www.theabfm.org/
- American Board of Internal Medicine - http://www.abim.org/
- American Board of Medical Genetics - http://genetics.faseb.org/genetics/abmg/abmgmenu.htm
- American Board of Medical Specialties - http://www.abms.org/
- American Board of Neurological Surgery - http://www.abns.org/
- American Board of Obstetrics and Gynecology - http://www.abog.org/
- American Board of Ophthalmology - http://www.abop.org/index1.asp

- American Board of Orthopaedic Surgery - https://www.abos.org/
- American Board of Otolaryngology - http://www.aboto.org/
- American Board of Pathology - http://www.abpath.org/
- American Board of Pediatrics - https://www.abp.org/
- American Board of Preventive Medicine - http://www.abprevmed.org/
- American Board of Psychiatry and Neurology - http://www.abpn.com/
- American Board of Radiology - http://www.theabr.org/
- American Board of Surgery - http://home.absurgery.org/default.jsp?index
- American Cancer Society - http://www.cancer.org/docroot/home/index.asp
- American College of Cardiology - http://www.acc.org/
- American College of Chest Physicians - http://www.chestnet.org/
- American College of Emergency Physicians - http://www.acep.org/
- American College of Obstetricians and Gynecologists - http://www.acog.com/
- American College of Physicians - http://www.acponline.org/
- American College of Preventive Medicine - http://www.acpm.org/
- American College of Radiology - http://www.acr.org/
- American College of Rheumatology - http://www.rheumatology.org/
- American College of Surgeons - http://www.facs.org/
- American Heart Association - http://www.americanheart.org/
- American Institute of Ultrasound in Medicine - http://www.aium.org/
- American Neurological Association - http://www.aneuroa.org/
- American Osteopathic Association - http://www.aoa-net.org/
- American Psychiatric Association - http://www.psych.org/
- American Roentgen Ray Society - http://www.arrs.org/
- American Society for Bariatric Surgery - http://www.asbs.org/
- American Society for Dermatologic Surgery - http://www.asds.net/
- American Society for Gastrointestinal Endoscopy - http://www.asge.org/
- American Society for Therapeutic Radiology and Oncology - http://www.astro.org/

- American Society of Addiction Medicine - http://www.asam.org/
- American Society of Anesthesiologists - http://www.asahq.org/
- American Society of Cataract and Refractive Surgery - http://www.ascrs.org/
- American Society of Clinical Oncology - http://www.asco.org/
- American Society of Internal Medicine - http://www.acponline.org/
- American Society of Ophthalmic Plastic and Reconstructive Surgery - http://www.asoprs.org/
- American Society of Plastic and Reconstructive Surgeons - http://www.plasticsurgery.org/
- American Thoracic Society - http://www.thoracic.org/
- American Urological Association - http://www.auanet.org/index.cfm
- Centers for Disease Control - http://www.cdc.gov/
- College of American Pathologists - http://www.cap.org/
- Council of Medical Specialty Societies - http://www.cmss.org/
- Endocrine Society, The - http://www.endo-society.org/
- Federation of State Medical Boards of the United States - http://www.fsmb.org/
- National Board of Medical Examiners - http://www.nbme.org/
- National Cancer Institute - http://newscenter.cancer.gov/
- National Council on the Aging - http://www.ncoa.org/
- National Eye Institute - http://www.nei.nih.gov/
- National Heart, Lung, and Blood Institute - http://www.nhlbi.nih.gov/index.htm
- National Hemophilia Foundation - http://www.hemophilia.org
- National Institute of Allergy and Infectious Diseases - http://www3.niaid.nih.gov/
- National Institute of Arthritis and Musculoskeletal and Skin Diseases - http://www.niams.nih.gov/
- National Institute of Child Health and Human Development - http://www.nichd.nih.gov/
- National Institutes of Health - http://www.nih.gov/
- National Institute on Aging - http://www.nia.nih.gov/
- National Institute on Deafness and Other Communication Disorders - http://www.nia.nih.gov/
- National Institute of Diabetes & Digestive & Kidney Diseases - http://www.niddk.nih.gov/
- National Organization for Rare Disorders - http://www.rarediseases.org/

- Radiological Society of North America - http://www.rsna.org/
- Society for Investigative Dermatology - http://www.sidnet.org/
- Society of American Gastrointestinal Endoscopic Surgeons - http://www.sages.org/
- Society of Cardiovascular & Interventional Radiology - http://www.scvir.org/
- Society of Critical Care Medicine - http://www.sccm.org/Pages/default.aspx
- Society of Nuclear Medicine - http://www.snm.org/
- Society of Thoracic Surgeons - http://www.sts.org/

MEDICAL TRANSCRIPTION ASSOCIATIONS:

- The Association for Healthcare Documentation Integrity {AHDI} -[Formerly: AAMT] - http://ahdionline.org/
- AHDI State/Regional Associations - http://www.ahdionline.org/
- Journal of the American Association for Medical Transcription - http://www.jaamtonline.com/
- Carolinas Regional Association for Healthcare Documentation Integrity {CRAHDI} - http://www.ahdionline.org/
- Florida Association for Medical Transcription - http://fl-amt.org/
- Utah Association for Medical Transcription - http://www.utahamt.org/

MEDICAL CODING ASSOCIATIONS:

- American Academy of Professional Coders – http://www.aapc.com/
- American Health Information Management Association – http://www.ahima.org/
- Association of Registered Health Care Professionals – http://www.arhcp.org/

MEDICAL BILLING ASSOCIATIONS:

- American Medical Billing Association - http://www.ambanet.net/AMBA.htm
- Electronic Medical Billing Network of America, Inc. - http://www.medicalbillingnetwork.com/
- Healthcare Billing & Management Association - http://www.hbma.org/
- Medical Association of Billers - http://www.e-medbill.com/
- National Electronic Billers Alliance - http://www.nebazone.com/

Template for Practice Communication to Patients about Reopening or Resuming Care
Highlighted text should be modified based on your practice's specific protocols/procedures

Dear [Patient],

Now, more than ever, it is important to care for your health and well-being, and regular medical care is essential to maintaining good health. Our office will be open and accepting appointments again on [DATE] / OR We want to remind all of our patients that we are still scheduling appointments.

As we re-open/resume medical care in our office, your health is our top priority. We want to help you access, and not delay, the care you need. It is more important than ever to take care of chronic conditions such as diabetes, high blood pressure, heart disease, and lung disease. Cancer screening and immunizations are also important to your continued health. Some routine care may be able to wait, but other issues should be addressed quickly.

Our staff will reach out to patients whose appointments were canceled, asking them to re-schedule care/ OR Please contact us [provide a contact phone/e-mail/patient portal link] to see if you should schedule an appointment at this time.

[Name of your clinical practice] is doing all we can to keep our patients and staff safe and healthy. If we decide that your care needs can be met by a telemedicine visit instead of an in-person office visit, we will provide a telemedicine appointment. We will make this decision with you during our tele-triage process.

It is natural to feel anxious about visiting our office in person also being advised to physically distance to prevent infection. To reassure you, here are some of the changes we are making to minimize any potential risk of virus transmission:

- Early morning and evening appointments for older and vulnerable patients.
- A "no-touch" registration option via your mobile phone.
- Less waiting time. Our office will send you a text alert when it's your turn to come back, so you can wait for your appointment in your car or outside of the building
- Our waiting room has been reconfigured to have chairs spaced apart, Plexiglas shields, and no shared reading material.
- Separate time and space for those experiencing COVID-related symptoms or other respiratory complaints.
- Care staff will wear full PPE (personal protective equipment) and are being regularly screened for symptoms of COVID-19.
- Requiring patients to wear masks at all times. We can provide you with a mask if you do not have your own.
- Requiring patients to have temperature checks and answer questions about symptoms prior to appointments.
- Office procedures that will limit the number of staff you interact with.
- Patient exam room changes that reduce unnecessary contact with in-room surfaces.
- Careful cleaning and disinfecting protocols between patients for all equipment that is used.
- Pre-visit lab testing, to make virtual or live visits more productive and cut down on the need for follow-up communication.
- Asking that you limit companions to individuals whose participation in the appointment is necessary based on your situation.

We understand that COVID-19 and our related policies present challenges to some of you. If you have concerns regarding companion care or transportation needs, please reach out to us. We are ready to problem solve with you. Please call the office first before going to the Emergency Room or calling 911, unless you are having a life-threatening emergency.

Our care team is committed to providing you with the same excellent care you've come to know and trust. Your visit to our office may be slightly different under today's circumstances, but what hasn't changed is our commitment to delivering safe care, when and where you need it most. We thank you for your patience, support, and cooperation as we work together to continue our care for your health and well-being, and for the health of our community.

If you have any questions or concerns, please reach out to [contact information].

Sincerely,

Office Manager
[Name of Medical Practice]

ATTENTION PATIENTS

If you have any of the following symptoms:
- **Cough**
- **Fever**

Please use hand sanitizer and put on a mask.

Have you traveled outside of the United States in the last 30 days? Please Tell the Nurse.

AVISO A PACIENTES

Si tiene cualquiera de los siguientes síntomas:
- **Tos**
- **Fiebre**

Utilice un desinfectante de manos y póngase una mascarilla.

Avísele a la enfermera si usted viajó fuera de los EE. UU. en los últimos 30 días.

تنبيه للمرضى

إذا كان لديك أي من الأعراض التالية :

- **السعال**
- **الحمى**

يرجى استخدام المطهر اليد ووضع على قناع
هل سافرت خارج الولايات المتحدة في آخر 30 يومًا؟
من فضلك أخبرالممرضة

病人請注意

如果你有任何以下症狀：
- **咳嗽**
- **發燒**

請使用洗手液並戴上口罩
請告訴護士您過去30天有沒有在美國以外旅行？

Stop Germs! Wash Your Hands.

When?

- After using the bathroom
- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage

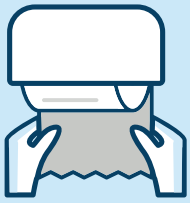
How?

Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.

Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.

Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.

Rinse hands well under clean, running water.



Dry hands using a clean towel or air dry them.

Keeping hands clean is one of the most important things we can do to stop the spread of germs and stay healthy.

LIFE IS BETTER WITH CLEAN HANDS

www.cdc.gov/handwashing

This material was developed by CDC. The Life is Better with Clean Hands Campaign is made possible by a partnership between the CDC Foundation, GOJO, and Staples. HHS/CDC does not endorse commercial products, services, or companies.

CS310027-A

¡Detenga los microbios! Lávese las manos

¿CUÁNDO?

- Después de ir al baño.
- Antes, durante y después de preparar alimentos.
- Antes de comer.
- Antes y después de cuidar a alguien que tenga vómitos o diarrea.
- Antes y después de tratar cortaduras o heridas.
- Después de cambiarle los pañales a un niño o limpiarlo después de que haya ido al baño.
- Después de sonarse la nariz, toser o estornudar.
- Después de tocar animales, sus alimentos o sus excrementos.
- Después de manipular alimentos o golosinas para mascotas.
- Después de tocar la basura.

¿CÓMO?

Mójese las manos con agua corriente limpia (tibia o fría), cierre el grifo y enjabónese las manos.

Frótese las manos con el jabón hasta que haga espuma. Asegúrese de frotarse la espuma por el dorso de las manos, entre los dedos y debajo de las uñas.

Restriéguese las manos durante al menos 20 segundos. ¿Necesita algo para medir el tiempo? Tararee dos veces la canción de “Feliz cumpleaños” de principio a fin.

Enjuáguese bien las manos con agua corriente limpia.

Séquese Séquese las manos con una toalla limpia o al aire.

Mantener las manos limpias es una de las cosas más importantes que podemos hacer para detener la propagación de microbios y mantenernos sanos.

LA VIDA ES MEJOR CON LAS MANOS LIMPIAS

www.cdc.gov/lavadodemanos

Este material fue elaborado por los CDC. La campaña La Vida es Mejor con las Manos Limpias es posible gracias a una asociación entre la Fundación de los CDC, GOJO y Staples. El HHS y los CDC no respaldan productos, servicios ni empresas comerciales.

CS310027-A

Social Distancing Guidelines

Social Distancing Guidelines

General Guidelines

- All persons should arrive wearing a mask.
- Provide a mask if needed
- Exceptions include:
  - Young children under age 2.
  - Anyone who has trouble breathing.
  - Anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Attempt to maintain social distancing of 6 feet
- Remember that hand hygiene is essential to maintaining safety, even if you are wearing masks. If the face mask is touched, adjusted or removed, hand hygiene should be performed.

Common Areas

- Do not congregate in groups
- Limit persons in elevators to maintain social distance.
- Attempt to maintain social distance of 6 feet.

Dining

- Food should be individually wrapped or boxed for distribution.
- Self-service from trays or buffets is discouraged
- Remove PPE and perform hand hygiene prior to eating

Environment

- Place visual markers to separate by 6 feet.
- Install physical barriers for protection such as Plexiglass.
- Limit seating to maintain social distance by removing chairs or otherwise labeling if not to be used.

Staff Guidance

- Don a mask when entering the facility.
- Eat at desk, alone at tables or outdoors, if feasible.
- Stagger meals and breaks by time and location.
- All staff areas should limit chairs and separate tables, so persons are separated by 6 feet.
- Avoid in person meetings. Use on-line conferencing, email or phone when possible, even when people are in the same building
- Unavoidable in-person meetings should be kept short and in rooms where social distance can be maintained.

This document provides guidance for the current situation and may change as the pandemic evolves as well as with government mandates and availability of resources.

Social Distancing – Ambulatory Care

Yale NewHaven Health

Social Distancing - Ambulatory Care

Before Arrival

- Use pre-appointment phone calls to assess patient symptoms and provide instructions regarding entering the facility.
- Consider phone and virtual visits.
- Stagger face-to-face visits with telehealth visits to decrease the number of patients in waiting rooms.
- Plan for ill patients who need to be seen in person.
- Some patients may need Covid-19 testing before they arrive for their appointment and or procedure (i.e., surgery).
- Do not advise patients to arrive 15 minutes prior to appointments.
- Remind patient to arrive with a mask.
- Consider limiting entry points into the facility.
- If you are located in a building with other offices, consider posting signage in key areas outside your building.

During Visit

- Provide a mask if patient arrives without one.
- Limit waiting room time by having patients wait outside or in their vehicle.
- Consider registering/rooming/screening patients while remaining in the vehicle.
- Unless absolutely necessary no person will be allowed to enter with the patient.
- Immediately room patient, if possible
- Limit the number of care givers per patient

Environment

- Place visual markers to separate by 6 feet.
- Install physical barriers for protection such as Plexiglass.
- Limit seating to maintain social distance by removing chairs or otherwise labeling if not to be used.
- Remove shared reading material from the waiting room.
- Temporarily restrict access to the nutrition centers to staff only.

Staff Guidance

- Don a mask when entering the facility.
- Eat at desk, alone at tables or outdoors, if feasible.
- Stagger meals and breaks by time and location.
- All staff areas should limit chairs and separate tables, so persons are separated by 6 feet.
- Avoid in person meetings. Use on-line conferencing, email or phone when possible, even when people are in the same building
- Unavoidable in-person meetings should be kept short and in rooms where social distance can be maintained.

Social Distancing – Clinical Care

Social Distancing - Clinical Care

Clinical Care

- Limit the number of care givers per patient.
- Coordinate with ancillary departments for scheduling blood draws, imaging, vital signs, etc.
- Curtains should be drawn in between patients in open wards and semi-private rooms.
- Maintain social distance while in charting areas and while conducting rounds.

Environment

- Place visual markers to separate by 6 feet.
- Install physical barriers for protection such as Plexiglass.
- Limit seating to maintain social distance by removing chairs or otherwise labeling if not to be used.
- Temporarily restrict access to the nutrition centers to staff only.

Staff Guidance

- Don a mask when entering the facility.
- Eat at desk, alone at tables or outdoors, if feasible.
- Stagger meals and breaks by time and location.
- All staff areas should limit chairs and separate tables, so persons are separated by 6 feet.
- Avoid in person meetings. Use on-line conferencing, email or phone when possible, even when people are in the same building
- Unavoidable in-person meetings should be kept short and in rooms where social distance can be maintained.

*Please complete the following information for all patients with a **laboratory-confirmed** diagnosis of COVID-19. Fax completed forms to DPH Epidemiology & Emerging Infections Program **860-629-6962**.*

PATIENT INFORMATION ***All dates in mm/dd/yyyy format.***

Name Last _____ First _____ Middle _____

Street Address_____

City_____ County_____ State_____ Zip _____

Phone: _____ **Date of Birth** _____

Race ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Other, specify: _____
Ethnicity: Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Gender ☐ Female ☐ Male ☐ Other ☐ Unknown **If female**, pregnant? ☐ Yes ☐ No ☐ Unknown

Did patient reside or spend time in a congregate setting? ☐ Yes ☐ No
☐ Reside ☐ Attend ☐ Work in ☐ Volunteer
☐ Long term care facility/assisted living ☐ Homeless shelter ☐ Jail/prison ☐ Other
If yes, name of facility: _____ **Town:** _____

Is the patient a healthcare worker? ☐ Yes ☐ No
If yes, name of facility: _____ **Town:** _____

Were there any symptoms associated with this illness/event? ☐ Yes ☐ No ☐ Unknown
If symptomatic, date of onset _____
Symptoms ☐ Cough ☐ Fever ☐ Shortness of breath ☐ Fatigue ☐ Headache

Did the patient develop pneumonia? ☐ Yes ☐ No ☐ Unknown If yes, abnormal chest CT/x-ray: ☐

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown
If yes, Hospital Name _____ MR# _____
Admission date:_____ Discharge date: _____
Was patient treated in the ICU? ☐ Yes ☐ No ☐ Unknown

Did patient die? ☐ No ☐ Yes (date of death: _____)

PROVIDER/REPORTER & FACILITY INFORMATION

Healthcare Provider: Last _____ First _____
Person Completing Report: Last _____ First _____
Facility Name: _____
Facility Address: _____
Phone Number: _____ **Fax Number:** _____
Email Address: _____

DPH USE

Case ID: _____ Report Date: _____
mm/dd/yyyy

FIT Testing Resources

- Concentra Respirator Fit Tests: https://www.concentra.com/physical-exams/respirator-fit-test/
- 3M FIT Testing Kits: https://www.3m.com/3M/en_US/safety-centers-of-expertise-us/respiratory-protection/fit-testing/
- Professional Fit Testing Services (in person and online): https://profittesting.com/
- National Safety Services: http://www.ntlsaf.com/

Note: This list of resources is provided for representative purposes only—other resources may be available. Additionally, CMG does not endorse or have any relationship with any of these companies.

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

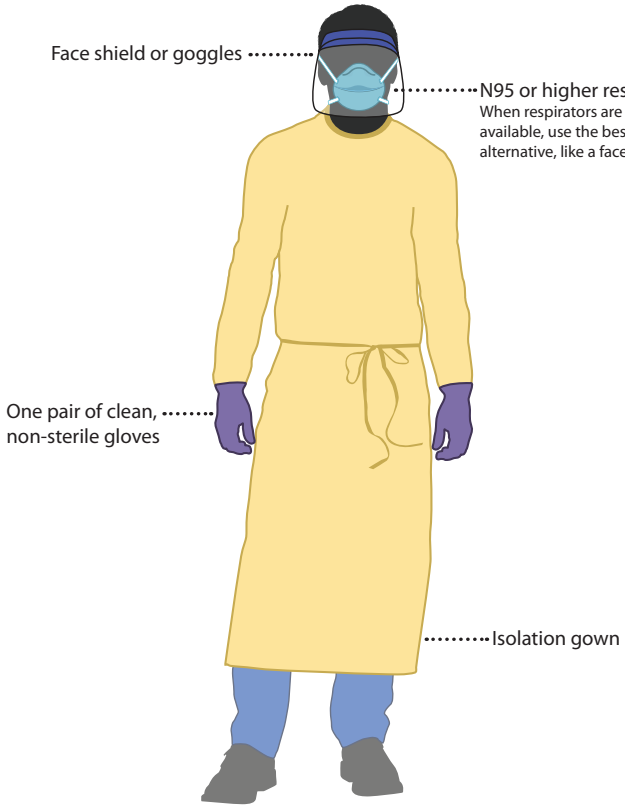
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

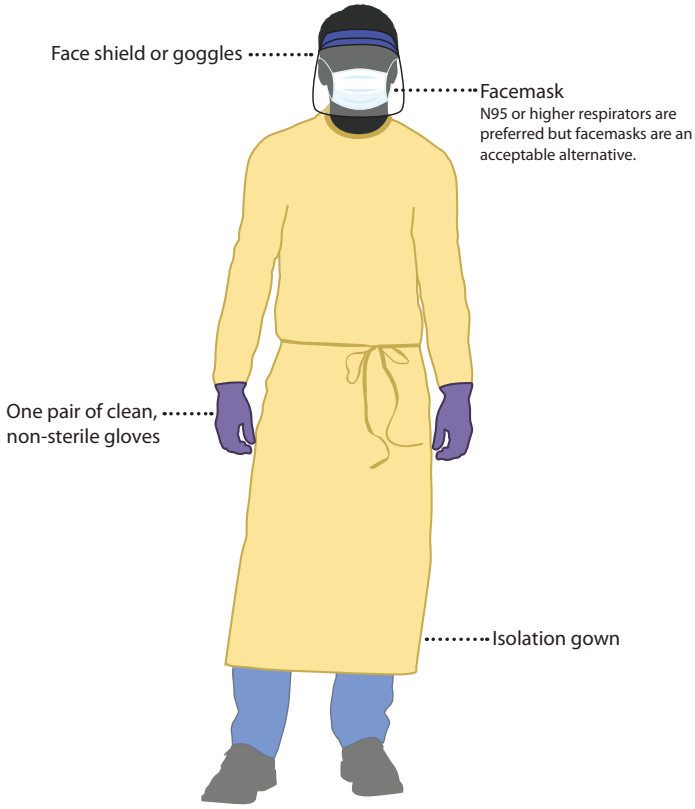
Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask



CS 316124-A 03/30/2020

Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
   - » **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - » **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Perform hand hygiene before putting on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
   - » **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
   - » **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance)

Summary of Recent Changes as of April 30, 2020

- Changed the name of the 'non-test-based strategy' to the 'symptom-based strategy' for those with symptoms and the 'time-based strategy' for those without symptoms, and updated these to extend the duration of exclusion from work to at least 10 days since symptoms first appeared. This update was made based on evidence suggesting a longer duration of culturable viral shedding and will be revised as additional evidence becomes available.
- Based on this extension of the symptom-based and time-based strategies, language about the test-based strategy being preferred was removed.
- Removed specifying use of nasopharyngeal swab collection for the Test-Based Strategy and linked to the Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV), so that the most current specimen collection strategies are recommended.

CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Who this is for: Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection [e.g., cough, sore throat, shortness of breath, fever] but did not get tested for COVID-19).

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

Symptomatic HCP with suspected or confirmed COVID-19 (Either strategy is acceptable depending on local circumstances):

- *Symptom-based strategy*. Exclude from work until:
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy.* Exclude from work until:
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

- *Time-based strategy.* Exclude from work until:
  - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

- *Test-based strategy*. Exclude from work until:
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Consider consulting with local infectious disease experts when making return to work decisions for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised).

If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information. As part of this, asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work in a crisis capacity strategy to address staffing shortages if they wear a facemask for source control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19 which is 14 days.

Footnotes

[1]All test results should be final before isolation is ended. Testing guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract specimens.

Definitions

Cloth face covering: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on design, use, and maintenance of cloth face coverings.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

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References

- American College of Physicians. Coronavirus Disease 2019 (COVID-19): Information for Internists. 7 May 2020. https://www.acponline.org/clinical-information/clinical-resources-products/coronavirus-disease-2019-covid-19-information-for-internists
- American College of Physicians. Telehealth Coding and Billing During COVID-19. 22 May 2020. https://www.acponline.org/practice-resources/covid-19-practice-management-resources/telehealth-coding-and-billing-during-covid-19
- American Medical Association. COVID-19: A Physician Practice Guide to Reopening. 2020. https://www.ama-assn.org/delivering-care/public-health/covid-19-physician-practice-guide-reopening
- Centers for Disease Control and Prevention. Cleaning and Disinfection for Community Facilities. 1 April 2020. https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html
- Centers for Disease Control and Prevention. Coronavirus Self-Checker. Undated. https://covid19healthbot.cdc.gov/
- Centers for Disease Control and Prevention. Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance). 30 April 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- Centers for Disease Control and Prevention. Get Your Clinic Ready for Coronavirus Disease 2019 (COVID-19). 11 March 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinic-preparedness.html
- Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. 31 January 2020. https://www.cdc.gov/handhygiene/providers/index.html
- Centers for Disease Control and Prevention. If You Are Sick or Caring for Someone. 24 May 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html#precautions.
- Centers for Disease Control and Prevention. Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19. 20 April 2020. https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html.
- Centers for Disease Control and Prevention. Phone Advice Line Tool for possible COVID-19 patients. 30 March 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/phone-guide/index.html
- Centers for Disease Control and Prevention. Public Health Recommendations for Community-Related Exposure. 30 March 2020. https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html
- Centers for Disease Control and Prevention. Respiratory Hygiene/Cough Etiquette in Healthcare Settings. 1 August 2019. https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
- Centers for Disease Control and Prevention. Sequence for Putting On Personal Protective Equipment (PPE). Undated. https://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf
- Centers for Disease Control and Prevention. Strategies to Optimize the Supply of PPE and Equipment. 18 May 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
- Centers for Disease Control and Prevention. Three Key Factors required a Respirator to be Effective. Undated. https://www.cdc.gov/niosh/npptl/pdfs/KeyFactorsRequiedResp01042018-508.pdf
- Centers for Medicare & Medicaid Services Website. https://www.cms.gov/
- Connecticut State Government. CONTACT Connecticut Contact Tracing Platform. Undated. https://portal.ct.gov/Coronavirus/ContaCT
- DecisionHealth. Part B News. 27 April 2020. Volume 34, Issue 17. https://pbn.decisionhealth.com/Articles/List.aspx?newsId=203016
- Immunize Action Coalition. Using Standing Orders for Administered Vaccines: What You Should Know. Undated. https://www.immunize.org/catg.d/p3066.pdf
- Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19. 5 May 2020. https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html
- Kareo, Inc. 10 Ways to Ease Patient Concerns About In-Office Appointments. 2020. https://www.kareo.com/resource/cl_23216/checklist-10-ways-ease-patient-concerns-about-office-appointments
- Mayo Clinic. COVID-19: Outpatient testing, management, and treatment: Aerosol-generating procedures. 27 May 2020. https://askmayoexpert.mayoclinic.org/topic/clinical-answers/cnt-20483282/sec-20485240

- Medical Group Management Association. Checklist to Prepare Physician Offices for COVID-19. Undated. https://www.mgma.com/resources/operations-management/mgma-covid-19-physician-office-checklist
- Medical Group Management Association. COVID-19 Medical Practice Reopening Checklist. 2020. https://www.mgma.com/MGMA/media/files/pdf/MGMA-Practice-Reopening-Checklist.pdf?ext=.pdf
- Medical Group Management Association. Physician revenue cycle management considerations during and beyond COVID-19. Undated. https://www.mgma.com/resources/revenue-cycle/physician-revenue-cycle-management-considerations
- MLMIC Insurance Company. Preparing for Post-COVID-19 Operations: Healthcare Practices. April 2020. https://www.mlmic.com/wp-content/uploads/2020/04/Checklist_Preparing-for-Post-COVID-19-Operations_Healthcare-Practices_042220.pdf
- Montgomery County, MD Medical Society. COVID-19 Practice Reopening Toolkit. 7 May 2020. https://www.montgomerymedicine.org/covid-19-practice-reopening-toolkit/
- National Institute for Occupational Safety and Health. Respirators. 9 April 2020. https://www.cdc.gov/niosh/topics/respirators/
- National Law Review. Is COVID-19 Recordable or Reportable to OSHA? 17 March 2020. https://www.natlawreview.com/article/covid-19-recordable-or-reportable-to-osha
- National Personal Protective Technology Laboratory. NIOSH-Approved N95 Particulate Filtering Facepiece Respirators. 12 May 2020. https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html
- Occupational Health and Safety Administration Website. https://www.osha.gov/
- Occupational Health and Safety Administration. Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19). 10 April 2020. https://www.osha.gov/memos/2020-04-10/enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19
- Occupational Safety and Health Administration. Occupational Safety and Health Standards: Personal Protective Equipment: Respiratory Protection. 8 June 2011. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
- Occupational Safety and Health Administration. Respiratory Protection eTool. Undated. https://www.osha.gov/SLTC/etools/respiratory/index.html
- Occupational Health and Safety Administration. Revised Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19). 19 May 2020. https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19
- Substance Abuse and Mental Health Services Administration. Phases of Disaster. 17 April 2020. https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster
- Texas Medical Association. Road to Practice Recovery: A Guide for Reopening Your Practice Post-COVID-19. 2020. https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/Road%20to%20Recovery.pdf
- U.S. Department of Health & Human Services. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. 30 Mar 2020. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- U.S. Department of Health & Human Services. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. 30 March 2020. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- U.S. Department of Health and Human Services: Office for Civil Rights. FAQs on Telehealth and HIPAA during the COVID-19 Nationwide Public Health Emergency. Undated. https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf
- U.S. Department of Health and Human Services: Office for Civil Rights. February
- U.S. Equal Employment Opportunity Commission. What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws. 7 May 2020. https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws
- University in San Francisco, California Health. UCSF Health COVID-19 Ambulatory On-site Workflow for Adult NON-Respiratory Screening Clinics. 17 April 2020. https://infectioncontrol.ucsfmedicalcenter.org/sites/g/files/tkssra4681/f/Ambulatory%20On-site%20Primary%20and%20Specialty%20Workflow%20for%20Patients%20with%20Respiratory%20Illness.pdf

- Yale-New Haven Health. Personal Protective Equipment (PPE). 12 May 2020. https://www.ynhhs.org/patient-care/covid-19/for-employees/ppe.aspx
- Yale-New Haven Health. Social Distancing – Ambulatory Care. 13 May 2020. Presentation.