Health and Human Services Reopening Approach

June 2020

HHS Reopening: Phase 2

Effective June 8, 2020, health care providers may incrementally resume in-person elective, non-urgent procedures and services, including routine office visits, subject to ongoing compliance with public health and safety standards. Moving into Phase 2 is contingent on Massachusetts maintaining sufficient statewide hospital bed capacity (≥30% ICU and ≥30% inpatient bed capacity, statewide).

- **Telehealth must continue to be utilized and prioritized, whenever feasible and appropriate.**
- **Health care providers should expand in-person services cautiously, using their clinical judgment to prioritize** urgent services, chronic disease management, and preventive care. Prioritization criteria should promote equitable access to care for all populations.
- **For non-essential, elective invasive procedures and services**, **providers must attest to monitoring patient volume** to reduce risk of COVID transmission and impact on health care system resources. Providers must also attest to meeting CDC and other public health guidance regarding environmental infection controls, which include mandated timeframes to suspend the use of all examination, procedural and surgical areas in-between patients, prior to the required thorough cleaning and disinfection of the room and equipment.
- **Elective cosmetic procedures and in-person day programs are postponed to future phases.**
- **Limited reopening of visitation**

Health care providers must continue to meet the following requirements to reopen or expand services:

- Attest to public health standards and specific guidelines
- Adequate Personal Protective Equipment (PPE) supply, PPE use policies, reliable supply chain (not reliant on the state emergency stockpile)
- Infection control readiness (workflow, cleaning, social distancing, etc.)
- Workforce and patient screening and testing protocols
- Individual hospitals or hospital systems must maintain ≥ 20% ICU and total bed capacity

Health care providers must establish and adhere to a prioritization policy for scheduling in-person services that:

- Maximizes telehealth wherever possible
- First focuses on **high-priority preventive services**, **pediatric care and immunizations**, and **urgent procedures** that lead to high risk or significant worsening of the patient's condition if deferred
- Identifies **patients and services** that, based on the provider's clinical judgment, **are most critical and time sensitive (e.g., chronic disease, adult preventive, progressive conditions, social factors)**
- Where possible, **defers non-essential, elective invasive procedures and services that have increased risk of transmission** (produce respiratory droplets) and/or impact health system resources

In Phase 2, health care providers that continue to meet Phase 1 criteria, including public health and safety standards, may *incrementally* resume in-person, non-urgent services and procedures.

	Phase 1: Start	Phase 2: Cautious	Phase 3: Vigilant	Phase 4: New Normal
	Telehealth must continue to be prioritized, whenever appropriate and feasible.			
Services Provided	Subject to hospital capacity criteria, health care providers who attest to meeting public health standards can provide a **limited set of in-person services**: • **High-priority preventative services** such as pediatric care and chronic disease care for high-risk patients • **Urgent procedures/ services** that would lead to high risk or significant worsening of the patient's condition if deferred	**Effective June 8, 2020:** Subject to ongoing hospital capacity criteria, health care providers who attest to meeting public health standards may *incrementally* provide **in-person elective, non-urgent procedures and services, including routine office visits, behavioral health, and dental visits**. • Providers must establish and adhere to a **prioritization policy** for providing and scheduling Phase 2 care, based on their clinical judgment • For non-essential, elective invasive procedures and services, providers must attest to **monitoring patient volume and specific safety standards**	Remove or modify service and volume restrictions **Cautiously reopen day programs** subject to guidelines and public health and safety standards to be developed in collaboration with stakeholders	**All services may reopen with guidelines in place** **Telehealth should be maximized**
Delayed/ Deferred Services	• **Most in-person routine care is not part of Phase 1** for most individuals with the exception of pediatric care, patients at high risk if not seen in person • **Elective procedures that are not urgent or do not create risk if deferred are not part of Phase 1**	• These **service types are postponed to future phases**: 1) **elective cosmetic procedures**; and 2) **in-person day programs**. • Additionally, health care providers should **consider delaying/deferring certain non-urgent services** that are expected to require significant PPE resources, result in hospital/ICU care or post-acute care, or that result in significant aerosolization		

Emergency and telehealth services available throughout

HHS Reopening: Summary of Services and Limitations

IN ALL PHASES:

Telehealth must be prioritized, whenever feasible and appropriate.

Public health and safety standards, including standards on PPE supply, workforce safety, patient safety, and infection control apply.

Service	Phase 1	Phase 2	Phase 3
✓ All Emergency Care (Services and Procedures) and Telehealth Provided Throughout			
Urgent Services and Procedures	✓	✓	✓
Primary Care, Preventative Care, Behavioral Health Care, and Chronic Disease Management	✓ *(High-priority only)*	✓	✓
Pediatric Care	✓	✓	✓
Other Health Care Services (e.g. office visits, physical therapy, dental cleanings, vision care)	⚠ *(Only urgent services likely to become emergent if deferred)*	✓ *(Subject to clinical prioritization)*	✓
Non-Essential, Elective Invasive Procedures and Services	⛔	✓ *(Subject to specific safety standards)*	✓ *(Volume % TBD)*
Elective Cosmetic Services	⛔	⛔	⚙ (TBD)
Day Programs	⛔	⛔	✓ *(At reduced volume)*
Group Behavioral Health Treatment	⛔	✓ *(Subject to specific conditions)*	⚙ (Timing and Conditions TBD)

Phase 2 Reopen Approach: Key Components

1. Prerequisites for Phase 2
2. Phase 2 Guidance on Appropriate Procedures and Services
3. Phase 2 Safety Standards for Non-Essential, Elective Invasive Procedures
4. Phase 2 Guidance Compliance and Attestation

1 Phase 2 Reopen Approach: Prerequisites for Moving into Phase 2

Effective June 8, 2020, hospitals and other health care providers are eligible to move into Phase 2 health care delivery if certain statewide and provider-specific criteria are met:

1. Statewide Hospital Bed Capacity

- **The statewide bed capacity thresholds from Phase 1 continue in Phase 2.**
  - **Intensive Care Unit (ICU) Bed Capacity:** The 7-day average of the number of available, staffed adult ICU beds statewide must be at least 30% of total staffed adult ICU beds (including staffed surge ICU beds).
  - **Inpatient Bed Capacity:** The 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) statewide must be at least 30% of total staffed adult inpatient beds (including staffed surge beds).

2. Hospital System or Hospital-Specific Capacity Criteria (Hospitals only)

- **The hospital or hospital system specific bed capacity maintenance requirements from Phase 1 continue in Phase 2.**
  - **Bed Capacity Maintenance:** Hospitals must ensure ongoing bed capacity maintenance as outlined in Phase 1 guidance: The 7-day average of the hospital's or hospital system's available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) must be at **least 20%** of its total staffed adult inpatient bed capacity (including staffed surge beds that can be staffed in 12-24 hours) throughout Phase 2.

3. Public Health and Safety Standards (All providers)

- **The public health and safety standards from Phase 1 continue in Phase 2.**
  - Hospitals and other providers must sign and maintain an updated attestation form for Phase 2 that includes all of the standards from Phase 1, with a small number of updates specific to Phase 2 care delivery (submission of attestation form to DPH is not required).

2 Phase 2 Reopen Approach: Guidance on Appropriate Procedures and Services

All health care providers must establish and adhere to a **prioritization policy** for Phase 2 non-urgent care and scheduling. The health care provider will use their **clinical judgment and prioritization guidance** to determine which in-person services meet the criteria outlined for in-person services in Phase 2. **These prioritization criteria should promote equitable access to care for all populations**.

Prioritization Guidance for Phase 2

- ***Telehealth must continue to be prioritized, whenever feasible and appropriate. Health plans should continue to cover telehealth.***
- Health care providers should **prioritize Phase 1 in-person services**, including high-priority **preventive services, pediatric care and immunizations, and urgent procedures** that would lead to high risk or significant worsening of the patient's condition if deferred.
- **Health care providers should then identify the patients and services that, based on the clinical determination of the provider, are most critical and time sensitive**. Priority scheduling should consider, without regard for patient's insurance type:
  - Patients with acute illnesses that cannot be addressed through telehealth
  - Patients with chronic illness, including but not limited to those that put patients at higher risk for complications from COVID-19
  - Patients with behavioral health conditions, disability, and/or risk factors related to social determinants of health
  - Adult preventive care clinically necessary to be performed in-person (including screening/diagnostic procedures), in addition to well child and vaccinations prioritized above
  - Patients with progressive conditions that will worsen without surgery/other intervention, or whose symptoms negatively affect their quality of life or ability to perform daily activities
  - Other patients needing in-person visits to monitor health status or assess progression of illness, etc.
- **Providers should consider deferring certain non-essential elective procedures and services** such as those that do not meet the prioritization criteria above and which are likely to produce high concentrations of respiratory droplets (aerosolization) and/or that require a significant level of certain health care system resources (e.g., PPE and pharmaceutical supplies in short supply; transfusions; general hospital, ICU, and/or post-acute admissions).
- In-person group treatment for behavioral health care should only be provided in limited circumstances (see next slide).
- The following service types are **postponed to future phases**: 1) elective cosmetic procedures, and 2) in-person day programs.

2 In-Person Group Treatment for Behavioral Health

In-person group treatment services for behavioral health may be provided in Phase 2 on a limited basis, within the following parameters:

- **Telehealth and/or in-person one-on-one treatment should be prioritized** in lieu of group therapy when clinically appropriate.
- In-person **group treatment should only be utilized when, in the clinical judgment of the provider, the benefit significantly outweighs the risks for the participants**, taking into account each individual's circumstances and medical and social risk factors.
- **No more than 6 people** may be present in a single group treatment session or room, including participants, facilitators and/or treatment providers. Rooms must be configured to ensure social distancing of at least 6 feet.
- **No food or drink** may be served. No physical contact and sharing of materials.
- In-person group treatment sessions should be **limited the minimum amount of time that the provider determines is clinically effective** (e.g., 60-90 minutes or less)
- **Providers must adhere to all DPH and CDC public health and safety standards**, including the Public Health and Safety Standards to which providers are required to attest for all Phase 1 and Phase 2 in-person services.

2 Phase 2 Reopen Approach: Examples of In-Person Services that Should Start in Phase 2

Types of In-Person Services	Services Initiated in Phase 1	Examples of new services to begin in Phase 2, subject to DPH prioritization guidance and clinical judgement
▪ **Preventative care**	▪ Pediatric visits, screenings for at risk patients (colonoscopies for individuals with family history of cancer), chronic disease management visits for high risk patients, placement of implantable contraception	• All screenings (e.g. colonoscopies, immunizations), chronic disease management visits for all patients prioritizing telehealth whenever feasible and appropriate
▪ **Diagnostic procedures**	▪ Mammograms for women with prior concerning findings, colonoscopy for blood in stool, biopsy for concerning lesions/ potential cancers, urgent labs, blood draws	• Mammograms, routine labs and imaging, including for non high-risk chronic disease management
▪ **In-person exams for new or worsening symptoms**	▪ In-person examination for breast lump, post-menopausal vaginal bleeding, chest pain, blurred vision, or other concerning symptoms	• In-person examination for any new or worsening condition for which telehealth is not appropriate or ~~f~~easible
▪ **Medical procedures**	▪ Removal of malignant skin lesions, orthopedic procedures to treat significant functional impairment or condition at risk of significantly worsening	• Medical procedures for which continued delay would lead to an adverse outcome
▪ **Behavioral health**	▪ Substance use disorder treatment including Medication Assisted Treatment	• All behavioral health services should be resumed except for in-person group treatment, prioritizing telehealth whenever feasible and appropriate
▪ **Rehabilitation services**	▪ Rehabilitation for post-stroke patients or severe traumatic injuries, post-operative physical therapy	• Routine physical therapy, occupational therapy, speech therapy, and chiropractic care can be resumed for all conditions for which further continued delay would lead to an adverse outcome, including in congregate care settings
▪ **Dental and vision services**	▪ Tooth extractions for significant infections	• Routine preventative dental care, including cleanings • Routine vision care

These service types should be postponed to future phases:
1) elective cosmetic procedures, and 2) in-person day programs.

3 Phase 2 Reopen Approach: Safety Standards for Non-Essential, Elective Invasive Procedures

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

- **For all non-essential, elective invasive procedures and services**, providers must attest to **monitoring patient volume** in each facility, clinic or office setting where such procedures and services are performed and must schedule patient visits in order to ensure:
  - Ongoing compliance with the **public health and safety guidelines in Phase 1** Guidance (Section IV) including, but not limited to, standards related to PPE supply and use, restricting the number of health care workers in the treatment space, screening patients in advance of a service or procedure, administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas and minimizing contact between patients through scheduling modifications.
  - Ongoing compliance with **CDC requirements** and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove **airborne-contaminants**[1] prior to the required thorough **cleaning and disinfection of the room and equipment**.
- Providers should postpone any non-essential, elective procedure or service if these safety standards, and the public health and safety standards required in the Phase 1 Guidance, cannot be met.

[1]https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

4 Phase 2 Reopen Approach: Compliance and Attestation

Phase 2 Attestation Form

- Before delivering Phase 2 services providers must first attest, on a form prescribed by DPH, to **continuing to meet all Phase 1 criteria and standards**, and **three additional conditions** for Phase 2: Cautious:
  1) The provider has established a prioritization policy to making clinical determinations about service provision in a manner consistent with health equity principles in such policy and this guidance;
  2) For non-essential, elective invasive procedures and services, the provider is monitoring patient volume in each facility, clinic or office setting where such procedures and services are performed and is scheduling patient visits in in a manner consistent with the guidance.
  3) The provider is in compliance is in compliance with CDC requirements and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove air-borne contaminants, prior to the required thorough cleaning and disinfection of the room.
- The attestation must be signed and maintained by the provider and made available to DPH upon request. Health care providers must prominently post a copy of the signed attestation form at each of its hospitals, facilities, clinics and office locations.
  - *Acute Care Hospitals Only:* Hospitals or hospital systems must submit the attestation form via DPH's secure reporting web-based portal, the Health Care Facility Reporting System (HCFRS).

Visitation at health care and human service facilities or residential settings

- Many health care facilities and human service residential sites began restricting visitors in March to mitigate against further spread
- Visitation policies will be modified cautiously to allow for visitors under limited circumstances (e.g., outdoor only, 1-2 visitors maximum) and so long as the provider is able to meet certain health and safety criteria
- Birth partners, parents of patients under 18, and companions for individuals with disabilities must be allowed and are not considered visitors

Type of provider or setting	Modifications to visitation	Effective date
▪ Skilled Nursing Facilities (SNF), Rest Homes and Assisted Living Residences	▪ Limited outdoor visitation of up to 2 individuals, subject to specific social distancing and infection control requirements	▪ Already effective (June 5)
▪ State operated Soldiers' Homes	▪ Same as for SNFs – limited outdoor visitation of up to 2 individuals, subject to specific social distancing and infection control requirements	▪ June 15, as long as infection rates continue to remain stable
▪ Hospitals (General, psychiatric, State Hospitals)	▪ Limited to one visitor at a time, subject to symptom screening and required facemask	▪ June 10
▪ Ambulatory health care (e.g., office visits)	▪ One individual/ companion may accompany the patient to an in-person provider visit	▪ June 10
▪ Human service residential congregate care / group homes	▪ Limited outdoor visitation up to 2 individuals, subject to specific social distancing and infection control requirements	▪ Adult (DDS, DMH, MRC, MCB, DPH) – June 10 ▪ Children/Youth (DCF, DMH and DYS) – on or before June 30

Day Programs

- Day programs including adult day health (ADH), DMH clubhouses, day habilitation programs and DDS community based day supports (CBDS) ceased in-person services as early as mid-March; some of these programs have continued to deliver services remotely or through alternative delivery models.

- **In-person day programs should be deferred until at least Phase 3 and should only resume in-person if provider is able to meet certain conditions. Deferral is necessary due to:**
  - High-risk, vulnerable populations that many of the day programs serve
  - By definition, most of these programs are delivered in group settings making proper social distancing and following other infection control measures a challenge

- **Timing for certain programs may vary depending on risk of population served** (e.g., consider earlier start date for programs serving transition-age youth and young adults without underlying medical conditions)

- In order to meet core health and safety standards, providers will likely have to **resume in-person services at reduced capacity** to allow for proper social distancing and adherence to other infection control protocol

- EOHHS is collaborating with providers, stakeholders, and families to develop an approach that **balances the health and safety of the clients with their clinical, behavioral and/or social need for such services.**
  - EOHHS will issue more details on guidance, attestation forms, and timing in the coming weeks.

Day Programs: Conditions for resuming in-person services in Phase 3

Public Health and Safety Standards	▪ **Providers must attest to meeting public health and safety standards:**
	  ▪ Adequate PPE for services provided
	  ▪ Infection control readiness (workflow, cleaning, social distancing, etc.)
	  ▪ Workforce and patient screening and testing protocols
	▪ *Considerations: suitability of program sites to allow for proper social distancing; feasibility of requiring face coverings, implementing other infection control protocols due to client/patient population*

Reduced Capacity	▪ Day programs should resume in-person services at reduced capacity (e.g., % of historical volume) as necessary to meet the above health and safety criteria, including proper social distancing
	▪ Develop strategies to implement reduced capacity including:
	  ▪ Alternating or staggered schedules
	  ▪ Criteria for identifying low-risk patients or those with highest need for in-person services based on clinical, social, or other factors
	  ▪ Continue to identify opportunities for remote or alternative delivery models

Other Operational Issues	▪ The resumption of in-person day programs will be conditioned on the safe provision of other key components of the program, including:
	  ▪ Transportation
	  ▪ Dining/ food services
	  ▪ Core activities that entail hands-on assistance or interaction