



Massachusetts Department of Public Health Guidance Reopen Approach for Acute Care Hospitals

NOTE: This guidance has been updated as of May 25, 2020 to provide the following clarifications:

- **Application to hospital-licensed services**
- **Bed capacity calculation methodology**
- **Continued capacity requirements for hospital systems**

I. Preamble and Purpose

On March 15, due to the public health emergency arising from the outbreak of COVID-19, the Baker-Polito Administration ordered that, in order to protect patients and health care personnel and to conserve personal protective equipment (PPE), hospitals and ambulatory surgical centers postpone or cancel any nonessential, elective invasive procedures.¹ This Order is consistent with the recommendation of the Centers for Medicare & Medicaid Services (CMS) that all elective surgeries and non-essential medical, surgical, and dental procedures be delayed.²

While hospitals and health care providers have been providing care to COVID-19 patients and other patients requiring emergency care and have expanded use of telehealth, many healthcare services beyond elective invasive procedures have also been delayed and deferred during the public health emergency. There is a need to begin to provide certain deferred care to patients that cannot be provided remotely via telehealth, while also recognizing that telehealth may not be feasible or clinically appropriate for all patients. The Baker-Polito Administration has determined that such care can begin to be provided in **Phase 1: Start** of the Commonwealth's reopening process, subject to guidance of the Department of Public Health (DPH).

DPH issues this guidance for how acute care hospitals³ can begin in-person provision of a limited number of additional, necessary services and procedures without jeopardizing health system capacity or the public health standards that are essential to protecting health care workers, patients, families, and the general public. This guidance applies to all hospital-licensed services except for hospital-licensed community health centers and does not apply to emergency care, which has been ongoing and will continue without limitation. DPH recognizes the importance of

¹ Elective Procedures Order. Massachusetts Department of Public Health (March 15, 2020):

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

² Press Release: CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. CMS (March 18, 2020): <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>.

³ As used in this document, "hospital" means an acute care hospital, unless otherwise specified. For the purposes of this guidance, acute care hospitals shall not include comprehensive cancer centers, as defined in G.L. c. 118E, § 8A, or freestanding pediatric hospitals, as defined in 105 CMR 130.

ensuring that this guidance promote equitable access to care, including high-priority preventative care, across all communities and patient populations, including low-income communities, children, and patients with disabilities.

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

II. Statewide and Hospital-Specific or Hospital System-Specific Capacity Criteria for Entering Phase 1: Start

Consistent with a cautious and deliberate reopening strategy, DPH has determined that no hospital will be eligible to enter Phase 1: Start before May 18, 2020.

Beginning on May 18, 2020, hospitals may be eligible to move into Phase 1: Start if both statewide and hospital-specific or hospital system-specific capacity criteria are met. All bed capacity criteria are calculated using a 7-day average, as described below.

A. Statewide Capacity Criteria

Before a hospital can move into Phase 1: Start, two statewide bed capacity targets must be met.⁴

1. **Intensive Care Unit (ICU) Bed Capacity:** The 7-day average of the number of available, staffed adult ICU beds statewide must be at least 30% of total staffed adult ICU beds (including staffed surge ICU beds).
2. **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).

DPH will assess progress against the statewide capacity criteria based on the data reported daily by hospitals in WebEOC, using a 7-day average, and will announce when the statewide capacity criteria have been met on or after May 18, 2020. In addition, DPH will continue to monitor bed capacity at both the statewide and individual hospital or hospital-system level and may suspend

⁴ To calculate statewide bed availability, based on the data reported daily by hospitals in WebEOC, DPH will: (a) calculate the numerator for each day: sum the number of adult medical/surgical and ICU patients (i.e., occupied beds) across the state. Then, (b) calculate the denominator for each day: sum the total adult medical/surgical and ICU staffed beds (including staffed surge) across the state for the current day. To calculate the occupancy percent, DPH will (c) divide the numerator by the denominator: the summed number of patients (i.e., occupied beds) by the summed total number of staffed beds (including staffed surge). To calculate the availability percent (d), DPH will subtract the occupancy percent from 1. To calculate a 7-day average, (e) DPH will calculate the bed availability rate for the current day, and using the same methodology calculate the rate from the previous 6 days, and take an average of the 7 rates. The ICU criteria is calculated using the same methodology, but using only adult ICU patients and staffed ICU beds (including staffed surge). For the purpose of this guidance, staffed surge beds (ICU or inpatient) means those beds that are currently staffed or that the hospital can staff within 12-24 hours. Unstaffed surge beds, i.e., those that can be made available within 72 hours, should not be included.

or limit provision of any of the procedures and services described in Section III of this guidance based on its determination that statewide bed capacity is deemed to jeopardize the hospital's, hospital system's, or overall health system's ability to respond to patient demand.

B. Hospital-Specific or Hospital System-Specific Capacity Criteria

Once the statewide capacity targets have been met, each hospital or hospital system⁵ seeking to provide the services described in Section III below must also meet initial and continuing hospital-specific or hospital system-specific capacity targets. In order to begin in-person delivery of such services, each hospital or hospital system must assess its own capacity and attest to DPH that it has met the capacity targets listed below. For purposes of these requirements, staffed ICU beds means ICU beds that are staffed in compliance with statutory and regulatory nurse staffing requirements.

Hospital systems are required to assess their bed capacity at the system level for all capacity criteria below. If a hospital system meets the capacity targets outlined below, all of its hospitals may move into Phase 1: Start, even if individual hospitals within the system do not each individually meet the targets. Conversely, no hospital that is part of a system may move into Phase 1: Start if the hospital system overall has not met the targets.

Entering Phase 1: Start⁶

1. **ICU Bed Capacity:** The 7-day average of the hospital's or hospital system's available, staffed adult ICU beds must be at least 25% of its total staffed adult ICU bed capacity (including staffed surge ICU beds).
2. **Inpatient Bed Capacity:** 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 25% of its total staffed adult inpatient bed capacity (including staffed surge beds).

⁵ For purposes of this guidance, a hospital system includes all acute care hospitals in Massachusetts that are owned or corporately controlled by a common parent entity.

⁶ To calculate bed availability at a hospital or hospital-system level, based on the data reported daily in WebEOC, the hospital or hospital-system should: (a) calculate the numerator for each day: sum the number of adult medical/surgical and ICU patients (i.e., occupied beds) across the hospital or hospital system. Then, (b) calculate the denominator for each day: sum the total adult medical/surgical and ICU staffed beds (including staffed surge) across the hospital or hospital system for the current day. To calculate the occupancy percent, (c) divide the numerator by the denominator: the summed number of patients (i.e., occupied beds) by the summed total number of staffed beds (including staffed surge). To calculate the availability percent (d), subtract the occupancy percent from 1. To calculate a 7-day average, (e) hospitals or hospital systems must calculate the bed availability rate for the current day, and using the same methodology calculate the rate from the previous 6 days, and take an average of the 7 rates. The ICU criteria is calculated using the same methodology, but using only adult ICU patients and staffed ICU beds (including staffed surge). For the purpose of this guidance, staffed surge beds (ICU or inpatient) means those beds that are currently staffed or that the hospital can staff within 12-24 hours. Unstaffed surge beds, i.e., those that can be made available within 72 hours, should not be included.

3. **Pediatric ICU and Psychiatric/Behavioral Health Beds:** The hospital must reopen and have the ability to staff all pediatric ICU beds and psychiatric/behavioral health beds consistent with pre-pandemic levels.⁷

*Continuing in Phase 1: Start*⁶

Bed Capacity Maintenance: 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) throughout Phase 1: Start.

Once they have entered Phase 1: Start, hospitals or hospital systems must assess their available bed capacity daily using a 7-day average bed availability rate. If the hospital's or hospital system's 7-day average available bed capacity falls below 20%, the hospital or hospital system must immediately notify DPH as described in Section V and promptly suspend the provision of non-emergent Phase 1 services at that hospital, or at any hospital within a system with bed capacity below 20%, described in Section III of this guidance. The hospital or hospitals within a hospital system may resume Phase 1 services once its available bed capacity is at least 20% and after it gives notice as prescribed by DPH in Section V. DPH will continue to monitor bed capacity at both the statewide and individual hospital or hospital-system level and may suspend or limit provision of any of the procedures and services described in Section III of this guidance.

III. Guidance on Recommended Procedures and Services

Once the statewide capacity criteria have been met, in Phase 1: Start, hospitals or hospital systems that have met the capacity criteria described in Section II and the public health and safety standards described in Section IV may begin in-person delivery of certain procedures and services that, based on the health care provider's clinical judgment, constitute:

1. High-priority preventative services, including pediatric care and immunizations, that cannot be provided safely and appropriately via telehealth, recognizing that telehealth may not be feasible or clinically appropriate for all patients.
2. Urgent procedures and services that cannot be delivered remotely and would lead to high risk or significant worsening of the patient's condition if deferred.

⁷ Hospitals may reduce operational bed capacity on reopened units for the sole purpose of social distancing (e.g., converting double occupancy to single occupancy rooms).

Hospitals should consider the following in making their determinations.

Criteria	Examples <i>Examples below are illustrative only and not comprehensive. Providers will use their clinical judgment to make a determination about appropriate service provision for a patient.</i>
High-priority preventative services, including pediatric care and immunizations	<ul style="list-style-type: none"> • High priority preventative visits that lead to high risk if deferred, e.g., immunizations; colonoscopies, mammograms, and cervical cancer screenings in high-risk groups (such as prior malignant or pre-malignant lesions); placement of implantable contraception; prenatal care; blood draws for INR in patients on warfarin; A1C in poorly-controlled diabetic patients; etc. • Pediatric visits • Chronic disease management for high-risk patients
Urgent procedures and services that cannot be delivered remotely and would lead to high risk or significant worsening of the patient’s condition if deferred	<ul style="list-style-type: none"> • Diagnostic procedures for high risk patients that lead to high risk if deferred, e.g., colonoscopy for blood in stool, biopsy of concerning skin lesions and potential cancers, diagnostic PCI for unstable angina, urgent tests, imaging, blood draws, etc. • Medical services or procedures that if deferred lead to substantial worsening of disease, e.g., excision of malignant skin lesions, orthopedic procedures for significant functional impairment, removal of breast malignancy, organ transplants, hysterectomy for continued bleeding, etc.

As hospitals begin planning to provide deferred or delayed care, they should develop a strategy to identify the patients and services that, based on the clinical determination of the provider, are most urgent. Such strategy should incorporate considerations such as chronic illness, disability, or risk factors related to the social determinants of health, without regard for a patient’s insurance type.

Because of unique considerations for children, consistent with the requirements of this guidance, in Phase 1, providers may resume routine pediatric care, including in-person well child visits. Missed scheduled vaccines should be prioritized. Providers should continue screening for social needs, behavioral health concerns, child abuse, and intimate partner violence.

Hospitals should also continue to provide services, including pre-operative and post-operative services, via telehealth to the greatest extent possible when clinically appropriate, while also recognizing that telehealth may not be feasible or clinically appropriate for all patients. Examples of services that may be clinically appropriate for telehealth include: preventative care; wellness; chronic disease management; consultations; behavioral health treatment; and pre-appointment patient screenings.

If a health care provider is unable to utilize telehealth for a patient where telehealth is clinically appropriate and the patient would otherwise be able to be served by telehealth, the provider should consider referring the patient to another provider with telehealth capabilities when appropriate. All patients should be encouraged to call their provider or urgent care facility prior to making an in-person visit, except in an emergency.

IV. Required Public Health and Safety Standards

In order to provide the services outlined in Section III in Phase 1: Start, hospitals must meet specific criteria related to: a) personal protective equipment (PPE); b) workforce safety; c) patient safety; and d) infection control. Each hospital must develop written policies and procedures that meet or exceed the requirements of this Section or incorporate the requirements of this Section into its existing policies and procedures. Hospitals must establish a governance body to oversee compliance with the capacity, clinical, and safety standards outlined in this guidance with representation from senior hospital or hospital system leadership and labor representatives.

A. Personal Protective Equipment and Other Essential Supplies

Hospitals must continue to follow the most recent guidelines issued by DPH⁸ that align with the CDC as it relates to PPE usage, including any updated guidelines released subsequent to the date of this guidance. In addition, hospitals must meet the following three standards related to PPE supply.

1. Hospitals must ensure that they have adequate supply of PPE and other essential supplies such as equipment and medications for the expected number and type of procedures and services that will be performed. Adequate supply for hospitals is defined as at least a 14-day supply of all necessary PPE. To meet this requirement, hospitals may not rely on additional distribution of PPE from government emergency stockpiles.
2. Hospitals must take reasonable steps to maintain a reliable supply chain to support continued operations.
3. Hospitals must develop and implement appropriate PPE use policies across departments in accordance with DPH and CDC guidelines.

B. Workforce Safety

Hospitals must meet the following five standards related to workforce safety.

1. All staff must have appropriate PPE to perform the service or procedure and any related care for the patient. If appropriate PPE is not available to protect the health care workers involved in the patient's care, the service/procedure should be cancelled.

⁸ Please see: <https://www.mass.gov/info-details/covid-19-guidance-and-directives>.

- a. Health care providers and other hospital staff must wear at least surgical facemasks at all times, consistent with DPH's Comprehensive PPE Guidance.
 - b. Eye protection (goggles, visor, or mask with visor) and N95 or equivalent respirator masks must be provided by the hospital and worn by all health care workers while engaged in direct patient care for procedures with increased potential for droplet aerosolization.
2. Hospitals must restrict the number of health care workers in the treatment space to those individuals necessary to complete the service or procedure for the patient.
 3. Hospitals must have a written protocol in place for screening all employees for symptoms of COVID-19 prior to entering the facility.
 4. Hospitals must adopt policies that address hospital worker safety and well-being.
 5. Hospitals must ensure social distancing for providers and staff to the maximum extent possible (see Section IV.D).

C. Patient Safety

Hospitals must meet the following four standards related to patient safety.

1. Hospitals must have a process for screening patients and companions for symptoms of or known exposure to COVID-19 prior to entering the facility.
2. Hospitals must have policies and procedures for screening patients in advance of a service or procedure, including policies and procedures to facilitate the testing of patients for COVID-19 when medically appropriate as well as for determining whether a procedure should go forward if a patient tests positive.
3. Hospitals must develop policies permitting patient companions only in special circumstances when necessary for the patient's well-being. Special circumstances and populations may include end-of-life care, labor and delivery, pediatric patients, behavioral health patients, patients with intellectual or developmental disabilities, patients with physical disabilities, or populations as otherwise identified by DPH. Hospitals must also ensure that policies address patient visitors consistent with DPH guidance. These policies must be accessible to patients seeking care.
4. Hospitals must require that all patients, companions, and visitors wear mouth and nose coverings as consistent with DPH guidance.⁹ However, the hospital may consider waiving the requirement for mask and nose coverings for patients and/or companions in special circumstances consistent with applicable guidance.

⁹ Please see: <https://www.mass.gov/news/wear-a-mask-in-public>.

D. Infection Control

Hospitals must meet the following six standards related to infection control.

1. Hospitals must demonstrate adherence to social distancing and relevant guidelines from Massachusetts DPH and CDC regarding infection control and prevention to maintain a safe environment for patients and staff.
2. Hospitals must adopt administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas, including by asking patients to wait outside until their appointment begins to the greatest extent possible. For any patients waiting in the hospital, social distancing and face coverings must be in place.
3. Health care providers must minimize contact between patients through scheduling, such as establishing different times of day or separate space to avoid possible exposure to COVID-19.
4. Hospitals must have signage to emphasize public health measures (i.e., distancing, coughing etiquette, wearing of face coverings, and hand hygiene) and must provide access to hand sanitizer for patients and staff.
5. Hospitals must have an established plan for thorough cleaning and disinfection of all common and procedural areas, including in-between patient encounters in treatment rooms, which may require hiring environmental services staff and reducing patient hours to allow for more frequent cleaning.
6. Hospitals must create non-COVID-19 care zones within the facility, if possible.

V. Compliance and Reporting

Attestation Form

Hospitals seeking to deliver the services described in Section III must first attest, [on a form prescribed by DPH](#), to meeting the capacity criteria outlined in Section II and the public health and safety standards outlined in Section IV, to having established a governance body as described in Section IV, to making clinical determinations about service provision in a manner consistent with this guidance, and to making reasonable efforts to recall furloughed direct care workers to the extent possible. The governance body must be responsible for overseeing compliance of these criteria and standards. The attestation must be signed by the chief executive officer (CEO) of the hospital or hospital system submitting on behalf of all system hospitals and include a named contact responsible for internal compliance with these criteria. A copy of the signed attestation must be submitted to DPH and prominently posted on the hospital's website with a link to the [Commonwealth's Reopening website](#) before the hospital moves into **Phase 1: Start** and begins providing expanded service.

Hospitals or hospital systems must submit the attestation form via DPH's secure reporting web-based portal, the Health Care Facility Reporting System (HCFRS). Hospitals or hospital systems

should upload the completed attestation as a new incident case, under the incident type “Phase 1 Attestation” and then submit it. If the hospital or hospital system no longer meets the Phase 1:Start criteria, the hospital or hospital system must notify DPH via a message in the notes section using the same incident case in HCFRS and promptly suspend provision of non-emergent Phase 1 services, as outlined in this guidance.

Written Policies and Protocols

Hospitals or hospital systems must maintain written policies and protocols that meet or exceed the standards outlined in this guidance for PPE and supplies, workforce safety, patient safety, and infection control and must document the processes for making clinical determinations outlined in Section III. Such policies, protocols, and documentation must be regularly updated and made available to DPH upon request at any time.

Compliance

DPH will monitor and assess compliance and may require remedial action or suspension of Phase 1: Start procedures and services as warranted.