Guidance on Reopening Outpatient Pediatric Neurology Clinics

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Introduction

In December 2019, a novel coronavirus, SARS-CoV-2, was identified and the associated illness subsequently labeled COVID-19. On January 30, 2020, the World Health Organization (WHO) declared the novel coronavirus outbreak a global public health emergency. As global case counts continued to rise it was officially labeled a global pandemic on March 11, 2020. Social distancing, face coverings and vigilant hand-hygiene became recommended methods for slowing the spread of COVID-19. In anticipation of an influx of ill patients with COVID-19, the initial response by many large health care institutions was to cancel non-urgent surgical cases and non-urgent medical appointments in order to reduce exposure to patients and medical staff, preserve supplies of personal protective equipment, and maximize inpatient bed capacity. Although patients with urgent medical needs continued to be cared for in face-to-face settings, an alternative means for delivering medical care via telemedicine quickly evolved. On March 6, 2020, Health and Human Services declared COVID-19 a public health emergency and The Centers for Medicare and Medicaid Services (CMS, Medicare), the largest US national payer network, issued a series of mandates that bypassed what would have been many years of regulatory and legislative efforts to bring ambulatory telemedicine into routine use. These measures made telemedicine relatively simple for providers and Medicare patients, and provided reimbursement for these services at a level that encouraged providers and health systems to quickly participate. State Medicaid and commercial plans soon announced plans to follow the CMS rules. As we enter June 2020, the infection curve of COVID-19 is flattening in many regions and local governments are now allowing for relaxation of social distancing rules. In line with other businesses, medical offices are now reopening to care for patients on a face-to-face basis. These guidelines are the initial recommendations for reentry of in-person visits in outpatient pediatric neurology. Because these recommendations are written to give practical advice to many different practice types, ranging from large hospital practices with parking garages located distant from the office to practices where the parking lot is only a few steps from the entrance, many recommendations are generic and should be interpreted with appropriate flexibility.

Follow Government and Employer Regulations

- Assure patient and staff safety to the best of ability.
- Remain flexible as infection-control plans and medical coverage decisions can change based on federal, state, and local regulations.
- Check federal, state, and local regulations regularly.
- See CDC guidance on assessment of risk, monitoring, PPE usage and work restriction decisions for health care professionals with potential exposure to COVID-19.

Monitor and Protect Staff

- Practices should screen all patients and family members before arrival at the clinical site to confirm they are not experiencing symptoms of COVID-19 (see below link).
- If a patient or household contact has fever, upper respiratory or other COVID-19-associated symptoms, but neurologic needs are still urgent enough to necessitate an in-person visit, use a dedicated exam room. If possible, use a back/side entrance and exit.
- Practices should screen all healthcare team members, such as personal and family symptom status, as well as check the temperatures of all staff each morning upon arrival.
- Post PPE guidelines for both staff and patients to read.
- Make hand sanitizer available and require use before entering the clinic area, and before/after use of door handles.
- Ensure that proper PPE is available for all staff, which should include face masks for interactions at a distance, and gowns and eye protection (goggles or face shields) when in direct patient contact.
- For children with excessive crying or behavioral issues that put them at higher risk of generating aerosolized particles, consider having the provider wear a face shield or goggles, along with a mask.
- All patients ages 2 years and older should be given and urged to wear masks. All caregivers should wear masks.
- Have the caregiver practice wearing masks prior to the clinic visit to help ensure use of mask during clinic visit.
- Offer hand sanitizer and/or hand washing station for patients and visitors.

Create Safe Physical Space

- Laminate paper signage and reusable forms for regular cleaning.
- Install plexiglass barriers at registration desk.
- Whenever possible implement a system that permits the patient and caregiver to use their vehicle as the waiting room (see below in Support Social Distancing).
- If multiple people must be in a waiting room, clearly define where to sit and stand in order to maintain the six-foot social distancing recommendation.
- If a patient can reasonably be anticipated to generate more aerosolized droplets than average (e.g., a patient with tracheostomy requiring routine suction), create greater physical separation and a longer time before the room is used for another patient.
- Consider limiting the number of patient visits per provider session and/or extending hours of operation to accommodate the extra time between patient visits.
- Allow only the designated caregiver and/or patient to utilize clinic restrooms.
- Designate specific and separate restrooms for patients and staff, if possible.

Maximize Pre-Visit Communication

- Encourage families to complete any screening or intake forms in advance using the electronic health record patient portal prior to the visit. Using paper forms should be a last resort, and ideally would be sent to the office before the visit via email or facsimile.
- If needed, obtain payments virtually through patient portal or collect payment information via telephone. Staff should consider using gloves if they need to handle cash or credit cards.
- Clearly communicate the clinic PPE policy with families and specify if you will supply PPE (masks or other PPE if needed) provided to families or if they should bring their own.

Support Social Distancing

- Consider implementing a default policy of using Telemedicine for all follow-up visits, unless the provider determines that an in-person visit is essential.
- Limit outpatient visits to one caregiver.
- Discourage extra adults and siblings attending the visit.
- If practical, have the caregiver call or text the outpatient clinic when they arrive to the parking lot and wait in their car until their visit room is ready.
- Establish one-way traffic flows through the clinic area if possible, and if not possible develop a policy where patients and staff have a clear pathway to their destination.
- Once all verbal information is obtained and verified, have the patient come to the clinic to be met by a nurse or medical assistant and escorted to the exam room where essential vital signs are obtained (at least temperature and weight).
- Avoid the use of a dedicated vital sign room unless it can be cleaned between patients.
- Limit people waiting for vital signs by keeping patients in the parking area.
- Assess waiting areas for the maximum safe number of visitors, and require that front desk staff maintain a count of people in waiting areas and enforce stricter limits on caregivers/siblings if that number is exceeded.

Minimize Fomites

- Remove all non-essential and difficult-to-clean items, such as soft toys and books, from waiting rooms.
- Disinfect each examination room or vital sign room with institution approved cleaning supplies between patients. Use signage to indicate when rooms were last cleaned. Regularly disinfect clinic restrooms throughout the clinic day.
- Discourage use of neckties and scarves by providers.

Prioritize Limited Populations of Patients

Clinically Urgent, for example:

- Ages less than 12 months
- Suspected infantile spasms
- New onset headache patients (duration less than one month)
- Progressive neurological illness
- Suspected idiopathic intracranial hypertension (IIH) patients
- Focal neurological symptoms (weakness, ataxia, sensory changes, etc.)
- New onset seizures
- Epilepsy surgery evaluation
- Significant hypotonia
- Patients requiring lumbar punctures for diagnosis or treatment
- Patients receiving IVIG, immunosuppressive therapies, or other IV treatments

Requires Face-to-Face Care (Partial List)

- Neurostimulation devices (VNS, DBS)
- Injected medications (botulinum toxin, phenol)
- All patients in need of fundoscopic examination
- When telemedicine (video) neurological examination was inconclusive

Potential Pitfalls in Triaging for Telemedicine

- Interstate reimbursement, institutional, or malpractice insurance limitations for telephone encounter (audio-only) visits
- Insurance denial for synchronous audio and video telemedicine visits
- Technology preventing telemedicine (lack of broadband internet or adequate cellular coverage)
- Caregiver preference for in-person clinic visit
- Diagnostic requirement for in-person neurological examination
- Immunocompromised individuals or patients with significant COVID-19 risk factors (see link below).
- Possible future reinstatement of rules that restrict payment for telemedicine or limit coverage for out-of-state providers

Plan for Reintroducing In-Person Clinic Visits

- Consider a slow start and use pre-defined metrics to guide expansion.
- Consider starting with 25% in-person clinic visits with limited number of providers and staff, and maintain telemedicine for remainder of visits (especially follow-up visits) when possible.

- Adjust provider in-person clinic templates on given days to limit the total number of providers to be physically in clinic on any given day.
- If workrooms for staff are utilized, maintain at least six feet social distancing between workstations.
- Gradually increase capacity for in-person clinic visits to 50% while maintaining video telemedicine visits.
- Eventually, consider having each neurology provider develop a stable schedule that mixes in-person clinic visits on specific days and locations and video telemedicine from a separate location for the remainder of their clinics.
- Consider restricting providers at higher risk of severe COVID-19 sequelae (e.g., those age 65 and older, or with immunodeficiency) to only performing video telemedicine visits to limit their exposure.

Conclusion

At this writing pediatric neurologists are just beginning to open their practices' in-office patients following the first wave of COVID-19 disease. It cannot be predicted if payers will continue to reimburse for telemedicine services at the current level of reimbursement or if there will be more waves of illness that will prompt long periods of societal social isolation. Reopening a medical practice in the face of ongoing, but lower rates of, COVID-19 disease requires changes that lessen the risk of contracting or spreading the illness as part of the office visit. These recommendations are suggestions for pediatric neurology practices.

Additional Resources

https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/pediatric-practice-management-tips-during/

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

https://www.aan.com/tools-and-resources/covid-19-neurology-resource-center/

https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html