Revamping Outpatient Care for Patients Without COVID-19

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Mayo Clinic's integrated multidisciplinary destination outpatient practices in Minnesota, Arizona, and Florida deliver care daily to thousands of unique patients. Substantial changes in care delivery were required during the coronavirus disease 2019 (COVID-19) pandemic to ensure the safety of patients, visitors, and employees in a population-dense environment. On the Rochester, Minnesota, campus of Mayo Clinic, for example, more than 9000 unique patients with complex medical conditions visit a concentrated campus, occupying less than 0.01 square mile, every day. The combination of patients, their accompanying visitors, and Mayo Clinic staff results in a medical campus with a population density an order of magnitude larger than the most population-dense US city. To protect the safety of patients and staff during the initial COVID-19 pandemic spread, Mayo Clinic deferred elective outpatient clinic care, as well as elective surgeries and procedures, on all of its campuses. Concurrently, clinical practice leadership recognized the urgency of caring for patients who require Mayo Clinic the most, and rapidly transformed processes, policies, and protocols in preparation for practice reactivation, allowing us to provide safe care in a COVID-19 environment that is in the best interests of patients, staff, and the communities we served.

Mayo Clinic focused on reactivating its clinical practice while nimbly navigating unprecedented conditions. Reforecasting of practice volumes and patient demand; effectively communicating to patients, staff, referring providers, visitors, and our communities; and implementing safety initiatives were key components of reactivation. To effectively scale and time operational adjustments, these changes occurred in parallel with nontraditional limiting factors such as molecular and serologic testing capacity, availability of critical pharmaceuticals and personal protective equipment, and reduced personnel as a result of staffing-to-workload interventions.

OUTPATIENT ACCESS

The approach to successful outpatient practice reactivation was patterned in part on the initial, structured deactivation. As the practice was deactivated, providers reviewed all scheduled appointments to define medical urgency and determine whether a virtual evaluation could be substituted for the original in-person appointment. Patients with urgent medical conditions continued to have in-person care (eg, oncology-related outpatient practices continued at 65% or more of normal), but appointments were converted to virtual evaluations when possible. Patient-initiated cancellations were also reviewed to prioritize rescheduling based on medical necessity. To support rescheduling activities, scripting and workflows were modified to include 1) an explanation of why we had paused routine outpatient care and the new safety protocols, 2) telephone screening for COVID-19 and a protocol to define when a patient who had positive test results could safely be rescheduled in the regular practice, and 3) a process to reassess patients for COVID-19 by telephone 12 to 48 hours before an in-person visit. Business performance reports were developed that allowed monitoring of our in-person outpatient practice and procedural reactivation. Safety and modeling teams were established, with focused resources to assist
high-throughput clinics struggling with the inefficiencies inherent in COVID-19 safety protocols. Daily touchpoints with scheduling office supervisors and the outpatient leadership team allowed us to keep an accurate pulse on scheduling challenges and maintain alignment with the latest COVID-19 institutional modeling. Finally, we developed models of demand capture that allowed us to strategically prioritize appointment offerings.

OPERATIONS
The initial rapid contraction of the outpatient practice and subsequent, staged reactivation required substantial operational agility and planning. Initial response efforts focused on assessing urgency of individual patient appointments and contacting patients to defer appointments for nonurgent or elective care. On the Rochester, Minnesota, campus, more than 38,000 appointments were deferred during the first week of the response, greater than six times the normal rescheduling rate. Nonessential operations staff were released to home or redeployed to new COVID-19 response activities such as patient and visitor screening. Operations management staff assessed novel training needs to prepare for practice reactivation and developed training modules and scripts for use by scheduling, screening, and patient-arrival staff. Reporting tools were developed to monitor demand and identify and track deferred appointments so that patients could be contacted during the reactivation phase. The medical staff continued to monitor new and deferred appointment requests during the contraction period to identify medically urgent requests, and the outpatient practice functioned at 30% of its normal capacity before the practice was reactivated—most of that care delivered via virtual/telemedicine mechanisms. Because of the highly integrated nature of Mayo Clinic, outpatient leadership worked in concert with surgical and hospital leadership to maintain a cohesive approach to reactivation of outpatient activities. Operations began reactivation efforts in earnest during the week of April 20, 2020—4 weeks after the initial contraction of the practice.

SYMPTOMATIC SCREENING AND TESTING
As Mayo Clinic moved to reactivate the practice, we sought to optimize safety by using infrastructure developed over the preceding weeks of the initial pandemic response. An algorithm was developed for use by nurses to screen symptomatic patients via telephone for COVID-19 diagnostic testing. This algorithm was maintained centrally and revised as new evidence and guidelines for screening became known. It was also utilized by employees acting in the role of screeners at Mayo Clinic entrances, to identify symptomatic patients upon arrival. Workflows were developed to quickly divert symptomatic patients to COVID-19 testing, temporarily pausing their clinical itinerary while results of diagnostic testing were pending. An important strength during this time was a robust laboratory capacity for molecular diagnostic and serologic testing. Reports in the medical literature suggested that many infected persons were asymptomatic or presymptomatic. Therefore, we developed protocols for testing and interpreting results for asymptomatic patients before they received certain types of care. For example, asymptomatic patients who were undergoing surgical procedures or beginning immunosuppressive therapy were tested to avoid a potentially poor outcome resulting from an unrecognized COVID-19 infection. In addition, we began testing asymptomatic patients before procedures that would confer additional exposure risk to employees participating in those procedures.

VIRTUAL CARE
A large proportion of patients who receive care at the Rochester, Minnesota, Mayo Clinic campus travel from locations outside of the local area. To connect with patients during a period of widespread travel restrictions, Mayo Clinic embraced telemedicine. The Centers for Medicare & Medicaid Services and other payors facilitated telemedicine use by granting substantial latitude for providing virtual visits. Before the COVID-19 crisis, telemedicine use was limited, most commonly to postoperative or other follow-up visits. During the weeks before practice reactivation, telemedicine visits increased 33-fold while in-person visits
decreased in parallel. During reactivation, in-person visits increased with a commensurate decrease in telemedicine visits, although an important role remains for the ongoing use of telemedicine. In particular, telemedicine intake visits provide a rapid point of first contact with patients who have serious and complex illnesses. These intake visits allow a member of the patient’s health care team to identify concerns, obtain important external records, and create an optimized and condensed itinerary that can reduce the amount of time a patient needs to remain on a Mayo Clinic campus for testing and treatment. Many departments and divisions recognize the benefit of ongoing telemedicine visits as part of the care continuum. Mayo Clinic outpatient practice leadership continues to encourage the utilization of telemedicine functionality and is working to incorporate telemedicine offerings in a systematic fashion in patient-seeing workflows.

COMMUNICATION
As Mayo Clinic reactivated the outpatient practice, clear communications were needed to inform patients, visitors, and health care team members of the rapidly-changing environment. Once safety interventions were in place, Mayo Clinic began contacting patients to inform them that outpatient services were being gradually expanded. Multiple methods were used to communicate this information, including Patient Online Services, texting to mobile devices, mailed letters, and direct telephone calls. Practice leadership worked closely with care team members to assure them that it was safe to reactivate the outpatient practice. This included communicating the development and implementation of safety measures within the internal work environment including universal masking of patients, visitors, and staff; patient/visitor screening; social distancing; molecular testing for high-risk patients; and optimized facility management. In addition, risk analysis from an external environment perspective was conveyed, which indicated signs of stabilization of COVID-19 spread (eg, increased viral doubling times and evidence of flattening of the curve). A series of employee-focused virtual question/answer sessions were held, highlighting what had changed internally and externally to allow the practice to be safely reactivated.

CONCLUSION
Mayo Clinic’s integrated multidisciplinary destination outpatient practice was substantially impacted by the COVID-19 pandemic. Multiple changes were made to optimize safety for patients, visitors, and care team members. The outpatient practice at Mayo Clinic has safely reactivated and will continue to evolve in the context of the COVID-19 pandemic.

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