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The Importance of Early Childhood Education on Health Outcomes

Volume 2 | 2020

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NHMS President

We see then that education has a significant and sustained impact on health.

President's Perspective
The Importance of Early Childhood Education on Health Outcomes

As we continue to explore the social determinants of health, one that has a profound effect on health outcomes is education. Educational achievement is strongly correlated with future employment and income, which directly affect access to high quality health care as well as health status. But education has been shown to have direct effects on health as well.

This correlation between education and health outcomes has been demonstrated throughout the lifespan, and from the standpoint of participation in formal evidence-based programs, it starts as early as ages 3 and 4. Early Childhood Education (ECE) has been shown to be an effective intervention that can actually prevent future adult disease and disability. ECE programs are standardized in that they are required to include an educational component that addresses one or more of the following learning objectives: literacy, numeracy, cognitive development, socioemotional development, and motor skills. In addition to these core requirements, programs may have additional offerings such as recreation, meals, health care, parental supports, and social services.

In the literature, there are generally three types of ECE programs that have been studied: the federal Head Start program, state and district programs, and model programs. The Head Start program and state programs are publicly funded and generally focus on low-income children, whereas the model programs have often been funded through grants as research projects, and in some cases successful model programs have been subsequently expanded using public funds.

There is a clear biologic basis for the rationale behind these programs; we know that "preschool-aged children experience profound biological brain development and achieve 90 percent of their adult brain volume by age six. This physiologic growth allows children to develop functional skills related to information processing, comprehension, language, emotional regulation, and motor skills. Experiences during early childhood affect the structural development of the brain and the neurobiological pathways that determine a child's functional development".[1] The early, structured, and targeted interventions implemented through ECE programs exert beneficial effects on the young developing brain. These interventions appear to have outsized effects on children disadvantaged by poverty, as many of these children would not otherwise have access to these sorts of educational and developmental opportunities.

There is a fair amount of evidence that ECE programs improve health outcomes. In a meta-analysis done by Hahn, et al.,[2] the authors found

meaningful effects of ECE programs not only on test scores, graduation rates, and grade retention, which all can have indirect effects on health, but also on crime, teen birth, and self-regulation. In their meta-analysis, emotional development was the only outcome that did not show a meaningful effect from ECE programs of the outcomes studied.

In another study published in Pediatrics in 2015,[3] participation in a Head Start program in Michigan over the course of two years led to a statistically significant decrease in BMI in initially overweight and obese children, and a statistically significant increase in BMI in initially underweight children in the programs, when compared to two control groups.

A 2011 study[4] examining a model program, the Carolina Abecedarian Project, showed that a high-quality comprehensive ECE program that also included health care, social work services, and nutritional supplements (offered equally to the control group) decreased risky health behaviors such as binge drinking, cigarette smoking, and marijuana use. The results were found to be independent of IQ, math and reading scores at age 15, educational attainment, or health insurance status. A subsequent analysis in *Science* in 2014[5] of the Carolina Abecedarian Project cohort as they moved into their 30s showed those in the treatment group to have lower ten-year Framingham risk for heart disease as well as lower blood pressure, lower rates of obesity, and, in males, lower rates of metabolic syndrome. These studies clearly show sustained benefits of ECE programs well into adulthood.

And finally, a summary of multiple studies from around the world presented at an international symposium in Copenhagen[6] showed clear statistically significant evidence of the benefits of education (not just ECE but throughout childhood and young adulthood) on multiple aspects of adult health, health behaviors, and well-being; "the effects were particularly robust and substantive for the outcomes of adult depression, adult mortality, child mortality, child anthropometric measures at birth, self-assessed health, physical health, smoking (prevalence and cessation), hospitalizations and use of social health care."

We see then that education has a significant and sustained impact on health. As physicians interested not just in delivering high quality health care, but in improving and supporting our patients' overall health, making sure our kids have access to high quality education and ECE opportunities should be important to all of us. Education, as with the other social determinants, is an area of significant inequity both here in New Hampshire and across the country, so one approach would be to combat these racial and economic disparities across different communities and provide equal access to a quality education. This difficult but critical work is already ongoing here in New Hampshire and across the country. Returning to early childhood education, however, there seems an even clearer opportunity to level the playing field, as there is no universal ECE program in our state or across the country. Fully available public ECE also seems to be one of those rare areas of broad agreement these days, where most across the political spectrum think it makes good economic sense to invest in making ECE programs accessible to all kids in the state and the country. As physicians, we can play a unique role in the conversation supporting expanded access to ECE here in New Hampshire, by emphasizing the significant and long-lasting benefits of ECE on the health of Granite Staters, in childhood and beyond. ■

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Mike Padmore
NHMS Director of Advocacy

Preventing Youth Tobacco and E-Cigarette Use

In 2018, we understood that cigarette use among New Hampshire teens had decreased to just 4.6%. Recent data suggests that 40% of Granite State youth have tried e-cigarettes and nearly 25% report regular use. Those numbers are the highest rate of youth e-cigarette use in the country. In my spare time, I coach the JV boys' basketball team at Central High School in Manchester, and when I asked my team about those figures, they quickly confirmed that assessment to be accurate.

There are some fairly obvious reasons for this shift in behavior. The easy to identify cigarette smell coming from the boys' and girls' bathroom has been replaced with an odorless vapor that dissipates in seconds. In fact, I'm told students regularly will "vape" in the middle of class, blowing any smoke into their sleeve. No odor, and virtually no visible smoke. Teachers are left helpless. Perhaps, a larger reason for this shift may be explained in that e-cigarettes have been relatively unregulated for the last decade in comparison to tobacco products. No limits on indoor use, no taxes on sales, and no prohibition on flavoring.

In 2019, New Hampshire lawmakers took a good step forward in combatting this trend, by passing House Bill 680 and House Bill 511. In combination, these bills prohibited use of e-cigarettes in indoor facilities and levied a tax on all sales.

Later that year, Congress took action establishing the federal purchasing age for tobacco and e-cigarettes as 21. However, in order for New Hampshire to effectively enforce that federal law, we must pass an individual state law as well. Senate Bill 248 (SB248) would do exactly that, raising New Hampshire's tobacco and e-cigarette purchasing age to 21. Practically, I expect this new law to have an impact on tobacco and e-cigarette use in our school system around the state. I'll explain why.

Recent data suggests that 40% of Granite State youth have tried e-cigarettes and nearly 25% report regular use.

Albee Budnitz, MD, testifies in favor of SB248, on March 5.

The Institute of Medicine found that a majority of underage tobacco users rely on social sources to purchase for them and that 90% of people who purchase cigarettes for distribution to minors are under 21. Limiting access is the key. Will Tobacco 21 laws eliminate youth access across the board? Of course not. But we can look to history for evidence that we are on the right track by passing such a law. When we raised the federal purchasing age for alcohol to 21, decreases were seen in drinking by high school seniors; and today's adults drink significantly less than those who grew up with a lower drinking age.

As it currently stands, SB248 has passed the Senate and is awaiting a vote from the House Commerce Committee. Due to the COVID-19 pandemic, the legislature has closed its doors until early June. When they reconvene, we fully expect the House to pass SB248 and for the Governor to follow suit by signing the bill into law. If you have any questions or would like to help advocate for this bill, other vaping or tobacco related bills, or anything else, please call me at (603) 858-4744 or email Michael.Padmore@nhms.org. ■

WANTED

Internal Medicine, Orthopedic, Neurologic, General or Family Practice Physicians interested in providing part-time or full-time staff medical consultant services for the Social Security Disability program, through the state Disability Determination Services office in Concord NH. Staff work involves reviewing disability claims on-site and requires no patient contact. SSA Training is provided.

OR

Physicians interested in performing consultative examinations in their office for the Social Security Disability program, through the state Disability Determination Services office. Compensation is provided per exam. All administrative aspects are performed by the DDS and no billing is required. Free dictation service and a secure web portal is provided for report submission.

Any interested physician must be licensed by the state of NH and in good standing. Please email inquiries to Anne.Prehemo@ssa.gov

Christine Arsnow, MD

Fitness and Nutrition in a Time of Pandemic

A balanced diet and regular exercise are essential to a child's physical and mental health. Recent restrictions due to the COVID-19 pandemic have caused increased anxiety and depression among children,[1] making it an extremely important time to maintain a healthy lifestyle. At the same time, many of these restrictions make it more challenging to find ways to engage in wellness. As physicians, we must work with families to help ensure that children stay healthy during this trying time.

Adequate nutrition, including sources of carbohydrates, protein, fat, vitamins and minerals is essential for children to grow and develop. Many American children consume diets lacking in crucial nutrients. A 2015 report demonstrated that 30-40% of the daily energy of U.S. children and adolescents is consumed as energy-dense, nutrient poor foods and drinks.[2]

The COVID-19 pandemic has made it more difficult for children to get the nutrition they need. As discussed in an article by Chris Peterson, MD, in the last issue of New Hampshire Physician, food insecurity is a problem faced by many children in our state. The pandemic has increased this stress tremendously by limiting access to school-based lunch programs[3] and cutting the incomes of thousands of New Hampshire residents. Even for families with access to adequate nutrition, increased stress caused by the pandemic may promote unhealthy eating habits. Without the structure of school and work, children may be snacking more and parents may feel too overwhelmed or busy to prepare healthy meals.

How can we help improve nutrition in our pediatric patients? Bringing it up at a child's annual physical is the first step. Say "what does your child have on a typical day for breakfast, lunch and dinner?" Providers should be aware of local resources including food pantries, WIC and SNAP. The NH DHHS website provides links to programs that offer food assistance in New Hampshire.[4] We can help by reminding caregivers that it is important to keep up with healthy and nutritious meals despite busy schedules and

In addition to a balanced diet, regular exercise is crucial to a child's health and well-being.

added stress during the pandemic. Families should be encouraged to cook together. This can be a relaxing and fun way to unwind after a busy day.

In addition to a balanced diet, regular exercise is crucial to a child's health and well-being. The American Academy of Pediatrics recommends that children and adolescents ages 6-17 get at least 60 minutes of moderate to vigorous physical activity daily. Evidence to support the benefits of regular exercise to a child's physical and mental health is vast. Unfortunately, fewer than 25% of all children ages 6-17 engage in the recommended amount of daily physical activity.[5, 6]

Restrictions due to COVID-19 make it even more challenging for children to get the recommended amount of daily exercise. Organized activities like dance classes, swimming lessons and sports leagues are closed. Playgrounds are closed and play dates are limited. These disruptions to daily life are also very stressful for children so they need the mental health benefits of exercise during this time of uncertainty.

As with nutrition, the first step to helping a family incorporate daily exercise into their lives is bringing it up. Say "The AAP recommends that children get at least 60 minutes of exercise per day; do you think your child has been getting that much?" Here are some tips you can offer to parents: 1. Make a daily schedule and include physical activity as part of that schedule. Having structure and making exercise intentional makes it more likely to get done. 2. Provide children with choices. Some kids may prefer to throw a ball, while others might prefer to go for a hike. On rainy days, parents can try searching YouTube for yoga videos such as Cosmic Kids Yoga or putting on the soundtrack to a child's favorite movie and dancing. Giving a child options will engage him or her in the activity. 3. Finally, it is best to exercise as a family.[7] Family involvement is important to help a child successfully modify his or her lifestyle.

A healthful diet and daily exercise are essential to help keep children physically and mentally well particularly during this confusing and stressful time. ■

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NHAFP has voted to donate $5,000 to NH Food Bank. We encourage all specialty societies and any physician that is in a position to do so, to donate any amount that they are able. https://www.nhfoodbank.org

NEW HAMPSHIRE ACADEMY OF FAMILY PHYSICIANS
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FEEDING AMERICA

Birthday Thank You

Hello NHMS STAFF and colleagues/friends,

Thank you so much for the birthday greetings - this virtual birthday cake is much appreciated because it is zero calories even if I consume it all. Much needed recipe because at 79 I want to keep my girlish figure. This is most unusual birthday, because usually we have a Philippine/Swedish smorgasbord and invite friends over. My husband and I will have fun celebrating ALONE TOGETHER. Because of this pandemic, ahead of my birthday I cooked some Philippine dish and made deliveries to long time husband and wife friends who are older than us. One of them were so appreciative of our gesture, absolutely surprised and quite impressed with our mode of delivery that the wife took our picture. As you could see, we are complying with the Covid-19 mitigation by wearing mask, and maintaining 6 feet social distancing with bamboo pole.

David and Cosy in compliance with Covid-19 mitigation requirement of wearing face mask sewn by yours truly, and maintaining 6 feet distance with the aid of a bamboo pole, while delivering the care package. Note that the face mask facing out is of cotton material with print, the part touching face is of plain cotton; both are lined by nonwoven interfacing making the mask close to or equal to N95, and sewn together. I copied pattern available via internet. However, I had to make modifications to fit my face and my husband so as not to have any gaps. Being at the at-risk age, we have to be careful

Wish and hope ALL is well there at NHMS members and staff.

Cosy aka Marcosa Santiago. ■

The virtual cake sent via email from NHMS staff

NHOA/NHSPA Summer CME

Friday, August 7, 2020

Visit nhosteopath.org & nh-spa.org for updates or contact joy.potter@nhms.org

Save the Date!

Transgender Mental Health For the Practicing Psychiatrist: A. Evan Eyler, MD, MPH

NH Psychiatric Society's Annual Meeting, Awards, Scientific CME Presentation and Poster Contest will be held virtually on September 2, 2020.

Details TBA – Questions? Catrina.watson@nhms.org

NEW DATE

NEW HAMPSHIRE ACADEMY OF FAMILY PHYSICIANS
DEDICATED TO QUALITY HEALTHCARE

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NHMS Welcomes New Members

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Hand–off Communication

How patient hand-off communication can be improved.

Make high-quality patient hand-offs a priority for helping to sustain a culture of patient safety.

High quality patient hand-offs require the use of excellent communication skills by the person/team sending the patient (sender) and the person or team receiving the patient (receiver), to ensure the receiver understands the patient care information provided by the sender.

Excellent communication skills require both the sender and receiver to:

- Seek information (ask pertinent questions: "is there anything else I should know")
- Give information (clear, concise and complete)
- Verify information (clarify, repeat back, double-check calculations/equipment settings)
- Validate each other (communicate with warmth and respect, thank the other)
- Use clear language. Avoid unclear or potentially confusing terms ("she's a little unstable," "he's doing fine," or "she's lethargic"). Avoid abbreviations or jargon that could be misinterpreted.
- Review these Practice Tips on communication:
  - o Strategies for Effective Communication
  - o Communication Between the Referring and Consulting Physician: "The Importance of Clarifying Roles"

Define success:

- What does a successful inter-facility hand-off look like for the sender, receiver and patient
- What does a successful shift change hand-off look like
- What is the right amount of information to share for a short-term hand-off to diagnostic imaging
- Monitor success and use this data to identify opportunities for process improvements

Educate the key players:

- Importance of quality patient hand-off information
- When a patient hand-off is required
- What is the most effective and efficient method to provide essential patient hand-off information

Plan the hand-off:

- Coordinate resources such as patient information, transport equipment and personnel
- Allow for adequate time
- Choose a quiet location and minimize interruptions

Use a standardized form or tool:

Standardize critical content to be communicated. Tailor the hand-off protocol to its users, the environment in which the hand-off is occurring, such as the emergency department, and to the type of patient.

Examples include:

- Checklists such as a pre-operative, pre-MRI, "ticket to ride" and discharge
- Mnemonics:

ISBARR

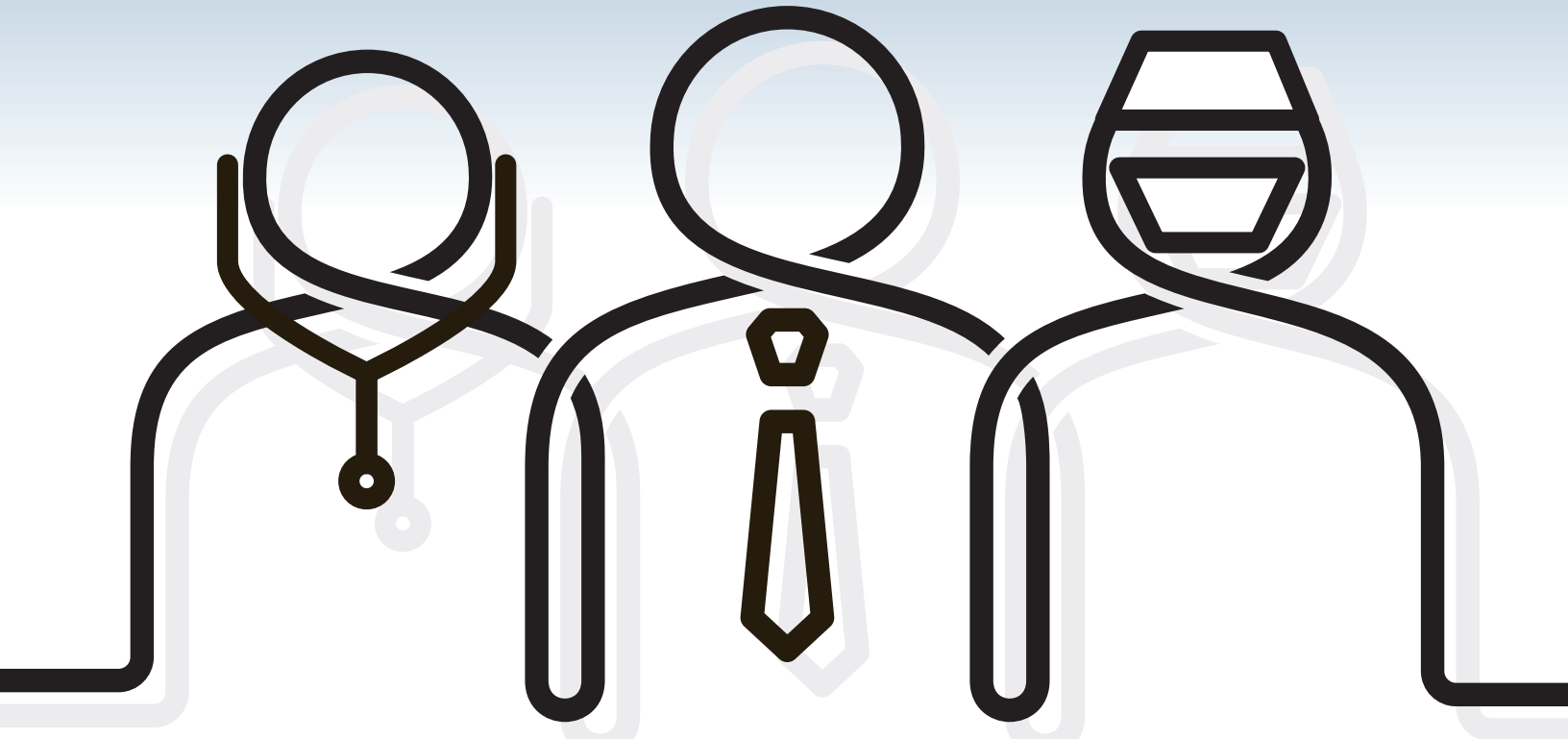
- o **I**ntroduction - introduce yourself including your department and role
- o **S**ituation - specify the situation. What has triggered this conversation and what is the patient's current condition
- o **B**ackground diagnosis, pertinent medical history, care to date
- o **A**ssessment - assess current needs, any outstanding studies or information
- o **R**ecommendation - explain what is being requested ("I would like you to see the patient now," or "I would like to schedule the ambulance. When will you be ready to receive the patient")
- o **R**epeat - ask the receiver to summarize the important details and ask if there are any questions

I-PASS

- o **I**llness Severity
- o **P**atient Summary
- o **A**ction List
- o **S**ituation Awareness and Contingency Planning
- o **S**ynthesis by Receiver ■

Medical Mutual's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

Partners in patient safety & medical liability protection



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...you may also find the need to attend to your personal financial well-being.

Fiscal Fitness For Your Life
Is it Time to Recalibrate?

At this writing, the individual and community responses to COVID-19 are placing both the healthcare and financial systems into uncharted waters. Of the many lessons being learned, one is a simple one that reminds us that lack of planning and continued vigilance can lead to tremendous dislocation of resources and the strain that accompanies crisis management. This moment in time certainly speaks to the interconnectedness of Physical, Financial and Emotional Health.

As you continue to focus your energies on serving the health and well-being of your patients and the greater New Hampshire community, you may also find the need to attend to your personal financial well-being. Just as the effort to remain healthy during this COVID-19 crisis calls for adopting new habits and the accessing of new resources, success in maintaining your financial health calls for adopting new habits, an increased level of diligence and the need to access new resources.

The recent renewal of the NHMS/Baystate Financial ***Fiscal Fitness For Your Life*** financial education and planning services initiative continues to provide NHMS members a resource to gain the financial guidance that can help you address the important financial issues you face.

In today's challenging environment you may find that the financial modeling available through Baystate's Fiduciary, Fee-Based financial planning services may provide you the analytics you need to re-calibrate your financial well-being strategies.

For information on Baystate's financial planning services, go to http://www.fiscalfitnessforyourlife.com/. ■

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Paul Mahon, MD
Healthcare for the Homeless, Manchester

Members' Corner includes selections focusing on personal and professional issues impacting doctors in New Hampshire - a forum for sharing the "voices" of NHMS members. We also encourage "Letters to the Editor," responding to articles published in prior editions. Please submit articles for our Members' Corner to james.potter@nhms.org

Members' Corner
Teflon and Thistles

In the past two weeks, two of our clinic patients died. Both were men in their fifties. This is a sadly routine occurrence in my office at Healthcare for the Homeless in Manchester, NH, a primary care clinic housed in the basement of our city's shelters but run by the Public Health department. I have worked there since 2007 as a family physician. I've long known what the research shows: If you are homeless, regardless of your age, gender or location, your homelessness alone increases your risk of death.

However, when I reviewed these two patients' charts, I learned something that I found even more disturbing. In all the years they had been enrolled in the practice, neither man had seen any doctor or nurse practitioner in our clinic more than once. Their medical records chronicle many street visits conducted by the outreach nurse and health educator, as well as dozens of visits to our hospital's emergency room—visits that were often followed by a phone call from the ER management pleading with us to better connect these men with medical follow up and primary care better delivered in an office setting. Although they weren't refused care, which would be illegal under federal law, the hospital staff did not welcome having to meet these patients' non-emergent and chronic health care needs.

The emergency room staff requests are rational, but there are many reasons why it's not easy for my colleagues and myself to do what they are asking. For one thing, we must overcome homeless patients' reluctance to come to the clinic for their basic medical needs.

At Healthcare for the Homeless, we try all sorts of ways to entice our patients to come to clinic. We distribute bottled water in summer and clean socks, hats and gloves in the winter. We give them crackers and peanut butter snacks to tide them over during the long stretch between breakfast and dinner at the shelter. We distribute samples of the most commonly needed medicines and personal use items like toothbrushes and facecloths. Even with these tokens, we still find it difficult to capture these patients. They defy our best measures. They're like Teflon; nothing attaches to them and they struggle to attach to others.

I suspect one source of their reluctance to enter our doors is the gauntlet of questionnaires and forms they must fill out just to enroll in our clinic. All of these forms are required by federal law annually to gather data. Every grant dollar donation we receive is paid for with paperwork, usually in the form of data collected about the people we see: How much schooling was attended? How many years of incarceration if any? How long has homelessness been a problem? Many people balk at the lengthiness of the questions which may take longer than the actual face time with a doctor. The questions about sexual orientation and practices of children in our immigrant populations are not crafted with a sense of cultural sensitivity. The

war refugees whom we see do not as a whole admit to sexual trauma, which some have undoubtedly suffered. These questions alone I see as a barrier to healthcare.

Another physical barrier that encourages our Teflon patients to slide away is that our clinic door is locked and requires admittance via a buzzer system. This is a reasonable response to the real safety concerns in our workplace. At another local shelter, an employee was murdered by a transient resident. Two years ago, there were gunshot murders outside the shelter where my car is parked. But still I see the locked door as a mixed message; we welcome the patients with one hand and push them away with the other. With the constraints of not owning the buildings in which we provide healthcare, this dilemma is currently insoluble.

There is also the harsh reality that homeless patients are traumatized people. As one shelter case worker said, "People don't end up in a shelter due to bad luck alone." In almost every case, there are elements of mental illness and substance abuse that impair the person's ability to maintain housing, jobs, or even the safety net of family. These same issues are caused by or may cause self-imposed social isolation.

"Social isolation is a growing epidemic," Dhruv Khullar, MD, said in the New York Times. No one exemplifies this as much as the homeless. Whatever painful circumstances led to their condition, the patient adopts habits that drive society away: never bathing, never changing clothes, public intoxication with a side order of angry outburst. Nothing drives a well-intentioned social worker away like fecal incontinence in clothing worn for days or weeks on end.

I look at our patients' charts and wonder what we physicians could do to become more like thistles, those large prickly seeds that attach to your trousers and socks when you walk through fields and woods. Somehow, I believe, we need to become like seeds quietly sticking to our patients so that they carry us along without even noticing.

My own dearest memories of receiving hospitality feature not fine hotels or dining rooms, but rather places that radiate personal warmth. It's my sense that the same holds true at Healthcare for the Homeless: a successful caregiver-patient relationship arises from an atmosphere of hospitality rather than from the service provided

In my own day to day dealings with patients, I find that asking them about themselves and giving them the opportunity to tell their stories is a powerful way of offering hospitality. I never start visits with a litany of questions about organ systems or illness. Instead, I ask questions like "Where are you from?", "How did you come to Manchester?", "Where did you go to school?", "What kind of job did you work?", "Tell me about your family".

I am constantly searching for common ground with my patients and for the connections that can be made. The stories our patients tell us are their gift to us. When we health care workers provide all the gifts, our patient relationship is no longer balanced. The gift receiver becomes indebted. I think some homeless patients try to avoid that kind of debt in anything more than a transient relationship.

I'm aware that this is not the model in many traditional doctor's offices. The business of medicine and its fifteen to twenty minute office visits does not support the kinds of social interactions necessary to construct a relationship with anyone. I do not see physicians or mid-level providers building patient relationships in the way businessmen build a relationship with customers. Ironically, as medicine has become more commercialized, the relationship building side of doing business is one of the few things that hasn't transferred. But relationship building, as important as it is to good caregiving for any group of people, is even more vital to delivering healthcare to populations such as homeless. Otherwise we will continue to see overutilization of Emergency Rooms with its high cost medical care, where health care relationships remain anonymous and socially isolating, as the norm for our homeless patients. ■

James G. Potter
NHMS Executive Vice President

Principles for Resuming Non-Urgent Patient Visits during COVID-19

In March, physicians and health care organizations responded to the Medical Society's and other requests to postpone non-urgent procedures, as well as face-to-face patient visits, appropriately, and postponed non-urgent visits to help flatten the curve of the COVID-19 spread across the Granite State. On May 1, in collaboration with NH Hospital Association and NH Department of Health and Human Services (DHHS), NHMS released our "Principles for Transitionally Resuming Non-Urgent Procedures during COVID-19." Since then, we have received numerous calls from physicians on how this guidance could be applied to resuming non-urgent face-to-face patient visits.

While many physicians have been able to keep in touch with patients and provide some medical care virtually, there are certain services that must be provided face-to-face, particularly where treatment and decision-making discussions need to happen. When opening up practices to patients, physician practices and facilities must consider changes in workflow, scheduling and taking safety precautions to minimize contact and do everything possible to keep physicians, staff team members, and, most importantly, patients safe.

...clinical judgement must drive individual care and treatment decisions...

Our principles to guide physicians and local facilities in their resumption of care in operating rooms and all procedural settings can also be applied in consideration of resuming other face-to-face patient visits. As always, clinical judgement must drive individual care and treatment decisions in partnership with patients. It is recommended that physicians consult with national specialty guidance for specific considerations and conditions for physicians and practice sites.

The following is a modified version of our guidance on resumption that can also be applied to other non-urgent face-to-face patient visits.

Timing for Resumption of Non-Urgent Patient Visits - Non-urgent face-to-face patient visits can be considered with COVID-19 data for the region stabilized and not showing signs of imminent exponential growth. Practices or facilities in the locality should be able to treat both patients requiring hospitalization and non-urgent patients as appropriate to the site of care without the NH Crisis Standards of Care (https://www.dhhs.nh.gov/documents/nh-csc-plan.pdf) being in effect, or compromising patient or staff safety and well-being to perform the planned patient visits.

Safety and Risk Mitigation - Practices and facilities should have and implement a COVID-19 physical distancing policy for staff and patients that meets then-current state recommendations for community isolation practices, while limiting patient visitors in non-restricted areas in the practice or facility. Universal infection prevention techniques, including respiratory spread, access control, workflow and distancing processes must be in place to create a safe environment in which non-urgent patient visits can occur, particularly for vulnerable patients. Environmental cleaning and sterilization processes should be in place according to evidence-based information.

Testing - Practices and facilities should use available testing to protect staff and patient safety and should implement a policy addressing requirements and frequency for patient and staff testing, including the turnaround time for test results. If unable to confirm a patient's COVID-19-negative status, then appropriate PPE should be utilized. Protocols should be in place outlining how a practice or facility will screen patients and respond to a COVID-19 positive worker, COVID-19 positive patient (identified preoperative, identified postoperative), person under investigation (PUI) worker, or PUI patient.

Personal Protective Equipment - Practices and facilities should not resume non-urgent patient visits until they have adequate PPE, as well as medical supplies appropriate to the number and type of patient visits. Policies should be developed for PPE conservation and any extended use or reuse of PPE per CDC and FDA guidance.

Case Prioritization and Scheduling - Practices and facilities should establish an objective prioritization strategy which may account for factors such as risk from further delay and patient comorbidities. Pre-visit planning, for both COVID-19 and non-COVID-19 issues, should incorporate a pre-visit online intake and assessment process to help limit wait times and contact with other patients. Utilize a tele-triage program to ensure that patients seeking appointments, particularly those with possible COVID-19 symptoms, are put on the right path by discussing the patient's condition and symptoms.

Patient Messaging and Communication - It is critical to ensure patients and community members understand that the prioritization of the safety of patients and health care team members is paramount as non-urgent patient visits are resumed. Clear communication needs to be reinforced in all messaging to patients and the public for plans to resume non-urgent patient visits, as well as considerations for ensuring their safety.

Data-Based Continuing Reevaluation - Practices and facilities should reevaluate and reassess policies and procedures frequently, based on infection data, resources, testing and other clinical information, and be prepared to flex back to postponing non-emergent patient visits upon any early indication of secondary COVID-19 waves or surges locally.

Specific guidance from the AMA and national specialty societies can be found with our resuming non-urgent visits guidance at https://conta.cc/2VTVSpt. ■

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