# Illinois Clinical Service Lines
# COVID-19 Guidelines

**Updated as of March 31, 2021**

*PLEASE Note – This document is being updated as new information becomes available. All system guidelines for ambulatory reactivation, AGP procedure & diagnostic testing guidelines, PPE, and Covid testing should be verified by accessing the Coronavirus COVID-19 Information Center: https://www.advocatehealth.com/covid-19-info/*

***For any service line specific questions, please contact the accountable owners listed on the face sheet before each service line section.***

## Table of Contents

AdvocateAuroraHealth

# Service Line: Behavioral Health

# COVID-19 Guidelines

**Accountable Owners(s): Dr. David Kemp and Renee Donaldson**

**Created: March 18, 2020**

**Last Updated: November 3, 2020**

# Behavioral Health Service Line IL COVID-19 Plan

## Hospital Based Programs

- Inpatient units at Good Samaritan, Illinois Masonic and Lutheran General remain open. At Christ, the adult medical-psych unit remains closed to behavioral health patients and is utilized for medical patients. At Christ, the adult behavioral health unit is open. Bed capacity remains at double occupancy where possible. Daily behavioral health inpatient census/potential discharges as well as ED patient needs is gathered and reported and the 1:30 p.m. Daily Bed Huddle.

- Service Line Directors monitoring inpatient Scope of Services to focus on throughput from AAH Emergency Departments to inpatient unit admissions.

- Construction has resumed at LGH. At CMC, the Intensive Treatment Unit is closed due to construction.

- Partial Hospital Program (PHP): Services are a combination of in-person & virtual.

- Intensive Outpatient Program (IOP): Services are a combination of in-person & virtual.

- All PHP/IOP in-person visits must meet established guidelines developed by the BH IL/WI Medical Directors and reactivation guidelines are being followed.

- Trauma Recovery Center: Team members working a combination of in-person and remote.

- HUB: Team members are working in a combination of in-person and remote.

- Electroconvulsive Therapy (ECT): For disease management and readmission prevention, will continue, if appropriate protocols and social distancing can be maintained.

- Some exceptions may need to be made and will be reviewed with BH Service Line.

## Outpatient Visits

- Clinics function in an open and remote status with regular clinic hours for telephonic and virtual visits. In person visits are allowed in accordance with reactivation timelines and established clinical criteria:
  - -Psychotic disorders
  - -Moderate to Severe Dementia
  - -Complicated with psychosis, SI or SIB

-Recent hospital discharge
-Requiring injectable antipsychotics
-Patients without access to video visits or not comfortable with video or telephone visit.
-Significant hearing and/or visual impairment.
-Patients in need of interpreter services or English as second language.
-Patients needing labs (e.g. breathalyzer or u/a screen)
-Patients on atypical antipsychotic needing AIMS monitoring every 6 months.
-Patients experiencing sever attention problems requiring a lot of redirection.

- Site leadership will coordinate schedules in accordance with established reactivation timelines to assure ability to provide social distancing. Appointments will be staggered to allow time to disinfect high-touch areas after each visit.

- Clinics are established as NON_COVID zones. Patient waiting areas will be set up to maximize social distancing, including removal of chairs.

- COVID PRE-SCREENING: All patients will be contacted 24-48 hours prior to an onsite visit to respond to COVID screening questions. If patient answers affirmatively to screening questions, then a virtual appointment will be offered instead of an on-site appointment.

- COVID-SCREENING: All patients will receive a temperature check before entering the building. All patients will be screened upon arrival per system COVID Screening guidelines. Patients presenting with symptoms will be cancelled for that day and rescheduled for a virtual appointment.

- PPE: Per system guidance, staff members and patients will wear a mask while in the facility at all times. The sites will provide masks to team members and patients.

- Any team members who handle payments or documents for signature will wear gloves. Pens and clipboards will be sanitized after each use.

- Taped lines will be placed on the floor at 6-foot intervals in waiting areas to indicate safe distances.
- Documentation must always include type of visit, length of visit, location of patient, and patients verbal consent to telephone or video visit and a GT modifier.

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# Service Line: Cancer

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Jon Richards, Dr. Jim Weese, Amy Bock and Karen Gordon**

**Created: March 18, 2020**

**Last Updated: December 9, 2020**

## CANCER SERVICE LINE GUIDING PRINCIPLES:

**Refer to https://www.advocatehealth.com/covid-19-info/ for any updated tools & information for Advocate Aurora Health team members and physicians during the rapidly evolving COVID-19 pandemic.**

1. **VISITORS:** No Visitor Policy - Patients should come to visits alone if possible or with 1 visitor if allowed per guidelines https://www.advocatehealth.com/covid-19-info/_assets/documents/no-visitor-policy-flyer-4.6.20.pdf

2. **SCREENING:**
    a. All patients should be called the day prior to appointment with screening questions from the COVID-19 Information Center.
    b. Oncology Departments should consider having at the department door screening - questions and temperature checking of patients and visitors.
    c. Patients who arrive with symptoms, team members should follow the AAH COVID-19 Outpatient Clinical Pathway and testing guidelines.

3. **COVID-19 TESTING:** Recommendations based on physician discretion, testing availability and Drive-Through COVID-19 Testing site operations. Patient must have an order and appointment to be tested. FAQ document https://www.advocatehealth.com/covid-19-info/_assets/documents/testing/covid_testing_faqs-06.23.20.pdf

    a. **Surgical patients** – follow system pre-surgical testing guidance. https://www.advocatehealth.com/covid-19-info/_assets/documents/emergency-department-hospital/aah-covid-urgent-surgery-guidelines-vi-04-23.pdf

    b. **Chemotherapy/infusion and radiation therapy patients** https://www.advocatehealth.com/covid-19-info/_assets/documents/testing-prioritization-for-inpatient-ed-and-ed-surge-tents-v2-04.15.20.pdf
        i. New start chemotherapy/infusion and radiation therapy simulation patients can be tested 24-72 hours prior to appointment and then direct patient to self-quarantine. Order - 2019 Novel Coronavirus (SARS-CoV-2) (aka COVID-19) - (LAB10635)
        ii. Patients with failed COVID screens. Order – 2019 Novel Coronavirus (SARS-CoV-2) (aka COVID-19) - (LAB10635)

4. **PPE Resource Guide, including details on Universal Masking -** https://www.advocatehealth.com/covid-19-info/_assets/documents/ppe-resource-guide.pdf

5. **INPATIENT CONSULTS** - Clinical Staff including Physicians and APCs should make every effort to AVOID hands on evaluation of COVID+ patients, to keep our staff safe, minimize the exposure to immunocompromised patients and conserve PPE. This includes but is not limited to Video Visits (COVID+ Unit tablets) and deferring clinical exams to colleagues such as hospitalist or intensivist.
6. **TELEHEALTH VISITS** – Video visits should be attempted first, if patient cannot connect or does NOT have technology, phone visit can be considered. Follow guidelines on COVID-19 Resource Center under Virtual Health for education and billing information.
7. **PUI/Confirmed COVID+ PATIENT TREATMENT** is based on physician discretion. Follow "COVID Positive Immunocompromised Pt" section of the COVID-19 isolation and deisolation criteria for acute care and ambulatory/outpatient settings document. https://www.advocatehealth.com/covid-19-info/_assets/documents/isolation-guidance/covid-isolation-and-deisolation_v3-5.26.2020.pdf .
    a. If the patient does not meet the test based or symptom-based criteria and the provider deems the benefits of cancer treatment outweigh the risks of COVID-19, follow the below guidance:
        i. Recommend consulting a second provider for consensus to treat when possible.
        ii. Utilize appropriate PPE for provider (procedure mask, gown, gloves, face shield/goggles) and patient (procedure mask).
        iii. Terminally clean after treatment following "Clinic Infection Prevention Best Practice Guidelines". https://www.advocatehealth.com/covid-19-info/_assets/documents/emergency-department-hospital/environmental-infection-prevention-best-practice-guidelines-v5-(002).pdf

            https://www.advocatehealth.com/covid-19-info/_assets/documents/ambulatory-physician-office/exam-room-cleaning-resource-guide-v2.pdf

        iv. Radiation Oncology Recommendations:
            1. Defer patients to end of day/afternoon treatment appointments
            2. Have patient wait in car until ready to treat when possible.
            3. Room patient in private area while awaiting treatment
            4. Limit PUI/Confirmed COVID+ patients to one vault in multi-vault departments.
            5. Clean areas as outlined per policy, "Clinic Infection Prevention Best Practice Guidelines" (above).

v. Infusion Recommendations:
   1. Have patient wait in car until ready to treat when possible.
   2. Treat in a private room with door when possible.
   3. Minimize number of team members interacting with patient.

8. **Nursing Home Patients** –
   a. Request nursing home test patient prior to new start.
   b. If patient cannot be tested, treat following guiding principle 7 above.
9. **Environmental Cleaning** – Follow system "Clinic Infection Prevention Best Practice Guidelines" https://www.advocatehealth.com/covid-19-info/_assets/documents/clinic-infection-prevention-best-practice-guidelines-il.pdf

## Medical Oncology/Hematology:

**1. CLINIC VISITS:**

a. Discuss patient list with physician and develop plan based on patient need.
b. Offer Virtual Visits for all non-essential in person visits.
   i. Any follow up visit with a timeframe of > 3 months should be changed to a Virtual Health visit unless patient reporting active problems.
   ii. Decouple lab and Video Visits, strategically schedule to ensure patient lab visit consistent with social distancing, ex: end of the day prior to video visit.
   iii. Supportive Care appointments – schedule supportive care appointments as appropriate (zometa/xgeva).
c. New Consults - Schedule newly diagnosed via virtual visit or in person visit based on physician direction.
d. Recurrent patients with symptoms in need of urgent care – schedule based on physician direction.
e. End of life discussion schedule based on physician direction.
f. Extend therapy with depot medications (Lupron) to the longest acting option available (3,6 months). Discuss with physician and receive new order as appropriate.
g. PORT FLUSHES- Patients should not be brought into the clinic solely for a port flush. Evidence demonstrates there is no need for frequent port care**. (refer to end of document for references)**
h. Active chemotherapy/hematology cases - Any patient on maintenance treatment should continue therapy unless there is a concern.
   a. Patients with curative intent – continue therapy
   b. Patients with palliative intent – Discuss with physician

i. Non-emergent treatments such as iron replacement (Venofer, etc.) - schedule based on physician direction.

**2. CHEMOTHERAPY:**

a. Consider the risk benefit ratio of chemo versus increased of exposure with possible subsequent development of COVID-19 disease with enhanced risk to adverse outcomes.
   i. Examples; adjuvant breast cancer, adjuvant lung cancer chemo, asymptomatic patients in non-curative intent chemotherapy regimens, decrease in duration of chemotherapy in colorectal cancer from 6-4 months. The question to ask is adjuvant therapy appropriate, could it be delayed?
   ii. Avoid starting chemotherapy in frail patients ECOG PS>1 and or >age 70. Other risk factors to consider include COPD, chronic respiratory conditions, DM, and immunocompromised patient.
   iii. Consider delaying chemotherapy in asymptomatic metastatic patients. Unless therapy to be done with curative intent.
   iv. Consider treatment breaks/holidays in patients in remission or doing well.

b. Drugs to use with caution include Cyclophosphamide and Taxanes due to lymphopenia secondary to these drugs, as well as drugs that induce profound mucositis (5fu regorafenib).

**3. HEMATOPOETIC GROWTH FACTORS:**

Coronavirus Disease 2019 (COVID-19) Resources for the Cancer Care Community - https://www.nccn.org/covid-19/ , https://www.nccn.org/covid-19/pdf/HGF_COVID-19.pdf

**Cautionary statement**: Physicians may wish to avoid use of or discontinue G-CSF in case of respiratory infection, respiratory symptoms, or confirmed or suspected COVID-19 to avoid increase in pulmonary inflammation or hypothetical risk of increasing inflammatory cytokines associated with adverse outcome.

**Consider implementing the following recommendations:**

a. Expand prophylactic use of granulocyte colony-stimulating factor (G-CSF) to minimize risk of febrile neutropenia, thus not adding to the overwhelming number of cases in emergency rooms (ERs) and hospitals.

b. Consider “restrictive” threshold for RBCs transfusion, e.g., -Hgb <7 g/dL as has been studied in intensive care units (ICU) (Cable et al) and hematopoietic cell transplantation (HCT) patients (Tay et al). Threshold can be increased for patients with cardiopulmonary or other comorbid conditions.

c. Considerations are below for broadening use of ESAs with blood supply shortages, as the Risk Evaluation and Mitigation Strategy (REMS) program was discontinued, and there are no recent data that use of ESAs targeting lower Hgb threshold accelerates cancer progression.

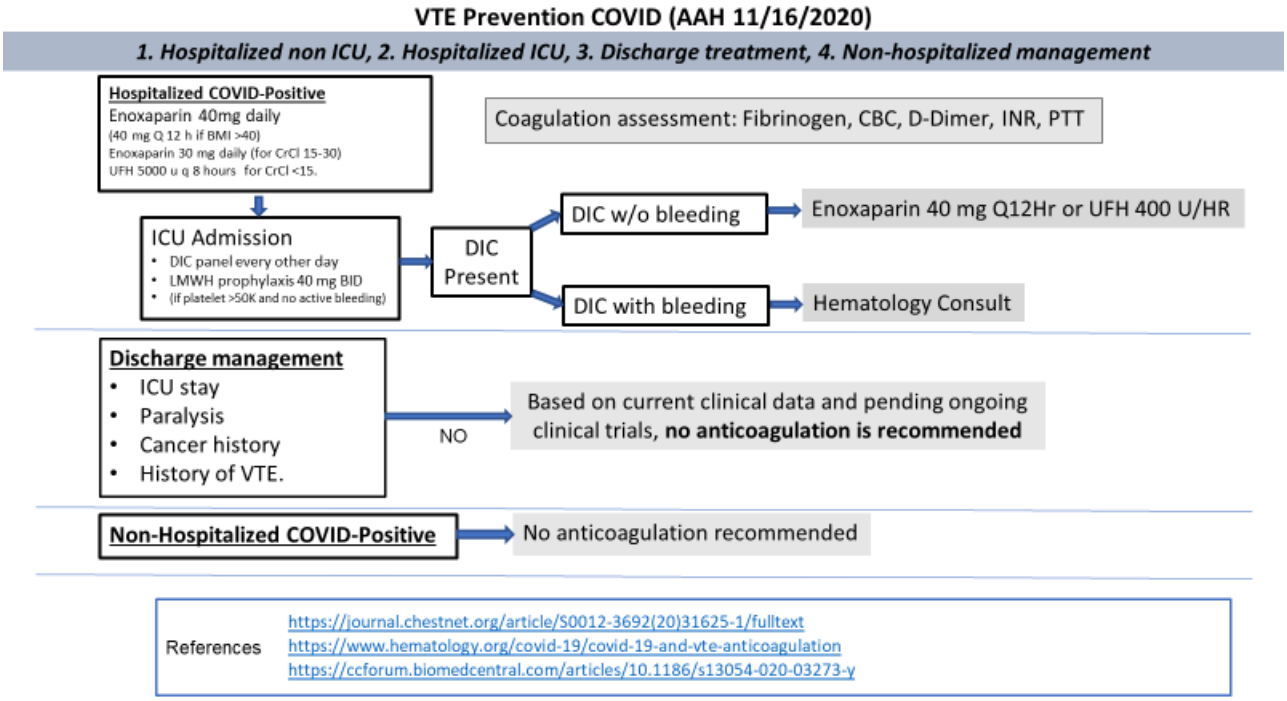
d. Lowered threshold for transfusion: Platelet count <10K (some centers using <20K for outpatient), modified for patients with bleeding.

4. **NON-ONCOLOGY INFUSIONS (GI, Rheumatology, Neurology, etc.):** The ordering provider will be contacted at least 24 hours prior to infusion appointment to confirm infusion should be administered

5. **TRANSPLANT:**
   a. All allogeneic & autologous transplant consults should be scheduled
   b. Allogeneic transplants for a hematologic malignancy should proceed with transplant
   c. Autologous transplants – DLBCL, other Hodgkin and non-Hodgkin lymphoma patient to proceed with transplant
   d. Myeloma/plasma cell disorder recipients for autologous transplant –
      i. Multiple Myeloma in 1st remission and Refractory/Relapsed patients should proceed with transplantation.
      ii. May need to collect stem cells if on therapy that will cause inability to achieve needed cell dose.
   e. Discuss myeloma consults at Transplant preparation/Pipeline to determine urgency
   f. Recurrent patients with symptoms needing urgent treatment
   g. Allogeneic transplant patients with a positive Covid screen or positive Covid test result should be reviewed & scheduled only based on physician direction. If exception arises these will be negotiated on an individual basis.

6. **CAR T-cell Therapy:**
   **a.** IL & WI - CAR-T cell patients should proceed with therapy.

7. **ANTICOAGULATION GUIDELINES related to Covid-19 (UPDATED 11/16/2020)**




## Radiation Oncology

**POLICY STATEMENT:** Adopt COVID-19 Information Center Resources. Radiation Oncologists will consider risk and benefit of continuing radiation therapy relative to risks of COVID-19.

1. **GUIDING PRINCIPLES:** refer to Guiding Principles for all cancer patients at the beginning of the Cancer Service Line section.
2. **CLINIC VISITS:**
    a. Discuss patient list with physician and develop plan based on patient need.
    b. Offer Virtual Visits for all non-essential in person visits.
        i. Any follow up visit with a timeframe of > 3 months should be changed to a Virtual Health visit unless patient reporting active problems.
        ii. Schedule all follow up appointments that have been deferred. Offer Virtual visits as appropriate.
    c. New Consults - Schedule newly diagnosed via virtual visit or in person visit based on physician direction.
    d. On Treatment Visits (OTV) –
        i. COVID negative patient – continue as scheduled

ii. COVID positive/PUI - OTV via telehealth is not ideal and should be used judiciously. This should be assessed on a case by case basis.

3. **SIMULATIONS/TREATMENTS-** Treatment of cancer patients is time sensitive. This problem is particularly acute in Radiation Oncology, where treatment breaks can negate the beneficial impact of radiation. Ultimately, the decision whether or not to treat patients testing positive with COVID-19 rests with the treating MD.
    a. Consider expanding treatment appointment times for more thorough cleaning of treatment table and accessories between patients
    b. Consider hypofractionation when indicated.
    c. When possible and to limit exposure, a single therapist should perform patient setup, while a second therapist assists at a distance with treatment. Consider rotating weekly.
    d. Palliative patients
        i. Pain or other non-life-threatening symptom → **treat with single fraction** or **terminate treatment in progress if delivered BED ≥ 8 Gy/1 fx**
        ii. Cord compression, brain mets, or other immediately life-threatening symptom → **shorten course of treatment** as feasible
    e. Definitive patients
        i. Low risk (no severe cough or pneumonia/ICU) → **complete course of treatment** or **defer at MD discretion**, accelerating as feasible
        ii. High risk (severe cough or pneumonia/ICU) → **defer remainder of treatment** and **make up after symptoms resolve and out of quarantine**

**Reference:** Guidelines for accelerating treatment and dealing with large breaks in treatment can be found in Table 3 of Gay H et al. Lessons Learned from Hurricane Maria in Puerto Rico: Practical Measures to Mitigate the Impact of a Catastrophic Natural Disaster on Radiation Oncology Patients. PRO 2019;9(5):305-321. (https://www.sciencedirect.com/science/article/pii/S1879850019300797)

    f. **Potential Treatment Algorithm Single Vault Facility**
        i. Decrease staff to limit staff exposure if feasible, with minimum safe staffing levels. Keep back-up staff remote/offsite in case of exposure if possible.
        ii. Treat all asymptomatic patients in the morning when possible.
        iii. Defer suspected (PUI) and confirmed COVID-19 positive patients to afternoon treatment appointments
            1. Patients, team members and physicians to follow AAH current COVID-19 PPE Resource Guide posted on the COVID-19 Information Center.
            2. Room patient in private area while awaiting treatment
        iv. Terminally clean vault at the end of patient treatment for the day

g. **Potential Treatment Algorithm Multiple Vault Facility**

i. Decrease staff to service single vault, if feasible, with minimum safe staffing levels. Keep back-up staff remote/offsite in case of exposure is possible.
ii. See steps 2 above for Treatment Algorithm Single Vault Facility.

**4. OTHER RECOMENDATIONS:**

a. **Reduction in onsite staff: Physician, Physicist, Therapist, Dosimetry, Nursing & support staff** if possible.
b. **Rotate staff** – if volumes are decreased, it may be possible to set up rotations where staff work in a week on/week off capacity. Keeping some staff out of clinic increases the number of uninfected staff, which would allow infected staff to quarantine and uninfected staff to rotate in.
c. **Daily Huddle**--daily huddle will continue to take place. This will be done via Teams/call in procedure. Lead therapist will send out outlook invite with conference bridge number. Work from home therapists will be expected to be on call. (Remote access will be requested for remote therapists to support for weekly chart checks, insurance verification's, preparing new patient charts, etc.)

## Surgical Oncology

### Guidelines for Surgery on Patients with Proven or Suspected Cancer

As of 11/15/2020, it has been determined that all cancer surgeries are considered urgent/essential and cases can be scheduled based on priority. This should be done by following the AAH **Essential/ Elective Surgery Reactivation Toolkit, Surgical Wait Priority Scoring System (SWAPS)** process. Local site governance committee determines procedures in light of resource constraints due to limited COVID-19 testing, PPE and other required resources.

Refer to system "Surgery/Procedure Reactivation Process" on the COVID-19 Information Center. https://www.advocatehealth.com/covid-19-info/_assets/documents/emergency-department-hospital/aah-covid-urgent-surgery-guidelines-vi-04-23.pdf

**REFERENCES:**

**2001 - Subcutaneous Ports Used for Vascular Access Need Only Be Flushed Every Eight Weeks to Maintain Patency Hoffman Proc Am Soc Clin Oncol 20: 2001 (abstr 1634)#oncorn**
https://www.asco.org/ASCOv2/Meetings/Abstracts?&vmview=abst_detail_view&confID=10&abstractID=1634

**2010 - A phase II trial of extended interval port-a-cath (PAC) flushes [2010; published online Sep 22, 2016] Janjua et al. JCO @ASCO_pubs Abstract e19635 http://ow.ly/H7Uw30qwNWY #oncorn**

**How frequently is subcutaneous central venous catheter care required to prevent luminal thrombosis? [2010; published online Sep 22, 2016] Odabas et al. JCO @ASCO_pubs Abstract e19587 http://ow.ly/5DxU30qwO0b #oncorn no need for very frequent port care**

**2016 - Phase II Trial on Extending the Maintenance Flushing Interval of Implanted Ports [Oct 23, 2016] Diaz et al. JOP @ASCO_pubs http://ow.ly/WNqo30qwNNM #oncorn q3mon is safe, effective, and likely to increase patient adherence and satisfaction while decreasing the associated cost**

**2019 - Regular Flush-lock is Unnecessary to Maintain Patency of Resting Totally Implantable Venous Access Device [Apr 2019] Lee - Hong Kong J Pediatrics http://ow.ly/65zQ30qwO4F #oncorn Omission of routine heparin saline flush-lock... does not seem to compromise their patency**

# Service Line: Cardiovascular and Thoracic

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Vincent Bufalino; Julie Kozlowski, MSN, APRN, CNS; Laura Grafrath and Virginia Friesen**

**Created: March 18, 2020**

**Last Updated: March 31, 2021**

# Cardiovascular and Thoracic Service Line

Daily: Please check COVID system guidance documents at Coronavirus COVID-19 Information Center: **https://www.advocatehealth.com/covid-19-info/**

Key Documents:

- Ambulatory/Physician Office: Clinic Infection Prevention best practice guidelines - **Key Word Search = Infection**
- PPE - **Key Word Search = PPE**
- Pre-screening and Screening. *For CV Pre-screening and day of testing, screening should evaluate whether patient's shortness of breath is related to baseline cardiac disease vs. new shortness of breath possibly related to COVID. Goal is to minimize cancellations due to cardiac related shortness of breath. Discuss with physician as needed.* - **Key Word Search = Screening**
- Testing Populations and Available Testing Pathways - **Key Word Search = Testing**
- **AEROSOL GENERATING PROCEDURES (AGPs) – Key Word Search = Aerosol**
- Reactivation Guidelines - **Key Word Search = Reactivation**
- Safe Care Promise - **Key Word Search = Safe Care**

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# Service Line: Medical Specialties

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Chintan Mistry**

**Created: March 18, 2020**

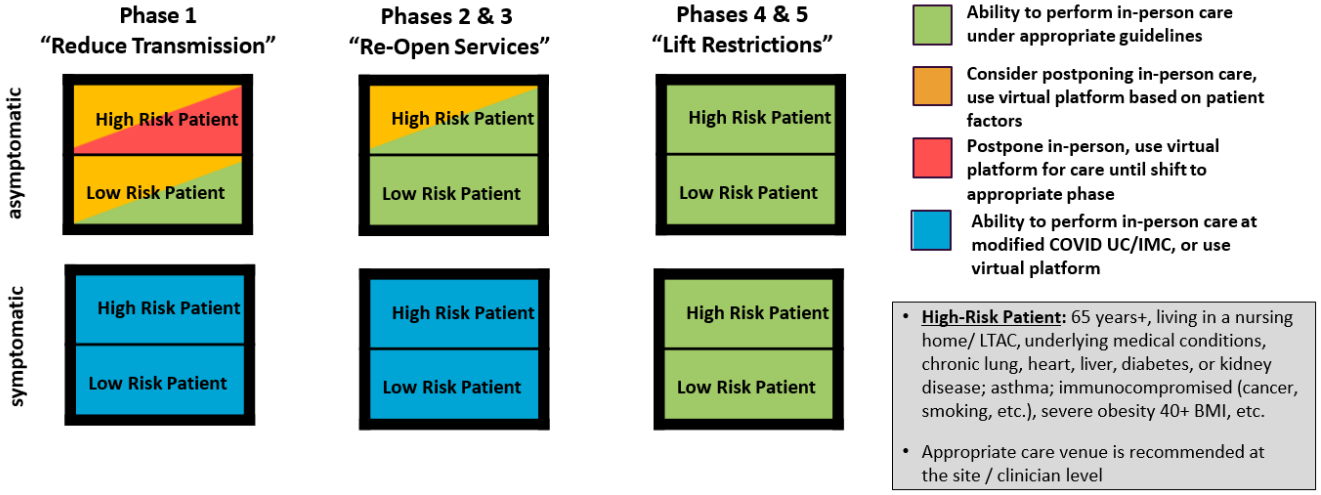
**Last Updated: May 19, 2020**

# Allergy Reactivation

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



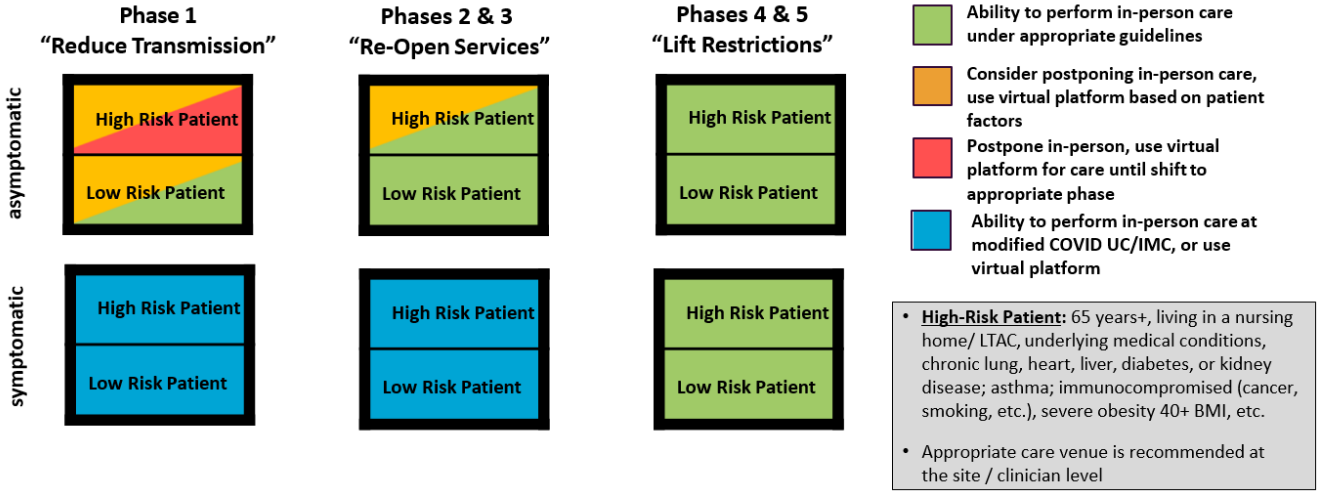
Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

# Dermatology Reactivation

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
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| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
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Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

# Service Line: Endocrinology

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Tahira Yasmeen**

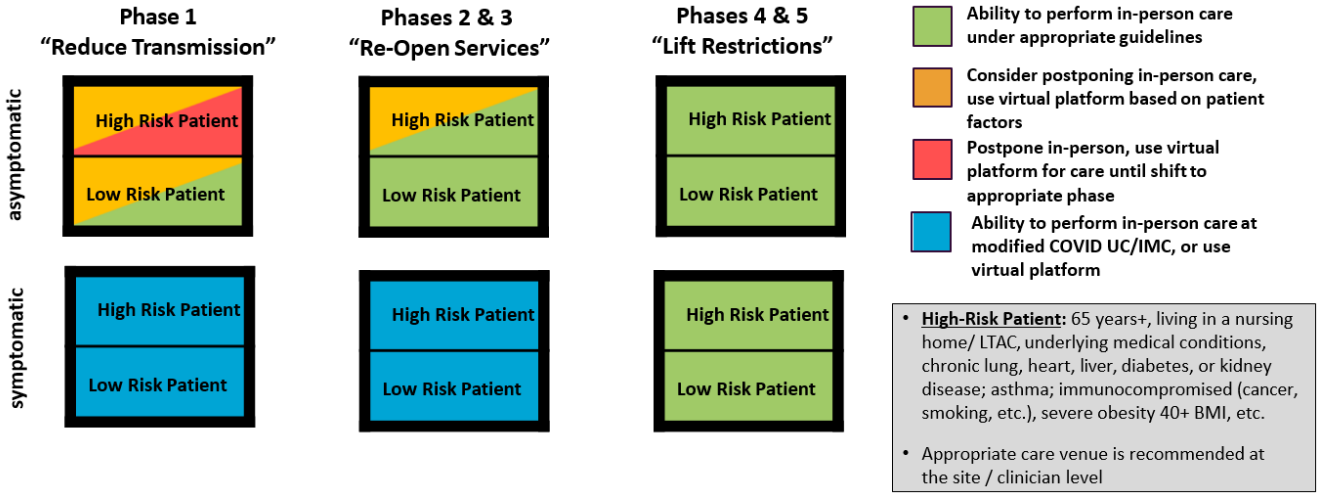
**Created: March 18, 2020**

**Last Updated: May 19, 2020**

# Endocrinology Reactivation and Recovery Practices

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

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| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
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| 5 | | • Return to full ambulatory access | • N/A |

**Phase 1: Current state**

a) Reschedule some non-essential visits, seeing patients via video and telephone visits mostly, in person visits only if deemed really necessary based on clinical scenario



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

b) Holding off on Non oral therapies for Osteoporosis-Holding Prolia and Reclast

c) Holding off on thyroid biopsies

**Phase 2:**

1. Offer **Video Visits** as first option, telephone visits can continue for now and in-person care may be resumed when safe care checklist completed and when ready to proceed as per the operations and physician leaders at your site. Consider initial pilot before rolling out. Consider in person visits for:
    a. Routine Diabetes Care in low risk patients
    b. Patients with thyroid disorders
    c. Routine Lab Follow up for other diagnosis
    d. New patients if not possible to do Video Visit, or if needed as per the clinical scenario (for e.g. a patient with rapidly enlarging neck mass). Telephone visits remain an option for New patients as well.
2. In patients with stable thyroid nodules, clinical decision to proceed to biopsy can be made with Video Visit.
3. Start scheduling medication administration: PROLIA, TESTOSTERONE (scheduled medications) in June. If Prolia is delayed for more than 1 month, consider switching to oral bisphosphonateas per recent guidance.
4. Start Dynamic Testing/e.g. ACTH stimulations testing when necessary with attention to scheduling.
5. Video visits for high risk patients>65, NH patients, patients with transplant and LVAD, CHF, cancer, consider telephone visit if Video Visit not feasible for patient.

**Procedures**

1. Consider resuming thyroid biopsies when in-person visit reactivation occurs. Reference system AGP/PPE/Testing Guidelines
2. Restart RECLAST infusions in clinic when possible or once infusion center resumes normal activities - as per recent guidance can wait for few months past due date
3. Resume routine labs for diabetes health maintenance or thyroid labs by June 1 – follow staggered appointments for lab as well if on site lab available
4. Resume routine DXA scans by June 1

**Overall Operational Concerns/ Suggestions**

- No more than 3 in-person visits in an hour or 50% of pre-Covid schedule
- Consider 30 min appt time slots if in person and stagger starts if multiple providers
- One provider can see 2-3 patients via Video Visits and one in-person visit per hour if VV interspersed with in-person. visits
- Can consider 20 min follow up if larger clinic space and if separate entry and exit points available and operations can provide waiting space changes (after virtual or phone check in from car would be best to have patient proceed to the assigned rooms rather than wait in a waiting area)
- If single provider: can stagger for appropriate waiting room flow and allow blocked time for video visits
- If > 2 providers in clinic- alternate AM /PM schedules for in person and Video
- If > 4 providers in clinic- half of providers should do video only for the day to allow proper distancing (Video Visits can be done from a remote location)

**Diabetes Education**

1. Continue video visits as first choice when appropriate for patient care
2. In person visits only if necessary and only on days when 2 or less providers in clinic with staggered appointment times

AdvocateAuroraHealth

# Service Line: Gastroenterology

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Rick Bone and Blake Meyer**

**Created: March 18, 2020**

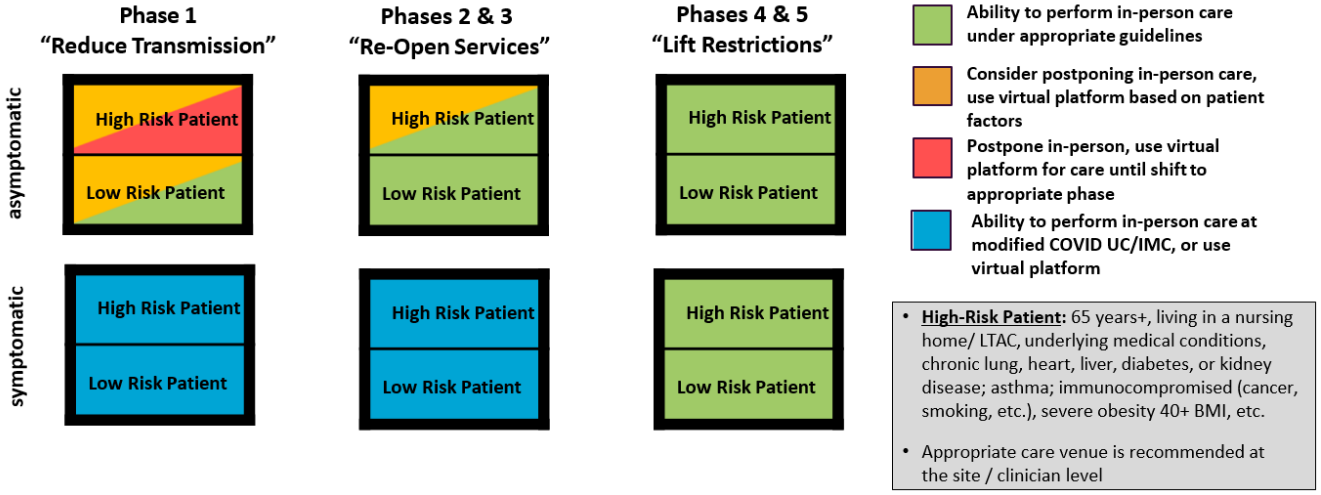
**Last Updated: May 28, 2020**

# Gastroenterology

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
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| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
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| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
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# Gastroenterology Reactivation Plan

## Date of GI Procedure Ramp Up

- Effective dates for GI ramp up and reactivation procedures and workflows are dependent on guidance from local site leadership and incident command based upon current state of Covid response within that geographical location.
- Continued need for extended hours, scheduling to support social distancing, and other extra-ordinary measures will be reevaluated on an ongoing basis with System and Site leadership.

## Procedure Scheduling

- Develop GI procedure schedule to ensure proper social distancing in all patient care areas; waiting room, prep area, procedural rooms, and recovery area.
    - Local site leaders should coordinate with their procedural schedulers or central scheduling to ensure appropriate procedure scheduling to support social distancing.
- Extend hours of operation in GI and Endoscopy departments to ensure continued access for patients and physicians to GI services.
- Open or expand weekend procedural scheduling availability to create greater access to AAH GI and Endoscopy facilities for patient and physicians.
- Local sites and departments must develop plans for care and management of Covid positive patients who need of urgent or emergent GI procedures.

## Screening and Testing for Patients

**Testing:** Patients undergoing GI procedures should be tested for Covid prior to the date of service.

- All GI Procedures have been designated by AAH to be Aerosol Generating Procedures (AGP) that require Covid testing prior to the procedure. This includes: Flexible Sigmoidoscopy, Colonoscopy, EGD, EUS, ERCP, ESD, EMR, Esophageal and Anorectal Motility Studies. Please click the following link for the most up-to-date procedure:
  **Aerosol Generating Procedures (AGP):** https://www.advocatehealth.com/covid-19-info/_assets/documents/aerosol-generating-procedures.pdf

  ***Several GI diagnostic tests have been categorized as an AGP. Please review the above reference guidelines.***

- Testing should occur within 48-72 hours of DOS to ensure the results are available prior to patient arrival at the facility. See this link for testing:
  **Testing** Populations and Available Testing Pathways: https://www.advocatehealth.com/covid-19-info/_assets/documents/testing-prioritization-for-inpatient-ed-and-ed-surge-tents-v2-04.15.20.pdf
- All Patients should still be screened for Covid symptoms within 24 hours of their DOS.
- If test is Covid positive, reschedule and follow-up with provider

- If the test is Covid positive, and the patient has an essential need, procedure should be scheduled at HOPD
- If test is Covid negative, provide procedure as scheduled with facility screening on DOS

**Screening:** All GI patients should be screened for Covid and Covid Symptoms prior to the date of service (DOS) in both procedural and ambulatory clinic settings.

- Screening should preferably occur 24 hours prior to DOS.
- If positive screening, reschedule and follow-up with provider
- If negative screening, provide procedure or ambulatory care as scheduled, with facility screening on DOS
    - Direct patient to NOT arrive early
    - Inform patient of visitor policies at your institution. Visitors should be restricted since they have not been tested.
    - Patient and team members masked per PPE resource guidelines.
- If patient does not answer their phone for facility screening prior to DOS, service patient as scheduled and perform facility and department screening on DOS
    - Patient and team member masked per PPE resource guide

## Site Facility and Environment Precautions

**Patient Arrival, Masking and Visitors**

- Prior to Date of Service (DOS) promote patients to wear mask to the facility. If patient does not have a mask to wear to the facility, provide patient a mask upon arrival.
- Consider having patient wait in car and call or page when they should proceed into facility.

**Waiting Room and Registration**

- Limit patient capacity in waiting room to ensure 6-foot distance between all patients.
- When queuing for registration/check in, distance of 6 feet should be maintained between patients. Consider temporary floor markings to ensure spacing.
- Waiting rooms and patient care areas must be adapted to promote principles of social distancing of at least 6 feet between patients.
    - Collaborate with site interiors team to move furniture in waiting rooms to create distance between patients.

**Disinfection**

- High touch surfaces in the waiting room, registration, and throughout the department should be frequently cleaned and disinfected using approved cleaning supplies.

**Personal Protective Equipment (PPE)**

- Team members and physicians should follow AAH PPE guidelines available in the Covid Toolkit. Types of PPE needed will depend on types of procedures, as well as testing results and availability.
  Please refer to Covid Toolkit for PPE recommendations related to all GI procedures considered AGP: System Guidance on **PPE**: https://www.advocatehealth.com/covid-19-info/_assets/documents/ppe-resource-guide.pdf

### Further References

American Gastroenterological Association (AGA): https://www.gastro.org/press-release/aga-dhpa-joint-guidance-for-resumption-of-elective-endoscopy

American Society of Gastrointestinal Endoscopists (ASGE): https://www.asge.org/docs/default-source/default-document-library/asge-guidance-for-reopeningI_4-28-2020.pdf

Joint GI Society Statement: Use of Personal Protective Equipment in GI Endoscopy: https://gi.org/2020/04/01/joint-gi-society-message-on-ppe-during-covid-19/

# Gastroenterology

### COVID-19: Recommendations to Protect GI Physicians and Staff

**Primary goals during the outbreak from Dr. Vincent Bufalino, MD - Chief Advocate Medical Group Officer:**

1. Prevent the spread of COVID-19
2. Keep our healthcare providers healthy
3. Take care of our sick patients

**Background on Endoscopy during the COVID-19 outbreak**

- **High quality, safe care is our priority.** Infection prevention measures and guidelines in the endoscopy department are needed to provide a high quality and safe environment for both patients and staff.

- **Novel Coronavirus Transmission Sources.** SARS-CoV-2 virus causes the COVID-19 illness. It is a novel virus and has similarities to SARS-CoV-1 and MERS-CoV which previously caused smaller outbreaks with significant mortality. SARS-CoV-2 transmission occurs via respiratory droplets, feces, contact with infected surfaces, and person-to-person spread. The CDC states that early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely[1].

- **GI symptoms.** The incidence of GI symptoms including nausea and/or diarrhea are uncertain with some reports below 5% and others at 50%. There have been some reports of isolated diarrhea preceding cough and fever[2].

- **Endoscopy is High Risk for Exposure and Transmission.** Airborne precautions are universally recommended for aerosol generating procedures, including endoscopy, which are considered high-risk for transmission of SARS-CoV-2[3].

**Recommendations for Endoscopy Procedures**

- Suspend all elective procedures to minimize exposure to health-care personnel, exposure to patients. Some non-urgent procedures are higher priority and may need to be performed (examples include cancer evaluations, prosthetic removals, evaluation of significant symptoms). Classification of procedures into non-urgent/postpone and non-urgent/perform may be useful[2]. Of note, CMS on advised hospitals to postpone all elective surgeries[4]. This will also minimize PPE use during the outbreak and save PPE for urgent cases.

- All patients who need urgent/emergent endoscopic procedures should be screened Pre-screen all patients for high risk exposure or symptoms. Patients should be asked about history of fever or respiratory symptoms, family members or close contacts with similar symptoms, any contact with a confirmed case of COVID-19, and recent travel to a high-risk area. Avoid bringing patients (or their escorts) into the medical facility who are over age 65 or have one of the CDC recognized risks listed above[2].

- During Aerosol Generating Procedures in the endoscopy unit such as EGD, ERCP and EUS which involve suctioning and aerosolization of oral and respiratory secretions, team members should follow guidelines for airborne precautions. Please refer to AAH Covid-19 Toolkit for guidelines on proper PPE use in cases requiring airborne precautions.

- Personal Protective Equipment (PPE) should be available to all personnel during any endoscopy procedures. Please refer to AAH Covid-19 Toolkit for guidelines on proper PPE use.

- For COVID-19 positive patients, or those awaiting test results, isolation precautions should be taken with procedures performed in negative pressure rooms[2].

- All equipment needs to be immediately available (e.g. staff should not be leaving the room to get additional equipment or supplies).

- Staff need to keep a reasonable distance (6 feet desirable) from every patient[2] during all steps before the beginning of the procedure (e.g. informed consent, vital signs, patient instructions, etc.).

- All patients who are confirmed COVID-19 cases or patients under investigation (PUI) should wear a surgical mask the entire time they are in endoscopy/OR. The surgical mask is replaced with the Procedural Oxygen Mask (POM mask) for EGDs but can remain in place during colonoscopy if considered safe by anesthesia. They should be replaced as promptly as possible if they have been removed

- For patients, placement of beds should be greater than 6 feet apart in open areas in the endoscopy unit in order support social distancing and limit potential for exposure.

- Terminal cleaning process should be followed for each room after performing a procedure on a COVID-19 positive patient, or a patient under investigation awaiting test results, to minimize risk of spread. There should be a detailed process for the terminal clean, so contaminated surfaces are not missed.

- Consider phone follow-up at 7 and 14 days to ask about a new diagnosis or development of symptoms of COVID-19[2].

**Endoscopy specific PPE guidelines**

- For the most up to date guidelines for PPE use in an Advocate Aurora Health facility, please refer to the *Advocate Aurora Health Covid-19 Toolkit PPE Guidelines*.

**Recommendations for GI Inpatient Consults**

- Minimize unnecessary contact with all patients during COVID-19 outbreak.
- Physicians will use their clinical and professional judgement to minimize unnecessary contact with patients. Consultation requests will be reviewed, and the consultation could be completed by obtaining information without face to face contact if appropriate (e.g. chart review, radiology review, phone interviews with patients or nurses, etc.).

**Next Steps and Current Needs**

- Develop Standard Operating Procedures for COVID-19 prevention and control
- Immediate training for all staff including anesthesia on PPE donning/doffing without contamination
- Protocol for urgent inpatients who need endoscopy
- Training on protocols for all staff
- Protocol for terminal cleaning after cases and for scope processing

## ADDITIONAL RESOURCES AND BACKGROUND INFORMATION

**American Society for Gastrointestinal Endoscopy (ASGE) recommendations**
https://www.asge.org/docs/default-source/default-document-library/press-release_impact-of-covid-19-onendoscopy.pdf

**American College of Gastroenterology Covid-19 and GI** https://gi.org/media/covid-19-and-gi/

**Joint Statement from the four GI Societies regarding COVID-19 posted March 15, 2020**
https://gi.org/2020/03/15/joint-gi-society-message-on-covid-19/

**American College of Surgeons COVID-19: Recommendations for Management of Elective Surgical Procedures** https://www.facs.org/about-acs/covid-19/information-for-surgeons/elective-surgery

**European Society of Gastrointestinal Endoscopy Position Statement on gastrointestinal endoscopy and the COVID-19 pandemic** https://www.esge.com/esge-and-esgena-position-statement-on-gastrointestinal-endoscopy-and-the-covid-19-pandemic/

**References**


1. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. cdc.gov. https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html .Updated March 19, 2020. Accessed March 22, 2020.

2. Joint GI Society Message on COVID-19. gi.org. https://gi.org/2020/03/15/joint-gi-society-message-on-covid-19/. Updated March 15, 2020. Accessed March 23, 2020.

3. Supplement I: Infection Control in Healthcare, Home, and Community Settings: Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS). cdc.gov. https://www.cdc.gov/sars/guidance/i-infection/healthcare.html. Accessed on March 23, 2020.

4. CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. cms.gov. Updated March 18, 2020. Accessed on March 22, 2020.

# Infectious Disease Reactivation

All disciplines will directly align with System recommendations

## Framework for Reactivation

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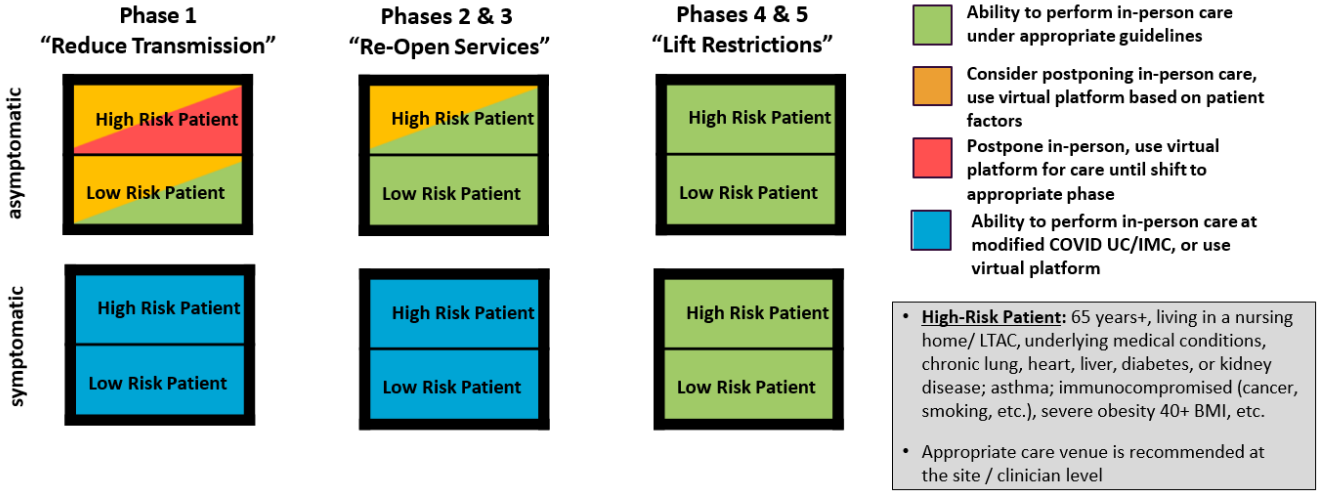


- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

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| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
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| 5 | | • Return to full ambulatory access | • N/A |



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# Nephrology Reactivation

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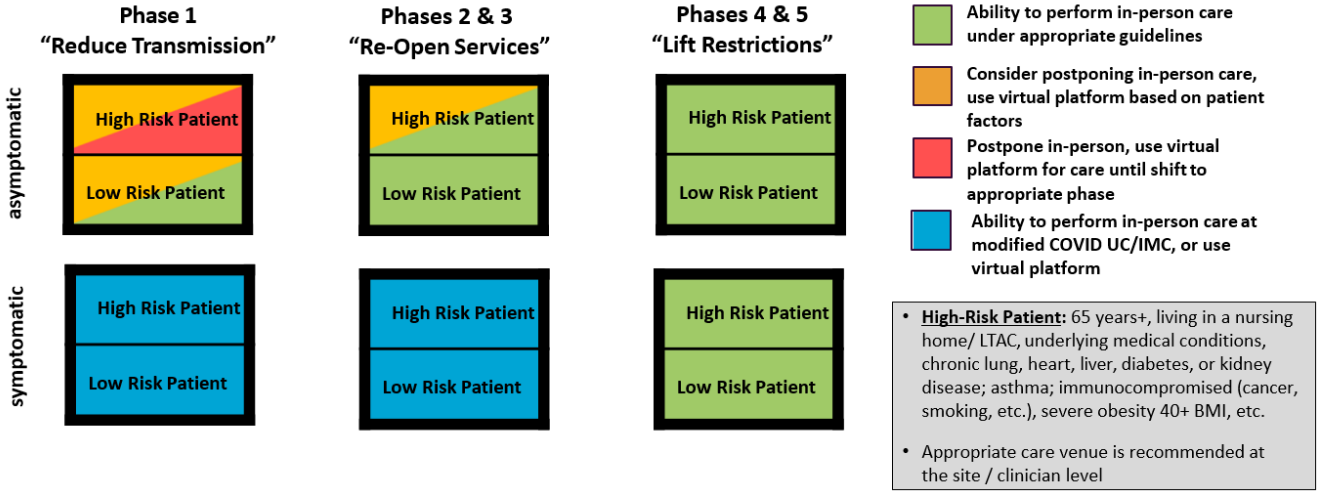


- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
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# Non-Interventional Pain Reactivation

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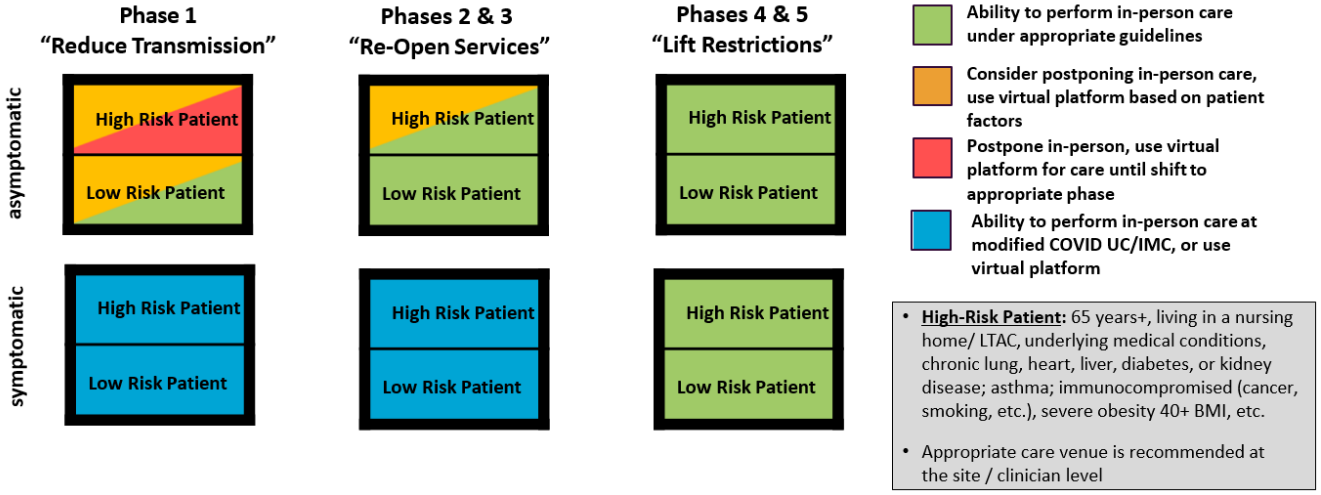


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# Pulmonary Medicine Reactivation

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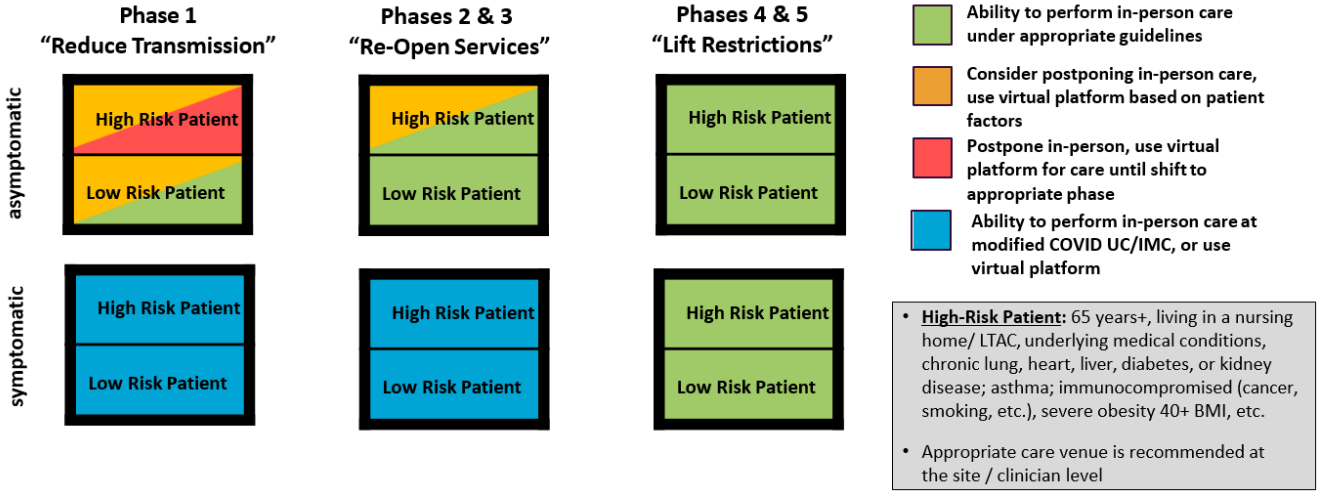


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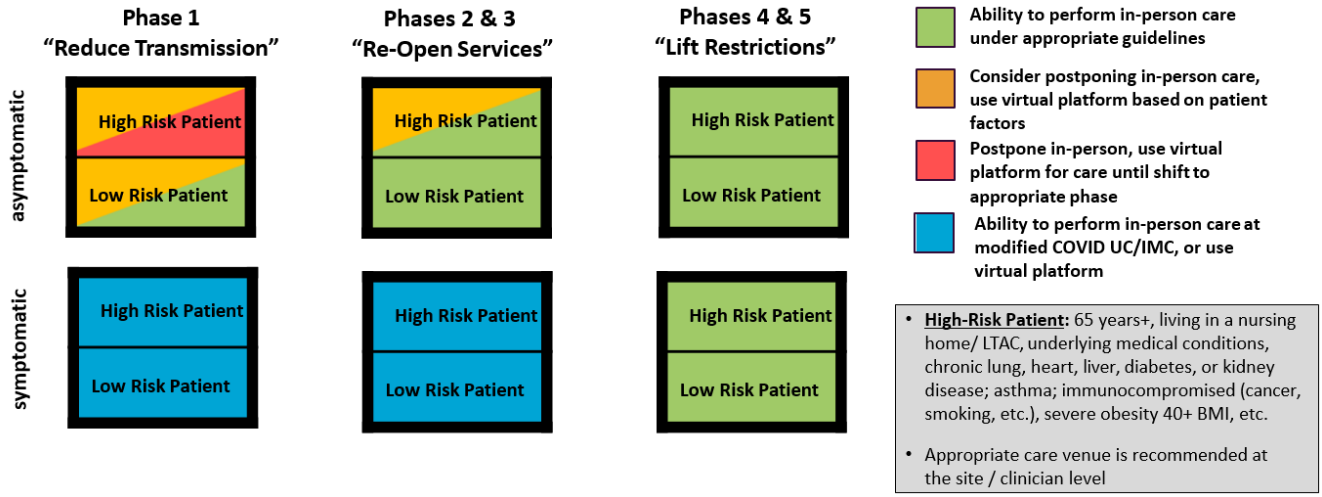
Approved by Tim Lineberry, MD

# Physical Medicine and Rehabilitation (PM&R)

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

## Existing Patients

Please limit patients for ambulatory evaluation that meet the following criteria:

With the guiding principles in leaving an element of discretion between the referring physicians and the PMR is important to maintain appropriate care.

Require Telephone/Telemedicine Visit

1. Physician to review patient list with staff and determine disposition
2. Conduct a telephone visit to determine need for in office visit
3. Therapy referrals or evaluations for rehab patients

Require In-Office Visit

1. Pump refill
2. Painful prosthetic
3. Botox needed that is causing worsening pain and limiting key function
4. Significant pain requiring intervention/procedure
5. EMG that needs to be performed more urgently for acute issues for pain and guiding treatment

Require Future Appointment

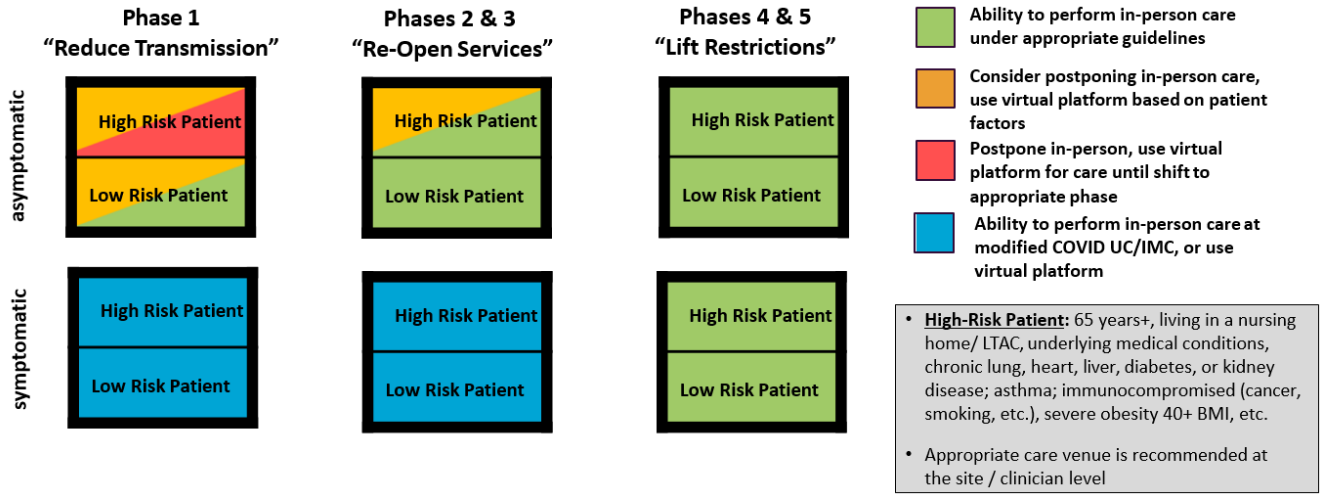
1. EMG
2. Wheelchair seating
3. Amputee
4. Physical medicine appointments that are not requiring more emergent intervention

# Rheumatology Reactivation

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

AdvocateAuroraHealth

# Service Line: Neuroscience

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Dean Karahalios, Dr. Nina Paleologos and Mike Busky**

**Created: March 18, 2020**

**Last Updated: May 28, 2020**

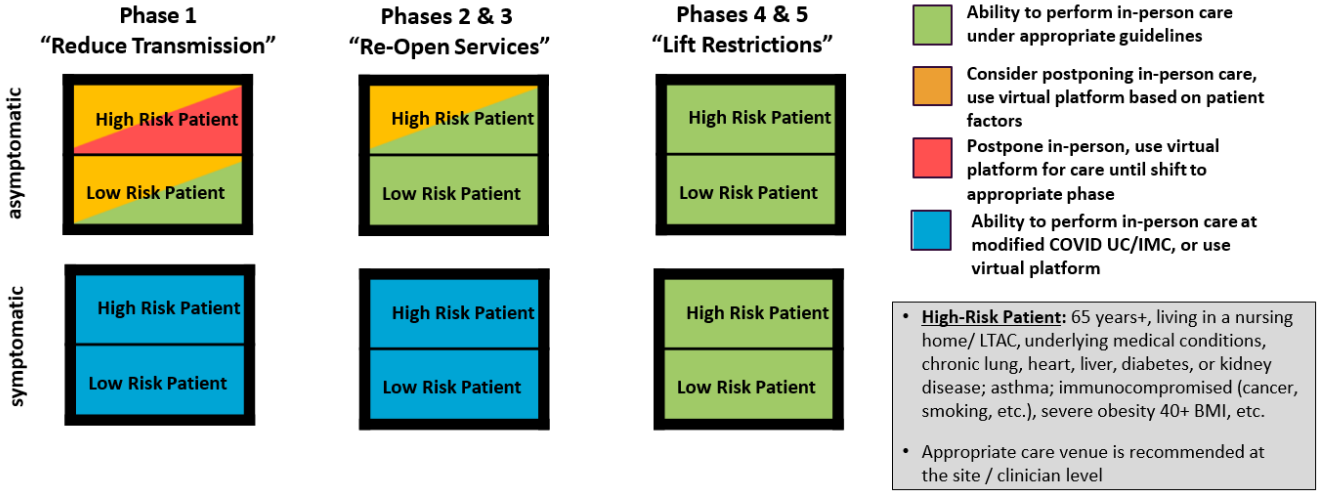
AdvocateAuroraHealth

# NEUROSCIENCE SERVICE LINE

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
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| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

# NEUROSURGICAL COVID-19 GUIDELINES

Daily: Please check COVID system guidance documents at Coronavirus COVID-19 Information Center: https://advocatehealth.sharepoint.com/sites/AO/Dept/infection-prevention/Pages/2019-nCoV-Coronavirus-Toolkit-.aspx?csf=1&cid=1ece4b97-3a43-4a68-bda9-b6636350b7e9

Key documents: (additional references at end of document)

- System Guidance on **PPE**: https://www.advocatehealth.com/covid-19-info/_assets/documents/ppe-resource-guide.pdf
- System Guidance on **Pre-screening** (https://www.advocatehealth.com/covid-19-info/_assets/documents/ambulatory-universal-screening-pre-visit-workflow.pdf) and **Screening** (https://www.advocatehealth.com/covid-19-info/_assets/documents/ambulatory-universal-screening-workflow-4.3.20.pdf).

Considering the anticipated worsening of the Covid-19 pandemic, the Neuroscience Executive Council of the Brain and Spine Institute has developed the following recommendations pertaining to neurosurgical patients and staff. The goal of these recommendations is to address two major goals: 1) Limit exposure in order to protect the greater population (especially at-risk groups such as the immunocompromised and the elderly) and to flatten the peak of infection. 2) Maximize the availability of anticipated high demand resources (ICU beds, ventilators, PPE, etc.).

With these objectives in mind, the Neuroscience Service Line has identified and created the following recommendations related to neurosurgery:

## Ambulatory

1. Screen clinics and postpone all non-essential visits.
2. Essential visits may include but are not limited to:
    a. New patients necessitating an in-person exam based on triage protocol.
    b. Post-operative patients requiring wound checks.
    c. Patients with concerning symptoms that may represent conditions that if not evaluated expeditiously may lead to severe or permanent harm (I.e. “red flag” symptoms commonly used in current triage practices).
3. Non-essential visits may include but are not limited to:
    a. Routine follow up of spine patients who do not have new or progressive symptoms. Imaging may be obtained and results communicated to the patient by phone.
    b. Routine surveillance of cranial patients (trauma, tumor, or vascular) who do not have any new or progressive symptoms. Imaging may be obtained and results communicated to the patient by phone.
    c. New spine clinic patients who have chronic and stable conditions or minor symptoms.
4. Consider virtual visits over the phone or telemedicine platform for new patients requiring visits.

5. For those patients who call, drop in, or who are instructed to present for an in-person visit, adhere to the universal screening pathway and outpatient clinical pathway (for those patients who screen positive).
6. Patients with imaging studies already completed may either drop off CDs or upload imaging via LifeImage to be nominated to PACS to facilitate virtual and in-person visits.
7. Schedule patients 20 min apart to minimize wait time in the lobby. Patients should be separated in all waiting areas and roomed as soon as possible.
8. Place patient in the furthest chair from clinician in the exam room.
9. Allow deferral of non-acute or non-emergent exams for patients if there are no relevant complaints on the interview. Could add a phrase "physical exam deferred due to social distancing".
10. Educate patients on the importance of strict hygiene and social distancing.
11. Patients should come to visits alone if possible, or if necessary, with only one additional supporting individual.
12. If possible, limit referrals for advanced imaging to ambulatory sites.
13. Educate all nurses, staff and patients on the signs and symptoms of COVID-19.
14. If possible, segregate staff into teams between which contact can be limited.
15. If possible, maximize the distance of providers within teams (i.e. physician and APC may interact remotely to accomplish virtual patient visits).
16. Providers who are ill should stay home and contact their primary care physician for guidance.

## Inpatient

1. Postpone all elective surgical procedures (applies to both hospital and ambulatory surgical center settings). These are broadly defined as cases that may be reasonably delayed without significant risk of severe or permanent harm. These may include but are not limited to:
    a. Spine cases in patients with chronic stable conditions and/or minor symptoms/deficits (i.e. minor radiculopathy).
    b. Peripheral nerve decompression.
    c. Cranial cases in patients with benign and/or stable neoplastic or vascular conditions.
    d. Cases that might otherwise result in the need for prolonged ICU stay especially with the potential for prolonged ventilator support.
    e. Chiari decompression.
    f. Shunting for normal pressure hydrocephalus.
    g. Functional cases (i.e. deep brain stimulator, vagal nerve stimulator).
    h. Routine follow-up diagnostic neurovascular testing.
2. Continue to operate on patients with emergent or urgent conditions. These may include but are not limited to:
    a. Trauma (i.e. subdural or epidural hematomas, intracerebral hemorrhages, open depressed skull fractures).

   b. Spontaneous intracerebral hemorrhage.
   c. Large benign tumors creating symptomatic mass effect that cannot be managed medically, and/or obstructive hydrocephalus.
   d. Malignant metastatic lesions and primary brain tumors.
   e. Intracranial infection (abscess, empyema).
   f. Shunting for obstructive hydrocephalus.
   g. Unstable spine fractures.
   h. Spinal infections (discitis/osteomyelitis).
   i. Spinal tumors causing symptomatic mass effect and/or neurologic deficits.
   j. Degenerative spinal conditions causing acute or subacute progressive myelopathy.
   k. Emergent neuroendovascular diagnostic testing and interventions.
3. Avoid admissions for non-surgical care (i.e. medical treatment for sciatica).
4. Facilitate the discharge of current inpatients to home, SNF, or rehab as is deemed most appropriate.
5. If possible, segregate staff into rotating teams between which contact can be limited.
6. Consider requesting remote consults if appropriate from other services (i.e. Neurology).

## Administrative

1. To help guarantee availability, limit unnecessary travel of frontline providers (surgeons and APCs) to prevent exposure/infection, and to avoid quarantine.
2. If possible, allow staff to work remotely.
3. Cancel all unnecessary in-person meetings.
4. Limit communications to those pertaining to immediate patient care, COVID-19 related issues, and business critical topics.
5. Provide remote access to case conferences.
6. Continue quality initiatives such as mortality and morbidity conferences.
7. Cancel or terminate student rotations.
8. Team huddle on a frequent basis to facilitate critical communications.
9. The guidelines outlined in this document will be reviewed and possibly modified by the Neuroscience Executive Council of the Brain and Spine Institute on a frequent basis.

AMERICAN COLLEGE OF SURGEONS: SURGICAL CARE & COVID-19

# NEUROLOGY COVID-19 GUIDELINES

With these objectives in mind, the Neuroscience Service Line has identified and created the following recommendations related to neurology:

## Ambulatory

1. Screen clinics and postpone all non-essential visits.
2. Essential visits may include but are not limited to:
    a. New patients with concerning symptoms that may represent conditions that if not evaluated expeditiously may lead to severe or permanent harm.
    b. Follow up patients with concerning symptoms and/or conditions or concerns that if not evaluated may lead to severe or permanent harm.
    c. Patients with conditions that require infusions or treatments which, if deferred or postponed may lead to severe or permanent harm.
    d. EMGs, EEGs, other procedures for patients with concerning symptoms that may represent conditions that if not evaluated expeditiously may lead to severe or permanent harm (for example progressing neuropathy, acute/progressing myopathy, subclinical seizures, possible seizure disorder in which EEG results would likely change management, procedures for severe medication intractable trigeminal neuralgia).
3. Non-essential visits may include but are not limited to:
    a. Routine follow up of patients who do not have new, progressive or worrisome symptoms. Imaging, if needed, may be obtained and results communicated to the patient by phone.
    b. Routine surveillance of patients (for example: stable migraine, non-acute neuropathy, stable seizure disorder, stable low grade or "benign" neoplasms) who do not have significant new or progressive symptoms. Imaging, if needed, may be obtained and results communicated to the patient by phone.
    c. New patients who have chronic and relatively stable conditions or minor symptoms.
    d. EMGs, EEGs, other procedures in patients whose symptoms are relatively stable and/or minor (carpal tunnel, many radiculopathies, mild non acutely progressing neuropathy, possible seizures in which the EEG is not likely to change management).
4. EMG:
    - Perform hand hygiene frequently
    - Remove all unnecessary and disposable items from machine and the room
    - Use antiseptic wipes to clean all surfaces before starting a study and between patients
    - Disinfect EMG machine and electrodes
    - Use disposable electrodes and wires
      * Natus item #019-415200, description: ELC/DISP 2DSK 1GRND 1m 24PCH D (disposable electrodes
      * Natus item #123-401600, description: TAPE/DISP MINI-TEMPHEART 100PK

- Consider clear plastic bag to cover EMG equipment
- If possible, EMG room should be used only for EMG procedures

5. EEG:
   - Avoid use of collodion on Covid positive and PUI patients
   - Hyperventilation should not be performed on Covid positive or PUI patients
   - On patients with low concern for Covid, consider performing hyperventilation only on patients where it is likely to have a high diagnostic yield
     (*For example, a patient with suspicion of absence or other primary generalized epilepsies.)*
   - Use of an air hose for application of collodion may constitute an aerosolizing procedure and should be avoided in Covid positive or PUI patients.
6. Consider virtual visits over the phone or telemedicine platform for new or follow up patients requiring visits.
7. Some guidance regarding patients with Multiple Sclerosis and Neuromuscular Diseases with links to useful websites is below.
8. For those patients who call, drop in, or who are instructed to present for an in-person visit, adhere to the universal screening pathway and outpatient clinical pathway (for those patients who screen positive).
9. Patients with outside imaging studies already completed may either drop off CDs or upload imaging via LifeImage to be uploaded to PACS to facilitate virtual and inpatient visits.
10. Schedule patients 20 min apart to minimize wait time in the lobby. Patients should be separated in all waiting areas and roomed as soon as possible.
11. Place patient in the furthest chair from clinician in the exam room.
12. Allow deferral of non-acute or non-emergent exams for patients if there are no complaints on the interview. Could add a phrase “physical exam deferred due to social distancing”.
13. Educate patients on the importance of strict hygiene and social distancing.
14. Patients should come to visits alone if possible, or if necessary due to cognitive or neurological impairment with only one supporting individual. If warranted others may be included via phone on speaker.
15. If possible, limit referrals for advanced imaging to ambulatory sites.
16. Educate all nurses, staff and patients on the signs and symptoms of COVID-19.
17. If possible, segregate staff into teams between which contact can be limited.
18. If possible, maximize the distance of providers within teams. (i.e. physician and APC or RN or CMA may interact remotely to accomplish virtual patient visits or care).
19. Providers who are ill should stay home and contact their primary care physician for guidance.

## Inpatient Consults

1. If possible segregate staff into rotating teams between which contact can be limited.
2. Limit the number of people having contact with patients, for example 1 APC or resident and 1 attending.
3. After discussion with referring physician consider the possibility of providing recommendations by phone or in a focused note. Providing guidance on differential diagnosis and workup prior to seeing a patient may help decrease the number of face – face interactions.
4. Avoid admissions for non-urgent care that may be handled over the phone or in the outpt setting (i.e. medical treatment for sciatica, one or a few brief focal seizures).
5. Facilitate the discharge of current inpatients to home, SNF, or rehab as is deemed most appropriate.

## Administrative

1. To help guarantee availability, limit unnecessary travel of frontline providers (MDs, APCs, RNs, PSRs, CMAs to satellite sites) to prevent exposure/infection, and to avoid quarantine.
2. If possible, allow staff to work remotely.
3. Cancel all unnecessary in-person meetings.
4. Limit communications to those pertaining to immediate patient care, COVID-19 related issues, and business critical topics.
5. Provide remote access to case conferences.
6. Continue quality initiatives such as mortality and morbidity conferences.
7. Cancel or terminate student rotations.
8. Team huddle on a frequent basis to facilitate critical communications.

## Multiple Sclerosis Guidelines

MS patients should remain on their immunotherapies and follow the CDC recommendations for limiting their risk of acquiring infection with regard to avoiding public gatherings and travel.

CDC COVID-19 HIGH RISK PATIENTS

If the patient is concerned about being at increased risk because of their medications, acknowledge that some medications may increase the risk of illness, but that the risk of MS relapse may be more significant, and that they should take more vigorous steps to prevent contact while remaining on their medication.

COVID-19 & MS DISEASE MODIFYING TREATMENT

COVID-19 & MS MEDICATION MANAGEMENT

## Neuromuscular Guidelines

All patients, families and providers should continue to follow the recommendations set forth by the CDC.

The Conquer MG association put out excellent information on 3/12/20.

GBS|CIDP Foundation regarding COVID-19

## Other Helpful Links

CDC

NIH

WHO

AdvocateAuroraHealth

# Service Line: Orthopedic

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Gregory Caronis and Elaine Kempers**

**Created: March 18, 2020**

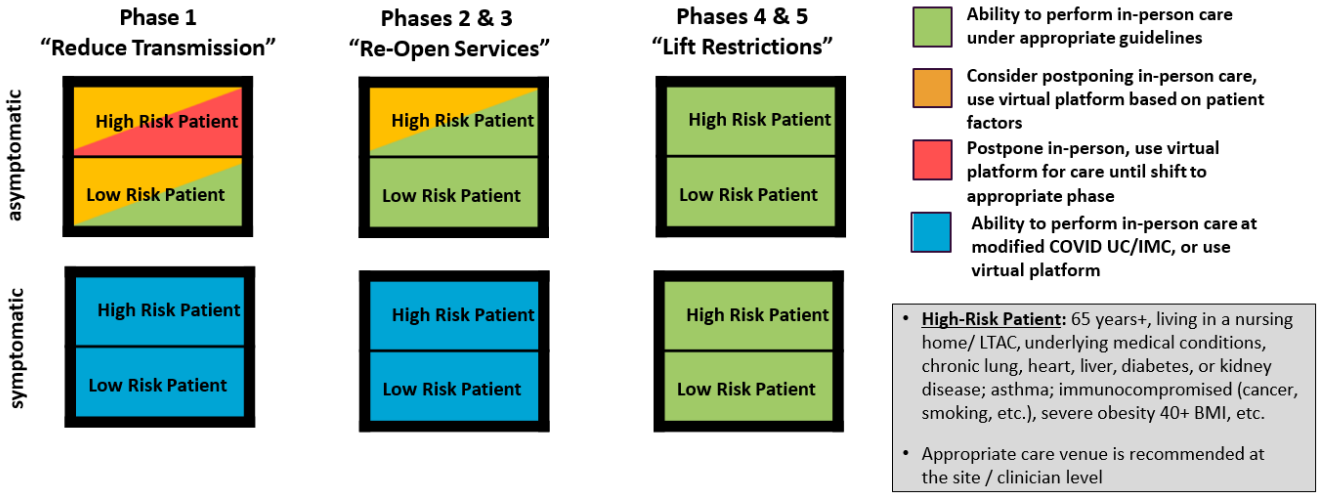
**Last Updated: May 19, 2020**

# Orthopedic Service Line – Orthopedics, Podiatry

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
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| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

It has been requested that to mitigate the potential risks of disease spread, a restriction in ambulatory patient scheduled visits, to be initiated immediately and maintained for at least the next two weeks onward, should prioritize only patients requiring urgent or acute care of their conditions.

Please limit patients for ambulatory evaluation that meet the following criteria:

- Acute post-operative or fracture evaluation affecting health outcomes up to six weeks (Individual clinician discretion for patients with delayed or deteriorating outcome)

- Patients with identified acute injury, presumptive or suspected infection, mass lesion, or acute deterioration in neurologic status, joint stability, or other acute deterioration of previously stable condition

- Requested services designated as Stat, Urgent, or ASAP by the referring physician. With the guiding principles is leaving an element of discretion between the referring physicians and orthopedists is important to maintain appropriate care.

- At this time, it is requested that patients treated for chronic stable conditions, routine follow-up, requesting temporizing care such as injection, be deferred or completed telephonically at this time.

AdvocateAuroraHealth

# Service Line: Pediatrics

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Frank Belmonte and Sara Jensen**

**Created: March 19, 2020**

**Last Updated: March 12, 2021**

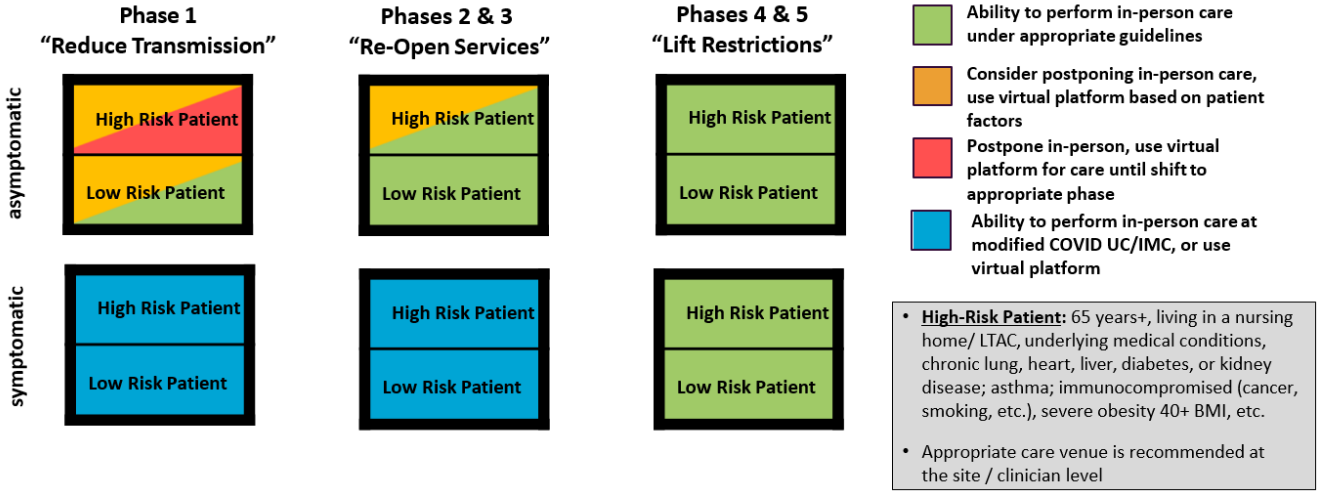
AdvocateAuroraHealth

# Pediatrics Service Line

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
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| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

AdvocateAuroraHealth

# Clinic Visit Recommendations

| Area | Recommendation |
|---|---|
| All clinics | • Group visits of all types to be cancelled<br>• Consolidate clinics to minimize the number of providers in clinic |
| Primary Care | • Screen all patients for fever and cough prior to visit on reminder calls – if they are sick, cancel the well visit and reschedule for 14 days out and see if they need a sick visit.<br>• Construct schedule to separate well visits from sick visits: i.e. well visits in the morning; sick visits in the afternoon<br>• Only bring in 0 to 15-month-old in for well visits during morning clinic – everyone over 15 months will be rescheduled – we will keep a log<br>• All follow ups (hospital follow up, ADHD, Behavioral Health) should be done by telephone at the discretion of the physician<br>• Room sick patients immediately and stagger appointment times<br>• Scheduled appointments in the evening will be cancelled at this time and rescheduled per point number 3.<br>• If a sick walk in patient presents, room patient immediately. Complete screen and treatment. |
| Sub specialty | • Screen all patients for fever and cough prior to visit on reminder calls - reschedule anyone who has symptoms<br>• All follow-up should be done by telephone at the discretion of the physician if clinically appropriate – phone billing advice to come<br>• New patients should be called, treating physician and division director will determine if these cases are urgent or can be rescheduled<br>• Surgeons will be reviewing surgical schedules to cancel elective cases<br>• Surgical post op follow-up visits should be a telephone visit and scheduled as an office visit if complication present<br>• Evaluate all behavior therapy treatment visits for urgency and management by telephone. Psychotherapy visits to be managed via telephone if possible<br>• Sleep studies are to be cancelled<br>• Encourage use of facilities not on the hospital campuses |
| PFTs | • All inpatient AND outpatient PFTs with any patients that have fever and cough will be cancelled.<br>• Inpatient PFTs will require technician to use an N-95 mask – pulmonary physician to approve any inpatient PFTs that will be done<br>• Outpatient PFTs will require technician to use an N-95 mask – pulmonary physician to approve any outpatient PFTs that will be done<br>• Outpatient cadence requires knowledge of room exchanges so appropriate room downtime can be maintained |
| Audiology | • Postponed unless urgently indicated by audiologist and referring provider<br>• Encourage use of facilities not on the hospital campus<br>• Bring patients immediately back to treatment area |
| Therapies (PT/OT/ Speech) | • Postponed unless urgently indicated by therapist and referring provider (post hospital, feeding dysphagia, etc.)<br>• Encourage use of facilities not on the hospital campus<br>• Bring patients immediately back to treatment area. Utilize private treatment spaces as much as possible |



Created by **Lois Elia and IL Service Line Leaders** | Created **3/18/2020** | Revised **3/31/2021**
Approved by **Tim Lineberry, MD**

AdvocateAuroraHealth

# Service Line: Primary Care

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Rich Kelly**

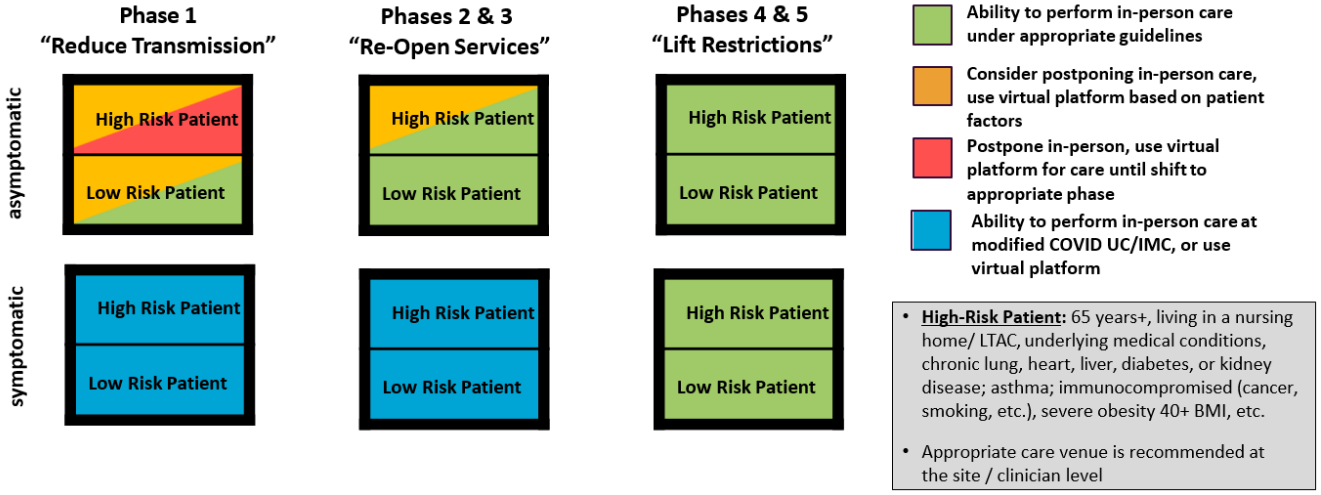
**Created: March 18, 2020**
**Last Updated: May 19, 2020**

# Primary Care Service Line

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
| 3 | • Validation of consistency and ability to expand within policies/procedures for additional volume<br>• Site Safety measures maintained and PPE aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

AdvocateAuroraHealth

# Service Line: Surgical Specialties

# COVID-19 Guidelines

**Accountable Owners(s):**

**Created: March 18, 2020**
**Last Updated: May 18, 2020**

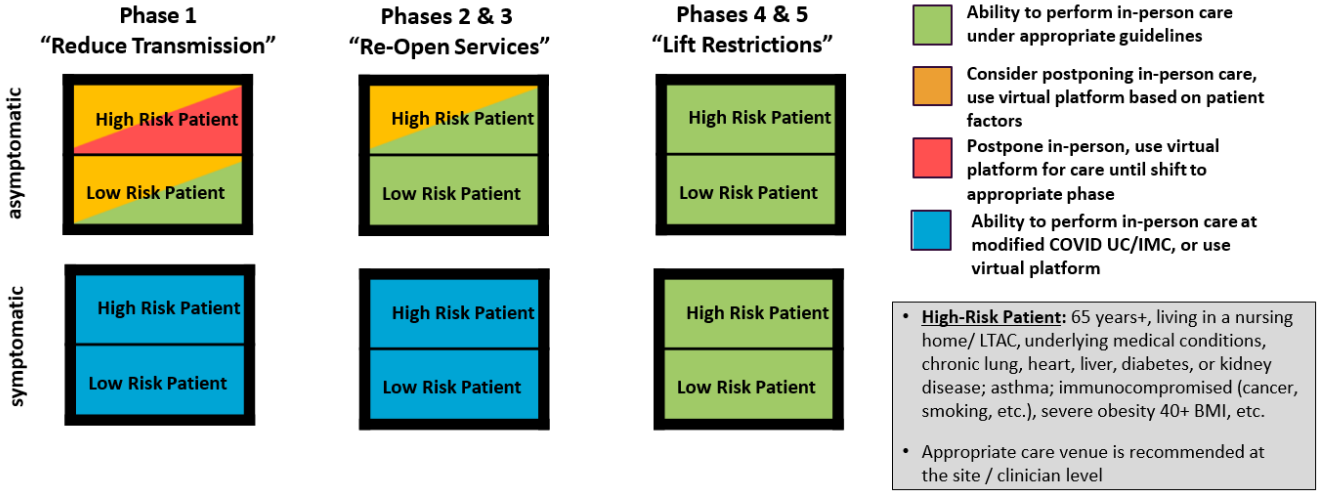
AdvocateAuroraHealth

# Surgical Specialties Service Line

All disciplines will directly align with System recommendations

## Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

## Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
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| 4 | • Validated ability to expand and maintain separate workflows for high-risk patients<br>• Site Safety measures maintained and PPE aligned | • Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category<br>• All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | |
| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

AdvocateAuroraHealth

# Service Line: Women's Health

# COVID-19 Guidelines

**Accountable Owners(s): Dr. Ann Windsor, Dr. Thomas Iannucci, Mira Ketzler and Beth Boland**

**Created: March 18, 2020**

**Last Updated: March 23, 2021**

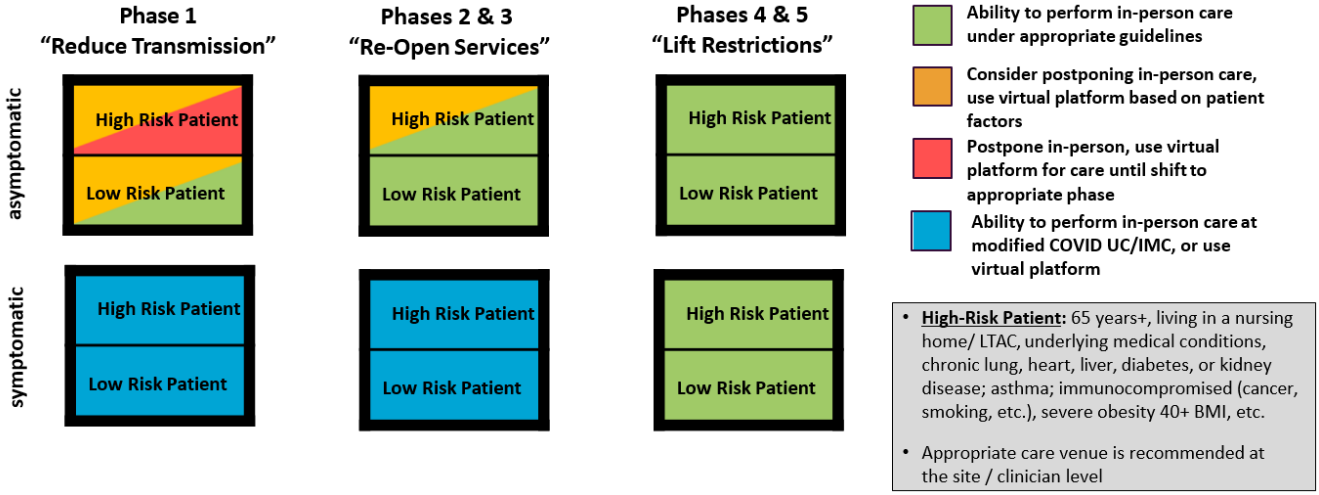
AdvocateAuroraHealth

## Women's Health Service Line

All disciplines will directly align with System recommendations

# Framework for Reactivation

Goal: Provide a framework to close care gaps with patients as well as reintroduce gradual volume for ambulatory patients, clinicians, and team members. Using a progressive introduction of increased ability with effective patient risk management, ensuring a safe environment for our patients, clinicians, and team members.




- **High-Risk Patient:** 65 years+, living in a nursing home/ LTAC, underlying medical conditions, chronic lung, heart, liver, diabetes, or kidney disease; asthma; immunocompromised (cancer, smoking, etc.), severe obesity 40+ BMI, etc.
- Appropriate care venue is recommended at the site / clinician level

# Framework for Reactivation

| Phase | Trigger | Acceptable Ambulatory Clinic Patients | Alternative Location for Ineligible Patients |
|---|---|---|---|
| 1 | • Successful implementation of modified schedule throughout clinic<br>• Current State | • Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | • Patients who are COVID asymptomatic & high-risk are strongly encouraged to be seen via video visit.<br>• For specialty practice, consult with physician regarding need to have patient seen in-person. Consider video visit. If the patient needs to be seen in-person, then schedule and prepare with plan for appropriate PPE, PPE conservation, distancing from asymptomatic and high risk patients.<br>• Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ ICC. |
| 2 | • Validation of policies/procedures in place as defined<br>• Site Safety measures achieved and PPE demand aligned | • Non-Acute & Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category | |
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| 5 | | • Return to full ambulatory access | • N/A |



Created by Lois Elia and IL Service Line Leaders | Created 3/18/2020 | Revised 3/31/2021
Approved by Tim Lineberry, MD

The following guidelines have been established by the Women's Health Service Line, in accordance with guidelines from the CDC; ACOG; SMFM; ACS and our internal physician experts. Our goal continues to be keeping our patients and team members healthy in accordance with CDC Guidelines.

**Keeping our patients healthy now means that we need to continue seeing patients for Well Women and annual visits.**
**As always, clinician discretion remains the key in the delivery of safe, quality care for our patients and should be taken into consideration with all recommendations.**

Below is a guide to assist in determining progression of reactivation of office visits that should be considered.

## Ob/Gyn

1. Continue prenatal care and visits per usual as this is what is recommended by ACOG (and endorsed by IDPH) including ultrasounds for pregnant patients.

2. Continue to schedule labor inductions and c-sections as would otherwise be appropriate.

3. Well women visits should again continue as per local guidelines. The individual offices should continue to follow the Advocate Aurora Safe Care Guidelines.

4. Post-op and post-partum patients without complaints can still be evaluated for possible video visits with an appropriate team member/clinician to evaluate for PP/Post Op issues and screening for depression that may require an office visit.

5. Visits with established patients for medication refills, UTI symptoms, yeast infections and other necessary but not acute issues can be managed by a video visit with either clinical staff or a physician as is appropriate. This should change to an in-person visit if symptoms worsen.

6. If patient has urgent but not emergent OB/Gyn needs, we should continue to provide access to care in the office to avoid patients presenting unnecessarily to the Emergency Dept.

7. Visits for fertility evaluation should be scheduled for video or in person visit at the physician and patient's discretion.

8. If a procedure is to be done in the office in regard to high concern for malignancy, evaluation should not be delayed at all. (see Gyn Oncology guidelines)

9. For LARCs should continue with appropriate visits with no delays.

10. Physicians/APNs should follow system guidelines for video visits. Video visits - FAQ and super user

11. The women's health service line has received several questions regarding the use of N95 masks with LEEP procedures. The purpose of the use of N95's with **LEEP** procedures is to **limit the spread of HPV** to caregivers and providers versus the spread of Covid-19. The use of N95 masks, plus the use of smoke evacuators during LEEP procedures is in accordance with CDC guidelines and provides clinicians with the necessary protection needed for the prevention of the transmission of HPV. LEEP procedures are the only gyn office procedures we are aware of that require the use of a N95 masks. Covid-19 testing is not required before these procedures as these procedures are not considered aerosolizing procedures for Covid-19. If a patient screens positive for Covid-19 questionnaire then consideration for postponing the visit should be undertaken.

12. Wisconsin only: Based on the clinician's discretion, utilization of Babyscripts and/or the modified prenatal visit schedule continue to be viable options for scheduling prenatal patients.

**Modified Prenatal Visit Schedule**

• 8 week - Telephone visit for OB Intake. This can be RN/APC as done prior to COVID-19. Summary forwarded to clinician for evaluation to determine if patient is candidate for routine COVID-19 schedule

• 12 week - In person visit – physical exam, US for dating/viability, prenatal labs, vaccines as indicated/genetic counseling/screening/testing

• 16 week - Telehealth with clinician.

• 20 week - In person - Anatomy US - give BP cuff if patient doesn't have one already. Ideally visit will be at a single site. Consider delaying anatomy scan until 22 weeks if BMI >40

• 24 week - Telehealth visit with clinician

• 28 week - In person – 28 week labs, RHOGAM if indicated.

• 32 week - In person – Tdap

• 34 week-Telehealth with clinician or Phone call with RN to report BP/symptoms

• 36 week - In person - GBS

• 37 week -Telehealth with clinician

• 38+ weeks - In person weekly

• Delivery

• Postpartum – Telephone/video visit with RN or MD at 3 weeks. Based on this visit, clinician will assess whether in person visit can be delayed until 12 weeks postpartum

If BP cuff is not available or patient is unable to use one, recommend converting telehealth visits after 32 weeks to in person visits

Ideally all telehealth visits will be Video Visits. These visits would include BP reading taken by patient.

Additional visits will be scheduled as needed on case-by-case visit for patients with high-risk factors

## MFM

1. MFM patients will continue to be seen as scheduled, aligning with the SMFM recommendations to provide "patients with high risk conditions necessary prenatal care and antenatal surveillance when indicated". Scheduling should follow the Advocate Aurora Safe Care Strategy.

2. Pre-conception consultations will be scheduled or can be converted to video visits.

3. Genetic counseling visits could be transitioned to video consultations.

## Gyn Oncology

All patients should be scheduled following the Advocate Aurora Safe Care Strategy.

1. New Patients:
    a. All cancers and clinical scenarios that are intended to rule out cancer will be scheduled ASAP
    b. All precancerous conditions including CIN, VIN, VAIN should be scheduled in a timely fashion.

2. Existing patients: All cancer surveillance follow-up visits will be scheduled according to ACOG/SGO guidelines.

3. The women's health service line has received several questions regarding the use of N95 masks with LEEP procedures. The purpose of the use of N95's with **LEEP** procedures is to **limit the spread of HPV** to caregivers and providers versus the spread of Covid-19. The use of N95 masks, plus the use of smoke evacuators during LEEP procedures is in accordance with CDC guidelines and provides clinicians with the necessary protection needed for the prevention of the transmission of HPV. LEEP procedures are the only gyn office procedures we are aware of that require the use of a N95 masks. Covid-19 testing is not required before these procedures as these procedures are not considered aerosolizing procedures for Covid-19. If a patient screens positive for Covid-19 questionnaire then consideration for postponing the visit should be undertaken.

## Urogynecology

All patients should be scheduled according to the Advocate Aurora Safe Care Strategy.

1. New Patients
    a. Patients with Prolapse and OAB symptoms can be seen

b. Recurrent UTI patients can be seen
c. All other Patients including those with SUI only, pelvic pain, IC will be scheduled at the physician's discretion.

2. Existing Patients: (apply to patients without any concerns) will be scheduled at the physician's discretion and according to appropriate specialty guidelines

## Fertility

All patients should be scheduled according to the Advocate Aurora Safe Care Strategy.

Fertility patients who are being scheduled for fertility evaluation, consultation and follow up should be scheduled for video or in person visits at the physician and patient's discretion. The fertility lab will continue to provide services as guided by SART (Society for Assisted Reproductive Technology).

***Please note, this is a continually changing environment as such recommendations may change over time, so please visit on-line "The COVID-19 Information Center"***