Aurora Health Care Medical Group
Clinical Service Lines and Departments
COVID-19
Ambulatory Visits Guidelines
Revised January 18, 2021

Note-The content of this document is intended for Clinicians and Operations leadership.
This document will be updated as new information is available.

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<tr>
<td>Behavioral Health</td>
<td>Dr. Srikrishna Mylavarapu</td>
<td>Pete Carlson / Jessica Small</td>
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<tr>
<td>Cancer</td>
<td>Dr. Jim Weese</td>
<td>Amy Bock</td>
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<tr>
<td>Cardiovascular &amp; Thoracic</td>
<td>Dr. Jasbir Sra</td>
<td>Patricia Marsden</td>
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<td>Children’s Health</td>
<td>Dr. Kevin Dahlman</td>
<td>Javairia Asad</td>
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<tr>
<td>Hospital Based – Hyperbaric/Wound</td>
<td>Dr. Satchi Hiremath</td>
<td>Kim Stapelfeldt</td>
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<tr>
<td>Medical Specialties</td>
<td>Dr. Andrea Gavin</td>
<td>Lori Adams</td>
</tr>
<tr>
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<td>Dr. Eric Maas</td>
<td>Rachael Wade</td>
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<tr>
<td>Orthopedics</td>
<td>Dr. Bruce Faure</td>
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<td>Primary Care</td>
<td>Dr. Julia Hester-Diaz</td>
<td>Lori Adams</td>
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<td>Surgical Specialties</td>
<td>Dr. Basil Salaymeh</td>
<td>Kelly Kosler</td>
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<tr>
<td>Women’s Health</td>
<td>Dr. Ann Windsor</td>
<td>Mira Ketzler</td>
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</table>
Behavioral Health Service Line

Hospital Based Programs

- IP remains open and census management based on staffing available, all inpatient rooms in Wisconsin will be single occupancy.
- Partial Hospital Program (PHP): Remains open and universal screening will be implemented for both adults and children.
- Intensive Outpatient Program (IOP): Adult services remain open and universal screening will be implemented. Child services are closed effective 3/16/20

Outpatient Visits:

- Closing to new patient visits
- Elimination of outpatient group therapy
- Centralizing clinic operations to specific geographic locations with Wisconsin.
  - Anticipate 12 locations across the state. Resulting in consolidation of over 40 locations and shift out of multispecialty sites. These locations will only see essential visits
- Non-essential visits will be cancelled, and care coordination will be done via phone and tele-psychiatry as available.
  - Phone visit templates being developed for providers to do reach out visits
- Outpatient operations will be continued to be evaluated to adjust based on volumes and needs.

- Essential visit type: Any patient with active symptoms as described
  - Child: Self harm, aggressive behavior, psychosis, severe anxiety/panic attacks.
  - Substance abuse: need for detox, self-harm
  - Geriatric: Agitation.
  - Adult: Psychotic, self-harm.
  - Long Acting Injectable Medication Appointments

- Non-Essential Visit Type:
  - Routine medication refills
  - Routine follow ups
  - Routine ongoing supportive therapy
Cancer Service Line - NEW

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
      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)

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.
   

   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”.
         
         

   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.


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, e.g. 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:**

   **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.
   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.
   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)*

   **VTE Prevention COVID (AAH 11/16/2020)**


   **Hospitalized COVID-Positive**
   - Enoxaparin 40mg daily
   - V6 mg q.12h (QHS) if frail
   - Enoxaparin 50 mg daily for CCI 5-15
   - UFH 5000 also q.8 hours for CCI >15.
   - Coagulation assessment: Fibrinogen, CBC, D-Dimer, INR, PTT
   - ICU Admission
     - DIC panel every other day.
     - LPAH prophylaxis 40 mg SID
     - Clopidogrel 300 mg and anti-platelet bleeding.
   - DIC w/ bleeding
   - Enoxaparin 40 mg Q.12Hr or UFH 400 U/Hr
   - DIC Present
     - DIC with bleeding
     - Hematology Consult
   - Discharge management
     - ICU stay
     - Paralysis
     - Cancer history
     - History of VTE.
   - NO
     - Based on current clinical data and pending ongoing clinical trials, **no anticoagulation is recommended**
   - Non-Hospitalized COVID-Positive
     - No anticoagulation recommended

   References
   - https://journals.lww.com/jcp/Abstract/2020/03626/3/fulltext
**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**

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
      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 RECOMMENDATIONS:**
   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.


REFERENCES:


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](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](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](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](http://ow.ly/65zQ30qwO4F) #oncorn Omission of routine heparin saline flush-lock... does not seem to compromise their patency
Reactivation of Cardiovascular and Thoracic Service Line (all disciplines) will directly align with System recommendations.

**Framework for Reactivation**

**Phase 1**
- "Reduce Transmission"
  - High Risk Patient
  - Low Risk Patient

**Phase 2 & 3**
- "Re-Open Services"
  - High Risk Patient
  - Low Risk Patient

**Phases 4 & 5**
- "Lift Restrictions"
  - High Risk Patient
  - Low Risk Patient

Table:
<table>
<thead>
<tr>
<th>Phase</th>
<th>Trigger</th>
<th>Acceptable Ambulatory Clinic Patients</th>
<th>Alternative Location for Ineligible Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Successful implementation of modified schedule throughout clinic Current State</td>
<td>Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category</td>
<td>Patients who are COVID asymptomatic &amp; high-risk are strongly encouraged to be seen via video visit. 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.</td>
</tr>
<tr>
<td>2</td>
<td>Validation of policies/procedures in place as defined Site Safety measures achieved and PPE demand aligned</td>
<td>Non-Acute &amp; Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category</td>
<td>Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ICC.</td>
</tr>
<tr>
<td>3</td>
<td>Validation of consistency and ability to expand within policies/procedures for additional volume Site Safety measures maintained and PPE aligned</td>
<td>Non-Acute &amp; Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category Add patients who are not in a high-risk category that meet criteria based on COVID-19 Patients Presenting for Ambulatory/Outpatient Services practice guidance**</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Validated ability to expand and maintain separate workflows for high-risk patients Site Safety measures maintained and PPE aligned</td>
<td>Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category All patients that meet criteria based on COVID-19 Patients Presenting for Ambulatory/Outpatient Services practice guidance**</td>
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<tr>
<td>5</td>
<td>Return to full ambulatory access</td>
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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)


<table>
<thead>
<tr>
<th>Type of Encounter</th>
<th>Guidance</th>
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</thead>
<tbody>
<tr>
<td>Ambulatory and HOPD:</td>
<td>See system COVID website for section on Virtual Health</td>
</tr>
<tr>
<td>See system COVID website for Ambulatory and HOPD Reactivation Overview and Reactivation Checklist (hyperlink not available)</td>
<td><strong>Guidance on Non-urgent Ambulatory Visits: Surge/Phase 1 Reactivation:</strong> <a href="https://www.advocatehealth.com/covid-19-info/_assets/documents/covid_19_non-urgent-ambulatory-visits-4.2.20.pdf">https://www.advocatehealth.com/covid-19-info/_assets/documents/covid_19_non-urgent-ambulatory-visits-4.2.20.pdf</a></td>
</tr>
</tbody>
</table>
### Hospital and ASC: Elective CV surgery, Cath, Peripheral vascular, Device, Ablation, IR, cardioversion


### Aerosol Generating Procedures


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

If an emergent/urgent patient tests COVID+ or is a PUI, the procedure must be done at HOPD where PPE is available to team members per PPE guidelines. Alternate non-aerosolizing testing should be considered as recommended below.

See System AGP and Testing Guidelines for:
- Pre-procedure COVID testing within 48-72 hrs. of procedure
- PPE guidelines
- Room and surface cleaning

### Cardio-diagnostic Testing

<table>
<thead>
<tr>
<th>Event Monitors</th>
<th>Holter Monitors</th>
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<tr>
<td>(by APS or Biotel) Mail</td>
<td>Risk assess</td>
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</tbody>
</table>

**Trans Thoracic Echo (TTE) Vascular Ultrasound**

- Consider use of focused echo protocol per provider using all modalities like 3D, speckle tracking
- Evaluate special considerations for immune compromised patients
- Assess whether contrast agent is needed and prepare prior to exam

**Trans Esophageal Echo (TEE) (AGP)**

Per ASE- “**TEEs should be postponed or canceled if an alternative imaging modality** (e.g. off axis TTE views, ultrasound enhancing agent with TTE, CTA, MRI) can provide the necessary information.** If physician identifies required and urgent need for TEE:

- Review need and urgency with site medical director for cardiology
- Use focused TEE protocol

**Exercise Stress/Exercise Echo/Nuclear stress: (AGP)**

Patients that test COVID+ or PUI and has clinical need for exercise stress test as determined by physician, must be referred to HOPD where PPE (N95/PAPR) available for team member.
- **ASE:** “Treadmill or bicycle stress echo tests on patients with COVID-19 may lead to exposure due to deep breathing and/or coughing during exercise. **These tests should generally be deferred or converted to a pharmacological stress echo.**”
- Consider pharmacological stress test

| Nuclear Cardiology | Per ASNC – **Procedures with a high probability of identifying serious abnormality and/or potential to change management within the next few weeks and could impact short-term prognosis should be performed.**
| | - Consider shortest duration protocols, standard dose with rapid imaging
| | - **Pharmacologic testing** (Lexiscan) preferred to avoid droplets from exercise
| | - Consider STRESS only Nuc (Close to normal ECG, Age< 70, Weight < 220 lbs, Breast Cup Size< D, No pacemaker, No CAD, PCI, CABG)
| | - One-day procedures
| | - Consideration after test for cameras with Attenuation correction CT: CT images acquired for attenuation correction should be interpreted in the context of possible COVID-19 pulmonary findings (bilateral and peripheral ground glass and consolidative pulmonary opacities).

| CT Angiography | Planned and scheduled in collaboration between ordering cardiologist and reading physician. Scheduling per Imaging protocols.
| | - CTA may be preferred to TEE in order to rule-out left atrial appendage and intracardiac thrombus prior to cardioversion in order to reduce coughing
| | - CTA may be preferred for post structural heart procedure evaluation
| | - CTA should be considered for patients at risk for COVID, COVID+ patients and PUI

| Cardiac MR | Planned and scheduled in collaboration between ordering cardiologist and reading cardiologist. Scheduling per Imaging protocols. **Per SCMR:**
| | - Urgent cases only with focused protocol
| | - For COVID+ patients that need testing (i.e. myocarditis) follow system protocol for PPE, scheduling for social distancing and cleaning protocols
| | - If planning to administer contrast, check the renal function as this can be altered in COVID+ patients

| INR Clinic (transition to lab draw with telephone visit) | **Essential Anticoagulation (AC) Monitoring:**
## Prioritization recommendations for Cardio-diagnostic Testing

Reference: The Society of Cardiovascular Computed Tomography (SCCT)

<table>
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<tr>
<th></th>
<th>Elective Indications (May be rescheduled &gt; 8 weeks)</th>
<th>Semi-Urgent Indications (Consider scanning within 4-8 weeks)</th>
<th>Urgent Indications (Consider scanning within hours to &lt; 2-4 weeks)</th>
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<tbody>
<tr>
<td>CAD</td>
<td>• Asymptomatic coronary artery calcium imaging</td>
<td>• Acute chest pain when sufficient clinical suspicion for CAD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stable chest pain without high suspicion for CAD</td>
<td>• Stable chest pain at high risk for events, or when there is concern for possible high-risk coronary anatomy</td>
<td></td>
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<tr>
<td>SHD</td>
<td>• Stable structural heart patients (eg TAVR, TMVR, LAA closure in conjunction with Heart Team)*</td>
<td>• Patient requiring urgent structural intervention (eg, TAVR, TMVR, LAA closure)</td>
<td></td>
</tr>
<tr>
<td>A-FIB</td>
<td>• Pulmonary vein assessment for A-Fib Ablation planning*</td>
<td>• Evaluation of left atrial appendage in chronic atrial arrhythmia prior to restoration of sinus rhythm</td>
<td>• Evaluation of left atrial appendage in acute atrial arrhythmia prior to restoration of sinus rhythm*</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>• Stable cardiomyopathy patients</td>
<td>• Acute inpatient cardiomyopathy in low to intermediate pretest probability of CAD, only if CCT would change management</td>
<td>• Evaluation of LVAD dysfunction</td>
</tr>
<tr>
<td>Valvular</td>
<td>• Evaluation for aortic stenosis severity</td>
<td>• Sub-acute to chronic prosthetic valve dysfunction</td>
<td>• Acute symptomatic prosthetic heart valve dysfunction, endocarditis, perivalvular extension of endocarditis or possible valve abscess</td>
</tr>
<tr>
<td>Masses/Congenital</td>
<td>• Cardiac masses, which are suspected to be benign or unlikely to plan biopsy or surgery</td>
<td>• New cardiac masses which are suspected to be malignant, if necessary to plan biopsy or surgery</td>
<td>• Rule-out left ventricular thrombus following equivocal echocardiography when alternative diagnostic tests (e.g., MRI) are not feasible</td>
</tr>
<tr>
<td></td>
<td>• Elective evaluation of congenital anatomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Especially in institutions that will delay such elective cases
*When cardioversion is deemed necessary

CAD = coronary artery disease; SHD = structural heart disease; A-Fib = atrial fibrillation; LAA = left atrial appendage; TAVR = transcatheter aortic valve replacement/implantation; TMVR = transcatheter mitral valve replacement/implantation; LVAD = left ventricular assist device

### References
- ASNC: [https://zenodo.org/record/3738020#.XqdX5flKiUm](https://zenodo.org/record/3738020#.XqdX5flKiUm)
- ASEcho: [https://www.asecho.org/ase-statement-covid-19/#review](https://www.asecho.org/ase-statement-covid-19/#review)
- Heart and Rhythm Society: [https://www.heartrhythmjournal.com/article/S1547-5271(20)30289-7/pdf](https://www.heartrhythmjournal.com/article/S1547-5271(20)30289-7/pdf)
Children’s Health

Phase 1 restrictions are currently in place, allowing us to proceed with well checks 0-2 yrs and separation of well and sick, fever/URI and non-fever/URI.
"Ability to move between phases (either up or down) will be determined by market recommendation and approval of ambulatory governance. Once your clinic site has been approved to advance to phase 2, please proceed with the following scheduling guidance for primary care pediatrics:

**WELL CHECKS:** Resume seeing ALL well child checks (with priority given to those due to immunizations). Continue dedicated time for well checks but adjust time accordingly to accommodate (8 am to 3 pm for example, decided upon by pediatric clinicians at site), with no more than 3 in-person visits per hour (may add virtual visits in between of course). Please perform call backs from cancellation lists, care management lists, and "physicals due" reports.

**OFFICE VISITS:** Continue dedicated time for office visits (3 pm to 5 pm for example, decided upon by pediatric clinicians at site), with no more than 3 in-person visits per hour (may add virtual visits in between of course). Continue to separate Fever/URI from non-Fever/URI by dedicated hallway/clinician when possible.

**VIRTUAL VISITS:** Remember that our productivity protection ends May 31. Even as we increase our in-person visits, we are unlikely to be at 100%. Please continue to perform virtual visits whenever possible.

**New Guidance for suspected or confirmed COVID-19:**

Mothers with suspected or confirmed COVID-19 can room-in with their newborns when precautions are taken to protect the infants from maternal infectious respiratory secretions, according to updated AAP interim guidance.

Details here:

**Outpatient Management of Newborns**

**Outpatient Management of Newborns, age 0-30 days, born to COVID-19 positive mothers**

- **Mom COVID19-Positive or PUI with test pending**
  - Send COVID-19 test on newborn prior to discharge
  - Any Lactation Visits done by scheduled video visit

- **Facilitate enrolling baby in My AdvocateAurora prior to discharge by calling the support line 855-624-9366 (24/7)**
  - Main staff 0700-2000 M-F

- **Baby COVID-19 Positive or pending, age 0-30 days; or**
  - Baby COVID-19 Negative, age 0-30 days, accompanied by mother; or
  - Baby COVID-19 Negative, age 0-30 days, accompanied by adult who is COVID-19 Positive or PUI
    - Provider wears full PPE*
    - Schedule at End of the day.
    - Room immediately. Adult in mask.
    - Schedule video visits for acute problems if possible

- **Baby COVID-19 Negative, age 0-30 days, accompanied by well Adult**
  - Provider does not wear PPE*
  - Attempt video or audio connection with mom during visit
  - Schedule in the morning

* Per AAH Covid PPE guidelines based on setting. Currently Droplet + Contact
** Another caregiver, well, no suspicion of COVID-19
Hospital Based Specialties Service Line - Hyperbaric Medicine and Wound Care

**Purpose**

- Provide safe guidelines for a phased return to normal operations with volume growth
- Prioritize and establish a consistent process for Hyperbaric Medicine and Wound Care consults, follow up visits and treatment plans that integrate both in-person and virtual platforms.
- Triage patient to receive clinical care through in-person vs. virtual platform. Type of care is based on clinical need: acuity level (risk for limb loss or admission), progression or decline of wound and clinical status, home support and resources, Home Health integration, ability to navigate a virtual platform, need for a procedure (debridement), need for objective clinical information (wound measurements), etc.
- Ensure clarity on prioritization of patients
- Leverage virtual health and home health options for our patients
- Provide weekly review of COVID-related procedural restrictions and determine if restrictions should remain in effect or be modified; modifications include:
  - Extend/shorten the restriction period
  - Revise opportunities to complete held procedures/treatments
- Extend support to operational leaders and clinicians to ensure adherence to the guidelines

**Goals:**

- Goal is to prevent harm to the patient, loss of limb and/or hospitalization by a delay in care or virtual care
- Optimize resources – human, equipment, supplies, etc.
- Reduce potential COVID exposure to physicians, team members and patients

**Guiding Principles**

- Guidelines are evidence-based and in accordance with COVID-related recommendations made by governmental and recognized medical societies
- Guidelines assist in organizational planning and decision-making; however, the clinician is the final arbiter working within AHCMG supported guidelines
- Patients, operational leaders and clinicians understand that given current conditions, clinical appointments and procedures may be canceled or rescheduled on short notice
- Patients understand they may remain on isolation when undergoing procedures/treatments that require COVID-19 testing or procedures/treatments that are completed in series
Essential HBO Treatment and Wound Care Procedure Planning Guide:

- Site-based Hyperbaric and Wound Care Clinicians should determine a patient’s status based on the definitions below
- Please note: If a patient’s status is deemed “Emergent or Essential”, resource needs could dictate a change in the location the procedure would be performed (i.e. Hyperbaric Oxygen Therapy completed at Hartford vs Grafton, etc.)

Hyperbaric Oxygen Therapy and Wound Care Procedure Definitions:

Emergent

- Life or limb threatening condition or injury requiring emergent treatment; life or tissue loss is imminent or expected quickly without treatment. It is presumed that this treatment would proceed regardless of COVID-19 status.

Essential

- Non-life or limb threatening condition in which delaying treatment could result in harm; delaying treatment is likely to have a negative impact on patient outcome

Elective

- Treatment or procedure that can safely be delayed for days, weeks or months, without resulting in permanent harm

Patient Considerations

The Hyperbaric Medicine and Wound Care patient population is primarily composed of elderly individuals, patients with multiple comorbidities, or both. As a result, they are at high risk for serious complications from COVID-19.

Ultimate categorization of level of urgency for Hyperbaric Oxygen Therapy should be determined by the treating physician. Individual patient conditions may escalate or de-escalate the level of urgency.

Hyperbaric Oxygen Therapy Emergent Treatment Indications

- Severe acute anemia
- Intracranial abscess
- Air or gas embolism
- Clostridial myonecrosis
• Compromised grafts and flaps
• Thermal burns
• Decompression sickness
• Carbon monoxide poisoning
• Crush injuries and skeletal muscle-compartment syndromes
• Idiopathic sudden sensorineural hearing loss
• Central retinal artery occlusion
• Necrotizing soft tissue infections / Necrotizing fasciitis
• Acute limb ischemia

**Hyperbaric Oxygen Therapy Essential Treatment Indications**

• Diabetic foot ulcers
• Delayed radiation injuries
• Refractory osteomyelitis
• Chronic limb ischemia

**Hyperbaric Oxygen Therapy Elective Treatment Indications**

• Delayed radiation injuries

**COVID Pre-testing:**

• Follow HOPD Reactivation Guidelines for COVID testing.
• COVID pre-testing should be completed 48-72 hours prior to start of procedures/procedure series that increase the risk of potential COVID exposure and transmission to physicians, team members and patients
  o Hyperbaric Oxygen Therapy
  o Ambulatory Treatment Center procedures that require sedation/anesthesia
  o Ultrasonic debridement utilizing Arobella – This procedure aerosolizes microbes.

• Patients are required to self-quarantine at home for the time between the test and their scheduled procedure. Their procedure/treatment may be rescheduled based on test results. Plan is determined by clinician. If patient condition requires the treatment/procedure to go forward, follow AAH COVID positive treatment guidelines.
• If an emergent procedure or treatment is required, testing will still be completed. The procedure, however, will not be delayed while awaiting test results. Patients will be considered COVID positive until proven otherwise.
  1) Testing patients prior to initiation of HBO new series start
  2) Testing patients prior to Ambulatory Treatment Center new series start
  3) Testing patients prior to initiation of Arobella debridement procedures

• Patients will complete the AAH COVID questionnaire/screening that is conducted on arrival to the hospital prior to each procedure/treatment. If the screening becomes positive, the patient should be re-tested for COVID (rapid testing is ideal - if approved). The procedure/treatment may be rescheduled while awaiting test results. Plan is determined by clinician. If the patient’s condition requires the treatment/procedure to be completed, follow AAH COVID positive treatment guidelines.

COVID Pre-testing Recommendation Goals:

• Follow HOPD Reactivation Guidelines for COVID testing.
• All patients should be tested prior to each procedure or start of series of the procedure that increases the risk of potential COVID exposure and transmission to physicians, team members and patients
  o Hyperbaric Oxygen Therapy
  o Ambulatory Treatment Center procedures that require sedation/anesthesia
  o Ultrasonic debridement utilizing Arobella – This procedure aerosolizes microbes.

• If a Hyperbaric Oxygen Therapy Treatment series is required, COVID testing should be completed prior to the initial treatment and then weekly.

Clinical Considerations:

Follow HOPD Reactivation Guidelines

HOPD In-Person Visits

Scheduling In-Person Visits

• Prioritize the frequency of in-person visits based on:
  o Acuity – Risk of wound deterioration, loss of limb risk, admission risk, high risk for infection, drainage management.
  o Patient’s ability to conduct virtual visits - lack of equipment, home support
  o Patient’s wound care support at home - Home Health is not involved/unable to conduct in home wound care.
Required utilization of advanced wound care – compression therapy, negative pressure wound therapy, and total contact casting.

Clinic procedure required. i.e. debridement, dermal replacement application

- All patient’s will be phased in utilizing the above systematic manner per clinician review and recommendation. This includes new clinic consults.
- Ambulatory Pre-Visit Universal Screening guidelines will be asked while scheduling. If a patient is symptomatic, inform their clinician and schedule/reschedule per clinician recommendation based on acuity and need for visit.
- All scheduled patients will receive reminder phone calls and will be discouraged from coming to the waiting room more than 15 minutes before their appointment time
- Staggered start times or every other appointment times will be scheduled to maximize social distancing
- Consider expansion of hours of operation: evenings, weekends as determined by site leadership
- Consider strategically scheduling by subcategorizing patients to reduce risk. (ex: COVID+/COVID-, with comorbidities/without comorbidities, inpatient/outpatient)

Rooming patients

- Patients will be screened upon entering the building; this will include the patient’s temperature being taken.
- Team members in the Hyperbaric Department and Wound Care Department will verify screening has been completed upon entering the clinic.
- Patients will be roomed upon arrival to clinic. If there is no exam room available, waiting room seating will be greater than 6 ft. apart to maintain social distancing.
- Patients will be asked to use hand sanitizer upon entering the room.
- Team members will always follow system PPE guideline located on COVID-19 website.
- Team members will follow universal hand hygiene guidelines.
- Only the patient will be roomed. Visitor presence will follow Hospital Guidelines.
- Critically review the need for Arobella ultrasonic debridement procedures. Utilize an alternate technique for debridement whenever possible. If it is determined that Arobella will be utilized, patients should complete COVID pre-testing.

Clinic Outpatient Supplies/Infection Control

- All disposable supplies will be disposed of in the patient’s room at the conclusion of the exam/procedure.
- All non-disposable supplies and equipment will be wiped down per manufacturer guidelines.
- EVS will clean rooms per site guidelines.
- Inventories of PPE and disinfection supplies will be taken weekly to maintain appropriate levels
Virtual Visits

- In order to provide ongoing care with a focus on patient safety, if a patient does not meet criteria for an in-person visit, we will schedule a virtual visit. As previously noted, criteria for in-person visits include:
  - Acuity – Risk of wound deterioration, loss of limb risk, admission risk
  - Patient’s ability to conduct virtual visits,
  - Required utilization of advanced wound care
  - Need for a procedure.

- New virtual platform was created and implemented for Hyperbaric Medicine and Wound Care Hospital Outpatient Departments to organize and schedule the appointments utilizing a HBO/WC site-specific Group Provider Account. This platform allows specialty teams to coordinate and complete care for patients as opposed to individual clinicians. This platform is also more streamlined and user-friendly for some patients and clinicians to be able to successfully navigate a virtual visit. If a patient is not able to navigate the EPIC/LiveWell App virtual visit platform, this specialty specific platform helps ensure all patients are able to successfully complete video visits.

- Clinic staff will contact patient prior to the start of the virtual visit to ensure patient can access the virtual platform, and to ensure they are on the virtual visit call.

- After the video visit is completed, EPIC documentation and charges will be filed. A GT modifier will be added in charge entry field.

Joint Home Health and Wound Care Clinician Visits

- Partnerships with home health nurses enable augmented virtual visit capabilities and better care for patients at home
  - Develop workflows for patients established with Home Health to be able to partner real-time virtual visits with HBO/WC Clinicians
  - Develop opportunity for expansion of Home Health support in patient care populations that otherwise would not qualify for home health services (contractual agreement to leverage current RN at home support to care for wound care patients at home)
  - Expand Wound Care / Home Health partnership pilot throughout system.

Inpatient Considerations:

- Augment telehealth visits for non-complex inpatient COVID positive visits
- Maintain 7 days/week clinical availability at SLMC
- Triage patients based on acuity and complexity to determine whether a virtual visit with the inpatient team can be completed for COVID positive patients.
- If wound management is complex, patient care is compromised, and/or the wound is deteriorating, the HBO/WC Clinician would continue to examine the wound in the room in person.
• If evaluation can be completed virtually, the Wound RN and/or Tech will enter the room with appropriate PPE and take down the wound dressing, clean, measure, and photograph the wound. A virtual visit with iPad/computer for visualization of wound for Provider assessment will be completed. If virtual capability/technology is not readily available, the wound RN or Tech will discuss the case with the Provider and review the photo of the wound to partner and decide if the patient’s wound requires an in-person clinician assessment.

• Utilize video visits or photographic documentation to be able to communicate with clinician outside the room

• Decrease the need for additional team members to don PPE

Inpatient/Outpatient Hyperbaric Medicine Considerations:

• COVID pre-testing should be completed prior to Hyperbaric Oxygen Therapy to decrease the risk of potential COVID exposure and transmission to physicians, team members and patients (please refer to COVID testing instructions above)

• If an emergent hyperbaric treatment is required, testing will still be completed. The procedure, however, will not be delayed while awaiting test results. Patients will be considered COVID positive until proven otherwise.

• If a Hyperbaric Oxygen Therapy Treatment series is required refer to COVID testing instructions above.

• Continue to utilize the census tracker to ensure patients treatment needs are evaluated weekly. If it is identified that a patient’s clinical status and categorization of urgency has changed to Emergent or Essential, Hyperbaric Oxygen Therapy may be implemented.

• Assess patient’s urgent need of Hyperbaric Oxygen Therapy to determine risk / benefit ratio of immediate scheduling
  o Consider HBO treatment depth protocol for hyperbaric patients to possibly eliminate air-breaks at the multi-place program. This modification requires patients to wear their treatment hood throughout the HBOT, thus decreasing potential exposure to staff members and other patients.
  o Utilize process to be able to treat COVID positive hyperbaric patients that have either critical care or non-critical care needs.
  o Staff should utilize PPE while caring for patients in the multi-place chamber.

Ambulatory Treatment Center Procedure Considerations (ASLMC only):

• Critically review need for ATC procedures

• COVID pre-testing should be completed prior to procedures that increase the risk of potential COVID exposure and transmission to physicians, team members and patients (please refer to COVID testing instructions above)
  o Ambulatory Treatment Center procedures that require sedation/anesthesia
  o Ultrasonic debridement utilizing Arobella – This procedure aerosolizes microbes.

• Team members will always follow system PPE guidelines located on COVID-19 website.

• Team members will follow universal hand hygiene guidelines.
Hyperbaric Medicine and Wound Care Resource Management and Patient Safety Plan

The Hyperbaric Medicine and Wound Care patient population is primarily composed of elderly individuals, patients with comorbidities, or both. As a result, they are at high risk for serious complications from COVID-19. The following recommendations focus on safety and decreasing potential exposure for our patients.

Outpatient Wound Care:

All visits, treatments and follow up appointments should be critically reviewed to determine the safest modality to continue clinical care. Options for consideration include:

- In-person evaluation and care.
- Partnered virtual visit with support in patient’s home or place of residence (i.e. Home Health nurse, facility nurse). Goal is a video visit, as opposed to telephone encounter.
- Independent virtual visit. Goal is a video visit, as opposed to a telephone encounter.
- Temporary postponement or decreased frequency of in-person visit. If it is believed that postponement or decreased frequency of an in-person appointment will cause physical harm, such as increased morbidity or threatened loss of limb, the patient should be scheduled for evaluation and care utilizing the most appropriate above modality.

Consider modifying patient treatment plans to ones that can be completed at home by the patient/family. i.e. 1) discontinue compression wraps and transition to tubular compression stockinettes, 2) temporarily suspend NPWT. These modifications should only be undertaken if nursing care at the patient’s place of residence cannot be established or the risk of in-person visits outweighs the benefits of these treatment modalities. These treatment modalities require frequent skilled nursing care.

For patients that will be seen in person, it has been recommended that the HOPD visits be scheduled throughout the course of the day/week, as opposed to being concentrated on a given day or portion of the day.

Inpatient/Outpatient Hyperbaric Medicine:

HBOT is implemented when there is high acuity, when other treatment modalities have not been successful in eradicating the medical condition, when there is significant concern over loss of limb, or when a surgical site is compromised. Many treatments may not be able to be avoided. If the benefits of HBOT outweigh the risks of frequent in-person care, HBOT should proceed. Standard safe practices of social distancing and pre-procedure testing with serial weekly testing should be utilized.

All patients receiving HBOT should be reviewed to determine the ability to decrease the total number of treatments required (end point). The goal is to minimize risk of COVID-19 exposure, but not negatively impact clinical outcome.
Medical Specialties Service Line

**Allergy: Phase 1**

**Existing Patients**

**Require In-Office Visit**

- Stratify anticipated high risk-controlled pts and schedule them into clinic over the next several days
- Physician to review with staff and determine disposition:
  - Severe asthma
  - Severe urticaria/angioedema
  - Severe allergic reactions
- Injections as determined necessary by the physician

**Require Telephone/Telemed Visit**

- Patients with acute symptoms or risk factors not consistent with COVID
- Patients who have missed appointments and need medication management and refills

**Require Future Appointment**

- Any patient who needs routine medication refills without any acute needs
- Allergy testing in patients that waiting is appropriate

**New Patients**

**Require In-Clinic Visit**

- No new patients until 03-27-20
- Physician to review with staff and determine disposition:
  - Severe asthma
  - Severe urticaria/angioedema
  - Severe allergic reactions

**Require Telephone/Telemed Visit**

- Patient to use existing established relationships with current providers
- Patients referred for allergy testing
# Allergy: Phases 2 – 5

<table>
<thead>
<tr>
<th>Tier</th>
<th>Spirometry</th>
<th>Meth Challenge</th>
<th>Patch testing</th>
<th>Food challenge</th>
<th>Drug challenge</th>
<th>Skin testing</th>
<th>New Consult Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong></td>
<td>No standing orders.</td>
<td>no</td>
<td>preops</td>
<td>Less than 24 mos – delay can add to food allergy</td>
<td>Urgent need</td>
<td>Deferred patients</td>
<td>Biologic needed; Repeat ER visits; High risk, low COVID-19 risk</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td>Doctor request. Nurse PPE. Dedicated room.</td>
<td>no</td>
<td>Deferred patients</td>
<td>Deferred patients</td>
<td>Deferred patients</td>
<td>Patients seen via video and ready to test</td>
<td>Deferred patients</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td>Resume per doctor orders only</td>
<td>Resume with new system vetted and appropriate PPE/?neg pressure</td>
<td>Resume all</td>
<td>Resume all</td>
<td>Resume all</td>
<td>Resume all</td>
<td>Resume all</td>
</tr>
<tr>
<td>Tier 1</td>
<td>New Consult</td>
<td>New Consult</td>
<td>New contact</td>
<td>New Follow</td>
<td>New Consult</td>
<td>Immunotherapy</td>
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<tr>
<td></td>
<td>Urticaria/AE/Drug/Food Allergy</td>
<td>cough</td>
<td>dermatitis</td>
<td>AR/sinusitis/nasal congestion</td>
<td>ups</td>
<td>Immunodeficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute/Active ER visits</td>
<td>Chronic cough – need PPE</td>
<td>Video visit and schedule patch testing visits based on findings</td>
<td>video visit preferred to gather history and then schedule for testing.</td>
<td>Acute/Unstable COVID Screening Questions-negative Video option</td>
<td>Urgent visits – recurrent infections, hospitalizations, CVID; weigh risk of bringing into clinic; consider initial video visit</td>
<td>Continue every 4 weeks dosing on maintenance</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Stable patients</td>
<td>Deferred patients -acute cough – video visit or triage</td>
<td>Initial video preferred – schedule patch testing based on findings</td>
<td>Deferred patients-PPE required for nasal and oral exams</td>
<td>Deferred patients Acute and chronic Video option If seen within 1 year and no acute issues</td>
<td>Deferred patients; take into consideration risk to patient to be seen in person; consider initial video visit to obtain history and labs with in-person follow-up</td>
<td>Go back to more frequent dosing on patients who are symptomatic or would like to move faster with injections</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Resume all</td>
<td>Resume chronic cough Acute cough –video or triage</td>
<td>Resume all</td>
<td>Resume all</td>
<td>Resume all patients taking into consideration risk to patient and offering initial video visit</td>
<td>Resume new IT starts</td>
<td></td>
</tr>
</tbody>
</table>
Dermatology: Phase 1

Existing Patients

Require In-Office Visit

• New lesion highly concerning for melanoma and/or rapidly changing lesions
• Rash or other dermatological problem causing severe functional and/or emotional impairment, that needs in-person evaluation and/or biopsy

Require Telephone/Telemed Visit

• Acne/Rosacea/perioral dermatitis
• Eczema/Dermatitis
• Psoriasis (including biologic patients)
• New rashes
• Some skin lesions – Physician to review with staff and determine disposition

Require Future Appointment

• New lesions that are not rapidly evolving
• Rash or other dermatological problem with mild or moderate functional impairment
• Skin cancer and melanoma follow-ups for high risk patients
• Patients taking systemic high-risk medications (ex. biologics)
• Annual routine skin cancer melanoma, mole exam, and actinic keratosis follow-up visits that have no immediate concerns
• Acne/rosacea
• Eczema/dermatitis/seborrheic dermatitis/psoriasis follow-up for patients being treated topically

New Patient

Same as above
### Dermatology: Phases 2 - 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
</table>
| **Tier 1 - Acute** | • Invasive melanoma  
• Merkel cell carcinoma  
• Melanoma in situ (particularly if they have already been waiting several months)  
• Nodular, fast growing SCC (particularly T2b and above)  
• SCC in high risk areas  
• Any highly symptomatic tumor (e.g. painful or bleeding BCC)  
• Rare tumors at relatively high risk for metastasis  
• Atypical melanocytic lesions that are high risk or suspicious for evolving melanoma  
• New lesion highly concerning for melanoma and/or rapidly changing lesions  
• Rash or other dermatological problem causing severe functional and/or emotional impairment  
• Patients who had been previously triaged or seen in Video Visit that need to be seen urgently |
| **Tier 2 - Sub-acute** | • DFSP, other rare tumors at relatively low risk for metastasis  
• BCC in high risk areas (e.g. infiltrative basal cell carcinoma on the alar rim)  
• SCC in situ (clinically high risk, popular/nodular/suspect SCC)  
• Dysplastic nevi  
• New lesions that are not rapidly evolving  
• Rash or other dermatological problem with moderate functional impairment  
• Skin cancer and melanoma follow-ups for high risk patients  
• Patients taking systemic high-risk medications |
| **Tier 3 - Chronic/Stable** | • Low risk BCC (trunk and extremity without high risk features)  
• SCC in situ (clinically low risk, macular/patch/typical Bowen’s)  
• Most yearly routine skin cancer follow-up, melanoma follow-up, mole exams (including patients with h/o dysplastic moles, actinic keratosis follow-ups that have no acute or subacute concerns  
• Acne, rosacea  
• Eczema/dermatitis/seborrheic dermatitis/psoriasis follow-up for patients being treated topically  
• Rash or other dermatology problems with mild functional impairment  
• Warts/Molluscum (timing of treatment of warts and molluscum per provider discretion based on severity and patient symptoms—may require sooner visit)  
• Cosmetic procedures (fillers, lasers, Botox) and consults  
• Removal of benign, asymptomatic or minimally symptomatic lesions (e.g. benign dermal nevi, asymptomatic cysts, skin tags) |
Endocrinology: Phase 1

Existing Patients

Require In-Office Visit

Physician to review patient list with staff and determine disposition

Require Telephone/Telemed Visit

- Type 1 or Type 2 DM patients with A1C >8% and not meeting exclusionary category (see below)
- Thyroid patients: if hyper or hypo and on medications
- Stable type 1 DM and type 2 DM (on oral medications, orals + basal or GLP1) with an A1C <8%
- Stable Bone Patients
- Stable Parathyroid patients

Require Future Appointment

- Stable Adrenal, Reproductive and Pituitary patients- need to ensure refills but can delay appointments
- Thyroid Cancer patients: labs can be reviewed, plan of care can be addressed with imaging, otherwise physical appointment not needed

New Patients

Require In-Office Visit

- New Patients with other endocrine issues – at the direction of the physician
- Parathyroid/Thyroid – at the direction of the physician

Require Telephone/Telemed Visit

- Hospital discharges
- Pregnant patients with endocrine disorders
- New Patients with Diabetes A1C >8% if not meeting any exclusionary category (see below)

Exclusionary Categories:

Type 1 or Type 2 DM patients with A1C >8% and:

- Age >70
- Any significant immunosuppression (HIV, cancer, transplant, steroid therapy, on a biologic agent)
- ESRD
- CHF
- Significant pulmonary disease
Endocrinology: Phases 2 - 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
</table>
| Tier 1 - Acute     | • Diabetics on insulin or injectable therapy  
|                    | • Diabetics on oral medications with A1C >8%  
|                    | • New diagnosis of diabetes  
|                    | • Hospital follow-ups  
|                    | • Cancer suspicion (new thyroid nodules, adrenal nodes, neuroendocrine)  
|                    | • Oncology follow-up  
|                    | • Hyperparathyroidism – new  
|                    | • Post-surgical follow-ups  
|                    | • Pregnant endocrine disorders  
|                    | • New fracture osteoporosis  
|                    | • New diagnosis of thyroid disease  
|                    | • Hyperthyroid follow-ups (medication and monitoring)                                           |
| Tier 2 - Sub-acute | • Osteoporosis on medications  
|                    | • Diabetics on oral medications with A1C <8%  
|                    | • Hyperparathyroidism follow-up  
|                    | • Reproductive disorders  
|                    | • Pituitary disorders  
|                    | • Adrenal disorders  
|                    | • Obesity disorders                                                                                      |
| Tier 3 - Chronic/Stable | • Annual hypothyroid follow-ups  
|                    | • Annual thyroid nodule follow-ups  
|                    | • Annual osteoporosis not on medications  
|                    | • Annual HRT follow-ups  

Infectious Diseases:  Phase 1

Existing Patients

Require In-Office Visit

- Post IP discharge per physician

Require Telephone/Telemed Visit

- Established ID patient with new complaint/concern
- Established HIV with new concern

Require Future Appointment

- Stable ID patient
- Established HIV with no concern

New Patient

Requires In-Office Visit

- New HIV diagnosis

Requires Telephone/Telemed Visit

- New diagnosis of infection – a physician referral

Infectious Diseases:  Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Acute</td>
<td>• Per physician</td>
</tr>
<tr>
<td>Tier 2 - Sub-acute</td>
<td>• Per physician</td>
</tr>
<tr>
<td>Tier 3 - Chronic/Stable</td>
<td>• Per physician</td>
</tr>
</tbody>
</table>
Gastroenterology: Phase 1

Existing Patients

Require In-Office Visit

- Unstable pts with inflammatory bowel disease having severe flare
- Patients with decompensated cirrhosis of the liver with altered mental status, fever and/or abdominal pain
- Active but not severe bleeding
- Active anemia with hemoglobin <10 gm

Require Telephone/Telemed Visit

- Abdominal pain
- Diarrhea
- Dysphagia
- Weight loss
- Jaundice
- Nausea and vomiting
- Abnormal imaging study

Require Future Appointment

- Reflux
- Bloating
- Abdominal cramps
- Irritable bowel syndrome / IBS
- Abdominal discomfort
- Nausea
- Throat discomfort
- Globus sensation

New Patients

Same as above
## Gastroenterology: Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
</table>
| Tier 1 - Acute | - Foreign body obstruction  
                  - Acute symptomatic GI bleeding with the potential for endoscopic intervention  
                  - Obstructive jaundice, management of ductal leaks, bile leaks and stent exchange  
                  - Dysphagia with weight loss |
| Tier 2 - Sub-acute | - Bleeding situations where endoscopic intervention is likely to change outcome  
                        - EUS: cancer staging, abnormal imaging, interventional EUS for infected pancreatic pseudocyst  
                        - Weight loss, positive Cologuard, abnormal CT scan with bowel thickening  
                        - ERCP with stent exchange  
                        - Suspected new diagnosis of IBD or IBD flare  
                        - Severe symptoms where intervention will reduce risk of ER/UC visit |
| Tier 3 - Chronic/Stable | - Conventional indications for endoscopy for colorectal cancer screening, Barrett’s screening, celiac disease, GERD, epigastric pain, changes in bowel habit |
Nephrology: Phase 1

Existing Patients

Require In-Office Visit

- Sick transplant visit
- CKD with worsening edema or volume status

Require Telephone/Telemed Visit

- Transplant patient routine visit

Require Future Appointment

- Stage II-IV CKD routine visits

New Patients

Physician to review patient list with team member and determine disposition

Nephrology: Phases 2 – 5

<table>
<thead>
<tr>
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<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Acute</td>
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</tr>
<tr>
<td>Tier 3 - Chronic/Stable</td>
<td>• Per physician</td>
</tr>
</tbody>
</table>
Non-interventional Pain: Phase 1

Existing Patient

Require In-Office Visit

- Provider review their patient list with staff and determine disposition
  - A physical exam is deemed essential to determine treatment (at discretion of provider)

Require Telephone/Telemed Visit

- Patients who need medication adjustment or change in medication
- Any patient on non-controlled substances who is over a month past their expected recheck date, or it has been over 6 months since last seen, and need medication management and refills on non-controlled substance
- Any patient on controlled substances who have not been seen in the past 3 months

Appointment Appropriate for Delayed Scheduling

- Any patient on non-controlled substances, who need routine medication refills without adjustments, and they have been seen in past 6 months
- Any patient on controlled substance, who need routine medication refills without adjustments, and they have been seen in past 3 months

New Patients

Require In-Office Visit

- Any patient who absolutely requires a physical examination to determine an appropriate course of treatment, and that physical examination cannot be deferred until a subsequent visit

Require Virtual Visit (video if possible, phone if patient doesn’t have required equipment)

- Any patient not meeting the above criteria
## Non-interventional Pain: Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
</table>
| Tier 1 - Acute    | • Requires physical exam to set treatment plan  
|                   | • Controlled substances unable to do virtual visits  
|                   | • Unwilling to do virtual visits  
|                   | • Inadequately controlled pain  
|                   | • Change in clinical condition requiring modification of treatment  
|                   | • Opioid safety monitoring  
|                   |   • Drug testing  
|                   |   • Pill counts  
|                   |   • Sign/re-sign opioid agreement  
| Tier 2 - Sub-acute| • 3-month follow-up on Schedule II controlled substances  
|                   | • 6-month follow-up on Schedule III-V controlled substances  
| Tier 3 - Chronic/Stable | • Annual visits for patients on non-controlled substances  |
Pulmonary Medicine: Phase 1

Existing Patients

Require In-Office Visit

- Any acutely ill patient deemed low risk for COVID 19 (e.g., acute asthma / COPD exacerbation, new/worsening hemoptysis, suspected bacterial pneumonia)
- Any patient deemed low risk for COVID 19 with increasing oxygen requirements
- IP post-discharge experiencing pulmonary decompensation

Require Telephone/Telemed Visit

- OSA patients recently started on therapy
- Any patient needing new or scheduled supplies.
- Any patients undergoing active medication titration (e.g., long term Prednisone weaning in hypersensitivity pneumonitis)
- Any IP discharged to a NH, group home or SAR facility

Require Future Appointment

- Stable OSA, COPD, asthma, ILD patients
- Any discharged patient that has already had an initial follow up visit and has fully recovered.

New Patients

Require In-Office Visit

- New / worsening SOB (w/o accompanying fever or other infectious signs/symptoms)
- Hemoptysis
- New / suspected lung cancer
- New / suspected large airway obstruction

Require Telephone/Telemed Visit

- Asymptomatic patients with new lung nodules identified on LDCT screening
- Asymptomatic patients with new lung nodules identified incidentally during screening for other purposes (e.g. calcium score)
- Asymptomatic patients with new mediastinal adenopathy

Require Future Appointment

- All patients with a suspected sleep disorder
- All patients with chronic cough > 3 months
- All asymptomatic patients with newly identified ILD
## Pulmonary Medicine: Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1 - Acute</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lung cancer / lung mass</td>
</tr>
<tr>
<td></td>
<td>• Hemothysis, acute</td>
</tr>
<tr>
<td></td>
<td>• Uncontrolled/acute exacerbation COPD</td>
</tr>
<tr>
<td></td>
<td>• Uncontrolled/acute exacerbation asthma</td>
</tr>
<tr>
<td></td>
<td>• Endobronchial lesion</td>
</tr>
<tr>
<td></td>
<td>• Acute hypoxemia</td>
</tr>
<tr>
<td></td>
<td>• Hospital follow-up</td>
</tr>
<tr>
<td></td>
<td>• Follow-up bronchoscopy</td>
</tr>
<tr>
<td><strong>Tier 2 - Sub-acute</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulmonary infiltrates or abnormality requiring short term (3-mon) imaging</td>
</tr>
<tr>
<td></td>
<td>• Pulmonary nodules requiring short-term (3-mon) imaging</td>
</tr>
<tr>
<td></td>
<td>• ILD with recent initiation of therapy</td>
</tr>
<tr>
<td></td>
<td>• Biologic injections</td>
</tr>
<tr>
<td></td>
<td>• MAI patients with recent initiation of antibiotic therapy</td>
</tr>
<tr>
<td></td>
<td>• New ILD/multifocal infiltrates</td>
</tr>
<tr>
<td></td>
<td>• New pulmonary nodule</td>
</tr>
<tr>
<td></td>
<td>• New PE</td>
</tr>
<tr>
<td></td>
<td>• New pulmonary hypertension</td>
</tr>
<tr>
<td><strong>Tier 3 - Chronic/Stable</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stable OSA / yearly follow-up and CPAP issues</td>
</tr>
<tr>
<td></td>
<td>• Stable COPD</td>
</tr>
<tr>
<td></td>
<td>• Stable asthma</td>
</tr>
<tr>
<td></td>
<td>• Stable ILD</td>
</tr>
<tr>
<td></td>
<td>• Stable pulmonary nodules (yearly imaging)</td>
</tr>
<tr>
<td></td>
<td>• New OSA</td>
</tr>
<tr>
<td></td>
<td>• New COPD/asthma</td>
</tr>
<tr>
<td></td>
<td>• New chronic cough/shortness of breath</td>
</tr>
</tbody>
</table>
PM&R: Phase 1

Existing Patients

Require In-Office Visit

- Pump refill
- Painful prosthetic

Require Telephone/Telemed Visit

Physician to review patient list with staff and determine disposition

Require Future Appointment

- EMG
- Wheelchair seating
- Amputee

New Patients

Require In-Office Visit

- New balcofen pump
- Painful prosthetic

Require Telephone/Telemed Visit

Physician to review patient list with team member and determine disposition

Require Future Appointment

- EMG
- Wheelchair seating
- MSK injuries
- Amputee
- Non-baclofen pump spasticity

PM&R: Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Acute</td>
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<td>• Per physician</td>
</tr>
<tr>
<td>Tier 3 - Chronic/Stable</td>
<td>• Per physician</td>
</tr>
</tbody>
</table>
Rheumatology: Phase 1

Existing Patients

Require In-Office Visit

- Acute joint pain like acute gout flare etc.
- Systemic Vasculitis disorders especially ANCA, Polyarteritis nodosa etc.
- Lupus with CNS, heart, lung or kidney involvement, Systemic sclerosis,
- Rheumatoid Arthritis (RA), psoriatic arthritis (PsA) flares
- Infusion per physician direction
- Post IP discharge per physician direction

Require Telephone/Telemed Visit

- Medication monitoring with lab review for stable patient
- Medication dose change and monitoring
- Mild flares, medication side effects
- Stable patient with RA and PsA
- Post IP discharge per physician direction

Require Future Appointment

- Routine care / follow-up, transfer of care
- Fibromyalgia
- Osteoarthritis

New Patients

Same as above

Rheumatology: Phases 2 – 5

<table>
<thead>
<tr>
<th>Patient Tier</th>
<th>Condition/Treatment/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Acute</td>
<td>• Pediatric</td>
</tr>
<tr>
<td></td>
<td>• Uveitis, vasculitis, SLE</td>
</tr>
<tr>
<td></td>
<td>• On biologic DMARDs</td>
</tr>
<tr>
<td></td>
<td>• On conventional DMARDs especially those requiring lab monitoring</td>
</tr>
<tr>
<td></td>
<td>• Acute gout flares</td>
</tr>
<tr>
<td></td>
<td>• Acute polymyalgia rheumatica flares</td>
</tr>
<tr>
<td></td>
<td>• Acute joint pain that may require arthrocentesis</td>
</tr>
<tr>
<td>Tier 2 - Sub-acute</td>
<td>• Primary osteoarthritis</td>
</tr>
<tr>
<td></td>
<td>• Chronic back pain</td>
</tr>
<tr>
<td></td>
<td>• Other chronic pain</td>
</tr>
<tr>
<td></td>
<td>• Fibromyalgia</td>
</tr>
<tr>
<td>Tier 3 - Chronic/Stable</td>
<td>• Per physician</td>
</tr>
</tbody>
</table>
Neuroscience Service Line – Neurology, Neurosurgery, Interventional Pain

Reviewed 11/30/2020

Outpatient Visits:

- The recommendation for outpatient visits is obviously varying greatly between specialty
- As it relates to neuroscience, the recommendation is that all patients be contacted for possible reschedule:
  - Restrict in clinic visits to those patients for whom a delay may result in harm.
  - Offer a physician phone call in lieu of an in-person visit.
  - If visits for post-op, complications, new cancers, etc. are identified, the appointment can remain
  - If they highlight new symptoms that require consultation, attempt to do any and all over the phone
  - If new symptoms require an on-site visit, you may proceed at your discretion
  - All outpatient procedural items like infusion, chemo, neurodiagnostics, etc. will be left to the discretion of the physician but are likely encouraged to continue
  - For those patients that WILL be seen, our ID team has requested they be spread throughout the week – we are better off to see 2 patients every day instead of streaming 10 patients in the same space in one day
Orthopedic Service Line – Orthopedics, Podiatry, Chiropractic

Updated 5/8/2020

Orthopedics and Podiatry: Phase 1

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 through the required crisis period, should prioritize only patients requiring urgent or acute care of their conditions.

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

1. Acute post-operative or fracture evaluation affecting health outcomes up to six weeks (individual clinician discretion for patients with delayed or deteriorating outcome)
2. 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
3. Requested services designated as Stat, Urgent, or ASAP by the referring physician.

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

Chiropractic: Phase 1

In an unprecedented situation and in effort to control the spread of the CoVid 19 virus, system leadership is requiring some changes in patient care. Elective care, for patients with conditions that are not progressive or urgent in nature, is being asked to be postponed. Please identify patients that fit this criteria and contact them to reschedule or postpone their care with an explanation as to the intent to curb the spread of the virus throughout the community. There is a level of discretion in identifying those patients that are in need of care.

Certainly patients that are experiencing disabling pain or would be expected to have their condition significantly worsen without intervention should still have access to care. As you make these decisions, please consider the goal is to limit visits in order to reduce the risk of spread of the virus.

In addition to alterations to patient scheduling in effort to reduce risk of spread, it is strongly recommended clinicians use gloves to limit direct contact. Of course hand hygiene has been highlighted from many sources as well. Also, please be conscious of social spacing and reduce waiting room or reception area congestion or traffic.
Reactivation - Orthopedic 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.

Phase 1
“Reduce Transmission”

- High Risk Patient
  - Asymptomatic
  - Low Risk Patient

- Symptomatic
  - High Risk Patient
  - Low Risk Patient

Phases 2 & 3
“Re-Open Services”

- High Risk Patient
  - Asymptomatic
  - Low Risk Patient

- Symptomatic
  - High Risk Patient
  - Low Risk Patient

Phases 4 & 5
“Lift Restrictions”

- High Risk Patient
  - Asymptomatic
  - Low Risk Patient

- Symptomatic
  - High Risk Patient
  - Low Risk Patient

- 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

<table>
<thead>
<tr>
<th>Phase</th>
<th>Trigger</th>
<th>Acceptable Ambulatory Clinic Patients</th>
<th>Alternative Location for Ineligible Patients</th>
</tr>
</thead>
</table>
| 1     | • Successful implementation of modified schedule throughout clinic  
        • 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.  
        • 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. |
| 2     | • Validation of policies/procedures in place as defined  
        • 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 | • N/A |
| 3     | • Validation of consistency and ability to expand within policies/procedures for additional volume  
        • 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  
        • Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance**  
        • Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | • Patients who are COVID symptomatic and are in need of an urgent evaluation are directed to a modified UC/ICC. |
| 4     | • Validated ability to expand and maintain separate workflows for high-risk patients  
        • 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  
        • All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance** | • N/A |
| 5     |                                           | • Return to full ambulatory access |                                           |

** Link to **

Definitions of successful expansion, modified schedule, safety elements by phase detailed on next slide practice guidance.
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.

Phase 1
"Reduce Transmission"
- High Risk Patient
- Low Risk Patient

Phase 2 & 3
"Re-Open Services"
- High Risk Patient
- Low Risk Patient

Phase 4 & 5
"Lift Restrictions"
- High Risk Patient
- Low Risk Patient

Algorithm:
- Ability to perform in-person care under appropriate guidelines
- Consider postponing in-person care, use virtual platform based on patient factors
- Postpone in-person, use virtual platform for care until shift to appropriate phase
- Ability to perform in-person care at modified COVID UC/ICC, or use virtual platform

- 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

Table:

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>• Successful implementation of modified schedule throughout clinic • Current State</td>
<td>• Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>• Validation of policies/procedures in place as defined • Site Safety measures achieved and PPE demand aligned</td>
<td>• Non-Acute &amp; Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>• Validation of consistency and ability to expand within policies/procedures for additional volume • Site Safety measures maintained and PPE aligned</td>
<td>• Non-Acute &amp; Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category. Add patients who are not in a high-risk category that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance**</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>• Validated ability to expand and maintain separate workflows for high-risk patients • Site Safety measures maintained and PPE aligned</td>
<td>• Non-Acute and Acute visits for patients who have screened negative for COVID symptoms, including those in a high-risk category. All patients that meet criteria based on COVID+ Patients Presenting for Ambulatory/Outpatient Services practice guidance**</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>• Return to full ambulatory access</td>
<td></td>
</tr>
</tbody>
</table>

Definitions of successful expansion, modified schedule, safety elements by phase detailed on next slide practice guidance

** Link to


Created by Helga Kowalski/AHCMG service line leaders | Created 03/16/20 | Revised 01/18/21 | Approved by Tim Lineberry, MD
Surgical Specialties Service Line

Abdominal Transplant

Post-transplant patients

➢ Require In-Clinic Visit
  • All (except long-term stable patients)
➢ Require Remote Visit (ex. telephone, telemed if available)
  • Coordinator to continue to monitor/document contact with patients
➢ Reschedule to/Schedule for Future Date
  • Long-term stable patients to be rescheduled for summer

Liver disease patients

➢ Require In-Clinic Visit
  • Acutely ill patients
  • Patient with criteria of high meld & outpatient at the discretion of the patient’s coordinator to determine if patient needs a work-up
➢ Require Remote Visit (ex. telephone, telemed if available)
  • Moderately ill, move to telemedicine once available
➢ Reschedule to/Schedule for Future Date
  • Stable to be rescheduled for summer

Fibroscan patients

➢ Reschedule to/Schedule for Future Date
  • All to be rescheduled out one month

Living donor kidney surgeries

➢ Reschedule to/Schedule for Future Date
  • All surgeries scheduled in March (3/19 and later) & April to be rescheduled for summer

Other patients

➢ Require In-Clinic Visit
  • Inpatient workups for sick, admitted patients
  • Patient’s status or condition changes (e.g.-newly transplanted patient, sick liver patient, emergency situation); physician to review & determine need for visit
  • Urgent cancer referral; physician to review & determine need for visit
➢ Reschedule to/Schedule for Future Date
  • Planned elective outpatient/inpatient work ups to be rescheduled out one month
  • All pre-transplant list related checks while on the waitlist (e.g. 6-month visits) to be rescheduled out one month
  • All non-urgent CKD patients to be rescheduled out one month
General Surgery

*Note-see classification chart on following page.*

Existing patients

- **Require In-Clinic Visit**
  - Clinician to review initial patient list for the next 2 weeks and decide patient disposition with staff, reassess weekly
  - Bleeding
  - Complication/post-op infection assessment
  - Suture/drain removal
  - Any associated patient fever must be assessed for protocol screening and proper PPE used during patient evaluation

- **Require Remote Visit (ex. telephone, telemed if available)**
  - Clinician to review initial patient list for the next 2 weeks and decide patient disposition with staff, reassess weekly
  - All visits could be screened first via telephone to assess appropriate follow-up timing interval or seen via Telemed when available

- **Reschedule to/Schedule for Future Date**
  - Clinician to review initial patient list for the next 2 weeks and decide patient disposition with staff, reassess weekly
  - Goal to reschedule those that do not require an in-clinic visit to a remote visit option or into the future with current CDC guideline of 8 weeks for social distancing
  - Special attention to those who meet CDC high risk definitions to avoid any unnecessary travel (visits, radiology/lab)

New patients

- **Require In-Clinic Visit**
  - Ongoing bleeding source: GI, wounds
  - Urgent infections or abscess soft tissue, thrombosed hemorrhoids
  - Urgent (non-emergent) surgery assessments may need to be seen in clinic setting to offload ED (see attached generalized NEST classification guideline **)
  - Any associated patient fever must be assessed for protocol screening and proper PPE used during patient evaluation

- **Require Remote Visit (ex. telephone, telemed if available)**
  - All new surgery patients could be seen via Telemed when available or telephone consultation with appropriate billing recommendations. In-clinic visit scheduling then would be based on urgent acuity needs and ongoing CDC/system updates regarding social distancing

- **Reschedule to/Schedule for Future Date**
  - Clinician to review initial patient list for the next 2 weeks and decide patient disposition with staff, reassess weekly
  - Goal to reschedule those that do not require an in-clinic visit to a remote visit option or into the future with current CDC guideline of 8 weeks for social distancing
• Special attention to those who meet CDC high risk definitions to avoid any unnecessary travel (visits, radiology/lab)

IP Discharge Follow Up

➢ Require In-Clinic Visit
  • Bleeding concerns from wound or GI
  • Post op infection concerns
  • Suture/drain removal
  • Any associated patient fever must be assessed for protocol screening and proper PPE used during patient evaluation

➢ Require Remote Visit (ex. telephone, teledmed if available)
  • All visits could be screened first via telephone to assess appropriate follow-up timing interval or seen via Teledmed when available

➢ Reschedule to/Schedule for Future Date
  • Clinician to review initial patient list for the next 2 weeks and decide patient disposition with staff, reassess weekly
  • Goal to reschedule those that do not require an in-clinic visit to a remote visit option or into the future with current CDC guideline of 8 weeks for social distancing
  • Special attention to those who meet CDC high risk definitions to avoid any unnecessary travel (visits, radiology/lab)

<table>
<thead>
<tr>
<th>Category</th>
<th>Ideal Time To Surgery (RTS)</th>
<th>Possible clinical scenario</th>
<th>Non-Elective Surgery Triage (NEST) level</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate (within minutes) 'break-in' to existing lists if required</td>
<td>Hemodynamic instability, for example: - Bleeding traumatic emergencies - GSW to the chest or abdomen</td>
<td>NEST 1</td>
<td>Immediate life-saving surgical intervention. Resuscitation simultaneous with surgical treatment. Life loss is imminent</td>
</tr>
<tr>
<td></td>
<td>Within an hour</td>
<td>Viscus perforation, vascular compromise, sepsis, for example: - Limb ischemia - Diffuse peritonitis - Soft tissue infection with sepsis - Abdominal compartment syndrome</td>
<td>NEST 2</td>
<td>Surgical intervention as soon as possible AFTER initial resuscitation. Limb, organ or tissue loss is imminent.</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 4 hours</td>
<td>Extremity compartment syndrome - Ascending cholangitis - Incarcerated hernia - Cranlontomies/pectomies</td>
<td>NEST 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 12 hours</td>
<td>Bowel obstruction - Localized peritonitis or soft tissue infection in need of surgery: a) Appendicitis b) Abscess not accompanied with sepsis - Open fractures</td>
<td>NEST 4</td>
<td>Repeat examinations while waiting for surgery</td>
</tr>
<tr>
<td>Semi-urgent</td>
<td>Within 48 hours</td>
<td>Second look laparotomy - Acute cholecystitis</td>
<td>NEST 5</td>
<td>Schedule in advance</td>
</tr>
<tr>
<td></td>
<td>Within 72 hours</td>
<td>1st debridement of burn cases</td>
<td>NEST 6</td>
<td>Schedule in advance</td>
</tr>
</tbody>
</table>

The Ophthalmology and Vision Department is adhering to the American Academy of Ophthalmology Guidelines

The COVID-19 guidelines are reviewed and updated daily.

The American Academy of Ophthalmology strongly recommends that all ophthalmologists provide only urgent or emergent care. This includes both office-based care and surgical care. The Academy recognizes that “urgency” is determined by physician judgment and must always take into account individual patient medical and social circumstances. Urgent problems include but are not limited to:

- Acute onset or change of floaters/flashig lights
- Sudden visual field loss
- Sudden loss of vision
- Sudden double vision
- Significant change in Amsler grid or monocular vision in macular disease patients
- Infectious symptoms in a postop patient
- Eyes with trauma or pain and/or acute change in vision
- Clinician triaged presentation or condition deemed as potential for eye damage or vision loss (e.g. anti-VEGF patients, glaucoma patients, known high stage diabetic retinopathy, red eyes)

List of Urgent and Emergent Ophthalmic Procedures

In response to the current COVID-19 pandemic, ophthalmologists have requested a master list of procedures that are generally performed in operating rooms at hospitals or ambulatory surgery centers as “urgent” or “emergent” procedures.

The American Academy of Ophthalmology has collated these procedures, along with their more common likely indications, into this single list. This list is not meant to cover all indications or all potential procedures but to include those, in the opinion of the major subspecialty societies listed, that are more commonly performed by ophthalmologists in practice.

The Academy thanks the following societies for their substantive contributions to this list:

- American Association of Ophthalmic Oncologists and Pathologists
- American Association of Pediatric Ophthalmology and Strabismus
- American Glaucoma Society
- American Society of Ophthalmic Plastic and Reconstructive Surgery
- American Society of Retina Specialists
- Cornea Society

For additional information visit the Academy’s resource page Coronavirus and Eye Care.
Existing patients

- **Require In-Clinic Visit**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
  - Non-elective to diagnose/treat cancer
- **Require Remote Visit (ex. telephone, telemed if available)**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
  - Consider telephone or telemed for patients that would normally be seen in the office, if available
- **Reschedule to/Schedule for Future Date**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
  - Non-urgent needs
  - Elective cases

New patients

- **Require In-Clinic Visit**
  - Non-elective to diagnose/treat cancer
  - Urgent need to be seen, such as: bleeding, compromised airway, fractures
  - Hospital consults with an acute issue; as determined by physician
- **Reschedule to/Schedule for Future Date**
  - Hospital consults with a non-acute issue; as determined by physician (communicate with the referring physician)
  - Non-urgent needs
  - Elective cases

IP Discharge Follow Up

- **Require In-Clinic Visit**
  - Drain/suture/staple removal
  - Concern for infection or complication
  - Cancer diagnosis
  - Cancer patients to review test results; based on clinician determination
- **Require Remote Visit (ex. Telephone, telemed if available)**
  - Consider telephone or telemed for patients that would normally be seen in the office, if available
Plastic Surgery

Existing patients

- **Require In-Clinic Visit**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
- **Require Remote Visit (ex. telephone, telemed if available)**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
- **Reschedule to/Schedule for Future Date**
  - Clinician to review patient list for the next 2 weeks and decide patient disposition with staff

New patients

- **Require In-Clinic Visit**
  - Acute injuries: MD to review X-rays & referral notes to determine need for visit
  - Infection
  - Cancer (excluding basal & squamous cell, which can be delayed)
- **Reschedule to/Schedule for Future Date**
  - Cancer (basal & squamous cell)

IP Discharge Follow Up

- **Require In-Clinic Visit**
  - Post op: Suture, splint, pin, drain removals
  - Post op: wound healing problems or infection
- **Reschedule to/Schedule for Future Date**
  - Post op: tissue expansion (more than 4 weeks out from surgery) should be deferred as long as possible
Urology

Existing patients

➤ Require In-Clinic Visit

- Clinician to review patient list for the next 2 weeks and decide patient disposition with staff.
- Postop patients, wound checks etc.
- All patients with ongoing or new problems

➤ Require Remote Visit (ex. telephone, telemed if available)

- Clinician to review patient list for the next 2 weeks and decide patient disposition with staff.
- UTIs.
- follow up psa, and lab results.
- X-ray results ie CT scans etc.
- Survivor clinic patients.
- Chronic testicle pain/individualize

➤ Reschedule to/Schedule for Future Date

- Clinician to review patient list for the next 2 weeks and decide patient disposition with staff
- Routine follow up for certain cancers, if NED.
- ED/low T
- OAB/incontinence.
- Chronic testicular pain/individualize.

New patients

➤ Require In-Clinic Visit

All new or suspected cancer patients.
Acute problems: Examples gross hematuria, acute stone, urinary retention.

➤ Require Remote Visit (ex. telephone, telemed if available)

UTIs
prostatitis

➤ Reschedule to/Schedule for Future Date

ED/low T
Lifestyle issues.
Microhematuria
OAB/incontinence.

IP Discharge Follow Up

➤ Require In-Clinic Visit

- Fresh postop patients.
- Urinary retention.
- Require Remote Visit (ex. telephone, telemed if available)
  - Follow up calls to patients after discharge/should be individualized.
- Reschedule to/Schedule for Future Date
  - If clinically doing well.

**Reactivation - Surgical Specialties Service Line**

All disciplines will directly align with System recommendations

**Reactivation - General Surgery**

In alignment with system ambulatory standards [Ambulatory reactivation overview](#) and with deference to the physician’s clinical judgement and local leadership/governance committee decisions; consider the recommendations below for reintroducing ambulatory patient volume.

Compliance with published PPE guidelines, universal screening protocols and disinfectant/cleaning procedures is assumed and will be necessary to ensure a safe environment for patients, clinicians and team members in our department.

<table>
<thead>
<tr>
<th>General Surgery Ambulatory Prioritization Guidelines</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Description</td>
<td>Acute visits*</td>
<td>Non-acute &amp; acute visits for backlogged patients*</td>
<td>Non-acute &amp; acute visits, including new patients*</td>
<td>All patients; start doing medically necessary</td>
<td>All patients (full access)</td>
</tr>
<tr>
<td>Acute Hemorrhoidal thrombus/necrosis</td>
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<tr>
<td>Perianal/rectal abscess evaluation</td>
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<tr>
<td>Chronic Cholecystitis/biliary colic with intolerance of diet (may be reflected as weight loss)</td>
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<tr>
<td>Bariatric dysphagia</td>
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<tr>
<td>Infection with surgical drainage/exploration deemed necessary</td>
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<tr>
<td>Postoperative management: drain removal, staple removal</td>
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<tr>
<td>Hernia with recurrent obstructive symptoms</td>
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<tr>
<td>Enteral feeding tube: tube malfunction or tube dislodged</td>
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<tr>
<td>Sepsis symptoms and colon cases</td>
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<tr>
<td>Routine follow ups (post op or ongoing assessments)</td>
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<tr>
<td>New patients/new consults (that do not meet essential evaluation criteria)</td>
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<tr>
<td>Malignancies</td>
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<tr>
<td>Symptomatic Cholelithias</td>
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<tr>
<td>Symptomatic hernia</td>
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<tr>
<td>Claudication</td>
<td></td>
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<tr>
<td>Gastric bypass patients (new and established) needing weight in/height in order to charge. Perhaps set up a weight-in/height area manned by a MA once weekly</td>
<td></td>
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<tr>
<td>Anyone who has or lives with anyone with viral illness symptoms</td>
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<tr>
<td>Patients unable to de elevated</td>
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<tr>
<td>Medically necessary clinic procedures</td>
<td></td>
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</tr>
</tbody>
</table>

**Key**

*Patient must screen negative for COVID symptoms

In Person

Telemedicine
Reactivation - Otolaryngology-Head and Neck Surgery

In alignment with system ambulatory standards Ambulatory reactivation overview and with deference to the physician’s clinical judgement and local leadership/governance committee decisions; consider the recommendations below for reintroducing ambulatory patient volume.

Compliance with published PPE guidelines, universal screening protocols and disinfectant/cleaning procedures is assumed and will be necessary to ensure a safe environment for patients, clinicians and team members in our department.

<table>
<thead>
<tr>
<th>Otolaryngology-Head &amp; Neck Surgery Ambulatory Prioritization Guidelines</th>
<th>Phase 2 &amp; 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Description</td>
<td>Non-acute &amp; Acute visits*</td>
<td>All patients*</td>
<td>All patients (full ambulatory)</td>
</tr>
<tr>
<td>Adenotonsillar disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dizziness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ear Pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ear Wax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial Trauma</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Head and Neck Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Loss</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neck Mass</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Post-op Patients</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Salivary Gland Tumors</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Skin Cancers/Lesions</td>
<td></td>
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<tr>
<td>Thyroid Nodule/Tumor</td>
<td></td>
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<tr>
<td>Chronic Sinusitis</td>
<td></td>
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<tr>
<td>Dysphagia</td>
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<tr>
<td>Dysphonias</td>
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<td></td>
<td></td>
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<tr>
<td>Facial Pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nasal Obstruction</td>
<td></td>
<td></td>
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<tr>
<td>Oral Cavity Lesions</td>
<td></td>
<td></td>
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<tr>
<td>Oropharyngeal Lesions</td>
<td></td>
<td></td>
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<tr>
<td>Throat Pain</td>
<td></td>
<td></td>
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<tr>
<td>Chronic Cough</td>
<td></td>
<td></td>
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<tr>
<td>Epistaxis</td>
<td></td>
<td></td>
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<tr>
<td>Reflux/LPR</td>
<td></td>
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<tr>
<td>Follow up Meds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**

*Patient must screen negative for COVID symptoms

In Person

Telemicine
Reactivation - Plastic Surgery

In alignment with system ambulatory standards Ambulatory reactivation overview and with deference to the physician's clinical judgement and local leadership/governance committee decisions; consider the recommendations below for reintroducing ambulatory patient volume.

Compliance with published PPE guidelines, universal screening protocols and disinfectant/cleaning procedures is assumed and will be necessary to ensure a safe environment for patients, clinicians and team members in our department.

<table>
<thead>
<tr>
<th>Plastic Surgery Ambulatory Prioritization Guidelines</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Non-acute &amp; acute visits*</td>
<td></td>
<td></td>
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<tr>
<td>Melanoma, SCC</td>
<td></td>
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<tr>
<td>Fracture (Hand or Face)</td>
<td></td>
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<tr>
<td>Acute Injury/Wound</td>
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<tr>
<td>New Onset Hand Pain/Problem</td>
<td></td>
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</tr>
<tr>
<td>Acute peripheral nerve</td>
<td></td>
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<tr>
<td>BCC</td>
<td></td>
<td></td>
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<tr>
<td>Anticipated Mohs Recon</td>
<td></td>
<td>Non-acute &amp; acute visits*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-cancer Breast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Hand Pain/Problem</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chronic Wound</td>
<td></td>
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<tr>
<td>Cosmetic</td>
<td></td>
<td></td>
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<tr>
<td>All patients (full ambulatory access)</td>
<td></td>
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</tbody>
</table>

NOTE:  Check with the physician prior to scheduling. The plastic surgeons will be monitoring their schedules to best determine if a patient should be seen in person or via telemedicine visit.

<table>
<thead>
<tr>
<th>Key</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>*Patient must screen negative for COVID symptoms</td>
<td></td>
</tr>
<tr>
<td>In Person</td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td></td>
</tr>
</tbody>
</table>

Created by Helga Kowalski/AHCMG service line leaders | Created 03/16/20 | Revised 01/18/21 | Approved by Tim Lineberry, MD
Reactivation - Urology

In alignment with system ambulatory standards Ambulatory reactivation overview and with deference to the physician’s clinical judgement and local leadership/governance committee decisions; consider the recommendations below for reintroducing ambulatory patient volume.

Compliance with published PPE guidelines, universal screening protocols and disinfectant/cleaning procedures is assumed and will be necessary to ensure a safe environment for patients, clinicians and team members in our department.

<table>
<thead>
<tr>
<th>Urology Prioritization Guidelines</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Description</td>
<td>Nonacute &amp; acute visits*</td>
<td>Nonacute &amp; acute visits*</td>
<td>Nonacute &amp; acute visits*</td>
<td>All patients (full ambulatory access)</td>
</tr>
<tr>
<td>Gross hematuria</td>
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<tr>
<td>Acute stone</td>
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<tr>
<td>Potential cancers</td>
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<tr>
<td>Elevated psa</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Urinary retention</td>
<td></td>
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<tr>
<td>Cysto high gr. TCC</td>
<td></td>
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</tr>
<tr>
<td>Testicular mass</td>
<td></td>
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<tr>
<td>Prostate biopsy</td>
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<td></td>
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<tr>
<td>post op check</td>
<td></td>
<td></td>
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<tr>
<td>Cysto low gr. TCC</td>
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<tr>
<td>vas consult</td>
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<tr>
<td>Scrotal abn.</td>
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<tr>
<td>Penile abn.</td>
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<tr>
<td>CAB/Incont.</td>
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<tr>
<td>Infertility</td>
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<tr>
<td>BPH/LUTS</td>
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<tr>
<td>F/u PSA/CT/Xray</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Microhematuria</td>
<td></td>
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<td></td>
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<tr>
<td>Survivors Clinic</td>
<td></td>
<td></td>
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<tr>
<td>Chronic Dx</td>
<td></td>
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<tr>
<td>Stone Dx</td>
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<tr>
<td>Prostate CA NED</td>
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<tr>
<td>ED/Low T</td>
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</tbody>
</table>

**Key**

* Patient must screen negative for COVID symptoms

In Person

Telemedicine
Reactivation - Ophthalmology & Vision

In alignment with system ambulatory standards Ambulatory reactivation overview and with deference to the physician’s clinical judgement and local leadership/governance committee decisions; consider the recommendations below for reintroducing ambulatory patient volume.

Compliance with published PPE guidelines, universal screening protocols and disinfectant/cleaning procedures is assumed and will be necessary to ensure a safe environment for patients, clinicians and team members in our department.

The American Academy of Ophthalmology website COVID-19 updates serve as a primary reference for clinical decision making in our department: https://www.aao.org/

Recommendations:

- **The majority of our patients will require an in-person visit.** Consult the clinician at your site for guidance on who may be able to receive care via telemedicine.

- **Anyone with a pink eye should be considered for a video visit.** Several reports suggest that, though uncommon, SARS-CoV-2 can cause a follicular conjunctivitis otherwise indistinguishable from other viral causes, and possibly be transmitted by aerosol contact with conjunctiva.

- **Anyone with a pink eye should NOT be allowed into the clinic as a walk-in until they have gone through more detailed questioning and should be considered for a video visit or intense triage.** After ophthalmic clinical staff triage, patients with other causes for pink eye can be seen using standard precautions. Several reports suggest that, though uncommon, SARS-CoV-2 can cause a follicular conjunctivitis otherwise indistinguishable from other viral causes, and possibly be transmitted by aerosol contact with conjunctiva.

- **Consider frame dispenses by appointment only**

*Helpful Reminders/Tips for Clinicians & Team Members:

- **During examination:**
  - Disinfect all hand-held testing equipment after each use. Hold testing items for patient (don’t let patient touch it).
  - Use a protective shield on the slit lamp and phoropter.
  - Avoid non-contact tonometry as it may micro-aerosolize the virus if it is on the ocular surface.
  - Consider binocular indirect or fundus photography to maximize distance during fundus examination.
  - Minimize specialty tests to critical clinical need (visual fields, optical coherence tomography, corneal topography, etc.).

- **Post examination:**
  - Clean tonometer tips with alcohol wipes, and if patient was seen for a red eye also use 1:10 bleach solution 5 minutes later.
  - Wipe down the slit lamp & phoropter face shields after every patient.
Fundus Exam Lenses should be placed on counter after use for cleaning or left on slit lamp if not used.

- **Vision center:**
  - Consider protective shield on pupilometers.

- **Glasses:**
  - Limit the number of frames a patient can try on.
  - Disinfect all frames after contact.

- **Contact lenses:**
  - Use trial bottles of contact lens solution and give to patient when done.
  - Mail contact lenses to patients.

*Helpful Reminders/Tips for Patients:*

- There is currently no evidence to suggest that contact lens wearers are at more risk for acquiring COVID-19 than eyeglass wearers
- Neither standard eyeglasses nor contact lenses are approved for use as personal protective equipment (PPE), according to the CDC.

- **Contact lenses:**
  - **Daily disposable lenses:** dispose of lenses after each wear.
  - **Reusable lenses:** clean and disinfect your lenses according to your eye care professional’s recommendations.
  - Properly clean, dry and dispose of the contact lens case, as directed. Monthly replacement of cases is suggested by experts.
  - As with any illness, anyone who does not feel well should stop contact lens wear until healthy again.

- **Eyeglasses:**
  - Wash eyeglasses regularly and wash your hands prior to handling them.
  - Standard eyeglasses do not provide protection from material entering from around the sides, top and bottoms of frames.

*Citations:

American Academy of Ophthalmology: [https://www.aao.org/](https://www.aao.org/)

American Academy of Optometry: [https://www.aaopt.org/](https://www.aaopt.org/)
Women’s Health Service Line

The following guidelines have been established by the Women’s Health Service Line, in accordance with guidelines from the CDC; ACOG; SMFM and our internal physician experts.

Our goal is to keep our patients and team members healthy. We want to support social distancing, as such, we encourage postponing non-essential visits. As always clinician discretion will be key in the delivery of safe, quality care for our patients and should be take into consideration with all recommendations.

Below is a guide to assist in determining those visits that should be considered for deferral. Reactivation plan follows the below.

**Ob/Gyn**

1. ACOG has recommended we be aware of the unintended impact of limiting access to routine prenatal care. Given this guidance, we recommend that prenatal visits continue. Clinicians can consider decreasing the frequency of visits for appropriately selected patients, provided blood pressure can be monitored at home and telephonic/video contact continues. **Wisconsin Only:** In addition to Babyscripts, a modified prenatal visit schedule has been developed. Please see “AHCMG Modified Prenatal Visit Schedule”.

2. Post op and post-partum patients without complaints should be evaluated by video visit in accordance with AAH Video Visit guidelines by a physician or APC. If the video visit identifies a need for an in-person visit (eg abnormal symptoms or LARC), the in-person visit should then be scheduled.

3. Scheduled labor inductions and c-sections should continue as planned. Continue to schedule labor inductions and c-sections as would otherwise be appropriate.

4. Well Woman visits should be delayed.

5. Ultrasound surveillance of pregnancy should continue as scheduled.

6. Visits with established patients for continued contraception management; UTI’s and yeast infection should be changed to telephonic or video visits, with in person visits if symptoms worsen.

7. Appointments for LARC placement should continue unless other contraceptive options are appropriate.

8. **Delay visits for fertility evaluation and treatment, although advice can be provided by phone**

9. We recommend evaluation and treatment of abnormal cervical screening tests per ASCCP guidelines. [https://www.asccp.org/covid-19](https://www.asccp.org/covid-19)

10. If a patient with an urgent but not emergent OB/Gyn need is identified, we should continue to provide access to care in the office to avoid patients presenting unnecessarily to the Emergency Dept.

11. Telephone visits with physician/APN may be billed and patients should be alerted to that when they are scheduled/initiated. Verbal consent is needed and appropriate. See guidelines for telephonic visits.

**MFM**

1. **Antenatal testing will resume to pre-COVID scheduling beginning May 4th.**

2. All other MFM patients will continue to be seen with modifications as noted in the Ob/Gyn section above.

3. Provided there are no comorbidities, antepartum fetal surveillance for patients with ages over 40 and BMI over 40 may be deferred.
4. When antepartum fetal surveillance is needed, the frequency of the visits may be modified on a case by case basis.
5. Genetic counseling visits should be transitioned to phone/telehealth consultations.
6. Appointments for preconceptual counseling should be deferred.

Fertility

1. Cancelling all in office new and follow up consultations and replacing these appointments with telehealth visits
2. Office visits for routine/non-urgent labwork and diagnostic studies will resume effective May 4\textsuperscript{th}, assuming social distancing principles can be applied. Examples of such tests include:
   a. Blood draws for FSH; prolactin; TSH; hormonal assays
   b. Semen analysis
   c. Sono-hystero gram
   d. Transvaginal ultrasound for antral follicle counts
   e. Pregnancy ultrasounds for confirmation of intrauterine pregnancy status
      i. Frozen embryo transfer and egg retrieval will begin after June 1.
      ii. Fertility preservation
        i. Patients requesting fertility preservation would have telehealth consultations to determine eligibility for fertility preservation
        ii. Our fertility centers will alternate procedural sites availability for egg retrievals.
           a. The Green Bay Fertility Center will not be available for any egg retrievals for cancer fertility preservation from 03/27/2020 till 04/20/2020. Any needed procedures would be performed at the West Allis Fertility Center. The West Allis Fertility Center will be closed for fertility preservation procedures from 04/21/2020 to approximately 05/20/2020. The continuation of alternate site availability will be adjusted based on recommendations from the Centers for Disease Control and Advocate Aurora Health.

Gyn Oncology

1. New Patients:
   a. All cancers and clinical scenarios that are trying to rule out cancer will be scheduled ASAP
   b. All precancerous conditions including CIN, VIN, VAIN will be deferred
   c. All surgically complicated benign patients (these usually come with a biopsy that is negative) will be rescheduled.
2. Existing patients: these apply to patients without any concerns.
   a. All uterine cancers greater than 2 years out from treatment/diagnosis will be moved
   b. All pre cancer surveillance visits will be rescheduled
   c. All vulvar cancers greater than 2 years out from treatment/diagnosis will be rescheduled until after April 10th.
   d. Annual visits for cancer diagnosed 5 years or greater from now will be rescheduled to be seen after three months.
   e. All benign surveillance patients will be rescheduled to be seen in 3 months.
3. All ovary cancer patients will keep their appointments as scheduled.
Urogynecology

1. New Patients
   a. Patients with Prolapse and OAB symptoms will be seen
   b. Recurrent UTI patients will be seen
   c. All other Patients including those with SUI only, pelvic pain, IC will be assessed on a case by case basis

2. Existing Patients: apply to patients without any concerns
   a. Postop patients will be seen if surgery with the last 3 months
   b. Preop appts will be postponed if surgery is to be postponed
   c. Annual med check or annual postop will be deferred
   d. Pessary checks if seen within the last 6 months and asymptomatic will be deferred to until after April 10th.
   e. Med check/pelvic floor therapy follow-up will be deferred

3. Procedures such as botox, coaptite and cystoscopy will be done at the provider’s discretion

4. Nurse visits for bladder instillations and PTNS will be deferred
Modified Prenatal Visit Schedule

During COVID-19 pandemic:

- 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

Please note, this is a continually changing environment as such recommendations may change over time, so please watch for additional updates.

Covid19 Hotline - 866-443-2584
Reactivation Plan – Women’s Health

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.

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phases 2 &amp; 3</th>
<th>Phases 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Reduce Transmission”</td>
<td>“Re-Open Services”</td>
<td>“Lift Restrictions”</td>
</tr>
</tbody>
</table>

- **High Risk Patient**
- **Low Risk Patient**

**Ability to perform in-person care under appropriate guidelines**
- Consider postponing in-person care, use virtual platform based on patient factors
- Postpone in-person, use virtual platform for care until shift to appropriate phase
- Ability to perform in-person care at modified COVID UC/IMC, or use virtual platform

**High-Risk Patients:** 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**

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Reactivation Plan – Ob/Gyn In Person Visits

**Level I**
- Current patients per COVID guidelines
- Antenatal testing (BPP, NST, growth ultrasound)
- Prenatal visits continue per modified prenatal schedule and utilization of Babyscripts
  - Recommend video visits as appropriate

**Level II**
- Consults
- Pre-Op
- LEEPs
- Colposcopies
- Cancer Screening
- Symptomatic patients
- Prenatal visits continue per modified prenatal schedule and utilization of Babyscripts
  - Recommend video visits as appropriate

**Level III**
- Annual Well Woman Exam w/out cancer screening
- Prenatal visits continue per modified prenatal schedule and utilization of Babyscripts
  - Recommend video visits as appropriate

**Key Assumptions:**
- Patient scheduling decisions ultimately reside with the clinician
- Video visits should continue as appropriate (Modified Prenatal Schedule; Contraceptive counseling; preconception counseling; visits not requiring a physical exam)
- Video visits are preferred over telephonic when appropriate

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5/12/2020