HOPD Reactivation Guiding Principles

Phase I – Pandemic Crisis Management
• Site specific surge plans are in full effect based on COVID volumes/parameters set at each location
  a. Critical care at 75% capacity r/t COVID
  b. Staff has been redeployed to staff COVID units
  c. COVID rates following upward trajectory (definition by states)

Triggers to consider activating Phase II
• COVID volumes decreasing/flattening (definition by states)
  a. 7-day supply of rapid tests available – supply to be inclusive of increased utilization with adding HOPD patient testing to current IP, ED, Procedural/Surgical demand
  b. 7-day supply of PPE available – supply to be inclusive of increased utilization with adding HOPD use to current IP, ED, Procedural/Surgical use

Phase II – Recovery
• HOPD procedures and diagnostics would align with Surgical and Procedural Reactivation Guidelines with the below additional recommendations.
• HOPD Medical Clinics would align with recommendations set forth by Ambulatory Clinic Guidelines with the below additional recommendations.

1. Considerations
   a. Priority Setting for New Appointments
      i. HOPD consult/procedure requests for patients with clinical concerns, declining clinical status, evolving risk of morbidity/admission, and/or progression of disease should be scheduled without delay.
      ii. HOPD procedure/consult orders identified as “routine” with a specific expected date of service would be scheduled in alignment with the expected date.
      iii. HOPD consult/procedure orders identified as “routine” without a specific expected date of service should be reviewed for clinical urgency.
      iv. Consider deferring some screening procedures beyond [date to be determined by site leadership]
   b. Priority Setting for “backlog” patients and patient follow up appointments
      i. Review list of patients in “backlog”. Clinician triages patients to receive in-person visit vs virtual visit.
         In-person visit:
         • Unable to complete virtual visit (lack of equipment, home support)
         • Requires physical exam
         • Risk of clinical deterioration, loss of tissue/limb, admission risk
         • Clinic procedure required
         Video Visit:
         a. Able to use virtual platform
         b. Clinical need able to be completed through virtual interview/history with supporting video/photos
      ii. Develop list of patients needing more immediate visits based on acuity and as noted above. Definition of higher acuity is specialty specific.
      iii. Consult with facility operations leadership with respect to space constraints.
iv. Create outpatient schedule with planned downtime between patients to create social distancing and time for disinfecting equipment and high touch surfaces between patients

v. Where clinics have shared waiting spaces, hardwire distancing: stagger schedules with other providers, room patient immediately when able, allocate a defined number of chairs for each area, mark floors for wheelchair parking and standing. Explore solutions such as waiting in cars.

vi. Begin scheduling 50% appointments/procedures (unless already safely exceeding) to space patient arrivals.
  1. Volumes to be expanded as situation changes and as department adjustments are implemented to safely accommodate more patients.

vii. For multispecialty shared waiting rooms, collaboration in scheduling is required to limit patient volume in that area.

c. Visit/Procedure Scheduling
   i. PPE availability and needs guide volumes able to be scheduled
   ii. Schedule clinic procedures based on need and acuity. Any delays should not lead to patient compromise.
   iii. All patients should be tested (rapid ideal) prior to procedure. Until the AAH test supply is adequate, follow general pretesting protocol through the established Surgery/Procedure Guidelines with an expansion to include additional qualifying procedures:
     1. Pre-procedure testing should include select non-invasive series procedures/treatments that are at high risk for patient/staff COVID exposure, as well as, those that impose a greater risk to the patient if given when a person is COVID+. (ex: radiation therapy, medical oncology, infusions, multiplace HBOT, series treatments that require frequent visits with greater than one hour, confined, close-proximity presence of staff and patients)
     2. Serial testing should be completed for select non-invasive series procedures/treatments that are at high risk for patient/staff COVID exposure, as well as, those that impose a greater risk to the patient if given when a person is COVID+. (ex: radiation therapy, medical oncology, infusions, multiplace HBOT, series treatments that require frequent visits with greater than one hour, confined, close-proximity presence of staff and patients).
     3. Frequency of serial COVID testing.
        • Ideally patients will be tested prior to each visit during a series of procedures/treatments. Until the AAH test supply is adequate, the recommended serial testing workflow includes:
        • Prior to start: Test patient 48 – 72 hours prior to initiation of the series. Patient to self-quarantine for 48-72 hours until procedure/treatment
          a. Test - : Proceed with initial procedure/treatment
          b. Test + : Reschedule the initial procedure appointment if clinically appropriate and delay will not cause patient harm. Plan determined by clinician. If patient condition requires the treatment/procedure to go forward, follow AAH COVID + treatment guidelines
• Ongoing follow-up series appointment: Patients should be counseled to take appropriate social distancing precautions.

• Perform AAH COVID screen prior to each appointment
  a. Screen - : Proceed with procedure/treatment
  b. Screen + : Test patient with rapid test, if available. If rapid test is not available - test patient, reschedule procedure/appointment, and send patient home to self-quarantine for 48-72 hours - as long as delay will not cause patient harm. If immediate treatment/procedure is required, consider patient as COVID + and follow AAH treatment/PPE guidelines.
  i. Test - : Perform procedure
  ii. Test + : Plan determined by clinician, if patient condition requires treatment/procedure to go forward, follow AAH COVID + treatment guidelines (spacing, isolation, appropriate PPE, cleaning, etc.). If patient can safely wait, reschedule procedure at least 10 days from positive test.
  iv. Consider expansion of hours of operation: Evenings, weekends as determined by site leadership
  v. Consider strategically scheduling by subcategorizing patients to reduce risk. (ex: COVID +/COVID-, with comorbidities/without comorbidities, inpatient/outpatient)
  vi. Create blocks in all HOPD schedules i.e. Every other time slot or some other strategy that achieves social distancing goal.
  vii. Follow site-based screening guidelines

• Resources/Supplies
  i. Evaluate if referral departments are available (examples: sleep lab, cardiac rehab, etc.)
  ii. Supply report to be available to clinics for levels of PPE/cleaning/disinfecting supplies available (utilization will increase when clinics begin activating)
  iii. Define and track how supplies (PPE, cleaning, disinfecting, etc.) are allocated between departments

• Infection Prevention/Disease Management
  i. Follow PPE guidelines per AAH
  ii. Follow screening guidelines per AAH
  iii. Follow testing guidelines per AAH
  iv. Triage patients by risk and comorbidities, prior to scheduling in-person visit

• Coordination with Other Teams
  i. Leverage technology where possible (virtual visits, group chats, etc.). HIT/informatics to provide support
  ii. Partner with HIT/Informatics to customize virtual platform to augment functionality
  iii. Encourage enrollment in MyChart, downloading of Live Well app.
g. Staffing
   i. Redeployed staff to return to clinics to support new workflow and processes.
   ii. Providers require full staff complement to support patient care and clinicians in new workflows/processes
   iii. Re-assign furloughed team members to cover expanded hours (work with local Labor Pool)
   iv. Redeployed staff are needed to rebuild efficiency

h. Metrics and Volumes
   i. Monitoring staff physical wellness with back up staffing plan for unanticipated staff quarantine
   ii. Daily reports on PPE/cleaning/essential supplies needed for clinics to guide clinic and procedure scheduling
   iii. Redefine productivity standard
   iv. Daily reports on bed availability in hospital distributed to HOPD to guide procedure scheduling

i. Processes and Protocols
   i. New scheduling: Continue with virtual platform when possible
   ii. Waiting area: Remove chairs, add spacers on floor, staggered appointments, work with clinic leaders when waiting areas are shared for additional options. (waiting in cars, etc.)
   iii. Call patients in advance: prescreening, visitor policy, masking, distancing, etc.
   iv. Immediate rooming when possible
   v. Coordinate with system communications to educate/reassure patients about safety measures in place to support their appointment and LiveWell app.

Triggers to Level III
   j. Absence of COVID in local population (defined by state)
   k. Critical care/hospital units functioning at pre-COVID capacity

Phase III – Transition / New Normal
   1. Considerations
      a. Increasing visit/procedure scheduling as systems ramp up
      b. Continued development and utilization of virtual visit model where appropriate
      c. Evaluation of par levels of supplies
      d. Preparation for recurrence of COVID