# Aurora Health Care Medical Group
## Clinical Service Lines and Departments
### COVID-19
#### Ambulatory Visits Guidelines

Revised April 8, 2020

*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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Service Line Contact Information

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Behavioral Health Service Line

Hospital Based Programs

- IP remains open and census management based on staffing availability, 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
COVID-19 Information Center for Team Members and Physicians - [https://www.advocatehealth.com/covid-19-info/](https://www.advocatehealth.com/covid-19-info/)  This resource is designed to provide helpful resources to Advocate Aurora Health team members and physicians during the rapidly evolving COVID-19 pandemic.


Universal Masking is now available to be used when NOT caring for suspect or COVID positive patients.

Medical Oncology

The following recommendations were approved by AAH Medical Oncologists and administrative leadership in WI & IL on 3/16/2020 & 3/20/2020, 3/27/2020.

RECOMMENDATIONS: (minimized – refer to Covid-19 website)

1. PATIENT DIRECTIONS: All patients should be called the day prior with screening questions from the COVID-19 Information Center.

2. SCREENING: Oncology Departments should have at the department door screening - questions and taking temperatures (even if building doing screening) of patients and visitors.

3. No Visitor Policy - Patients should come to visits alone if possible or with 1 visitor if required.
4. Patients who arrive with symptoms, team members should follow the AAH COVID 19 Outpatient Clinical Pathway.

5. Allow deferring of physical exams for patients undergoing chemo if there are no complaints on the interview. Could add a phrase “physical exam deferred due to social distancing”.

6. Virtual Health Video Visits or Telephone Visits may be an option for evaluation of certain patients both new consults as well as follow ups after discussion with staff. Refer to COVID-19 Information Center for directions and updates as technology options evolve.

CLINIC VISITS:

DEFER: Reschedule all non-essential visits by 4-6 weeks

1. Reschedule all FU appointments >6wks. (FU 3 mo, 6mo & 12mo) Any FU visit with a timeframe of > 3 months should be automatically deferred unless patient reporting active problems. Move by 4-6 weeks. If patient has results of scans, physician can consider Virtual Visit by telephonic or video visit discussion. Discuss with physician and reschedule as appropriate.

2. Consider delaying the supportive care appointments if appropriate for patients (zometa/xgeva) Discuss with physician and reschedule as appropriate.

3. Extend therapy with depot medications (Lupron) to the longest acting option available (3,6 months). Discuss with physician and receive new order as appropriate.

4. PORT FLUSHES- OK to delay & reschedule 6 weeks.

CONTINUE: Patients that clearly need to be seen:

1. Newly diagnosed of cancer and/or urgent need for workup/eval

2. Recurrent patients with symptoms in need of urgent care

3. End of life discussion

4. Active chemotherapy 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 and delay therapy 6 weeks receive new order as appropriate.
   c. Any patient receiving Venofer – Defer - pregnant women may be an exception – discuss with physician.

CHEMOTHERAPY:
There is data that patients on chemotherapy have a higher likelihood of serious complications to COVID-19 infection. In addition, the frequent clinic visits increase risk of COVID-19 exposure. Accepted recommendations to limit these risks are:

1. 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.
   a. 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?
   b. Avoid starting chemotherapy in frail patients ECOG PS>1 and or >age 70 other risk factors to consider include COPD, chronic respiratory conditions, DM immunocompromised patient.
   c. Consider delaying chemotherapy in asymptomatic metastatic patients. Unless therapy to be done with curative intent.
   d. Consider treatment breaks/holidays in patients in remission or doing well.

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

**NON-ONCOLOGY INFUSIONS (GI, Rheumatology, Neurology, etc.):**

1. The ordering provider will be contacted at least 24 hours prior to infusion appointment to confirm infusion should be administered.

**Hematology**

**CLINIC VISITS:**

**DEFER:** Reschedule all non-essential visits >6 weeks

1. Routine follow up visits – excludes allogeneic transplant recipients less than Day +180 or Autologous Recipients ≤ Day +100
2. Any new patient that does not have a diagnosis of hematologic malignancy - review at pipeline Meeting for verification of delayed visit

**CONTINUE:** Patients that clearly need to be seen:

1. New diagnosis hematologic cancer/urgent auto or allo transplant consult
   a. All allogeneic consults should be scheduled
   b. Autologous transplant consults for DLBCL should be scheduled
   c. Discuss myeloma consults at Pipeline Meeting to determine urgency
2. Recurrent patients with symptoms needing urgent treatment
3. All allogeneic transplant recipients less than Day +180 or Autologous Recipients ≤ Day +100
CHEMOTHERAPY:

1. 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 – delay therapy >6 weeks (Direction per MD)
2. Any patient receiving Venofer – DEFER

TRANSPLANT:

1. All Allogeneic transplants for a hematologic malignancy to proceed with transplant
2. Autologous transplants – DLBCL, other Hodgkin and non-Hodgkin lymphoma patient to proceed with transplant
3. Myeloma/plasma cell disorder recipients for autologous transplant –
   a. DEFER >6 weeks for patients with Multiple Myeloma in 1st remission
   b. CONTINUE Refractory/Relapsed patients should proceed with transplantation.
   c. May need to collect stem cells if on therapy that will cause inability to achieve needed cell dose.

CAR T-cell:

1. IL - CAR-T cell patients should proceed with therapy.
2. WI - Launch of program is on hold.

INPATIENT CONSULTS:

After discussion with referring physician consider the possibility of providing recommendations by phone or focus note. Providing guidance on differential diagnosis and workup prior to seeing the patient may help decrease the number of face-face interactions.

Radiation Oncology

The following recommendations were approved by AAH Radiation Oncologists in WI & IL and administrative leadership on 3/16/2020, 3/19/2020 & 3/31/2020.


Option 1: Continue radiation therapy.

Option 2: Delay radiation therapy.

Potential Treatment Algorithm Single Vault Facility

1. Decrease staff to limit staff exposure if feasible, with minimum safe staffing levels. Keep back-up staff remote/offsite in case of exposure is possible.
2. Treat all asymptomatic patients in the morning when possible.
3. Defer suspected and confirmed COVID-19 positive patients to afternoon treatment appointments
   b. Room patient in private area while awaiting treatment
4. Termination clean vault at the end of patient treatment for the day

**Potential Treatment Algorithm Multiple Vault Facility**

1. 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.
2. See steps 2-4 above for Treatment Algorithm Single Vault Facility.

**Additional Detailed Guidelines:**

I. Follow COVID-19 Information Center:

1) **Follow enhanced hygiene practices** – frequent hand washing, no handshakes or otherwise unnecessary bodily contact, patients and staff should use hand sanitizer before entering vault.

2) **Minimize the number of people coming into clinic (One to No Visitors)**

3) **Follow enhanced sanitation practices**
   a. Wipe down all patient areas (chairs, tables, etc) and staff areas at end of day
   b. Wipe down treatment table after each patient
   • Encourage patients in waiting areas to maintain > 6 feet from each other
   • Encourage patients to wait in automobiles or have family members wait in automobile.

4) **Cancel all non-critical meetings and move all remaining meetings to virtual meetings as possible.**

II. Other Recommendations:

• **Reduction in onsite Physician, Physicist, Therapist, Dosimetry staff**

• **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.

• **Daily Huddle** – daily huddle will continue to take place. This will be done via Skype/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.)
• **Follow Up Procedure**- MD and RN to discuss timing of follow up for existing patients. Each week physicians and NPs will review their follow up schedule for the next 1-2 weeks.
  
  o Physician/NP to review schedule and decide which patients must be seen, which patient appointments can be delayed (per clinically appropriate decision making), and which patients can have a virtual visit.
    ✪ Decision to be made for in-person/virtual/reschedule
    ✪ Any patient appointment delays MUST be documented in the electronic medical record.

  □ Prior to telephone follow-up front desk/nursing/etc. need to verify insurance/registration information and update information in electronic medical record

• **Consults**- telephone/video consults only to be performed in rare instances
  
  o Verification of insurance and registration information as well as intake forms need to be completed by nursing/front desk/etc.
  
  o Physician must document initially that this was a phone/video conversation in lieu of in person visit

• **Simulations**- consider delaying elective patient's simulation/new starts as medically appropriate per physician

• **Treatments**-
  
  o Consider expanding treatment appointment times for more thorough cleaning of treatment table and accessories between patients
  
  o Consider hypofractionation when indicated.
  
  o 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.

### III. Minimize the negative impact of infected patients

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.

One potential algorithm:
• Palliative patients
  o Pain or other non-life-threatening symptom → **treat with single fraction** or **terminate treatment in progress if delivered BED ≥ 8 Gy/1 fx**
  o Cord compression, brain mets, or other immediately life-threatening symptom → **shorten course of treatment** as feasible

• Definitive patients
  o Low risk (no severe cough or pneumonia/ICU) → **complete course of treatment** or **defer at MD discretion**, accelerating as feasible
  o High risk (severe cough or pneumonia/ICU) → **defer remainder of treatment** and **make up after symptoms resolve and out of quarantine**


**Surgical Oncology**

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

The following recommendations were approved by AAH Cancer Service Line (breast & hepatobiliary) surgeons in WI & IL and administrative leadership which occurred on 3/16/2020 & 3/24/2020 & 3/30/2020.

In response to the American College of Surgeons and the Surgeon General’s recommendations to postpone elective surgery, the following guidelines have been developed to help patients with proven or suspected cancer. This has been reviewed by senior leadership, and pertains to our current situation, changes may be needed based on changes in our situation and resource availability.

Most cancer operations are not elective. Delays may cause both physical and psychological harm. All decisions about whether to delay surgery or procedures should be made by the surgeon with judgement about the risk versus benefit of delaying surgery or proceeding as scheduled.

All multidisciplinary clinics where patients physically attend should be suspended until further notice.

All tumor boards and cancer conferences will continue as virtual meetings.

**Virtual Health Video Visits or Telephone Visits** may be an option for evaluation of certain patients both new consults as well as follow ups after discussion with staff. Refer to COVID-19 Information Center for directions and updates as technology options evolve.
SURGERY:

1. All cancer surgeries currently scheduled should proceed as planned provided the resources are available to do so safely.
   a. Surgeons should check that adequate resources are available prior to starting any major resection (ICU bed, ventilator etc...)
2. If the surgery can be safely delayed, without harm to the patient, it should be considered. (for at least 2-4 weeks)
3. Scheduling of surgical cases should consider the risks to the patient (Hospital exposure), resource availability and the risks associated with delaying surgery.
   a. Cancers patients may experience worse outcomes if infected due to the compromise in their immune systems.

CLINIC VISITS:

DEFER: Reschedule all non-essential visits until after May 1 (or perform virtually)
1. Routine follow-ups
2. Non-urgent issues

CONTINUE: Patients that clearly need to be seen:

All office visits should be reviewed, with the following cases prioritized to be seen:

1. All new or suspected cancers
2. All recent post-operative patients
3. All patients with ongoing or new problems

Breast Care & Surgery

The following recommendations came from a meeting of the breast surgeons which occurred 3/16/2020, and a consensus meeting of the Chicago Area Breast Surgeons.

In response to the American College of Surgeons and the Surgeon General’s recommendations to postpone elective surgery, the following guidelines have been developed to help patients with proven or suspected breast cancer. This has been reviewed by senior leadership, and pertains to our current situation, changes may be needed based on changes in our situation and resource availability.

Most cancer operations are not elective. Delays may cause both physical and psychological harm. All decisions about whether to delay surgery or procedures should be made by the surgeon with judgement about the risk versus benefit of delaying surgery or proceeding as scheduled.

1. Breast Screening
   a. It was felt that we should hold off on breast screening until after May 1 and reassess as we see the availability of our resources and personnel
b. We should continue doing diagnostic imaging and biopsies on moderate to highly suspicious lesions

c. Low risk lesions should be deferred until after May 1

2. Benign lesions
   a. Benign breast surgeries (fibroadenomas, ADH, papillomas, etc.) should be delayed unless a lesion is discordant on core biopsy and/or suspicious on imaging.
   b. Office visits and surgery for patients with benign lesions should be deferred Until after May 1 (or performed virtually)

3. High risk screening visits in the absence of cancer or high-risk lesions should be deferred Until after May 1 (or performed virtually)

4. Management of High-Risk lesions
   a. Patients with high-risk lesions who are scheduled (or need to be scheduled) for surgery should be managed based on the best judgement of the surgeon considering the following factors
      i. Risk of delaying surgery
      ii. Risk of having the patient come into the surgery center or hospital
      iii. Available resources
      iv. Age and health of the patient
      v. Availability of alternative treatment strategies

5. Management of Cancers and DCIS
   a. Patients with cancer or DCIS who are scheduled (or need to be scheduled) for surgery should be managed based on the best judgement of the surgeon considering the following factors
      i. Risk of delaying surgery
      ii. Risk of having the patient come into the surgery center or hospital
      iii. Available resources
      iv. Age and health of the patient
      v. Availability of alternative treatment strategies (Neoadjuvant therapy)
   b. Selectively, surgical treatment of some cancers can be safely delayed
      i. Postmenopausal women with small, highly ER+ tumors that can be placed on endocrine therapy and surgery delayed.
      ii. DCIS in postmenopausal women with high ER+ tumors that can be placed on endocrine therapy and surgery delayed
   c. Surgery should still be performed as soon as reasonable (Resources permitting) on premenopausal women with ER+ or ER- tumors, and those completing neoadjuvant chemotherapy.
   d. When possible, women with ER-, Triple Negative or Her2neu+ tumors should be started on neoadjuvant chemotherapy.
   e. Mastectomy patients
      i. Patients should be encouraged to consider breast conservation instead of mastectomy if they are appropriate candidates
i. Reconstructions will be limited to tissue expander/implant for the next few weeks (Per plastic surgery)

ii. Contralateral prophylactic and risk reducing mastectomies should be delayed until the elective surgery guidelines have been lifted (until after May 1) and we have an idea of personnel and resource availability

6. Routine follow-up visits should be postponed or handled virtually

7. The following patients should be seen as soon as reasonable
   a. New or potential cancers
   b. Fresh post-op patients
      i. Virtual visits at the option of the surgeon
   c. Any patients with new complaints or ongoing problems

Melanoma Guidelines
Short-term Recommendations for Cutaneous Melanoma Management During COVID-19 (Contributions from City of Hope, Cleveland Clinic, Fred Hutchinson Cancer Research Center/Seattle Cancer Alliance, Huntsman Cancer Institute, Massachusetts General Hospital, MD Anderson Cancer Center, and Stanford Cancer Institute)

1. PRIMARY CUTANEOUS MELANOMA (CM):
   a. Diagnostic Biopsy:
      i. Attempt excisional/complete saucerization biopsy whenever possible with intent to remove the clinical lesion.
         1. Histologic transection of the in-situ component at the peripheral margin is of less consequence.
      ii. Broad (more superficial) shave biopsy should be performed for larger suspected melanoma in situ, lentigo maligna type lesions, i.e., melanoma on chronically sun damaged skin (CSD melanoma).
         1. In person or telehealth evaluation for new patients with completion of the H&P on the day of surgery if needed.
      iii. Wide excision (WE) of in situ and invasive melanoma:
         1. Delay WE of melanoma in situ (MIS) until after May 1.
         2. Delay WE for invasive melanomas of any depth, for which previous biopsy had clear margin or histologic peripheral transection of the in-situ component until after May 1.
         3. Delay WE for T1 melanoma (≤1 mm thickness) until after May 1 even for positive margin on biopsy, if the biopsy removed the majority of the lesion.
            a. Perform complete/excisional biopsy with 1 cm surgical margins in the office/outpatient setting.
         4. Offer sentinel lymph node biopsy (SLNB) for CM >1 mm thickness, but consider deferring SLNB for T1b melanoma (0.8-1.0 mm with or without ulceration), unless high risk features are evident (e.g., lympho-vascular
invasion, very high mitotic rate, young patient age [≤40 years], or a combination of these factors).

5. Surgical management of T3/T4 melanomas (>2 mm thickness) should be performed as soon as reasonable (Resource permitting)

6. Surgical management for any melanoma that is partially/incompletely biopsied where a large clinical residual lesion is evident should be performed as soon as reasonable (Resource permitting)
   a. WE/SLNB should be performed at the same time (resource permitting).
   iv. Conduct follow-up visits by telehealth when possible with patient images sent to the provider (preferably using EHR systems in place).
      1. In person visits for new patients and recent post-ops should be at the discretion of the practitioner/

2. STAGE III (REGIONAL NODAL) MELANOMA:
   a. As per current NCCN guidelines consider deferring completion lymph node dissection following a positive SLNB (when possible) and perform regional nodal ultrasound surveillance (if radiologic expertise available) or other imaging surveillance (CT, FDG PET-CT, MRI), as appropriate.
   b. Defer surveillance imaging (US, CT, FDG PET-CT, MRI) for 3-6 months in asymptomatic, surgically resected patients, who are not on systemic therapy.
   c. Delay surveillance imaging (US, CT, FDG PET-CT, MRI) for 3 months for those who are clinically NED but on systemic adjuvant therapy.
   d. Defer therapeutic lymphadenectomy in the setting of clinically palpable regional nodes, offering neoadjuvant systemic therapy immune checkpoint blockade (ICB) or BRAFi/MEKi instead.
   e. The NCCN Melanoma Panel does not consider neoadjuvant therapy as a superior option to surgery followed by systemic adjuvant therapy for stage III melanoma, but available data suggests this is a reasonable resource-conserving option during the COVID-19 outbreak.
   f. Neoadjuvant considerations include
      i. higher-dose pembrolizumab (400 mg IV x 1-2 cycles every 6 weeks), two cycles of nivolumab (480 mg IV every 4 weeks), BRAFi/MEKi x 8 weeks followed by surgery, or two cycles ipilimumab 3/mg/kg and nivolumab 1 mg/kg (or ipilimumab 1 mg/kg and nivolumab 3 mg/kg) pre-operatively.
   g. Surgery should be performed 8-9 weeks after initiation of neoadjuvant therapy.
      i. Short-interval monitoring with imaging (ultrasound, if available, vs CT, FDG PET-CT) may be indicated. For patients with clinical and/or radiologic response, consider ongoing immunotherapy over surgery.

3. Metastatic resections (stages III and IV) should be deferred until after May 1 (Resource permitting) unless the patient is critical/symptomatic
   a. Patients should be continued on systemic therapy.

4. Stage III adjuvant therapy & Stage IV per management of Medical Oncology
Cardiovascular and Thoracic Service Line

Guiding Principles –

- Reduce patient traffic to our ambulatory and inpatient settings.
- Provide care that helps reduce patient utilization of our ED/UC/Hospital/PPE resources.
- Only perform services that are time sensitive in nature where the patient might experience serious or permanent harm if not performed.
- Physician discretion for care will be maintained at all times.

Ambulatory Setting

- Clinic
  - Routine care scheduled through the end of March would be postponed until after May 1st. Routine care would be defined as established patient follow up visits of 3 month increments or greater. All other visits will be triaged by the care team to determine need. Appropriate visits will be conducted via telephone and those that need to be seen in person will be contacted to determine their desire to come in.
  - Exception for CVT Surgery/Transplant where all patient visits will be evaluated individually to determine need.
    - Every Monday we will evaluate the current state with physician leadership via teleconference and make a decision about subsequent weeks one week at a time.

- EP Devices/Event Monitoring/Ambulatory BP Monitoring
  - All in person device checks should be changed to remote checks for the next 4 weeks.
  - Event and Ambulatory BP Monitoring should be scheduled for after May 1st.

- Imaging (Echo/CT/Nuclear/PET/Stress/Vascular US)
  - All routine imaging scheduled through the end of March will be postponed until after May 1st.
  - Any new studies to be performed would have to be designated as acute in nature and necessary to prevent ongoing harm to a patient if not performed.
  - CT Calcium Scoring should be discontinued at this time.
  - Echo School – In person learning to be discontinued until April 6th.
  - Vascular US
    - Limited to:
      - DVT Evaluation
      - Leg pain
      - Leg edema
      - Symptomatic/Critical Carotid disease
      - Limb Ischemia

- Anti-Coagulation Clinic
  - All in person visits should be changed to lab draws and phone management similar to the time when home meters were not available.
  - Anti-coag RNs would be considered for remote work as it is important to preserve this specialized resource.
Children’s Health

In an effort to minimize risk of exposure and spread of COVID-19, eliminating or delaying all non-essential visits, separating healthy neonates and infants from sick individuals, we are making the following operations changes to our pediatric clinic schedules EFFECTIVE IMMEDIATELY:

**Well Infant/Child/Adolescent Exams**
- All well child checks >15 months and older should be canceled immediately (and placed on reschedule list kept by individual clinic sites)
- All newborn and well child checks 0-15 months should be consolidated onto morning schedule only and eliminated from afternoon/evening schedules (except for COVID mom’s – refer to workflow below).

**Acute Illness Visits**
- All sick visits that are appropriate for office visits should be scheduled for afternoon/evening only.
  (Of note, all sick visits should be triaged by physicians to ensure appropriateness. When appropriate, patient should be guided to COVID-19 hotline, virtual visits, ED, and home care.)
- This will require you to call most patients to assess, gather updates, and provide care over the phone as appropriate.
- Please provide medication refills via a video/telephone visit at this time.

**Chronic Illness and Follow-up Visits and all other visit types**
Patients should be placed on "reschedule list" kept by individual clinic sites

**Pediatric Specialty Visits**
- Screen all patients for fever and cough prior to visit on reminder calls - reschedule anyone who has symptoms
- All follow-up should be done by telephone at the discretion of the physician if clinically appropriate – we will provide phone billing advice to the clinicians
- New patients should be called, treating physician will determine if these cases are urgent or can be rescheduled
- Surgical post op follow up visits should be a telephone visit and scheduled as an office visit if complication present

**Reschedule list kept by individual clinic sites**
Please do not reschedule canceled visits until further direction is provided

**COVID-19 hotline**
We have launched a COVID-19 hotline at **1-866-443-2584** where patients can call so we can help triage their care, better manage patient flow and prevent exposure. Patients will speak with one of our team members, who will ask about their symptoms and determine the best way to proceed with care, which can include assisting in scheduling an appointment or a virtual visit for further screening via our **LiveWell app**.
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 COVID19 test on newborn prior to discharge

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

Any Lactation Visits done by scheduled video visit

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

Aurora Children’s Health
Hospital Based Specialties Service Line - Hyperbaric Medicine and Wound Care

In an effort to help control the spread of COVID-19 and to ensure the safety of our patients, AAH leadership is requesting changes in patient care visits for at least the next two weeks.

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 that will not cause physical harm as a result of postponement should be temporarily delayed. The proposed reschedule recommendation is after the curve of contamination is contained. Since this is timeframe is unknown, clinical appointments should be minimized at least through the end of the month (March 31, 2020).

If it is believed that postponement of an appointment will cause physical harm, such as increased morbidity or threatened loss of limb, the patient may be scheduled. The frequency of appointments, however, should be decreased as much as possible.

Consider modifying patient treatment plans to ones that can be completed at home by the patient. (i.e. 1) discontinue compression wraps and transition to tubular compression stockinette, 2) temporarily suspend NPWT)

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

Possible additional opportunities for phone triaging and virtual patient care are being evaluated. Phone call or virtual care by clinicians could lessen the need for on-site visits for some patients.

**Inpatient/Outpatient Hyperbaric Medicine:**

All Hyperbaric Medicine Treatments that are able to be delayed or postponed without causing harm to the patient should be held. Understandably, 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.

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.

All patients who are receiving HBOT for any schedulable procedures (i.e. dental extractions) should have their treatments held until at least March 31, 2020. Again, this is provided that the patient’s outcome would not be negatively impacted.

Information and recommendations are actively changing. Please stay current with your email so you are aware of updates real-time. **We will be holding brief touch-base meetings for all HBO/WC clinicians.** They will occur on Mondays, Wednesdays and Fridays at noon to enhance communication for each of our sites and to answer questions. Please make every effort to attend.
Medical Specialties Service Line

Allergy

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:
  o Severe asthma
  o Severe urticaria/angioedema
  o 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:
  o Severe asthma
  o Severe urticaria/angioedema
  o Severe allergic reactions

Require Telephone/Telemed Visit

• Patient to use existing established relationships with current providers
• Patients referred for allergy testing
Dermatology

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
Endocrinology

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
Infectious Disease

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
- Fever of unknown origin – a physician referral
**Gastroenterology**

**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
Nephrology

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
Non-interventional Pain

**Existing Patient**

Require In-Office Visit

Physician to review patient list with team member and determine disposition

Require Telephone/Telemed Visit

Physician to review patient list with team member and determine disposition

**New Patients**

Same as above
Pulmonary Medicine

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
PM&R

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
Rheumatology

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
Neuroscience Service Line – Neurology, Neurosurgery, Interventional Pain

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

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.

Chiropractics

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.
Primary Care Service Line

Routine Exams:
In an effort to minimize exposure and decrease the risk of spread of Covid-19, we are going to be cancelling all nonessential clinic visits.

- This will include Medicare Wellness Visits, most Physicals and Routine follow ups.

We will continue to provide TCM visits and care for those patients with an acute problem that screen negative through the universal screening algorithm.

You will be provided a list of all of your scheduled patients for the next two weeks and your help is critical in determining which patients need to be seen and which can be rescheduled.

You may need to reach out to your patients by phone yourself to go over their clinical problems and make sure they are stable.

As you can imagine, our telephone triage RNs will be overwhelmed with our patients calling in with questions and concerns as their appointments are canceled, they will need your help in answering these patient’s questions.

Workflow:

The triage protocols for refills will be relaxed during this time to allow the RNs to refill medications that fall out of protocol because the visit was canceled.

As of now, we are asking that you go into the clinic and work out of your office to help with patient phone calls and any patient that needs to be seen. If you feel you need to work from home due to child care issues, etc. I ask that you work out a plan with your local management to make sure there is adequate patient coverage at your sites.

For now, the clinic schedules will be modified for 2 weeks and those patients will be held to be rescheduled at a later date, rescheduling them to 3 weeks out may result in having to move them again as this situation is changing daily.

Compensation and Billing:
The details of production compensation have not been worked out but the organization is committed to protecting the income of production based clinicians going forward.

There is an algorithm that is being developed currently by Dr. Winga on how to properly document and charge for a telephone visit. I ask that we hold on using that code for a few days while we decide what direction to go. I am concerned that those codes will go through but then be denied by insurance and balance billed to a patient. We need to ensure that our process related to those codes is in intact.
Video Visits:

Finally, I am overwhelmed by the outpouring of willingness to help and the desire to begin video visits.

The IT department and Dr. Winga are working as fast as they can to deploy video visit capability to all of you. This involves a software download and hardware to be delivered to you and then training must be done.

The status currently is that all of the Manitowoc county physicians who have been part of a video visit pilot are being trained today to help with the on-demand platform and will begin helping with on demand visits today.

Yes, you can bill and perform a video visit for routine medical problems and those visits are billed as a 99213 and 99214. We are working as fast as we can to get that capability to all of you, **please be patient**.

There will be a separate communication from Kevin Dahlman on the plans for pediatric patients, Family Practice clinicians will receive this communication as well.
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, teledem 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 Teledem 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, teledem if available)**
  - All new surgery patients could be seen via Teledem 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, telemed if available)**
  - 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)

<table>
<thead>
<tr>
<th>Category</th>
<th>Ideal Time To Surgery (TTS)</th>
<th>Possible clinical scenario</th>
<th>Non-Elective Surgery Triage (NEST) level</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency</strong></td>
<td>Immediate (within minutes)</td>
<td>Hemodynamic instability, for example:</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>‘Break-in’ to existing lists if required</td>
<td>- Bleeding traumatic emergencies&lt;br&gt;- GSW to the chest or abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within an hour</td>
<td>Viscus perforation, vascular compromise, sepsis, for example:</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></td>
<td></td>
<td>- Limb ischemia&lt;br&gt;- Diffuse peritonitis&lt;br&gt;- Soft tissue infection with sepsis&lt;br&gt;- Abdominal compartment syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent</strong></td>
<td>Within 4 hours</td>
<td>Extremity compartment syndrome</td>
<td>NEST 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ascending cholangitis&lt;br&gt;- Incarcerated hernia&lt;br&gt;- Cricotomies/ectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 12 hours</td>
<td>Bowel obstruction&lt;br&gt;- Localized peritonitis or soft tissue infection in need of surgery:</td>
<td>NEST 4</td>
<td>Repeat examinations while waiting for surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) Appendicitis&lt;br&gt;b) Abscess not accompanied with sepsis&lt;br&gt;- Open fractures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Semi-urgent</strong></td>
<td>Within 48 hours</td>
<td>Second look laparotomy&lt;br&gt;- 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>

Ophthalmology & Optometry - NEW

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/flashing 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.
Women’s Health Service Line - NEW

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. These visits will be deferred through April 24th.

When placing consult orders, please note, if a patient needs to be seen for referral prior to May 1st, please tag the ‘referral to’ order as STAT. Routine consults will be scheduled after May 1st.

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
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. MFM patients will continue to be seen with modifications as noted in the Ob/Gyn section above.
2. Provided there are no comorbidities, antepartum fetal surveillance for patients with ages over 40 and BMI over 40 may be deferred.
3. When antepartum fetal surveillance is needed, the frequency of the visits may be modified on a case by case basis.
4. Genetic counseling visits should be transitioned to phone/telehealth consultations.
5. 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. Cancelling all procedures at our fertility center and hospital moving forward until guidance is received from the CDC and Advocate Aurora Health
   - i. No vaginal ultrasounds, with the exception of pregnancy ultrasounds for the confirmation of intrauterine pregnancy status versus ectopic pregnancy
   - ii. No laboratory testing for fertility evaluations (e.g. semen analysis, hormonal assays)
   -   i. Laboratory evaluation will only be for those patients in early pregnancy.
   - iii. No intrauterine inseminations
   - iv. No office hysteroscopy
   - v. No hysterosalpinograms in the hospital.
   - vi. No hysterosonograms in the office
   - vii. Cancelling all frozen embryo transfer cycles
   - viii. Cancelling all egg retrievals, with the exception, of the patients currently in cycle in Green Bay (ending March 27, 2020) and patients with cancer requesting egg retrievals for 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
b. Our fertility centers in Green Bay, West Allis and Kenosha will be available Monday through Friday for men diagnosed with cancer wishing to undergo sperm freezing after they have undergone fertility preservation counseling by one of our physicians.

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 seen after April 10th.

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 to an appointment after April 10th.
   b. All pre cancer surveillance visits will be rescheduled to an appointment after April 10th.
   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 until after March 31st
   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 until April 10th.

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 until after April 10th.
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