Veterans Health Administration
Moving Forward Together
Safe Care is Our Mission

PRIORITIZATION FOR EXPANDING OUTPATIENT CONSULTATIONS, PROCEDURES, AND APPOINTMENTS, v4.0

Purpose: This document provides specific guidance across a range of specialty areas for prioritizing consultations, appointments, and procedures as facilities continue to expand clinical care throughout the ongoing COVID-19 pandemic. Chapters were developed by National Programs as a companion to the Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) CPRS COVID-19 Consult Toolbox (CTB) tabs that include requirements to aid in prioritizing scheduling and rescheduling of Veterans for episodes of care associated with Outpatient Consults during the COVID-19 pandemic. The COVID-19 CTB allows a standardized way for designated providers to communicate clinical triage needs for internal and community care consults and assist with prioritizing care delivery to all Veterans. Use of the COVID-19 tab is expected for consult management, with few exceptions as determined locally. For more information on the CTB, please visit the Office of Veterans Access to Care (OVAC) Consult Management page https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NA/ACAO/ConsultManagement/SitePages/Consult%20Toolbox.aspx

Language in the following chapters may vary for each specialty area and generally follows the priority categories below that are described in the CTB for receiving or revising a consult. Chapters also include prioritization of appointments and procedures that may not be driven solely by consults.

- **Priority 1 – Schedule despite COVID-19.** (Use when you anticipate decline or delays of care are likely to lead to harm to patients. For VA consults, clinicians should identify the date for scheduling.)
- **Priority 2 – For scheduling once authorized by clinical review.** (New patient visits for conditions with possible decline and for community care consult scheduling based on local market availability)
- **Priority 3 – Optional grouper, your department defines what this means.** (Routine clinical practices for care of complex chronic diseases, new or established. Postponing by months likely not to affect patient health status)
- **Priority 4 – Optional grouper, your department defines what this means.** (Less urgent than Priority 3. Substantial delays unlikely to lead to decline in health status (screening). Note: CTB verbiage cannot be changed to reflect local guidance issued by the department/clinical service for Priority 3 and 4.)

This guidance is posted on the VHA Integrated Clinical Community Prioritization folder on the HCI SharePoint, available at: https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/Moving%20Forward/Moving%20Forward%20Plan

When to Use: Prioritization for expanding outpatient consultations, procedures and appointments will vary by geographic location, based upon the epidemiology of the pandemic and the resources available to deliver care. For additional guidance related to transitioning back to full operation, please reference the following documents:

- Moving Forward Plan and it's supporting documents are found on the HCI SharePoint Moving Forward Folder
  - Moving Forward Plan: *Safe* Care is Our Mission
  - Moving Forward: *Guidance for Resumption of Procedures for Non-Urgent and Elective Indications*
  - Moving Forward: *Personal Protective Equipment (PPE) in the Ambulatory Care Setting*
  - *COVID-19 Testing in VHA*
  - *COVID-19 Screening in VHA*
- *Guidance for Urgent/Emergent Operating Room Procedures for COVID-19 Patients*
- *Medical Center & CBOC Cleaning Matrix*
- *Clinical Strong Practice (CSP): Types of Respirators and Masks Available in the Health Care Setting for COVID-19*

How to Use: Use in conjunction with Facility/VISN Surge Planning and Planning Updates. Planning considerations in this document should be used in conjunction with the Moving Forward Plan and subsequent guidance as referenced above addressing the continued engagement of safe access to care for both VA direct services and community care services, following the White House Guidelines for Opening Up America Again, as well as other VA guidance and Federal, state and local policies. This document provides guidance to providers and is not meant to substitute or replace clinical decision making by front-line staff.

Additional Considerations:

- Staff who are licensed by their state are encouraged to review their individual state licensure and registration requirements ensuring they follow the rules and regulations set forth by their state, to the extent that they do not interfere with their Federal duties.
- Consider levels of stress and fatigue in otherwise healthy workers. Workers returning to work following a COVID-19 infection may especially be at risk for physical and emotional exhaustion. Employee Support Resources has a range of content to support employees.

Document History Log

The Prioritizations for Consultations, Procedures and Appointments is a living document that will be updated to reflect new guidance and resources. Below is the Document History Log of changes.

Document Type	Revision Date	Description
Baseline Release (1)	05/13/2020	First draft release
Revision 2: All 1.0 chapters were reviewed for alignment with current national guidance referenced in the summary and POC added	05/22/2020	Sections Added: • Chiropractic Care • Nephrology • Nutrition • Physical Medicine & Rehabilitation (PM&R) and Rehabilitation Therapies • Sleep Medicine Sections Updated: • Cardiac Electrophysiologic (EP) Procedures • Cardiology Outpatient Clinics • Cardiology Procedures: Diagnostic and Interventional Invasive • Dental • GI Endoscopy
Revision 3: All 2.0 chapters were reviewed for alignment with current national guidance referenced in the summary	06/24/2020	Sections Added: • Acupuncture and Massage Therapy • Audiology • GeriPACT • Home Based Primary Care • Speech Pathology Sections Updated: • Summary: Consult Toolbox link update • Gynecology: Section 6 - Chaperone guidance added • Transplant Referral Guidance link added to following sections o Cardiology Outpatient Clinics o Hematology/Oncology Consults o Liver Disease o Nephrology o Pulmonary
Revision 4: All 3.0 chapters were reviewed for alignment with current national guidance referenced in the summary	09/01/2020	Sections Added: • Medical Foster Home and Community Residential Care Sections Updated: • Imaging: Radiology and Nuclear Medicine

Contents (titles hyperlinked to section)

Acupuncture and Massage Therapy Care Delivery

Last Updated: June 08, 2020

Questions on this chapter should be directed to the Integrative Health Coordinating Center: VHA OPCC&CT Integrative Health vhaopcctintegrativehealth@va.gov

- Moving forward plans will be influenced by many factors and should be done in consultation with facilities' incident command operations teams.
- Continue to consider and offer virtual options available through medical centers, however, in person care will be necessary for many Veterans.
- Recommend phasing in percentages of in person care over time to allow for adequate physical distancing and PPE.
- Judicious use of consults is important. In the case of chronic pain management, if there are consults that may overlap (i.e. acupuncture, chiropractic, massage therapy, physical therapy), we strongly encourage:
    - Whole Health approach to care https://www.va.gov/wholehealth/
    - Stepped-care approach to pain management https://www.va.gov/PAINMANAGEMENT/Providers/index.asp
- The following factors may be considered when prioritizing rescheduling of Veterans in VHA for in person acupuncture and massage therapy. Clinical priority decisions should be made by qualified providers.*Within each priority group, oldest CID date should be scheduled first.

1. **COVID-19 Priority 1** – when facilities resume in person scheduling, make appointments for priority 1 patients first. They should be appointed first based on CID.
    1.1. Acute pain or condition resulting in significant functional impairment and in person visit could avoid ED visit or hospitalization
2. **COVID-19 Priority 2** – after priority 1 patients are situated, priority 2 should be scheduled. Departments may define criteria for priority 2 vs 3 as they see fit as is clinically appropriate.
    2.1. Chronic pain with exacerbations and/or condition resulting in functional impairment; in whom delay of care increases physical/mental health risks
    2.2. Self-care ineffective or not prescribed; Desire to maximize non-pharmacologic options;
    2.3. Visit could offset urgent care or PCP visit
3. **COVID-19 Priority 3** – after priority 2 patients are situated, priority 3 should be scheduled.
    3.1. Patients > 69 years old, patients with significant cardiovascular disease, uncontrolled DM or chronic respiratory disease with chronic, stable pain (effort to minimize exposure to this high-risk population if possible)
    3.2. Chronic pain with no recent progression; Using self-care strategies
    3.3. Group treatments*

**In certain circumstances in person group treatments may be considered. Proper physical distancing and hygiene practices must be incorporated. Consider decreasing the number of participants to meet room size and additional practitioner demands. Site specific guidance for group treatment should also be followed.*

Allergy Medical Service Outpatient Clinic and Procedures

Last updated: May 5, 2020

Questions on this chapter should be directed to Dr. Joe Yusin, Chair of the VHA Field Advisory Committee on Allergy and Immunology at Joseph.Yusin2@va.gov

1. Restoration of Clinic Visits
   Patients most suitable for in person visits include those with asthma, urticaria, moderate sinusitis/nasal polyp disease/idiopathic anaphylaxis, CVID and other immunodeficiency, angioedema and atopic dermatitis. Rhinitis patients will continue telephone or VVC. Note in person visits will be determined by the allergist/immunologist. Telephone Visits and VVC visits will continue, ultimate decision regarding type of visit will be from chief allergist immunology at the specific VA center. Please see tables below for suggestions for phased restarting of allergy appointments.

2. Procedure Priorities
   Begin with least invasive procedures: e.g., patch testing, skin testing, medication challenges. Avoid procedures requiring spirometry and nebulization at this time, unless deemed urgent. If urgent and if procedure requires pulmonary function testing and or nebulization, patient and staff will need to follow testing recommendations for SARS-CoV-2 per *Guidance for Resuming Procedures for Non-Urgent and Elective Indications*

3. Allergen Injections
   Allergen Immunotherapy: Will continue to spread out visits, exact plans will vary among centers, some centers have stopped environmental allergen immunotherapy vs others (the majority) have spread out the visits. Example as follows:

4. Decrease interval Schedule: monthly maintenance decreasing to every 2 months, on maintenance patients less than monthly injections go to once monthly injections, patients on build-up, keep with current dose or decrease as needed and go to monthly injections, no starting of new allergen immunotherapy patients

5. **Biologics**:
   5.1 Approved anti IL5 and dupilumab injections at home will continue (all FDA approved)
   5.2 Omalizumab: option to receive at home injections will continue as an option for patients.

Outpatient encounter	Re-establishing operations: Phase 1		
	In person visit	Telephone visit	VVC visit
Clinic visit: outpatient	Patient with active disease that would benefit from in person visit over telephone or VVC Active Disease: asthma, urticaria, moderate sinusitis/nasal polyp disease/idiopathic anaphylaxis, CVID and other immunodeficiency, angioedema, atopic dermatitis	Available	Available for those patients interested
Pulmonary function testing During Visits	COVID-19 testing and screening per protocol prior to PFT	N/A	N/A
Skin Testing for Aeroallergens and Foods	On Hold, replaced by IgE blood testing	N/A	N/A
Patch Testing	Plan to Increase number: i.e. less urgent add as well. decision by provider	N/A	N/A
Penicillin Skin Testing	Urgent cases only (i.e. use of penicillin/beta lactam ab required)	N/A	N/A
Drug/Medication Skin Testing	Urgent cases only (i.e. use of penicillin/beta lactam ab required)	N/A	N/A
ASA Desensitivation	Urgent cases only: patient needs prescreening for COVID-19 since PFT and nebulization required for procedure	N/A	N/A
Medication Challenges	Medication Challenges on hold unless urgent need for medication at the time of testing	N/A	N/A
Food Challenges			
Nebulization Tx	On Hold (if needed refer to ER/Urgent Care vs. Give Patient albuterol MDI)	N/A	N/A
Anti IL5 agents: Mepolizumab, Benralizumab	continue self-administration patient can receive in clinic if unable to self-administer	N/A	N/A
Dupilumab	continue self-administration patient can receive in clinic if unable to self-administer		
Omalizumab	continue self-administration patient can receive in clinic if unable to self-administer	N/A	N/A
IVIG	continue gamma globulin treatment at infusion center	N/A	N/A
Allergen Immunotherapy (aeroallergens and venom imtx)	Continue to have imtx reduction as stated prior with following exceptions: 1. venom hypersensitivity: initiate imtx recommended 2. aeroallergen imtx patients: can be discussed on case by case basis with majority continuing imtx reduction 3. no new allergen environmental allergen immunotherapy, same as prior	N/A	N/A
Consults: Inpatient	plan to most inpatient consults: Appropriate PPE as indicated	can consider	can consider
	canceled due to close contact with tech and patient		

Outpatient encounter	Re-establishing Operations: Phase 2		
	In person visit	**Telephone visit**	**VVC visit**
Clinic visit: outpatient	most patients	follow up patients with controlled illness: i.e. allergic rhinitis. Noted illness listed as "active" should be seen in clinic unless telephone visit or VVC preferred by patient and condition is controlled	recommendation of VVC visits over Telephone visits
Pulmonary function testing During Visits	resume as prior	N/A	N/A
Skin Testing for Aeroallergens and Foods	skin testing preferred over IgE testing	N/A	N/A
Patch Testing	resume patch testing similar to pre COVID-19	N/A	N/A
Penicillin Skin Testing	resume penicillin skin testing similar to pre COVID	N/A	N/A
Drug/Medication Skin Testing	resume drug/medication skin testing similar to pre COVID	N/A	N/A
ASA Desensitivation	resume ASA desensitization testing similar to pre COVID	N/A	N/A
Medication Challenges	resume medication challenges similar to pre COVID		
Food Challenges	resume food challenges similar to pre COVID		
Nebulization Tx	resume nebulizer tx similar to pre COVID	N/A	N/A
Anti IL5 agents: Mepolizumab, Benralizumab	continue in home use unless administration in clinic preferred by patient	N/A	N/A
Dupilumab	continue in home self-administration use unless administration in clinic preferred by patient		
Omalizumab	administration in clinic not at home		
IVIG	continue gamma globulin treatment at infusion center		
Allergen Immunotherapy (aeroallergens and venom imtx)	Resume Allergen Immunotherapy similar to pre-COVID. New patient can now be started on allergen immunotherapy		
Consults: Inpatient	plan to see all inpatient consults: Appropriate PPE as indicated	N/A	N/A
	Re-establishment of Telehealth Services		

Audiology Care Delivery

Last updated: May 27, 2020

Please direct questions on this chapter to Dr. Rachel McArdle, National Program Director for Audiology and Speech Pathology at: Rachel.McArdle@va.gov

1. Contact patients who are being/have been cancelled and not already triaged, contacted or rescheduled.
2. Triage and define Risk Priority level via phone interview with Veteran.
3. The descriptions in the table below are suggestions but do not exercise authority over clinical decision making or local medical facility protocols.
4. When triaging, consider virtual modalities to provide requested care.

Priority	Description
Risk Priority 1: Make appointment now, despite COVID-19 crisis.	Urgent and emergent conditions: 1. Sudden loss of hearing 2. Ototoxic monitoring 3. Pre-op/Post-op testing 4. Cochlear implant patients with no working devices 5. Sudden onset of debilitating vertigo (per facility protocols) 6. New onset of persistent tinnitus or debilitating tinnitus 7. Object stuck in ear (per facility protocols) 8. Employee hearing conservation screenings
Risk Priority 2: Wait until normal scheduling resumes, and then make appointments for priority 2 patients first. They should be appointed first based on CID.	Other conditions that warrant timely care: 1. Initial hearing aid fittings for new patients 2. New cochlear implant evaluations 3. Hearing aid aftercare for those without functioning spare hearing aids (for those who cannot do VVC) 4. Cochlear implant patients with only one functioning device 5. New patients requesting hearing evaluation 6. Required pre-employment hearing testing for Veterans
Risk Priority 3: After priority 2 patients are situated, priority 3 should be scheduled.	1. Established patient requesting hearing evaluation 2. Hearing aid aftercare (for those who cannot do VVC)
Risk Priority 4: After priority 3 patients are situated, priority 4 should be scheduled.	1. Auditory Processing Disorder evaluations 2. Neurodiagnostic testing and vestibular assessment/rehabilitation 3. Tinnitus treatment individual or groups (for those who cannot do VVC) 4. Audiologic Rehabilitation individual or groups (for those who cannot do VVC)

Cardiac Electrophysiologic (EP) Procedures

Last updated: April 23, 2020

Please direct questions on this chapter to Dr. Richard Schofield, National Program Director for Cardiology at: Richard.Schofield@va.gov

The VHA National Cardiology Program presents the following framework as a suggested guide for prioritization of Cardiac Catheterization Laboratory-based invasive cardiac electrophysiologic procedures as operations return closer to normal after the initial phase of the COVID-19 pandemic. For many reasons, it is critically important that in any individual patient, a procedure may not fit in the priority level listed in this document and clinicians should individualize decisions on the priority of care for each patient.

1. **COVID-19 Priority 1** – Emergent or Urgent Cardiac Electrophysiology (EP) procedures that should be performed despite the COVID-19 pandemic (including consuming PPE) due to unacceptable risk of patient harm in the event of delay:
   - 1.1. Temporary and permanent pacemaker implantation for patients with severe symptoms and/or high risk bradyarrhythmia's
   - 1.2. EP study and catheter ablation of ventricular tachycardia (VT) for VT storm or VT not responding to antiarrhythmic drug therapy
   - 1.3. Atrial fibrillation (AF), atrial flutter (AFL), or atrioventricular (AV) nodal ablation if hemodynamically significant, severely symptomatic, drug and/or cardioversion refractory
   - 1.4. EP study and catheter ablation of Wolff-Parkinson White syndrome or pre-excited AF with syncope or cardiac arrest
   - 1.5. Implantation of an implantable cardioverter-defibrillator (ICD) for secondary prevention of VT or ventricular fibrillation (VF) not due to a reversible cause
   - 1.6. Cardiac implantable electrophysiology device (CIED) pulse generator replacement approaching or beyond end of life (EOL) in a patient with high risk due to pacemaker dependency or need for tachyarrhythmia therapies.
   - 1.7. Cardiac resynchronization therapy (CRT) implantation for severe refractory heart failure
   - 1.8. CIED lead and pulse generator extraction for infection
   - 1.9. DC cardioversion of AF or AFL associated with either hemodynamic instability, congestive heart failure, or rapid ventricular response not adequately responsive to medical therapy.

2. **COVID-19 Priority 2** – Urgent or Time-sensitive EP procedures that should be prioritized as soon as safely possible
   - 2.1. EP study and catheter ablation of symptomatic supraventricular tachycardia (SVT) and atrial flutter not meeting criteria for ablation in Priority 1
   - 2.2. EP study and catheter ablation of symptomatic VT not meeting criteria for urgent/emergent ablation in Priority 1
   - 2.3. EP study and/or implantable loop recorder (ILR) placement for syncope of suspected arrhythmic etiology

2.4. Cardiac resynchronization therapy (CRT) implantation for symptomatic heart failure, reduced LVEF, and wide QRS (Class I or IIa indications) not meeting criteria in Priority 1
2.5. ICD implantation for VT induced at the time of EP study

3. **COVID-19 Priority 3** – Elective/time-sensitive procedures of higher priority than Priority
   3.1. Primary prevention ICD or permanent pacemaker implantation in patients with Class I or II indications not otherwise addressed in Priority 1 or Priority 2
   3.2. EP study and catheter ablation for premature ventricular complexes (PVCs) associated with symptoms or cardiomyopathy
   3.3. Catheter ablation of AF in patients who have symptomatic AF and have failed at least one antiarrhythmic drug
   3.4. Elective lead extraction to facilitate CIED system upgrade
   3.5. CIED pulse generator replacement for patients at the elective replacement interval not meeting criteria for Priority 1
   3.6. DC cardioversion for AF or atrial flutter not meeting criteria for Priority 1

4. **COVID-19 Priority 4** – Elective procedures of priority lower than Priority 3
   4.1. Left atrial appendage occlusion
   4.2. Catheter ablation of AF in patients who desire ablation before attempted antiarrhythmic drug therapy
   4.3. EP study and catheter ablation with indications not meeting criteria for Priority 3
   4.4. CIED implantation for indications not meeting criteria for Priority 3
   4.5. CIED pulse generator pocket modification for discomfort and/or mechanical issues
   4.6. Tilt table testing for evaluation of syncope

Operational Considerations in EP Cardiology:
With the outbreak of COVID-19, consideration should be given to the flow of air through the Electrophysiology Laboratory in each institution. Sites should work with their infection control and facilities management teams in order to understand where the air comes from, how it is filtered and where it goes once it leaves the procedure room. This should guide plans for care in each institution. A second consideration is to avoid aerosolizing procedures such as intubation and transesophageal echocardiography in the Electrophysiology Laboratory. Plans should be made locally to determine the best place to perform such procedures.

It would be reasonable to move toward a normalization of EP procedure care to include procedures in Priorities 2, 3, and 4 in a stepwise fashion after the initial COVID-19 surge, and when appropriate as detailed in the *Guidance for Resuming Procedures for Non-Urgent and Elective Indications*

Cardiology Outpatient Clinics

Last updated: April 23, 2020

Please direct questions on this chapter to Dr. Richard Schofield, National Program Director for Cardiology at: Richard.Schofield@va.gov

1. **COVID-19 Priority 1**: appointment should be made now, despite COVID-19 crisis
   - 1.1. Known heart disease with acute worsening of symptoms that cannot be evaluated by, or that failed to improve with, virtual care visits. Examples might include:
     - 1.1.1. Worsening chronic heart failure (NYHA class II-IV)
     - 1.1.2. Worsening chronic angina (CCS III) despite titration of anti-anginal therapies
     - 1.1.3. Worsening or recurrent symptomatic cardiac arrhythmias
     - 1.1.4. Known moderate-severe valvular heart disease with new or worsening symptoms
   - 1.2. Patients with no prior cardiac history but concerning cardiac nature of symptoms, and/or abnormal/high risk noninvasive cardiac testing
     - 1.2.1. High risk cardiac stress testing
     - 1.2.2. Newly depressed Left Ventricular ejection fraction
     - 1.2.3. Atrial arrhythmias with rapid ventricular response
     - 1.2.4. Symptomatic or frequent non-sustained ventricular tachycardia
     - 1.2.5. New anginal chest pain with intermediate to high pretest probability for coronary artery disease
     - 1.2.6. New onset syncope with malignant features, suspected cardiac in nature
2. **COVID-19 Priority 2**: wait until normal scheduling resumes, and then make appointments for priority 2 patients first. The timing of appointment should be based on clinical judgement of the Cardiology consult reviewer.
   - 2.1. New patient referrals with stable cardiovascular symptoms, and/or with noninvasive cardiac testing without features of high risk
     - 2.1.1. Moderate risk cardiac stress testing
     - 2.1.2. Moderately severe valvular heart disease
   - 2.2. Symptomatic chronic angina or heart failure (NYHA class III-IV) with stable symptoms
   - 2.3. Asymptomatic severe valvular heart disease
   - 2.4. Asymptomatic or mildly symptomatic patients with non-life-threatening cardiac arrhythmias (e.g. atrial arrhythmias without rapid ventricular response, NSVT without features of high risk)
   - 2.5. Undetermined syncope
   - 2.6. Severe pulmonary hypertension with stable symptoms
3. **COVID-19 Priority 3:** these patients should be scheduled after priority 2 patients, with the timing of appointment based on clinical judgement of the Cardiology consult reviewer.
   - 3.1. Patients wishing to transfer care who are otherwise stable with outside providers
   - 3.2. Asymptomatic patients with known chronic cardiovascular disease of a non-critical nature
     - 3.2.1. Mild valvular heart disease
     - 3.2.2. Mild heart failure
     - 3.2.3. Known or suspected CAD with mildly abnormal cardiac stress testing

3.2.4. Atrial arrhythmias without rapid ventricular response, or symptoms
3.2.5. Mildly abnormal findings on echocardiography
3.3. Anything not Priority 1 or 2.

NOTE: For Veterans requiring heart transplant referral, evaluation and/or transplant procedure, including at community transplant centers, a referral must be submitted to a VA Transplant Center through TRACER. Link to TRACER: https://vaww.tracer.nso.med.va.gov.

Guidance for transplantation care in community, see Guidance transplantation through Community Care, released by Office of Community Care on 6/17/19: http://vaww.dushom.va.gov/DUSHOM/surgery/docs/Guidance_for_Transplantation_through_Community_Care.pdf.

Transthoracic Echocardiography (TTE)

1. **COVID-19 Priority 1:** appointment should be made now, despite COVID-19 crisis
   1.1. Inpatients with known or suspected cardiovascular disease, in whom echo findings will change clinical management
   1.2. Inpatients or outpatients with known or suspected cardiovascular disease, in whom echo findings are necessary to make a decision for urgent surgical procedures
2. **COVID-19 Priority 2:** wait until normal scheduling resumes, and then make appointments for priority 2 patients first. The timing of appointment should be based on clinical judgement of the Cardiology reviewer.
   2.1. Outpatients with known or suspected cardiovascular disease, with active cardiac symptoms, in whom echo findings will change clinical management
3. **COVID-19 Priority 3:** these patients should be scheduled after priority 2 patients, with the timing of appointment based on clinical judgement of the Cardiology reviewer.
   3.1. Outpatients with known or suspected cardiovascular disease, without symptoms

NOTE: There are concerning reports of COVID-19 transmission to sonographers who perform TTE procedures on patients with either known COVID-19 infection, or unknown COVID-19 status who subsequently test positive for COVID-19. Review the *Guidance for Resuming Procedures for Non-Urgent and Elective Indications for testing and PPE recommendations.*

Transesophageal Echocardiography (TEE)

1. **COVID-19 Priority 1:** appointment should be made now, despite COVID-19 crisis
   1.1. Inpatients with life-threatening cardiovascular conditions, in whom the findings of TEE will substantially change clinical management
2. **COVID-19 Priority 2:** wait until normal scheduling resumes, and then make appointments for priority 2 patients first. The timing of appointment should be based on clinical judgement of the Cardiology consult reviewer.
   2.1. Outpatients with urgent cardiovascular conditions, in whom the findings of TEE would substantially change clinical management
3. **COVID-19 Priority 3:** these patients should be scheduled after priority 2 patients, with the timing of appointment based on clinical judgement of the Cardiology reviewer.

NOTE: TEE involves high risk for generation of aerosolized droplets and high risk for transmission of COVID-19 by asymptomatic patients. Review the *Guidance for Resuming Procedures for Non-Urgent and Elective Indications for testing and PPE recommendations.*

Cardiac Stress Testing

1. **COVID-19 Priority 1:** appointment should be made now, despite COVID-19 crisis
   1.1. Inpatients with known or suspected cardiovascular disease, with active symptoms, in whom findings of stress testing would change clinical management

2. **COVID-19 Priority 2:** wait until normal scheduling resumes, and then make appointments for priority 2 patients first. The timing of appointment should be based on clinical judgement of the Cardiology reviewer.
   2.1. Outpatients with known or suspected cardiovascular disease, with active symptoms, in whom findings of stress testing would change clinical management

3. **COVID-19 Priority 3:** these patients should be scheduled after priority 2 patients, with the timing of appointment based on clinical judgement of the Cardiology reviewer.
   3.1. Outpatients with known or suspected cardiovascular disease, without active symptoms, in whom findings of stress testing may change clinical management

NOTE: In patients with known or suspected COVID-19 infection, exercise cardiac stress testing (treadmill, bicycle, or supine) should not be performed due to high risk for aerosolization and subsequent COVID-19 transmission. In these situations, or when COVID-19 status is unknown, patients should undergo pharmacologic cardiac stress testing with nuclear imaging.

Cardiology Procedures: Diagnostic and Interventional Invasive

Last updated: April 23, 2020

Please direct questions on this chapter to Dr. Richard Schofield, National Program Director for Cardiology at: Richard.Schofield@va.gov

The VHA National Cardiology Program presents the following framework as a suggested guide for a possible prioritization of Cardiac Catheterization Laboratory-based diagnostic and interventional invasive cardiac procedures as operations return closer to normal after the initial phase of the COVID-19 pandemic. For many reasons, it is critically important that in any individual patient, a procedure may not fit in the priority level listed in this document and clinicians therefore should individualize decisions on the priority of care for each patient.

1. **COVID-19 Priority 1** – Diagnostic and interventional invasive cardiology procedures that should be performed despite the COVID-19 pandemic (including consuming PPE) due to unacceptable risk of patient harm in the event of delay:
   - 1.1. Acute coronary syndromes
     - 1.1.1. ST-segment elevation myocardial infarction (STEMI)
     - 1.1.2. Non-ST-segment elevation myocardial infarction (non-STEMI)
     - 1.1.3. Unstable angina
   - 1.2. Sudden cardiac arrest
     - 1.2.1. Ventricular fibrillation
     - 1.2.2. Ventricular tachycardia
   - 1.3. Heart failure
     - 1.3.1. Endomyocardial biopsy for suspected allograft rejection in patients with heart transplantation
   - 1.4. Structural heart disease
     - 1.4.1. Transcatheter aortic valve replacement (TAVR) in symptomatic patients with mean aortic valve gradient > 55 mmHg
     - 1.4.2. Repair of paravalvular leak in patients with symptomatic heart failure
   - 1.5. Post-surgical complications in patients following cardiac surgery
     - 1.5.1. Post-CABG complications
     - 1.5.2. Post-valve repair/replacement complications
   - 1.6. Cardiac tamponade
   - 1.7. Peripheral vascular disease
     - 1.7.1. Acute limb ischemia
   - 1.8. Thromboembolic venous disease
     - 1.8.1. Acute pulmonary embolus with hemodynamic compromise

2. **COVID-19 Priority 2** – Non-urgent, but time-sensitive procedures that should be prioritized as soon as safely possible
   - 2.1. Stable ischemic heart disease
     - 2.1.1. Known or suspected symptomatic coronary artery disease with high risk cardiac stress test
     - 2.1.2. Known symptomatic coronary artery disease with high risk lesions but stable symptoms (e.g. left main CAD)
   - 2.2. Heart failure

2.2.1. Coronary angiography in patients with newly depressed LV ejection fraction
2.2.2. Endomyocardial biopsy in patients with acute onset unexplained heart failure
2.2.3. Right heart catheterization in patients with symptomatic heart failure and uncertain volume status; or with moderate to severe symptomatic pulmonary HTN

2.3. Structural heart disease
2.3.1. TAVR for symptomatic aortic stenosis
2.3.2. MitraClip for symptomatic mitral regurgitation
2.3.3. Repair of paravalvular leak in patients without heart failure

2.4. Peripheral vascular disease
2.4.1. Carotid stenting in symptomatic carotid stenosis
2.4.2. Peripheral vascular interventions for patients with chronic limb ischemia (Rutherford 4-6)

3. **COVID-19 Priority 3** – Elective procedures to be scheduled after completion of Priority 1 & 2 procedures

3.1. Stable ischemic heart disease
3.1.1. Patients with angina, and abnormal/positive stress testing, but no features of high risk
3.1.2. Patients with angina and known CAD, for staged elective percutaneous intervention
3.1.3. Coronary angiography in patients requiring pre-transplant evaluation for non-cardiac organ transplantation
3.1.4. Coronary angiography in patients requiring pre-operative evaluation prior to non-cardiac surgery

3.2. Heart failure
3.2.1. Right heart catheterization in patients with stable chronic heart failure
3.2.2. Surveillance endomyocardial biopsy in patient's s/p cardiac transplantation
3.2.3. CardioMEMS procedures for placement of pulmonary artery pressure sensors to monitor stable chronic heart failure

3.3. Structural heart disease
3.3.1. Elective closure of patent foramen ovale or atrial septal defect

3.4. Surgical
3.4.1. Elective placement of pre-operative intra-aortic balloon pump in patients planned for elective cardiac surgery, when IABP could be placed at bedside or in OR

3.5. Peripheral vascular disease
3.5.1. Carotid stenting in asymptomatic carotid stenosis
3.5.2. Peripheral vascular intervention in patients with chronic limb ischemia (Rutherford 1-3)

Operational Considerations in Interventional Cardiology:
With the outbreak of COVID-19 19, consideration should be given to airflow in the Cardiac Catheterization Laboratory, which is normally a positive airflow procedural area. Sites should work with their infection control and facilities management teams in order to understand where the airflow originates, how it is filtered and where it exits once it leaves the procedure room. This should guide plans for care in each institution, in particular any local decision to reverse airflow to make the procedural suite negative air pressure. A

second consideration is to avoid aerosolizing procedures such as intubation and transesophageal echocardiography in the Cardiac Catheterization Laboratory. Plans should be made locally to determine the best place to perform such procedures.

It would be reasonable to move toward a normalization of diagnostic and interventional procedure care beyond Priority 1 to include procedures in Priorities 2, and 3 in a stepwise fashion after the initial COVID-19 surge, and when appropriate as detailed in the *Guidance for Resuming Procedures for Non-Urgent and Elective Indications*

Chiropractic Care Delivery

Last Updated: May 21, 2020

Please direct questions on this chapter to the Chiropractic Program Office at: Anthony.lisi@va.gov

1. **COVID-19 Priority 1** – Urgent cases where a chiro visit could substitute for an ED visit
   1.1. Acute MSK conditions where a chiro visit could avoid ED visit or hospitalization
   1.2. Cases where it is determined that prompt in person follow-up is indicated based on a chiro telehealth visit

2. **COVID-19 Priority 2** – Should be done as soon as we are able to schedule non-urgent cases - Veteran with functional impairment where a chiro visit could substitute for an urgent care or PCP visit
   2.1. Acute MSK conditions where a chiro visit could avoid urgent care or PCP visit
   2.2. Patients with significant functional impairment due to MSK conditions, and desire to maximize non-pharmacological management
   2.3. Patients where MSK self-care options have not been prescribed or are ineffective

3. **COVID-19 Priority 3** – Routine cases that are less time sensitive than Priority 2 - all other consults/appointments
   3.1. Chronic MSK conditions with no substantial recent progression
   3.2. Patients with mild-moderate functional impairment due to MSK conditions, and desire to maximize non-pharmacological management
   3.3. Patients where MSK self-care options have been prescribed and are somewhat effective

NOTE: Priority 1 will vary based on the capacity and infection control measures in place at the point of chiropractic service delivery. Generally, Veterans in any Priority should be contacted to assess patient risk factors and clinical need for services, and initially offered virtual care if clinically appropriate.*

**Assessment of risk should include consideration of factors know to relate to more severe illness in coronavirus infections. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html*

Dental Care Delivery

Last Updated: May 22, 2020

Please direct questions on this chapter to the National Dental Program Office at: vha10nc7action@va.gov

Introduction

The VA suspended elective dental care to aid physical distancing to flatten the peak incidence of active COVID-19 cases. Since the majority of dental procedures are aerosol-generating and dental service staff work within the droplet zone, the Occupational Safety and Health Administration (OSHA) places Dental Health Care Professionals at the very high risk of exposure to COVID-19. They must utilize the highest level of PPE practical. When the supply chain for appropriate PPE and disinfectants has rebounded, and COVID-19 testing is available, VA dental services should resume providing elective dental care.

This chapter offers guidelines and recommendations to help local facilities plan for resumption of elective dental care. It is a harmonization of guidelines and recommendations published by the American Dental Association, American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, American Hospital Association, Centers for Medicare Services, Centers for Disease Control, and the VA.

The COVID-19 pandemic is dynamic. The guidance for resuming elective dental procedures utilized the best available evidence when the document was written.

Dental Care Prioritization

The decision to increase operational capacity requires VISN Lead Dentist and Facility Dental Service Chief consultation with facility leadership and the Logistics Service to review:

- Local, regional, and national epidemiological trends.
- The availability of appropriate PPE as defined by the VA, CDC and OSHA.
- Testing availability.
- Existing engineering controls such as air exchanges.

During development of the local prioritization process, please refer to the table at the end of this chapter, and consider the following:

1. Environmental Considerations
   1.1. Treatment room turn-around and facility cleaning policies. Cleaning, in all areas, along the continuum of care should be addressed (e.g., clinic, x-ray areas, dental laboratories, dental equipment, waiting areas, restrooms, etc.), and be in alignment with VA's Moving Forward Together Plan.
   1.2. OR availability and expansion. Strategy for allotting daytime "OR time"—block time, revised blocks, prioritization, other.

2. Scheduling Considerations
   2.1. Scheduling cases according to priority.

2.1.1.1. Grouping similar cases together to increase scheduling efficiency. For example, provide similar dental procedures such as endodontics in the same room or aerosol-generating procedures later in the day.

2.2. List of previously canceled/postponed cases.

3. Procedural Considerations
   3.1. Integrate digital technology for impression taking where possible to reduce dental clinic/lab bioburden.
   3.2. The prioritization process and criteria may vary in real-time according to institutional resources, capabilities, business priorities, and other issues. Issues in question should be evaluated in concert with local leadership.
   3.3. Prioritization criteria will likely be modified as our knowledge of diagnosis and treatments of COVID-19 evolve, and as more COVID-19-related dental outcome data become available.
   3.4. Establish a dental review-governance committee to review such issues as the process of prioritization.
   3.5. Defer according to dental specialties' as needed in the prioritization of care.
   3.6. Dental Service capacity for usual levels of emergency care, trauma care, and others
   3.7. Potential sites for resuming elective dental care, including those facility areas that were converted or closed during the surge, such as Community Based Outpatient Clinics.
   3.8. Strategy for the phased opening of the dental service to ensure that a post-COVID-19 elective dental care surge will not overwhelm the local facility. (see table below)
      3.8.1. Over-booking patients should not be considered at this time
   3.9. Other areas of the hospital that support Dental Services must be ready to commence operations, including Logistics, Clinical Laboratory, Pharmacy, and Sterile Processing Services (SPS).
   3.10. Ensure primary personnel availability is commensurate with increased dental service volume and dental service hours (e.g., dentist, dental hygienist, dental assistant, housekeeping, engineering, SPS, etc.)
   3.11. Ensure adjunct personnel availability (e.g., pathology, laboratory, pharmacy, other)
   3.12. Ensure facility and vendor support for supply availability (e.g., PPE, medications, dental supplies)

4. The resumption of elective dental care utilizes a phased approach to dental care combined with levels of operational capacity. The phased approach to care, as outlined in the table below, follows widely accepted treatment planning approaches taught in most dental schools, and consists of:
   4.1. Acute Phase
   4.2. Disease Control Phase
   4.3. Definitive Phase
   4.4. Maintenance Phase

5. In addition to National VA Guidance on PPE, Testing, and Environmental Cleaning, the following should be considered at each phase:

5.1. Use of the lightest touchpoint communication style first to include TeleDentistry, My HealtheVet, telephone consults, etc.
5.2. Screen patients 24-48 hours before the dental appointment as recommended by the American Dental Association (ADA) and the CDC.
5.3. Utilization quality improvement programs/care standards to help support achieving safe, high-quality, high-value patient care.
5.4. Documentation of COVID-19 questions asked responses received, temperature readings, titles of everyone involved in the care provided and the type of PPE worn.
5.5. Use of risk-adjusted data to evaluate patient care and outcomes.
5.6. Treatment decisions based on clinical judgment and known facts, combining:
    5.6.1. Patient health/risk factors/geographic incidence of COVID-19.
    5.6.2. Procedural requirements/clinical risks (production of aerosol, inducement of patient cough during the procedure, ability to employ the use of rubber dam.)
    5.6.3. Availability of PPE with relation to risk using COVID-19 testing results and adherence to PPE use guidelines.
    5.6.4. ADA Interim Mask and Face Shield Guidelines
    5.6.5. Understanding Mask Types
    5.6.6. No documented evidence exists at this time to support the pre-procedural rinses to reduce the transmission of the COVID-19 virus, but certain rinses such as 1% hydrogen peroxide may reduce the levels of bacterial and viral load.
5.7. Use professional judgment to employ the lowest aerosol-generating armamentarium when delivering any type of restorative or hygiene care.
    5.7.1. As an example, use hand scaling rather than ultrasonic scaling when appropriate.
    5.7.2. High-velocity evacuation should be employed whenever possible.
5.8. If using nitrous oxide: use disposable nasal hood; tubing should either be disposable or, if reusable, sterilized according to the manufacturer's recommendations.
5.9. After removing PPE, refer to the ADA's Hand Hygiene for the Dental Team.

The table below lists the types of care for each phase.

Resumption of Elective Dental Care					
	Operational Capacity (average encounters per day)				
	Contingency Operations	Phase 1 25%	Phase 2 50%	Phase 3 75%	Phase 4 100%
I. Acute Phase (as defined by the ADA)					
a. Dental emergencies are potentially life threatening and require immediate treatment to stop ongoing tissue bleeding, alleviate severe pain or infection, and include:	X	X	X	X	X
i. Uncontrolled bleeding	X	X	X	X	X
ii. Cellulitis or a diffuse soft tissue bacterial infection with intra-oral or extra-oral swelling that potentially compromise the patient's airway	X	X	X	X	X
iii. Trauma involving facial bones, potentially compromising the patient's airway	X	X	X	X	X
b. Urgent dental care focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments. These should be treated as minimally invasively as possible.	X	X	X	X	X
i. Severe dental pain from pulpal inflammation	X	X	X	X	X
ii. Pericoronitis or third-molar pain	X	X	X	X	X
iii. Surgical post-operative osteitis, dry socket dressing changes	X	X	X	X	X
iv. Abscess, or localized bacterial infection resulting in localized pain and swelling	X	X	X	X	X
v. Tooth fracture resulting in pain or causing soft tissue trauma	X	X	X	X	X
vi. Dental trauma with avulsion/luxation	X	X	X	X	X
vii. Consults and dental treatment required before critical medical procedures	X	X	X	X	X
viii. Final crown/bridge cementation if the temporary restoration is lost, broken or causing gingival irritation	X	X	X	X	X
ix. Biopsy of abnormal tissue	X	X	X	X	X
c. Other urgent dental care:	X	X	X	X	X

Resumption of Elective Dental Care					
	Operational Capacity (average encounters per day)				
	Contingency Operations	Phase 1 25%	Phase 2 50%	Phase 3 75%	Phase 4 100%
i. Extensive dental caries or defective restorations causing pain. (Manage with interim restorative techniques when possible such as silver diamine fluoride, glass ionomers)	X	X	X	X	X
ii. Suture removal	X	X	X	X	X
iii. Denture adjustment on radiation/ oncology patients	X	X	X	X	X
iv. Denture adjustments or repairs when function impeded	X	X	X	X	X
v. Replacing temporary filling on endo access openings in patients experiencing pain	X	X	X	X	X
vi. Snipping or adjustment of an orthodontic wire or appliances piercing or ulcerating the oral mucosa	X	X	X	X	X
II. Disease Control Phase					
a. Caries Control		X	X	X	X
i. Provisional restorations		X	X	X	X
ii. Definitive restorations (i.e., amalgam, composite, glass ionomers)		X	X	X	X
b. Extractions of hopeless/problematic teeth		X	X	X	X
i. Possible provisional replacement of teeth		X	X	X	X
c. Periodontal disease Control		X	X	X	X
i. Scaling and root planning and prophylaxis as part of periodontal therapy.		X	X	X	X
ii. Controlling other contributing factors		X	X	X	X
1. Replacement of defective restorations, remove caries		X	X	X	X
2. Reduce or eliminate parafunctional habits, smoking		X	X	X	X
d. Replacement of defective restorations		X	X	X	X
e. Endodontic therapy for pathologic pulpal or periapical conditions		X	X	X	X
f. Stabilization of teeth with provisional or foundational restorations		X	X	X	X

Resumption of Elective Dental Care					
	Operational Capacity (average encounters per day)				
	Contingency Operations	Phase 1 25%	Phase 2 50%	Phase 3 75%	Phase 4 100%
g. Post-treatment assessment		X	X	X	X
III. Definitive Treatment Phase					
a. Advanced periodontal therapy					X
b. Stabilize occlusion (vertical dimension of occlusion, anterior guidance, and plane of occlusion)					X
c. Occlusal adjustments					X
d. Definitive restoration of individual teeth (crowns)					X
i. For endodontically treated teeth					X
ii. For key teeth					X
iii. Other teeth					X
e. Replacement of missing teeth					X
i. Removable partial dentures					X
ii. Complete dentures					X
iii. Fixed partial dentures, implants					X
f. Delivery of prothetic appliances started before the mitigation of dental care due to COVID-19		X	X	X	X
g. Post-treatment assessment					X
IV. Maintenance therapy phase					
a. Periodic visits					X

Adapted from: Stefanac S, Nesbit S. Diagnosis and Treatment Planning in Dentistry. St. Louis: Mosby;2017

6. Additional considerations for Dental Staff:
   6.1. Dental staff should review individual state licensure and registration requirements ensuring they follow the rules and regulations set forth by their state, to the extent that they do not interfere with their Federal duties.
      6.1.1. Any concerns about state licensure rules and regulations should be elevated to appropriate leadership and National Dental Program Office.
   6.2. Expand on current contingency planning in the potential situation of newly diagnosed health care workers.

7. Additional considerations for Communicating with Dental Patients
   7.1. Dental patients may have myriad questions and concerns regarding the ramp-up period. Clear messaging and communication will be paramount

7.1.1. Organize patient messaging and communication using the facility and professional organization (e.g., American Dental Association) scripting and guidelines. A copy of the Welcome Back Reassurance Letter from the ADA Toolkit may be useful to customize the messaging for your dental service.

7.2. Potential messaging-communication topics include:

7.2.1. COVID-19 screening questions and advising the patients of secondary screening/temperature check at in-person visit (consider using facility's and/or ADA's Patient Screening checklists/forms)

7.2.2. Remind patients about the VA policy on Universal Source Control.

7.2.3. Remind patients/guardians to limit extra companions on their trip to your office to only essential people to reduce the number of people in the reception area.

7.2.4. Procedure prioritization.

7.2.5. Individual patient risk.

7.2.6. COVID-19 testing policies for patients and employees

7.2.7. Safety for patients receiving care within the health care system

7.2.8. PPE use and safety of dental care staff members

7.2.9. Patient family/visitor guidelines.

7.2.10. Post-discharge care/follow-up

7.3. Communication topics and strategies during the visit:

7.3.1. Potential messaging-communication topics include:

7.3.1.1. Pre-procedural screening-accomplished upon entering the hospital or at the Dental Service

7.3.1.2. Be prepared to discuss why we screen and what to say if the patient screens positive

7.3.1.3. Maintain patient confidentiality during the screening

7.3.1.4. Stress adherence to appropriate patient privacy

7.3.1.5. Utilization of increased PPE and infection control processes during the COVID-19 pandemic

7.3.1.6. Stress previous high VA Dentistry standards for infection control that have been augmented due to guidelines and science during COVID-19 pandemic.

7.3.1.7. Post-operative reminder for patients to report any signs or symptoms of COVID-19 within 14 days to both their physician and the Dental Clinic.

Dermatology Guidance

Last updated: May 6, 2020

Questions on this chapter should be directed to Dr. Robert Dellavalle, Chair of the VHA Field Advisory Committee on Dermatology at Robert.Dellavalle@va.gov

Priority	Description
Risk Priority 1: Make appointment now, despite COVID-19 crisis.	Urgent conditions that carry morbid consequences (SJS, TEN, worsening bullous dermatoses, Merkel cell excision, melanoma excision, biopsy of lesions suspicious for melanoma, etc.)
Risk Priority 2: Wait until normal scheduling resumes, and then make appointments for priority 2 patients first. They should be appointed first based on CID.	Dermatologic conditions causing severe distress or not responded to telephone triage--worsening inflammatory dermatoses, uncontrolled itching, etc.
Risk Priority 3: After priority 2 patients are situated, priority 3 should be scheduled.	Patients on medications with potential severe side effects.
Risk Priority 4: After priority 3 patients are situated, priority 4 should be scheduled.	Patients with high likelihood of skin cancer development.

Endocrinology and Diabetes

Last updated: April 17, 2020

Please direct questions on this chapter to Dr. Leonard Pogach, National Program Director for Diabetes and Endocrinology at: Leonard.Pogach@va.gov

1. Clinic visits should be prioritized for Veterans who are:
   1.1. Being started on continuous glucose monitors
   1.2. Need to have a thyroid fine needle aspiration for suspicion of lymphoma/anaplastic concerns (history/physical examination/ultrasound)
   1.3. Osteoporosis treatment with Prolia (Reclast can be delayed)
   1.4. Management of urgent endocrinology conditions
2. For those consults that require discussion with Veterans, arrange for the lowest complexity virtual modality.
3. All other consults should be converted to e-consults if possible
4. Encourage the use of MyHealtheVet portal for the Veteran to provide glucose monitoring results, or other essential documentation.
5. If additional laboratory testing is necessary, it should be delayed based upon evaluation of individual circumstances. If the patient is scheduled to have an in person encounter for other reasons, consider scheduling laboratory testing on the same day.

GeriPACT

Last updated June 16, 2020

Questions on this chapter should be directed to :Cheryl Schmitz National Director, Home and Community-Based and Purchased Care Programs for the Office of Geriatrics and Extended Care at Cheryl.Schmitz2@va.gov

The below guidance can also be used to guide care of new and established Veterans. In many situations, decisions will need to be made on a case-by-case basis, considering resource availability (e.g. PPE), level of community spread of COVID-19 and risk to the Veteran.

Priority Category	Veteran Category	Delivery of Care	Comments
Priority 1: **Clinical urgency where a delay in care could lead to negative outcomes (Hospitalizations, ER visit, decline in health status & chronic conditions)**	Established	Clinic or virtual (VVC or telephone) visit; virtual modality is preferred over in-person if clinically appropriate & capable	Examples include but are not limited to change/decline in condition- physical or mental, transition in care back to home post institutional discharge, change in medications, active problems requiring in-person care and/or physical assessments (nutrition, environment/function, priority labs, psychosocial) etc.
	New	Clinic or virtual (VVC or telephone) visit; virtual modality is preferred over in-person if clinically appropriate & capable	Examples to allow for assignment to a GeriPACT panel when clinical urgency is apparent. Some examples may be frequent falls, malnutrition, uncontrolled chronic conditions that may lead to emergency care or hospital utilization, high caregiver burden and/or no caregiver with unmet psychosocial needs, suspicion of abuse/neglect, recent or multiple hospitalizations, high risk for long term care placement, etc.
Priority 2: **Moderate priority where conditions require time sensitive interventions**	Established	Schedule clinic or virtual (VVC or telephone) visit: Virtual modality is preferred over in-person if clinically appropriate & capable	These visits are in line with prevention for those identified as stable but requiring timely assessment and intervention - team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver

Priority Category	Veteran Category	Delivery of Care	Comments
	New	Schedule clinic or virtual (VVC or telephone) visit: Virtual modality is preferred over in-person if clinically appropriate & capable	These visits are in line with prevention for those identified as stable but requiring timely and ongoing assessment & intervention- team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver
Priority 3: Condition stable. Needed services can be prioritized after priority 1&2 Veterans.	Established	Telephone visits or virtual visits such as VVC should be used to maintain usual appointment times and to support identification of potential decline or increased needs for visit priority escalation. Virtual modality is preferred over in-person if clinically appropriate & capable. In-person visits can resume when appropriate based on clinical determination of the need for an in-person evaluation, local decision making, and Move Forward progress.	New Referrals are prioritized under 1 & 2 priority levels. Priority 3 are consistent with stable conditions, requiring ongoing assessment and follow-up. Team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver

Link to Primary Care Field Guide for Managing COVID-19

GI Endoscopy Consults Prioritization Guidance

Last updated: May 20, 2020

Please direct questions on this chapter to Dr. Jason Dominitz, National Program Director for Gastroenterology at Jason.Dominitz@va.gov

The National Gastroenterology Program Office recommends that all GI Sections make use of the new COVID-19 Consult Toolbox that allows efficient documentation of a Priority designation for each consult. In many situations, decisions will need to be made on a case-by-case basis, considering resource availability (e.g. PPE, staff availability), level of community spread of COVID-19, and risk to the patient.

The guidance listed below is subject to change depending upon a variety of factors, such as the duration and local severity of the COVID-19 pandemic, availability of testing for active infection with COVID-19 and access to safe locations for the performance of endoscopy and appropriate personal protective equipment.

A. RECOMMENDED INDICATIONS FOR EACH PRIORITIZATION CATEGORY

1. Priority 1

1.1. Guiding principle: Urgent or emergent procedures that should be performed despite the COVID-19 pandemic

1.2. Suggested indications for Priority 1 include:

- 1.2.1. FIT + (especially ≥3 months since test positive)
- 1.2.2. Upper and lower GI bleeding or suspected bleeding leading to symptoms
- 1.2.3. Dysphagia significantly impacting oral intake (including EGD for intolerance of secretions due to foreign body impaction, inability to take medications, or malignancy (including stent placement))
- 1.2.4. Cholangitis or impending cholangitis (perform ERCP)
- 1.2.5. Symptomatic pancreaticobiliary disease (perform EUS drainage procedure, if necessary, for necrotizing pancreatitis and non-surgical cholecystitis, if patient fails antibiotics)
- 1.2.6. Palliation of GI obstruction [UGI, LGI (including stent placement for large bowel obstruction) and pancreaticobiliary]
- 1.2.7. Patients with a high likelihood of malignancy whether by symptoms (e.g. weight loss, anemia, bleeding), abnormal imaging or other time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
- 1.2.8. Cases where endoscopic procedure will urgently change management (e.g., IBD flare)
- 1.2.9. PEG tube placement
- 1.2.10. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

2. Priority 2

2.1. Guiding principle: should be done as soon as we are able to schedule non-urgent procedures

2.2. Suggested indications for Priority 2 include:

2.2.1. Symptoms that are concerning for a possible serious condition but not meeting criteria for Priority 1
2.2.2. FIT+ (<3 months since test positive)
2.2.3. Follow-up colonoscopy after a high-risk polyp resection (e.g. high-grade dysplasia or suspected incomplete resection)
2.2.4. Stable iron deficiency anemia without overt GI symptoms
2.2.5. Barrett's esophagus with high risk features (e.g. nodules, high grade dysplasia) or for ablation
2.2.6. Banding of esophageal varices – secondary prevention and prior banding
2.2.6.1. *NOTE:* patients with recent acute variceal bleeding may be appropriate for serial banding of varices in the Priority 1 group
2.2.7. Intermittent or chronic dysphagia with history of benign etiology (EoE, complex esophageal stricture in the past)
2.2.8. Follow-up gastric ulcer healing concerning for malignancy based on prior EGD
2.2.9. Stent removal/exchange after advanced endoscopic procedure performed

3. **Priority 3**
3.1. Guiding principle: routine cases that are less time sensitive than Priority 2 but more time sensitive than Priority 4
3.2. Suggested indications for Priority 3 include:
3.2.1. Surveillance colonoscopy that is overdue by at least 12 months
3.2.2. High risk screening colonoscopy (e.g. 1st degree family history, Lynch, familial adenomatous polyposis (FAP))
3.2.3. Workup for chronic diarrhea without alarm symptoms
3.2.4. Follow-up severe esophagitis healing

4. **Priority 4**
4.1. Guiding principle: routine cases that are not particularly time sensitive
4.2. Suggested indications for Priority 4 include:
4.2.1. Average risk screening colonoscopy
4.2.1.1. Please note that FIT should be used during the COVID-19 crisis per the recently issued Primary Care memo
4.2.2. Surveillance colonoscopy that is due this year
4.2.3. Screening for Barrett's esophagus
4.2.4. Barrett's surveillance that is due this year
4.2.5. Screening for esophageal varices
4.2.6. Pancreatic cyst surveillance
4.2.7. Dyspepsia in the absence of alarm symptoms
4.2.8. Gastroesophageal reflux disease in the absence of alarm symptoms

B. UTILIZING THE PRIORITIZATION FOR PATIENT SCHEDULING

1. Through the process of assigning a Priority score to each consult that is active or pending, it is possible to sort these consults by their Priority. Any consults without a Priority are at risk of being improperly delayed in scheduling.
2. The Office of Veterans Access to Care (OVAC), in collaboration with VSSC and others, is developing reports that include the Priority designation as a searchable and/or

sortable field. These reports will allow scheduling staff to identify the highest priority Veterans who should be scheduled first. Further guidance will be forthcoming.

Gynecology: Resumption of Clinical Operations for Gynecology Specialty Clinics – Ambulatory Guidelines on Essential Care

Last updated: May 5, 2020

Please direct questions on this chapter to the Director of Comprehensive Women's Health at: Sally.Haskell@va.gov or Amanda.Johnson@va.gov

General Guidance: Consider continuing offering telehealth and VVC visits for conditions that can be managed/treated remotely. Triaging of patients to determine those appropriate for telehealth modalities of care and those who require in person visits is recommended (see section 5 below).

Decisions about prioritizing patients and resumption of services should be made locally based on available resources such as personnel and PPE, as well as individual patient needs.

1. **Priority 1** – Emergent or Urgent encounters that should be performed despite the COVID-19 pandemic (including consuming PPE) due to unacceptable risk of patient harm in the event of delay.
   - 1.1. Postoperative patients with suspected complications
   - 1.2. Urgent gynecologic symptoms i.e. acute abdominal-pelvic pain to rule out pelvic inflammatory disease, ovarian torsion, ectopic pregnancy and other acute gynecologic conditions
   - 1.3. Abnormal uterine bleeding causing systemic symptoms suggestive of anemia (dizziness, shortness of breath) and/or requiring blood transfusion
   - 1.4. Abnormal uterine bleeding requiring endometrial biopsy, including post-menopausal bleeding, to rule out endometrial cancer
   - 1.5. New known or suspected gynecologic cancers, this includes imaging or symptoms suggestive of ovarian or endometrial cancer and high-grade cervical dysplasia with suspicion of invasive disease
   - 1.6. Treatment of moderate to severe cervical dysplasia
   - 1.7. F/u of HSIL pap
   - 1.8. Provision or removal of LARC contraception; continuation of injectable contraception, in those cases where there is not an acceptable alternative method of contraception that can be managed via telehealth technology
   - 1.9. Evaluation and treatment of suspected infected Bartholin's cyst
   - 1.10. Pessary f/u when bleeding or discharge is present
   - 1.11. Management of first trimester pregnancy loss
   - 1.12. Indicated testing for sexually transmitted disease (can be done in lab-setting only; blood draw for HIV, syphilis, hepatitis B and C; urine clean catch for chlamydia and gonorrhea screening)

Priority 2 – Urgent or Time-sensitive encounters that should be prioritized as soon as safely possible

- 1.13. Postoperative evaluations for completed surgeries without suspected complications

1.14. Colposcopy for evaluation of LGSIL
1.15. Chronic pelvic pain
1.16. Endometriosis
1.17. Abnormal uterine bleeding that does not require biopsy or does not require urgent evaluation
1.18. Vaginitis symptoms refractory to empiric treatment

2. **Priority 3** – Elective/time-sensitive encounters of higher priority than Priority 4
   2.1. New referrals from primary care for urogynecology complaints (urinary incontinence, prolapse)
   2.2. Follow-up of patients with urogynecology complaints
      2.2.1. Urinary incontinence/medication follow-up can be done by phone.
      2.2.2. Pessary checks if the patient has no symptoms (bleeding/discharge)
      2.2.3. All in-office urogynecology procedures (cystoscopy, urodynamics, PTNS)
   2.3. Infertility visits
   2.4. Office hysteroscopy procedures

3. **Priority 4** – Elective encounters of priority lower than Priority 3
   3.1. Routine exams
   3.2. Well-women visits

4. **Conditions that might be managed via telehealth include but are not limited to:**
   4.1. Menopause management
   4.2. Initial visit for gender affirming hormone therapy
   4.3. Contraceptive management (other than LARC, which require in person visits
   4.4. Sexual dysfunction
   4.5. Follow up of abnormal uterine bleeding, urinary incontinence, sexual dysfunction, menopause management, gender affirming hormone therapy, pelvic pain
   4.6. Initial visit history for the conditions listed below:
      4.6.1. Infertility
      4.6.2. Referral from Primary Care for Urinary incontinence

NOTE: See Imaging: Radiology and Nuclear Medicine Chapter for guidance on mammography.

5. Guidance for Chaperones
   5.1. For in person visits during SARS-CoV-2 and reopening, continue to use chaperones per WH policy 1330.01 and the TeleWomen's Health Supplement.
   5.2. Chaperones will follow same PPE guidance as provider. PPE guidelines
   5.3. Chaperones should also be used for VVC visits when a breast or genital exam is deemed necessary at that visit. If it is known in advance that a chaperone is needed, then a chaperone should be scheduled to call in.
   5.4. If there is an unexpected need to do a breast or genital exam during a VVC visit and a chaperone is not available, the provider should obtain and document consent, ensure the Veteran is in a safe and private space, and remind the patient that VVC visits are not recorded.

Home Based Primary Care

Last updated June 16, 2020

Questions on this chapter should be directed to Dayna Cooper, National Program Director VA Home and Community Care, Geriatrics and Extended Care at: Dayna.Cooper3@va.gov

The below guidance can also be used to guide care of new and established Veterans. In many situations, decisions will need to be made on a case-by-case basis, considering resource availability (e.g. PPE), level of community spread of COVID-19 and risk to the Veteran.

Priority Category	Veteran Category	Delivery of Care	Comments
Priority 1: **Clinical urgency where a delay in care could lead to negative outcomes (Hospitalizations, ER visit, decline in health status & chronic conditions)**	Established	- Home Visit: Convert to virtual modality if appropriate & capable or maintain in-person care	Examples include but are not limited to change/decline in condition- physical or mental, transition in care back to home post institutional discharge, change in medications, active problems requiring in-person care and/or physical assessments (nutrition, environment/function, priority labs, psychosocial) etc.
	New	- Home Visit: Schedule for visit, virtual modality is preferred over in-person if clinically appropriate & capable	Examples to allow for assignment to a panel when clinical urgency is apparent. Some examples may be frequent falls, malnutrition, uncontrolled chronic conditions that may lead to emergency care or hospital utilization, high caregiver burden and/or no caregiver with unmet psychosocial needs, suspicion of abuse/neglect, recent or multiple hospitalizations, high risk for long term care placement, etc.
Priority 2: **Moderate priority where conditions require time sensitive interventions**	Established	- Home Visit: Virtual modality is preferred over in-person if clinically appropriate & capable	These visits are in line with prevention for those identified as stable but requiring timely assessment and intervention - team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver
	New	- Home Visit: Virtual modality is preferred over in-person if	These visits are in line with prevention for those identified as stable but requiring timely and

Priority Category	Veteran Category	Delivery of Care	Comments
		clinically appropriate & capable	ongoing assessment & intervention- team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver
Priority 3: Condition stable. Needed services can be prioritized after priority 1&2 Veterans.	Established	- telephone visits or virtual visits such as VVC should be used to maintain usual appointment times and can be used to support identification of potential decline or increased needs for visit priority escalation. Home visits can resume when appropriate based on clinical determination of the need for an in-person evaluation, local decision making, and Move Forward progress	New Referrals are prioritized under 1 & 2 priority levels. Priority 3 are consistent with stable conditions, requiring ongoing assessment and follow-up. Team members may collaborate by having 1 team member conduct face-to-face visit & facilitate Video/virtual visits for other team member evaluations as clinically appropriate and as visit time/length is tolerated by Veteran/Caregiver

Link to Primary Care Field Guide for Managing COVID-19

Hematology/Oncology Consults Prioritization

Last updated: April 23, 2020

Questions on this chapter should be directed to the Oncology National Program at cancer@va.gov

The National Hematology/Oncology Program Office recommends that all Hematology/Oncology Sections make use of the new COVID-19 Consult Toolbox that allows efficient documentation of a priority designation for each new consult. The below guidance can also be used to guide care of established Veterans. In many situations, decisions will need to be made on a case-by-case basis, considering resource availability (e.g. PPE), level of community spread of COVID-19 and risk to the Veteran.

Priority Category	Veteran Category	Delivery of Care	Comments
Priority 1: Condition critical, life-threating or unstable. Immediate need is greatest.	Established	- Clinic appt: Convert to virtual modality if appropriate or maintain in person care - Treatment: Continue treatment - Procedure: Refer for procedure	- Consider lowest frequency dosing schedule of infusions - Consider change from IV/infusion to oral treatment and/or home administration - Consider omitting care with low or unknown impact on outcome
	New	- Clinic appt: Schedule for visit, virtual modality is preferred over in person if clinically appropriate - Treatment: Start treatment - Procedure: Refer for procedure	- Consider lowest frequency dosing schedule of infusions - Consider initiation of oral treatment and/or home administration rather than IV/infusion - Consider omitting care with low or unknown impact on outcome
Priority 2: Condition stable, non-life threatening. Needed services may be deferred for a time during surge.	Established	- Clinic appt: Virtual modality is preferred over in person if clinically appropriate, otherwise consider delaying or omitting in person care - Treatment: Continue treatment or consider treatment holiday for Veterans with stable disease - Procedure: Discuss with proceduralist if can be delayed	- Consider lowest frequency dosing schedule of infusions - Consider change from IV/infusion to oral treatment and/or home administration - Consider omitting care with low or unknown impact on outcome

Priority Category	Veteran Category	Delivery of Care	Comments
	New	- Clinic appt: Virtual modality is preferred over in person if clinically appropriate - Treatment: Start treatment if deemed clinically necessary - Procedure: Discuss with proceduralist if can be delayed	- Consider lowest frequency dosing schedule of infusions - Consider initiation of oral treatment and/or home administration rather than IV/infusion - Consider omitting care with low or unknown impact on outcome
Priority 3: Condition stable. Needed services can be postponed safely if care cannot be delivered virtually.	Established	- Clinic appt: Virtual modality is used, no in person should be delivered - Treatment: Continue oral therapy, postpone any therapy that requires in person delivery - Procedure: Postpone - Surveillance scans: Postpone	- Consider lowest frequency dosing schedule of infusions - Consider change from IV/infusion to oral treatment and/or home administration - Consider omitting care with low or unknown impact on outcome
	New	- Clinic appt: Complete consult as an E consult with recommendations for future timing of care, if consult cannot be completed as an E consult, triage and hold for scheduling at appropriate PID - Treatment: Start oral therapy, postpone any therapy that requires in person delivery - Procedure: Postpone - Surveillance scans: Postpone	- Consider lowest frequency dosing schedule of infusions - Consider initiation of oral treatment and/or home administration rather than IV/infusion - Consider omitting care with low or unknown impact on outcome

** Modified from NCCN.org and the University of California San Francisco Hellen Diller Family Comprehensive Cancer Center available here: https://www.nccn.org/covid-19/pdf/Cancer_Services_Patient_Prioritization_Guidelines.pdf

** Virtual modalities of care include telephone, VVC and E consult

NOTE: For Veterans requiring bone marrow transplant referral, evaluation and/or transplant procedure, including at community transplant centers, a referral must be submitted to a VA Transplant Center through TRACER. Link to TRACER: https://vaww.tracer.nso.med.va.gov.

Guidance for transplantation care in community, see Guidance transplantation through Community Care, released by Office of Community Care on 6/17/19: http://vaww.dushom.va.gov/DUSHOM/surgery/docs/Guidance_for_Transplantation_through_Community_Care.pdf.

Imaging: Radiology and Nuclear Medicine

Last updated: August 21, 2020

Please direct questions on this chapter to Dr. William F. Arndt, Director, National Radiology Program, Diagnostic Services at VHANationalRadiologyProgramOffice@va.gov

1. **General Guidance/Background:** Radiology and Nuclear Medicine diagnostic imaging procedures are not driven by consults, rather by orders for imaging exams, entered by referring clinical providers. The COVID-19 Consult Toolbox and associated priorities are therefore not used for Radiology and Nuclear Medicine imaging exams. For diagnostic imaging exams, radiology providers are provided a brief clinical synopsis of the issue requiring imaging, but otherwise may not have sufficient clinical familiarity with the patients to reliably assign priority of the requested exams for the purpose of scheduling in a resource-constrained environment. As a result, guidance for Radiology and Nuclear Medicine scheduling and orders management during the COVID-19 pandemic requires prioritization of all imaging exams requiring scheduling (e.g. CT, MRI, US, Nuclear Medicine/PET/CT, etc.) to be based on a process for ongoing clinical review of each individual imaging order (excluding unscheduled/walk-in exams).
   1.1. Early in the COVID-19 pandemic, as VHA issued policy requiring cessation of scheduling non-urgent exams [see 10N Memorandum dated 18 March 2020, "Radiology and Nuclear Medicine Clarification—Coronavirus (COVID-19) -- Guidance for Elective Procedures"], these clinical reviews were required at the time the order was placed on "Hold" with the reason "Covid-19 Concerns." In subsequent months, VHA facilities have resumed scheduling of "non-urgent" exams which were originally placed on "Hold", with the goal of steadily eliminating the backlog of these "COVID-19 Hold" exams.
   1.2. In addition to the initial clinical review, VHA sites are directed to conduct ongoing clinical reviews for all imaging orders on "Hold" for "COVID-19 Concerns","COVID-19 Clinical Review," and "COVID-19 Clinical Review Complete to Schedule" no less frequently than every 60 days past the provider's CID. This allows for reprioritizing, scheduling according to clinical urgency, or alternatively canceling exams that are either no longer clinically indicated, or as requested by patient or provider. More frequent clinical reviews may be appropriate for some orders/exams, depending on the nature of the exams and clinical indications, which should be locally determined on a case by case basis after reviewing the orders.
   1.3. Although clinical reviews and overall orders management should be organized and accomplished locally, VISN Leadership, including VISN Diagnostics ICC Clinical Leads, should be actively involved in monitoring overall numbers of Radiology and Nuclear Medicine orders on "Hold", including both COVID-related and other "Hold" reasons. This involves ongoing tracking, trending, giving feedback and assisting to develop action plans as necessary to manage COVID-19 "Hold" orders.
   1.4. NOTE: Until further notice, sites that have begun to schedule non-urgent exams (which includes most or all VHA sites as of August 2020), should no longer be placing orders on "Hold" with the "COVID-19 Concerns" "Hold" reason. Instead, sites should systematically conduct clinical reviews on all orders on "Hold" for "COVID-19 Concerns," and based on the clinical reviews, either schedule according to clinical urgency, cancel (if appropriate), or if continuing on "Hold", move these orders to "COVID-19 Clinical Review," where they can be tracked,

reviewed, and managed along with other orders on "Hold" for COVID-19 reasons, until they are appropriately dispositioned.

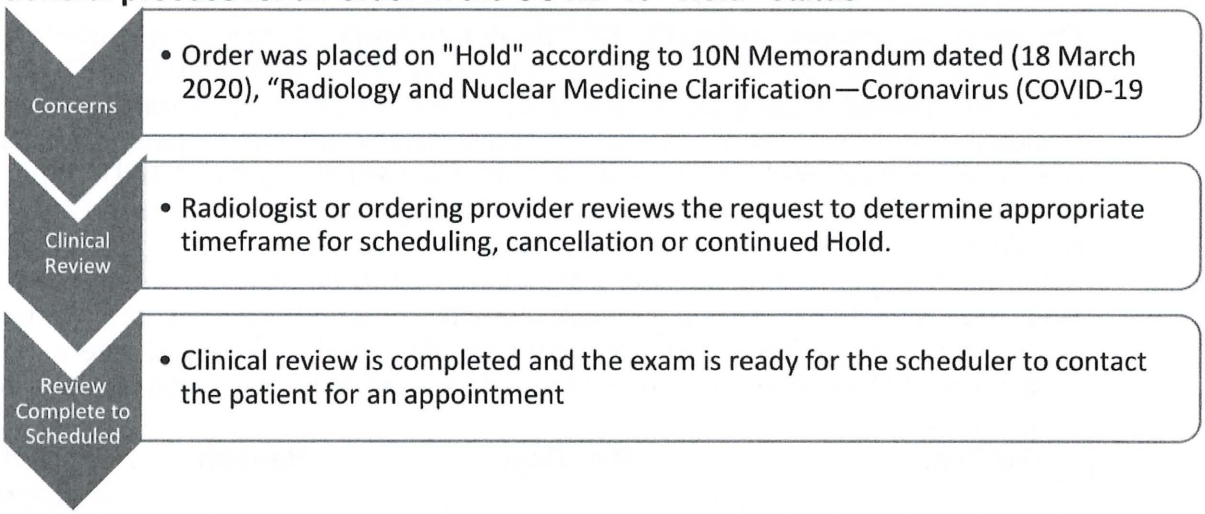
2. **Clinical Reviews—General Comments and Responsibilities**: Clinical reviews are a critical component in the management of all imaging orders on "Hold" for any of the COVID-19 reasons, creating a systematic process that minimizes the likelihood of delays in care during the COVID-19 pandemic. Although clinical reviews of COVID-19 "Hold" imaging orders may be accomplished by radiologists, ordering providers, or other Licensed Independent Practitioners (LIPs), in most cases this is a shared responsibility between Radiology and the ordering providers. In other words, radiologists typically will make the first attempt to review the orders and assign a clinical priority, but when unable or if other questions remain, will refer to the ordering providers to complete the reviews. This process assures an appropriate distribution of responsibilities in a way that expedites management of imaging orders and timely delivery of care.
   2.1. NOTE: Importantly, whenever orders for scheduled exams are Canceled, the ordering provider/surrogate should be alerted to the potential for delayed care, and this should be documented by a CPRS note adding the ordering provider as an additional signer. CPRS notes should also be entered when patients "No-Show" or request to be scheduled more than 30 days beyond the ordering provider's CID. This extra step allows providers to intercede with patients potentially at risk for delays in care, or to change the overall management strategy according to patients' wishes as appropriate. If there are particular concerns, radiologists may be involved to review and communicate directly with providers.
3. **Orders management during the COVID-19 pandemic**: Due to unique concerns about patient reluctance to schedule their imaging exams during the COVID-19 pandemic, limited imaging capacity and the potential need to systematically manage backlogs of orders on "Hold", Radiology and Nuclear Medicine guidance for orders management guidance should be temporarily adjusted during the COVID-19 pandemic (see table below). Orders for all scheduled imaging modalities that exceed these limits should be cancelled with the associated reason as indicated, including a cancellation note requiring an ordering provider's signature. Canceling obsolete orders or when Radiology is unable to contact a patient alerts the ordering providers, prompting them to reevaluate the clinical indications, treatment plans and necessity of orders, update clinical information and reenter new orders if necessary, based on discussions with patients:

Order Type	# of Days	Reason	CPRS Note Required?
Pending General Radiology	90 days after CID	Obsolete Order	No
Hold COVID-19 Reasons	180 days after CID	Obsolete	Yes
Community Care	180 days after CID	Community Care	Yes
Letter Sent My HealtheVet Contact	14 days after second documented scheduling attempt*	Unable to Contact	Yes
All other reasons	180 days after CID	Other	Yes

Order Type	# of Days	Reason	CPRS Note Required?
Past Scheduled	Run list daily, see guidance below for No Shows and Reschedules		

*Two documented attempts to contact the patient (Phone call, and Letter or My HealthVet contact) must be documented

4. **Prioritization of imaging orders on "Hold" for COVID-19 reasons**: Although as stated, most or all facilities as of August, 2020 are scheduling non-urgent exams, in general, the workflow for clinical review and tracking of orders on "Hold" for COVID-19 reasons changes based on whether restrictions on scheduling of non-urgent exams have been lifted at facilities, whether there are additional surges or otherwise extended scheduling restrictions. Instructions for management/prioritization of Radiology and Nuclear Medicine "Hold" for COVID-19 reasons are described in this guidance.
5. **Moving Forward – Scheduling Restrictions Lifted**: Once restrictions for scheduling non-urgent exams have been lifted, an additional clinical review should be conducted for all remaining imaging orders on "Hold" for COVID-19 Concerns, to assure timely management, and to minimize potential for delays in care in this setting. A high-level flow chart for managing orders in the "Hold" status for all COVID-19 reasons (COVID-19 Concerns, COVID-19 Clinical Review, And COVID-19 Clinical Review to Schedule) can be found in **Appendix A.**
6. **General process for an order in the COVID-19 "Hold" status**



6.1. Specific workflow for the post-COVID-19 pandemic setting (after lifting scheduling restrictions) is detailed in **Appendix B.** During this time period, sites are directed to discontinue placing imaging orders on "Hold" for COVID-19 Concerns, and to move to pre-COVID-19, standard scheduling and orders management guidance.

6.2. All orders should undergo a clinical review at least every 60 days past the ordering provider's CID. Clinical reviews can be completed by radiology, the ordering provider or their designee. When a clinical review is initiated, the order's "Hold" status is updated to "COVID-19 Clinical Review." After the clinical review is completed, if the decision is made to schedule, the order's "Hold" status is updated to "COVID19-Clinical Review to Schedule" to signify the clinical review is complete and the exam is ready for scheduling. The outcome of the clinical review may in

some cases be the decision to cancel the order as no longer clinically indicated, or as obsolete. If the order is cancelled by Radiology, a cancellation note should be entered to alert the provider of the cancellation.

6.3. All facilities with imaging orders in any of the "COVID-19 reasons" are instructed to develop a tracking plan to assure that all required clinical reviews are completed, and all "Hold" orders for COVID-19 reasons are managed appropriately, according to clinical urgency.

6.4. **Comments:** Radiology may assist with this clinical review, but often Radiology has insufficient clinical familiarity with the patients to complete the reviews, especially with potentially changing clinical status over the duration of the COVID-19 pandemic. In those cases, Radiology must request assistance by the ordering providers to complete the clinical reviews, and thereby assure the most accurate and up-to-date prioritization of imaging exams needing scheduling.

6.5. Although ongoing clinical review may result in reprioritization of some "non-urgent" orders to "urgent" status, for the remainder of non-urgent "COVID-19 Hold" orders, scheduling decisions should be made on a case-by-case basis following updated clinical review and consultation with ordering providers, allowing providers to select one of several options, including scheduling and cancellation. This process should also incorporate local policy regarding the scheduling non-urgent exams.

7. **Unscheduled Exams (Plain films)**

7.1. Plain film orders become obsolete 90 days past the ordering provider's CID. At times, the patient may come in for their exam after an order has already been canceled. Facilities should ask the radiologist or the ordering provider for permission to re-enter the plain film x-ray order under the original ordering provider's name which allows the report to go to the original ordering provider. Facilities should have a local policy outlining the process. Management of unscheduled ("walk-in," e.g. general radiology "plain film") exams is detailed in **Appendix C**.

8. **Patient reluctance to schedule, patient requests to reschedule, and "No Shows"**

8.1. Some sites have observed reluctance by patients to schedule their Radiology/Nuclear Medicine exams due to fear of COVID-19 infection, transportation availability or other concerns, and consequently "no-show" rates may be elevated during the COVID-19 pandemic. Other times, patients may request appointment dates in the future, long after the provider's CID, or alternatively may reschedule multiple times, delaying the date of the exam.

9. **Patient reluctance to schedule and rescheduling exams during the COVID-19 pandemic:**

9.1. If a patient declines to schedule, the order should be canceled and a CPRS note entered that alerts the ordering provider.

9.2. If a patient declines to reschedule, the order should be canceled and an CPRS note entered to alert the ordering provider and the appointment updated in the VistA's Appointment Management software.

9.3. When a patient requests an appointment date well beyond (e.g. more than 30 days) the original ordering providers CID or the "adjusted" CID (based on the clinical review), schedule the appointment with the patient and enter a CPRS note to alert the ordering provider of the patient's preference. This extra step allows providers to intercede with patients potentially at risk for delays in care or collaborate with the patient and Radiology on an earlier appointment date.

9.4. NOTE: All CPRS notes should have the ordering provider added as an additional signer.

9.5. See **Appendix D** for Veteran Requesting to Reschedule an Appointment During Additional Surges and/or Extended Scheduling Restrictions.

10. Patient "No Shows"

10.1. Standard Radiology orders management guidance (outside of the COVID-19 pandemic) calls for cancellation of "no-shows" that cannot be explained by inclement weather or other obvious causes, with a CPRS cancellation note that adds the ordering provider as an additional signer. Because of the unique circumstances presented by the COVID-19 pandemic, however, and because many of these patients will need to be rescheduled, when these circumstances occur during the COVID-19 pandemic, sites are encouraged not to cancel these exams after the first "no-show."

10.1.1. *First No-Show:* Contact the patient to ask them if they would like to reschedule. Place the order on "Hold" for "COVID-19 Clinical Review to Schedule," if the patient cannot be contacted. By placing in this status, the order can be tracked until the patient can be scheduled or canceled by policy or provider/patient request. If the patient is not contacted, enter a CPRS note to alert the ordering provider the patient failed to keep their appointment. If the patient is not contacted, document the attempt to contact by phone and send a letter requesting them to contact Radiology. If after 14 days, the patient does not contact Radiology to schedule an appointment, the order can be canceled with the reason Unable to Contact Patient. A CPRS cancellation note is entered to alert the ordering provider that scheduling attempts were made and not successful. If and when the patient calls to schedule the appointment, schedule the appointment in the VistA Radiology and Appointment Packages, according to local policy. If the appointment requested by the patient is more than 30 days beyond the ordering provider's CID, then a CPRS note is entered to alert the ordering provider to the potential for delayed care, adding the ordering provider as an additional signer.

10.1.2. *Second No-Show:* Cancel the order and enter a CPRS cancellation note to alert the ordering provider the patient "no-showed" their appointment.

10.1.3. NOTE: All CPRS notes are to include the ordering provider as an additional signer. Schedulers must enter patient no shows into VistA Scheduling.

10.2. See **Appendix E for** No-Show Processes During COVID-19 Pandemic.

11. Appendices A through E (flow charts), and Appendix F, Frequently Asked Questions, can be found on the Radiology SharePoint site https://dvagov.sharepoint.com/:f:/r/sites/VHADiagnosticservices/NRP/Mammography/COVID19%20VA%20Information/Prioritization%20for%20Expanding%20Outpatient%20Consultations,%20Procedures%20and%20Appointments%20V4.0?csf=1&web=1&e=CX792R

12. Special considerations for Mammography (consensus statement by National Radiology Program, Deputy Chief Consultant, Women's Health, and the National Surgery Office): The following are guidelines for breast imaging during and after the COVID-19 pandemic:

12.1. **Screening breast imaging**: During the COVID-19 pandemic and additional surges while scheduling restrictions are still in place, VHA medical facilities may postpone all breast screening exams of asymptomatic patients (to include screening mammography, ultrasound, and Magnetic Resonance Imaging (MRI)) until such time as elective, nonurgent exams are resumed as determined by VHA guidance and local policy based on local conditions. Following lifting of restrictions for non-urgent breast imaging exams (which is most or all of VHA facilities as of August 21, 2020), breast screening should resume in an expeditious manner, based on local scheduling processes, available imaging capacity for more urgent imaging exams, provider and patient preferences.

12.2. **Diagnostic breast imaging and intervention**: Some clinical indications require emergent breast examination (typically by mammography or ultrasound) and possible intervention (such abscess drainage) for which even short postponement would significantly affect the patient's outcome; these cases should not be delayed by COVID-19 concerns. Breast abscess formation is an example of a condition that must be addressed without undue delay.

12.2.1. During the COVID-19 pandemic and in the resource-constrained post COVID-19 period, urgent exams need to be addressed in a timely, though not emergent, manner. In the COVID-19 setting, diagnostic imaging for an abnormal screening mammogram (BI-RADS 0), suspicious breast symptoms, biopsies, and breast MRI for extent of disease evaluation or pre-chemotherapy assessment should be considered urgent and scheduled accordingly, weighing risks of COVID-19 at individual facilities against risks of delaying procedures, taking into account patient and ordering provider preferences. Urgent exams are typically scheduled within 14 days, and often earlier, based on individual circumstances.

12.2.2. BI-RADS category 3 patients returning for follow-up diagnostic mammography have a potentially lower level of urgency while scheduling restrictions are in place, though ideally disposition would occur in a prompt manner (typically within three months of the clinically indicated date or as determined by overriding local policy). Prior to and after lifting of scheduling restrictions, Timing of these exams and procedures should encompass appropriate clinical decision-making regarding the individual circumstance as well as the patient's judgement regarding desire for resolution versus risks engendered by the COVID-19 pandemic.

12.2.3. Because of the dynamic environment, varied local and regional COVID-19 risks and changing national guidance, it is critical for VHA facilities to constantly evaluate and review scheduling policies and associated risk/benefit ratios for different types of examinations and patient groups during the COVID-19 pandemic, and following lifting of COVID-19 scheduling restrictions for non-urgent exams. Importantly, as with all other Radiology and Nuclear Medicine Exams, any patients whose breast imaging examinations and procedures are delayed due to the COVID-19 environment should undergo periodic clinical review and reprioritization (including shared decision-making with patients) as necessary, until the exams/procedures are completed. If there are difficult clinical questions, interdisciplinary discussion and documentation is recommended.

Patients living with HIV and the prevention of HIV

Last updated: May 6, 2020

Please direct questions on this chapter to the HIV, Hepatitis, and Related Conditions Programs at VHAHHRC@va.gov

	Priority 1	Priority 2	Priority 3	Priority 4
HIV care	a) New diagnosis of HIV b) New diagnosis of OI c) CD4 <200 with detectable VL d) Serious ARV adverse effect e) OI symptoms To be seen in expedited manner, clinician to determine if in-person or via telehealth, with preference for in-person care when situation permits	a) OI on treatment b) Known HIV diagnosis, transferring to VA care c) New VL >200, any CD4 d) CD4 decrease by 50% or more To be seen as soon as possible, clinician to determine if in-person or via telehealth. Most may require in-person care when situation permits.	a) Recent change in ART or OI prophylaxis b) CD4 <200 with undetectable VL To be seen when clinically indicated, clinician to determine if in-person or via telehealth. Telehealth appropriate in most situations.	All of the following: a) No OI symptoms b) VL <200 c) CD4 ≥200 d) Stable ART e) Stable prophylaxis To be seen when clinical indicated. Clinician to determine timing, and whether care delivered in-person or via telehealth. Deferring labs and visits likely clinically acceptable, and telehealth appropriate in most situations.
HIV prevention	a) New PrEP start To be seen in expedited manner, clinician to determine if in-person or via telehealth, but telehealth likely appropriate for most situations		a) PrEP continuation To be seen in manner that prevents disruption in PrEP prescription. Clinician to determine if in-person or via telehealth. Telehealth appropriate in most situations. Clinician may decide to extend period between labs.	

Infectious Diseases: Outpatient Priority Considerations

Last updated: April 21, 2020

Please direct questions on this chapter to the National Infectious Disease Service at 513-246-0270.

Priority Level	Description	Action
1.	High Risk of Morbidity or Mortality (e.g., endocarditis, infected joint)	See patient
2.	Urgent Need (e.g., severe pain, significant worsening of infection despite therapy)	Telehealth or see patient
3.	Follow-up for urgent visit (e.g., complex antibiotic therapy)	Telephone/Telehealth or rarely see patient
4.	Follow-up of less complex patient (e.g., mild cellulitis)	Telephone/Telehealth
5.	Routine patient (e.g., Urinary tract infection (simple), simple med refill as with some stable and long-term HIV or MAC patients)	Telephone or Telehealth (uncommon) Patient can come in for lab if needed

Liver Disease Care Delivery

Last updated: April 22, 2020

Please direct questions on this chapter to the HIV, Hepatitis, and Related Conditions Programs at VHAHHRC@va.gov

	Priority 1	Priority 2	Priority 3	Priority 4
Definition	Should receive in-person or telehealth visit, and/or lab tests and imaging, without delay.	In-person visit, lab tests, and imaging can be postponed 2-3 months. Telehealth can be substituted for most patients.	In-person visit, lab tests, and imaging can be postponed 3-6 months. Telehealth can be used most patients.	In-person visit, lab tests, and imaging can be postponed 6-9 months. Telehealth can be used most patients.
HCV	• Currently receiving DAA treatment. • Decompensated cirrhosis, willing to get blood tests and be followed by telehealth during DAA Rx. • (Consider deferring patients with high risk of treatment interruption or hospitalization.)	• Compensated cirrhosis, willing to get blood tests and be followed by telehealth during DAA Rx	• Non-cirrhotic who has been difficult to get into treatment, who agrees to treatment now.	• Non-cirrhotic
Cirrhosis	• Decompensated cirrhosis receiving liver-related medications (e.g., diuretics, lactulose) that have been adjusted in the prior 2 months. • Other liver-related interventions or high-risk complications (e.g., esophageal variceal hemorrhage, serial paracentesis for refractory ascites, SBP, HRS, recent discharge from inpatient setting). • Patients undergoing liver transplant evaluation or on liver transplant list should be referred to the responsible transplant center for guidance.**	• Decompensated, on stable doses of meds (e.g., diuretics, lactulose, rifaximin, SBP prophylaxis, NSBB, etc.) and no ongoing significant liver injury	• Compensated cirrhosis, with ongoing significant liver injury (HBV and elevated DNA, ALD with alcohol use, etc.). • Compensated cirrhosis not up to date with HCC or variceal surveillance.	• Compensate d cirrhosis, seen within 6 months prior to COVID-19 and up to date with surveillance.
HCC Surveilla	• Loco-regional therapy (e.g., TACE, RFA,	• HCC imaging may be safely	• HCC imaging may be safely	• HCC imaging may be

	Priority 1	Priority 2	Priority 3	Priority 4
nce imaging and treatment of known HCC, and evaluation, of suspected HCC.	SBRT, etc.) within prior 6 months. • Being evaluated for surgical resection. • Receiving chemotherapy (e.g., sorafenib, nivolumab, lenvatinib, etc.). • Undergoing liver transplant evaluation or on liver transplant list. • Imaging suggestive of possible/probable HCC.	postponed 2-3 months in most cases for the following patient groups: • Loco-regional therapy (e.g., TACE, RFA, SBRT, etc.) 6-12 months ago and no viable tumor on imaging after procedure. • Loco-regional therapy and overdue on follow-up imaging by more than 3 months.	postponed 3-4 months in most cases for the following patient groups: • Loco-regional therapy (e.g., TACE, RFA, SBRT, etc.) 12 -24 months ago and no viable tumor on imaging after the procedure. • Overdue for HCC surveillance for >12 months.	safely postponed 4-6 months in most cases for the following patient groups: • Loco-regional therapy (e.g., TACE, RFA, SBRT, etc.) >24 months ago and no viable tumor on imaging after the procedure. • Overdue for HCC surveillance for 6-12 months.

***NOTE: For Veterans requiring liver transplant referral, evaluation and/or transplant procedure, including at community transplant centers, a referral must be submitted to a VA Transplant Center through TRACER. Link to TRACER: https://vaww.tracer.nso.med.va.gov.*

Guidance for transplantation care in community, see Guidance transplantation through Community Care, released by Office of Community Care on 6/17/19: http://vaww.dushom.va.gov/DUSHOM/surgery/docs/Guidance_for_Transplantation_through_Community_Care.pdf.

Medical Foster Home and Community Residential Care Delivery

Last Updated: September 1, 2020

Questions on this chapter should be directed to Dayna Cooper, Director, VA Home and Community Care, Geriatrics and Extended Care at: Dayna.Cooper3@va.gov

The below guidance can also be used to guide care of new and established Veterans. In many situations, decisions will need to be made on a case-by-case basis, considering resource availability (e.g. PPE), level of community spread of COVID-19 and risk to the Veteran.

Visit Category	Veteran Category	Delivery of Care	Comments
MFH/CRC Admission	New	- Home Visit: Schedule for visit, virtual modality is preferred over in person, if clinically appropriate & capable	Examples for new admission when in person clinical coordination may be needed could include difficult transition to MFH or CRC setting, uncontrolled chronic conditions that may lead to emergency care or hospital utilization, high caregiver burden.
MFH/CRC Monthly Oversight Coordinator Visit	Establ-ished	- Home Visit: Complete screening process and schedule in person visit. In person is preferred but virtual modality may be used if positive screen for symptoms of COVID.	MFH and CRC require Coordinator in person oversight of these programs to ensure safety and care needs of the Veteran are met. The purpose of the monthly oversight Coordinator visit is to assess programmatic standards.
MFH/CRC Case Management Visit	Establ-ished	- Home Visit: Schedule for visit, virtual modality is preferred over in person if clinically appropriate & capable	Examples include but are not limited to change/decline in condition- physical or mental, transition in care back to MFH/CRC post institutional discharge.
MFH/CRC Inspections	N/A	**Initial** Inspections of MFH or CRC: Schedule in person inspection utilizing appropriate PPE, minimizing contact with Caregivers and residents in the MFH/CRC.	Approval of new MFH or CRC requires in person, onsite inspection. Consider local facility plans for returning to community, maintain social distancing with Veterans and Caregivers/Sponsors, wear recommended PPE and follow CDC recommendations for hand hygiene with hand sanitizer of at least 60% alcohol before and after inspections occur.
		Annual inspections of established MFH or CRC: Schedule in person inspection utilizing appropriate PPE, minimizing contact with Caregivers and residents in the MFH/CRC. Virtual inspections may occur as determined by local facility leadership and inspectors when in person inspections are not recommended.	Where inspections are performed virtually due to COVID-19, it is understood that 1) the scope of the inspection is limited due to the virtual nature and 2) the outcome may vary when facility staff conducts an onsite inspection.

Nephrology Care Delivery

Last Updated: May 18, 2020

Questions on this chapter should be directed to National Program for Nephrology at VHANationalKidneyProgram@va.gov

Acute and Chronic Dialysis Units have maintained services despite the COVID-19 crisis.

Nephrology Outpatient clinics have converted most care to virtual care visits except for complex patients requiring in person visits.

1. **COVID-19 Priority 1**:
   - 1.1. Progressive Chronic Kidney Disease (CKD) or Acute Kidney Injury that cannot be evaluated by, or that failed to improve with, virtual care visits. Examples might include:
     - 1.1.1. Stage IV and V CKD requiring new laboratories and a physical exam to evaluate for preparation or initiation of dialysis.
     - 1.1.2. Patients with CKD and severe anemia who require IV iron infusions and/or in-clinic ESA injections (if the patient is unable to administer ESA at home)
     - 1.1.3. New Acute Kidney Injury of any etiology
     - 1.1.4. Patient requiring a kidney biopsy which cannot wait > 3 months
     - 1.1.5. Patients requiring pre-transplant evaluations or post-transplant visits due to complications.
     - 1.1.6. Worsening symptoms consistent with uremia

2. **COVID-19 Priority 2**: wait until normal scheduling resumes, and then make appointments for priority 2 patients first. The timing of appointment should be based on clinical judgement of the nephrology consult reviewer. Virtual care will continue for appropriate patients.
   - 2.1. New patient referrals requiring clinic visits for urinalysis and microscopy by nephrology.
   - 2.2. Urgent hypertension consults

3. **COVID-19 Priority 3**: these patients should be scheduled after priority 2 patients, with the timing of appointment based on clinical judgement of the Nephrology consult reviewer.
   - 3.1. Patients with routine RTC or New Patients who cannot be evaluated by virtual care visits or need lab or radiologic testing.
   - 3.2. Anything not Priority 1 or 2.

NOTE: For Veterans requiring kidney transplant referral, evaluation and/or transplant procedure, including at community transplant centers, a referral must be submitted to a VA Transplant Center through TRACER. Link to TRACER: https://vaww.tracer.nso.med.va.gov.
Guidance for transplantation care in community, see Guidance transplantation through Community Care, released by Office of Community Care on 6/17/19: http://vaww.dushom.va.gov/DUSHOM/surgery/docs/Guidance_for_Transplantation_through_Community_Care.pdf.

Neurology Care Delivery

Last updated: April 23, 2020

Please direct questions on this chapter to Dr. Don Higgins, National Program Director for Neurology at: Donald.Higgins@va.gov

1. **COVID-19 Priority 1:** Emergent/urgent. Contact the neurologist in clinic or on-call to arrange care.
   1.1. Onset of stroke-like symptoms (BE FAST – balance problems, vision change, facial drooping, arm weakness, speech difficulties, etc.).
   1.2. Worst headache of life (i.e. thunderclap), intractable headache or new headache with focal neurologic symptoms (weakness, sensory change, etc.)
   1.3. Prolonged seizure unresponsive to usual acute interventions.
   1.4. Sensorimotor disturbance, emerging/evolving over brief time interval (i.e. 24-72 hours), prompting concern for Guillain-Barre syndrome or myasthenic crisis.
2. **COVID-19 Priority 2:** Moderate risk. If available, use clinically indicated date (CID) from previous notes to prioritize.
   2.1. Scheduled injection therapy with botulinum toxin for treatment of headache, dystonia or spasticity.
   2.2. Scheduled programming of neuromodulation device (i.e. deep brain stimulation, vagal nerve stimulation or responsive neurostimulation).
   2.3. New referral or follow-up care for neuromuscular disorder such as amyotrophic lateral sclerosis, inflammatory neuropathy, or myasthenia gravis.
   2.4. Electromyography (EMG)/nerve conduction study (NCS) for evolving sensorimotor disturbance unlikely to represent an entrapment syndrome (i.e. carpal tunnel syndrome) or chronic neuropathy.
   2.5. Admission to Epilepsy Monitoring Unit for characterization or refractory epilepsy and consideration of candidacy for resection or neuromodulation.
   2.6. Electroencephalography for characterization of seizure events that have been unresponsive to standard treatment, first seizure, or transient event possibly due to newly diagnosed seizure.
   2.7. Early follow-up of patients with TIA not admitted to the hospital (may be via telemedicine).
   2.8. Subacute onset of new neurological symptoms requiring expedited diagnostic work-up or alteration in medical therapy, such as new onset of MS or acute MS exacerbation.
3. **COVID-19 Priority 3:** Low risk - all other patients not covered in Priority 1 or 2. If available, use clinically indicated date from previous notes to prioritize.
   3.1. All routine Neurology care: to include, but not limited to, management of long-standing headache disorder, well controlled epilepsy, chronic stable neuropathy, well controlled tremor and other movement disorders.

NOTE: Referrals may be adjusted based on provider staffing, local referral guidelines, protocols and procedures associated with COVID-19 protection, physical distancing, and availability and access of services, including telehealth and community care.

Nutrition and Food Services

Last updated: May 18, 2020

Questions on this chapter should be directed to Nutrition and Food Services at VHANFACnut@va.gov

Nutrition and Food Services (NFS) is an integral part of the interdisciplinary team.

1. Nutrition clinic scheduling is aligned with VHA Moving Forward plans and VHA Operations guidance.

2. Patient Priority is based on acuity. Nutrition scheduling will vary based on the Nutrition clinics and care modalities available at the facility. Referrals may be adjusted based on these availabilities, local referral procedures and protocols associated with COVID-19 protection.

3. All telehealth options should be continued. Telehealth should be leveraged for nutrition assessments *utilizing clinical judgment to evaluate priority/acuity and patient need for an in person visit.* More information about patient Priority is available here: https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/ConsultManagement/SitePages/Consult%20Options%20for%20COVID%20Pandemic.aspx.

4. It is estimated that the majority of Nutrition patients will be Priority 3-4, but Priority 1 or 2 may be used when patient acuity and needs require an in person visit. Some examples may include but are not limited to: nutrition support, malnutrition, or other significant conditions that require in-person nutrition-focused physical exam or hands-on education to develop the nutrition care plan.

Ophthalmology Care Delivery

Last updated: April 20, 2020

Questions on this chapter should be directed to Dr. Glenn Cockerham, National Program Director for Ophthalmology at Glenn.Cockerham@va.gov

1. **Priority 1:** Emergent/urgent. Contact the ophthalmologist in clinic or on-call to arrange care.
   1.1. Eye or eyelid trauma with pain, redness or visual change.
   1.2. Acute onset of vision loss.
   1.3. Acute onset of flashes, floaters or shade in vision.
   1.4. Red eye, particularly when associated with pain.
   1.5. Headache associated with eye pain and/or visual change.
   1.6. Acute onset of double vision (diplopia).
   1.7. Chemical injury to eye (acid, alkali).
   1.8. Vision changes in a patient with known history of ocular disease such as macular degeneration, glaucoma, or diabetic retinopathy

2. **Priority 2:** Moderate risk. If available, use clinically indicated date (CID) from previous notes to prioritize.
   2.1. Scheduled intraocular injections for diabetic retinopathy or age-related macular degeneration.
   2.2. Follow-up for diabetic retinopathy without vision changes. Refer to telehealth if available.
   2.3. Follow-up for glaucoma requiring medications without vision changes. Refer to telehealth if available.
   2.4. Follow-up for macular degeneration without vision changes. Refer to telehealth if available.
   2.5. Follow-up for other known chronic eye diseases without vision changes, including but not limited to uveitis, corneal edema, retinal disorders.

3. **Priority 3:** Low risk - all other patients not covered in Priority 1 or 2. If available, use clinically indicated date from previous notes to prioritize.
   3.1. All routine eye care: diabetic screening in patients without a diagnosis of retinopathy, and periodic examinations for use of systemic medications known to affect eyes and/or vision in patients without visual changes. If ophthalmology has no availability, consider referral to optometry, telehealth or community care if available.
   3.2. Spectacle requests, specialty contact lens requests. Refer to optometry or community care.
   3.3. New patients without visual/ocular complaints. If patient is authorized for VA eye care, refer to optometry, telehealth or community care if available.

NOTE: The Ophthalmology Work Group understands that referrals may be adjusted based on eye care provider staffing, local referral guidelines, protocols and procedures associated with COVID-19 protection, physical distancing, and availability and access of

services, including telehealth and community care. Eye care guidelines should ideally be reviewed with leadership from Primary Care, Optometry, Emergency Medicine, Community Care and the Call Center.

Optometry Care Delivery

Last updated: April 20, 2020

Please direct questions on this chapter to Dr. John Townsend, National Program Director for Optometry at: John.Townsend@va.gov

1. Contact (March/April) patients who are being/have been cancelled and not already triaged, contacted or rescheduled.
2. Triage and define Risk Priority level via phone interview (per table below)
3. Begin scheduling patients back into clinics based on the Risk Priority level as described below consistent with VHA Directive 1121.

Priority	Description
Risk Priority 1: Make appointment now, despite COVID-19 crisis.	Urgent and emergent conditions at high risk for vision loss: 1. Sudden loss of vision (including transient vision loss). 2. Sudden shade in vision, or new onset of flashes or floaters. 3. Sudden onset of diplopia (double vision). 4. Sudden eye lid droop (ptosis). If associated with facial weakness refer to neurology. 5. Painful red eye in a contact lens wearer. 6. Red eye with significant visual symptoms or significant pain. 7. Trauma to the eye or periorbital area sufficient to cause pain or visual symptoms.
Risk Priority 2: Wait until normal scheduling resumes, and then make appointments for priority 2 patients first. They should be appointed first based on CID.	Other conditions that warrant timely care: 1. Age-related macular degeneration (AMD). 2. Glaucoma. 3. Diabetic retinopathy. 4. Systemic disease with eye manifestations. 5. Systemic medications with ocular toxicity. 6. Eye motility disorders. 7. Lid disorders. 8. Presumed visual impairment (low vision, blindness). 9. Cataracts. 10. Uncorrected refractive error. 11. Vision examination for a driver's license.
Risk Priority 3: After priority 2 patients are situated, priority 3 should be scheduled.	1. New patients. 2. Established patients not seen in 2 years. 3. Eye Telehealth Screening patients "at risk" for AMD, diabetic retinopathy and glaucoma.
Risk Priority 4: After priority 3 patients are situated, priority 4 should be scheduled.	1. Established patients seen within 2 years with last exam being normal.

Pain Clinic & Pain Procedures Prioritization

Last updated: April 27, 2020

Questions on this chapter should be directed to the National Pain Program at VHAPM@va.gov

Background

The National Pain Program Office recommends that all Pain Clinics/Pain Management Teams make use of the new COVID-19 Consult Toolbox that allows efficient assignment and documentation of a Priority designation for each consult to pain services, for specialty care evaluations and management including interventional pain services.

Suggestions for priority assignments are based on patient diagnosis including acuity and risk of progression, and patient general health and co-morbidities. Due to the subjective nature of pain, priority is not based on a numerical pain score, although that may be a part of the consideration for scheduling. Suggestions are meant to assist, not supplant a clinician's overall clinical impression and judgement: decisions will need to be made on a case-by-case basis. Telehealth appointments including urgent/emergent appointments for VVC (or phone, if tele video is not available or applicable) may be utilized to expedite evaluation and may result in modification of the priority score.

The guidance listed below is subject to change depending upon a host of factors, including the duration and severity of local COVID-19 outbreak, availability of testing for active infection with COVID-19, availability of personal protective equipment. Considerations also include potential risk related to the procedure, such as steroid injection resulting in immunosuppression with potentially increased risk for COVID-19 infection or worsening of outcome. Other factors include access to locations for the performance of interventional pain procedures and vendor support.

A. RECOMMENDED INDICATIONS FOR EACH PRIORITIZATION CATEGORY

1. Priority 1

1.1. High priority urgent or emergent pain clinic evaluations/procedures that should be performed despite the COVID-19 pandemic

1.2. Schedule now due to imminent harm from delay due to the potential for loss of life or significant loss of function.

1.3. Suggested indications for Priority 1 include conditions with the potential for neurologic injury and/or chronification of acute pain, or the potential for a medication induced adverse or sentinel event and as such, necessitates timely interventions to mitigate these risks and to offer potential for improvements by interventional pain treatments or medication management adjustments respectively.

1.3.1. Implanted pain devices with complications including device failure, infection, catheter or lead fracture, and intrathecal granuloma – to be given priority in facilities performing these procedures.

1.3.2. Cancer-related pain with failure of medical management requiring destructive neurolysis.
1.3.3. Acute radiculopathy or acute on chronic spinal stenosis with associated weakness or change in bowel/bladder function.
1.3.4. Orofacial/HA disorders minimally responsive to standard medical care, such as cluster headache, trigeminal neuralgia, status migrainosus.
1.3.5. Vertebral compression fracture > 6 weeks and poor pain relief despite adequate trial of medications
1.3.6. Sympathetic nerve block for vascular compromise (i.e. limb salvage in acute/chronic vascular compromise.
1.3.7. Patient with medication regimens potentially of high-risk including potential for overdose or death, such as combination of opioid therapy with benzodiazepine(s), high dose opioid therapy, opioid therapy in the context of recent aberrant urine drug testing result, or opioid therapy in the context of evidence for opioid use disorder.
1.3.8. Patient previously stable on opioid therapy regimen presenting with acute or subacute onset or significant decline in general health (physical or mental), comorbidity or functioning for expedited assessment including evaluation for urgent treatment and medication adjustment (such as tapering or discontinuation of opioid medication or otherwise) or other intervention.
1.3.9. Opioid therapy in the context of severe active mental health condition, including prior suicide attempt(s) or substance on opioid therapy, recent hospitalization with need to assist with opioid planning or adjustment (including tapering),
1.3.10. Cluster headache or other poorly controlled headache disorder.
1.3.11. (Acute musculoskeletal pain conditions with need for multi-/interdisciplinary approach.)
1.3.12. Scheduled medication regimens that require retreatment, such as botulinum toxin for migraine.

2. Priority 2

2.1. Moderate priority referrals should be scheduled as soon as able to schedule non-urgent visits.
2.2. Suggested indications for Priority 2 include symptoms that are concerning for a possible serious condition or high risk, but not fulfill criteria for Priority 1. Included are patients with indications for pain procedures or medication management with the potential to mitigate risk, reduce pain, and/or increase function and that may allow for reduce requirement of medication such as opioids.
2.2.1. Complex Regional Pain Syndrome, Type I and II, with acute/subacute presentation and urgent medication/non-pharmacological treatment including consideration for sympathetic nerve block.
2.2.2. Acute/subacute radiculopathy with associate weakness (or diminished reflexes if exam is available) and consideration for epidural steroid injection.

2.2.3. Low back pain with failure of medical management with consideration for radiofrequency ablation (RFA) of medial and lateral branch nerves.
2.2.4. Knee pain with failure of medical management with consideration for intraarticular injection (*NOTE:* steroid medication may increase risk for COVID-19) and/or RFA of genicular nerves.
2.2.5. Patients with recently started opioid therapy on increased risk due to other conditions, such as recent MH exacerbation or recent discharge from acute care and significant medical comorbidities.
2.2.6. Patients with stable chronic pain disorder presenting with acute new pain complaint(s)
2.2.7. Patient with previously stable headache disorder than has changed in quality, severity, nature
2.2.8. Stable patient in the context of identified risk factors or chronic decline in general health (physical or mental), comorbidity or functioning requiring consideration for the initiation or management of a slow opioid taper, supporting treatments, or elevated frequency of monitoring.

3. Priority 3

3.1. Low priority referrals should be scheduled after patients with priority 2.
3.2. Suggested indications for Priority 3 include
3.2.1. Acute/subacute radiculopathy with no focal symptom or finding (other than sensory) with consideration for epidural steroid injection (*NOTE:* focal motor symptom suggest priority 2).
3.2.2. Peripheral neuropathy including neuritis/neuropathic pain and consideration for peripheral nerve block.
3.2.3. Patients with severe pain conditions not responsive to medical management who may benefit from office-based procedures, such as injections (unless higher priority due to criteria above).
3.2.4. Joint pain with consideration for pulsed RFA of peripheral nerves
3.2.5. Trial/implant of spinal cord stimulator, dorsal root ganglion stimulator or intrathecal drug delivery device.
3.2.6. Minimally invasive lumbar decompression *(i.e. MILD ® procedure)
3.2.7. Implant of spinal spacer device *(i.e. Vertiflex® placement).
3.2.8. Chronic pain conditions that are stable, with request for optimization of pain care, such a chronic radiculopathy or chronic joint pain or other musculoskeletal conditions, potentially with risk factors including opioid therapy and/or mental health comorbidities.
3.2.9. Patient deemed stable but with moderate risk factors in which

4. Priority 4

4.1. Low priority referrals should be scheduled after patients with priority 3
4.2. These include patients with chronic pain that appears stable and without significant risk factors, or consideration for medication management or pain procedures that

are used for chronic, stable pain conditions or which may be used for diagnostic purposes.

5. Common Pain Procedures (may include but are not limited to)

5.1. Neurolysis for cancer pain (celiac plexus, superior hypogastric, impar ganglion)
5.2. Intrathecal drug delivery trial/implant
5.3. Spinal cord stimulator trial/implant
5.4. Dorsal root ganglion stimulator trial/implant
5.5. Spinal decompression device (i.e. Vertiflex)
5.6. Spinal decompression procedure (i.e. MILD)
5.7. Vertebroplasty
5.8. Kyphoplasty
5.9. Epidural steroid injections
5.10. Medial branch nerve block
5.11. Facet joint block
5.12. Lateral branch nerve block
5.13. Sacroiliac joint block
5.14. Joint injections
5.15. Peripheral nerve blocks
5.16. Radiofrequency ablation
5.17. Genicular nerve ablation
5.18. Pulsed radiofrequency ablation
5.19. Sympathetic nerve blocks
5.20. Platelet Rich Plasma injections
5.21. Prolotherapy injections
5.22. Botulinum toxin/chemoneurolysis
5.23. Basivertebral nerve RFA
5.24. Disc biaculoplasty

Physical Medicine & Rehabilitation (PM&R) and Rehabilitation Therapies (Physical, Occupational, Speech and Kinesiotherapy)

Last Updated: May 21, 2020

Please direct questions on this chapter to the National Program Director for PM&R Services and TBI/Polytrauma System of Care at: Joel.Scholten@va.gov

1. **COVID-19 Priority 1** – Urgent or emergent procedures
   1.1. Acute neuro, cardiac, and musculoskeletal injuries/issues if untreated would require hospitalization or institutional care

2. **COVID-19 Priority 2** – Should be done as soon as we are able to schedule non-urgent procedures- Veteran with functional impairment that if left untreated would likely result in ER visit or institutional care
   2.1. High chance of adverse outcomes without participation in rehab
   2.2. Post op patients with functional deficits which left untreated would likely result in ER visit or institutional care
   2.3. High risk of harm (immobilization/fall/pain) without medical, therapeutic or prosthetic intervention

3. **COVID-19 Priority 3** – Routine cases that are less time sensitive than Priority 2 - all other consults/appointments
   3.1. Low/moderate risk of adverse outcomes without participation in rehabilitation
   3.2. Moderate/low risk profile relative to COVID-19 19 with moderate-low rehab need
   3.3. Group clinics/activities

NOTE: Veterans should be contacted, to assess patient risk factors and clinical need for services, and initially offered virtual care if clinically appropriate. Physical Distancing factors should be considered as it relates to optimize space and appointment management.

Podiatry Care Delivery

Last Updated: April 23, 2020

Please direct questions on this chapter to Dr. Jeffrey Robbins, National Program Director for Podiatry at Jeffrey.Robbins@va.gov.

1. Contact (March/April) patients that are being/have been cancelled
2. Triage and define Priority category via phone interview (per table below)
3. Begin scheduling patients back into clinics based on the risk priority action as defined below.

Priority	Description
Risk Priority 1: Make appointment now, despite COVID-19 crisis.	Urgent conditions that carry morbid consequences (diabetic foot infections, fracture/dislocation, ulcer/wound care, etc.)
Risk Priority 2: Wait until normal scheduling resumes, and then make appointments for priority 2 patients first. They should be appointed first based on CID.	• Prevention of Amputation in Veterans Everywhere (PAVE) Foot Risk Score (FRS) 3 patients as defined in VHA Directive 1410 Prevention of Amputation in Veterans Everywhere. • High Risk medically necessary conditions as defined in VHA Directive 1122, Podiatry Medical and Surgical Service
Risk Priority 3: After priority 2 patients are situated, priority 3 should be scheduled.	• PAVE FRS 2 patients as defined in VHA Directive 1410 Prevention of Amputation in Veterans Everywhere. • Moderate Risk medically necessary conditions as defined in VHA Directive 1122, Podiatry Medical and Surgical Service
Risk Priority 4: After priority 3 patients are situated, priority 4 should be scheduled.	• PAVE FRS 0 and 1 patients as defined in VHA Directive 1410 Prevention of Amputation in Veterans Everywhere. • Low Risk medically necessary conditions as defined in VHA Directive 1122, Podiatry Medical and Surgical Service

VHA Directive 1410 and 1122 risk definitions:

Risk Score	PAVE 1410	Pod. Service 1122
High	These individuals demonstrate peripheral neuropathy with sensory loss (i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament) and diminished circulation and foot deformity, or minor foot infection and a diagnosis of diabetes, or any of the following by itself:	• Documented Peripheral Arterial Disease • Documented Sensory Neuropathy • Prior history of foot ulcer or amputation

Risk Score	PAVE 1410	Pod. Service 1122
	(1) Ulcer or Prior ulcer, osteomyelitis or history of prior amputation; (2) Severe Peripheral Vascular Disease (PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene); (3) Charcot's joint disease with foot deformity; and (4) End Stage Renal Disease.	
Moderate	These individuals demonstrate sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament) and may have one of the following additional findings: (1) Diminished circulation as evidenced by absent or weakly palpable pulses (this would require follow-up examination to determine level of vascular disease before a final risk score can be determined). (2) Foot deformity or minor foot infection and a diagnosis of diabetes.	• Visually impaired • Physically impaired • Neuromuscular diseases, • Severe arthritis • Cognitive dysfunction • Chronic anticoagulation therapy
Low	These individuals demonstrate one or both of the following: (1) Foot deformity or minor foot infection (and a diagnosis of diabetes).	• >70 years old without other risk factors • Diabetes without foot complications • Obesity
Normal	These patients have no evidence of sensory loss, diminished circulation, ulceration, or history of ulceration or amputation. Patients with diabetes should receive foot care education and annual brief foot check. These patients do not require therapeutic footwear	

Pulmonary Care Delivery

Last updated: April 30, 2020

Questions on this chapter should be directed to Dr. Claibe Yarbrough, National Program Director for Critical Care, Pulmonary and Sleep Medicine at: WC.Yarbrough@va.gov

1. Any emergent care by definition should be handled as a STAT consult. Emergent care is outside the scope of the COVID-19 toolbox.

2. In person care requires consideration of need for PPE, infection risk factor mitigation, cleaning requirements for equipment. Also requires supply chain management of PPE, disposable equipment and processing of soiled medical equipment.

3. Consideration should be made based on the status of COVID-19 in the community and possible risk to patient from both SARS-CoV-2 and underlying clinical issue that requires being addressed. Goal to maximize protecting patient/providers during interactions while delivering necessary services. Consideration of care will often require coordination with supportive additional services.

4. Priority for diagnostic and therapeutic procedures should follow the priority placed on the clinical indication. Examples include pulmonary function testing for lung mass evaluation (priority 1) should have higher priority than new nodule evaluation (priority 2).

5. Many of our priority 1 and 2 patients require testing processes that are under the expertise of collaborative services. These groups may also have demand (radiology, PFT, echocardiography, etc.) that impacts availability of those of our services and priorities. Their priority ratings may be inherently different than those for pulmonary medicine. They are also going to have to manage highly complex processes. At a local level, highly encourage discussions about aligning our priorities to improve timeliness and consistency of services. Integrated practice units or other approaches to decrease burden/streamline process for care coordination for staff and visits should be considered. Example of an urgent patient who cannot receive timely diagnostic tests has the potential to adversely affect outcomes for both the patient and VA.

6. For pulmonary nodules, decision making for priority should be influenced by estimating the pretest probability of cancer. Many incidentally detected nodules can follow Lu-Rad or ACR recommendation of follow-up with virtual care visits

7. Screening for lung cancer should be limited during community activity of SARS CoV-2. Prior to initiating or continuing to screen, patients should be eligible for screening. Currently ~50% of patients receiving LCS in VA are not eligible for screening. Inappropriate screening increases risk to patients and staff and consumes resources without potential for benefit.

8. For Pulmonary Function Testing, the routine collection of interval pulmonary function data in absence of new symptoms or diagnostic indication is strongly discouraged.

Lung function testing and the choice of individual tests should only be performed if it changes clinical management. We recommend interpreting negative SARS-CoV-2 tests in the context of community prevalence. The predictive value of a negative test will be greater in the context of low community prevalence. In situations of high community prevalence, there is a higher chance of having a false negative test (lower negative predictive value) that subsequently increases risk of transmission to staff and others. Negative pressure ventilation is ideal for PFT labs but may not possible in all situations. Meet with infection control section in regards to frequency of room cleaning, use of UV light, etc.

a. Dispose of these materials after each use: pneumotach, filter, circuit, nose clips. In some pulmonary function systems, it may not be possible to entirely dispose of the patient circuit, and additional cleaning may be needed.
b. Cleaning of plethysmography equipment is challenging and may not be possible. If using lung volume measurement, consultation with equipment manufacturer and/or infection control is encouraged. When lung volume estimations will change clinical decision making, an alternative approach could be nitrogen washout.
c. Use a patient filter when testing
d. Only perform tests necessary for clinical decision making.
    i. Example: lung cancer screening - pulmonary function testing are not needed unless evaluating patient tolerance for lung resection
    ii. Example: lung nodule evaluation - pulmonary function testing are not needed unless evaluating surgical candidacy (or similar) for suspected lung cancer.
e. Routine measurement should not be performed.
f. If high community prevalence and/or limited SARS COV-2 testing capability.
    i. Only urgent or greater (consistent with Priority 1)
    ii. Lung volume measurement should not be performed
g. If adequate SARS COV-2 testing and moderate community prevalence
    i. Lung volume measurement should not be performed unless required inform clinical decision making (e.g. LVRS)
h. If adequate SARS COV-2 testing and low community prevalence
    i. Based on clinical context.
i. Hours of operation of pulmonary function testing lab:
    i. Because pulmonary function testing with provocation is considered aerosol generating (and PFT without provocation a possible AGP), these may cause delays in study performance.
    ii. Consideration could be made for broadening overall hours of operation and weekends.
j. PFT testing outside pulmonary function testing laboratories is generally not recommended. Accordingly, recommend delaying spirometry in community-based outpatient clinics. Primary care clinics can continue to refer patients to pulmonary function laboratories.
k. We recommend that research specific spirometry at a minimum meet the standards set forth for clinical services.

Guidance for priority ratings (see notation 1 for emergent services)

Priority 1: Anticipate decline or delays of care are likely to lead to harms to patients.

Priority 2: New patient visits for conditions with possible decline.

Priority 3: Routine clinical practices for care of complex chronic diseases (new or established). Postponing by months likely not to affect patient health status

Priority 4: Less urgent than 3. Substantial delays unlikely to lead to decline in health status (screening)

Examples of clinical priority for pulmonary conditions, related services and visit modality			
Priority	Clinical condition/Dx	Integrated practices/common collaborating services/scarce resources (assumption that serologic based studies are available)	Clinical visit modality options
1	**Lung Mass Evaluation**	**Pulmonary Clinic**	**Virtual or In Person**
		Collaborative in person services that may be required:	
		Diagnostic radiology	In Person
		Nuclear Medicine	In Person
		Interventional radiology	In Person
		Pulmonary function lab	In Person
		Nodule board	Virtual
		Thoracic surgery clinic	Virtual or In Person
		Preprocedural clearance and consent	Virtual or In Person
		Bronchoscopy	In Person
		Interventional Bronchoscopy	In Person
		Pathology	Neither
	Escalating symptoms/exacerbation from any etiology (examples)	**Pulmonary clinic (for all examples)**	**Virtual or In Person**
	1. Obstructive lung disease 2. Tumor related 3. Thromboembolic disease 4. Pleural diseases 5. Neuromuscular weakness 6. Interstitial lung disease 7. Bronchiectasis 8. Infectious disease	Collaborative In Person services that may be required Pulmonary function Bronchoscopy suite Pharmacy Diagnostic radiology Interventional radiology Cardiology Echocardiography Cardiac catheterization Stress testing	
	Infusions therapies	**Pharmacy**	**In Person (clinic or home)**
2	**New evaluations**	**Pulmonary clinic (for all examples**	**Virtual or In Person**
		Collaborative In Person services that may be required	

Examples of clinical priority for pulmonary conditions, related services and visit modality			
Priority	Clinical condition/Dx	Integrated practices/common collaborating services/scarce resources (assumption that serologic based studies are available)	Clinical visit modality options
	1. Pulmonary artery hypertension 2. ILD 3. Acute thromboembolic disease 4. Bronchiectasis 5. Hypoventilation 6. Escalating COPD (less than 1) 7. Escalating asthma (less than 1) 8. Pulmonary nodules GT than 6mm	Pulmonary function lab Cardiology Cardiac Cath Lab Exercise physiology lab Diagnostic radiology PFT Bronchoscopy suite Pathology	
3	**Lower acuity new patients or stable routine visits for follow-up**	**Pulmonary clinic**	**Virtual or In Person**
	1. COPD 2. Asthma 3. Low-moderate risk pulmonary nodules 4. VTE-anticoagulation question 5. ILD follow-up	Collaborative In Person services that may be required (as above)	
4	**Low acuity (less than priority 3)**	**Pulmonary clinic**	**Virtual or In Person**
	Screening studies	Collaborative In Person services that may be required (as above)	

NOTE: For Veterans requiring lung transplant referral, evaluation and/or transplant procedure, including at community transplant centers, a referral must be submitted to a VA Transplant Center through TRACER. Link to TRACER: https://vaww.tracer.nso.med.va.gov.

Guidance for transplantation care in community, see Guidance transplantation through Community Care, released by Office of Community Care on 6/17/19: http://vaww.dushom.va.gov/DUSHOM/surgery/docs/Guidance_for_Transplantation_through_Community_Care.pdf.

Sleep Medicine

Last Updated: May 21, 2020

Questions on this chapter should be directed to Dr. Claibe Yarbrough, National Program Director for Critical Care, Pulmonary and Sleep Medicine at: WC.Yarbrough@va.gov

The VHA National Sleep Program presents the following suggested practices for patient prioritization of sleep testing and sleep clinical care as operations resume.

	Priority 1	**Priority 2**	**Priority 3**
Definition	Should be performed due to risk of patient harm or harm to others in event of delay in care:	Urgent or time-sensitive procedures that should be prioritized as soon as safely possible with timing of appointment based on clinical judgement, PPE availability	Should be scheduled after priority 2 patients with timing of appointment based on clinical judgement, PPE availability
Laboratory Polysomnography (PSG).	• Patients at-risk for severe sleep related breathing disorders AND are not able to complete home sleep apnea testing. o evidence of hypoventilation or severe hypoxemia OR o with significant cardiovascular, pulmonary or neuromuscular comorbidities OR o with significant daytime somnolence posing risk to self/others (e.g. history of drowsy driving, high-risk professions) OR o those who are considered high risk in the opinion of the sleep physician • Patients with suspected REM Sleep Behavior Disorder and a history of dream enactments with risk of injury to self or bedpartner	• Patients with suboptimal control failed empiric PAP therapy needing manual titration without significant medical comorbidity • Patients with suspicion of significant sleep related breathing disorder who are unable or have failed home sleep apnea testing.	• Patients with suspicion for other sleep disorders that require PSG diagnosis (e.g. Parasomnias, Periodic Leg Movement Disorder)
Home Sleep Apnea Testing (HSAT)	• Patients at-risk for severe sleep related breathing disorders o evidence of hypoventilation or severe hypoxemia OR o with significant cardiovascular, pulmonary or neuromuscular comorbidities OR o with significant daytime somnolence posing risk to self/others (e.g. history of drowsy driving, high-risk professions) OR o those who are considered high risk in the opinion of the sleep physician	• Patients with suspicion of obstructive sleep apnea felt to be impacting other comorbidities (e.g. Hypertension, Somnolence, Post Traumatic Stress Disorder)	
In-Person Positive	• Patients with suspected/ known severe sleep related breathing disorder and known	• Patients with non-severe or high risk sleep	

	Priority 1	Priority 2	Priority 3
Airway Pressure (PAP) Clinics	or high risk for sleep related hypoventilation (COPD, neuromuscular, OSH) or sleep related hypoxemia (CHF, PAH, IPF) **AND** ○ are unable to successfully complete PAP setup via mail-out or VVC/Tele appointment. OR ○ require assistance with existing PAP equipment which cannot be addressed with VVC/Tele appointment	related breathing disorder who require assistance with PAP that cannot be addressed by VVC/Tele appointment.	
In-Person Sleep Provider Clinics	• Patients with known or high risk for severe sleep apnea with associated sleep related hypoventilation (COPD, neuromuscular, OSH) or sleep related hypoxemia (CHF, PAH, IPF) whose sleep needs are unable to be addressed by VVC/Tele appointment. • Patients who are considered high risk in the opinion of the sleep physician	• Patients with sleep disorders felt to be impacting other comorbidities whose sleep needs are unable to be addressed by VVC/Tele appointment.	

Risk Mitigation Strategies to Reduce Viral Transmission in Sleep Centers:

1. Clear communication and use of transmission-based precautions for potential aerosol generating procedures such as positive airway pressure testing and treatment, actigraphy and PAP set-up, and drug-induced sedation endoscopy.

2. During PSG, the sleep technician should minimize entry to the PSG rooms as much as possible once the study has started; consider having a single sleep technician responsible for monitoring only one patient per night; consider having a higher tolerance for loose electrodes during the study.

3. For PAP titration studies, use of a negative pressure room is recommended whenever possible. Recommend cohorting patients whose studies require titration to the same night to enhance efficiency of PPE use. Consider instructing patient on how to remove their mask and turn off the PAP device so this can be done at the end of the study prior to the technician entering the room.

4. For HSAT, use disposable testing equipment if possible and limit face-to-face encounters for setup instructions. Equipment can be mailed to the patient with written instructions on use and mailed back to the sleep center after use.

Speech Pathology Care Delivery

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Questions on this chapter should be directed to Nan Musson, National Speech Pathology Discipline Lead at: Nan.musson2@va.gov

1. New inpatient consultations: All new inpatient consultations are considered priority

2. New outpatient consultations:
   A) Contact the patient or caregiver by telephone or telehealth to review the complaints and symptoms and determine the urgency for an in-person visit.
   B) Following a patient-centered approach, offer the appropriate procedure(s) and discuss options for an in-person appointment or virtual care including telehealth, secure messaging, texting, or telephone and document the plan.
   C) Notify the referring provider or interdisciplinary team to discuss the urgency for scheduling and document a Plan of Care.

3. Established outpatients:
   A) Review the patient-centered Plan of Care
   B) Schedule an appropriate in-person appointment when virtual care is not an option.
   C) Assure patients have access to technology (prosthetics and telehealth) and items for self-care in the home. Assistive Technology devices and Pharmacy items (disposables) may be mailed to the patient with follow-up virtual care.
   D) Review options with vendors to provide virtual care vs. in person appointments.

Note: The descriptions in the table below are suggestions for triaging. However, do not exercise authority over clinical decision making or local medical facility protocols for testing, available PPE for AGP procedures, or scheduling patients.

Priority	Description
Risk Priority 1: Make appointment now, despite COVID-19 crisis.	Urgent and emergent conditions: 1. Unmitigated tracheoesophageal puncture (TEP) prosthesis failure 2. Dysphagia (swallowing problem) impacting oral intake or high-risk for choking/aspiration and an outpatient instrumental exam is warranted *- fluoroscopy requires collaboration with Radiology Services* *- laryngoscopy may be in coordination with ENT* *- collaboration with Neurology for new stroke symptoms* *- collaboration with GI for esophageal symptoms* *3.* Pre-op counseling* 4. Pre-surgical or pre-radiation therapy assessment 5. Sudden change in communication or swallow function due to an acute or progressive neurological etiology*

Priority	Description
	6. Change in voice quality requiring an instrumental exam (laryngoscopy +/- stroboscopy) in consultation with otolaryngology or pulmonary services
Risk Priority 2: Wait until normal scheduling resumes, and then make appointments for priority 2 patients first. They should be appointed first based on CID.	Other conditions that may warrant timely care: 7. Speech, language, or cognitive-communication, impairments* 8. Moderate-low risk for aspiration and an outpatient instrumental exam (fluoroscopy or laryngoscopy) is warranted. - *fluoroscopy requires collaboration with Radiology Services* - *laryngoscopy may be in coordination with ENT* 9. Dysphagia treatment for established high-risk outpatients* 10. Post-op voice intervention*
Risk Priority 3: After priority 2 patients are situated, priority 3 should be scheduled.	3. Communication intervention for stable conditions with the potential for decline* 4. Routine tracheoesophageal puncture (TEP) voice prosthesis change. 5. Routine dysphagia evaluation and treatment*
Risk Priority 4: After priority 3 patients are situated, priority 4 should be scheduled.	5. Communication intervention for chronic conditions that are not time sensitive* 6. Auditory Processing Disorder treatment services* 7. Group treatment for established outpatients*

*In clinic appointment when virtual care is not an option.