

# Emerging Practices to Combat Coronavirus Disease (COVID-19)

COVID-19 Clinical Knowledge Transfer from Vizient members and industry resources

Updated: March 30, 2020

Vizient is committed to ongoing research of Vizient members' emerging practices and other related updates to federal and regulatory guidelines in support of efforts to combat the COVID-19 pandemic. The purpose of this document is to assist our members with critical information to supplement this work. As new information surfaces, updates will be provided.

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DISCLAIMER: Vizient is compiling information and emerging practices from members to aid in knowledge transfer during the COVID-19 response. PLEASE NOTE THAT THE PRACTICES DESCRIBED HEREIN ARE IN MANY CASES EMERGING, INNOVATIVE AND AT TIMES UNTESTED METHODS TO ATTEMPT TO ADDRESS NEW AND UNPRECEDENTED SITUATIONS. VIZIENT MAKES NO REPRESENTATION OR WARRANTY REGARDING THE SAFETY OR EFFICACY OF THE PRACTICES. DECISIONS REGARDING WHETHER AND HOW TO UTILIZE ANY OF THESE PRACTICES SHOULD BE MADE BY HEALTH CARE PROVIDERS, AT THEIR OWN RISK, WITH CONSIDERATION OF INDIVIDUAL CIRCUMSTANCES. As information is changing rapidly, Vizient encourages you to always refer to the CDC, your state's department of health, and your local public health authority for guidance. Vizient does not provide legal, regulatory, or medical advice and disclaims liability or responsibility for the accuracy, completeness, and/or clinical efficacy and safety for the products or processes contained herein. Members should seek their legal counsel's advice on local, state, and federal legal/regulatory matters. The links to information referenced in this document are the products of the named organizations and they are solely responsible for their content. For the most up-to-date information, please visit Vizient's [Disaster Preparedness](#) page. To submit practices your organization is using to prepare for COVID-19, please e-mail [disasterresponse@vizientinc.com](mailto:disasterresponse@vizientinc.com).

## Managing critical supplies (including PPE conservation)

National Emergency Stockpile –To obtain product not available through your distributor or contracted supplier, make a request through your state and be sure to develop a “case for need” of those supplies once they arrive at the state level. Include how many cases you currently have, how many you anticipate, and how many are currently under investigation, and use rate.

- [ASTHO Authorization Toolkit](#)
- [HHS Strategic National Stockpile](#)

Added 3/23/20

[FDA Policy for Temporary Compounding of Certain Alcohol-Based Hand Sanitizer Products](#) during the Public Health Emergency

Added 3/23/20

A number of provider organizations are accepting homemade masks, but others are still restricting sourcing of such supplies through their standard manufacturing channels. Some organizations are making their own, working with local manufacturers or accepting donated homemade masks

- [CDC: Updated Guidelines for Crisis Alternate Strategies for N95 Respirators](#)
- [Kaiser NCAL Covid-19 Playbook](#)
- [The Joint Commission Statement on Shortage of PPE](#)

Resources for the sterilization of PPE:

- [University of Nebraska provider resources](#)
- [Guidelines from Journal of Patient Safety](#)
- [ClordiSys decontamination](#)
- [3M statement](#)
- [JAMA Call for Ideas for Conserving PPE](#)

Supplies to monitor and prepare for shortages:

- Portable critical care monitors
- IV Pumps
- IV solutions, IV pump cassette sets, IV standard tubing, IV start kits, IV flushes
- MDI (metered dose inhalers)
- ET tubes
- All respiratory-related consumables (nasal cannulas, tubing, O2 face masks)

*Added 3/23/20*

Some hospitals have started to use 3D printers to make face masks.

Cox Health designed a reusable face shield from stock items in L&D and Endoscopy through 3D printing.

- The [USP Statement](#) discourages the reuse of disposal PPE outside of their best practice standards (i.e. the reuse of a disposable gown for 1 shift/day) due to the contamination risk. However USP is not an enforcement agency.
- Due to COVID-19 pandemic shortages, sterile compounding personnel are faced with the option of reused PPE for product protection or none at all.
- Some State Boards of Pharmacy (one of the enforcers of USP standard/related state laws) have provided guidance regarding sterile compounding compliance under conditions related to COVID-19 and resultant shortages that allow for USP non-compliant PPE conservation strategies during this pandemic.
- Prior to the USP statement, Vizient's USP compliance expert, Katrina Harper provided this information: [The Effect of COVID-19 PPE Supply Shortages on USP Compliance: Recommendations for Management](#) for member pharmacy teams.

Vet gray market suppliers claiming to have N95 masks or other PPE. Request they show the Establishment Registration # or Firm Registration # and a copy of the device listing along with the Regulation # of the specific device.

The FBI issued its [White Notice LIR 200323006 “Criminals Exploiting COVID-19 Outbreak for Financial Gain through Procurement and Consumer Fraud.”](#) The notice includes details on markings and where models #'s should be located on the mask.

Additional links include:

- [Options for organizations to report fraud or scam](#)
- [FBI field office information to report fraud](#)
- [FBI fraud submission site](#)

FDA has concluded based on the totality of scientific evidence available that certain imported disposable FFRs that are not NIOSH-approved are appropriate to protect the public health or safety. Read the statement [here](#).

[FDA Policy for Temporary Compounding of Certain Alcohol-Based Hand Sanitizer Products During the Public Health Emergency](#)

Reuse face shields for the same patient when possible by disinfecting with your approved disinfectant.

Increase utilization of expired respirators by reviewing the recent list from the FDA

- [Authorized NIOSH Approved Respirators](#)

Hand sanitizer conservation:

- Redistribute from non-clinical areas to clinical areas
- Pull product from non-clinical areas that are now working from home

Remove product from non-clinical areas that are still working on campus but leave one full bottle for every three or four staff/desks

Prepare for possible reduction in blood supply due to schools, colleges, and educational facilities not having blood drives.

- Recommend elective surgeries are cancelled.
- Adhere and enforce transfusion guidelines by communicating short supply.
- Remind clinicians to test pre and post transfusion to ensure the transfusion is clinically indicated.
- Cell salvage is recommended except where there are contraindications.

Use remote interaction with patients in isolation as appropriate to conserve PPE:

- Remote telemonitoring equipment if available
- Utilize phone or two-way intercom
- Video conferencing or baby monitors are options
- Some organizations are considering moving IV pumps outside the door into the hallway and running IV *tube extension sets to the patients to reduce the amount of PPE used.*

*Added 3/23/20*

## PPE conservation

Vet suppliers on the gray market claiming to have N95 masks or other PPE by requesting they show the Establishment Registration # or Firm Registration # and a copy of the device listing along with the Regulation # of the specific device.

*Added 3/23/20*

Increase utilization of expired respirators by reviewing the recent list from the FDA (provided below)

*Added 3/23/20*

Understand memorandum of understanding (MOU) information between hospital and local stores/community businesses for emergency supplies. See resources from CDC [here](#).

*Added 3/23/20*

Create anesthesia packs with needed supplies and airway code boxes.

*Added 3/23/20*

Know your PPE burn rate. COVID-19 patients will significantly increase your normal rate.

[Template for Calculating PPE Burn Rate](#)

*Added 3/23/20*

Centralize access and maintain strict control of critical PPE, especially N95 masks, to prevent theft and overutilization

*During live polling on Vizient's March 25 webinar, 86% of respondents had centralized PPE*

*Added 3/16/20*

If you cannot procure hand sanitizer, the FDA has issue guidance for temporary compounding [here](#).

To assist with the alleviation of the shortage of aseptic hand sanitizing products, the FDA will temporarily allow pharmacists in state-licensed pharmacies or federal facilities and registered outsourcing facilities to compound alcohol-based hand sanitizers according to their policy. An email address, [compoundingpolicy@fda.hhs.gov](mailto:compoundingpolicy@fda.hhs.gov), has been established for compounders to submit questions regarding the preparation of hand sanitizers.

The hand sanitizer is compounded using only the following United States Pharmacopoeia (USP) grade ingredients in the preparation of the product (percentage in final product formulation) consistent with World Health Organization (WHO) recommendations:

- a) Alcohol (ethanol) (80%, volume/volume (v/v)) in an aqueous solution denatured according to Alcohol and Tobacco Tax and Trade Bureau regulations in 27 CFR part 20; or Isopropyl Alcohol (75%, v/v) in an aqueous solution.
- b) Glycerol (1.45% v/v).
- c) Hydrogen peroxide (0.125% v/v).
- d) Sterile distilled water or boiled cold water.

USP has developed a [Compounding Alcohol-Based Hand Sanitizer During COVID-19 Pandemic](#) document which provides three formulations for compounding alcohol-based hand sanitizers.

Due to increased demand for USP-grade ethanol, isopropyl alcohol and glycerol, these ingredients have become harder to procure. Fisher Healthcare (contract #) has the products reportedly available. We are currently engaging other contracted suppliers as alternative sources.

A non-contracted supplier, Professional Compounding Centers of America (PCCA), is also seeing an increase demand for hydroxychloroquine sulfate USP, ethyl alcohol USP (190 proof and 200 proof), isopropyl alcohol 99% USP, hydrogen peroxide 3% USP, and glycerin USP (glycerol). Their inventory of these products is continuously being qualified and replenished. In order to purchase these ingredients, members will need to open a purchasing account by either calling 800-331-2498, emailing [customerservice@pccarx.com](mailto:customerservice@pccarx.com), or visiting <https://www.pccarx.com/ApplyNow>. Pre-order allocations are allowed and when inventory is received and qualified, the order will be fulfilled.

*Added 3/23/20*

As of March 20, 2020, all 50 states, the District of Columbia, five territories and one tribe are working directly with FEMA under the Nationwide Emergency Declaration for COVID-19. FEMA is coordinating the full federal response along with the U.S. Department of Health and Human Services and the White House Coronavirus Task Force to ensure states local, tribal and territorial governments receive the supplies and support they need, including medical supplies. See the [FEMA FAQ](#) for more information.

**National Emergency Stockpile** – To obtain product not available through your distributor or contracted supplier, make a request through your state and be sure to develop a “case for need” of those supplies once they arrive at the state level. Include how many cases you currently have, how many you anticipate, and how many are currently under investigation, and use rate.

- [ASTHO Authorization Toolkit](#)
- [HHS Strategic National Stockpile](#)

Added 3/23/20

***Update from the CDC with regard to healthcare facilities manufacturing masks:***

Measures (in the link below) are *not* commensurate with current U.S. standards of care. However, individual measures or a combination of these measures may need to be considered during periods of expected or known N95 respirator shortages. It is important to consult with entities that include some combination of: local healthcare coalitions, federal, state, or local public health officials, appropriate state agencies that are managing the overall emergency response related to COVID-19, and state crisis standards of care committees. Even when state/local healthcare coalitions or public health authorities can shift resources between health care facilities, these strategies may still be necessary. See [the CDC Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies](#)

Added 3/23/20

Consider moving IV pumps outside the door into the hallway and running IV tubing extension sets to the patients. This will reduce the amount of PPE used.

Added 3/23/20

Reuse face shields for the same patient when possible by disinfecting with your approved disinfectant.

Added 3/23/20

Utilize expired respirators by reviewing the recent list from the FDA (provided below).

Added 3/23/20

Implement N95 conservation strategies: create firm guidelines for N95 use and assess for appropriate use. Alternative strategies may include having Pharmacy convert to PAPRS for USP 800 and ½ masks to reduce use of N95 masks.

Added 3/16/20

Implement N95 conservation by adapting practice based on CMS guidance of March 10, ‘Guidance for Use of Certain Industrial Respirators by Health Care Personnel. This document addresses acceptable temporary alternatives and practices when the supply chain of respirators cannot meet the demand. See [CMS Guidance from March 10](#).

Added 3/16/20

*During live polling on Vizient’s March 26 webinar, 75% of organizations with no COVID-19 hospitalizations have not implemented a strategy to prolong the lifespan of N95 masks.*

Limit entry into patient isolation rooms (use phones, video conferencing)

Added 3/16/20

Cohort patients in a way that allows for longer use of a single N95 mask

Added 3/16/20

Reserve N95 for patient care resulting in aerosolization such as ventilated, suctioned patients or patients on nebulizers

Added 3/16/20

Change treatment regimen from nebulizer to metered dose inhaler (MDI), when possible  
Added 3/16/20

## Resources

- [JAMA: N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel](#)
- [WHO: Rational Use of Personal Protective Equipment for Coronavirus](#)
- [CDC: Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings](#)
- [Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response \(CDC\)](#)
- [OSF Healthcare is conserving masks in preparation for COVID-19](#)
- [Authorized NIOSH Approved Respirators](#)
- [CDC PPE Strategy](#)
- [Kaiser NCAL Covid-19 Playbook](#)
- [CDC- Section "10. Implement Environmental Infection Control"](#)
- [The Effect of COVID-19 PPE Supply Shortages on USP Compliance: Recommendations for Management](#)
- [Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators](#)
- [WHO: Rational Use of Personal Protective Equipment for Coronavirus](#)
- [CDC - Section "10. Implement Environmental Infection Control"](#)
- [JAMA: N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel](#)
- [WHO: Rational Use of Personal Protective Equipment for Coronavirus](#)
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- [The Effect of COVID-19 PPE Supply Shortages on USP Compliance: Recommendations for Management](#)

## Emerging clinical evidence

### Research and treatment

Review Vizient's summary of evidence on monotherapy trials and combination trials:

#### [Pharmacotherapy for COVID-19](#)

One investigational treatment being explored for COVID-19 involves the use of convalescent plasma collected from recovered COVID-19 patients. To learn more, visit the FDA website on [Investigational COVID-19 Convalescent Plasma - Emergency INDs](#).

According to a study titled [Association of Cardiac Injury with Mortality in Hospitalized Patients With COVID-19 in Wuhan, China](#) in JAMA Cardiology, cardiac injury is a common complication among those hospitalized with COVID-19 and is associated with an unexpected high risk of mortality during hospitalization.

A [study](#) of patients with COVID-19-related acute respiratory distress syndrome suggests that alternating patients' body position, particularly in the prone position, may improve lung recruitability.

#### [SARS-CoV-2 Transmission in Patients with Cancer at a Tertiary Care Hospital in Wuhan, China](#)

### Specialty care

As the number of critically ill patients surges in hospitals, non-ICU clinicians may be needed to care for critically ill patients. The Society of Critical Care Medicine provides online education to healthcare professionals who may benefit from critical care training: [Critical Care for the Non-ICU Clinician](#)

The American Association of Neuromuscular and Electrodiagnostic Medicine provides [COVID-19: Guidance for AANEM Members](#) on caring for their neuromuscular patients, many of whom may be immunocompromised.

CDC website has information on [Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 \(COVID-19\) in Inpatient Obstetric Healthcare Settings](#).

#### Neonatal care protocols

IP OB: Follow guidance from the CDC, ACOG and SMFM for pregnant patients and breastfeeding. Providers should consider their appropriate space and staffing needs to prevent transmission and reconfigure to:

- Appropriately isolate pregnant patients who test positive or are PUIs
- Ensure processes protect newborns at-risk

*Added 3/23/20*

#### Ambulatory care

Based on a framework mirrored after the federal Incident Command System, [Seeking Evidence-Based Covid-19 Preparedness: A FEMA Framework for Clinic Management](#) discusses triaging appointments, screening, telehealth visits, internal and external communications, and comprehensive resource management.

For guidance on the postponement of elective, non-essential surgery, below are links to resources:

- [Joint Statement Recommending a Surgical Review Committee for COVID-19-Related Surgical Triage Decision Making](#)
- [COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures](#)

#### Respiratory care

The Anesthesia Patient Safety Foundation provides a summary of [Recommendations for Airway Management in a Patient with Suspected Coronavirus \(2019 nCoV\) Infection](#).

#### Long term care

Resources for long term care:

CDC website has information on [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#).

Post-acute care (SNF, LTC, etc.) protocols

- Ensure SNFs have aggressive control measures in place

*Added 3/23/20*

#### Home health care

Resources for home health care:

CDC website has information on [Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 \(COVID-19\)](#).

#### Ethical considerations

The Hastings Center has assembled [ethics resources](#) for responding to novel Coronavirus (COVID-19).

- [Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic](#)
- [COVID-19: Supporting Ethical Care and Responding to Moral Distress in a Public Health Emergency](#)

#### Patient care protocols, algorithms and care pathways

### ED care pathway

- Divide ED into ILI and non-ILI
- Create care pathways from the ED (Example: Care Pathway ED to Observation/Inpatient unit from [University of Chicago Shared Pathway](#))
- *Added 3/16/20*

### IP care pathway

- If patients need to be admitted, limit non-invasive ventilation given the risk of aerosolization. Intubate using PAPR/CAPR and ideally in a negative pressure room.
- Develop a regional coalition or stand-up an ethics committee to work on scarce resource utilization and crisis standards of care algorithms (i.e. rationing care).
- Actively engage palliative care teams.
- Create physician back-up system; develop standard operating procedures for training non-MDs to assist in low-acuity and/or designated areas

*Added 3/23/20*

Screening, testing and surge algorithms

Screening: aim to reduce patients on campus

- Prepare outpatient telemedicine which can be an alternative to the ED (quarantined providers can assist)
- Identify alternate sites of care for triaging potential cases at point of entry
- Establish drive through testing (currently by appointment)
- Set up tents in parking lots
- Use hotels, dorms, etc.
- Create designated COVID clinic to assist with triaging

Screening: Emergency departments

- Create separate waiting rooms for potential respiratory isolation (staff address patients in PPE based on presence of respiratory complaints)
- Set up a tent in ED for RTI surge capacity
- Encourage RN to forward triage in the ED (*In Vizient's March 25 webinar, 86% said they were triaging patients in a setting outside of the ED*)
- Creatively isolate using lobby space or evaluate stable patients in cars
- Investigate implementing a 100% telemedicine process for patients versus a focused inpatient assessment as part of EMTALA medical screening exam

Testing

- Aim to determine testing at the site (which should no longer involve calling the Department of Health prior to ordering)
  - Send out labs with delayed results (TAT 1 or 2 days) using labs on site, state, commercial labs
  - Provider responsible for calling back positive cases and notifying the Department of Health and local infection prevention team
  - Providers trying to call back negative cases (seek assistance from ED, Infection Control or nursing supervisors)
- Potential testing algorithm for testing prioritization:
  - Sickest patients (high-risk cases with a clear epidemiologic link)
  - Increased risk of complications (symptoms, clinical course, diagnosis)
  - Increased risk of transmission

Surge

- Evaluate outpatient settings (clinics, urgent care centers) for evaluation and testing
- Create surge space in the ED (cool and hot zones) for triage
- Assess inpatient/ICU capacity, # of ventilators, ECMO capabilities/options, Supply Chain/PPE, Pharmacy, SNFs
  - Create cohort units
  - Develop protocols in the event ventilators need to be rationed
  - Suggestion for quick construction job: install fans in windows and convert a unit to negative pressure
- Begin to plan for case cancellation in the event of surge. Evaluate and prioritize how elective procedures and non-essential cases will be cancelled in the event of supply, personnel or capacity shortages.

Added 3/23/20

Home care protocols

- Send all high-risk symptomatic patients not needing admission home with a thermometer, a pulse Oximeter, and an app to follow patients and RN complete virtual checks-in

Added 3/23/20

Ensure IT capability and capacity support of anticipated work for EMR and other technical updates

Added 3/16/20

## Resources

- Vizient resource: [Pharmacotherapy for COVID-19](#)
- FDA: [Investigational COVID-19 Convalescent Plasma - Emergency INDs](#)
- Shi S, Qin M, Shen B. [Association of Cardiac Injury with Mortality in Hospitalized Patients with COVID-19 in Wuhan, China. JAMA Cardiology.](#)
- Pan C. [Lung Recruitability in SARS-CoV-2 Associated Acute Respiratory Distress Syndrome: A Single-center, Observational Study. American Journal of Respiratory and Critical Care Medicine](#)
- [SARS-CoV-2 Transmission in Patients with Cancer at a Tertiary Care Hospital in Wuhan, China](#)
- Society of Critical Care Medicine: [Critical Care for the Non-ICU Clinician](#)
- Anesthesia Patient Safety Foundation: [Recommendations for Airway Management in a Patient with Suspected Coronavirus \(2019 nCoV\) Infection.](#)
- CMS: [General Provider Telehealth and Telemedicine Tool Kit](#)[CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes Webpage](#)
- [CDC Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States webpage](#)
- [CDC Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 \(COVID-19\) in Inpatient Obstetric Healthcare Settings webpage](#)
- [Guidelines on the Management of Critically Ill adults with COVID1- from the Surviving Sepsis campaign](#)
- [Resources from the US Society of Critical Care Medicine \(includes checklist and videos\)](#)
- [University of Washington provider resources and Washington American College of Emergency Physicians; https://covid-19.uwmedicine.org/Pages/default.aspx](#)
- [UCSF provider resources](#)
- [Nebraska Medicine provider resources](#)
- [Lifespan, The Miriam Hospital provider resources; https://www.lifespan.org/centers-services/infectious-diseases/novel-coronavirus-information/providers](#)
- [The University of Chicago Medicine provider resources](#)

## Testing

Utilize the CDC coronavirus [self-checker](#) to help patients self-guide through appropriate testing considerations.

Check for new FDA EUA approved SARS-CoV-2 PCR tests for possible sourcing to improve the availability of testing.

Monitor the [FDA EUA approved listing](#) to check for the availability of rapid serology antibody test kits. These tests are in development from many manufacturers, but as of March 26, none have yet gone through the FDA EUA process. Some manufacturers and laboratories have notified FDA that they have validated and are offering [serology tests](#) as set forth in Section IV.D of the FDA's Policy for Diagnostic Tests for Coronavirus Disease-2019. However, the accuracy of these serology tests is not yet known.

Consider using rapid testing, e.g. from [Cepheid](#) or [Biofire](#), which provide results in about 45 minutes, in hospitalized patients in cases where it would improve patient management.

Consider anterior nares round foam swabs for specimen acquisition rather than nasopharyngeal sampling. Based on submitted data, FDA believes that nasal swabs may be just as accurate as nasopharyngeal sampling and more [comfortable for patients](#). Self-testing using this technology may also reduce the consumption of PPE.

Create your own [viral transport media](#) or use sterile saline to cope with shortages of conventional transport media. These transport media may stabilize the SARS-CoV-2 RNA without meaningful degradation.

In a rural hospital setting, consider home-based testing for patients with respiratory illness. In one model, the hospital will send a staff member out to the home to test patients. The patient will remain at home until the test results are available, unless their condition changes.

Develop alternate sites to conduct testing to reduce exposure to patients and staff in facilities.  
*Added 3/23/20*

Standardize triage, testing and treatment algorithm throughout organization  
*Added 3/23/20*

Create patient segregation/cohorting plan for locations where patients will be seen: ED, ICU and medical/surgical areas  
*Added 3/23/20*

Establish or utilize telemedicine services for person under investigation (PUI) for COVID-19 patients and/or meeting criteria for testing (as well as drive through)  
*Added 3/16/20*

Develop drive-through testing. See the Drive-Through Medicine [template](#) from the American College of Emergency Physicians.  
*Added 3/16/20*

Provide publically available education on testing (how, when and where to seek care) and the process to expect (include alternative testing sites)

- Use web site, COVID hotlines and PR capabilities

*Added 3/23/20*

## Resources

- [CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes Webpage](#)
- [CDC Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States webpage](#)
- [CDC Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 \(COVID-19\) in Inpatient Obstetric Healthcare Settings webpage](#)
- [Children's Hospital of Philadelphia Clinical pathway](#)
- [Guidelines on the Management of Critically Ill adults with COVID1- from the Surviving Sepsis campaign](#)
- [Resources from the US Society of Critical Care Medicine \(includes checklist and videos\)](#)
- [University of Washington provider resources and Washington American College of Emergency Physicians; <https://covid-19.uwmedicine.org/Pages/default.aspx>](#)
- [UCSF provider resources](#)
- [Nebraska Medicine provider resources](#)
- [Lifespan, The Miriam Hospital provider resources; <https://www.lifespan.org/centers-services/infectious-diseases/novel-coronavirus-information/providers>](#)
- [The University of Chicago Medicine provider resources](#)
- [CDC Evaluating and Testing Persons for Coronavirus Disease 2019 \(COVID-19\) Webpage](#)
- [CDC page](#) on interim guidance and resources for laboratory professionals working with specimens from persons under investigation (PUI) for coronavirus disease 2019 (COVID-19).
- [CDC Research Use Only Real-Time RT-PCR Protocol for Identification of 2019-nCoV Webpage](#)
- [CDC Coronavirus Disease 2019 \(COVID-19\)](#)
- [FDA Emergency Use Authorizations](#)
- [FDA FAQs on Diagnostic Testing for SARS-CoV-2](#)
- [AACC Coronavirus Resource](#)
- [University of Washington provider resources](#)
- [UCSF provider resources](#)
- [Nebraska Medicine provider resources](#)
- [Drive Through Medicine - Triage Template](#)

## Surge capacity

Emergency department/outpatient surge planning

#### Emergency department

- Create surge space in the ED for triage using cool and hot zones
- Investigate implementing a 100% telemedicine process for patients versus a focused inpatient assessment as part of EMTALA medical screening exam
- Use phone triage and telemedicine as an alternative to the ED (quarantined providers can assist)
- Have two on-call physicians ready and available every day in case of emergency

#### Ambulatory/outpatient surge planning

##### Ambulatory/Outpatient

- Evaluate outpatient settings such as clinics, urgent care centers, etc. For evaluation and testing to avoid ED usage
- Some organizations have created COVID clinics for providers to evaluate patients with flu-like symptoms, upper respiratory illness, fever and cough
- Recommend urgent care centers use a staff greeter to meet patients
- Greeters assess all patients and guests prior to entering the building to ensure health and safety of everyone
- Restrict number of visitors for urgent care patients
- Give urgent care patient masks and utilize specific exam rooms
- Cohort any patients that present with illness or injuries other than fever, upper respiratory illness including cough or shortness of breath into specific areas
- Some organizations created an online COVID-19 screening tool for patients with symptoms of fever and upper respiratory illness, including dry cough or shortness of breath
- Providers review symptoms are reviewed by a provider, WHO recommends additional treatment if appropriate and addresses where to go for this care
- Leverage phone triage and virtual health platforms as much as possible
- Creatively isolate using lobby space or evaluate stable patients in cars

Develop plans to cohort positive and PUI patients. See the Kaiser Permanente Coronavirus Mitigation [Playbook](#) for more specific information.

*Added 3/23/20*

Cancel elective surgery/procedures [Vizient Polling 3/18/20](#): Vizient members were asked, “Are you currently canceling/postponing elective surgeries?” **Of the 559 respondents – 399 (71%) answered yes and 160 (29%) answered no**

[ACS Statement Regarding Non-Emergent Surgical Procedures](#)

*Added 3/16/20*

Identify alternate sites of care in the event of a surge such as warehouses, empty malls, convention centers, empty dorm rooms)

*Added 3/16/20*

Consult with hospital biomedical engineering to understand options for alternate negative flow rooms, ventilation exchange rates, optional areas for cohort COVID-19 patients

*Added 3/16/20*

#### Triage

Triage patients in the ED by influenza-like illness (ILI) and non-ILI areas.

- Triage patients in the ED by influenza-like illness (ILI) and non-ILI areas. Use the [University of Chicago Shared Pathway as a guide](#)
- Send triage patients not needing hospitalization home and:
  - Provide remote monitoring if possible (e.g., thermometer, pulse oximeter)
  - Provide education, a monitoring schedule and/or virtual check-ups
- Use reverse triage to assess inpatients for discharge or movement to a step-down facility, if allowed

Develop alternate sites to conduct triage to reduce exposure to patients and staff

- RN-based telephone triage protocols
- Unused hospital space, dedicated repurposed space (one hospital within a system)
- Drive through triage template
- Enhance telemedicine/virtual capabilities
- Repurpose urgent care/ambulatory facilities into screening and testing locations
- Limit points of entry to the facility

*Added 3/23/20*

Limit companions during triage in accordance with newer restrictive visitor policies

- Place a mask on companions as they could be the source of infection or have been infected by the patient

*Added 3/23/20*

Limit healthcare worker and patient contact episodes

- Utilize apps, phones and telemedicine for in-hospital triage whenever possible

*Added 3/23/20*

Triage patients not needing hospitalization to home

- Provide remote monitoring if possible (e.g., thermometer, pulse oximeter)
- Provide education, a monitoring schedule and/or virtual check-ups

*Added 3/23/20*

Forward triage by moving triage sites outside of the tradition ED triage area (tents, parking lots, adjacent empty building spaces, etc.)

*Added 3/16/20*

Identify alternate sites of care to serve as isolation and testing areas to limit exposure to staff and patients in facilities. Consider surge tents, convention centers, warehouses, local dorms, etc. **Vizient Polling 3/18:** Vizient members were asked, "Are you currently leveraging alternative sites of care for triage?" **Of the 565 respondents - 317 (56%) answered yes and 248 (44%) answered no**

Triage patients and segregate to influenza-like illness (ILI) and non-ILI areas of the ED. See the [University of Chicago Shared Pathway](#)

*Added 3/16/20*

Reverse triage: assess inpatients for discharge or movement to a step-down facility, if allowed.

*Added 3/16/20*

## Telemedicine strategies

*During Vizient's March 25 webinar, a majority of respondents (56%) said they had increased telemedicine visits by 25% or more.*

Download [General Provider Telehealth and Telemedicine Tool Kit \(PDF\)](#) from CMS that is specific to general practitioners as well as providers treating patients with End-Stage Renal Disease (ESRD)

- View [Medicare Telemedicine Healthcare Provider Fact Sheet](#) that reviews Medicare coverage and payment of virtual services
- Develop a far-reaching plan to screen and treat ED patients as well as outpatients in every specialty via videoconferencing. (China made 50% of their care virtual)
- Convert regular ambulatory visits to telehealth visits
- Jefferson Health is using JeffConnect service to screen, assess and test patients
- Jefferson Health is scheduling 500-600 telephone visits per day across each specialty
- UAMS has a robust and secure online system for handling incoming queries, both for COVID-19 related screening and telemedicine visits
- UK Healthcare using Zoom videoconferencing platform for (1) unscheduled acute care, (2) previously scheduled outpatient visits
- Create a COVID hotline for RN to manage, triage and screen patients.
- Patients who screen positive schedule a telemedicine visit and are evaluated by ED physician who has been quarantined
- Isolate those patients in a video-equipped room to be evaluated via HIPAA-compliant videoconferencing platforms (Zoom, Laptops, iPads. Commercial companies: Amwell and Teledoc)
- PPE equipped RN takes vital signs and draws blood
- Patient is either admitted to hospital or discharged for COVID-19 testing or isolation.
- Consider deploying sophisticated telehealth technologies to monitor the sickest intensive care unit patients
- UW Medicine is purchasing InTouch robots to help staff ICUs to help handle critical shortage of PPE
- Develop training modules for providers on the use of videoconferencing platforms
- Use online training modules developed by University of Arkansas for Medical Sciences
- Certify providers for virtual visit care with Emory University developed e-learning training module
- Develop a plan to handle broadband and cellular service barriers (i.e. inconsistent access to cellphones and other technologies)
- Create a virtual war room from UAMS model where 15-20 tech people work around the clock to ensure systems stay online and not strained by the surge in demand.

## Inpatient

- Assess inpatient/ICU capacity
- Develop plans to cohort Patients Under Investigation (PUI) and patients testing positive.
  - [Check the Kaiser Permanente Coronavirus Mitigation Playbook for more specific information](#)
- Plan for case cancellation in the event of surge, supply and/or personnel capacity shortages
  - Reschedule elective surgeries and non-essential procedures (routine and non-urgent clinic visits) as necessary
  - Special accommodations may be made for bone marrow transplant, oncology, solid organ transplant and pregnant patients where special units are created if they become COVID-19 positive
  - Shift elective urgent inpatient diagnostic and surgical procedures to outpatient settings, when feasible
  - View [American Academy of Surgeons acuity scale](#) from
  - Review [Ambulatory Surgery Center Association state guidance](#) on elective surgeries
  - Examine [CMS tiered framework on elective surgeries](#) as guidance on decisions whether to provide elective surgeries during community spread of COVID-19.
  - Cancel elective surgery/procedures
    - [Vizient Polling 3/18/20](#): Vizient members were asked, “Are you currently canceling/postponing elective surgeries?” **Of the 559 respondents – 399 (71%) answered yes and 160 (29%) answered no ACS Statement Regarding Non-Emergent Surgical Procedures**
- Create cohort units
  - Separate known or suspected COVID-19 patients from other patients
  - Identify additional, dedicated space to care for both COVID-19 and/or a surge of critically ill patients
    - Use alternate and separate spaces in the ER, ICUs, ambulatory surgery centers, OR and other patient care areas to manage known or suspected COVID-19 patients
    - Convert long term care facilities into COVID-19 treatment centers to cohort patients in separate facilities
    - Consider choosing a pulmonary unit to create easy transition for care teams, including respiratory therapists and nurse, while ensuring adequate supplies
  - Create a separate space in the ED for patients presenting with any flu-like symptoms or respiratory illness (including separate space for triaging as mentioned above)
- Increase bed capacity
  - Utilize other patient care areas (i.e. OR, ambulatory surgery centers, non-ICU beds, closed beds/units/buildings, etc.) to increase access to ICU beds
  - Identify alternate sites of care (such as breakrooms, conference rooms, warehouses, empty malls, convention centers, empty dorm rooms) to temporarily transform space into a hospital and increase access to beds
  - Consult with hospital biomedical engineering to understand options for alternate negative flow rooms, ventilation exchange rates, optional areas for cohort COVID-19 patients
    - Suggestion for quick construction job: install fans in windows and convert a unit to negative pressure
- Create physician back-up system
  - Develop standard operating procedures for training non-MDs to assist in low-acuity and/or designated areas
- Discharge planning
  - Practice patient flow best practices twice a day (rounding, discharge early or when ready) to improve hand-off communication
  - Use the recommended 15 by 10 model by Mike Rosenblatt, Beth Israel where each service must have everything ready to discharge 1 patient by 10 am. (i.e. orders, nursing teaching, med rec, etc. If no ride, they are sent home at 10 with a medical Uber or go to discharge lounge)
    - For rehab and SNF discharges –one large organization purchased 5 ambulances that sit in the parking lot with their engines on ready to take patients before 10 to the next level of care

- Do not hold discharges for the Patients to am if they are ready for discharge the day before
    - Measurement and display of data to create accountability is critical
  - Develop specialized post-acute care environments for patients who may be contagious
    - Long-term care hospitals and hospital-based skilled nursing facilities may be able to adopt this specialized role
    - Use rural hospitals, with less than 50% occupancy rates, as post-acute care sites as many have “swing bed” capacity
    - Military bases and college dormitories may also be used as temporary post-acute care settings

#### Resource utilization (supplies, equipment, workforce, etc.)

- Develop and implement a crisis standard of care plan through your state’s Department of Health (DOH) that addresses legal, ethical, palliative care and mental health issues
  - Review [Minnesota DOH Crisis Standards of Care](#)
- Develop protocols to ration ventilators, if necessary
- Model the ventilator triage process at Oregon Health and Science University
  - Utilize critical care ventilators until exhausted
    - Reroute G-5, AVEA, LTV 1200 and Trilogy patients to other facilities with equipment/beds
    - Use PACU for overflow/surge, anesthesia will support their ventilators
    - Request disbursement from Strategic National Stockpile
    - Use V60s in invasive mode
    - Disperse single use Vortran vents
    - Activate ventilator triage protocols as a united system prioritizing for younger patients and those with better odds of survival
  - Review [State of Alabama Ventilator Triage](#) process following a Mass-Casualty Respiratory Emergency
- Assess ECMO capabilities/options
- Develop staff surge plan to involve bedside staff as needed (include nursing and non-clinical staff) to help manage patients
  - Check University of Washington Medical Center website for template of a staff surge plan (currently under development)
- Develop medical staff structure that utilizes all providers across specialties across different areas: emergency department, urgent care (assist with triaging), critical care, acute med/surg
  - Adhere to GME requirements and regulations to appropriately allocate workforce
- Follow example from Medical University of South Carolina Health (MUSC) to deploy staff in Endoscopy, Procedure areas and OR/Periop to other areas. They did an inventory of staff, background, when they moved positions (if in last year just do skills checklist, but if over a year then attend skills labs). Of those who just relocated, will be reallocating those into their prior or similar unit

#### Tools

- Register to access [Sg2 COVID-19 Surge Demand Calculator and Resource Kit](#)
  - Sg2 experts developed the insights and resources you need to inject data-driven planning for inpatient bed and ICU capacity to inform your surge response
- Access the [Penn Medicine Hospital Impact Model for Epidemics](#), an open-source tool to help hospitals plan for patient increases and intake during COVID-19 spread in the Philly area
- Rothman Index optimizes discharge planning to increase capacity for COVID-19 cases
  - This includes Global Clinical Surveillance, Sepsis Risk Alerting, Early Warning to monitor suspected or confirmed cases of COVID-19 and ICU optimization
- Review [Johns Hopkins developed isolation bed algorithm tool](#) to help design cohort plan
- Use [University of Washington and Institute for Health Metrics and Evaluation partnership resources and tools](#) to help identify COVID-19 projections and help prepare for surges
  - Additional details will become public on ongoing basis

#### Communication/Command centers

- Provide publicly available education on testing (how, when and where to seek care), the process to expect (include alternative testing sites) through web site, COVID hotlines and PR capabilities
- Create a coalition as a part of a health system to develop a coordinated, united response and communication plan to expand hospital bed capacity, align criteria for testing and expand the health care workforce
  - The state of Oregon is expanding the health care workforce by automatically renewing the license of any medical professional whose license had recently expired
- Access materials from [FEMA's Incident Command System \(ICS\)](#) Resources to assist with implementation of ICS's
- Review [Rush University Medical Center Command Center Structure](#)
  - Developed to navigate preparing for a disaster, emergency or event and impacts on daily operations

## Resources

- Santa Clara County drive-through triage template
- University of Chicago Shared Pathway
- CMS tiered framework on elective surgeries
- Medicare Telemedicine Healthcare Provider Fact Sheet
- Kaiser Permanente Coronavirus Mitigation Playbook for more specific information
- American Academy of Surgeons acuity scale
- Ambulatory Surgery Center Association state guidance
- CMS tiered framework on elective surgeries
- ACS Statement Regarding Non-Emergent Surgical Procedures
- Minnesota DOH Crisis Standards of Care
- State of Alabama Ventilator Triage
- Penn Medicine Hospital Impact Model for Epidemics
- Johns Hopkins developed isolation bed algorithm tool
- University of Washington and Institute for Health Metrics and Evaluation partnership resources and tools
- FEMA's Incident Command System (ICS)
- Rush University Medical Center Command Center Structure
- AAMC: <https://www.aamc.org/news-insights/covid-19-races-through-communities-hospitals-ramp-telehealth-protect-patients-and-providers>
- CDC Interim Guidance for Health Care Facilities: Preparing for Community Transmission of COVID-19 in the United States webpage
- CDC: Interim Guidance for Healthcare Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html>
- CMS: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>
- Duty to Plan: Health Care, Crisis Standards of Care and Novel Coronavirus SARS-CoV-2\_(National Academy of Medicine, March 5)
- COVID-19 National Strategic Plan for Emergency Departments (ACEP)
- COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures from American College of Physicians: <https://www.facs.org/about-acs/covid-19/information-for-surgeons/triage>
- HHS: Crisis Standards of Care Guidelines <https://asprtracie.hhs.gov/technical-resources/63/crisis-standards-of-care/0>
- HHS: New telehealth guidance: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
- IDSA: COVID-19 Prioritization of Diagnostic Testing: <https://www.idsociety.org/globalassets/idsa/public-health/covid-19-prioritization-of-dx-testing.pdf>
- JAMA: Critical Care Utilization for the COVID-19 Outbreak in Lombardy, Italy
- HHS: Topic Collection—Hospital Surge Capacity and Immediate Bed Availability
- HHS: Topic Collection—Coronavirus (e.g., SARS, MERS and COVID-19)
- Medpage: Post-Acute Care: Brace for Influx of COVID-19 Patients

## Staff impact

### Review regulations for clinical license portability, scope of practice and transition

- National Conference of State Legislatures (NCSL) Occupational Licensing During Public Emergencies (includes state-by-state tracking of actions)  
[National Conference of State Legislatures \(NCSL\) - COVID-19](#)
- American Association of Colleges of Nursing (AACN) releases Policy brief supporting practices/academic partnerships to assist the nursing workforce during COVID-19 [American Association of Colleges of Nursing: COVID-19](#)
- NCLEX exams resuming in limited capacity March 25, 2020 [National Council of State Boards of Nursing](#)
- Some organizations are seeking approval for early graduation for 4th year medical students, to allow residencies to start in April instead of July
- Some organizations have created Graduate Medical Education (GME) policies and workflows for residents and fellows to participate in telemedicine services, provided the right staffing models are in place
- Evaluate emergency licensing and privileging waivers, suspended requirements and internal requests (Some States have suspended or lifted licensing requirements to provide flexibility during the pandemic [Federation of State Medical Boards: License and regulatory guidance](#))

### Identify staffing and labor pools:

- Clinical: Create a centralized, master list of all clinical provider/leader availability to assign coverage and meet staffing needs
- Under-utilized: Establish non-clinical labor pool to support: patient and employee screening, calls to patients, scheduling, scanning, data entry/spreadsheet management, moving supplies and hospitality support
- Determine training plan and assess competencies

*Added 3/23/20*

### Human Resources considerations:

- Develop policy around staff seeking exceptions to caring for COVID-19 patients
- Some organizations are adjusting compensation plans to keep productivity based providers whole
- Conduct virtual staff interviews and orientation to keep the process going  
[American Society for Health Care Human Resources Administration \(ASHHRA\) COVID-19](#)

### Reduce COVID-19 stigma:

- Use official terms: Novel coronavirus, COVID-19
- Do not attach locations or ethnicities to the disease to avoid stigmatization
- Use “people first language”
  - Talk about “people who have or are recovering from COVID-19”
  - Refrain from referring to people with COVID-19 as “cases” or “victims”
  - Talk about people “acquiring” or “contracting” COVID-19, not “transmitting, infecting or spreading the virus” which implies intention and assigns blame

**Assess workforce roles, skills and personal stressors:**

- Assess each role's ability to: work remotely, technological knowledge, training needs, etc.
  - Determine childcare needs: some organizations utilize medical students or nursing school staff to assist with childcare services
  - Establish financial support for staff:
    - Allocate funds, use grants, interest free loans (use 3<sup>rd</sup> party administrator to process claims)
    - Some organizations set up:
      - Hardship/Employee Disaster funds
      - Craigslist type of site where people could volunteer for staff needs
      - Paid Time Off (PTO) donation policies (staff donate PTO to other individuals)
      - Advance 40, 80 or 120 PTO hours for quarantine, isolation or family care needs related to COVID-19
      - Some organizations are paying PTO at 25% of salary to offset the rapid reduction of PTO
  - Provide internal psychiatry and psychology team resources and support for staff
  - Provide close parking for front line care givers
- [CDC: Information for Healthcare Professionals](#)  
[CDC: Manage anxiety and stress](#)

Re-assign ambulatory, surgical, non-clinical or underutilized staff to assist with:

- Intake, triage, testing, and staff monitoring (temperatures, symptom screening)
- Coverage in ED, drive-through clinics, home health, occupational health, telehealth, transportation services and ICU areas, etc.

*Added 3/23/20*

Establish early, frequent and transparent communication with staff, outlining:

- Pay practices for quarantined and considerations of furlough, etc.
- Operating procedures/guidelines for COVID-19 response
- Utilize all communication channels (YouTube, email, intranet, bulletin, etc.)
- Establish a central intranet page for all updates, policy updates and clinical guidelines
- Distribute daily staff communication with 3-5 areas of focus and ensure review

*Added 3/23/20*

Reduce staff exposure and adhere to social distancing:

- Institute a work-from-home policy for non-patient facing staff: Finance, billing, scheduling, revenue cycle, quality, analytics, administrative staff, etc.
- Establish drive-thru testing sites and telephone triage hotlines for employees
- Consider allowing staff with negative COVID-19 to return to work 24-hours later (wearing mask)
- Suspend all non-essential reporting, meetings and initiatives
- Restrict large staff meetings and gatherings. The CDC recommends no gatherings larger than 10 people.
- Limit entry into patient rooms (use phones, videoconferencing)
- Restrict staff travel

*Added 3/23/20*

Advise frontline staff to bring clean change of clothes for after shift, and to bag and launder clothing at home. Consider hospital issued/laundered scrubs for high-risk staff in areas such as ICU.

*Added 3/23/20*

Utilize quarantined licensed providers (who are not ill) to conduct tele-visits, phone screening, etc.

*Added 3/16/20*

Assess IT capability and capacity now. As more staff are quarantined or experience school closures, the need for remote workers will rise. This will have significant bandwidth and security considerations. Staff may need to use their personal computers if an organization exhausts the lap top supply because new stock from China has been constrained.

*Added 3/16/20*

Implement social distancing (non-essential staff working from home)

*Added 3/16/20*

Restrict large staff meetings and gatherings. The CDC recommends that groups be no larger than 10 people.

*Added 3/16/20*

Provide internal psychiatry and psychology team resources and support for staff

*Added 3/16/20*

### **Resources**

- [AAMC Statement: Medical Students and Patients with COVID-19: Education and Safety Considerations](#)
- [National Center for Post-Traumatic Stress Disorder for Health Care Workers](#)
- [CDC: Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel](#)
- [American Association of Colleges of Nursing: COVID-19](#)
- [National Council of State Boards of Nursing](#)
- [CDC: Reducing Stigma](#)
- [Federation of State Medical Boards: License and regulatory guidance](#)
- [USA.GOV: Coronavirus](#)
- [CDC: Information for Healthcare Professionals](#)
- [CDC: Manage anxiety and stress](#)
- [American Society for Health Care Human Resources Administration \(ASHHRA\) COVID-19](#)

## **Visitation**

Restrict visitation policy to visitors accompanying minors or patients in end-of-life care. Vizient Polling 3/18: Vizient members were asked to, “Check the level of visitation policy that best corresponds with your current practice.” Of the 569 respondents – 53 (9%) answered discouraging, 282 (50%) answered limiting and 234 (43%) answered restricting.

To reduce facility-based transmission\*.

No visitors should be allowed in rooms of Persons Under Investigation (PUIs) or COVID-19 positive patients. T

The following visitors should not be allowed:

- Persons with a fever or other cold or flu-like symptoms
- Minors under the age of 16
- People over the age of 70 who have chronic conditions and may meet one of the exceptions below are strongly encouraged not to visit

Common exceptions include:

- Emergency department patients– one visitor (at least until stable)
- Surgery patients–one visitor (at least until stable)
- Obstetric patients–one partner and one birth support person
- Nursery and Neonatal Intensive Care Unit (NICU) patients–birth parent(s) or support person
- Patients who are at the end-of-life–up to two visitors
- Patients with disruptive behavior, altered mental status or developmental delays–one family member or support person who is key to their care and safety
- Minors under the age of 18–one parent or support

Ambulatory facilities and clinics should follow the same visitation precautions as inpatient facilities.

*Added 3/16/20*

Hospitals in New York City have further restricted their visitation policies, removing nearly all exceptions including for obstetric patients. The new restrictions only allow one parent or guardian in pediatric units/NICUs (who should remain the same for the course of admission; no rotating in/out). In some end-of-life and extenuating circumstances, temporary visitors may be allowed.

- [New York-Presbyterian visitation policy update](#)
- [Mount Sinai Health visitation policy update](#)
- [New York Times article highlighting new restrictions for obstetric patients](#)

Long-term care facilities should apply more restrictive policies regarding visitation. The [CDC Guidelines for Long-term Care Facilities, Nursing Homes](#) are as follows:

- Restrict all visitation except for certain compassionate care situations, such as end of life situations•
- Restrict all volunteers, including non-essential healthcare personnel (e.g., barbers)•
- Cancel all group activities and communal dining
- Implement active screening of residents and healthcare personnel for fever and respiratory symptoms

*Added 3/23/20*

Communicate restricted visitation policy clearly, using plain language on facility website main page\*.

- Provide phone number for more information.
- Use live chat features available on web sites.
- Communicate updated visitor policy to community members via public service announcements, social media, email, newsletters, etc.
- Place signage outside of all facility entrances.

\*In keeping with patient centered care principles, explain that although patient care depends greatly on engaging families to be part of the healing process, “routine” visitation must be suspended until the transmission of COVID-19 is no longer a threat.

*Added 3/23/20*

Reduce access into facilities.

- Limit entryways into facility so visitors, staff, and vendors with deliveries can be screened.
- Suspend the use of community and conference spaces by the public.

Added 3/23/20

Screen all visitors and staff and vendors before entrance.

Ask screening questions such as:

- Have you had a fever, shortness of breath, sore throat, runny nose, or a new cough in the last 14 days?
- Have you traveled internationally or to any US cities with high levels of ongoing transmission of COVID-19 (mainland China, South Korea, Iran, Italy, New York City, Seattle, etc.) in the last 14 days?
- Have you been in close proximity to someone who is currently sick with COVID-19 or any other respiratory illness within the past 14 days?
- Conduct temperature checks where possible.

Added 3/23/20

#### Resources

- [Coronavirus Disease 2019 \(COVID-19\) Hospital Preparedness Tool](#)
- [UW Medicine Visitor Policy](#)
- [Institute for Patient and Family-Centered Care](#)

#### COVID-19 Studies and Resources

- [China CDC study](#)
- [Johns Hopkins Clinicians Biosecurity News: What US Hospitals Should Do Now to Prepare for a COVID-19 Pandemic](#)
- [Johns Hopkins University COVID-19 Global Cases Dashboard](#)
- [Lancet COVID-19 Resource Center](#)
- [Nebraska Medicine COVID-19 Provider Resources \(including PPE training, protocols and checklists\)](#)
- [The Joint Commission Statement 3-16-2020](#)
- [UCSF provider resources](#)
- [CMS press release: CMS announces relief for clinicians, providers, hospitals and facilities participating in quality reporting programs in response to COVID-19](#)