From: Schwartz, David
Sent: Sunday, March 15, 2020 4:58 PM
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Subject: Initiation of COVID-19 Research Consortium
Attachments: COVID-19 Communication 3.14.20.pdf; Elective Case Postponement 20200315.docx; DOM Covid-19 update

Hi.
Now that we have initial plans in place to both: 1) protect our workforce and 2) focus our providers on essential medical care (see attached), I've decided we should move ahead and establish a COVID-19 Research Consortium. While there are a number of basic issues that are being pursued by our outstanding virologists and immunologists, I see this Research Consortium as primarily establishing/coordinating:

- Clinical database
- Biobanking samples
- Coordinating COVID-19 clinical trials
- Identifying translational research priorities
- Identifying the campus-wide basic research investigators/projects that could contribute to the above effort

To initiate this process, please let me know if you'd like to get involved and what specific expertise you could provide. I need your answer by noon tomorrow (3/16), since I plan to assemble the initial team tomorrow afternoon. In parallel with our effort to establish a Research Consortium, Jean Kutner and Tom Flaig are developing guidance for laboratories, research facilities, and ongoing clinical research. Stay well and stay in touch.
David

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COVID-19 Elective Surgical and Procedural Case Postponement Plan

Because of our need to conserve personal protective equipment and ensure appropriate staffing levels, UCHealth physician and administrative leadership has decided that non-urgent, elective surgeries and procedures should be postponed through Tuesday, March 31, 2020. This will be effective, Monday, March 16, 2020 and will be reassessed weekly to respond and react to the dynamic environment. Leadership will be reaching out to you about any exceptions to this policy.

It is important to note that any time-sensitive cases should move forward, and we are prepared to do them. In preparation for postponing cases, we ask that you evaluate your procedure/surgical schedule for the next two weeks and determine which cases are elective/non-urgent vs. those that are urgent or emergent. Please meet with your local clinical and administrative team to look at the list of cases and determine which should be postponed. To help with this process, we have developed a suggested workflow for local entities to follow below.

This is a very difficult decision and is subject to change at any time; however, due to the uncertainty of this pandemic, we felt the need to act right now by postponing non-urgent, elective surgeries and procedures to preserve PPE and maintain hospital and personnel capacity.

Process and Guidance:

1. Work with your team to prepare a list of elective or non-urgent cases to be postponed by each day for the next 2 weeks. For surgical cases, the anesthesiologist in charge of the next day(s)' schedule may work with individual surgeon to determine which cases are elective or non-urgent.
    a. Considerations in determining which cases to postpone:
        i. High-risk patients (age greater than 64 years, multiple comorbidities)
        ii. If the procedure requires the use of any PPE beyond normal surgical attire, such as gowns or face shields, for any reason including for respiratory or contact for MRSA/VRE/C. difficile
        iii. If the procedure has the risk for requiring ICU-level care, post-procedure
        iv. If the patient is anticipated to be discharged to a post-acute care facility (e.g. SNF)
    b. Considerations in determining which cases to continue:
        i. If the procedure is part of an ongoing active treatment plan or not proceeding could significantly, adversely impact the patient
        ii. Cancer patients that have a medical and/or psychological urgency
2. For those cases determined to be emergent or urgent, proceed as planned.
3. For those cases determined to be elective or non-urgent that can be postponed, please work with your team to contact the patient using the attached. In most cases, it would be ideal to have the attending surgeon or provider performing the procedure call to speak with the patient; however, each area should determine what would work best to meet the needs of the patient and the clinical team.

Distribution: UCH Ambulatory Directors, Managers, Clinical Nursing Leadership; UCHMedical Group Leaders, CUMed Leaders, Patient Line Leaders

MESSAGE FROM MEDICAL AND ADMINISTRATIVE LEADERSHIP:

Clinical Leaders:
We know that there have been a number of questions and concerns regarding potential risks to patients and to providers who may be at higher risk regarding COVID-19 infection. CU School of Medicine, CU Medicine and UCHealth leadership have jointly developed the following guidance regarding: 1) ambulatory care appointments; 2) high risk providers.

Non-urgent or Routine Ambulatory Clinic Appointments
This communication is to provide clarity related to the scheduling/canceling of patients in the ambulatory setting. Procedural areas should reference the separate communication regarding scheduling/canceling of elective procedures.

Non-urgent or routine ambulatory clinic appointments should be deferred or changed to virtual visits for patients who:

- Are age >/= 65
- Lives in residential facility or group setting (e.g. e.g dorms, fraternities, sororities, shelters, jail, prison, skilled nursing facilities, adult family homes)
- Heme malignancy or Solid malignancy on chemotherapy
- Solid organ transplant
- Advanced HIV (CD4 count < 200) or AIDS
- Immune deficiencies or condition requiring treatment with immunosuppressive agents (common examples here):
    - Prednisone >0.5mg/kg or equivalent (≥ 40mg prednisone or equivalent in patients 70 kg and above)
    - Thymoglobulin in last 6 months
    - Alemtuzumab in last year
    - Rituximab in last 6 months
    - TNF-α inhibitor in last 3 months (e.g. infliximab, etanercept, golimumab, adalimumab, certolizumab)
    - Calcineurin inhibitors (tacrolimus and cyclosporine – excludes topical/ophthalmic administration routes)
    - mTOR-inhibitors (everolimus, sirolimus – excludes topical routes)
    - Mycophenolate, azathioprine, cyclophosphamide in the last 1 month
    - Belatacept in past 2 months
    - Eculizumab in last 6 months
- Have chronic underlying health conditions, e.g.: ESRD, CHF, Chronic lung disease (e.g. pulmonary hypertension; on supplemental oxygen), uncontrolled diabetes (Hgb A1c > 9)
- Pregnancy

Clinical situation and needs of the patient should be considered in determining the best approach to individual patients.

Work policy for providers and CU SOM employees who are in a "high risk" group
Providers and staff who have any of the following characteristics are considered "high risk":

- Are age >/= 65
- Lives in residential facility or group setting (e.g. e.g dorms, fraternities, sororities, shelters, jail, prison, skilled nursing facilities, adult family homes)
- Heme malignancy or Solid malignancy on chemotherapy

- Solid organ transplant
- Advanced HIV (CD4 count < 200) or AIDS
- Immune deficiencies or condition requiring treatment with immunosuppressive agents (common examples here):
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    - Mycophenolate, azathioprine, cyclophosphamide in the last 1 month
    - Belatacept in past 2 months
    - Eculizumab in last 6 months
- Have chronic underlying health conditions, e.g.: ESRD, CHF, Chronic lung disease (e.g. pulmonary hypertension; on supplemental oxygen), uncontrolled diabetes (Hgb A1c > 9)
- Pregnancy

- Providers who have any of these high-risk conditions may be excused from providing direct clinical care to patients who have confirmed or suspected/are under investigation for COVID-19.
- These providers should continue to provide clinical care to patients who are not under investigation for or have confirmed COVID-19. Opportunities to provide care via virtual visits may also be a viable option for providers.

Any changes to usual clinical responsibilities must be approved by the relevant Service Line Chief, Division Head or Department Chair. Service Line Chiefs, Division Heads and Department Chairs are responsible for assuring that clinical service needs continue to be met.

All UCHealth and CU Medicine PPE policies, protocols, and recommendations for providing care for patients with infectious diseases are designed to protect all healthcare workers, regardless of their age, health or pregnancy status. These PPE policies, protocols and recommendations should be followed regardless of risk category.

For PPE conservation and to minimize exposure, <u>all</u> services should minimize the number of people who go into patient rooms. Clinicians should only enter the room if it is essential for clinical decision-making.

As of 3/14/20 6:00pm