

Dear SGO members, friends and colleagues,

We have each had many people reach out for guidance and tips on what is going on in Seattle at the University of Washington in response to COVID-19. In response, we have put together a list of things we have implemented specifically in our division. Many other changes have been made at the institutional or cancer center level and UWM has created numerous detailed protocols (i.e., how to transfer a COVID+ patient, discharge of a COVID+ patient, how to clean a room, etc) all available to the public and updated in real-time. These protocols may be of value to other institutions, so please do pass on this link, but remember to look for recent updates, as they have changed frequently.

<https://covid-19.uwmedicine.org/Pages/default.aspx>

Hopefully, your institution is following CDC guidelines. When there is disconnect between institutional policies and CDC guidelines it is very stressful, particularly if those differences are perceived as driven by lack of protective equipment or resources.

Please get your N95 mask (or equivalent) fitting and PPE training now if not already done.

Separate from institutional mandates and policies, here are some things we have done within our gyn onc division that are proving useful, and may be things to consider:

1. Make sure everyone knows how to zoom (or other platform if that is what you use) as all meetings are virtual. Encourage everyone to use video functionality to maintain connections versus joining only by audio.
2. Delegate and Communicate. Make it clear who is responsible for which function. For example, Renata Urban is director of our main outpatient clinic, while Heidi Gray is director of our main inpatient ward. Dr. Gray rounds twice daily with nurse manager and makes rounds on the floor. She is the main communicator to group as to concerns and changes for inpatients, including feedback about no visitor policy etc. Dr. Urban does the same for our clinic. This helps us catch issues early before they build up as major stressors and maintains a team approach.
3. Remember that all your staff is under stress and check in frequently with them to make everyone feel supported. Have back up plans in place for when people cannot come in.
4. Establish/rotate schedule for staff/faculty working from home. Some functions such as patient calls can be done from home, so it may be possible for one clinic nurse per day to work from home for example. You might rotate that option or you might choose a more high risk person to work from home.
5. if you have more than one site of practice, delegate who goes where to minimize traffic between institutions, each with their own risks. Try to consolidate services as much as possible. This might be the time to shutter a low volume clinic.
6. Instead of everyone rounding on our own inpatients, we are trying to minimize trafficking on our wards by having designated inpatient providers, although we recognize complex patients with end of life decisions are better served with their long-term doc, so we are being flexible on this at present. We are reducing traffic to all patient rooms by not having residents enter as group- one resident enters and examines/interviews the patient, rest of rounds are done outside room, even if patients are not themselves on droplet precautions.

7. We have stopped clinical trial enrollment on all phase 1 and phase 3 trials. Clinical trial treatment takes more staff time and allows less flexibility on changes to plan. Similarly, we are conserving resources by not opening any new trials and we are telling sponsors that some visits are happening by telehealth and our IDS pharmacy is shipping meds for patients on maintenance.

8. Our institution has stopped all non clinical research activities occurring in clinical areas (like tissue collections, etc).

9. Be consistent with your cancer center (if affiliated) as those policies apply best to our clinics. We are pre-screening all scheduled outpatients with text and/or phone call 24 hours in advance of their visit for symptom review before they come to hospital. We want to screen them before they get to an entrance. These phone calls are being made by the infusion RNs (for patients on chemo) or clinic staff (non-chemo visits). Patients are then screened again on day of presentation. If patients are symptomatic and need to rule out, then we delay chemo infusions by a week- there is not enough room to have all of these patients accommodated safely in infusion.

10. We have set up a jeopardy schedule for attendings where we have 2 on backup every day for last minute faculty staying home. Before we would come to work with a URI or cough, but those days are gone. If you develop any symptoms, cannot come into work no exceptions. Since only urgent/timely cancer surgeries are being done, we don't think we can afford to reschedule cancelled surgeries. We tell patients right at their pre-op appointment: "if you surgeon gets sick, we have an assigned qualified back up surgeon etc." Patients are also scared and want their surgeries done, so this has not been a problem to date. We also have a jeopardy schedule for on call attending with first and second back up and a live calendar where we know which providers are healthy and available and which are out and expected duration.

11. Set up a list of childcare backup resources for essential faculty/staff. Tell friends who ask what they can do to help that they can provide childcare for HCP in need as a great service (and also donate blood).

12. Daily am huddle of doc in clinic that day with all staff going over plan for the day, including what patients are coming in needing droplet precautions, which staff and providers are in or working from home or not available each day, etc.

13. Set up telemedicine ASAP. Get your entire service trained and online ready ASAP

14. We have scheduled zoom biweekly all division COVID meetings with all providers, schedulers, nurse manager, admin to go over changing situation and plans to manage.

15. The institution has cancelled all elective surgeries. Each surgeon has reviewed their upcoming case list to identify patients whose surgeries are not urgent. Patients whose surgeries have been cancelled are called by attending to notify, not staff. We are also not doing surgeries if patient will require SNF placement (these are not available). We are doing endometrial cancer cases now ASAP as we expect soon we will not be able to do those cases and we may not have another window for several months. EIN are getting progestin IUDs.

16. We are not accepting referrals for 2nd opinions or transfer of care. For these referrals, we have MD call referring MD to explain- that may become less necessary over time as everyone starts to get what is happening in Seattle. We try to help outside oncologists with decision making on the phone whenever possible, including reviewing scans, records, etc.

17. Expect a massive blood shortage. Encourage donations from friends who want to help. Consider how you can conserve blood now. Plan your OB accretas closely with the OB team. For example, we have 4 accretas in the next month coming up and we are planning to be present at the beginning (not waiting until many liters down). Need to preserve the blood supply.

18. Advanced OC patients are getting neoadjuvant chemo as default strategy to reduce blood use, hospital stay and OR use unless clear reason for primary surgery (i.e, low grade serous, etc). When there is a choice between therapies, we are considering patient safety as most important. For example, weekly chemo will not be as safe as q3 week if outcomes similar (less trips, less exposure). For patients who live outside Seattle, we try to arrange for them to get chemo locally, even if they want to come here.

19. Medical students 3rd and 4th year rotations have been suspended by SOM. Some outside residency site are likely to close to residents.

20. Clearly communicate visitor policy to surgical patients in advance, preferably at pre-op teaching. Our institution allows no visitors in the hospital except a brief visit in recovery area and then again for discharge. In the clinic, patients may arrive with one visitor.

21. Tell the residents that they cannot come to work with symptoms and this time say that you really mean it, not like the mixed messages we have given them in the past. Reassure them that while they are losing cases and other valuable opportunities, they still matter and are important. These trainees are in the midst of something we never were taught. These lessons will have value too. About 1/4 of our residents are currently at home ruling out (or in). Work with your education leaders to plan for at least 1/3 decrease in residents. With elimination of elective cases and decrease in clinic visits, you will be able to consolidate and should proactively develop a priority plan.

22. Address intubation with all your incurable cancer patients. It is time to have some tough conversations. They are not likely to survive intubation if for COVID.

23. Normalize COVID to reduce fear. As COVID moves through the community, we and our patients are going to have exposures and some of us (and family members) will test positive. There is a lot of anxiety and stress when patients come into clinic or on floor and have symptoms and need to enter a rule out. Remain calm, assure staff and providers to protect themselves first and make sure everyone knows that if they test positive we will support them and care for them. There is a lot of stigmata that needs to be addressed.

24. Remember every day that you must function as a team and everyone is under a great deal of stress. Tell everyone on the healthcare team – including cleaning staff and food service a hearty thank you for their work and ask them how they are doing. Practicing social distance away from work exacerbates feelings of stress and isolation. As surgeons, many of us have personalities more suited to this type of strain than some of our support staff. While, we cannot hug each other, we can share respect and verbal support frequently.

25. Be flexible and calm. The situation will change daily.

26. Care for yourself as well as others. This will be a long journey.

Thank you to many who have reached out and wished us well. We treasure our SGO relationships and hope to see you all safely again soon

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