Illinois Eye
AND EAR INFIRMARY

Interim COVID-19 Protocol

April 15, 2020

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INTRODUCTION

Dear Colleagues and Friends,

On behalf of the Department of Ophthalmology and Visual Sciences at the Illinois Eye and Ear Infirmary at the University of Illinois at Chicago, we would like to share our initial experience with you regarding our response to the COVID-19 pandemic.

The following document has been prepared through a collaboration by our Faculty, Residents, Fellows, Staff, and Administrative team with guidance by information provided by the American Academy of Ophthalmology, UI Health, and friends and colleagues from around the world.

We wish you and your families well during these challenging times.

Sincerely,

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Professor and Head, Department of Ophthalmology and Visual Sciences
The John H. Panton, MD Professor of Ophthalmology
Illinois Eye and Ear Infirmary
University of Illinois at Chicago

Would you like to receive protocol updates?
Please contact us by clicking the button below.

Receive Updates from the IEEI

www.chicago.medicine.uic.edu/eye

Disclaimer: These emergency protocols are applicable during the COVID-19 pandemic to ensure patient and provider safety.

ACKNOWLEDGEMENTS

UI Health

UI Health | UIC

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Special thanks to our dedicated staff on the front lines of the COVID-19 pandemic.

American Academy of Ophthalmology

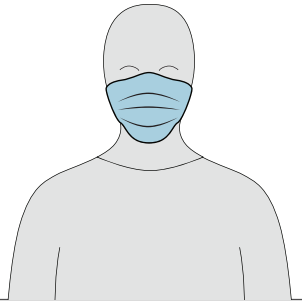
AMERICAN ACADEMY OF OPHTHALMOLOGY®

Edward S. Harkness Eye Institute
Columbia University Department of Ophthalmology
Dr. Royce W.S. Chen and Dr. George A. Cioffi

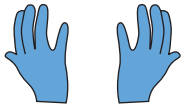
INTERIM PPE GUIDELINES

When needed:
N95 Face masks, eye shields, and gowns are stored in the IEEI minor OR on the 2nd floor of 1855 W. Taylor.

Currently, there are national and international shortages of personal protective equipment (PPE). Excessive use of PPE may deplete the supply of critical equipment required in the future for patients with COVID-19 as the epidemic expands. UI Health and the EEI recommend the following usage:

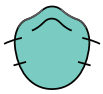
CLINICAL SITUATION	PPE RECOMMENDATION	
All Patients & Visitors	• Mask	
All Staff / Providers	• Mask • Eye protection (goggles) • Gloves	
All Staff / Providers Interacting with Symptomatic or COVID+ Patient or Visitor or Aerosol-generating Procedures or Nasopharyngeal, Oropharyngeal Swabs	• **N95 mask*** or Powered Air-Purifying Respirator (PAPR) • Eye protection (goggles) • Gloves • Gown / Coat	

CORRECT PPE REMOVAL SEQUENCE

1. Gloves 

2. Goggles 

3. Gown/Coat 

4. Mask 

5. Hand Hygiene 

*See extended use guidelines from the CDC.

TRIAGE WORKFLOW

To avoid contact with others, any patient who is screened over the phone as symptomatic will be asked to enter the building via the west entrance. They will call the triage tech when they arrive and someone will escort them directly into the isolation room.
Physicians calling to speak with a physician will be answered immediately by the designated resident in clinic. All patient calls will be routed through the triage pathway noted here.

SURVEY COMPLETION → **TRIAGE** → **SCHEDULING**

1 SURVEY COMPLETION *PROTOCOL FOR TRIAGE TECHNICIAN*

A. Physical walk-in

1. Patient enters EEI and is screened for COVID symptoms by a medical assistant. **A mask is placed on all patients.**
    - If the patient has COVID symptoms, he/she is immediately placed in isolation by the triage technician.
    - If the patient does not have COVID symptoms, he/she will proceed to the triage technician at the front desk.
2. The triage technician provides the patient with the iPad and instructs the patient to complete the survey. If the patient has a smartphone, he/she can also be encouraged to complete the survey via the website URL or QR code.
    - iPad sleeves are replaced after every patient use.
3. Once completed, patients not in isolation room will proceed to EEI classroom (with partitions) until survey is reviewed. The patient will be instructed by the triage tech to wait until the doctor calls his/her phone (if patient does not have a phone with them, the doctor will call the triage technician at the IP phone).

B. Phone call **Currently, the call center is answering all calls. If the call center closes, we will move to triaging via survey directly.**

1. Any patients the call center has questions about are transferred to the IP phone, which will be answered by the triage technician.
2. The triage technician will fill out " " "

C. Website

1. Patient completes triage survey via URL on website.
2. Upon completion of the survey, the patient will see a note that states someone will respond to them during business hours and to call the on-call number if outside business hours and in need of immediate attention.

2 TRIAGE *PROTOCOL FOR TRIAGE DOCTOR*

The triage doctor will receive a notification to the designated email address.

1. Doctor will review survey and determine urgency of visit (Urgent EEI, ED, Routine, Telehealth)
2. Doctor will call the patient to inform them of the decision.
    - If the patient is at EEI and does not answer their phone, call the triage tech

    A. Emergency department

        1. The patient will be instructed to go directly to the ED.

2. Call ED to give pre-arrival information to accepting the attending. Document call to ED in Cerner.

B. Urgent EEI visit

1. Instruct the patient on what time to come in for visit. If patient is physically at EEI, instruct the patient to proceed to GEC front desk.
   - Note: If the patient is symptomatic or COVID+, the patient will already be in the isolation room
2. Inform the front desk staff that patient is being added to schedule
   - Provide staff with Name/DOB/phone number/ new vs. established, and reason for visit.

C. Routine visit

1. If the patient marks routine visit request on survey, this will be responded to within 1 week.
2. If the patient marks eye complaint, but the doctor believes this is routine, they must call the patient, inform them of the decision and that someone will be calling them within 1 week to schedule a visit.

D. Telehealth

1. Doctor must call the patient and inform of the option to have telehealth visit, and ask if patient is interested (must document that the patient initiated telehealth visit).
   - Time for visit is up to the discretion of the doctor and can be same day. Please inform the staff so the patient can be scheduled for the visit.

3. Respond to email notification (Patient survey #, decision made, and front desk staff informed).

4. Respond to survey (document visit urgency)

5. Document via "Ophthalmology triage" template in Powerchart.

1. Document HPI for all urgent and ED patients.

6. Designated triage attending will be assigned if triage resident needs assistance

3 SCHEDULING *PROTOCOL FOR TRIAGE FRONT DESK STAFF*

A. ED

1. Patients are directed to ED by triage doctor. Staff is not responsible for calling the patient.

B. Urgent EEI visit

1. Physical walk-ins are instructed to come to front desk to complete intake/registration.
2. Phone call and website submissions
   - Call the patient to complete intake and registration prior to patient entering EEI.

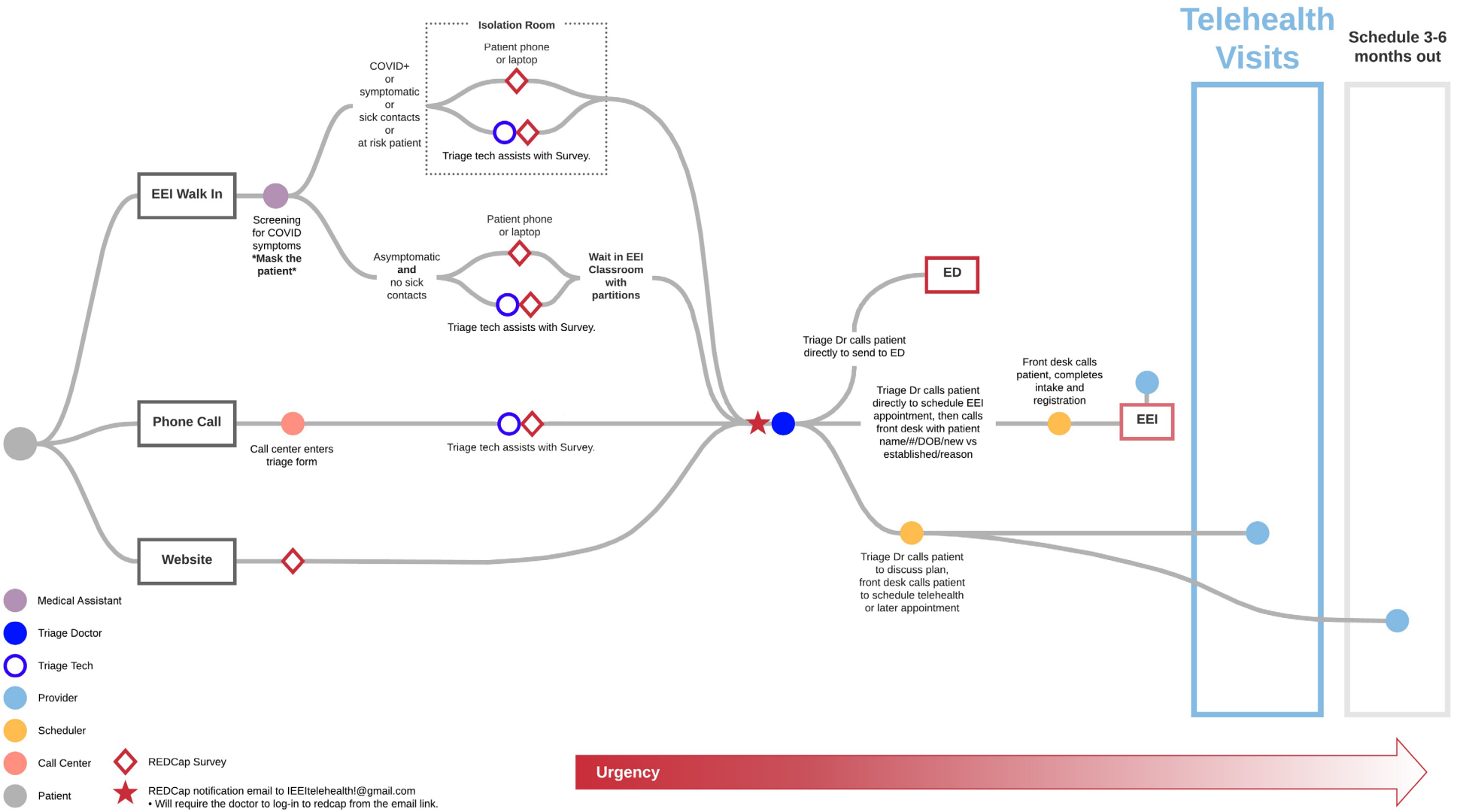
C. Routine

1. A list of routine patients requesting an appointment will be provided weekly.
   - Staff will be provided with a list of patients who need to be called, including Name/DOB/phone #/new vs. established patient/reason for visit.

D. Telehealth

1. Call patient for registration and intake, and schedule patient based on triage doctor's decision.
2. Provide patient with directions on how to prepare for telehealth call
   - Directions and link can be texted or emailed to patient.
   - Please see phone script

TRIAGE WORKFLOW

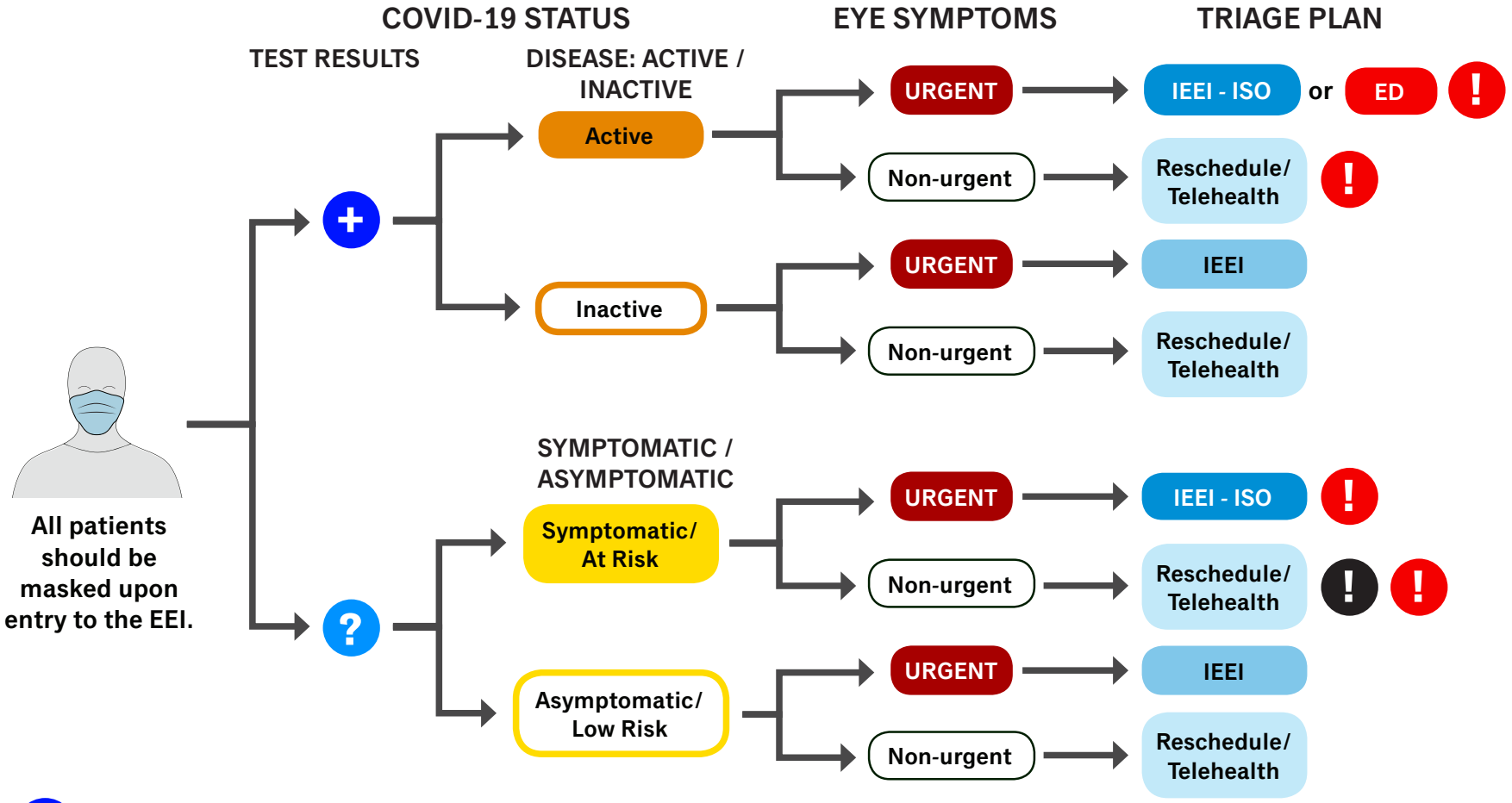


COVID TRIAGE

***ED only if higher level care needed**
EVS (specific questions should be directed to Infection Prevention)

All patients should be masked upon entry to the EEI.

COVID-19 status	Eye Symptoms	Triage Plan	Other Comments
Test +, active disease	Urgent	EEI* in isolation room vs ED if hemodynamically unstable	Page Roving COVID Response Team, Notify ED of patient
Test +, inactive disease (asymptomatic 2 weeks after resolution of symptoms)	Urgent	EEI* regular room	
Unknown status, symptomatic or history of sick contacts or at risk patient (elderly, immunocompromised)	Urgent	EEI* in isolation room	Page Roving COVID Response Team
Unknown status, asymptomatic with no history of sick contacts	Urgent	EEI* regular room	
Test +, active disease	Non-urgent	EEI within 2 months +/- telehealth visit	Page Roving COVID Response Team
Test +, inactive disease (asymptomatic 2 weeks after resolution of symptoms)	Non-urgent	EEI within 2 months +/- telehealth visit	
Unknown status, symptomatic or history of sick contacts or at risk (elderly, immunocompromised)	Non-urgent	PCP, drive-through or ED for COVID testing, EEI within 2 months +/- telehealth visit	Page Roving COVID Response Team
Unknown status, asymptomatic with no history of sick contacts	Non-urgent	EEI within 2 months +/- telehealth visit	
Routine ophthalmic issues and previously scheduled appointments should be rescheduled for after anticipated end of outbreak/pandemic, or rescheduled as telehealth appointments if possible.			



***ED only if higher level care needed**
EVS (specific questions should be directed to Infection Prevention).

OUTPATIENT TRIAGE STRATIFICATION

IEEI Ophthalmology Outpatient Triage			
	High Risk (In person visit)	**Telemedicine or Phone Visit** (Note: all patients require telephonic triage before telemedicine consultation)	**Low risk (Rebook in 3-6 months)**
****Note: General Ophthalmology guidelines apply to ALL patients****			
General Ophthalmology / COMP			
New	• Sudden vision loss • New onset flashes/floaters	• Eye pain, discomfort • Red eye	• Refractive • Routine • Diabetic eye exams
Follow-up	• All postop patients within one month • Any postop having an issue • Patients with new onset/active problem for follow up	• Phone/video consultation as necessary	• Annual exams • Glaucoma suspect follow up of previously stable patients • Established patients with glaucoma (probably this needs to be on a case by case basis) • Postponement or discharge from phone/video triage
Contact Lens			
New	• New cases will be identified by another service. (eg, scleral lens in persistent epithelial defect patient).	• None	
Follow-up		• Lens-induced irritation in medically necessary CL patients • Pain, redness, photophobia (needs risk assessment)	• Delays acceptable in other patients

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Cornea and Cataract			
New	• Patient by patient at the • discretion of the physician • Visual loss in any patient • Corneal infections • Infections - active keratitis • Impending perforation	• Patient by patient at the discretion of the physician	• All routine, dry eye
Follow-up	• Any symptomatic corneal transplant patient • Active inflammatory disease with risk of perforation • Recent post-operative patients within one month of surgery • Complex post-op or complications • Visual loss, Pain, Discharge in any corneal transplant patient at any time • Patients with a history of CMV, HSV or HZV with new complaints	• Phone/video consultation as necessary	• Annual exams • Glaucoma suspect follow up of previously stable patients • Established patients with glaucoma (probably this needs to be on a case by case basis) • Postponement or discharge from phone/video triage
Dry Eye and GVHD			
***All oGVHD, Sjogrens, OCP and SJS dry eye patients cannot co-mingle in main area waiting rooms because these patients have immunosuppression and other coexisting ailments making them at high risk for mortality if they contract COVID-19. These patients will be seen on the 2nd floor Clinical Trials Center (Suite 2186C).**			
New	• Onset of new ocular symptoms in any post bone marrow transplant patient (or any underlying autoimmune conditions i.e. SJS, Sjogrens, OCP)	• Referrals from heme/onc and rheumatology. Patient by patient at the discretion of the physician	• Non-immunological dry eye disease • Meibomian gland dysfunction • Epiphora
Follow-up	• Patients with a history of HSV or HZV with new complaints • Patients with bandage contact lenses • Significant increase in light sensitivity, vision loss and corneal foreign body sensation (r/o HSV Keratitis)	• Serum tear or PRGF refills (dispensed by appointment only – call or text 312-918-0900 to schedule) • Increase in ocular pain or substantial increase in dryness. Patient by patient at the discretion of the physician	• Annual exams • Patients satisfied with current Rx regiment

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Glaucoma			
New	• Acute elevated IOP: Urgent internal or external referrals with IOP >30mmHg • Urgent internal referrals with uveitis, neovascular glaucoma • Acute Angle-Closure Glaucoma	• Healthy patients who feel they need to be seen	• Patient by patient triage of new referrals needed
Follow-up	• High risk avoidable vision loss within 2 months - ound by review of clinic notes • Post-op patients with surgery <3 months • Acute or immediate post-treatment follow-up within 1 week • Peri-operative post-op visits up to 4 weeks for cataract, and 8 weeks for glaucoma surgery. • Patients with gradual vision loss and known glaucoma condition • -One month follow up, or laser (case by case) • Consultant led clinics where followup interval 4 weeks or less (suggesting high risk)	• Post-op cataracts (no previous glaucoma Sx) performed by glaucoma service • Medication Refills • Stable follow-ups	• Stable monitoring/Virtual clinic patients moved without review • Routine 4 month, 6 month, or annual visits. • Non urgent laser • Consultant led clinics - either patient by patient stratification or blanket extension of followup by 50%

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Neuro-Ophthalmology			
New	• Papilledema • Acute painless vision loss • Acute painful vision loss • Acute diplopia • Amaurosis fugax • Case by case basis	• Neuromuscular disorders	
Follow-up	• Case by case basis	• Neuromuscular disorders	• Stable myasthenia gravis patients with no symptoms • Resolved microvascular ischemic cranial nerve palsies • Stable MS patients with no visual symptoms • Stable visual pathway tumors (the patient may have a local ophthalmologist who can perform ancillary testing) • Stable IIH (the patient may have a local ophthalmologist who can perform ancillary testing) • Most patients coming for yearly follow up • Stable NAION • Chronic non-glaucomatous optic neuropathy new patients or follow-ups with normal workup.
Ocular Oncology			
New	• All new referrals but with enhanced triage by team		
Follow-up	• Patients on less than 12 month follow-up interval	• Patients on greater 12 month follow-up interval	• Patients with no issues on video/ telephone triage could be delayed further

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Oculoplastics			
New	• Suspected neoplasm (periocular squamous cell, sebaceous cell, merkel cell) • Orbital infection/cellulitis • Necrotizing fascitis • Compartment syndrome • Compressive optic neuropathy • Pediatric floor fracture • Mucormycosis • Abscess (except dacryocystitis) • Corneal ulcer not responsive to max corneal intervention, related to lid malposition/lagophthalmos • Rhabdomyosarcoma • childhood tumors of malignant nature • OIS with vision loss	• Lid lesions - chalazion/ papilloma unless concern for cancer • Mild thyoid eye disease patients • New blepharospasm • Ptosis/ Dermatochalasis/ Brow ptosis • New watery eye/ lacrimal patients • Mild thyroid eye disease patients • Proptosis • Dacryocystitis	• Any cosmetic patients • Uncomplicated tearing • Mild ptosis • Eyelid malposition • Ptosis • Blepharoplasty • Ectropion • Brow ptosis • Eyelid retraction • Chalazion • Tearing • Thyroid without pain or vision loss • Socket or prosthetic issues (without pain or pus) • Puffy eyelids without pain • Anything beyond 1 week post ops that aren't having a problem • Consideration for seeing photos of early post ops
Follow-up	• Post-op complex surgery • Orbital cases with visual loss • Tumor cases • Severe inflammatory orbital cases	• Post-op simple surgery with or without sutures needing removal (suture removal arranged locally) • Stable thyroid eye disease patients	• Patient by patient review to check no high risk factors, but most routine followups could be moved by 3-4 months easily • Botox patients
Pediatrics and Strabismus			
New	• Sight threatening conditions • Cataracts, glaucoma • R/o papilledema • Triage of referrals on patient by patient basis • Abnormal red reflex • Acute onset strabismus	• Case by case basis for failed vision screen age 5 or less	• Failed vision screen in children over age 5 years • Uncomplicated tearing or NLDO • Glasses update • Routine examination
Follow-up	• Post-ops within last 2 weeks • Children on medication (drops or systemic) glaucoma, uveitis, corneal disease	• Pediatric oculoplastic/ adnexal cases with worsening symptoms • Red eye, conjunctivitis	• Patient by patient triage by attending • Patients having amblyopia treatment

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Retina			
New	• Referral for RD, tear, CNVM, CRVO, Retinopathy noted on Diabetic screening, community optometry, A&E • Endophthalmitis acute or immediate post-treatment follow-up • Any retinal tear / detachment		• Delay by 3 months to Face to Face clinics - Referrals from DR Screening with Severe NPDR, Referrals from community optom/GP with suspicion of BRVO, Recent onset CSCR. • Low-risk choroidal nevus
Follow-up	• <Q8 week injection schedule for AMD • First follow-up post PRP or injection for Neovascular glaucoma • Surgical postops with elevated IOP, risk for re-detachment, complexity • Peri-operative post-op visits up to month 1; patients receiving frequent intravitreal injections, patient with sudden or recent severe vision loss and known retinal condition, any patient scheduled for laser/ PDT/ office procedure	Call to find out whether in person visit is needed: • Genetic Retinal Disease • Flashes, floaters follow-up • Routine surgical postops <3 months	• New Genetic Retinal Disease • Consider delaying DME/RVO injections if > 8 weeks interval but priority for reinjection at 3 months • Delay by 3 months to Face to Face clinic -Severe NPDR (recent progression), Post-op macular edema, Chronic CSCR, any other macular edema • Cystoid macular edema • Dry AMD • Routine annual visits for high myopia, diabetes, routine AMD screens, sickle cell routine screens, plaquenil/ other drug routine visits • Delay by 6 months to Virtual clinic or Face to Face - R1/M1 patients, 'stable' Severe NPDR (R2) patients (no progression over past two visits), Stable treated PDR, Stable BRVO/CRVO.

	High Risk (In person visit)	Telemedicine or Phone Visit	Low risk (Rebook in 3-6 months)
Uveitis			
New	• Panuveitis • Posterior Uveitis • Retinal vasculitis • Intermediate Uveitis with vision loss		
Follow-up	• Reviewed on a patient by patient basis but potentially 1/3 of patients may have to continue to attend	• Anterior Uveitis patients (symptom check, medication management) • Stable patients on drops	
Ophthalmic Imaging			
	• Any studies that guide treatment and/or diagnostic decisions in real-time, e.g.: • OCT re: intravitreal or other pharmacologic therapy • Ultrasound studies to assess: • Endophthalmitis • Potential retinal detachment • Trauma • Suspected malignancy • When urgent assessment of the posterior segment is necessary and not possible • Media opacity per your discretion • Pediatric or other uncooperative patients		• Color fundus/slit lamp/external photos for photo documentation • OCT for NFL/ONH assessment and monitoring • Non-urgent anterior- and posterior-segment OCT that does not influence urgent treatment and/or diagnostic decisions • Angiography studies that do not influence urgent treatment and/or diagnostic decisions • Any non-urgent echographic studies (B-scan, UBM, biometry)

SURGICAL TRIAGE STRATIFICATION

IEEI Ophthalmology Surgical Triage					
Emergent (ASAP)	**Urgent (Within 24 hours)**	**Priority (Within 72 hours)**	**Soon (72 hrs - 2 weeks)**	**Non-elective (2-6 weeks)**	**Elective (>6 weeks)**
****Note: General Ophthalmology guidelines apply to ALL patients. Any procedure may become urgent or emergent if it threatens irreversible visual loss if not performed in a timely manner.****					
General Ophthalmology / COMP					
• Corneal/scleral laceration/open globe • Uncontrolled IOP • Life/sight-threatening conditions	• Phacomorphic lens with high IOP • Phacoanaphylactic lens		• Phacomorphic lens with normal IOP	• Cataract causing 20/200 or worse vision in the better eye due to cataracts	• Cataract surgery other than phacomorphic or anaphylactic
Cornea and Cataract					

• Dehisced PKP or other anterior segment wound, including dislocated LASIK flaps
• Corneal/scleral perforation/ impending perforation
• Cornea or anterior segment trauma, including lacerations, blunt rupture or deeply embedded corneal foreign body
• Keratoprosthesis and other implantable device extrusion
	• Cataract:
	  • Congenital cataract in the amblyogenic period
	  • Monocular patients with vision loss limiting ADLs or self-care
	  • Extreme anisometropia after recent lens extraction
	• AC washout for anterior segment infection or impending blood staining
	• Bilateral corneal blindness in the amblyogenic age range
	• Ocular surface reconstruction/other tectonic procedures following acute chemical injury or for acute Stevens Johnson Syndrome
	• Excisional biopsy (and cryo) for conjunctival malignancies
	• Corneal biopsy or repair for undiagnosed cornea disease (melt, infection)
				• Ocular surface or anterior segment malignancy for which there is no medical treatment (i.e., conjunctival melanoma or chemotherapy-resistant ocular surface squamous neoplasia)	• PTK, LASIK, PRK, CXL, SuperK's, EDTA chelation treatment, all forms of corneal transplants other than therapeutic, e.g. perforations, dehiscence, recalcitrant infectious keratitis
					• Cataract and other lens surgeries other than phacomorphic or anaphylactic glaucoma unless monocular & cannot care for themselves

Emergent (ASAP)	Urgent (Within 24 hours)	Priority (Within 72 hours)	Soon (72 hrs - 2 weeks)	Non-elective (2-6 weeks)	Elective (>6 weeks)
Glaucoma					
"Risk" refers to likelihood of significant vision damage if not treated in this time-frame, and adjusting for other factors such as monocular status, age etc.					
• Endophthalmitis • Blebitis • Acute primary and secondary angle closure glaucoma • High IOP with pain/vomiting not responsive to initial treatment elsewhere • Increased IOP in the setting of sickle cell disease • Suprachoroidal hemorrhage • Flat AC • High risk vision loss in only eyes including 5% of cataract surgery for high risk angle closure eyes	• Eight ball hyphema • Malignant Glaucoma • Early childhood glaucoma • High IOP >40 on maximal tolerated therapy • Hypotony with kissing choroidals in child	• Tube erosion • Exposed plate • Bleb leak • Hypotony in high risk eye (high myopia; buphthalmos, previous suprachoroidal hemorrhage, only eye) • High IOP in high risk eye	• High IOP in moderate risk eye • Severe glaucoma threatening fixation with IOP above target	• Bleb revisions for cosmesis, dysesthesia • Tubes /trabs in slowly progressive glaucoma, pts unable to come in sooner • High IOP in low risk eye	• Phaco (in pts with controlled IOP) • 75% may be delayed by 3 months without significant loss • 95% of cataract surgery in glaucoma pts may be deferred

Emergent (ASAP)	Urgent (Within 24 hours)	Priority (Within 72 hours)	Soon (72 hrs - 2 weeks)	Non-elective (2-6 weeks)	Elective (>6 weeks)
Neuro-Ophthalmology					
	• Biopsy of temporal artery - Suspected giant cell arteritis	• Optic nerve sheath fenestration			
Pediatrics and Strabismus					
Guidelines for infants needing urgent surgical care and PACU monitoring. Overnight NICU stay is not currently an option for infants older than 1 month. **Infants 0-1 months:** • Immediately contact NICU (Dr. De-Ann Pillers). • If they have availability, operate ASAP. Overnight observation is allowed for infants under 1 month of age. **Infants 1-3 months old:** • Refer out to Lurie Children's for the next 4 weeks (congenital glaucoma and cataract) **Infants older than 3 months:** (They do not need overnight stay unless they are premies) • Check with Anesthesia • If they are OK with no overnight stay - operate ASAP					
• EUA: retinoblastoma, endophthalmitis, uveitis, Coats Disease, glaucoma, retinal detachment, ocular trauma, or presumed intraocular foreign body	• Dacryocele • Congenital ptosis • Torn or lost extraocular muscle?	• New congenital glaucoma	• Infant cataracts • Glaucoma	• Secondary IOL • EUA	• Adult and pediatric strabismus • NLDO

Emergent (ASAP)	Urgent (Within 24 hours)	Priority (Within 72 hours)	Soon (72 hrs - 2 weeks)	Non-elective (2-6 weeks)	Elective (>6 weeks)
Ocular Oncology					

		• EUA for new retinoblastoma referral		• Intraocular tumor:
				  • Enucleation
				  • Plaque insertion and removal
				  • Tantalum marker placement
				  • Fine needle aspirate biopsy
				  • Iridectomy/ iridocyclectomy
				• Conjunctival excisional biopsy with cryotherapy
				• EUA: Retinoblastoma patients with active tumors
				• Intraocular melphalan injection for retinoblastoma
				• EUA: Stable retinoblastoma patients (varies from q4 weeks - q3 months)
				• Excision/drainage of iris cyst	

Emergent (ASAP)	Urgent (Within 24 hours)	Priority (Within 72 hours)	Soon (72 hrs - 2 weeks)	Non-elective (2-6 weeks)	Elective (>6 weeks)
Oculoplastics					
• Tumor cases or orbital with visual loss • Acute orbital hemorrhage with compressive optic neuropathy (canthotomy/ cantholysis/ evacuation of hematoma)	• Pediatric White-Eyed Blowout fractures with vasovagal issues • Orbital Fracture: hemodynamic instability or oculocardiac reflex • Orbital cellulitis – threatening vision or sinus thrombosis; orbital abscess drainage (may actually be initially managed by on call team)	• Canalicular laceration repair • Eyelid or face laceration repair	• Rapidly growing orbital or lid mass consistent with aggressive malignancy • Acute, progressive orbital inflammation/ severe, vision-threatening thyroid eye disease • Progressive vision loss due to pseudotumor cerebri requiring semi-urgent optic nerve sheath fenestration • Patients needing temporal artery biopsy • Recent orbital fractures – with entrapment, diplopia • Severe lid malpositions threatening health of the eye and failing non-surgical intervention • Acute dacryocystitis (can be delayed to "elective" if already being managed on systemic antibiotics and clinic I&D)	• Orbital fractures > 1 month old • Benign lid lesions: skin tags, telangiectasias, chalazia • Very slow growing malignancy (small BCCA) • Stable thyroid eye disease • Benign orbital masses	• Cosmetic concerns • Brow ptosis/ Dermatochalasis/ Ptosis/Ectropion/ Entropion • Epiphora • Mild/chronic orbital inflammatory disease

Emergent (ASAP)	Urgent (Within 24 hours)	Priority (Within 72 hours)	Soon (72 hrs - 2 weeks)	Non-elective (2-6 weeks)	Elective (>6 weeks)
Retina					
• Endophthalmitis • Vitrectomy, ocular trauma	• Intraocular foreign body • Acute Rhegmatogenous Retinal Detachment • Ciliary block glaucoma • Malignant Glaucoma • Lens induced glaucoma due to retained or dislocated lens • Retinal tear • Misdirected aqueous • Vitreous prolapse • Tube shunt that blocks filtration	• Acute Rhegmatogenous Retinal Detachment, macula off • ROP Laser • ROP Surgery • Advanced PDR • Complex preretinal membrane	• Acute subfoveal hemorrhage • Monocular hemorrhage in good eye • Diagnostic vitrectomy • Chronic Retinal Detachment • Advanced PDR	• Macular hole • Dislocated IOL • Proliferative vitreoretinopathy	• Macular pucker • Removal vitreous floaters
Uveitis					
					• Cataract surgery for uveitis patients could be delayed

ED TRIAGE GUIDELINES

Goal: Limit unnecessary exposures to high-risk environments for both patients and staff, decompress ED space
If in any doubt, please consult the ophthalmology on-call resident for additional guidance.

	TRIAGE: COVID-19 symptoms or Influenza-Like Illness?		
Eye Urgent Care Center OPEN Mon. - Fri. 7:30 AM - 5 PM	YES	→	Admit to ER
	NO	→	UIC Eye Urgent Care Center

	TRIAGE: COVID-19 symptoms or Influenza-Like Illness?			
Eye Urgent Care Center AFTER HOURS Mon. - Fri. 5 PM - 7:30 AM Sat. & Sun.	YES	→		Admit to ER
	NO	**Emergency Ocular Complaints** * See Back for Triage Guide	→	Admit to ER
		Non-Emergent Complaints	→	Schedule appointment at Eye and Ear Infirmary

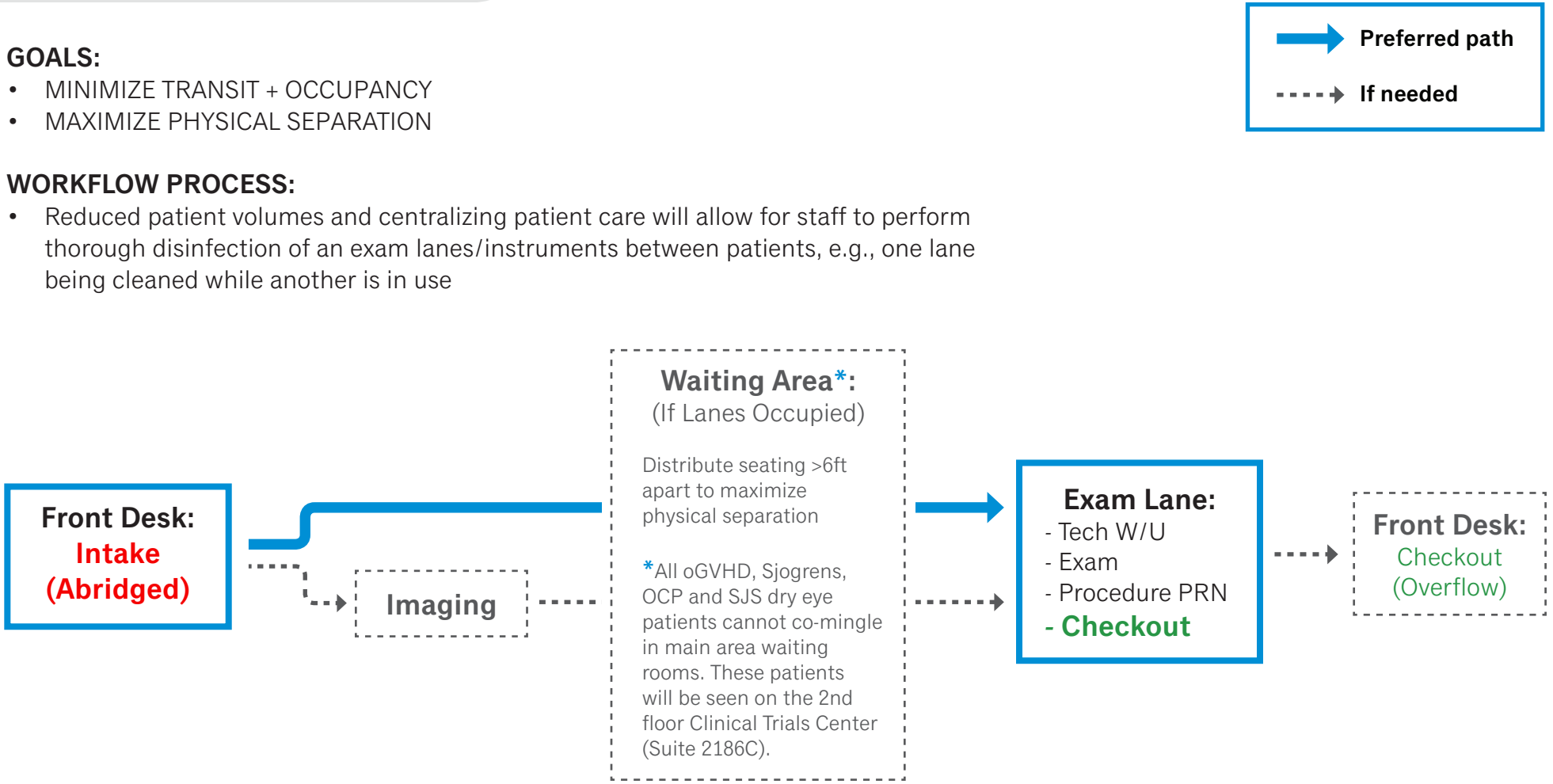
Eye emergencies:

- Orbital cellulitis
- Retrobulbar hemorrhage or orbital compartment syndrome
- Orbital fracture with muscle entrapment in pediatric patient
- Margin-involving eyelid laceration with canalicular damage or postseptal involvement
- Third nerve (CN3) palsy
- Giant cell arteritis
- Chemical burns
- Corneal ulcers
- Corneal transplant wound dehiscence
- Open globe or intraocular foreign body (IOFB) (history of trauma)
- Acute angle closure glaucoma
- Central retinal artery occlusion
- Macula-on retinal detachment (Macula-on RD)
- Endophthalmitis

PATIENT MOVEMENT

GOALS:
- MINIMIZE TRANSIT + OCCUPANCY
- MAXIMIZE PHYSICAL SEPARATION

WORKFLOW PROCESS:
- Reduced patient volumes and centralizing patient care will allow for staff to perform thorough disinfection of an exam lanes/instruments between patients, e.g., one lane being cleaned while another is in use



Minimum Patient Transitions: **1**
Maximum Patient Transitions: **4**

EYE EXAM PROTOCOL

Please follow all screening protocols for patients who come in for urgent visits.

VISITORS:

- Limit of one adult visitor per patient. The visitor does not come back into exam.

WAITING AREAS:

- Chairs/seating spaced >6ft apart

CHECK IN DESK:

- Tape on floor, sign asking patients to stand behind the tape for check in

TECHNICAL STAFF:

- Call patient into exam room (ideally, keep patient in same exam room)
- Basic history of why patient is there, taken from the doorway at a distance of > 6 feet
- Check visual acuity (occluders must be cleaned between patients)
- **Tonometry with tonopen**
  - If applanation necessary and indicated by provider, use of disposable applanation tips
- Leave patient in room with door closed and notify provider patient is ready
- Additional instructions wil be provided by the doctor

PROVIDERS:

- See patient in same exam room
- Advise patient not to talk during examination
- Perform slit lamp and indirect examination, limiting patient contact and exposure time
- Focused examination only: not all patients need dilation, i.e. if anterior segment issue (consider if patient needs dilation as we currently do not have single use vials)
- Consider using OPTOS for fundus examination if appropriate
- Discharge patient and instruct patient that they will be called to schedule follow up
- Limit diagnostic testing (OCT, etc) unless urgent/necessary for care

Other potential considerations for high-risk patients:

- Perform clinical history taking over the phone (either prior to visit or before going in to do exam)

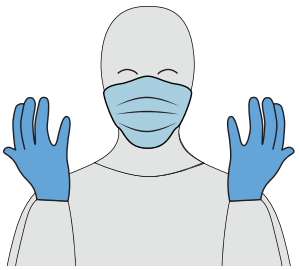
NOTES:

- Limiting visual fields, other ancillary testing; defer all contact ultrasound testing unless absolutely necessary
- Rooms should be cleaned after every patient, see disinfection guide on next page
- Please remember to disinfect your own equipment (lenses, cellphones), preferably after each patient

DISINFECTION GUIDE

DISINFECTION OF EXAM LANE:

1. **PPE Donning:**
    - Staff should wear disposable gloves and standard masks for all tasks in the cleaning process, including handling trash.
    - Gloves should be compatible with the disinfectant products being used.
        - Additional PPE might be required based on the cleaning/ disinfectant products being used and whether there is a risk of splash.
    - Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures to their supervisor.



2. **Clean the following areas in the EXAM room, using Cavicide 1:**
    - All horizontal surfaces
    - Exam chair including arm rests
    - Counter (desk)
    - Slit lamp
    - Cabinet handles
    - Door handles
    - Sink basin
    - Facet/handles to sink
    - Computer keyboard
    - Mouse
    - Items dedicated to the room including: occluder, retinoscope, finoff, indirect
    - Pen

3. **PPE Doffing:**
    - Gloves should be removed after cleaning a room or area occupied by ill persons.
        - Gloves should be removed carefully to avoid contamination of the wearer and the surrounding area.

4. **Wash Hands**
    - Clean hands immediately after gloves are removed.
        - Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

5. **When complete:** place CLEAN sign on chair and bring room number to front desk so they are aware the lane is empty and ready for use

TELEHEALTH: INTRO & FAQ

Please work with your staff to determine patients that might benefit from a telehealth visit. Patients that are currently entering our system via the triage protocol will be selected for telehealth visits if they meet the criteria (Refer to page 11 for Outpatient Triage Protocol).

Telehealth can assist in identifying patients who need to be seen in clinic. Also, patients who are immunocompromised or elderly might be able to avoid an in person visit. Other considerations include some post-operative follow-up visits, routine follow-up visits for dry eye or medication refills, and some acute care visits such as red eye or swollen lids.

FAQS FOR TELEHEALTH AND TELEPHONE ENCOUNTERS:

- A telehealth visit requires real-time audio **and** video > InTouch
  - Note that Telehealth services professional reimbursement is the same as in person visits; however, there are no facility fees for telehealth encounters.
- A telephone visit requires real time audio only > Doximity dialer
  - Telephone services professional reimbursement for some insurances could be a fraction (around 10%) of telehealth reimbursement.
- CMS made changes to increase accessibility to healthcare through telehealth during COVID-19
  - Allows professional services nationwide for beneficiaries in all settings, including their homes
  - Allows the use of ALL non-public facing video platforms
    - HIPAA compliant preferred (WebEx, Doxy.me, InTouch)
  - Allows practitioners to evaluate new and established patients via telehealth platform
  - CMS allows healthcare providers to practice across states lines
- Per the hospital, you should not be trying to collect upfront copays for telehealth visits. You should not be trying to collect upfront self-pay fees for telehealth visits.

EHR TEMPLATE: TELEHEALTH

Please note that the italicized statements are required for all telehealth encounters.

A. Ophthalmology Telehealth Encounter

This telehealth visit was initiated by the patient or patient guardian who was located at [home]. Before the initiation of today's documented service, the patient or patient guardian confirmed identity with full name and date of birth and verbally consented to virtual/remote treatment. The patient presented [alone/with xxx] at [time], and the visit was given via [webex, etc] platform due to the COVID-19 outbreak.

Chief complaint:
HPI:
ROS: negative unless otherwise noted in HPI
PMOHx:
Ocular medication

	Right Eye	Left Eye
Pred acetate (pink)		
Ofloxacin (tan)		
Timolol (yellow)		
Alphagan (purple) Brimonidine		
Trusopt/Azopt (Orange) Dorzolamide/Brinzolamide		
Xalatan/Travatan/Lumigan Latanoprost **(teal)**		
Cosopt (blue) Dorzolamide/Timolo**l**		
Combigan (Blue) Brimonidine/Timolol		
Simbrinza (light green) Brimonidine/Brinzolamide		

Past medical history:
Medications: per EMR, pertinent medications noted here:
Allergies: (autopopulates)

The patient is AOx3, respirations appear non-labored, and the patient is in no apparent distress.

A. Ophthalmology Telehealth Encounter, continued

EXAM	OD	OS
Pupils	Unable to test	Unable to test
Vision	No vision changes per patient	No vision changes per patient
CVF	Fields full per patient	Fields full per patient
EOM	Full	Full
Adnexa	(-) edema	(-) edema
Eyelids	Appear clear, (-)edema	Appear clear, (-)edema
Conjunctive/Sclera	(-) injection	(-) injection
Cornea*	Unable to view	Unable to view
Iris	Appears normal	Appears normal
Anterior Chamber*	Unable to view	Unable to view

**Slit lamp examination is required to evaluate cornea and anterior chamber*

Review of labs or imaging:
Assessment:
1.
2.
3.

Plan:
1.
2.
3.

*Any physical exam detailed is from audio and video inspection performed during this patient encounter. A total of ** minutes was spent with the patient, >50% in counseling and coordination of care. Time was allowed for answering of all questions regarding the patient's condition, laboratory or imaging results, medication prescribed, plan of care, and when applicable, the risks, benefits, and alternatives to any procedure or surgery were discussed. This visit was not related to a face-to-face encounter or procedure that occurred within the past 7 days.*

ICD 10:
CPT code:

EHR TEMPLATE: TELEPHONE

B. Ophthalmology Telephone Encounter

Before the initiation of today's documented service, the patient confirmed identity with full name and date of birth. In addition, the patient or patient guardian verbally consented to virtual/remote treatment.

Chief complaint:

Summary of call:

*A total of ** minutes was spent with the patient. Time was allowed for answering of all questions regarding the patient's condition, laboratory or imaging results, medication prescribed, plan of care, and when applicable, the risks, benefits, and alternatives to any procedure or surgery were discussed. This call was not related to a face-to-face office visit or procedure that occurred within the past seven days.*

*ICD10 Diagnosis associated with call: ****

CPT Code:

BILLING: TELEHEALTH VISIT

BILLING:

- If billing based on time use the following public phrase: /Billingphrase "xx minutes were spent face to face with the patient, in which >50% were in counseling and coordination of care regarding xxx."
- Only attending time should be counted when billing based on time.
- Note that this service cannot originate from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- Established patients: 2 of 3 elements (history, exam, medical decision making) must meet or exceed the code level
- New patients: 3 of 3 elements (history, exam, medical decision making) must meet or exceed the code level
- Bill E/M code with modifier -95

BILLING: TELEHEALTH VISIT

Established Patients Level 2, 3, 4

2 of 3 elements (history, exam, medical decision making) must meet or exceed the code level. *+-95 modifier required.

	Level 2 (99212)	Level 3 (99213)	Level 4 (99214)
Case History	• Chief complaint • HPI (1-3)	• Chief complaint • HPI (1-3) • ROS (1)	• Chief complaint • HPI (4+) • ROS (2-9) • Pertinent past, family &/or social history (1-3)
Exam	1-5 bullets	6-8 bullets	9+ bullets

Medical Decision Making	• Minimal overall risk
	• Must meet one of the following:
	  • New problem to examiner: stable, improved or worsening
	  • Clinical lab test(s): ordered or reviewed
	  • Radiology tests: ordered or reviewed
	  • Other diagnostic tests: ordered or reviewed
	  • Review of old records and/or additional history from other than the patient
	• Must meet one of the two categories:
	Presenting problem(s)
	• 1 self-limited or minor problem
	Management Options
	• Bandage or superficial dressing
	• Observation
	• Home care instructions, i.e. warm compresses, lid scrubs
		• Low overall risk
		• Must meet two of the following criteria:
		  • Established problem to examiner: stable, improving or resolved
		  • Established or new problem to examiner: worsening (only one necessary)
		  • Clinical lab test(s): ordered or reviewed
		  • Radiology tests: ordered or reviewed
		  • Other diagnostic tests: ordered or reviewed
		  • Review of old records and/ or additional history from other than the patient
		• Must meet one of the two categories:
		Presenting problem(s)
		• Two or more self-limited or minor problems
		• 1 stable chronic illness
		• Acute uncomplicated illness or injury
		Management Options
		• OTC drugs or rx
		• Minor surgery recommended with no identified risk factors
			• Moderate overall risk
			• 3 dx/management options
			Orientation:
			AOx3 (alert and oriented to person, place, and time)

Billing Based on time	10 minutes	15 minutes	25 minutes

BILLING: TELEHEALTH VISIT

New Patients Level 1 & 2 All 3 elements (history, exam, medical decision making) must meet or exceed the code level. *+-95 modifier required.		
	Level 1 (99201)	**Level 2 (99202)**
Case History	• Chief complaint • HPI (1-3)	• Chief complaint • HPI (1-3) • ROS (1)
Exam	1-5 bullets	6-8 bullets

Medical Decision Making	• <1 diagnosis and management options; <1 data;
	• Minimal overall risk
		• Must meet one of the following criteria:
		  • New problem to examiner: stable, improved or worsening
		  • Clinical lab test(s): ordered or reviewed
		  • Radiology tests: ordered or reviewed
		  • Other diagnostic tests: ordered or reviewed
		  • Review of old records and/or additional history from other than the patient
		• Must meet one of the two categories:
		Presenting problem(s)
		• One self-limited or minor problem
		Management Options Selected
		• Bandage or superficial dressing
		• Observation
		• Home care instructions, i.e. warm compresses, lid scrubs

Billing Based on time	10 minutes	20 minutes

BILLING: TELEPHONE VISIT

Powerchart note: *Ophthalmology telephone encounter*

Note: This service cannot originate from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
Powerchart note: Ophthalmology telehealth encounter

Documentation:

- Confirm patient identity
- Verbal consent for service
- Time spent

Billing - all based on time:

All Patients		
G2012	5-10 minutes	$14.81
99441	5-10 minutes	$14.44
99442	11-20 minutes	$28.15
99443	21-30 minutes	$41.14

BILLING: OTHER SERVICES

A. Reviewing photos or video submitted by patient with interpretation and report: *G2012*

- Established patients
- Can be sent via email, text, portal, phone, video
- Verbal follow-up with patient required
- Reimbursement: $12.27
  - **Note:** can be combined with **G2012**

B. E-visits: Online communication (portal, secure email)

Established Patients		
99421	5-10 minutes	$15.52
99422	11-20 minutes	$31.04
99423	21 minutes	$50.16

- **Note:** this is for cumulative communication time over seven days

C. Doctor-to-doctor consults (OD, OMD, PCP)

- Both the doctor requesting the consult and the consulting doctor can bill
- Payment to the consulting doctor
  - Requires a verbal and written report to the requesting doc

New or Established Patient		
99446	5-10 minutes	$18.41
99447	11-20 minutes	$37.17
99448	21-30 minutes	$55.58
99449	31 minutes	$73.98

- Payment to the doctor requesting the consult
  - Requires a verbal and documented consult from the patient

New or Established Patient		
99452	30 minutes	$37.53

- **Note:** The patient does not need to be present during the consult; this cannot be a doctor-to-doctor consult within Department of Ophthalmology

TELEHEALTH: RESOURCES

- University of Arizona Visual Acuity Chart
- **Smartphone apps:**
    - **Eye Handbook**
        - Provides near vision chart, amsler grid, color vision, contrast sensitivity, OKN drum, etc.
        - 

    - visualFields Easy

CLINICAL STAFF: TELEPHONE SCRIPT

SCRIPT FOR SCHEDULING PATIENTS BY PHONE:

"The Eye and Ear Infirmary now offers the ability to have a virtual visit with one of our providers. You would be able to use your smart phone or computer to video chat through a program called InTouch. Your doctor thinks you would be a good candidate for this type of visit. Are you interested in setting up a virtual appointment with Dr. XXX? Please be aware that these visits will be billed to your insurance carrier just as if you had come into the office."

The patient must agree and verbal consent documented in the chart.

"Do you have a smartphone or computer with video camera?"

- If YES: *"Have you used InTouch before?"*
    - YES / NO: *"Please confirm a phone number or email address we can send a meeting invitation to."*
- If NO: *"Would you like to schedule a phone visit instead?"*

Please document the following in the appointment notes:

- **The patient's confirmed phone number or email address.**
- ***"Patient has opted for a [telehealth/telephone] visit with Dr. _____, Patient is aware that this encounter will be billed to their medical insurance."***