

HRS COVID-19 Task Force Message #1 (March 20, 2020)

The COVID-19 pandemic is rapidly evolving. We aim to provide timely and reliable information to help guide electrophysiology patient care and recommend “best practices” in this complex and challenging time. This communication is intended to provide guidance specifically for the EP community and there will be subsequent communications as more information or updates become available.

The fundamental current goal is to limit in-person contacts to minimize unnecessary exposure that increases patient or health care worker risk for infection with COVID-19. Importantly, avoiding elective procedures conserves precious resources, such as personal protective equipment (PPE).

1. Recommendations for managing EP procedures:

Due to the impact of COVID-19 cases on healthcare resources, including hospital beds, PPE, and increased risk to patients and healthcare providers by contact with individuals who are infectious, hospitals and practices should follow CDC recommendations to postpone elective EP procedures. Elective procedures may include, but are not limited to, ablation in clinically stable patients, device upgrades, most primary prevention ICD implants, left atrial appendage closure device implants, and implantable loop recorders. This is currently recommended as a “best practice.”

Screen all patients for symptoms of fever, URI symptoms, high risk travel, or high risk contacts.

Ensure appropriate PPE is available for all members of the care team, and conserve appropriately. Use of powered air-purifying respirator (PAPR) or N-95 mask is recommended in cases with known covid-19 infection due to the potential risk of urgent bag-mask ventilation or intubation requirement during the procedure.

Learn how to don and doff PPE correctly (<https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>).

Assign personnel strategically to minimize concomitant exposure. It is important to protect the healthcare workforce.

2. Recommendations for managing EP clinics:

In patients with a cardiac implantable electronic device (CIED), remote monitoring is a powerful tool for assessing patients without requiring an office visit. For patients who are already followed by remote monitoring who have no other active ongoing conditions or drug therapies that require in-person evaluation, healthcare providers should strongly consider replacing routine office visits with a remote visit (video, telephone, remote monitoring of CIED, etc.). For patients who are not currently enrolled in remote monitoring, new enrollment should be considered. For

patients without implanted devices, ambulatory monitors can also be requested remotely and mailed to the patient; smartphone or smart watch acquired ECGs can be considered.

Routine in-hospital in-person device interrogations for patients hospitalized for other unrelated issues or for stable patients in long-term care facilities are discouraged, particularly when remote monitoring can replace in-person contact. This will help to reduce patient, personnel, and programmer exposures that may enhance spread of the virus.

Although COVID-19 is spread primarily through respiratory droplets and close contact with an infected person, the virus may also be spread by contact with contaminated surfaces. Therefore, the CIED programmer and wand should be cleaned with a germicidal wipe between uses. Healthcare providers should also consult with their hospital's infection control or COVID-19 task force regarding recommended cleaning.

The Centers for Medicare & Medicaid Services (CMS) has expanded telehealth services. Many in-person visits may now be converted to virtual healthcare visits to reduce patient contact with infected individuals. Wound check visits may also be performed by telehealth visits using videoconferencing or by sending a picture to the healthcare provider combined with a telephone visit. Reimbursement rules are rapidly evolving.