Greetings Ambulatory Clinics –

We are starting into the next phase of limiting our ambulatory clinic access for adults, children and cancer patients. This process is beginning because of the increasing concern about patients coming into our facilities, and our mutual increased risk of exposure to COVID-19, as well as increasing concern expressed by SFDPH as they limit access to our hospitals.

- High risk procedures need to be discontinued immediately, unless they are urgent/emergent. These include, but are not limited to, scoping in OHNS, and pulmonary, PFTs, GI endoscopy. Please discontinue any non-emergent/urgent procedures that are considered hi risk in your areas effective Monday, March 16, 2020.

- We would like to separate the patients into three groups and implement the changes by Wednesday, March 18, if possible:

    1. **Urgent** – need to be seen and can't wait.
        - Convert to video visit, if possible – 1st priority for video visit capacity
        - If not, keep as in-person visit – 1st priority for in-person capacity

    2. **Semi-Urgent** – cannot wait for a month to be seen without increasing the risk of worse medical outcomes, even given the risk of coming into a medical facility.
        - Please evaluate if they can be managed with a video visit, or if they need an appointment – 2nd priority for video visit or in-person capacity
        - If you postpone these patients, please keep a list of them, and I will work w/ Apex to see if we can track them in Apex for you so we do not let them get lost to follow up.

    3. **Fully Elective Visits** – can be safely postponed for more than three months without risk.
        - Convert to video visit if there is capacity – 3rd priority for video visit capacity
        - If not, cancel and reschedule for more than three months into the future.

Semi-Urgent is particularly difficult to determine, and will likely need each provider to review their schedules to make the decision about when the patient needs to be seen. If a patient is not able to perform a video visit, but can do a telephone visit, please feel free to use that modality.

- We will need to keep a skeletal staff in most clinics. Please try to estimate the number of urgent/emergent slots you are likely to need. We will try to find ways of letting staff who can work from home support us from home. Computers may be a bottleneck if they do not own a computer at home. If they do, security software can be uploaded to allow them to connect to UCSF and Apex. Please obtain a tally of staff who do not have a computer.
- Some clinics may be able to share staff as we move to a more limited on-site ambulatory workforce. We will likely need to move some staff to new functions to help cope with the pandemic.
- We are considering swabbing only clinics or workflows, for those who have been screened via VV, but need to clarify the testing capacity. There are limitations on supplies that may affect this.

Starting soon, we will need additionally to:

- Screen employees before they enter the building
- Limit visitors to only "essential" visitors – caretakers who come along with patients and are essential to care of the patient. Here's the most recent visitor guidance that has already been implemented in the hospitals : https://coronavirus.ucsf.edu/visitors
- Limit employees to "essential" employees.

We do not have a timeline for putting these measures in place yet.

Thanks to everyone for all their continued hard work.

Susan Smith and Dave Morgan