Department of Veterans Affairs

Memorandum

Date: MAR 2 0 2020

From: Deputy Under Secretary for Health and Operations Management (10N)

Subj: Primary Care Guidance for COVID-19 Pandemic Response

To: Veterans Integrated Service Network Directors (10N1-23)

Thru: Assistant Deputy Under Secretary for Health Clinical Operations (10NC) JMB

1. The purpose of this memorandum is to provide general guidance from the Veterans Health Administration (VHA) Office of Primary Care (10NC3) that is intended to support patient care throughout the COVID-19 pandemic response.

2. All Primary Care appointments should be reviewed and if clinically appropriate, converted to virtual modalities. The guidance for this is to use the modality that has the lowest technology requirement such as secure messaging or telephone unless a video visit is more clinically appropriate or if a Veteran prefers a video visit. If a Veteran requires a face-to-face appointment based on clinical need or they are unable to participate in virtual care (e.g., Veteran does not own smart device with internet connectivity, cannot comprehend virtual care communication steps, etc.), he or she should be scheduled accordingly. Group face-to-face appointments should be converted to virtual modalities or individual face-to-face care, if clinically indicated.

3. Follow up appointments should be scheduled as virtual (secure messaging, phone call, VA Video Connect), whenever clinically and technically appropriate, for at least the next 90 days.

4. Annual face-to-face visits without the need to address new concerns or significant abnormalities should be scheduled out a minimum of 90 days. If there is a clinical reason to maintain the appointment, it should be converted to a virtual modality, when clinically appropriate.

5. It is the expectation that Primary Care teams are **proactively reaching out to their high-risk Veterans to inquire about their needs**. This strong practice should divert calls from the Clinical Contact/Call Centers that are already backlogged and divert visits to the Emergency Departments where the Veterans run the risk of exposure.

6. All orders for consults and imaging should continue as usual for urgent needs or concerning clinical scenarios with the appropriate patient indicated date. Any non-urgent or routine consults or imaging should be placed as a future-care consult scheduled out for at least 90 days or more until further notice.

7. Formal guidance for colorectal cancer screening during the COVID-19 pandemic will be coming out shortly. Until then, **colorectal cancer screening for average risk patients should be performed via FIT testing** (which will satisfy the reminder for a year if negative) unless there is a reason the Veteran cannot perform the FIT test (blindness, etc.). In the latter scenario, a screening colonoscopy request can be placed, however it will likely not be acted upon for months. **Surveillance or diagnostic colonoscopy requests should be placed as usual utilizing the latest guidelines, as outlined in Attachment A** focusing on the changes for 1-2 adenomas <1 cm and 3-4 adenomas <1 cm. The submitted patient indicated date for surveillance colonoscopy should incorporate the ordering provider's dialogue with the patient.

8. Clinical reminders should be acted upon to the extent possible until further notice.

9. Electronic consults (e-consults) should be utilized whenever clinically appropriate.

10. Elective procedure consults should be delayed for a minimum 90 days.

11. Medication refills should be mailed whenever clinically appropriate.

12. See Attachment B for additional COVID-19 resources, information, and links to important websites and tools for Primary Care staff.

13. Questions concerning this guidance may be directed to Dr. Thomas Mattras, Director for Primary Care Operations in the VHA Office of Primary Care (10NC3) at VHA10NC3Action@va.gov.

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Attachments