RANZCO NZ Branch Guidance: Change to COVID-19 Level 3

Background

The government has advised New Zealand that as from Tuesday 28 April we will be at COVID-19 alert level 3.

RANZCO NZ Branch has been in consultation with the Ministry of Health, Heads of Departments and RANZCO head office. We were particularly grateful for ONZ allowing us to tack on to their already planned and very timely meeting on 21 April, including those who are not members of ONZ, so that we could consult with the majority of our members as well as take further advice from the Ministry of Health.

The RANZCO NZ Branch guidance should be read in conjunction with the MOH correspondence regarding ***Increasing and improving Planned Care in accordance with the National Hospital Response Framework*** and the ***COVID-19 National Hospitals Response Framework*** (describing alert levels) also bearing in mind that these documents (attached) are 'living' and subject to change by the MOH.

The principles are that delivery of elective healthcare should recommence if it can be provided in a manner that minimizes the potential COVID-19 spread and morbidity, patients should be treated in an equitable manner regardless of the payer and that patients should not suffer needless ocular morbidity.

Therefore, in line with the wishes of the Ministry of Health, the majority of yourselves as expressed at the meeting on 21 April and, as it happens, consistent with what is happening in Australia, RANZCO supports the resumption of elective ophthalmic clinics and surgery in New Zealand when we step down to level 3, if such care can be provided in a safe environment that minimizes the chance of spreading COVID-19. This is a new environment in which it is important that public and private ophthalmology work together to provide as equitable an outcome for New Zealanders as can be achieved, regardless of the funding model. RANZCO therefore encourages, as the Ministry of Health does, outsourcing of work that DHBs are unable to perform to the private sector, and at the same time expects that the private sector make available their resources as required by the DHBs, which may well require the latter to prioritise public work above those private patients that do not have as urgent a need. DHBs are strongly encouraged to have discussions with private providers about how the sector can contribute to the response (with appropriate safeguards for staff and patients), and coordinate service delivery in the recovery phases of this outbreak.

Please remember that these are guidelines and there should be flexibility to match the principles to local need and local COVID-19 issues and no doubt the situation will continue to change. A thorough risk assessment of patients planned for elective surgery is essential. The underlying principle is that people should be able to receive elective care if it is provided in a safe way and the ongoing precautions to reduce the COVID-19 pandemic should not cause a burden of unmet health need in our patients. Members can access guidelines from the Ministry of Health website and should keep up to date with developments.

Personal protective equipment is a critical element of staff safety and the use of PPE should be in accordance with national guidelines. See latest updated guidance on the use of personal protective equipment (PPE) in health care.

Why there is a mismatch between Government levels and Hospital levels?

The national alert framework is determined by the Government and describes the whole of Government response to COVID-19. This should work in tandem with the National Hospital Response

Framework (NHRF) to give greater clarity on local health response. As always, urgent non-deferable care should be delivered where possible.

Is the minimum time we'll stay in Level 3 known?

Any movement between the national ALERT levels will be a decision from Government and will be based on many factors, not just the health impacts. The NHRF provides trigger points for moving between levels in the health response. There has been no definitive timeframe suggested for a change in levels nor any indication of a defined time at any level. The Ministry of Health acknowledges that this makes planning for delivery very challenging.

Minimum conditions to be treated

Delivery of elective care should recommence but there may be capacity constraints, particularly given that it is likely that COVID-19 precautions will reduce patient-throughput, and there will be patients for whom resumption of their elective care is not appropriate (see below). There are many ophthalmic conditions for which assessment and treatment is not an emergency but should not wait more than three months. It is important that our patients do not suffer due to lack of care or failure to provide care, although such care has to be provided in a safe manner without increasing the spread of COVID-19.

Therefore, the following conditions, where deterioration or significant morbidity is likely, should be treated in all patients regardless of the setting, with other elective work being done as local resources allow while still maintaining safe delivery.

General Ophthalmology		
New/Follow-up	**ANY ACUTE SEVERE VISUAL LOSS**	
Cataract		
Surgery	Cataract surgery for intractable high IOP (phacomorphic, phacolytic glaucoma, angle closure)	Cataract surgery for cataract blindness when the patient is significantly visually impaired (e.g. combined effect of BCVA <6/18 in both eyes or field of vision constricted to 10 degrees or less of arc around central fixation in the better eye), if it is an only eye (depending on clinical factors), if driving is essential for role as carer or for occupation or if cataract surgery is required for review of potentially blinding retinal pathology
Cornea/Refractive		
New/Follow-up	Microbial keratitis Keratoconjunctivitis (HZO review 7-10 post rash to assess for uveitis)	Minor trauma (e.g. abrasions, foreign bodies, recurrent erosion syndrome)
	Chemical injury (depending on severity) Corneal trauma (including FB if concerns) Conjunctival laceration	Corneal ectasia with moderate risk of progression (age <21 or documented progression >1D in 6 months)
	Acute Peripheral Ulcerative Keratitis	OSSN
	Neurotrophic cornea with ulceration	Marginal Keratitis (follow-up with telehealth if appropriate)
	Therapeutic (bandage) contact lens patients	Severe sight-threatening ocular surface disease
	Corneal graft rejection	Routine post-operative patients
Surgery	Urgent tectonic keratoplasty (perforations)	Keratoplasty for bullous keratopathy with high risk of infection or pain
	Graft rupture	Keratoplasty in patient <6/60 in both eyes with expected short term improvement
		Cross linking for progressive ectasia (either rapid progression or borderline thickness)
Glaucoma		
New/Follow-up	IOP>40mmHg	After change of glaucoma therapy where IOP is anticipated to change
	Acute angle closure	Routine post-operative care for glaucoma filtration surgery/tubes

	Acute neovascular glaucoma	New referral optometrist diagnosed glaucoma early/moderate/advanced according to RANZCO referral pathway for glaucoma management
	Acute uveitic glaucoma	Optometrist referred glaucoma suspect with high suspicion of disease (as per RANZCO Referral Pathway) where optometrist and ophthalmologist consider urgency is medium
	Acute lens related glaucoma	Anyone with IOP>30mmHg and glaucomatous visual field defect
	New referral that is referred and ophthalmologist consider urgent	Uncontrolled glaucoma
Surgery	Lens extraction surgery to ameliorate angle closure disease not controlled with laser or medical therapies	Lens extraction surgery to ameliorate angle closure disease when risk of progression of angle closure or glaucoma over the next 6 months is unacceptably high. This includes the at-risk fellow eye of eyes blinded by angle closure disease
	Glaucoma surgery for IOP lowering of any type in advanced glaucoma, rapid progression or very high IOP where clinically important progression is likely in the next 1 month, where conservative therapies have failed, are likely to fail, or are contraindicated	Glaucoma surgery (e.g. trabeculectomy, tubes, i-stents) for IOP lowering of any type in glaucoma where clinically important progression is likely in the next 9 months, where conservative therapies have failed, are likely to fail, or are contraindicated.
	Any surgery to manage acute sight threatening complication of glaucoma surgery (e.g. bleb or tube infection)	
Medical Retina		
New/Follow-up	Suspected or confirmed CNV needing treatment	Macular oedema requiring treatment
	Intravitreal injections for: Neovascular AMD, Diabetic macular oedema, Retinal vein occlusion (particularly new CRVO with no previous treatment) , other CNV, macular oedema. **Treat and extend to maximum interval possible or maintain on maximum fixed dosing with no assessment unless decrease in vision)**	
	Active proliferative diabetic retinopathy requiring treatment (PRP laser or intravitreal-antiVEGF)	
	Malignant hypertensive retinopathy	
Vitreoretinal	**Surgery/Trauma**	
New/Follow-up	Acute retinal detachment	Full thickness macular holes
	Suspected retinal tears	Severe vitreomacular traction syndrome
	Open globe injuries: Including PEI, IOFB	Myopic traction maculopathy with foveal detachment
	Acute endophthalmitis	Heavy liquid, densiron removal
	Vitreous haemorrhage (dense, requiring vitrectomy)	Exposed scleral buckles at risk of infection
	Dropped nucleus requiring vitrectomy/lensectomy	Significant epiretinal membranes
	Submacular haemorrhage requiring vitrectomy	
	Aqueous misdirection requiring vitrectomy	
	Complex Surgery post-ops (minimise visits)	
	Diagnostic vitrectomy for infectious or oncological causes	Most routine post ops (minimise visits and use telehealth)
Surgery	Surgery for the above	Surgery for the above
Uveitis		
New/Follow-up	Panuveitis	New cases of Acute Anterior Uveitis should be given a standard 6-8 week tapering course of drops and review (or telephone consult) at 4-6weeks. Clinic review in 3 months if indicated by telephone consult at that time point.
	Posterior Uveitis	Chronic/persistent anterior uveitis managed with topical therapy only, telehealth recommended where possible
	Intermediate Uveitis with vision threatening complications	Quiescent/stable forms of uveitis on stable systemic therapy (prednisolone dose <=7.5mg/daily); telehealth recommended where possible
	Retinal vasculitis	It is highly recommended that patients receiving an intravitreal depot steroid injection for uveitis have at least 1 clinic review/in person IOP check (ophthalmologist or optometrist) 3-6 weeks post-injection

	Patients with uveitis of any form affecting an only eye (VA in fellow eye <6/60)	
Surgery	Vitreous biopsy and/or AC tap for infectious/inflammatory uveitis	
Ocular Oncology		
New/Follow-up	Suspected malignant ocular tumours (e.g. ocular melanoma, metastases, intraocular lymphoma)	Fundus tumours causing macular exudation (choroidal haemangioma, Coats, retinal capillary haemangioblastoma)
	Confirmed malignant ocular tumours requiring acute treatment	Tumours previously booked for up to 6 months planned follow-up interval – telehealth if possible
	Tumours previously booked for 3 month planned follow-up interval – telehealth if possible	
Surgery	Surgery for malignant tumours (including plaque brachytherapy for choroidal melanoma)	Surgery for the above
Oculoplastics		
ALERT: BE CAUTIOUS IN NASOPHARYNGEAL SURGERY AS THE RISK OF COVID-19 TRANSMISSION IS HIGH		
New/Follow-up	Severe thyroid eye disease	*Progressive* benign orbital tumours
	Orbital tumours (sight-threatening or malignant-suspected/known	Moderately-severe thyroid eye disease
	Orbit: Vascular (CCF, progressive/sight-threatening vascular anomalies- e.g. extensive haemangioma, progressive vascular malformation e.g. acute bleed)	Entropion (if appropriate)
	Orbital inflammatory disease (orbital/periorbital cellulitis, sight-threatening orbital inflammation of any cause; acute dacryocystitis/sac abscess)	BCC (if appropriate) Abscess (if no concerns about systemic sepsis, see GP for oral antibiotics, review for IV antibiotics +/- incision and drainage if no improvement/ worsening after 48 hours)
	Periocular malignancy (biopsy proven or suspected) including melanoma (invasive & in situ), sebaceous carcinoma, SCC, other high grade malignancy (Merkel cell, adnexal carcinoma etc.), high risk BCC (medical or lateral canthal, recurrent, high risk subtype, locally advanced i.e. orbital invasion)	Lacrimal: Recurrent/low grade dacryocystitis, canaliculitis.- be aware of COVID-19 risk with DCR
	Post-operative complex surgery	Post-operative simple surgery
	Recent trauma including eyelid and canalicular lacerations, orbital fractures and suspected orbital foreign body	Paediatric ptosis with known/high risk of amblyopia (visual deprivation, failed amblyopia therapy)
	Dacryocystocele (paediatric CNLDO with nasal involvement not resolving/acutely infected). Be aware of COVID-19 risk with DCR	
Surgery	Surgery for the above	Surgery for the above
Paediatrics		
New/Follow-up	Sight or potential life (systemic) threatening conditions	Patients having amblyopia treatment. Where possible, use telehealth
	Cataracts causing amblyopia or under 4 months old	Paediatric oculoplastic/adnexal cases
	Reduced vision in both eyes	Reduced vision in one eye over age 7. Where possible, use telehealth video/photos to triage
	Reduced vision in one eye underage 7 Post-ops within last 2 months	Examination under anaesthesia where management is time-sensitive
	ROP screening	
	Children on medication (drops or systemic) for glaucoma uveitis, corneal disease	
Surgery	Cataract surgery in under 4-months olds or where causing amblyopia	
Strabismus		
New/Follow-up	Triage of referrals on case by case basis (accept suspected neurological strabismus)	Strabismus where amblyopia management is also required

Surgery	Acute trauma related requiring surgery	
Neuro-Ophthalmology		
New/Follow-up	Acute optic neuropathies, suspected SOL or raised intracranial pressure, neurological diplopia, acute pupillary abnormalities, functional visual loss to exclude organic pathology, GCA	
Surgery	Optic nerve sheath fenestration for severe visual loss in IIH	

Clinic patients

Elective patient clinics should resume if such care can be provided in a safe manner, however RANZCO recognizes that capacity constraints will mean that it may be difficult to see all patients within the usual timeframe. In some settings patients may already have been re-triaged and, where this has not been done, efforts should be made to see patients within the normal timeframe but if this is not possible then in such uncertain times it may not be unreasonable to increase the follow up time between visits by another 50-100% if such is done in an equitable manner.

In alert level 3, we also need to take into account the COVID-19 risk. The risk of exposing patients to COVID-19 infection during an ophthalmology appointment must be weighed against their risk of non-reversible sight loss e.g. a patient who is >70 years old with comorbidities/immune suppression. As a reminder, even at level 2 alert, the official advice from MOH is keep >70 at home. Telehealth should be considered as an alternative to reduce risk.

A record should be kept of which patients are seen by which staff, including nurses, photographers, technicians and doctors, so that if COVID-19 is later diagnosed in any patient or staff contact tracing is easier.

Diabetic photo-screening

Diabetic photo-screening should recommence, particularly if the patient could be at risk of visual loss sooner rather than later if the appointment interval is postponed. Markers of this could include

- An appointment interval of 3 months or less
- Being a new patient
- If their risk factors are known, such as their retinopathy grade at last screen, HBA1C, years of disease, etc.

Telehealth

Telehealth may be useful in some circumstances, particularly where it is inappropriate, for instance patients living in aged residential care with deferrable conditions, that some patients to be asked to come into a clinic. The NZ Branch of RANZCO has formed a Telehealth subcommittee to develop our understanding in this area and shall keep members advised of progress in this regard.

Intravitreal injections

Intravitreal injections should proceed in a safe manner.

Surgery

RANZCO supports the resumption of elective surgery in New Zealand, along with the Ministry of Health. There are likely to be capacity constraints, however, and priority should be given to the following conditions:

- VR
    - Non-resolving vitreous haemorrhage
    - High risk diabetic vitrectomy
    - Full thickness macular hole
    - ERM 6/15 or worse + distortion
    - Severe VMT
    - Retinal detachment (both mac on and mac off)
    - Endophthalmitis
    - Trauma
    - Retained IOFB
    - Vitreous biopsy
- Glaucoma
    - High risk of clinically significant progression in the next 9 months
    - Lensectomy / other treatment for angle-closure glaucoma
    - Paediatric glaucoma
- Other
    - Paediatric ptosis for amblyopia
    - Paediatric cataract
    - ROP screening and treatment
    - Enucleation for blind painful eye
    - Orbital decompression for sight threatening pathology
    - Eyelid and canalicular repair
    - Lid malignancy – invasive BCC (may or may not require semi-urgent surgery, clinical guidance needed), SCC and melanoma
    - Orbital biopsy / abscess drainage
    - Malposition of lids causing corneal damage
    - Corneal grafts, especially so that graft tissue is not wasted
    - Priority should be given to severe cataracts or those affecting activities of daily living very significantly, which might be cataracts with BCVA <6/18 in both eyes, only eye situations or patients who are required to drive for an important reason, e.g. work, or perform some other function in life that is vital to them or someone else (but not if they just want to drive for social purposes) and can't do that because of cataract should be considered for priority cataract surgery at a lower threshold to get them back driving
    - TABs where these are done by ophthalmology
    - Plaque, enucleation, stereotactic radiotherapy and other treatments as required for intraocular malignancies

Of course, guides such as this or CPAC do not take into account the COVID-19 risk and such guides for surgery should only be guides. The risk of exposing patients to COVID-19 infection during an ophthalmology appointment/surgery must be weighed against their risk of non-reversible sight loss e.g. a CPAC 70 patient who is >70 years old with comorbidities/immune suppression (the official advice from MOH is keep >70 at home!). Which patients get operated on should be a case-by-case judgement by a consultant, along with a careful discussion with the patient.

Before patients arrive

COVID-19 screening questions to ask patients: (assess on the phone and confirm before permitting them to enter premises):

1. Are you unwell with fever, cough, sore throat or trouble breathing OR have you travelled and returned from overseas in the past 14 days OR have you been in contact with anyone that has returned from overseas in the past 14 days OR have you been in contact with anyone who has COVID-19?
2. If they answer YES to Question No.1 then they must be refused entry unless it is an absolute emergency, in which case they should be seen in a negative pressure room and treated as a COVID-19 patient in terms of PPE. If they have respiratory symptoms, they should be referred to their GP. If they are a close contact or have had recent overseas travel, remind them of their responsibilities regarding isolation.
3. Patients should be advised to be transported by someone in their bubble, if possible. Advise them that their accompanying person should remain in the car. If their accompanying person needs to escort them into the premises, the same screening questions need to be asked of the accompanying person before they are permitted to enter.

Appointment guidelines

These guidelines can only be guidance and some may need to be adapted. For instance, some eye clinics are a long way from a carpark (e.g. Greenlane Clinical Centre), some people do not use a car, so asking a support people to wait in a car might not always be practical.

- Follow the current Ministry of Health public health measure guidelines, published on their website
- Ensure a clean and safe environment for all staff and patients
- Clinical and Administration staff will follow all MoH protocols and guidelines to ensure safety of all staff and patients
- If patients have a support person(s) with them, please ask the support person to wait in their car. If the patient is frail and unstable on their legs, support person will be permitted. (Remember to ask COVID-19 screening questions)
- Attempt to stand at least 2 metres back from them e.g. at reception desk or when opening the door.
- Ensure patient (and support people) sanitise their hands and wear a mask if they have a URTI (not COVID-19), or if the medical staff request (which may be, for instance, if the patient requires a long time for their appointment, e.g. for PRP or an expected long consultation, or if it makes the medical staff more comfortable). Some DHBs are giving masks to all patients (e.g. CMDHB) but there are reasons that this might not be a good idea, e.g. it might make the wearer more comfortable, they may touch their face more.
- Allow a minimum of 15 minutes between appointment times.
- Avoid aerosolized non-contact tonometry. Consider Icare with disposable tips if possible.
- Staff working within 2 metres of a patient should wear a mask; it is ok to wear a mask for the whole session.
- Limit contact time with patients to less than 15 minutes where possible. Consider avoiding examination at slit-lamp and assess by alternative methods e.g. OCT and retinal photos. Equipment will require appropriate cleaning between patients. Recommend only essential investigations be performed.
- Cleaning of all equipment that the patient came in contact with (e.g. slit-lamp, camera, OCT etc.) recommended between every patient.
- Post Visit Clean: Ensure all surfaces that the patient may have come in contact with are sanitised with the Sanicloths (or equivalent). This will include handrails, lift buttons or anything they may have touched or placed on the reception counter. Remember to clean doorknobs/handles, phones, computer keyboards/mice.

Personal Protective Equipment

- Normal surgical mask for patient contact within 2m (for doctors/optometrists, nurses, techs, front desk admin.)
- To lower the risk of transmission via drop- lets, install protective shields (made of plastic) on slit lamps and avoid touching the patient if possible (see Article Lai 2020)
- Minimise time in clinic as risk is for >15 mins contact.
- For a clinical session (1/2 day) wear same mask (resources need to be used judiciously and sparingly)
- Careful hand washing, and cleaning after every patient, especially after removing mask - avoid touching the mask – handle by the ties/elastic when removing)
- Scrubs are encouraged.

For further PPE information, check the Ministry of Health website. This is particularly important as the guidelines may change.

Inter-district flows

Under Alert Level 3 people can access essential and necessary medical care. Where needed that includes being able to travel both locally, or across regions to access appropriate treatments. Patients requiring care in another district will follow the usual pattern for referral, acceptance and transport as appropriate to their clinical condition and the national Alert level.

Hence, as per usual, patients whose condition requires an inter-district transfer should be accepted by a consultant ophthalmologist at the location they are being transferred to. Usually this will be done by phone. The consultant is able to delegate this authority to a senior trainee (usually a fellow).

When the patient returns to their own district, the accepting DHB should be notified first and the patient should adhere to whatever instructions they are given. This might include a recommendation to self-isolate on their return. If there is any doubt as to whether they will adhere to these guidelines the Ministry of Health should be informed.

There may also be consideration given to travel restrictions within DHBs, particularly large ones such as Southern DHB. RANZCO understands that, in terms of 'districts' SDHB has already been broken into its component Otago and Southland regions, based on Dunedin and Kew (Invercargill) hospitals respectively and supports the government's efforts to 'keep things regional'.

Considerations around elderly patients

<u>Ongoing restriction of patients aged over 70</u>

In other countries people over the age of 70 have been encouraged to maintain 'lockdown' for a prolonged period. At this stage there has been no indication that this is planned for NZ. However, it is recognised that this is a vulnerable population in general and makes up a large part of the ophthalmology patient population.

There must be a balance between the risk of a patient not being treated optimally with the risk of illness and spread of COVID-19. This balance of risk is different in New Zealand (where there are lower levels of community spread) to other jurisdictions.

As always, appropriate assessment of potential risk is advised. Alternative options such as telehealth should be explored. Delays to care can cause anxiety, so communication between the DHB and patients about what is happening with any planned appointments or procedures that may be deferred, and that they can still access health care if they need it, is essential.

There is information for older persons on the Ministry of Health website:

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-advice-older-people

Patients who are in aged residential care

Please see the guidance for ARC providers. The policies for managing restricted access advised for facilities are all visitors by approval/appointment only and allow only essential health care associated visits, for example, chemo, renal dialysis.

Essential medical appointments at outpatients should proceed only if they are non-deferable and cannot be done using telemedicine and residents should be accepted back by the facility afterwards.

On return, residents will need to be maintained in isolation in a single room for a 14-day period on return to the facility. During this time, support workers should observe physical distancing of 2 metres. This means that residents should remain in ensuite rooms, and staff should practice safe distance and hand washing protocols as per guidance on use of PPE available on the Ministry of Health website.

Deferred care information and modelling of impact

The Ministry of Health is tracking and analysing data on the number of patients whose care is being deferred and the economic impacts of the COVID-19 outbreak.

Modelling is underway to determine what position a DHB will be in once restrictions are eased. This is somewhat fluid, but there is an expectation that DHBs are planning recovery processes to see and treat deferred patients and resume business as usual services.

The Ministry is encouraging clinicians to be involved in these discussions.

Contact tracing

Facilities should track which health professionals and patients see who, in case of COVID-19 positivity in the future.

Other

Optometrists can be used for dealing with patients who live further away. Some DHBs (e.g. SDHB) are paying for these consults if they ask the patient to see an optometrist rather than come in and be seen by the DHB. There is nothing preventing DHBs entering into contracts with private providers. If this is related to services due to COVID-19, then this is being tracked.

RANZCO NZ Branch, 22 April 2020