

Safe Reintroduction of Cardiovascular Services during the COVID-19 Pandemic: Guidance from North American Society Leadership

David A. Wood, MD, Ehtisham Mahmud, MD, Vinod H. Thourani, MD, Janarthanan Sathananthan, MBChB, MPH, Alice Virani, MA, MS, MPH, PhD, Athena Poppas, MD, Robert A. Harrington, MD, Joseph A. Dearani, MD, Madhav Swaminathan, MD, Andrea M. Russo, MD, Ron Blankstein, MD, Sharmila Dorbala, MD, James Carr, MD, Sean Virani, MD, MSc, MPH, Kenneth Gin, MD, Alan Packard, PhD, Vasken Dilsizian, MD, Jean-François Légaré, MD, Jonathon Leipsic, MD, John G. Webb, MD, Andrew D. Krahn, MD

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David A. Wood, MD^{1,2}, Ehtisham Mahmud, MD³, Vinod H. Thourani, MD⁴, Janarthanan Sathananthan, MBChB, MPH^{1,2}, Alice Virani, MA, MS, MPH, PhD⁵, Athena Poppas, MD⁶, Robert A. Harrington, MD⁷, Joseph A. Dearani, MD⁸, Madhav Swaminathan, MD⁹, Andrea M. Russo, MD¹⁰, Ron Blankstein, MD¹¹, Sharmila Dorbala, MD¹¹, James Carr, MD¹², Sean Virani MD, MSc, MPH^{1,2}, Kenneth Gin, MD^{1,2}, Alan Packard, PhD¹³, Vasken Dilsizian MD¹⁴, Jean-François Légaré, MD¹⁵, Jonathon Leipsic, MD^{1,2}, John G. Webb, MD^{1,2}, and Andrew D. Krahn, MD^{1,2}

North American Cardiovascular Societies represented: American College of Cardiology, American Heart Association, Canadian Cardiovascular Society, Canadian Association of Interventional Cardiology, Society for Cardiovascular Angiography and Interventions, Heart Valve Society, American Society of Echocardiography, Society of Thoracic Surgeons, Heart Rhythm Society, Society of Cardiovascular Computed Tomography, American Society of Nuclear Cardiology, Society of Nuclear Medicine and Molecular Imaging, Society for Cardiovascular Magnetic Resonance, Canadian Heart Failure Society, and the Canadian Society of Cardiac Surgeons.

¹Centre for Cardiovascular Innovation, St Paul's and Vancouver General Hospital, Vancouver, Canada

²Centre for Heart Valve Innovation, St Paul's Hospital, University of British Columbia, Vancouver, Canada

³University of California, San Diego Sulpizio Cardiovascular Center, La Jolla, California, USA

⁴Department of Cardiovascular Surgery, Marcus Valve Center, Piedmont Heart Institute,
Atlanta, GA

⁵Department of Medical Genetics, University of British Columbia, Vancouver, Canada

⁶Brown University School of Medicine, Providence, RI

⁷Department of Medicine, Stanford University, Stanford, CA

⁸Department of Cardiovascular Surgery, Mayo Clinic, Rochester, MN

⁹Department of Anesthesiology, Duke University School of Medicine, Durham, North Carolina

¹⁰Cooper Medical School of Rowan University, Camden, NJ

¹¹Brigham and Women's Hospital, Harvard Medical School, Boston, MA

¹²Northwestern University Feinberg School of Medicine, Chicago, Illinois

¹³Division of Nuclear Medicine and Molecular Imaging, Department of Radiology, Children's
Hospital Boston/Harvard Medical School, Boston, MA

¹⁴Department of Diagnostic Radiology and Nuclear Medicine, University of Maryland School of
Medicine, Baltimore, MD

¹⁵New Brunswick Heart Centre, Dalhousie University, Saint John, NB

Correspondence:

David A Wood MD, FRCPC, FACC, FESC

Centre for Cardiovascular Innovation, St. Paul's and Vancouver General Hospitals,

University of British Columbia

2775 Laurel Street (9th Floor)

Vancouver, British Columbia, Canada, V5Z 1M9

Telephone: 604 875-5601; Fax: 604 875-5504;

E-mail: david.wood@vch.ca

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Running Title: Safe Reintroduction of Cardiovascular Services during the COVID-19 Pandemic

Abbreviations and Acronyms

AGMP: Aerosol-generating medical procedure

ASD: Atrial septal defect

CHF: Congestive Heart Failure

CV: Cardiovascular

HCW: Health care workers

LAAC: Left atrial appendage closure

MI: Myocardial infarction

NSTEMI: Non-ST elevation myocardial infarction

PPCI: Primary percutaneous coronary intervention

PFO: Patent foramen ovale

PPE: Personal Protective Equipment

STEMI: ST elevation myocardial infarction

TAVR: Transcatheter aortic valve replacement

TEE: Transesophageal echocardiography

TTE: Transthoracic echocardiography

UA: Unstable angina

TEVAR: Thoracic endovascular aortic repair;

EVAR: Endovascular repair of aortic aneurysm

Clinical problem

The COVID-19 pandemic has led to marked global morbidity and mortality¹⁻³. There have been appropriate but significant restrictions on routine medical care to comply with public health guidance on physical distancing, and to help preserve or redirect limited resources. Most invasive cardiovascular (CV) procedures and diagnostic tests have been deferred with North American cardiovascular societies advocating for intensified triage and management of patients on waiting lists⁴. Unfortunately, patients with untreated cardiovascular disease are at increased risk of adverse outcomes⁵. Delays in the treatment of patients with confirmed cardiovascular disease will be detrimental. Similarly, reduced access to diagnostic testing will lead to a high burden of undiagnosed cardiovascular disease that will further delay time to treatment. Although there will be a myriad of competing demands from multiple disciplines, this risk warrants the prioritization of cardiovascular patients as healthcare systems return to normal capacity⁴. While COVID-19 has had a global impact, there are regional differences in the burden of the pandemic. Some regions have not experienced a significant surge of cases variably related to social and health care adaptation measures, or the surge has passed and was less substantial than predicted. In these areas, there are available health sector resources that can be redeployed quickly. As regions move along the journey of managing the COVID-19 pandemic, there is an opportunity to reintroduce regular cardiovascular care in a progressive manner with appropriate safeguards.

Cardiovascular societies have released a number of position or guidance statements which predominantly focus on the provision of cardiovascular care during the peak of the pandemic⁶⁻¹². These documents highlight the central theme of balancing essential cardiovascular care services while reducing exposure and preserving health care resources to address the pandemic. As the COVID-19 pandemic abates, developing appropriate strategies to reintroduce routine cardiovascular care will be crucial. Unprecedented times require unprecedented collaboration. In this consensus report, we harmonize recommendations from North American cardiovascular societies and provide guidance on the safe reintroduction of invasive cardiovascular procedures and diagnostic tests after the initial peak of the COVID-19 pandemic.

Strategies and evidence

Ethical Considerations

Similar to rationing decisions made in preparation for the initial surge of COVID-19 cases, progressive and thoughtful reintroduction of cardiovascular services must be based on robust ethical analysis¹³. Relevant values to be operationalized include¹⁴: 1) *Maximizing benefits* such that the most lives, or life years are saved so that procedures or tests that are likely to benefit more people and to a greater degree are prioritized over procedures that will benefit fewer people to a lesser degree; 2) *Fairness* such that like cases are treated alike, taking into consideration baseline health inequities; 3) *Proportionality* such that the risk of further

postponement is balanced against the risk of exacerbating COVID-19 spread; and 4) *Consistency* such that reintroduction is managed across populations and among individuals regardless of ethically irrelevant factors such as ethnicity, perceived social worth or ability to pay. Finally the promotion of *procedural justice*, with the use of an ethical framework¹⁵, is essential to ensure all decisions reflect best available evidence with transparent communication.

Collaboration between regional public health officials, health authorities and cardiovascular care providers

Some regions have seen an escalation in COVID-19 cases when social restrictions and physical distancing have been eased. Hospital based CV teams must establish active partnerships with regional public health policy makers to exchange up-to-date information on both the local status of the pandemic and the growing morbidity and mortality on cardiovascular waiting lists. This is essential for the safe reintroduction of regular CV services. There should be a sustained reduction in the rate of new COVID-19 admissions and deaths in the relevant geographic area for a prespecified time interval as determined by local public health officials before changes can be implemented. Importantly, if COVID-19 admissions and deaths start to increase, there must be immediate and transparent cessation of most elective invasive procedures and tests. Resumption of these services would occur in collaboration with regional public health policy makers. As discussed below, COVID-19 testing of potential patients and health care workers (HCW), as well as personal protective equipment (PPE), must also be carefully monitored to minimize the risk of shortages as the pandemic escalates and abates. A

cohesive partnership with regional public health officials will facilitate management of the dynamic balance between provision of essential cardiovascular care and responding to ongoing fluctuations in COVID-19 admissions and deaths.

Protection of patients and HCWs

The protection of patients and HCWs must be addressed before any reintroduction of cardiovascular procedures and tests. Regions must have the necessary critical care capacity, PPE, and trained staff available before the recommendations summarized in Table 1 can be implemented. Importantly, a transparent plan for testing and re-testing potential patients and HCWs for COVID-19 must be operationalized before elective procedures and tests are resumed.

Additional considerations include:

- 1) Physical distancing: Consider strategies to minimize patient contact with HCWs performing invasive cardiovascular procedures and diagnostic tests. These may include virtual pre-procedural clinics, virtual consenting for procedures and diagnostic tests, and minimizing the number of HCWs in physical contact with any given patient. Restrictions should be implemented on the number of people that can accompany a patient or visit a patient after a procedure or test. Whenever possible, multiple tests or procedures should be consolidated into a single comprehensive visit.
- 2) COVID-19 Screening: Encourage routine screening of all patients prior to any cardiovascular procedure or test to ensure the safety of HCWs. This testing may include nasopharyngeal swabs and saliva or rapid antibody tests and should be guided by local

institutional infectious disease experts and closely coordinated with regional public health officials. Key considerations include the availability and accuracy of the above tests as well as the frequency and timing of COVID-19 testing and re-testing.

Appropriate PPE is required to protect HCWs even if patients are asymptomatic, as the sensitivity of available tests are low in this setting. A significant benefit of testing is the opportunity of defer COVID-19 positive patients if they remain clinically stable.

- 3) PPE: The use of PPE for HCWs during routine cardiovascular procedures and diagnostic tests will be an important consideration. The need to ensure staff safety must be balanced against the need to conserve PPE supplies in the event the pandemic escalates. Emergent cases, such as ST segment elevation myocardial infarction (STEMI) patients and urgent surgeries, or aerosol-generating medical procedures (AGMP) will likely continue to require the highest level of PPE for the foreseeable future and thus available supplies must be carefully monitored.

Areas of uncertainty

Leaders from the North American cardiovascular societies acknowledge that the recommendations in this guidance document are based predominantly on expert opinion. This reflects the global challenge of managing a new and rapidly evolving pandemic where evidence is limited.

Guidance from professional societies

Table 1 harmonizes recommendations from major North American cardiovascular societies and provides guidance on the safe reintroduction of invasive cardiovascular procedures and diagnostic tests during the COVID-19 pandemic. Important considerations when implementing Table 1 include:

- 1) Decisions regarding transitioning between Response Levels requires close collaboration with public health officials and health systems. It is expected this process will be dynamic and continue to evolve as new information becomes available.
- 2) A transparent collaborative plan for COVID-19 testing and PPE use must be in place before a safe reintroduction of procedures and tests can occur.
- 3) It is expected that different regions will be at different Response Levels as the pandemic escalates and abates.
- 4) Within a given region, different invasive procedures and diagnostic tests may be at different Response Levels depending on local COVID-19 penetrance and infrastructure requirements.
- 5) In general, a minimally invasive procedure with a shorter length of stay (LOS) is preferable if both strategies have similar efficacy and safety.
- 6) A less invasive test or alternative imaging modality should be considered if both tests have similar efficacy.
- 7) The language in Table 1 was chosen to give clinicians, health systems and policy makers the maximum flexibility when moving between Response Levels in their

region. COVID-19 prevalence, admission and death rates as well as appropriate time intervals for safe reintroduction will change and thus, we utilized “selective” cases and “some” or “most” cardiovascular procedures in Table 1.

- 8) Maintaining reserve capacity to ensure the ability to manage a possible second surge in COVID-19 cases is a key competing priority. This balance should be actively managed as regions pass through different levels of restriction to ensure the capability of supporting both elements of care delivery focused on net population health.

Conclusions

This consensus report provides harmonized guidance from North American cardiovascular societies. It provides an ethical framework with appropriate safeguards for the gradual reintroduction of invasive cardiovascular procedures and diagnostics tests after the initial peak of the COVID-19 pandemic. A collaborative approach will be essential to mitigate the ongoing morbidity and mortality associated with untreated cardiovascular disease.

References

1. Zhu N, Zhang D, Wang W, et al. A Novel Coronavirus from Patients with Pneumonia in China, 2019. *N Engl J Med*. 2020;382(8):727-733.
2. Holshue ML, DeBolt C, Lindquist S, et al. First Case of 2019 Novel Coronavirus in the United States. *N Engl J Med*. 2020;382(10):929-936.
3. Bhatraju PK, Ghassemieh BJ, Nichols M, et al. Covid-19 in Critically Ill Patients in the Seattle Region - Case Series. *N Engl J Med*. 2020.
4. Driggin E, Madhavan MV, Bikdeli B, et al. Cardiovascular Considerations for Patients, Health Care Workers, and Health Systems During the Coronavirus Disease 2019 (COVID-19) Pandemic. *J Am Coll Cardiol*. 2020.
5. Garcia S, Albaghdadi MS, Meraj PM, et al. Reduction in ST-Segment Elevation Cardiac Catheterization Laboratory Activations in the United States during COVID-19 Pandemic. *J Am Coll Cardiol*. 2020.
6. Wood DA, Sathananthan J, Gin K, et al. Precautions and Procedures for Coronary and Structural Cardiac Interventions during the COVID-19 Pandemic: Guidance from Canadian Association of Interventional Cardiology. *Canadian Journal of Cardiology*. 2020;March 24th.
7. Shah PB, Welt FGP, Mahmud E, et al. Triage Considerations for Patients Referred for Structural Heart Disease Intervention During the Coronavirus Disease 2019 (COVID-19) Pandemic: An ACC /SCAI Consensus Statement. *JACC Cardiovasc Interv*. 2020.
8. Kirkpatrick JN, Mitchell C, Taub C, Kort S, Hung J, Swaminathan M. ASE Statement on Protection of Patients and Echocardiography Service Providers During the 2019 Novel Coronavirus Outbreak. *J Am Coll Cardiol*. 2020.
9. Choi AD, Abbara S, Branch KR, et al. Society of Cardiovascular Computed Tomography Guidance for Use of Cardiac Computed Tomography Amidst the COVID-19 Pandemic. *J Cardiovasc Comput Tomogr*. 2020;2020 Mar 21 (e-published ahead of print).
10. Haft JW, Atluri P, Alawadi G, et al. Adult cardiac surgery during the COVID-19 Pandemic: A Tiered Patient Triage Guidance Statement. In. *J Thorac Cardiovasc Surg* . 2020 Apr 16 (e-published ahead of print).
11. Hassan A, Arora RC, Adams C, et al. Cardiac surgery in Canada during the COVID-19 Pandemic: A Guidance Statement from the Canadian Society of Cardiac Surgeons. *Can J Cardiol*. 2020.
12. Mahmud ED, Harold L Welt, Frederick GP Messenger, John C Rao, Sunil V Grines, Cindy Mattu, Amal Kirtane, Ajay J. Jauhar, Rajiv Meraj, Perwaiz Rokos, Ivan C. Rumsfeld, John S., Henry TD. Management of Acute Myocardial Infarction During the COVID-19 Pandemic. *JACC: Cardiovascular Interventions (In Press)*. 2020.
13. Emanuel EJ, Persad G, Upshur R, et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *N Engl J Med*. 2020.
14. Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. *Lancet*. 2009;373(9661):423-431.

15. White DB, Lo B. A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic. *JAMA*. 2020.

Table Legend

Table 1: Safe Reintroduction of Invasive Cardiovascular Procedures and Diagnostic Tests during the COVID-19 Pandemic: Guidance from North American Society Leadership

(STEMI: ST elevation myocardial infarction; NSTEMI: Non-ST elevation myocardial infarction; UA: Unstable angina; CHF: Congestive heart failure; MI: Myocardial infarction; GRACE: global registry of acute coronary events; TAVR: Transcatheter aortic valve replacement; ASD: Atrial septal defect; PFO: Patent foramen ovale; LAAC: Left atrial appendage closure; PPE: Personal protective equipment; PPCI: primary percutaneous coronary intervention; CCT: cardiac computed tomography; AGMP: Aerosol-generating medical procedure, TEVAR: thoracic endovascular aortic repair; EVAR: endovascular repair of aortic aneurysm)

Table 1: Safe Reintroduction of Cardiovascular Procedures and Diagnostic Tests during the COVID-19 Pandemic: Guidance from North American Society Leadership

Response Level (in collaboration with public health officials)	Level 2 Reintroduction of some services	Level 1 Reintroduction of most services	Level 0 Regular services (ongoing COVID-19 testing/surveillance and monitoring of PPE availability)
INTERVENTIONAL and STRUCTURAL CARDIOLOGY			
STEMI	<ul style="list-style-type: none"> COVID-19 status may be unavailable at time of STEMI. Use of PPE will be dictated by regional health authority and COVID-19 penetrance. PPCI for most patients. Selective pharmacoinvasive therapy as per regional practice. If moderate/high probability or COVID-19 +ve consider alternative investigations (TTE and/or CCT) prior to cath lab activation or pharmacoinvasive therapy 	<ul style="list-style-type: none"> COVID-19 status may be unavailable at time of STEMI. Use of PPE will be dictated by regional health authority and COVID-19 penetrance. PPCI for most patients. Selective pharmacoinvasive therapy as per regional practice. If moderate/high probability or COVID-19 +ve consider alternative investigations (TTE and/or CCT) prior to cath lab activation or pharmacoinvasive therapy 	<ul style="list-style-type: none"> COVID-19 status may be unavailable at time of STEMI. Use of PPE will be dictated by regional health authority and COVID-19 penetrance. PPCI for most patients. Selective pharmacoinvasive therapy as per regional practice. If moderate/high probability or COVID-19 +ve consider alternative investigations (TTE and/or CCT) prior to cath lab activation or pharmacoinvasive therapy
ACS (NSTEMI/UA)	<ul style="list-style-type: none"> NSTEMI (High Risk) – Invasive strategy (Refractory symptoms, hemodynamic instability, significant LV dysfunction, suspected LM or significant proximal epicardial disease, GRACE risk score >140) Medium Risk NSTEMI – Selective invasive strategy Low Risk NSTEMI and UA – Medical therapy 	<ul style="list-style-type: none"> NSTEMI (High Risk) – Invasive strategy (Refractory symptoms, hemodynamic instability, significant LV dysfunction, suspected LM or significant proximal epicardial disease, GRACE risk score >140) Medium Risk NSTEMI – Invasive strategy Low Risk NSTEMI and UA – Selective invasive strategy 	Routine service for all cases

Elective Cath Lab Cases	<ul style="list-style-type: none"> Outpatients with symptoms AND non-invasive testing suggesting high risk for CV events in the short term. 	<ul style="list-style-type: none"> All outpatients who are clinically considered to be moderate and high risk. Stable cases may still be deferred 	Routine service for all cases
TAVR	<ul style="list-style-type: none"> Inpatients and outpatients with severe symptomatic aortic stenosis 	<ul style="list-style-type: none"> Most patients accepted by the Heart Team Stable cases may still be deferred 	Routine service for all cases
MitraClip	<ul style="list-style-type: none"> Inpatients and outpatients with severe symptomatic mitral regurgitation 	<ul style="list-style-type: none"> Most patients accepted by the Heart Team Stable cases may still be deferred 	Routine service for all cases
ASD/PFO	<ul style="list-style-type: none"> Selective cases 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
LAAC	<ul style="list-style-type: none"> Selective cases 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Other	Selective cases: <ul style="list-style-type: none"> Pulmonary hypertension Adult congenital 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
CARDIOVASCULAR SURGERY			
Coronary	<ul style="list-style-type: none"> Inpatients waiting for surgery Outpatients with progressive symptoms or LV impairment 	<ul style="list-style-type: none"> All inpatients waiting for surgery Majority of outpatients Stable cases may still be deferred 	Routine service for all cases
Valve Surgery	<ul style="list-style-type: none"> Inpatients waiting for surgery Outpatients with severe symptomatic valvular disease or LV impairment 	<ul style="list-style-type: none"> All inpatients waiting for surgery Majority of outpatients Stable cases may still be deferred 	Routine service for all cases
Other	<ul style="list-style-type: none"> Acute aortic dissection Valvular endocarditis Heart transplant/VAD High risk cardiac tumours Severe symptomatic congenital heart disease 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
ELECTROPHYSIOLOGY			
Ablation	<ul style="list-style-type: none"> Pre-excited AF AF with recurrent admissions +/- CHF Drug refractory VT 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Devices	<ul style="list-style-type: none"> PPM for all inpatients and selective high-risk outpatients Secondary prevention ICD and selective primary prevention ICD. 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases

	<ul style="list-style-type: none"> • Device generator elective replacement indicator activated 		
Other	<p>Selective cases:</p> <ul style="list-style-type: none"> • Lead replacement, revision and extraction with infection or inappropriate shocks • Implantable loop recorder for syncope • Ambulatory monitoring • Cardioversion 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
ECHOCARDIOGRAPHY			
Transthoracic Echocardiography	<ul style="list-style-type: none"> • All inpatients • Selective outpatients in which TTE will alter short term management 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
Transesophageal Echocardiography	<ul style="list-style-type: none"> • All patients where TEE will alter short term management. Given potential for false -ve COVID-19 testing, consider aerosol level PPE for possible AGMP. 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
Exercise Testing with Imaging	<ul style="list-style-type: none"> • Selective cases where exercise testing will alter short term management • Pharmacologic testing preferred over exercise testing 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
CARDIAC COMPUTED TOMOGRAPHY			
CT Coronary Angiography	<ul style="list-style-type: none"> • All inpatients and selective symptomatic outpatients 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
Structural Heart Disease	<ul style="list-style-type: none"> • Preprocedural structural heart disease planning for all inpatients and selective outpatients 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
Other	<p>Selective cases:</p> <ul style="list-style-type: none"> • Pulmonary vein assessment for AF ablation planning • Cardiac masses • Congenital heart disease 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
CARDIOVASCULAR MAGNETIC RESONANCE IMAGING			
LV/RV Assessment	<ul style="list-style-type: none"> • All inpatients and selective outpatients • Consider alternate imaging modality 	<ul style="list-style-type: none"> • Majority of cases • Stable cases may still be deferred 	Routine service for all cases
Infiltrative/inflammatory	<ul style="list-style-type: none"> • All inpatients and selective outpatients 	<ul style="list-style-type: none"> • Majority of cases 	Routine service for all cases

Disease		<ul style="list-style-type: none"> Stable cases may still be deferred 	
Myocardial Viability	<ul style="list-style-type: none"> All inpatients and selective outpatients 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Stress Cardiac Imaging	<ul style="list-style-type: none"> All inpatients and selective outpatients Consider alternate imaging modality 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Other	Selective cases: <ul style="list-style-type: none"> Congenital heart disease Cardiac masses Vascular: thoracic aortic disease and pulmonary vein mapping 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
NUCLEAR CARDIAC IMAGING			
Exercise Testing with Imaging	<ul style="list-style-type: none"> All inpatients and selective outpatients Preference for vasodilator testing over exercise testing 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Myocardial Viability	<ul style="list-style-type: none"> All inpatients and selective outpatients 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Other	Selective cases: <ul style="list-style-type: none"> LV assessment Preoperative organ transplant assessment Infiltrative diseases 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
HEART FAILURE / TRANSPLANT			
Cardiopulmonary Testing	<ul style="list-style-type: none"> All inpatients and selective outpatients 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Endomyocardial Biopsy	Selective cases: <ul style="list-style-type: none"> Transplant surveillance in patients deemed to be at high risk for rejection Guide treatment in patients with presumed myocarditis 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
Right Heart Catheterization	Selective cases: <ul style="list-style-type: none"> Facilitate transplant listing or candidacy for mechanical circulatory support Tailored hemodynamic therapy in cardiogenic shock 	<ul style="list-style-type: none"> Majority of cases Stable cases may still be deferred 	Routine service for all cases
VASCULAR			

Critical Limb Ischemia	<ul style="list-style-type: none">• All inpatients and selective outpatient cases	<ul style="list-style-type: none">• Majority of cases• Stable cases may still be deferred	Routine service for all cases
TEVAR/EVAR	<ul style="list-style-type: none">• All inpatients and selective outpatient cases	<ul style="list-style-type: none">• Majority of cases• Stable cases may still be deferred	Routine service for all cases
Other	Selective cases: <ul style="list-style-type: none">• Mesenteric ischemia• Symptomatic DVT	<ul style="list-style-type: none">• Majority of cases• Stable cases may still be deferred	Routine service for all cases