**Guidance for BMT Center Functioning during COVID-19 Pandemic**

**Programmatic**
- Establish and activate the Hospital Incident Command System (HICS).
- Establish and activate the HCT/IEC Emergency Preparedness Team (HEPT).
- Disseminate disaster operations memos regularly to keep all staff informed of changes in operations.
- Adhere to social distancing at all times.
- Triage all non-staff members at building entrances. Consider closing some entrances to limit building access as possible.
- Be aware of potential need for escalated security.
- Institute COVID-19 testing with rapid turnaround.
- Ensure clear guidance for staff from HR re management of exposure, symptoms etc.
- Ensure staff performing NP swab for COVID know only to use one swab per patient (not two).
- Employees who are age 60 or older, pregnant, or diagnosed with an immunosuppressive disorder can request a medical exemption from providing direct care for patients testing positive or under investigation for COVID-19.
- Limit research activities to those that are potentially curative.
- Establish reliable application for remote conference calls. Beware of crashes.
- Recognize that the situation is fluid, and alter the guidance as appropriate and ensure rapid dissemination of modified operations.

**Health Care Provider and Allied Health Care Professionals**
- Any MD or allied health professional that is not involved in direct patient care should preferably work from home.
- All PharmDs, Social Workers, Fellows, coordinators should work remotely.
- Establish mechanism for majority of administrative staff to work from home.
- Set up cross coverage for MDs and staff so if one gets sick all their responsibilities automatically go to the other person (buddy system).

**Cellular Therapy Activities**
- Establish a triage algorithm to cancel and delay as many transplant and IEC activities as possible. These include but are not limited to:
  - Patients with predicted low (<20%) chance of disease-free survival (e.g. CAR T cell candidates with high disease burden and elevated LDH);
  - Patients with underlying cardiac and pulmonary comorbidities (at higher risk of NRM);
  - Diseases that can wait (Low-grade lymphomas; Intermediate-risk MRD-negative AML in CR1; MRD-negative ALL in CR1; MDS without excess blasts; stable MPN/MF/CMML; multiple myeloma).
- For patients that cellular therapy cannot be delayed, and are asymptomatic, screen and swab within 72 hours of their admission (and/or start of conditioning/lympho-depletion regimen).
- As capacity deteriorates increase stringency of requirement to proceed to transplant/IEC therapy.

**Inpatients:**
- Faculty, APPs and nurses are encouraged to use PPE at all times in the hospital.
- Ration the PPE as possible. Follow the guidelines for how to reuse PPE safely.
COVID+ patients: establish center-specific workflow.
Create COVID floors for inpatients and dedicated rounding teams that are COVID only.
Get palliative care involved in COVID+ patients and have goals of care discussions as appropriate.
Patients with COVID-19 exposure: Identify the first and last day of their exposure. Screen, swab as necessary, and quarantine for 14 days from the last date of most recent exposure.
Non-COVID patients: To protect patients / staff and restrict PPE use, establish the workflow of how you round and minimize staff entering the room.
Perform one exam per patient per day (either by APP or MD), if appropriate, and in select patients forego physical exam.
One PharmD on site each day (not on the floor), the rest work remotely.
Encourage all staff to maintain appropriate distancing including when using computers.
Perform WebEx rounds, which allows everyone on the team to discuss patients in real time without being in the same location.
Ban all visitors/ caregivers except extenuating circumstances and pediatric patients.
Ensure clear plan as to where patients will be housed immediately upon discharge if not returning home.

Management of symptomatic COVID-19 patients

COVID+ clinical pearls from hospitalist:
- Pulse Ox (<94% RA) and CXR have been two most useful tools. ICU/intubation team consulted when COVID+ patient on 6L and O2 sat 92% or less.
- Create a COVID pager to call for positive patients > COVID response team with ID.
Treatment:
- Hydroxychloroquine +/- azithromycin.
- Consider tocilizumab (IL6 receptor antagonist to manage cytokine release).
ICU:
- Utilizing experienced intubation teams for all intubation: only 3 people in room: anesthesia, respiratory therapist and RN. Negative pressure rooms dedicated for intubation and fully stocked to limit time and exposure during high risk procedure. Increased PPE for this team.
- Seeing benefit from prone position for vented patients, although requiring more resources from staff to do so.
- Palliative care involved in all COVID+ patients. Having goals of care discussions and supporting family via video.

Outpatients

- Screen all non-staff members for symptoms at building entrances and ensure efficient workflow for subsequent triage.
- Consider closing some entrances to limit building access as possible.
- Ban caregivers from in person outpatient visits (rare exceptions).
- Cancel all non-essential visits such as anniversary visits, survivorship, vaccines.
- Reduce in-person visits to as close to zero as possible.
- Switch as many outpatient visits to telemedicine visits as possible.
- Provide guidance to staff re documentation and billing codes for telemedicine.
- Minimize all non-essential lab work and radiology appointments.
- Decrease parenteral cancer therapy utilization in a safe and effective manner.
- Oral therapies should be favored, when clinically appropriate.
- PCP prophylaxis: stop inhaled and IV pentamidine and switch to either Bactrim or atovaquone.
- Consider holding immunosuppression taper on patients beyond 3 months who are not on high-dose corticosteroids.
- Hold post-transplant maintenance therapies if possible.
- Have goals of care conversation with all your patients as clinically appropriate.
- Extend the frequency of RN visits for Mediport flushes to 10-12 weeks given the low level of evidence to do more frequently.

Allogeneic Donors
- Cryopreserve all related and unrelated donor products ahead of transplant admission.
- PBSC will be prioritized over bone marrow product.
- For all allo-transplants have a primary and a backup donor. Where possible, prioritize domestic donors/ cord blood banks over internationals.
- Screen and swab all asymptomatic donors within 72 hours of their line placement and/or collection.

Coping with Stress
- Establish center-specific workflow for support groups.

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