IOWA HOSPITAL ASSOCIATION

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Iowa Hospital Association

Guidance for Restarting Nonessential or Elective Surgery and Procedures

Introduction

In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS), the surgeon general and many medical specialty associations, such as the American College of Surgeons and the American Society of Anesthesiologists, recommended interim cancellation of elective surgical procedures. Thursday, March 26, Gov. Kim Reynolds restricted elective surgeries and procedures in Iowa. Physicians and health care organizations responded appropriately and canceled nonessential cases across the state.

Friday, April 24, Gov. Reynolds issued a proclamation that included provisions on nonessential or elective surgeries and procedures. The following is a list of considerations to guide hospitals in their resumption of care in operating rooms and procedural areas.

The Governor's Proclamation set out general guidelines in several areas including:

Personal Protective Equipment

Facilities should not resume nonessential or elective surgeries and procedures until they have adequate personal protective equipment and medical surgical supplies appropriate to the number and type of procedures to be performed.

Hospitals must have:

- Adequate inventories of personal protective equipment and access to a reliable supply chain without relying on state or local government stockpiles to support continued operations and timely respond to an unexpected surge.

- A plan to conserve personal protective equipment consistent with guidance from the Centers for Disease Control and the Iowa Department of Public Health.

Capacity

Hospitals must:

- Continue to accept and treat COVID-19 patients and not transfer COVID-19 patients to create capacity for nonessential or elective surgeries and procedures.

- Reserve at least 30% of intensive care unit beds and 30% of medical/surgical beds for COVID-19 patients.

Testing

- A hospital or provider must have a plan for timely COVID-19 testing of symptomatic patients and staff to rapidly mitigate potential clusters of infection and as otherwise clinically indicated. Providers must comply with relevant testing requirement guidance for patients and staff issued by the Iowa Department of Public Health, the Centers for Disease Control or a provider's professional specialty society.

- For scheduled surgeries, patients should have a negative COVID-19 test performed within 48 hours of the surgery date. If a COVID-19 test is not available, a hospital or provider should consider alternative methods to determine the patient's probability of COVID-19. If the patient has symptoms of fever, cough or low oxygen saturation, postponement of the surgery is recommended.

For further information please refer to IHA's Nonessential or Elective Surgeries and Procedures Proclamation Q&A.

In an effort to provide further direction for hospitals, IHA provides the following guidelines for hospitals to consider as they evaluate providing nonessential or elective surgeries and procedures:

Responsible Restart:

Facilities should:

- Establish a prioritization policy committee consisting of surgery, anesthesia and nursing leadership to reassess all nonessential or elective surgeries and procedures that have been delayed consistent with the Governor's Executive Orders.

- Have a process in place to assess the need for a post-acute care facility stay and make appropriate arrangements before the procedure (e.g., rehabilitation, skilled nursing facility).

- Have a process in place to promote patient discussion with their surgeon about advance directives, especially those patients who are older adults, frail or post-COVID-19.

Phased Approach:

Hospitals may develop a plan for a phased approach to restarting nonessential or elective surgeries and procedures. This approach may be based on surgery/procedure types, surgery/procedure volumes or another variable that allows for a gradual restart of services.

If a COVID-19 test is not available, consider other lab tests usually abnormal in COVID-19 patients including CBC with lymphocyte count, ferritin level, LDH, D-dimer, ESR, C-reactive

protein, procalcitonin and chest x-ray to determine the patient's probability of COVID-19.

An example of a phased approach based on surgery/procedure type would be a plan to begin to schedule and perform surgeries and procedures that have a minimal to low impact on inpatient hospital bed capacity and use minimal amounts of personal protective equipment with the intent to expand to additional surgery/procedure types over time. Examples of procedures that fall within this category include:

- Allergy testing
- Cardiac stress testing
- Cataract removal
- Excision of suspicious skin lesions
- Joint injections
- Prostate biopsy
- Pulmonary function testing
- Screening colonoscopy
- Screening mammography

An example of a phased approach based on surgery/procedure volume is a plan to begin to schedule and perform surgeries in a portion of available operating rooms with the intent to incrementally expand the number of operating rooms in use over time.

Regardless of the approach selected, before expanding to a next phase in the plan, the facility should consider COVID-19 case data and trends in the region and conduct an internal assessment of readiness to progress. This assessment must include a review of inventories and incoming supply of personal protective equipment, supplies, equipment and medicines, and a determination of adequate bed and staff capacity to address expanded elective procedures while maintaining the ability to respond to an increase in COVID-19 cases as more businesses reopen in the community.

Restarting such nonessential or elective surgeries and procedures should continue to be predicated on minimizing adverse patient outcomes associated with delayed care, minimizing community transmission and preserving personal protective equipment. Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate.

Finally, the plan for phasing in nonessential or elective surgeries and procedures also should include identification of trigger points that would signal the need to pull back in response to a surge in COVID patients.

Case Prioritization and Scheduling Principle:

Facilities should establish a prioritization policy committee consisting of surgery, anesthesia and nursing leadership to develop a prioritization strategy appropriate to the immediate patient

needs.

Prioritization policy committee strategy decisions should address case scheduling and prioritization, and should account for:

- Previously cancelled and postponed cases.
- The use of an objective priority scoring system, which may include MeNTS scoring, CMS guidelines, objective review by peer surgery committees or other scoring systems.
- Specialties' prioritization (cancer, organ transplants, cardiac, trauma).
- A strategy for allotting daytime "operating room/procedural time" (e.g., block time, prioritization of case type [i.e., potential cancer, living related organ transplants]).
- The identification of essential health care professionals and medical device representatives per procedure.
- A strategy for phased opening of operating rooms:
    - Identify capacity goal before resuming (e.g., 25% versus 50%).
    - Operating rooms simultaneously will require more personnel and material.
    - Outpatient/ambulatory cases start first followed by inpatient surgeries after a 14-day period to observe the impact on COVID-19 case trend.
    - Strategy for increasing "operating room/procedural time" availability (e.g., extended hours before weekends).
- Issues associated with increased operating room/procedural volume.
    - Ensure adequate availability of inpatient hospital beds, intensive care beds, ventilators and staffing for the expected postoperative care.
    - Ensure adjunct personnel availability (e.g., pathology, radiology).
    - Ensure availability of post-acute care beds for patients who will need this level of care.
    - Ensure primary personnel availability commensurate with increased volume and hours (e.g., surgery, anesthesia, nursing, housekeeping, engineering, sterile processing).
    - Ensure supply availability for planned procedures (e.g., anesthesia drugs, procedure-related medicines, sutures, disposable and non-disposable surgical instruments).
    - New staff training.

Environmental Mitigation

Providers should demonstrate they are adhering to social distancing and relevant Iowa Department of Public Health and Centers for Disease Control and Prevention Guidelines for infection control and prevention to maintain a safe environment for patients and staff. Patients must be confident that the environment in which they will receive care is safe. Examples of the

precautions that should be taken include:

- A process in place to screen all staff and visitors for COVID-related symptoms before entering the facility.

- A process in place to screen patients for COVID-19-related symptoms before scheduled procedures (by telephone, online, or in person). COVID-19 testing may be appropriate for certain patients and certain surgeries and procedures. Providers must take all necessary precautions to minimize opportunities for disease spread.

- All patients and companions must wear mouth and nose coverings (either provided by the patient or by the site) when in public areas.

- Eye protection (goggles, visor or mask with visor) must be provided and worn by all health care professionals while engaged in direct patient care for patients undergoing procedures with increased potential for droplet aerosolization.

- Only those essential to conducting the surgery or procedure will be in the surgery or procedure suite or other patient care areas where personal protective equipment is required.

- Population is clearly separated from the emergency department or intensive care unit (ambulatory surgery facility or outpatient surgery area is away from the emergency department and intensive care unit).

- Protective equipment and supplies should be worn and used as necessary to ensure staff and patient safety. This may require surgical, N95, KN95, or other health care-equivalent masks to be worn by all patients and providers when engaged in patient care.

- Providers must have written procedures for disinfection of all common areas.

- Providers must post signs to emphasize social restrictions (distancing, coughing etiquette, wearing mouth and nose coverings, hand hygiene) and liberal access to hand sanitizer for patients and staff.

- The waiting room is kept empty except for patients. Patient companions are permitted only if staff is at the minimum number required for direct patient assistance.

- Waiting room chairs must be spaced to require a minimum of six feet for social distancing.

Governance

Hospitals should maintain an internal governance structure to ensure the criteria and principles outlined above are followed. Providers also should consult with any guidance issued by relevant professional specialty societies about appropriate prioritization of procedures. It is recommended that the hospital or health care facility form either a surgical review committee or

similar medical committee to review proposed cases for nonessential or elective surgeries and procedures and resolve any disputes that may arise about the appropriateness of performing the elective surgery or procedure.

Resources

1. https://www.aha.org/standardsguidelines/2020-04-17-roadmap-aha-others-safely-resuming-elective-surgery-covid-19-curve
2. https://www.facs.org/covid-19/clinical-guidance/roadmap-elective-surgery
3. https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf
4. https://coronavirus-download.utah.gov/Health/UHA%20CMO%20Group%20-%20Utah%20Guidance%20for%20Urgent%20Time-Sensitive%20Surgery%20v5%20(002).pdf
5. Responsible Return to Surgeries and Procedures. https://coronavirus.ohio.gov/wps/portal/gov/covid-19/home