Question: When can hospitals restart elective surgeries and procedures?

The Centers for Medicare and Medicaid Services (CMS), in collaboration with various medical and surgical societies and associations, recommended postponing all elective surgeries and nonessential medical, surgical, and dental procedures in mid-March 2020. These recommendations resulted in the canceling of many thousands of orthopedic, neurosurgical, and other surgical procedures and resulting furloughs, redeployment or layoffs of surgical personnel as well as lost income for many hospitals who were already financially strapped. Now that discussions and planning are underway in many states and regions to "reopen the economy" questions abound as to if, when, and how elective surgeries can be resumed safely in outpatient and inpatient facilities. On April 7, 2020, CMS proposed a tiered approach to resuming non-emergent, elective medical services and treatments, but these recommendations **did not** provide guidance on resuming elective surgical services. However, these guidelines provide useful advice related to assessing and preserving adequate supplies of personal protective equipment (PPE) and necessary measures to protect patients from exposure to SARS-CoV-2 in healthcare facilities. These guidelines also explain the need to assess the current and projected numbers of COVID-19 cases when making decisions about resuming non-elective care processes. (1)

The White House recently announced "gating criteria" for a phased "comeback" to economic normalcy. These criteria specifically include the issue of resuming elective surgeries. The White House's gating criteria envision three incremental phases of returning to full economic activity. Phases 1 and 2 include recommendations for resuming elective surgery. Phase 1 allows resumption of surgery in outpatient surgical centers; phase 2 allows resumption in both inpatients and outpatient settings (2). It is important to note that the White House gating criteria clearly state that all of the following criteria must be met ***before any state or region proceeds to Phase 1.*** These criteria include the following:

- SYMPTOMS: A "downward trajectory" of reported "influenza-like illnesses" AND "COVID-like syndromic cases" within a 14-day period
- CASES: A downward trajectory of "documented cases" OR "Positive tests as a percent of total tests" within a 14-day period (flat or increasing volume of tests)
- HOSPITALS: Assurance of the ability for local hospitals to "treat all patients without crisis care" AND establishment of "robust testing program for at-risk healthcare workers, including emerging antibody testing."

After all of the preceding criteria have been achieved, with no evidence of rebound, hospitals can proceed sequentially from phases 1 to 3

Phase I: ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient basis at facilities that adhere to CMS guidelines.

Phase II: ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient and in-patient basis at facilities that adhere to CMS guidelines.

Phase III: Nothing specific to surgery - assume back to normal operations

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The American College of Surgeons (ACS) recently published recommendations to guide decisions about the local resumption of elective surgeries. (3) Before elective surgeries may be safely reinstituted, several distinct issues need to be addressed locally within the subcategories of **I. COVID-19 Awareness, II. Preparedness, III. Patient Issues, and IV. Delivery of Safe High-Quality Care,** as described below:

I. **COVID-19 AWARENESS**

- Know your community's COVID-19 numbers, including prevalence, incidence, and isolation mandates
- Know your COVID-19 diagnostic testing availability and test turnaround times
- Know your testing, masking and screening policies for patients and health care workers
- Know your health system or facility's furlough policies
- Understand your state and county guidelines and restrictions

II. **PREPAREDNESS**

- Understand and clarify PPE policies for your health care workers. Calculate **PPE burn rate** for the OR/peri-op platform, and plug this into the larger health system model to see if facilities have adequate supply to perform these procedures while still being able to care for COVID-19 patients. Surgery PPE burn rate should account for
  - The number of people who must be in the OR for specific types of cases
  - The PPE required for each type of team member for each type of case
  - The number of proposed cases for each type of case
- Know your health care facility capacity (beds, intensive care units (ICUs), ventilators), including surge capacity
- Ensure OR supply chain/support areas
- Address workforce staffing issues
- Assign a **governance committee** (see below)

III. **PATIENT ISSUES**

- Patient communication
- Prioritization protocol/plan

IV. **DELIVERY OF SAFE AND HIGH-QUALITY CARE**

Ensuring safe, high-quality, high-value care of the surgical patient across the Five Phases of Care continuum (3)

- Phase I: Preoperative period
- Phase II: Immediate Preoperative Period
- Phase III: Intraoperative Period
- Phase IV: Postoperative Period
- Phase V: Post Discharge Period

We endorse and support the need for all hospitals to convene a '**governance committee' early** in their planning process. Such a governance committee should be given clear authority and necessary resources to develop, clarify, interpret, and iterate policies, make real-time decisions and initiate and

communicate messaging. Such a committee address matters such as the need to designate areas where elective surgery patients can be safely provided care, OR rooms or areas where elective surgeries can be performed, design workflows including transit paths to and from these areas and assess PPE needs. Early establishment of a governance committee can also facilitate the collection, interpretation and analysis of the many types of data needed to meet the stringent requirements outlined above.

As facilities consider restarting surgeries, different states and healthcare systems are likely to be at different points in terms of meeting the gating criteria and planning/assessments discussed above. As individual states begin to rescind previous stay-at-home policies, the need and ability to resume elective surgeries will be significantly affected by local policies. Hence, each facility should coordinate their efforts to resume elective surgeries with regional health authorities while assessing their local PPE supplies and preparedness.

References:

1. CMS Non-Emergent, Elective Medical Services, and Treatment Recommendations
2. Guidelines for Opening Up America Again
3. American College of Surgeons: Local Resumption of Elective Surgery Guidance