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Alerts

Practical Considerations for Hospitals and Ambulatory Surgery Centers Resuming Elective Surgical Services

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Health Care Alert

On April 19, 2020, the Centers for Medicare & Medicaid Services (CMS) published recommendations for re-opening facilities to provide non-emergent non-COVID-19 health care services. The recommendations provide guidance for hospitals, health care systems, and facilities such as ambulatory surgery centers (ASCs) in states or regions with low incidence of COVID-19 disease as they consider resuming in-person care of non-COVID-19 patients. Resumption of in-person care is to be made "consistent with public health information and in collaboration with state public health authorities." As we reported in our April 28, 2020 Client Alert, the Illinois Department of Public Health published guidance allowing hospitals and ASCs to begin resuming elective surgeries on May 11, 2020.

General Considerations. In addition to following guidance from state and local public health authorities, consider the following suggestions.

- Hospitals and ASCs should not immediately resume their prior full capacity; services should be reintroduced in a cautious, phased process in order to minimize risk for staff and patients.
- Hospitals and ASCs should establish a surgical review committee (SRC) consisting of leadership across all areas of operations in their facilities. The SRC should include leadership in surgery, anesthesia and nursing, and an individual administrator who coordinates contractor relationships with cleaning crew, waste management and the like.
- The SRC should establish a standard process for determining which procedures should be re-introduced at each phase of reopening to ensure continuing compliance with state and federal guidance. Various protocols and processes have been proffered to evaluate this re-introduction, but one analysis to consider is the "Medically Necessary Time-Sensitive" (MeNTS) prioritization scale methodology developed recently by a team of investigators and surgeons at the University of Chicago, which was published as an "article in press" on the Journal of the American College of Surgeons website ahead of print.
    - The MeNTS methodology evaluates 21 factors, balancing the risks and need for surgeries of all types, to determine which should be prioritized in the restart. The factors are rated on a 5-point scale, with 5 points reflecting the greatest risk and 1 reflecting the lowest risk. The rating given to each factor for a single procedure should be added together.

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The higher the total score, the lower it should be on the prioritization list because it reflects a greater risk to the patient, a higher utilization of health care resources and a higher chance of viral exposure to the health care team. The tables of factors and considerations for rating on the 5-point scale can be found within the ACS article referenced in footnote 2.

- The facility should ensure adequate personal protective equipment (PPE) with respect to the number and type of procedures performed, as well as an adequate supply for a possible surge of COVID-19 activity within the next 14 days.
- Facility cleaning policies in all areas along the continuum of operative care should follow established infection control procedures.
- Other areas of the facility that support perioperative services should be ready to commence operation with uniformly heightened infection control practices, including sterile processing, the clinical laboratory and diagnostic imaging.
- To implement the rescheduling of prioritized procedures, create a COVID-19 cancellation code, which can be implemented prospectively and retrospectively. This will allow the facility to determine its surgical backlog and ensure accuracy in its reports. The scheduler should remain informed as to which procedures are being prioritized.
- Establish a wait period between scheduling the surgery and actually performing the surgery for each patient. The wait period should allow 14 days from the date of scheduling to the date of the procedure. During this period, patients should be tested for COVID-19 automatically upon being added to the schedule. They should test negative twice, and self-isolate from the time of being scheduled until their procedure.
- Health care staff should be tested each day upon coming to work and should remain home if they exhibit any symptoms of COVID-19, (e.g., cough, shortness of breath, a fever). They also should wear masks at all times. Social distancing among staff should be enforced to the extent possible. Ensure that all requisite staff needed for the scheduled procedures are healthy and available. Having on-call staff available in the event a scheduled staff member falls ill from COVID-19 will be critical during this time. A workforce must be available across all fields of the practice, from the OR to the ICU to the pharmacy to the lab to the cleaning staff.
- Ensure that patients remain informed of the risks associated with receiving the procedure, which must now include considerations associated with the risk of catching COVID-19, as well as the risks of declining the procedure.
- Implement social distancing for patients in the waiting room by spreading out chairs at 6-foot increments, and minimize wait times to the extent possible.
- Remain cognizant of trends for COVID-19 in the area of your facility. Plan to cancel procedures if COVID-19 infections begin to surge. Also remain informed of recommendations submitted by local, state and federal public health officials. These recommendations at the federal level can be found at the links below:
  - Centers for Medicare & Medicaid Services
  - Centers for Disease Control and Prevention
  - Food and Drug Administration
  - U.S. Department of Health and Human Services

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https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf; https://www.whitehouse.gov/openingamerica/

https://www.journalacs.org/article/S1072-7515(20)30317-3/fulltext