Tennessee Hospital Association
Principles for Returning to Elective Surgery and Procedures

April 23, 2020

Background and Timeline

As response to the COVID-19 pandemic ramped up in early- and mid-March, hospitals began following guidance to reduce elective procedures. Soon after, Governor Bill Lee's Executive Order (EO) 18 was issued on March 23 to suspend all elective procedures in the state to conserve personal protective equipment (PPE), preserve hospital inpatient capacity and promote social distancing to reduce risk for transmission of COVID-19. This prohibition on elective procedures was followed by a mandatory statewide stay at home order that included the temporary closure of all nonessential businesses in the state.

These actions have resulted in a "flattening of the curve" such that Tennessee has thus far avoided a surge in COVID-19 infections that would have overwhelmed Tennessee hospitals. These actions also bought the healthcare system time to implement PPE conservation protocols, identify and attempt to address supply chain problems and put into place a variety of policies and practices that position hospitals to address the now likely scenario of a lengthy and sustained period in which COVID-19 is present at lower levels in the community, with the potential for focal areas of increased transmission that will require a prompt public health response to prevent another significant surge.

With the current ban on elective procedures set to expire on April, 30 and as Governor Lee's Economic Recovery Group works to establish plans for beginning to reopen the state's economy as soon as April 27 and throughout the month of May, the following guidance has been developed to enable hospitals to approach reentry in a manner that is most appropriate for their community and unique circumstances.

Purpose

The COVID-19 pandemic does not recognize geographic boundaries and has affected the eight hospital districts in Tennessee to different degrees. The current level and trajectory of disease activity supports a statewide decision to lift the ban on elective procedures, but the specific approach to restarting and continuing to perform such procedures is most appropriately developed and implemented at the district and hospital level, taking into account the extent of COVID-19 disease in the region and any resource constraints within facilities. This document has been developed and endorsed

by the Tennessee Hospital Association (THA) to guide those decisions as Tennessee begins the journey of economic recovery from COVID-19.

Recommendations:

Disease and Resource Reporting

All hospitals must continue to input all required data elements on a daily basis into the Tennessee Department of Health's Health Resource Tracking System (HRTS).

District Approach

A regular cadence of meetings with the leadership of the major hospitals and systems in the district should be established and maintained prior to re-initiating elective procedures and for the foreseeable future as the threat of a resurgence of COVID-19 continues to loom.

Ideally, a consensus would be reached at the district level with a consistent approach to the types and timing of elective procedure resumption.

District level disease trends and resource utilization must be reviewed at these regularly scheduled meetings and adjustments to decisions regarding the continued performance of elective procedures should be made as needed in light of these data.

Access to PPE, Supplies, Equipment and Medicine

Prior to restarting elective procedures, providers must ensure they have:

- adequate inventories of PPE, supplies, equipment, and medicine in their facility;
- a plan for conserving PPE; and
- access to a reliable supply chain to support continued operations and respond to an unexpected surge in a timely manner.

Providers who are in specialties or practice settings that may not experience a surge in COVID-19 patients must be situationally aware of statewide PPE, supplies, equipment and medicine needs and be prepared to contribute as necessary. The Tennessee Department of Health should continue to monitor such providers and their PPE resources in the event supply shortages occur due to an increase in COVID-19-related care.

Testing

Providers should develop a policy and plans for determining the requirements and frequency of testing for patients and staff. Providers must have a defined process, whether in-house or referral to another testing provider, 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 any relevant guidance related to testing requirements for patients and staff issued by the CDC.

Environmental Mitigation

Providers must demonstrate that they are adhering to social distancing and relevant CDC guidelines regarding infection control and prevention to maintain a safe environment for patients and staff. Patients must be confident that the environment where they will receive care is safe. Examples of the precautions that should be taken include, but are not limited to, the following:

- A process in place to screen patients for COVID-19-related symptoms prior to scheduled procedures (by phone, online, or in-person). COVID-19 testing may be appropriate for certain patients and certain surgeries and procedures; and providers are required to take all necessary precautions to minimize opportunities for disease spread.
- A process in place to screen all staff and visitors for COVID-19-related symptoms prior to entering the facility. Visitation should continue to be restricted.
- Personal protective equipment should be worn and utilized by healthcare providers and staff, consistent with current CDC guidelines, to ensure staff and patient safety.
- N95 masks and eye-protection (goggles, visor, or mask with visor) must be provided and worn by all healthcare professionals while engaged in direct patient care for patients undergoing procedures with increased potential for droplet aerosolization.
- All patients and visitors/companions must wear mouth and nose coverings (either provided by the patient or by the site) when in public areas.
- Only individuals who are essential to conducting the surgery or procedure shall be in the surgery or procedure suite or other patient care areas where PPE is required.
- Waiting room chairs must be spaced to require a minimum of six-feet social distancing.
- Providers must have written procedures for disinfection of all common areas.
- Providers must have signage to emphasize social restrictions (distancing, coughing etiquette, wearing of mouth and nose coverings, hand hygiene) and liberal access to hand sanitizer for patients and staff.

Responsible Restart

Facilities should have a process in place to promote patient discussion with their surgeon on advanced directives, especially those patients who are older adults, frail or post-COVID-19.

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

Facilities should establish a prioritization policy committee consisting of surgery, anesthesia and nursing leadership to reassess all surgeries and procedures that have been delayed consistent with the Governor's Executive Orders. All surgeries and procedures should be prioritized and performed if there is a:

- Threat to the patient's life if the surgery or procedure is delayed;
- Threat of permanent dysfunction if of an extremity or organ system if delayed;
- Risk of metastasis or progression of staging if delayed; or
- Risk of rapidly worsening to severe symptoms if delayed.

Phased Approach

Each district and/or facility must develop a plan for a phased approach to restarting elective procedures. Such approach may be based on surgery/procedure types or surgery/procedure volumes or some other variable that allows for a gradual restart of services.

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 utilize minimal amounts of PPE, with the intent to expand to additional surgery/procedure types over time.

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

Regardless of the specific approach selected, prior to expanding to a next phase in the plan, the facility must take into account COVID-19 case data and trends within the region and conduct an internal assessment of readiness to progress. This assessment must include a review of inventories and incoming supply of PPE, 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 within the community.

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

Of consideration in decisions to expand the volume of elective surgeries/procedures will be the availability of sufficient testing and PPE to protect individuals living and working in congregate environments (nursing homes and prisons, for example). Hospitals and

health systems will collaborate with their peer facilities within their service areas to facilitate a community wide approach.

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

Governance

Each hospital and outpatient surgery or procedure provider shall maintain an internal governance structure to ensure the criteria and principles outlined above are followed. Providers may also consult with any guidance issued by relevant professional specialty societies regarding appropriate prioritization of procedures.