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Elective Surgeries Resume in California

At the height of COVID-19 related state restrictions, more than 30 governors, including California Governor Gavin Newsom, had issued executive orders limiting or prohibiting elective surgeries. Governors from more than a dozen states have now loosened restraints to allow some degree of elective treatments to start again in the coming weeks. On April 22, Governor Newsom joined that trend in rolling back the limitations previously placed on elective procedures. That's good news for both patients and the hospital industry, especially since hospital revenues in March were down 13 percent from the same month last year.

With California hospitals well below capacity, Governor Newsom modified his executive order to specifically permit medically necessary surgeries that are "not an emergency but if left neglected for months and months could become an emergency." Governor Newsom said hospitals could immediately start scheduling procedures like heart valve replacements, tumor removals and preventative services such as colonoscopies, which he called "foundational to people's health."

The ability to do elective surgeries while still dealing with the COVID-19 pandemic raises a whole new set of issues for hospitals, from patient priority to expanded safety procedures. Some surgeons have expressed concerns about performing elective surgeries on asymptomatic COVID-19 patients, fearful that patient mortality and ICU rates can increase significantly for those with unknown infection at the time of surgery. In fact, people with unknown Covid19 infection at the time of surgery had a 21% mortality rate and 44% ended up in the ICU.

A good starting place to consider the implications of elective surgeries in the midst of COVID-19 is the "Roadmap for Resuming Elective Surgery after COVID-19 Pandemic" developed by the American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses and the American Hospital Association.

Some of the key concepts in that roadmap include the following:

1. 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, accounting for the following:

- Previously cancelled and postponed cases.
- Objective priority scoring (e.g., MeNTS instrument).
- Specialties' prioritization (cancer, organ transplants, cardiac, trauma).
- Strategy for allotting daytime "OR/procedural time" (e.g., block time, prioritization of case type [i.e., potential cancer, living related organ transplants, etc.]).
- Identification of essential health care professionals and medical device representatives per procedure.
- Strategy for phased opening of operating rooms.

2. Facilities should adopt policies addressing care issues specific to COVID-19 and the postponement of surgical scheduling, including, among others, the following pre-operative, intraoperative, post-operative and discharge planning considerations:

- **Pre-operative**
  - Consider use of telemedicine as well as nurse practitioners and physician assistants for components of the preoperative patient evaluation.
  - Some face-to-face components can be scheduled on day of procedure, particularly for healthier patients.
  - Laboratory testing and radiologic imaging procedures should be determined by patient indications and procedure needs. Testing and repeat testing without indication is discouraged.
  - Assess preoperative patient education classes vs. remote instructions.
  - Advanced directive discussion with surgeon, especially patients who are older adults, frail or post-COVID-19.
    Immediate Preoperative
  - Guideline for pre-procedure interval evaluation since COVID-19-related postponement.
  - Assess need for revision of nursing, anesthesia, surgery checklists regarding COVID-19

- **Intraoperative**
  - Assess need for revision of pre-anesthetic and pre-surgical timeout components.Guideline for who is present during intubation and extubation.
  - Guideline for PPE use.
  - Guideline for presence of nonessential personnel including students.
- **Postoperative**
  - Adhere to standardized care protocols for reliability in light of potential different personnel. Standardized protocols optimize length of stay efficiency and decrease complications (e.g., ERAS).
- **Post Discharge**
  - Post acute care facility availability.
  - Post acute care facility safety (COVID-19, non-COVID-19 issues).
  - Home setting: Ideally patients should be discharged home and not to a nursing home as higher rates of COVID-19 may exist in these facilities.

3. Facilities should reevaluate and reassess policies and procedures frequently, based on COVID-19 related data, resources, testing and other clinical information. Facilities should collect and utilize relevant facility data, enhanced by data from local authorities and government agencies as available, including:

- COVID-19 numbers (testing, positives, availability of inpatient and ICU beds, intubated, OR/procedural cases, new cases, deaths, health care worker positives, location, tracking, isolation and quarantine policy).
- Facility bed, PPE, ICU, ventilator availability.
- Quality of care metrics (mortality, complications, readmission, errors, near misses, other – especially in context of increased volume).

4. Facilities should have and implement a social distancing policy for staff, patients and patient visitors in non-restricted areas in the facility which meets then-current local and national recommendations for community isolation practices.

5. Facilities should be prepared to address other COVID-19 Related Issues, including:

- Healthcare worker well-being: post-traumatic stress, work hours, including trainees and students if applicable.
- Preoperative testing process.
  - For COVID-19-positive patients.
  - For non-COVID-19-positive patients.
  - Environmental cleaning.
- Prior to implementing the start-up of any invasive procedure, all areas should be terminally cleaned according to evidence-based information.
- In all areas along five phases of care (e.g. clinic, preoperative and OR/procedural areas, workrooms, pathology-frozen, recovery room, patient areas, ICU, ventilators, scopes, sterile processing, etc.):
  - Operating/procedural rooms must meet engineering and Facility Guideline Institute standards for air exchanges.
  - Re-engineering, testing, and cleaning as needed of anesthesia machines returned from COVID-19 and non-COVID ICU use.

Nelson Hardiman lawyers, with their vast health care experience and which include former scientists, a current clinician and a former hospital administrator, are available to assist you in developing processes and procedures that fully consider the current COVID-19 operating environment so that you best address the needs of patients and health care practitioners when resuming elective surgeries.

References:

1 Kaufman Hall, National Hospital Flash Report, April 2020

2 https://www.thelancet.com/action/showPdf?pii=S2589-5370%2820%2930075-4

3 https://www.aha.org/standardsguidelines/2020-04-17-roadmap-aha-others-safely-resuming-elective-surgery-covid-19-curve

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