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VOICE OVER:

This is a special ASA ACHE joint report on strategies on restarting and expanding elective surgery after COVID-19. It was recorded on May 7, 2020. Slides from individual presentations and a video recording are available at asahq.org/covid19info.

DR. ADAM STRIKER, HOST:

Welcome to another episode of Central Line. I'm Adam Striker. Today, we're sharing more information from ASA's most recent COVID-19 Town Hall, bringing you up to date information from our experts in the field. Here's what they said.

DR. MARY DALE PETERSON:

Good evening everyone. I welcome you all to this special ASA ACHE joint webinar. Welcome to my fellow anesthesiologists, members of the anesthesia care team, anesthesiology assistants, nurse anesthetists, anesthesia techs, and administrators and executives from across the healthcare spectrum. We also welcome our special guests on tonight's joint webinar the American College of Healthcare Executives and Deborah Bowen their President and Chief Executive Officer.

ASA and the American College of Healthcare Executives have a long-standing collaborative relationship. ASA, along with the American College of Surgeons, The American Hospital Association, and the Association of Perioperative Registered Nurses recently released a joint statement titled Roadmap for Resuming Elective Surgery After COVID-19 Pandemic. I want to recognize and thank our President-Elect Dr. Beverly Philip for her leadership from the ASA on that statement.

In our special joint webinar tonight, we will review how to evaluate the necessity of elective surgery based on clinical needs and discuss criteria to prioritize procedural patient case care. We will discuss the recommendations on testing patients and staff prior to resuming elective surgery, and summarize the most recent public health

information. We will examine the prioritization of PPE, the use for non-elective surgeries and procedures. Finally, we will talk about the coordination and leadership needed to resume these surgeries and procedures.

I'm happy to know that the doctor Joseph Szokol, ASA's Chief Health Policy Officer will be moderating tonight's webinar. Dr. Szokol?

DR. SZOKOL:

Thank you. Dr. Peterson and welcome everyone. Tonight's speakers are members of ASA and ACHE and recognized leaders in surgery, nursing, anesthesiology and healthcare administration.

Our first speaker is Dr. Harry Sax, Fellow of ACHE and Vice-Chair of Surgery and Executive Vice-Chair, Department of Surgery Administration at Cedar-Sinai Hospital.

Our second speaker is Dr. Robyn Begley, Chief Executive Officer, American Organization for Nursing Leadership and Senior Vice President, Chief Nursing Officer for the American Hospital Association.

Our third speaker is Dr. Mary Dale Peterson, Fellow, American College of Healthcare Executives, (sic), President of the ASA and Executive Vice President & COO at Driscoll Children's Hospital.

Our fourth speaker is Dr. Alan Kaplan, Fellow, ACHE, Chief Executive Officer, University of Wisconsin Health.

I now welcome Dr. Harry Sax for his presentation on how we prioritize patients, and how we reassure their families. Harry?

DR. SAX:

Thanks very much, Joe, and good evening everyone from Los Angeles. I have no, uh, relevant disclosures or conflicts of interest. I do want to thank ACHE and ASA for inviting me and also acknowledge the contributions of your former president, Dr. Jim Grant, who is now our Chief of Anesthesia here and I've worked with very closely, uh through the COVID crisis, and much of what you'll hear things that we've developed together. Um, in the next slide, what you'll see is a quick overview over the next 10 minutes, and we'll leave plenty of time for discussion. I'm going to try to provide, from a surgeon's point of view, how we both turned the tap off, how we're going to turn it back

on, deciding who goes first, how quickly do we ramp up knowing that perhaps we're going to need to shut things back down or at least pull back a bit? How do we assure that people feel safe, both from the operative team as well as the patient? And what do we do if patients don't want to come back? There's a lot of fear out there.

Uh, whenever I'm thinking about deep thoughts, I always look to the great philosophers and today's words of wisdom, uh, come from, uh, Yogi Berra and, uh, I don't think any of us, three months ago would think that we'd be sitting here talking about a novel coronavirus, but it is tough to make predictions, especially when they're about the future and probably many of the things that we discuss today, we may find, uh, have changed by the time we meet again, uh, in a month or two.

Uh, I want to explain what we've done at Cedar-Sinai. Cedar's, for those of you that are not familiar with it, is in Los Angeles. We are an academic medical center about 900 beds, tertiary and quaternary care, large transplant programs, a very strong, uh, quaternary medicine programs, and we have a been running census in excess of a hundred percent, at times close to a thousand patients.

In mid-March, when we needed to begin to shut down in response to the COVID crisis and not knowing how quickly we would see the influx, and seeing what happened in New York, we were very aggressive, and about March 14th a group of us met, including representatives from surgery, the operating room, anesthesia, and we looked at all of the cases being, uh, planned for the next 4 weeks, hoping that this would be a relatively uh, short uh, pullback. We prioritized those cases that clearly needed to proceed and the others we postponed and notified the surgeons. In many cases, surgeons were able to provide additional data to suggest if things were time-sensitive and we were able to get those cases back on, so we didn't completely shut down surgery, but we certainly significantly restricted it to create the capacity for the COVID patients and also, at that point, to also a maintain PPE.

Over the course, we've actually postponed more than fifteen hundred cases. Uh, these are patients that needed surgery, that continue to need surgery. And so we do have a significant conundrum on how we bring those back. We also took the opportunity to train our operative staff and create COVID-specific operating rooms, recognizing that there would be patients that would come in with surgical emergencies that also were COVID-positive, as well as patients admitted with COVID that would develop surgical emergencies. And we've certainly seen that, including for example, the need to place patients on ECMO.

Initially, we had very little screening capacity to look at who was colonized. We've now been able to expand our screening capacity, and we'll talk a little bit about that, allowing uh, further discussion by some of the other participants. Not surprisingly, and I think many of you probably saw the same thing, which is that patients that we thought could be delayed for 4 weeks really couldn't be, and they started to come back with expanding aneurysms, recurrent bowel obstructions, and needed to be done more urgently and perhaps need larger operations. The other interesting thing we saw was a fallout and for example, things like appendectomy, but we saw were more and more perforated appendices coming in. So there was clearly a lot of delay of care that was then presenting with more progressive disease.

As we noticed that our, uh, population of COVID patients began to stabilize at around a hundred, and we had the capacity, we were able to then titrate an expansion of surgical services, and we'll talk little bit more about that.

On the next slide is just a quick overview of the range of decreases. And you can see, we cut we our surgical volumes by almost 80%. Uh, the one area that did not go down, the cath lab went down, intervention went down, the procedure center switched from doing procedures on surgical patients to doing procedures on COVID patients. So a very, very significant decrease, and something that we accomplished really over a period of about seven to ten days, and were able to maintain that over the last few months.

What you're going to see is a prediction, and again, even though Yogi says it's hard to predict future. This is something we got from GE Healthcare and I think it's a way for us to think about the fact that COVID is going to be with us for at least the next year and perhaps longer. In the old normal, we were able to run our hospitals. We had a lot of surgical procedures. In some cases were above 100% capacity. We rapidly, uh, cut that down in response to not knowing how quickly our COVID patients would rise. We're now in Phase 2. We're beginning to see stabilization and a bounce-back. We will see recrudescences of COVID as we get into the fall and winter with the influenza season. We may need to pull back again. And then hopefully as we get, uh, beyond a year, and a year-and-a-half will get into a new normal and I don't think we're ever going to go back. I think we've learned a lot of actually very exciting things about the way we can provide care and how we can streamline. And some of those things will continue, even as the number of COVID patients, uh, fall out.

I want to talk to you a little bit about how we reopened access and we had to think about it and really two different aspects. One is being cognizant of the fact that in-patient, uh, beds will continue be taken up by COVID patients. On the other hand, many of the

cases that we canceled were ambulatory. So we recognize that we may be able to ramp up ambulatory more quickly than we're going to ramp up, uh, patients that are going to require an in-patient bed. And that includes thinking about post discharge planning. We tried to create COVID-free zones, in part, uh, both for the use of PPE, as well as to reassure patients. And we're fortunate at Cedars that we have some operating room in a building separate from the main hospital and that's the area that we're concentrating as we begin to ramp up both ambulatory and short-stay.

We also made the decision that we would go from screening selective COVID patients to screening all COVID patients, and that has been really a game-changer in our ability to both preserve PPE, as well as reassure both patients and operative staff.

Um, we had a pluralistic medical staff where many of the preoperative clearance has been done in the community. Not all of those, uh, participants run Epic and what we found is that as part of trying to bring things back, and be more efficient, we've centralized both the ordering of screening as well as preoperative assessments, and actually have found that to be working quite well. And working with our Hospital, we've developed guardrails should we need to pull back if COVID volumes ramp up again.

Shutting it down wasn't really as difficult as starting back up, uh, because we were able to pretty much decide whether a case needed to go in the next 4 weeks. The point is now we have about 1,600 to 1,800 cases that need to come back on, with multiple specialties. And so what we've done is we've asked our service line, uh, Chiefs, and, uh, Medical Directors to look at all of the postponed cases. And we divided those into ambulatory and those that require admission, and then asked them to prioritize them by cases that should be done in the next 4 weeks, those that should be done in four to eight weeks, and those that can truly wait greater than 8 weeks. We then look at urgency. We try to cohort both the patients by their type. In other words we're asking surgeons now not to mix up a day of two patients are going to be admitted, and 3 ambulatory and instead do all of their cases for patients who are going to be admitted on one day and then in the ambulatory setting, with quick turnovers, we're trying to get more of their ambulatory cases. So we're both, uh, changing the block times, we no longer have individual blocks, we've moved to service lines. That's given us a great deal of flexibility and, and frankly, I don't know that we're necessarily going to go back to individual blocks, held by individual surgeons anytime soon as we try to go both work through this, uh, backlog, as well as provide care for patients that are now coming in and now need care on top.

So we're looking at something for the next 6 months at least and we're very cognizant of the fact that if we do see COVID come back in the fall, that we may have additional problems and create additional backlogs.

The next slide is a high level overview of our screening protocols. I'm not going to go into a lot of detail, but I just basically want to say that what we're trying to do is get all of the elective cases in 48 hours ahead of time, uh, and have them screen. We're doing that with a drive-thru screening. Uh, if you're an in-patient and you were screened on admission, which were doing now in the operating room, you do not need to be rescreened, especially if you're asymptomatic. In the emergency cases, gunshot wounds, ruptured aortas, they're going to the COVID OR with all of the use of PPR's and so on, and then they're subsequently screened. What we found interesting in our screening of over a thousand, again, this may reflect Los Angeles, is that our positive rate in asymptomatic patients has actually been less than 1%. And that may be something that will change as we go forward, but it's something you need to each look at, as you look at your capacity for screening, your capacity for the utilization of PPE's and the decisions thereof.

Next slide will discuss the big question that we have, which is are they going to come back? And as we're already seeing people are putting off necessary care because the fear of getting COVID, and as much as we as individual hospitals can talk about how safe it is to come back, it needs to be on a really greater scale. And on the next slide, there's some suggestions of how you can perhaps try to re-encourage folks and reassure both them, as well as your own medical staff, that is safe to come back. And that probably is better coming from County Health Departments, your State Medical Boards and so on, about the importance of not delaying needed care, and about the fact that hospitals are working very, very diligently to make sure that it's safe.

As an individual hospital, for example, we have temperature checks on all of our folks coming in and out. Everybody wears a mask, even if you're in a non-clinical area. And I think emphasizing that gives people a, a good sense of security knowing that we're looking now, we are not at this point culturing or doing antibody testing routinely, and that's something that we'll need to be thinking about future. Although again some of this antibody, excuse me, that's been cultured and is negative today, may in fact be colonized tomorrow. And what you would be doing is have them wear a mask.

Um, the other area to think about is visitor restrictions, especially encouraging people to come back in. Uh, we were very, very tight on restricting visitor access. I mean to the point of laboring mothers could have one person with them, and then that person had to leave after the baby was born. We have since recognized there's some downsides with

that, as well as with some of the pediatrics, and with surgery, especially with folks that may be in. So think about is there a way that you can allow a, at least one visitor to stay that may encourage patients come back. That make them feel safer, but figure out how you're going to screen those visitors so that they don't necessarily bring uh, COVID back in with them.

So these are just some thoughts. Each of you are going to have to look at your own environment, uh, the rate of asymptomatic COVID in your community, and the comfort within your own hospital to the degree of screening that's necessary.

So, in summary, who goes first? Uh, you again need to look at your service line Chiefs, as well as try to think about organizing ambulatory versus those that need to be admitted. Certainly people have been waiting longer, the oncology group, transplant, cardiac, those are patients that clearly should be prioritized. Their diseases tend to get worse, and, uh, they also tend to need a greater operation, some, sometimes, excuse me, if you go too long. Uh, try to do screening as, as much as possible. And if they don't want to come to the hospital, you still can a work that through.

So in the final slides, I just want to reflect for a moment, as a surgeon, what has been really a, a remarkable couple of months. We have done things. We have built the airplane on the fly and one thing that we've recognized is that we aren't going to get it perfect. We do the best we can and we realize that we're going to get new information. We're going to change it on the fly, and the fact is that if the world were perfect, it wouldn't be. So once again, I am very grateful to ASA and ACHE for the opportunity to share my thoughts with you, and I look forward to hearing from the remainder of the panelists, and thank you.

DR. SZOKOL:

Thank you, Dr. Sax. Our next speaker is Dr. Robyn Begley, who will be speaking on testing and workforce issues. Robin?

DR. BEGLEY:

Good evening everyone. It's my pleasure to be here tonight with you all. Um, Dr. Peterson initially referenced the document that was issued about 3 weeks ago, the joint statement, recognizing the potential for the immense patient demand, uh, for surgeries and, you know, provided a list of principles to guide us all. And I think Dr. Sax really did a great job of, you know, speaking to that pent-up demand. Earlier this week the AHA released the COVID-19 Pathways to Recovery document. This is a resource to outline

important considerations and checklists and the joint statement that was referenced earlier along with the CDC guidance was utilized to develop this document. It's not intended to be all-inclusive. It will evolve over time as we learn more, but the first part of this compendium that was released this past Monday, includes workforce considerations, testing and contact tracing, internal and external communications, and supply chain information. New sections are being developed, and will address additional topics and the entire document will be updated as we learn more. And the reason that I mentioned this, is that although we are here to discuss the resumption of elective surgeries and procedures, we all recognize that the interdependency of all of the hospital and health system components must be considered as we move forward.

As we look at workforce considerations, we know that issues vary between COVID hotspots and areas less affected. While many hospitals in the hotspots have been overwhelmed with COVID patients, many hospitals have significantly reduced patient volumes due to cancellation of non-emergent surgeries and lack of patients presenting to ED's, primarily out of fear.

In preparation for tonight, I, um, I actually surveyed over 40 CNO's this week across the country. The variation in the responses was greater than I expected and reflects different levels of penetration of COVID-19 and also bearing state and local requirements, and I was actually quite frankly just surprised at the variation and I'm not really sure about the reason why. My comments are intended to be a guide for consideration of priority issues in your setting.

As we look at staffing, um, when we think about it, one of the most important questions to consider is do we have a comprehensive plan and process to strategically bring back workers who were furloughed? Considering which services can and should be reopened first. Can and should some of the furloughed workers be deployed to allow those who've been on the front lines of treating COVID-19 patients to take time off to rest and recuperate? What are the skills and competencies required? Do you have a communications plan so everyone is clear about expectations?

The slide that's up contains a number of considerations outlined in the resource that I referenced. I asked the CNO's from across the country, what was the most pressing workforce issue at their institution, and overwhelmingly, it is workforce exposure. A staff member may work a shift without any symptoms and then exhibit, exhibit symptoms when they go home or the next day. This requires identifying all other potentially exposed for the past 48 hours the staff, you know, the the time that the staffer may have worked, resulting in additional staff at home self-monitoring for up to 14 days. I heard reports of 50 to 80 staff members out at one time for this reason.

You know, Dr. Sax mentioned fear, and as elective surgery resumes, hospitals may find that healthcare providers who has been off, you know, utilizing telehealth, uh, meth, methodologies or working remotely are initially fearful, very resistant to return to work. Some, uh some responses in terms of staffing COVID-19 units, we are seeing across the country, innovations in team-based models, especially in our COVID-critical care units. We've all heard about the proning teams, you know, we've heard intubation teams, you know, for those especially hard-hit areas, and there's a lot of creativity in those team-based models. It will be very interesting to see the outcome, after, you know, we've passed the, uh, phase one of the pandemic. I asked the question about volunteer or mandatory, you know, are we asking staff to work in the COVID units or is it mandatory, and the responses were varied. We are, we are pretty consistently, reassigning staff with immuno-compromised condition or if they are pregnant, and other staff members do have legitimate concerns about working in a COVID unit. They're usually referred to HR, for appropriate either reassignment or work restrict, excuse me, restrictions.

And, you know, I think one of the most important things for us to be asking is how is caring for COVID-positive patients being received by your staff? Um, the responses were varied. Many were scared, especially in the early days two months ago, you know, we're on COVID time, but not as much since. Many teams have rallied together with even stronger engagement and teamwork to step up the, up to this heroic challenge in cases that did, or in situations that reported that they did have problems, these were at times, mitigated by providing COVID pay incentives on, on those particular units and the emergency departments. But most reported they didn't have issues with staff refusing to work or resignation. So a real variety in responses here, you know, we know that resiliency and burnout in physicians and nurses was already a concern before the pandemic. The National Academy of Medicine launched an action collaborative on clinician well-being and resilience, and published their findings and recommendations last October, pre-COVID. Um, I think add what they learned and reported to the gut-wrenching stories that we are all witnessing. You know, we know that resilience and burnout are critical issues that healthcare organizations need to have a plan to address, and this will continue for some time.

Some questions we may ask, you know, how are we appropriately celebrating and recognizing accomplishments? Are we communicating effectively with employees, ensuring that information is flowing from leadership as we continue to transition back to normal operations? Transparency is really key to trust, have we considered the impact to staff teams who prepared for readiness and were not utilized? How do we encourage and support people to take time to recover and take time off, so they have renewed energy to be ready for a potential second wave of COVID. Um, and do we have special

provisions? I think this is particularly important. Um, do we have special provisions in place for those work units that have experienced a loss due to COVID-19. For example, have they lost a colleague, a family member, etc. So, many more questions that could be addressed in this round, but this is a real issue that we will have to, um, that we deal with now and we will have to con, you know, consider for some time.

So on to the next slide, um, education and training. You know, again, not so many answers but more questions and considerations. What training needs to be created or revamped to ensure that our organization is better prepared for future outbreaks? Have we reviewed and considered potential flexibility or waivers for annual competency reviews or performance appraisal, appraisals? Have we considered other technology training needs to successfully operate new and increased usage of systems, such as those used for telemedicine? Are there protocols in place for shifting clinicians via competency-based training to work in critical care units or other areas where they are most needed? The list goes on. Have we curated and shared appropriately all the lessons learned from the pandemic? I know every day, we see, you know, email after email with resources and I really believe that we need to make sure that that is, you know, appropriately organized for our field. You know, as far as, uh, teaching, when will, when will we reinstate any suspended clinical rotations, internships, or other training program offerings? And are we working with universes, and universities and colleges to modify the clinical experiences if necessary as we resume clinical training?

So, the next slide is more of an overview of considerations that to effectively reopen services including, of course, elective surgeries and procedures. We will need to be able to plan for and execute effective surveillance, testing and tracking protocols that cover any number of populations that we serve, patients, staff, vendors, high risk community populations. This really requires collaboration and coordination with public health services that we may not have had experience in interacting with at this level for a very long time. And to get more granular at the next slide, we will, um, look a little bit at planning. Testing sites need to be identified, supplied and staffed appropriately. We need to consider the following areas, ensuring adequate supplies, confirming types of analyzers available and where they are located, coordinating with regional state organizations for additional capacity, ensuring all high-risk communities have access to testing, and finally to ensure cultural competency and needs of our diverse communities. And in terms of testing criteria set up for patients, there is wide variation. In my responses I received from, from the nursing leaders across the country, pretty consistently, all organizations are screening all patients. Some are testing all patients, but there is a real wide range of responses and some referenced testing materials which are still, you know, um, not widely available.

When we focus in on workforce testing procedures, you know, questions to consider. What testing criteria have you set up for staffing with, with your confirmed COVID patients and those working in um, areas, we, where we do not, we have not placed COVID patients. You know, most hospitals, in my informal survey, are trying to cohort COVID and non-COVID. Again, there's wide variation. Determined, depending on size of facility, location of facility, um, most are screening all staff daily. This includes taking temps before shift and mid-, and in some places mid-shift, having screening attestations randomly throughout shift on computers pop up and staff need to enter, um, the answers to the questions. Another response is, we are not presently doing any widespread testing of employees unless they have a workplace exposure. This process is the same if they are caring for COVID patients or not. Others are testing staff that develop symptoms, um, another response, all staff and visitors are required to wear masks when entering any of our facilities and we are starting to see hospitals pilot testing for antibodies and some of those facilities are starting with their healthcare workers.

So, some additional questions, you know, that, that, we need to all consider. How are we incorporating rapidly changing screening guidelines? And I think that's a challenge for every organization. Um, every time the CDC guidelines change, all screening for staff and patients are updated and rolled out system-wide, including expanded guidelines for testing and PPE. That was a response by several of our nurse leaders. Um, now, seeing patients present with non-traditional COVID-19 systems, symptoms, excuse me, who through differential diagnosis are then tested and sometimes test positive. Um, separate non-COVID testing areas for testing have been setup for low-risk patients who are being scheduled for a procedure.

So, I guess another question that's important, and we've all considered is, what is the protocol for sick staff return to work, for those that have been, um, tested and tested positive? And again, a wide variation: have to be fever free for 48 hours and no symptoms for 7 days, another response was 10 days and others uh, responded 14 days. And most of our staff are also working through occupational medicine when they do return or employee health. So employee health, um, monitors staff through temperature checking twice a day. After testing, they call to the staff each case can be different based on symptoms and exposure and staff are brought back to work when determined to be asymptomatic and beyond the quarantine time, and in this case, it was 14, 14 days. So, um, lots of you know varying information as we look across the country, but I think importantly, examine the, uh, their own policies and procedures and make sure that it is in compliance with the newest science.

So, one other question I thought you would find of interest, what procedures have been successful in protecting staff and families, and people that the staff live with? Donning and doffing education, keeping scrubs at work, and shower before leaving or interacting with family, free hotel options for staff preferring to isolate from family and as many places report, we adopted universal masking several weeks ago and have UV shoe cleaners at entrances to hospitals.

So as we, uh, move to the next slide, data collection and infrastructure to predict, identify and address and track outbreaks, testing data must be collected, analyzed and reported across the community. A data collection and reporting protocol should be developed in conjunction with key community partners and this protocol should identify not only the partners, but responsibilities and resources in three main areas that you see on your screen, data collection and submission, data analysis and reporting, and data security.

I just want to speak a little bit about surveillance and contact tracing. So hospitals and health systems should coordinate with state, regional and local health departments. And we have to remember, many times, this would also include a neighboring state. Um, partner with them to surveil and, and, contact (sic) for, excuse me, for surveillance and contact testing protocols, and execution of these protocols. Coordination should include, again, the points on the screen. Defining surveillance, include use of serial testing, establishing infrastructure and procedure for tracing and documenting hospital-acquired COVID-19 infections and staph infections. Consider use of community health workers and community connections to supplement tracing resources, and this, I heard actually that the use of medical students and nursing students for this work has been very effective in certain communities. Investigating and identifying appropriate tools for follow-up, monitoring of people quarantined at home, including using technology and telehealth solutions.

That concludes my comments. I want to thank you all for inviting me to, to, uh, promote and to advance the, the point of view of our nursing leaders, um, and I welcome questions at the end. Thank you.

DR. SZOKOL:

Thank you, Robyn Begley. Our next speaker is Dr. Mary Dale Peterson who will speak about PPEs and (sic) of care. Mary Dale?

DR. PETERSON:

Thank you, Joe, I appreciate that very much. On the, the next slide, um, I had to follow, uh, Harry's, start here, you know, looking at Yogi Berra, and so you got to be very careful if you don't know where you're going because you might not get there. So hopefully we will understand a little bit better where we're going even though there's still a lot of uncertainty, um, out in the future.

So I think timing we've already talked about a little bit, but, um, these are some recommendations that the joint statement brings up, so that we can have sustained reductions in the rate of new COVID cases for 14 days. Now, I know there's been some criticism out there that some states are opening up things and they haven't shown a sustained reduction in 14 days. I know, I'm in Texas, our Governor says that he's mainly following the hospitalization rates because his testing is either low or high, you might get variations in that, but hospitalizations should be a better bellwether of how we're doing. I'm not sure if that's right or not, but, uh, that's, that's one opinion. Um, obviously, you can't reopen for elective, or non-emergent surgeries if it's not authorized by municipal, county and state authorities. I know, and once again in Texas, they had very stiff penalties, if you did any case that was considered potentially elective. Obviously, we've got to have a capacity in our hospitals without resorting to crisis standards of care. Um, that includes beds, uh, making sure that we have enough personal protective equipment, enough ventilators, drugs, we're seeing shortages, you know, we had them before COVID, and we're seeing certain drugs, um in shortage now because of the needs in the ICUs, and just general supplies. Our supply chains, um, have been stretched. They were stretched before COVID. And now, it's worse since it really doesn't require a lot of coordination when materials management, hospital administration, making sure that we have everything we need to safely take care of our patients. And obviously, surgeons need to work with the anesthesiologists and other OR staff to determine which patients go first from the backlog that's there.

We can talk a little bit about patient testing, and this is, this slide here will talk about the group um, road map and then ASA and APSF have some more specific recommendations. The testing we're trying to do is to protect both staff and patients. We really don't want patients to be undergoing elective surgery if they are, either not recovered from COVID, or perhaps are in the beginning of having COVID, and then they may not be, um, that symptomatic. So we really all need to, um, develop policies, implement policies that would address the requirements and frequency, um, for patients and when we should be testing staff. Um, facilities should account for a lot of controversy, and you really have to understand what your hospital is able to offer. If, if they offered it all. I know, our hospital, we're still not able to get the reagents for our PCR platforms, and so those are send-out tests. Um, I'm so I think all that has to be taken into consideration, um, as far as what you're doing at this point in time as you're

resuming surgery. And then really creating and following care policies on how to respond to positive workers, positive patients, or if you have a person under investigation, either a healthcare worker, or a patient.

I'm going to delve a little bit more into the ASA APSF joint tape, uh, statement. As has been discussed before, really all patients coming into your facility, whether for surgery or not, should be screened for symptoms prior to coming to any part of your facility. It is our recommendation that patients undergoing elective surgery, non-emergent, um, that they received the PCR nucleic acid amplification test. This is to, you know, really ensure the safety of patients. If the patient tests positive, then elective surgery should be postponed until the patient is no longer infectious, and has demonstrated recovery from COVID-19. And if you go to the CDC guidelines, they have two different guidelines that you can look at either a test-based strategy or non test-based strategy. But really the bottom line is, you need to be, um, sure that you understand that not only is the patient no longer infectious, but that they have fully recovered or they're optimized as best they can be, because we know that some patients that have had a particularly difficult course with COVID, may end up with chronic lung disease for quite a while. And so I think understanding their additional risk for surgery is really important for both the surgeon and, and the anesthesia team.

So antibodies, I wanted to make a point about antibodies. So those develop in about the second week of symptoms and not all patients may necessarily develop strong antibody response. So antibody testing is not good testing for preoperative screening. We really need to be using a PCR type screening for preoperative testing. Antibody screening may become important from a public health perspective, or really understanding how much of our healthcare workforce is potentially protected from COVID, having had it and developed an antibody response.

I want to talk a little bit about the personal protective equipment. And I know this is perhaps a little bit of a controversial area. However, um, it is our position, and this is the ASA and APSF, regardless of screening and testing that we all need to be wearing appropriate protective equipment. And especially true for aerosol generating procedures, which should require N95 mask for the equivalent of that as well as eye protection. A lot of people are asking us, well what are these AGPs, sort of these aerosol-generating procedures? Well, in the anesthesia world, we're pretty clear that it's intubation, exubation, bag-mask ventilation, bronchoscopy, anything that would induce a lot of coughing. So, I know I saw in the chat box, what about LMA's? Anything where you're really involved in the airway and could potentially generate these, these micro droplet aerosols is an AGP. In the surgical literature, they suggest that there's a

potential for a AGPs with even in laparoscopy, endoscopy, and we know that ENT procedures can be fairly high-risk procedures.

I want to delve into this a little bit more on the PPE. You might ask, well, you know, if the person tests negative, why am I still wearing an N95? And that really is because we know that there are, uh, false negatives. And so, I, I think the false negatives come from how, how well you have actually gotten the sample, all the way to how well the machine, um, and the reagents and, and, all of that are able to, to properly analyze it. So you can have errors at sampling, as well as, you know, you have a margin of error just from the machine. And so, even if your machine, even if you're 98% sure you still have a 2% where you're not sure. And so I think that's where the issue comes in, is we see hundreds of patients come in our operating rooms or in our non-operating room locations requiring care, um, really making sure that, that we are wearing appropriate PPE.

Some of the recommendations on the reuse are that if you have a known COVID-positive patient, that that should really only be a single-use. However, if you think it's a low-risk, the patient's asymptomatic or COVID-negative, then we can reuse those because we still feel that probably most institutions do not have enough N95 supplies to toss after every single patient encounter.

I can talk a little bit about the purified, powered air purifying respirators. Um, depending on the airflow settings, the, the use of PAPRs could reduce the risk of exposure to healthcare workers. And, um, in some cases we've seen these recommended for very high risk procedures like a pituitary adenomas, where you're going through the nasopharynx, or basal skull procedures. Experts are really unclear on the effects of PAPRs as far as the sterile field. And in that, they're worried not too much about COVID, you know, going into the room, um, obviously, we're trying to protect ourselves with, from COVID with, with these PAPR devices, but it's really our own flora and is our own microflora being pushed into the outside air and then could potentially land on the surgical field.

We can only find one abstract, um, from the American Journal of Infection Control that showed no difference in the particulate counts at the surgical table, weather the PAPR was turned on or off. So that's about the only scientific information we have. On the one hand, PAPRs, you know, are, aren't as hot, you've got your own air supply. On the other hand, they can be cumbersome to use, especially for a surgeon that can limit visibility if they fog up. You can't use the headlight, you may not be able to hear as well, and it may make your eyes even dryer. But it would be preferable probably, for those who fail the N95 fit test, um, or in those very high-risk procedures that, um, I was mentioning earlier.

So what do we do about the continued PPE shortages? And, you know, we're, we're all, many of us, it's better than it was perhaps two months ago. And I know a lot of us are still concerned with supply chains, um, you know, coming from China, until the other companies, you know, ramp up their supplies of N95s, a lot of us are still going to have to either reuse or figure out ways of decontaminating and re-sterilizing our N95s. So these are some ideas that are out there. Some of those are in CDC guidance, we also have them in our FAQs on the ASA and APSF websites. So all these are potential ways of doing it. Most of us have the hydrogen peroxide sterilization units in our ORs. So, um, you know, that might be one way that, that you could re-sterilize your N95s. Now, you know, you need to mark how many times you've done it, and that should be done on the strap and not on the N95 itself. And we need to instruct, um, everyone around us on our teams to, to do a seal check. Now, this is not a fit test, this is a seal check, where you can feel, you do a check, kind of like if you used to wear a mask, uh, scuba diving or snorkeling, making sure that, um, you can see if there was a leakage of air if you can feel the leakage of air. That should not be reused if you can feel that.

So obviously we've had to reconstruct, um, all of our policies, procedures, and patient flow. Um, not only with the screening and testing, and how far in advance that's done, making sure the results are back in the chart, but how we manage our patient flows, that the patients aren't too close to each other, where there is, in holding areas, in our PACUs, waiting areas. Do we need to do (sic)? Can we skip phase one recovery? And recover those patients in the operating room? Regional techniques, we certainly use less PPE and may help us in, in phasing patients through. You know, all the phases of perioperative care, obviously relying on our ambulatory care center, surgical centers to help with some of this backlog and then obviously have to have all those same considerations and sometimes even more challenging in non-operating room, uh, locations, like MRI and cath labs.

So I think in returning to our new normal, um, we will all be performing enhanced infection control. I know that we thought, uh, significantly more personnel in our operating rooms helping us clean in between cases. We've had to adjust our work flow. It may not be as efficient. It probably won't be as efficient as what we were used to in the past, and that'll increase chart over times. So I know that's never fun for anyone but especially our surgical colleagues, and so I think we all have to work together and, and recognize these are all additional challenges. We're still working in a, in a difficult environment and we just need to, you know, really work together and help each other and, and be patient. I think in trying to get as efficient as we can, but making sure that everybody is comfortable, that we're providing the safest environment possible for our patients and our healthcare workers.

And I think that may be the, next slide please. I think that may be my last one, Joe.

DR. SZOKOL:

Uh thank, thank you, Dr. Peterson. Our next speaker is Doctor Alan Kaplan who will speak and workforce resiliency, leadership clinical, go-forward plans, reimbursement, regulatory needs, financial control. Alan?

DR. KAPLAN:

Thank you. So over the past few months all of us have been engaged in crisis management, which tends to be very tactical, with quick real-time problem solving and as we engage in business recovery, it is important for leadership to transition from that tactical thinking to strategic thinking. Uh, stakes are very high and time, I believe, is of the essence for us to make smart moves and avoid big mistakes. And the biggest mistake would be to settle back to our old normal.

So we have learned a lot about ourselves during this crisis. For me, it's been a slight shift in priorities. Meeting the demands of the patient has always been my number one driver for all my decision-making. And it is still that way, but I think about it a little bit differently for the first time sometime during this preparation of this pandemic, I became concerned that I actually would not have people to take care of our patients. And so the shift was, that while I still cared for my patients as number one, I now thought more that I had to spend my time focusing on our physicians and our staff because my number one priority was to make sure they were safe and their needs were met, inside and outside of work, so that they can care for our patients.

Everyone is traumatized, whether they live in a hotspot or not. Uh, we worry about disease exposure, family safety, daycare and economic issues, which has taken its toll on everyone. And yet everyone comes to work in service to others and I remain because of that committed to them. Uh, Robyn addressed resiliency and burn out very well, and I believe it all starts with an unwavering leadership commitment to care for those who deliver the care. As long as I can remember, and before my time, hospitals never shuttered due to an infectious disease. So why is this different?

Several months ago, we didn't understand COVID-19. How it was spread, its morbidity and mortality rate. We did not have policies and procedures to keep patients, staff and visitors safe. We didn't have testing capabilities. We didn't have dependable supplies of, uh, PPE we can have innovation such as intubation boxes. We didn't have the promising treatments, such as Remdesivir and plasma infusions. And society was what,

not well informed. Can you imagine us telling patients that they can only have one visitor and they need to wear a mask at all times in the hospital several months ago before this all happened? We would, again, have an empty hospital just by asking for those things. And all these things are in place now, so I believe we can move forward with confidence. I believe that in the future, we will ebb and flow our census to community need without prospectively shutting down in anticipation of a worse scenario, uh, like we had to in the last few months.

Our world has been turned upside down. Now for years, uh, as long as I can remember, we focused on efficiency, on flow, on lean management. And now we've lost that efficiency because we have to practice social distancing and pre procedural, uh, patient testing, and extra cleaning procedures. Uh, financial setbacks are severe. At UW Health, we're losing about a hundred million in net revenue per month. As of Feb, end of February, we had a 4.1% positive net margin, 100 million, uh, in, in positive cash flow, and we are hoping with a lot of effort, by the end of our fiscal year June 30th, to end up with a negative 2% margin for a loss of a hundred million. We have so far canceled 9,000 procedures and we think a negative 2% margin would be great at this point.

The uh, on the bright side, a long-awaited relative, regulatory release, such as a 3-day (sic) rule has been lifted. There's been acceptance of location agnostic work such as work at home and adoption of virtual meetings. And telehealth has taken off with some facilities reporting over a two thousand percent increase in utilization.

Prior to COVID-19, telehealth adoption was slow. It was not reimbursed, except in very limited circumstances, and believed to be most applicable, applicable to younger patients with mild illness. This has all changed. Reimbursement has been expanded although still significantly less than clinic visits. My physicians are telling me they don't want to go back. This is a huge satisfier for them. Surgeons are reporting the ability to more efficiently screen for operating room cases. And our dermatologists are telling us that at least 60% of their visits can be done online. This would mean smaller facilities, less require staff, such as receptionist medical assistants, and ambulatory nurses who operate the clinics and who are hard to recruit, our elderly patients and those with chronic disease are liking the convenience, and we see other opportunities such as building our retail pharmacy and increasing the profitability of our provider owned health plan.

So, it's a paradox that a, a single strand of RNA has proven to be more pow, have more power to rapidly change the healthcare industry than the thousands of innovators and billions of dollars of private equity dollars that have preceded this virus. Financial

stressors will help us maintain a burning platform for change, and only a week ago, I was on the phone with Eric Hargan the Deputy Director of HHS and there's a hunger to maintain some of the regulatory changes, particularly in telehealth. For decades we worried about disruptors like retail clinics, Amazon, Google and Apple changing our world. And for the first time, I believe the most likely disruptor will be from the inside. It will be us in the provider community. And with that I will turn it over to the moderators.

DR. SZOKOL:

Uh, thank you, Dr. Kaplan. Now, we will recap the discussion and ask a couple of questions of Dr. Sax, Dr. Begley, Dr. Peterson and Dr. Kaplan. So the first one is to Dr. Sax. Are you using any scoring system such as Menths (M E N T H S) to prioritize surgery and product lines to come back online?

DR. SAX:

Yes, so the MENTHS system was developed actually after, uh, the epidemic in 2009. It, we're doing many of those things. We're probably not using age as much as a criteria because we have many very vital older patients, as well some younger folks with chronic disease, but we use, we use many of those criteria. We don't assign a specific number.

DR. SZOKOL:

Thank you. The next one is for uh, Dr. Begley. Are you seeing staffing shortages during this time of surgery build up, and, and sort of a second question, is, is burnout becoming a factor a, among staff?

DR. BEGLEY:

Um, I would say that we are not currently seeing a shortage, particularly for the perioperative space because those, those staff, um, in many cases, were furloughed. The exception would be in the hotspot areas that there have been widespread shortages and the follow up on burnout, I believe that, you know, we've got a multi-generational workforce. We've got, I believe, an issue with some resilience through nursing and you know and, and throughout the healthcare industry and, and the healthcare field, I would say. I do think we are going to see some significant issues post the first phase of COVID-19 and I think that there's a lot of baby boomers that are very close to retirement right now, and have expressed that once we get beyond this first wave of COVID, that it may be time for them to retire. We know from a nursing

perspective for sure, that there's a worldwide need for more nurses in the next 20, 10 to 20 years. So we do expect to see shortages.

DR. SZOKOL:

Thank you. The next one is directed to Dr. Peterson. When would we believe it is safe to pull back the requirement for full PPE for every aerosol generating procedure? Do you ever, ever foresee that happening?

DR. PETERSON:

That's an interesting question, Joe. Um, I, I think when we stop seeing community, uh, transmission of the virus might be one point, or we get a vaccine, but there has been some talk in some communities, um, that perhaps it's time to revisit, um, just like we did, really I remember when HIV first came out and before then we didn't even use gloves when intubating patients and we went to universal precautions, and really being more careful about blood born pathogens. And I remember back then, um, you know, a lot of people, a lot of healthcare workers, got hepatitis. Um, and so maybe we're in a new phase where we're going to have to start thinking, about, um, these micro droplets in the aerosol generating procedures, and maybe N95s, may become the new normal. I don't know that. I do think we need more research and trying to understand that. Um, you know what it, there's a continuum between, um, what is airborne transmission vs. these micro droplets that are aerosolized and how far they go. And so, I think we need more research to determine how far we're going to be, but, I think we're going to have it for the near future, at least.

DR. SZOKOL:

Thank you. The next question is for Dr. Kaplan. Did you apply for a Paycheck Protection Program loan, and did you receive funds from the PPP?

DR. KAPLAN:

Well, that will be an easy answer, because it's no, we did not.

DR. SZOKOL:

Okay. Thank you. And could I ask you why not?

DR. KAPLAN:

We just didn't need it. Uh, we, um, we were able to cash flow okay, and, um, it just, something we just didn't pursue.

DR. SZOKOL:

So the next question is really to, to the panel. What's the best way to work with my hospital administration about the importance of patient testing?

DR. PETERSON:

Well, I, I'll start with that, and then maybe Harry, maybe you can, you can add on a little bit. But I think this is really a challenge right now. I hope it gets better in the next couple of months as we have less shortages of reagents and more widespread ability to do the PCR testing, um, but a lot of us or having to do what I would call work-arounds that aren't ideal, where you know, yes, we set up our testing centers and, but we've got to send it away to one of the, the big labs and then it's, you know, a couple of days before you get it back and said trying to stage your elective procedures is three or four days um, and we know that in that interval that's not totally ideal. I know I'm getting a lot of questions are members that are concerned that some either surgeons or hospitals are doing antibody testing. I think our guidance has been pretty clear about that, that antibody testing, the WHO says the same thing, should not be used for determining whether a patient is COVID-positive or not. And maybe, Harry, you have other points of view on that, but um, I think, you know, I think our guidance this out there for people to work with your Administration to, to try to provide the best safe they care they can.

DR. SAX:

Uh, yeah, Mary, I'd, I'd agree. Let me just re-emphasize, we don't use antibody testing. Uh, there is, I think, it will be an interesting thing among healthcare workers to try to understand prevalence. I'll bet it really doesn't make it a difference when you're looking at the level of PPE that you're going to need. So from our administration, they were very supportive, uh, for one, in fact, we have now moved to testing all of our patients being admitted even if they're not being admitted for COVID, because it makes a difference as to the level of PPE that they're going to be used, on the floors that we put them on, and frankly, uh, from the point of view of the hospital for financial viability, we need to be able to safely get surgeries up and running. We need to make sure the patients that need their care are getting it before their disease progresses, and the use of, um, preoperative screening is reassuring to patients and reassuring to the medical staff. And so, I, I think it's a, it's a no-brainer for most institutions.

DR. SZOKOL:

So Dr. Sax, you spoke earlier about block allocation. How do you decide block allocation among different service lines who are all competing or service in sort of a finite space, right?

DR. SAX:

Right, and, and you get all this is obviously a, a new criteria. What we're doing, first and foremost, is the cases that have been deferred 4 to 8 weeks, uh, cancer patients, patients with cardiac, they get priority regardless of, of the blocks or the availability. Uh, what we then do is, we're looking, frankly, at the people that were deferred the greatest and the groups that took the biggest hit right now are Orthopedics, specifically as our joints as well as spine. And as we have capacity, they will disproportionately get that care and get that space because they have the largest number of patients, uh, that were deferred and the largest percentage that need to be treated.

DR. SZOKOL:

Thank you. Now, this, is to the entire panel. How should staff with immuno-compromised states or perhaps are older, be assigned? What precautions or policies are people instituting for these individuals? Maybe I'll direct that to Dr. Dr. Begley. What do, what do we do with the immuno-compromised, uh, provider or, or the older uh, clinician?

DR. BEGLEY:

Well, I don't know so much about older clinician, because there is a definition whether at 60, 65, but for sure you don't clinicians with pre-existing conditions, including, you know, being immune, immuno-compromised, know and I referenced, you know, pregnant clinicians earlier. They, you know, most of our occupational health and human resource departments are making appropriate accommodations for those staff. They must, you know, obviously work with, um, their OcMed and HR departments to disclose that but then they, from my experience working with the, uh, nurse across the country. They have been, um, either assigned to areas where there's less risk to the to the clinician or in some cases they've been put on leave.

DR. SZOKOL:

Thank you. Dr. Peterson, this question, question's directed to you. You're a pediatric anesthesiologist, so two-part question. One, should pediatric patients be tested? And, what about bringing their parents into the, um, operating room for induction of anesthesia on pediatric patients?

DR. PETERSON:

So on the first question, pediatric patients should be tested for elective surgery, and we can do the nasopharyngeal testing on pediatric patients just like we do on others. And you know, it's very common for us to do that in RSV season in infants, um, and should be done for prior to elective surgery. Uh, I think most hospitals, right now, are still limiting, um, the number of visitors or caregivers, legal guardians coming in. It's not our practice to have parents in the operating room to begin with. On rare occasions, we might allow it. We usually try to, um, you know, through, you know, premedication or you know other types of, of methods, um, really ensure that the, the family the child is not anxious prior to going in, but this is probably not a good time to have additional people in, and the use of PPE. You're really trying to limit that period of time. Of the number of people that are exposed, um, and we're trying to limit the number of people in our hospital overall.

DR. SZOKOL:

Thank you. So there at=re a lot of questions about testing. What should we do if a patient refused to be tested for COVID-19?

DR. PETERSON:

Well, Dr. Sax, I mean, you're the surgeon, would you just say, no, we're not going to do... (Laughter)

DR. HARRY SAX:

Yeah, I, I think I'd wanna understand, uh, why they didn't want to be tested. Um, if it is an elective case, uh, we would defer the case. If it was, uh, an urgent case, uh, and you know a trauma, uh, where we had to go, we would do it, assuming they were positive with, uh, the you know P APR, and the full, in our COVID OR. But, I, I, we have not had anybody refusing testing. I think, in fact, because of how difficult it is actually to get testing in asymptomatic patients, uh, they're actually quite willing.

DR. PETERSON:

I know, in one of my list serves that I'm on that they were having some parents that were refusing to wear a mask in the hospital, or you know, appropriate masking, and, and I, I think to Dr. Sax's point, you know, we try to accommodate where we can, um, you know, what is the reason for the refusal? You know, one of them was an autistic child that would just freak out or whatever and so it wasn't an urgent procedure, well let's just wait til we're a little bit further down, and we don't have to bring this child in. But if there is no really legitimate reason, um, you know, really we're trying to protect the health care workers and other patients and so, um, you know, we just say it is a requirement, basically.

DR. HARRY SAX:

Yeah, I, I did notice there was a chat that said, that's cuz I'm in Los Angeles, and it wouldn't happen in Oklahoma. Uh, I, I've been to Oklahoma, um, but I would think that, uh, you, you still need to be at you'd be able, be able, to talk to people, if they want to make a choice. Uh, it's our responsibility as healthcare providers, uh, to do the best for the patients, but also to be able to protect, uh, our teammates, and if we feel that's important, we, uh, should, uh, be willing to defer the procedure.

DR. SZOKOL:

And, and what, what about testing in office-based surgeries, one, and do you test for patients even presenting with cataract surgery?

DR. HARRY SAX:

Uh, right now, we are testing for all ambulatory surgeries. I think that uh, we're going to probably see some pull back of that once we get a better idea of the overall community incidence. Um, the argument on cataracts is whether, uh, you're going to do that under, uh, sedation and if there's the risk of the patient needing to be intubated, which potentially could be aerosolizing. That's sort of been, uh, why we've been testing folks if there's any possibility of needing intubation.

DR. SZOKOL:

Thank you. And, and, and, Mary Dale this is for you. Uh, do we think we need to revise sort of the position on LMA use?

DR. PETERSON:

We have had some discussions on our list serve, you know, is this, is it better or worse using an LMA vs. intubating? Um, I think, you know, obviously extubating from an endotracheal tube, you usually have more coughing than you do, uh, taking out an LMA. You know, whether you have a good fit, I think with the LMA, and that's been the concern, um, obviously, if you don't have a good fit with your LMA and, you know, then that can be aerosol producing, but we are I think re-looking at that. We have new FAQ's that are up on, uh, use of LMAs, so, I, I don't see really one is necessarily preferable over the other. I think we've got to protect ourselves with N95s and the full, full PPE, regardless. Um, so I think it really is what your preference, and what you think the patient needs the most.

DR. SZOKOL:

What about, what about, testing who need serial procedures, staged procedures like ECT or Cancer Treatments? How often do you test those patients?

DR. SAX:

Uh, I'll take that one. We do not, wait, let me start, let me back up. If it's an inpatient and they've had a negative test and they don't show COVID symptoms, they don't get retested, uh, if they need a procedure. Uh, if it is, let's say a pediatric oncology patient you may want an initial test. These folks and their families know a whole lot about protecting about neutropenic precautions, avoiding contact and so on, and if they're doing that in the home and using uh, PPE when they're out, without symptoms again, don't see any real reason to re-test. Um, again with ECT and, and it's been a long time since I've done psychiatry, I, if I recall, I don't know if we're still intubating those patients but not, but again assuming that there's been no exposure, and they're uh, doing appropriate social distancing, and they're asymptomatic. I'm not sure everything's needed.

DR. SZOKOL:

So maybe the next when I'll give to Dr. Kaplan. What about the redesign of patient flow in the hospital after reopening? Do we go to divide the OR suite into two separate tracks one for the COVID-positive patient, and one for the COVID-negative patient?

DR. KAPLAN:

So that's a good question. We have not done that, uh, and we uh, we certainly have different procedures for COVID-positive patients and non COVID-positive patients, but we have not segregated the operating room.

DR. SZOKOL:

And, and, Dr. Sax, has, has been that your experience too?

DR. SAX:

Uh, well, what we've been trying to do, is at least for the ambulatory electives that were working down, we're fortunate that we have a, an operating room in a separate building but in the main operating room, we do have some designated COVID rooms that we try to use the patients in, uh, but we do non-COVID patients, uh, on the same floor.

DR. SZOKOL:

Um, and, and a little bit more about what Dr. Kaplan was talking about. The question is about telemedicine. What opportunities do you see for telemedicine in both pre, pre and postoperative care?

DR. KAPLAN:

So, uh, obviously I don't work in the operating room. Uh, I'm not an anesthesiologist or a surgeon but our anesthesiologists are quite excited about it. Uh, they're talking about using it quite extensively to pre-screen patients, to follow-up with patients. So I do think it's going to be adopted. I think what's happening, is that people are finding all sorts of uses telehealth that we weren't even thinking about before the pandemic and so I don't even believe we started to tap the potential and people are quite innovative. Uh, they like the idea of what it can do for efficiency, for flow, uh, for keeping social distancing. Uh, so, I think we're going to see all sorts of applications in and around the perioperative area.

DR. SZOKOL:

Thank you. And, this, this is for all panelists. How will your organization prepared for the potential resurgence of COVID-19. What, what kind of preparedness plans do you have in place, or are looking at?

DR. PETERSON:

Well, I think I'll be grateful that at least we have our policies and procedures, um, that we had to make up, as Harry said earlier on the fly, while flying the airplane. At least we have some experience with how to, to manage through that. We know we may be in the same place that we were a month or so ago before everything, all the elective cases just got cancelled if we are overwhelmed. But I think we have learned that, by, early on in the, in the epidemic. And I think those of us that got hit a little bit later than maybe the East coast and the West coast were able to avoid maybe the worst of it, with um, with the social, um, mitigation measures. And so hopefully those things would be triggered before hospitals become overwhelmed again, at least that would be my hope so that we don't have the situations like we saw in New York City, and I don't know Alan and Harry and the rest, if y'all have other opinions on that.

DR. KAPLAN:

Yeah, so I don't believe we're going to proactively empty our hospitals again, empty our procedure rooms. We have, as you said, we have policies and procedures we didn't have before, we understand the disease before, we know how many of our staff actually catch the disease if we follow the protocols. We have a better supplier, will have a better supply of PPE, and so I see us just ebbing and flowing to the disease burden just like we due to influenza, just like we do, uh, to when we had alleged Legionella issues, so I don't see us proactively stopping procedures the way we did in the past.

DR. SZOKOL:

What types of PPE should be used for elective surgery in patients who test negative for COVID-19 within 48 hours of the procedure? And Dr. Sax is smiling, so maybe I'll direct that question to him.

DR. SAX:

So, I know that I'm a guest in the ASA house here, so, and I've read. We feel, again, because of what we've seen in our testing, a, a very low rate a positive test in asymptomatic patients, well less than 1%, and the need to be appropriate in our use of PPE. If we have an asymptomatic patient, uh, that has tested negative within 48 hours, we use standard universal protocols. We do however, if individual staff want N95s, they can have them. We do recommend that they reuse them throughout the shift.

DR. SZOKOL:

Now for N, so let's talk about PAPRs for example. How do you prioritize PAPRs for, for healthcare providers? And maybe I'll give that one to Dr. Peterson.

DR. PETERSON:

Well, obviously it depends, I think all on, at what, how many you have. Um, you know, we actually prioritize those to those working in our ED's and in our quick care clinics. You know, really more so because of the potential concern in the OR. Um, obviously anybody that is unable to wear an N95, you know, mask, and they would need a, we actually use the cappers, and what we like about them is, um, it's pretty reusable so you don't blow through as much of your in N95 equipment. Um, I think, you know, I think hospitals and will probably be adopting more of those. I think it's a little bit more comfortable to wear for long shifts.

DR. SZOKOL:

And, and what is the protocol for a staff member has come down with COVID-19 to return to work? What's the time frame on that?

DR. PETERSON:

Well, CDC has guidance on, uh, whether you do a test-based or non test-based, so the non test-based is just looking at the amount of time from when they finished having all their symptoms. We have actually preferred, in our institution, to use test-based, uh, but it's interesting because we've had a couple of employees that had, you know, had been exposed by other employees, or the community, and they tested positive and they were asymptomatic and so if you look at the non taste, test-based strategy that CDC recommends, that you could be, you know, able to legitimately use, there were no symptoms that this person ever had to look at a time frame. You know, a week later they could go back to work. Uh, we tested a week later, the individual was still positive, we tested a week after that, we aren't to the third week yet, but it, it was very interesting. And of course, we have all of our, everybody is universal masking, and eye protection for anybody that's doing any patient care at all, for everyone. So it's, it's probably a low-risk, but we had preferred the, the test-based and so we're still waiting and the person's still on medical leave. Um, but, but it is interesting and I don't think we know the answer. And here's part of the problem. The testing that we're doing, using, the PCR test, on the one hand we talked about it, may be missing a few positives. On the other hand, we've known for a long time that PCR picks up, even what I would call, dead fragments of, of the virus, and you know, we've known this in our multiplex respiratory panels, and all for a while, that you can pick up on a PCR test, if somebody's positive for something and

yet they may not be infectious. So that's another challenge is really feel, figuring out, that doesn't necessarily mean infectivity. So we, we obviously have more to learn about this.

DR. SZOKOL:

Thank you. Thank you, Doctor Peterson. And I'd like to thank uh, the listeners for their questions, and I want to thank our panelists for their time during tonight's special ASA ACHE joint webinar.

The slides for tonight's presentation will be available within a next few hours. The on-demand video of this webinar will be available within 24 hours to view at www.asahq.org/townhalls. Dr. Peterson, I now hand it back to you.

DR. PETERSON:

Thank you all for joining us tonight for our special joint webinar with the ACHE. As we move forward together into this new healthcare landscape, it will require a lot of teamwork from hospital administration, nursing and other support staff, anesthesia care team as well as all the positions you are performing surgeries and procedures in patients requiring anesthesia. It is our hope that, armed with new knowledge and lessons learned in the COVID-19 environment, we can effectively and safely begin to re-open our ORs. We will continue to provide you with the necessary resources and answer your questions as we are able, to ensure patient and staff safety. Thank you so much for your time tonight. Please stay well and have a good night.

DR. STRIKER:

Thanks for joining us. We will continue to keep you updated here on Central Line. And, for more information, you can find video of the original Town Hall at asahq.org/covid19info, where additional COVID-19 resources can also be found. Stay safe, and join us again soon.

(OUTRO MUSIC)