Beth Israel Lahey Health

System-wide Recovery Guidelines

Team: **Non-Operative Procedures**
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Introduction
This document offers a set of guidelines and tools to help BILH hospitals plan for the resumption of elective, non-office-based procedural care**.

The Procedural guidelines are organized into the following categories:

I. Prioritization of Clinical Services

II. Operationalization of Infection Control Guidelines
   a. Staff Education
   b. Pre-procedure Testing and Screening

III. Operational Requirements for Resumption of Elective Procedures
   a. Assess Readiness
   b. Assess Staff Availability

IV. Patient Pathway
   a. Pre-procedure Care
   b. Care on Day of Procedure
   c. Post-procedure Care

The following checklists are provided to facilitate assessment of facility readiness to resume elective procedural care (*forthcoming*).

- Screening and testing
- Operational readiness

** Procedures defined as non-operative, non-office-based interventions requiring special rooms and some form of anesthesia. Examples include endoscopy and interventional GI, interventional radiology, interventional cardiology, interventional pulmonology, dermatologic procedures, pain management, wound and hyperbaric oxygen therapy (HBOT), and electroconvulsive therapy (ECT).

I. Prioritization of Clinical Services

A. Each hospital should adopt a cogent patient prioritization system for the purpose of procedural scheduling to maximize efficient use of limited resources while preserving patient equity. This prioritization system may be an existing external algorithm adopted by the institution or internally created and agreed upon by procedural area or service line leadership. The adopted model should be described in writing, representative of all procedural area stakeholders, and transparent to all providers within the procedural area. Scoring systems should consider and provide ranges across the principles listed below.

Prioritization Principles

i. Urgency of procedure based on risk of clinical deterioration if delayed. Cases should be categorized as elective (minimal risk of deterioration), semi-elective (low to moderate risk), and urgent (moderate to high risk). Note that emergency procedures should proceed as per current operational guidelines

ii. Postprocedural risk of physiological complications secondary to COVID-19 infection

iii. Sedation decisions, appropriate to the procedure and patient needs, that can expedite recovery

iv. Use of limited hospital resources
   a. Anesthesia staffing
   b. PPE in procedure room
   c. Recovery stay
   d. ICU bed/stay
   e. Med/Surg bed/stay

B. Each procedural case should be scored according to the prioritization system in place. These scores should be maintained in a tracking database. Each hospital should measure and monitor the percent utilization of the prioritization scoring system within each procedural area.

C. It is recommended that procedure area service line chiefs or medical directors determine the amount of baseline capacity that will be opened (e.g., 25%, 50%, etc.). Service line chiefs or medical directors are responsible for using the agreed-upon prioritization methodology to assign cases to maximize use of opened procedural room capacity.

D. There is an expectation that physicians will have constant communication with their patient list to understand patients' desire and readiness to proceed with the procedure.

E. Utilization of all BILH procedural resources within the system will be considered to allow cross-pollination of available capacity to be matched to patient demand and needs.

II. Operationalization of Infection Control Guidelines

BILH's Infection Control Guidelines can be referenced here. The guidelines below outline recommendations for how these guidelines should be operationalized in the procedural setting.

A. Staff Education

i. To optimize patient care within locally implemented symptom-screening and testing workflows, BILH hospitals must:
   a. Educate staff on COVID-19 symptom and exposure screening questions to be asked of patient, the location of the screening information, and follow-through steps for screen-positive patients,
   b. Educate staff on testing including preferred timing of tests, testing locations, counselling PCR-positive patients, indications and process for rapid testing, and follow-up for PCR-positive patients.

B. Pre-procedure Testing and Screening

i. To minimize the number of visits patients must make to the hospital prior to the procedure, hospitals should, when possible:
   a. Consolidate pre-procedure testing needs (e.g., COVID-19 PCR testing, blood bank testing, etc.),
   b. Facilitate the availability of testing at ambulatory sites rather than the hospital, and
   c. Use virtual care to collect and discuss information.

ii. To maximize symptom and exposure screening and testing of patients, hospitals should assure consistent implementation of policies for screening and pre-procedure testing across all procedure areas. Each procedure area should identify who is responsible for:

   a. Ordering the test,

b. Communicating with the patient regarding the need to be tested and the process, and
c. Following up on test results, including
    - Communicating with the procedural team regarding positive test results, and
    - Communicating with the patient regarding test results and whether to proceed with procedure.

iii. Adopt best-practice telehealth models in use by fellow BILH hospitals. For example, some organizations are conducting pre-procedure symptom screening via a text-messaging-based system, while others are collecting this information via telephone.

iv. To streamline communication around reduction of risk of nosocomial COVID-19 infection, facilities will use BILH-developed FAQs and talking points about transmission risk and the preventive measures in place to ensure the safety of patients undergoing elective procedures.

v. To ensure consistency of messaging to patients and the community, BILH requires hospitals to educate procedural and anesthesiology staff on how to access and use the aforementioned communication tools.

III. Operational Requirements for Resumption of Elective Procedures

BILH has put forward an Operational Readiness Checklist (*forthcoming*). Below are recommendations to supplement this checklist.

A. Assess Readiness

i. Hospitals should create teams focused on longer-term and immediate-term planning and corrective action. Hospitals are encouraged to create a multidisciplinary Recovery Governance Committee to develop local policies and protocols, drive local planning efforts, and ensure readiness criteria are met. This Committee should focus on planning over the longer-term horizon, including identifying the phases of recovery and the targeted volume or capacity utilization for each phase. The Committee should outline the processes by which it can attest that adequate supplies, capacity, screening and testing, staffing and other mitigating conditions are present so that elective procedures can resume responsibly.

ii. The local hospital should establish daily huddles focused on immediate-term planning and operational needs. These huddles bring together front-line providers, staff, and managers to focus on more immediate needs. These huddles might include:

   a. Daily Safety Huddles with nurse manager/director, anesthesiology lead (where appropriate), proceduralists, technician lead, pre-procedure and post-procedure nursing leads

   b. Daily multidisciplinary Recovery Huddles assessing hospital capabilities specific to elective care re-opening, including anesthesiology (if appropriate) and nursing resources, PPE counts and distribution, post-procedure recovery and ICU capacity, and any other “issues of the day”.

iii. Hospitals should share local recovery plans with physicians and staff to allow them to provide input and feedback. Transparency and regular communication will encourage provider and staff engagement and buy-in, while ensuring a more robust recovery plan and unified messaging to patients and the broader community.

   a. Hospitals should evaluate existing communication channels to
   determine whether they need to be adapted or supplemented to meet recovery plan communication needs. Examples of such channels include department meetings, email distribution lists, and intranet sites.

iv. The reclaiming of space and equipment may involve multiple departments and take several days to achieve. To determine whether space/equipment is ready to be reclaimed, and the time required to convert such space, leaders should liaise with colleagues regarding:
   a. Continued need for use by COVID-19 patients,
   b. Cleaning / Environmental services,
   c. Clinical Engineering services, and
   d. Equipment, furniture, and supplies (e.g., will they be cleaned/disinfected and used in space, moved to a COVID-19 care area, or discarded).

v. Local procedural teams should work with their Facilities colleagues to identify signage needs to facilitate patient wayfinding and patient cohorting strategies.

vi. Local procedural teams should work with their Supply Chain colleagues to ensure a robust communication protocol regarding the demand and supply of key supplies, including PPE.

vii. Local procedural teams should work with their Pharmacy colleagues to ensure a robust communication protocol regarding the demand and supply of key medications, including sedatives.

B. Assess Staff Capacity

i. Hospitals are encouraged to build up capacity over time, giving staff time and flexibility to ease into the expanded schedule. Building capacity too quickly may lead to staff burnout and a subsequent ramp down of available procedural time.

ii. Each procedural area should have a designated contact to coordinate with other hospitals regarding physicians who may practice at more than one facility.

IV. Patient Pathway – Recommendations by Periprocedural Stage

A. Pre-procedural Preparation

i. During the scheduling process, hospitals should assess patient readiness to come into the organization and address safety concerns.
   a. Educate all members of the care team on BILH-wide talking points to ensure consistency of messaging to patients.
   b. If patients decline to schedule procedure, record their reason for doing so.

ii. As noted in Section II, hospitals should minimize the need for in-person visits prior to procedure by:
   a. Consolidating testing requirements,
   b. Identifying opportunities to use tele-health:
      - Pre-registration by phone, including any financial clearance conversations,
      - Symptom and exposure screening via telephone or text-based system 48-72 hours prior to procedure, and

- Virtual patient education, including information regarding what to expect the day of the procedure and the need to arrive to the facility wearing a mask or cloth face covering. For patients who do not have a mask or face covering, one will be provided upon arrival.

iii. Local procedural teams should work with their Facilities Department to identify pathways for patients to enter the facility and to follow throughout the procedural visit.
   a. When appropriate, consider having patients wait in car (rather than the waiting room) and call or text when patient should enter the facility. (Hospitals will need to consider cellular reception in areas such as underground parking garages.)
   b. For short procedures, consider having visitors wait in car rather than entering facility.

iv. Periprocedural leaders should educate the team on physical distancing considerations (e.g., waiting areas) and determine how these guidelines will be enforced.

v. To adhere to BILH visitor policies, periprocedural teams should:
   a. Educate patients regarding the BILH visitor/escort policy in advance of the day of the procedure, including sharing expectations regarding symptom/exposure screening and mask use. Visitors and essential escorts should arrive at the facility wearing a mask or cloth face covering; a mask will be provided to those who arrive without one and should be worn at all times in the facility.
   b. Inquire during pre-registration who will accompany patient
   c. Determine where visitors/escorts will wait during the procedure.

vi. Hospitals should assess post-discharge care needs as early in the process as possible to ensure patients' care needs across the continuum are met.
   a. Proceduralist (or designated clinical provider) should complete a checklist to frontload coordination of post-procedure services needed.
   b. Involve case management in conversation prior to procedure.
   c. Prior to booking case, the care team should determine the likelihood that a patient will need to go to post-acute care facility and understand the patient's geographic preference.

- Ensure case management understands facility testing requirements and capacity to accept patients.

B. Care on Day of Procedure

i. Hospitals should have a plan for enforcing compliance with masking, screening, social distancing, visitor/escort protocols, and other Infection Control policies. Hospitals should explicitly identify staff responsible for enforcement.

ii. Providers are encouraged to use regional anesthesia, when appropriate, to avoid intubation and expedite recovery.

C. Postprocedural Care

i. Hospitals should identify opportunities to use tele-health for post-procedure care and teaching to minimize need for patients to return to the facility.
    a. If a patient needs to return to the hospital for an imaging study, for example, the provider can conduct the post-procedure visit via tele-health, if clinically appropriate.

ii. The care team should identify ways to enhance post-procedure teaching (e.g., reinforce during post-procedure phone call), especially as family members might not be with patients during in-person post-procedure instruction.

iii. The care team should utilize home health services to eliminate visit(s) to hospital (e.g., VNA nurse to remove stitches/sutures), when clinically appropriate.