Welcome to Tonight’s Webinar

COVID – 19 Updates
Restarting Surgery: Issues to Consider

Welcome to Tonight’s Webinar

Please submit questions in the control panel

Live Tweet with #ASMBSCOVID
CORONAVIRUS (COVID-19)
ASMBS Webinars: Available online

April 14:
“COVID-19 Updates from the ASMBS”

https://asmbs.org/resources/covid-19-updates-from-asmbs

April 21:
“Embracing Telehealth”

https://asmbs.org/resources/covid-19-updates-embracing-telehealth
Agenda

1. Welcome and Introductions. Matt Hutter, MD

2. Local Resumption of Elective Surgery Guidance. Cliff Ko, MD
   - American College of Surgeons

3. Lessons learned from China. Peng “Charles Zhang, MD
   - Beijing, China

4. Considerations for Restarting Metabolic and Bariatric Surgery in the USA after COVID-19 Eric DeMaria, MD
   - Immediate Past President

Next Webinar: Tuesday 5/5 6 pm EST
Local Resumption of Elective Surgery Guidance

Clifford Y. Ko, MD, MS, MSHS, FACS
Vice Chair and Professor of Surgery, UCLA
Director, Division of Research and Optimal Patient Care, American College of Surgeons
Use this checklist as a guide to ensure issues have at least been considered. Ten Issues in these four categories.

I. COVID-19 Awareness
II. Preparedness
III. Patient Issues
IV. Delivery of Safe High-Quality Care
Use this checklist as a guide to ensure issues have at least been considered.
Ten Issues in these four categories.

1. **COVID-19 AWARENESS**
   1. Know your community’s COVID-19 numbers, including prevalence, incidence, and isolation mandates
   2. Know your COVID-19 diagnostic testing availability and policies for patients and health care workers

2. **PREPAREDNESS**
   3. Promulgate personal protection equipment (PPE) policies for your health care workers
   4. Know your health care facility capacity (beds, intensive care units (ICUs), ventilators), including expansion plans (e.g., weekends)
   5. Ensure OR supply chain/support areas
   6. Address workforce staffing issues
   7. Assign a governance committee

3. **PATIENT ISSUES**
   8. Patient communication
   9. Prioritization protocol/plan

4. **DELIVERY OF SAFE AND HIGH-QUALITY CARE**
   10. Ensuring safe, high-quality, high-value care of the surgical patient across the Five Phases of Care continuum
I. COVID-19 AWARENESS

1. Know your community’s COVID-19 numbers, including prevalence, incidence, and isolation mandates. Know your facility’s numbers as well.
   • Some have recommended that a decrease in measures of COVID-19 incidence for at least 14 days
   • Be aware of possibility of second wave

2. Know your COVID-19 diagnostic testing availability and policies for patients and health care workers.
   • RT PCR – there are many companies with varying testing characteristics (i.e., sensitivity, specificity).
   • Develop local diagnostic testing policies for patients
II. PREPAREDNESS

3. Promulgate personal protection equipment (PPE) policies for your health care workers
   • What level of PPE is needed? Who in the OR should be wearing what? High risk procedures (e.g., intubation) – consider wait times.

4. Know your health care facility capacity (beds, intensive care units (ICUs), ventilators), including expansion plans (e.g., weekends)
   • How is your facility resuming OR procedures?

5. Ensure OR supply chain/support areas
   • PPE
   • Other

6. Address workforce staffing issues
   • Especially in light of resumption of “elective” surgery, possible expansion, individual staff issues (health, well-being, childcare, etc)

7. Assign a governance committee
   • Several issues including prioritization
III. PATIENT ISSUES

8. Patient communication
   • Messaging-Communication
     • Procedure prioritization
     • COVID testing
     • PPE use
     • Isolation
     • Consent
     • Other

9. Prioritization protocol/plan
   • Collaborative process
   • Sensitive to institution’s resources, priorities, and patient needs
IV. DELIVERY OF SAFE, HIGH-QUALITY CARE

10. Ensuring safe, high-quality, high-value care of the surgical patient across the Five Phases of Care continuum.

• Preoperative
• Immediate Preoperative
• Intraoperative
• Postoperative
• Post Discharge
Thank you and Be Safe
Questions?

? Please submit questions with the chat function in the control panel....
Lessons learned from China:

Impact of COVID-19 on Bariatric Surgery

and How to Restart Your Practice

Peng (Charles) Zhang, MD PhD FACS
Chief, Metabolic and Bariatric Surgery
Beijing Friendship Hospital, Capital Medical university
Beijing, China
Outbreak of COVID-19 in China

Confirmed Cases Over Time

84,237 confirmed cases

Deaths Over Time

4,642 deaths

Data Source: World Health Organization
Pandemic pattern of outbreak of respiratory illness

Source: CDC’s “Updated Preparedness and Response Framework for Influenza Pandemics.”
84,237 confirmed cases

4,642 deaths

Source: World Health Organization
Confirmed Cases Over Time

84,237 confirmed cases
Source: World Health Organization

Deaths Over Time

4,642 deaths
Source: World Health Organization

Elective Surgery Discontinued Jan 25

Elective Surgery Resumed With COV Screening Mar 16

Elective Surgery Resumed Without COV Screening ???
Elective Surgery Discontinued Jan 25

Elective Surgery Resumed With COV Screening Mar 16

Elective Surgery Resumed Without COV Screening ???

Confirmed Cases Over Time
84,237 confirmed cases
Source: World Health Organization

Deaths Over Time
4,642 deaths
Source: World Health Organization
Classification of Surgery

- **Emergency surgery**: Delay might forever damage a patient’s health, significantly reduce function, or cause death.
- **Semi-elective surgery**: To preserve health, life, or bodily function, but there is a larger window of time in which they can be performed.
- **Elective surgeries**: Performed for conditions that don’t necessarily imply health risk.

Classification of Patient Cohorts

- **Cohort A**: Suspected / confirmed COVID-19 patients
- **Cohort B**: Patients under quarantine due to closed contact with COV-RNA positive/suspected patients
- **Cohort C**: Confirmed without COVID-19 infection
Patients in emergent/urgent condition

- Patient Cohort C
  - Semi-elective
    - Further COVID testing
      - Confirmed no Infection: Continue surgery
      - Suspected or Confirmed: Postpone surgery

- Patient Cohort B
  - Emergency Life saving

- Patient Cohort A
  - Elective or Semi-elective
    - Cancel/postpone surgery

- Emergency surgery
Patients in emergent/urgent condition

- Patient Cohort C
  - Semi-elective
  - Further COVID testing
    - Confirmed no Infection
      - Continue surgery
    - Suspected or Confirmed
      - Postpone surgery

- Patient Cohort B
  - Emergency Life saving

- Patient Cohort A
  - Elective or Semi-elective

**Level 1 PPEs**
- Confirmed no Infection
  - Continue surgery

**Level 2/3 PPEs**
- Suspected or Confirmed
  - Postpone surgery
- Emergency surgery
- Cancel/postpone surgery
# Levels of PPEs

<table>
<thead>
<tr>
<th></th>
<th>White coat/Scrub</th>
<th>disposable surgical cap</th>
<th>disposable gloves</th>
<th>disposable shoe cover</th>
<th>anti-fog safety glasses/face shield</th>
<th>disposable surgical gown</th>
<th>protective coverall suit</th>
<th>disposable surgical masks</th>
<th>N95 masks or higher</th>
<th>Full face respirator or positive pressure headgear</th>
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<tr>
<td><strong>Level 1</strong></td>
<td>✓</td>
<td>✓</td>
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<td><strong>Level 2</strong></td>
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<tr>
<td><strong>Level 3</strong></td>
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</tbody>
</table>
Goals of protection

- Protect our patients
- Protect ourselves
- Protect our coworkers
- Protect our family members & relatives
- Protect our communities

- In ER / Fever clinic
- Transferring to OR
- In OR
- After operation
- During recovery
- Going home
On route to OR

- Designated outpatient examination area (Fever clinic)
- **Designated patient transporting route**
  - Appropriate PPEs during transporting: patient fully covered, surgical face mask, face shield, disposable surgical cap
  - Transport personnel (Level 2/3 protection): Disposable protective coverall suit, shoe cover, double gloves, N95 masks, face shield/eye protection
  - Spraying disinfectant (500mg/L Chlorine containing disinfectant) following the route
  - Disinfecting elevators
Inside OR

• **Negative pressure system OR strongly recommended**

• Have minimum number of personnel in the OR. No visitors or observers

• Level 2/3 protection required: disposable protective coverall suit & impermeable gowns, shoe cover, double gloves, N95 masks, face shield

• Intubation risks, surgeons and personnel not needed for intubation should remain outside the OR until anesthesia induction and intubation are completed

• **Consider avoiding laparoscopy and endoscopy**

• Minimizing the use of electrocautery and ultrasonic devices (low power setting and avoidance of long desiccation times)

• Minimizing the use of drainage tubes, urinary catheter, nasogastric / orogastric tube, gastric feeding tube, etc.
Laparoscopic surgery

- Laparoscopic suction is recommended to remove surgical plume and desufflate the abdominal cavity (do not vent pneumoperitoneum into the room)
- Use lower intra-abdominal pressure (10-12mmHg) if feasible
- Avoid rapid desufflation of pneumoperitoneum
- Specimen extraction should be performed with minimal CO$_2$ escape
- Minimize blood/fluid droplet spray or spread
- Minimize leakage of CO$_2$ from trocars (check seals)
After operation

• **Cohort A patients:** transfer to a designated room or hospital

• **Cohort B patients:** waiting for COV-RNA in OR. If negative, transfer back to ward, if positive, transfer to a designated room or hospital, if can’t confirm, treat as Cohort A patients

• Change PPEs when exiting OR

• Disposables contained

• Minimum number of transport personnel
During recovery / going home

- Single isolated patient room
- Designated personnel with level 2 PPEs
- ERAS protocol is preferred
- Do not discharge until COV-RNA becomes undetectable for at least two consecutive days (>24 hour interval)
Continue to take care of our patients

• Online seminars
• Tele-consultations
• Non-surgical weight loss approaches should be prioritized
84,237 confirmed cases

4,642 deaths

Elective Surgery Discontinued Jan 25

Elective Surgery Resumed With COV Screening Mar 16

Preparation for restart
Elective / Semi-elective surgery

COVID Screening

Patient Cohort B

Patient Cohort C
- Continue surgery

Wait 2 wks, Re-Screening

Patient Cohort A
- Postpone surgery
 Elective / Semi-elective surgery

COVID Screening

Patient Cohort B

Wait 2 wks, Re-Screening

Patient Cohort C

Continue surgery

Patient Cohort A

Postpone surgery

Level 1 PPEs

Continue surgery
COVID-19 Screening protocol

- Travel history
- Symptoms: Fever, cough, shortness of breath, etc.
- CBC & CRP
- Chest CT
- COV-RNA test (A must since April 27)
Thanks for your attention!
Questions?

? 

Please submit questions with the chat function in the control panel....
Considerations for Re-Starting Bariatric / Metabolic Surgery in the USA after COVID-19

Eric J. DeMaria, MD
Director of Bariatric Surgery
East Carolina University
Per ACS- Bariatric / Metabolic procedures

Elective
(May be delayed for months without threat to life or organ damage)

Bariatric: primary gastric bypass, sleeve, duodenal switch, gastric band

Revisions for weight gain
Post-ponement of elective procedures

Bariatric Surgery = Elective Surgery

We have fought for decades to remove the elective label!
The ASMBS strongly disagrees with the concept that bariatric surgery is an ‘elective’ procedure

Underlying implication: a type of cosmetic procedure.
Only ‘elective’ in the sense that there is flexibility in scheduling

Bariatric surgery is life-saving surgery, with survival benefit for patients treated by surgery over those treated without surgery
Primary bariatric procedures allow flexibility in scheduling...like many other operations

- During the pandemic we have prioritized cases based on whether or not harm would occur if delayed—more urgent cases have been triaged ahead of less urgent cases.
- However once we start operating on the “flexible scheduling category” how do we prioritize this (very large) group?
Not all Bariatric and Metabolic Procedures are EQUAL!

• In terms of **URGENCY**
  – Transplant candidates, pseudotumor cerebri – clock is ticking

• In terms of **SURGICAL RISK**
  – Patients who are optimized after months of preparation

• In terms of **COVID RISK**
  – Obesity, diabetes, HTN, heart disease increase risk of bad outcome
Patients with obese / associated comorbidity
Note- also an issue for non-bariatric operations

• Higher risk of a bad outcome from COVID-19
• Do we prioritize the low risk, low / zero comorbidity patient
  – we have gotten so good at what we do, how would we justify a bad outcome in such a patient when there was no urgency to move forward with surgery
  
  or

• Do we prioritize the higher risk / higher comorbidity patient
  – This is usually the group we prioritize for treatment however more likely to have a bad outcome if COVID infection occurs
Re-start plans: NOT Business as usual!
Basic Concerns-

• Local conditions
  – COVID status – curve flattening
  – Testing status- for pre op patients
  – Hospital status- ICU’s, ventilators
  – PPE status
  – HCW status
Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic

Vivek N Prachand, MD, FACS¹, Ross Milner, MD, FACS², Peter Angelos, MD, FACS³, Mitchell C Posner, MD, FACS⁴, John J Fung, MD, FACS⁵, Nishant Agrawal, MD, FACS⁶, Valluvan Jeevanandam, MD, FACS⁷, Jeffrey B Matthews, MD, FACS⁸

¹Department of Surgery, University of Chicago Medicine and Biological Sciences, Chicago, Illinois

<table>
<thead>
<tr>
<th>Variable</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>OR time, min</td>
<td>&lt; 30</td>
<td>30-60</td>
<td>60-120</td>
<td>120-180</td>
<td>≥180</td>
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<td>Estimated LOS</td>
<td>Outpatient</td>
<td>&lt;23 hrs</td>
<td>24-48 hrs</td>
<td>≤3 d</td>
<td>&gt;4 d</td>
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<tr>
<td>Postop ICU need, %</td>
<td>Very unlikely</td>
<td>&lt;5</td>
<td>5-10</td>
<td>10-25</td>
<td>≥25</td>
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<tr>
<td>Anticipated blood loss, cc</td>
<td>&lt; 100</td>
<td>100-250</td>
<td>250-500</td>
<td>500-750</td>
<td>≥750</td>
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<tr>
<td>Surgical team size, n</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>&gt;4</td>
</tr>
<tr>
<td>Intubation probability, %</td>
<td>≤1</td>
<td>1-5</td>
<td>5-10</td>
<td>10-25</td>
<td>≥25</td>
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<tr>
<td>Surgical site</td>
<td>None of the following</td>
<td>Abdominopelvic MIS Surgery</td>
<td>Abdominopelvic open surgery, infraumbilical</td>
<td>Abdominopelvic open surgery, supraumbilical</td>
<td>OHNS/upper GI/thoracic</td>
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## Patient comorbidity factors in MeNTs

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
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<tbody>
<tr>
<td>Age, y</td>
<td>&lt;20</td>
<td>20-40</td>
<td>40-50</td>
<td>50-65</td>
<td>&gt;65</td>
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<tr>
<td>Lung disease (asthma, COPD, CF)</td>
<td>None</td>
<td>--</td>
<td>-</td>
<td>Minimal (rare inhaler)</td>
<td>Minimal</td>
</tr>
<tr>
<td>Obstructive sleep apnea</td>
<td>Not present</td>
<td>-</td>
<td>-</td>
<td>Mild/moderate (no CPAP)</td>
<td>On CPAP</td>
</tr>
<tr>
<td>CV disease (HTN, CHF, CAD)</td>
<td>None</td>
<td>Minimal (no meds)</td>
<td>Mild (≤ 1 med)</td>
<td>Moderate (2 meds)</td>
<td>Severe (≥ 3 meds)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>None</td>
<td>-</td>
<td>Mild (no meds)</td>
<td>Moderate (PO meds only)</td>
<td>&gt; Moderate (insulin)</td>
</tr>
<tr>
<td>Factor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>Nonoperative treatment option</td>
<td>None available, &lt;40% as effective as</td>
<td>Available, 60% to 95% as effective as</td>
<td>Available, equally effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>effectiveness</td>
<td>surgery</td>
<td>surgery</td>
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<td></td>
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</tr>
<tr>
<td>Nonoperative treatment option</td>
<td>Significantly worse/not applicable</td>
<td>Somewhat worse</td>
<td>Equivalent</td>
<td>Somewhat better</td>
<td>Significantly better</td>
</tr>
<tr>
<td>resource/exposure risk</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Impact of 2 wk delay</td>
<td>Significantly worse</td>
<td>Worse</td>
<td>Moderately worse</td>
<td>Slightly worse</td>
<td>No worse</td>
</tr>
<tr>
<td>in disease outcome</td>
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<td>Worse</td>
<td>Moderately worse</td>
<td>Slightly worse</td>
<td>No worse</td>
</tr>
<tr>
<td>in surgical difficulty/risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Impact of 6 wk delay</td>
<td>Significantly worse</td>
<td>Worse</td>
<td>Moderately worse</td>
<td>Slightly worse</td>
<td>No worse</td>
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We may not have as many cases to do as we think...

Economic downturn - less money for co-pays, deductibles, etc.

Unemployment

Changes in health insurance status – loss or government pay

Challenges completing pre op requirements

Difficulty obtaining new insurance authorizations for re-scheduled patients (previously approved)

   even getting someone on the phone can be a challenge!
   need a reliable date of surgery

Fear of COVID!       Local estimate in NC of 30%
34 surgical cases in early asymptomatic phase of COVID

- 15 (44.1%) patients required admission to intensive care unit (ICU) during disease progression, and 7 patients (20.5%) died after admission to ICU

- Bad outcome: older, comorbidities, more difficult surgeries
4 gastric bypass cases 1, 2, 4, and 14 days after surgery-3 required readmission (2 ICU), ultimately all survived
### Unemployment and Loss of Insurance—also increases in Medicaid coverage

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Unemployment Rate</th>
<th>Medicaid</th>
<th>US Population (in millions)</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-COVID</td>
<td>3%</td>
<td>71</td>
<td>13</td>
<td>163</td>
</tr>
<tr>
<td>Low</td>
<td>10%</td>
<td>82</td>
<td>12-13</td>
<td>151</td>
</tr>
<tr>
<td>Medium</td>
<td>17.5%</td>
<td>88</td>
<td>13-14</td>
<td>140</td>
</tr>
<tr>
<td>High</td>
<td>25%</td>
<td>94</td>
<td>13-15</td>
<td>128</td>
</tr>
</tbody>
</table>

Consider participating / impact of an increase in government pay on your practice
Preop patients “in the funnel” heading to surgery

a. Maintain contact / enthusiasm / motivation- telehealth options
b. Stretch pre-op care (lifestyle modification, pharmacotherapy…)
c. Find out the impact on their lives / insurance status etc.
d. ? More Surgery in ASC/OP

Bigger picture issues – local / national payer considerations
a. Relief from payers on pre-op conditions
b. Reducing / eliminating pre-op diet qualifications
Questions?

? Please submit questions with the chat function in the control panel....
Surgical Community Letters to HHS

April 21 HHS and CMS
- Telehealth and Other Non-Face-to-Face Services
- Accelerated and Advance Payments Program
- Prior Authorization
- Global Surgery Data Collection
- Preoperative History and Physical Requirements
- PPE/Essential Medical Equipment Distribution and Access
- Public Health and Social Services Emergency Fund

April 24 HHS, CMS and National Coordinator for Health Information Technology
- CMS Quality Payment Program (QPP)
- CMS Final Rule on Advancing Interoperability & Patient Access to Health Data
- ONC Final Rule on Interoperability, Information Blocking and the ONC Health IT Certification Program
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Going Forward:

• Regularly scheduled webinars with issues important to our members:

  **Next Webinar:**
  
  *Tuesday May 5, 6 pm EST:*
  
  Independent/Community Practices – Surviving COVID-19

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*Please let us know what matters most to you!*

[communications@asmbs.org](mailto:communications@asmbs.org)

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*Please share with us stories of how your colleagues are making an impact!*
Support your patients.
Help out however you can.
Use the opportunity to transform how we provide care.

Stay safe!