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Guidance on Resumption and Continued Provision of Non-Emergent and Elective Procedures at Hospitals

Background: On March 19, 2020, Governor Brown issued Executive Order No. 20-10 to cancel all elective and non-urgent health care procedures that require personal protective equipment (PPE) effective March 23, 2020. On April 27, 2020, Governor Brown issued Executive Order No. 20-22, which allows hospitals and other care settings to resume elective and non-emergent procedures that require PPE, starting May 1, 2020, if the criteria in this Oregon Health Authority (OHA) guidance can be met.

Authority: Executive Order No. 20-22, ORS 433.443, ORS 431A.010, ORS 441.025

Applicability: This guidance is applicable to a hospital licensed under ORS 441.025 and any office or facility that operates under the hospital's license, regardless of the type of services that are provided at the office or facility.

Guidance

Definitions: For purposes of this guidance, the following definitions apply:

- "CDC" means the U.S. Centers for Disease Control and Prevention.
- "PPE contingency capacity strategies" means policies and procedures adopted during times of resource constraint or surges in healthcare need as described in OHA and Oregon Occupational Safety and Health Administration (OR-OSHA)'s Interim Guidance: Use of Personal Protective Equipment by Healthcare Personnel in Resource-Constrained Settings.
- "Crisis standards of care" means standards of care for non-conventional conditions (i.e., contingent or crisis conditions) as described in Oregon's Crisis Care Guidance.
- "Elective and non-emergent procedures" means procedures that require PPE and that will not result in irreversible harm to the patient if delayed for up to 90 days.
- "PPE crisis capacity strategies" means a set of strategies used by facilities in face of severe PPE shortages as described in OHA and Oregon Occupational Safety and Health Administration (OR-OSHA)'s Interim Guidance: Use of Personal Protective Equipment by Healthcare Personnel in Resource-Constrained Settings.
- "FDA" means the U.S. Food and Drug Administration.
- "Hospital bed availability" means the availability of staffed intensive care unit (ICU), step-down, and medical/surgical beds.

- "Large hospital" means a hospital licensed under ORS 441.025 with 50 or more licensed beds, but does not include a rural hospital.
- "NIOSH" means the National Institute for Occupational Safety and Health which is a part of the CDC.
- "Non-emergent" means not urgent.
- "Open supply chain" means having a contract in place with a vendor that allows for sustained PPE supply with no reliance on local or state government to fulfill PPE requests.
- "Personal protective equipment' or "PPE" means medical grade gloves, gowns, face shields, surgical masks, N-95 and single-use respirators or other reusable respirators (e.g., powered air purifying respirators) that is intended for use as a medical device.
- "Region" means the region within which a hospital is located, according to Oregon's existing Health Preparedness Program (HPP) regions which align with the Oregon Area Trauma Advisory Board (ATAB) regions as defined in OAR 333-200-0040.
- "Regional resource hospital (RRH)" means a hospital that has entered into agreement with the Oregon Health Authority to serve as the regional hospital bed management and transfer center for one or more regions during the COVID-19 emergency.
- "Rural hospital" has the meaning given that term in ORS 442.470.
- "Small hospital" means:
  - A hospital licensed under ORS 441.025 with fewer than 50 beds.
  - A rural hospital.
- "Threat of irreversible harm" includes:
  - Threat to the patient's life;
  - Threat of irreversible harm to the patient's physical or mental health;
  - Threat of permanent dysfunction of an extremity or organ;
  - Risk of cancer metastasis or progression of staging; and
  - Risk of rapidly worsening condition (i.e., need for the procedure is time-sensitive).

I. Criteria for hospitals to resume or continue providing elective and non-emergent procedures

A. Hospital Capacity

The hospital bed availability at the hospital, as well as the healthcare workforce must be able to accommodate an increase in COVID-19 hospitalizations, post-procedure hospitalizations and other ongoing needs for hospital level of care. Specifically:

1. Hospital bed availability in the region must be able to accommodate a 20% increase in suspected or confirmed COVID-19 hospitalizations compared to the number of suspected or confirmed COVID-19 hospitalizations in the region at the time Executive Order No. 20-22 was issued.
2. A hospital must be able to treat all patients requiring hospitalization without resorting to crisis standards of care.

B. Adequate PPE supplies

1. A hospital must have adequate PPE supplies on hand that have been approved by the NIOSH or FDA for use in medical settings. Adequate PPE supplies requires that:

   a. A large hospital must have an adequate 30-day supply of PPE on hand appropriate to the number and type of procedures to be performed or an open supply chain.

   b. A small hospital must have an adequate 14-day supply of PPE on hand appropriate to the number and type of procedures to be performed or an open supply chain.

   c. The hospital implements and sustains conventional strategies, Tier I or Tier 2 PPE contingency capacity strategies for PPE usage guidelines as detailed in OHA and Oregon Occupational Safety and Health Administration (OR-OSHA)'s Interim Guidance: Use of Personal Protective Equipment by Healthcare Personnel in Resource-Constrained Settings. Hospitals may only use Tier 2 PPE contingency capacity standards if conventional strategies and Tier 1 PPE contingency strategies are not sustainable. Engineering and administrative control measures must be fully implemented to the extent possible before implementing PPE contingency capacity strategies.

      The hospital must cancel non-emergent and elective procedures if a hospital needs to institute PPE crisis capacity strategies (i.e., Tier 3 and 4 strategies). Any hospital that needs to use Tier 3 or 4 PPE strategies must notify OHA immediately.

2. Each hospital in Oregon must have a PPE Safety Committee operating by September 1, 2020, in order to continue providing non-emergent and elective procedures. The primary purpose of the Committee is to establish a collaborative venue to ensure worker safety and to promote safe patient care. The Committee's tasks, responsibilities and membership must follow the July 20, 2020 recommendations submitted by the Workgroup on PPE Guidance for Non-Emergency and Elective Procedures.

3. Each hospital must have an internal accountability process to address complaints about PPE safety and ensure that procedures for addressing PPE complaints comply with state and federal regulatory requirements regarding employee safety. The hospital's internal accountability process must follow the July 20, 2020 recommendations submitted by the Workgroup on PPE Guidance for Non-Emergency and Elective Procedures.

4. Hospitals must regularly report standardized information about PPE supplies through Oregon's Hospital Capacity web system (HOSCAP). OHA shall make the reports publicly available.

   a. Beginning August 15, 2020, hospitals must submit weekly reports of the following PPE data through HOSCAP:

      i. Days on hand

      ii. Burn rate

      iii. Current inventory

   b. As soon as possible, hospitals must also report on the use of reprocessed masks.

5. Hospitals must begin sharing the data in subsection 4 above with hospital staff by August 15, 2020 and with their PPE Safety Committee as soon as that group is formed.

6. A hospital must submit a form, prescribed by OHA, that attests that the facility meets the PPE requirements in this guidance. If a health system's PPE supplies on hand are calculated at a health system level, the health system must attest that it can meet the PPE requirements in this guidance for each of its facilities using this form. Hospitals must ensure that the attestation on file is consistent with current OHA guidance and immediately notify OHA if it no longer meets the requirements in this guidance.

The attestation form can be found here.

C. Strict infection control and visitation policies

1. A hospital must implement strict infection controls in accordance with OHA guidance.

2. A hospital must have and implement visitation policies that are consistent with OHA's visitation guidance. OHA's visitation guidance can be found here.

D. Resources for peri-operative care

A hospital must ensure that patients have access to pre- and post-operative visits with necessary providers, laboratory, radiology and pathology services, and other necessary ancillary services before proceeding with non-emergency or elective procedures.

II. Procedure volume and patient prioritization

A. A hospital must have and implement a written plan to reduce or stop non-emergent and elective procedures if a surge/resurgence of COVID-19 cases occur in its region or if any of the criteria in Section I. of this guidance cannot be met. A hospital must provide OHA with a copy of this plan upon request.

1. A hospital must prioritize non-emergent and elective procedures based on whether their continued delay will have an adverse medical outcome for a patient.

   a. The hospital Chief Executive Officer must appoint or delegate authority to appoint to the chief medical officer, a medical committee to review and prioritize cases based upon indication and urgency in situations where procedures must be limited.

2. A hospital must strongly consider and balance the risks and benefits of performing non-emergent and elective procedures for patients at higher risk of contracting COVID-19, such as those over age 60, those with compromised immune systems, or chronic lung or heart disease.

3. A hospital must consider ongoing postponement of non-emergent and elective procedures that are expected to require any of the following:

   a. Transfusion

   b. Use of pharmaceuticals that are in short supply

   c. ICU admission

   d. Transfer to skilled nursing facility or inpatient rehabilitation

III. Reporting, monitoring and enforcement

A. Hospitals must:

1. Continue to report all PPE supplies, COVID-19 hospitalizations and hospital bed availability through HOSCAP.
2. Monitor the region's hospital bed availability through one or more of the following:
    a. Oregon's Hospital Capacity web system (HOSCAP).
    b. Any other data tool that allows for real-time monitoring of the region's hospital bed capacity.
    c. The regional resource hospital (RRH) if established.
3. Comply with a request for information from OHA immediately, upon request.
4. Monitor compliance with this guidance and cease performing non-emergent and elective procedures should the hospital no longer be able to meet these requirements.

B. Enforcement

1. If OHA finds that a hospital or region is not meeting the criteria in Section I of this guidance or is not complying with other provisions of this guidance, OHA will issue a warning letter to the hospital informing the hospital that it must cease performing non-emergent or elective procedures until it can again meet criteria.
2. If a hospital is found to be in repeat non-compliance with this guidance OHA may issue civil penalties or take other enforcement actions.
3. If OHA finds that multiple hospitals are failing to comply with the guidance, it will request that the Governor reimpose the restriction on all non-emergent and elective procedures.

Document Accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact Mavel Morales at 1-844-882-7889, 711 TTY or OHA.ADAModifications@dhsoha.state.or.us.