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Frequently Asked Questions Regarding Guidance for Resumption of Non-Emergent and Elective Procedures

On April 30 and May 1, 2020, the Oregon Health Authority (OHA) issued guidance implementing the Governor's Executive Order (EO) 20-22 that allowed the resumption of non-emergent and elective procedures on and after May 1, 2020. Hospitals, ambulatory surgery centers (ASC), medical and dental offices, veterinary clinics, and other care settings must comply with OHA's guidance before resuming non-emergent and elective procedures. The guidance can be found at www.healthoregon.org/coronavirus[1]. The information below is intended to clarify aspects of the guidance.

General:

What does the term "procedure" mean for the purposes of this guidance?

A procedure means the provision of health care *that requires personal protective equipment* (i.e., even before the COVID-19 pandemic) and includes but is not limited to:

- An instrument or device being inserted into the body through the skin or a body orifice for diagnosis or treatment.
- Operative procedures in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.

What is a "non-emergent or elective" procedure?

A non-emergent or elective procedure is one that, if delayed, would ***not*** put the patient at risk of irreversible harm. A 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).

[1] The OHA guidance documents on resuming non-emergent and elective procedures can be found at www.healthoregon.org/coronavirus in the following locations: 1) under the "OHA Guidance and Rules" tab, or 2) on the "Healthcare Partners" page under the "Healthcare Providers and Clinical Laboratories" tab.

Any procedures that, if delayed, would put the patient at risk of irreversible harm should continue and are not subject to the requirements in this guidance.

Does EO 20-22 indicate that the health care system is back to normal?

No. Most health care settings are operating in new ways in response to the COVID-19 pandemic in order to reduce the exposure to and transmission of SARS-COV-2. In addition, the health care system has faced significant financial impacts due to COVID-19. While EO-22 allows non-emergent and elective procedures to resume if the criteria outlined in the guidance are met, these procedures must start slowly and must be prioritized based on indication and urgency.

Can health care clinics re-open now that Governor Brown has issued EO 20-22?

Health care clinics were never required to close in Oregon under either EO 20-10 or EO 20-12. EO 20-10 issued March 23, 2020, only canceled elective and non-urgent procedures that utilized PPE but did not impact a health care clinic that wanted to provide other health care services. EO 20-12 specifically states that the required closures do not apply to "health care, medical, or pharmacy services."

Under EO 20-12 medical spas, facial spas, day spas, and non-medical massage therapy services are required to remain closed.

For a facility (i.e., an ambulatory surgical center; medical, dental or other health care facility) operating under a hospital's license, which OHA guidance do they need to follow?

Any facility that operates under a hospital's license must follow the hospital guidance for resuming nonemergent and elective procedures.

Physical Distancing:

Am I required to maintain a distance of at least 6 (six) feet between staff and patients except during a procedure, or is that just a recommendation?

It is a strong recommendation. An office should implement, to the extent possible, physical distancing measures within waiting rooms and other areas of the office.

How can I best limit the number of people in a waiting area?

The following are some best practices:

- To the extent possible, have patients wait in their cars before entering your facility, and contact them when it is time for their procedure.
- Ask patients if they are bringing someone with them, so you know whether to expect more than just the patient.
- Ask anyone waiting to take a patient home after a procedure to wait outside the facility and call them when the patient is ready to be picked up.

Can I use curtains between patients during post-procedural and post-surgical recovery in place of physical distancing?

Curtains may be used for patient privacy but should not be a substitute for physical distancing. Post-procedural and post-surgical recovery areas should be reconfigured to maintain, to the

extent possible, 6 feet of distance between each patient. For example, leaving one empty bed, chair or stretcher between patients could maintain adequate distancing. If curtains are used between patients; they should be non-permeable and easy to disinfect. Cloth curtains are not recommended because they can become contaminated and theoretically lead to indirect transmission of SARS-CoV-2 virus or other pathogens. Ensure that your physical distancing measures allow for appropriate monitoring after a procedure.

Personal Protective Equipment (PPE):

The guidance requires that a facility must be able to sustain "recommended PPE use for its health care workforce." What is the recommended PPE use for the health care workforce?

PPE supplies should be used responsibly to ensure their availability for any potential urgent procedures in a facility. PPE strategies should be supplemented by source control and effective hand hygiene; standard precautions should always be used.

For procedures requiring contact and droplet protection, recommended PPE includes:

- Face mask (i.e., surgical or procedural mask)
- Eye protection (face shield or goggles)
- Gown
- Gloves

While performing aerosol-generating procedures, health care personnel should also wear a fit-tested[2] N95 respirator or higher respiratory protection. A limited list of aerosol-generating procedures can be found in Appendix I of OHA's guidance on infection control here.

OHA guidance for resuming non-emergent and elective procedures specifies that PPE used during health care procedures must be medical grade, follow Oregon Occupational Safety and Health Administration rules and be approved by the National Institutes of Occupational Safety and Health (NIOSH; see list of NIOSH-approved respirators) or by the U.S. Food and Drug Administration (FDA; see list of emergency use authorized PPE and a COVID-19 medical device information website to answer questions about PPE).

What is the recommended PPE use for health care providers in dental offices?
Dental health care personnel should use the PPE appropriate for the type of procedures performed (i.e., PPE for contact, droplet, and aerosol-generating procedures) as outlined above. Dental settings have unique characteristics that warrant additional infection control considerations. The CDC has issued infection control guidance for dental offices that provides more information on PPE use for these settings here. While the CDC currently recommends that elective procedures, surgeries, and non-urgent dental visits be postponed, OHA recognizes that as delays lengthen, dental procedures grow in urgency, threatening a patient's dental and overall health. Oregon dental offices may resume elective and non-urgent procedures according to EO 20-22 if the criteria issued in OHA's guidance can be met.

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[2] Annual fit testing is generally required by federal Occupational Safety and Health Administration (OSHA) for employees using N95 respirators. OSHA suspended for the COVID-19 the requirement that this be done annually; however, an initial fit testing is still required. See it here.

Is use of NIOSH-approved alternatives to N95 respirators acceptable in meeting PPE requirements to begin offering non-urgent and elective procedures?

Yes. The FDA has issued emergency use authorization to authorize all NIOSH approved particulate-filtering air purifying respirators (APRs) to be used in health care settings, including all NIOSH-approved filtering facepiece respirators, elastomeric APRs, and powered air purifying respirators. However, use of expired NIOSH-approved filtering facepiece respirators, and respirators that have been decontaminated pursuant to the terms and conditions of an authorized decontamination system are not included as part of a standard, on-going approach to ensuring PPE availability.

Does home-made PPE count toward my supply of PPE that is required under the guidance?

No, in order to be counted in the required days of PPE on-hand under the guidance, the PPE must be medical grade and meet the standards set by the Oregon Occupational Safety and Health Administration, the National Institute for Occupational Safety and Health and the U.S. Food and Drug Administration.

Can any health care personnel or patients use non-medical grade PPE, such as home-made face coverings?

All health care providers involved in direct patient care must use medical grade PPE. Health care staff not involved in direct patient care as well as patients and caregivers can use home-made face coverings, in accordance with the following guidance for the general public here.

Testing:

The guidance states that when adequate testing is available, facilities should consider screening patients by laboratory testing for SARS-COV-2 before a nonemergent or elective procedure. What factors should be considered when determining whether to order pre-procedural laboratory testing?

There is currently no evidence that pre-procedural COVID-19 viral testing prevents health care worker infection, and there is currently no evidence-based recommendation on the ideal timing for when to collect a pre-procedural viral test. Facilities may choose to order pre-procedural laboratory testing for SARS-COV-2 prior to proceeding with nonemergent or elective procedures for asymptomatic patients in order to inform:

- PPE usage i.e., whether to use a higher-level respiratory protection.
- Whether to proceed with the nonemergent or elective procedure i.e., if the procedure would confer greater risk for an asymptomatic carrier.
- Patient cohorting in the facility during post-procedure recovery.

When considering pre-procedure testing, the following factors should be considered:

(1) The prevalence of SARS-COV-2 in the area and the sensitivity of the COVID-19 test being used; a false negative test can increase the provider's risk of COVID-19 exposure if appropriate PPE is not worn during the patient encounter.

(2) The timing of the test. It is important to note that a patient incubating the SARS-CoV-2 virus could have a negative virus test on one day, then become positive and

contagious the following day. There is currently no evidence-based recommendation on the ideal timing for when to collect a pre-procedural viral test.

COVID-19 Reporting:

Do facilities (i.e., hospitals, ASCs, or medical, dental, and other health care settings) have to report suspected or confirmed COVID-19 cases to state or local public health officials?

Health care facilities and health care providers are required to report the following, within 24 hours, to state or local public health authorities:

- Human cases of laboratory-confirmed COVID-19
- COVID-19 hospitalizations
- COVID-19 deaths

Laboratories are required to report:

- All test results indicative of and specific for COVID-19 within 24 hours (including weekends and holidays); and
- All negative test results for COVID-19 within one local public health authority working day.

The requirements for reporting can be found at OAR 333-018-0900.

For Hospitals:

What are the regions for purposes of determining hospital capacity?

The regions are Oregon's existing Health care Preparedness Program (HPP) regions which align with the Oregon Area Trauma Advisory Board (ATAB) regions as defined in OAR 333-200-0040. See Appendix A for a map of the HPP-ATAB regions.

How does a hospital determine it can meet the following criteria for resuming nonurgent and elective procedures: "hospital bed availability in the region can 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 on the date EO 20-22 was issued (April 27, 2020)"?

Hospitals within a region should work together to determine if the region can accommodate a 20% increase of COVID-19 patients based on the total number of hospitalized COVID-19 patients in the region on April 27, 2020. The total number of hospitalized COVID-19 patients that each region must be able to accommodate is highlighted in the chart below. Hospital emergency plans or "COVID-19 surge plans" are an important resource for hospitals to utilize when determining whether they can meet this criterion.

The left column of the following chart shows the total number of hospitalized COVID-19 patients by region[3] on April 27, 2020 as reported by hospitals to the OHA's web-based hospital capacity monitoring system (HOSCAP). The right column shows the total number of COVID-19 hospitalizations that each region must be able to accommodate (i.e. total hospitalizations on April 27, 2020 plus a 20% increase) in order to meet the criteria in OHA's guidance for **resuming** nonemergent and elective procedures.

	Total suspected or confirmed COVID-19 hospitalizations on April 27, 2020	Total COVID-19 hospitalizations on April 27, 2020 plus a 20% increase
Region 1	138	**166**
Region 2	59	**71**
Region 3	26	**32**
Region 5	13	**16**
Region 6	4	**5**
Region 7	6	**8**
Region 9	4	**5**

Once a hospital resumes nonemergent and elective procedures, how should it determine whether the region can continue to accommodate a 20% increase in COVID-19 hospitalizations?

Hospitals within a region should monitor regional bed capacity together and determine whether the region can accommodate a 20% increase or "surge" of COVID-19 patients at any given time. For example, if there are 100 hospitalized patients with confirmed or suspected COVID-19 in the region on any given date, the region must be able to accommodate a 20% increase in such patients (i.e. 120 total patients) using available beds and surge capacity in order to **continue** to offer nonemergent and elective procedures. Hospitals have a variety of resources to assess regional hospital bed and surge capacity including HOSCAP, other data tools that allow for real-time monitoring of the region's hospital bed capacity, hospital emergency or "surge" plans, and the region's regional resource hospital, if established.

If a region has less than 20% of its total number of staffed adult medical/surgical, step down and ICU hospital beds available, but the region has a plan in place to accommodate a 20% surge of hospitalized COVID-19 patients, does that meet the hospital capacity requirement in the guidance?

Yes, the region meets the hospital capacity requirement in the guidance if:

- The region has a plan in place to accommodate a 20% surge in hospitalized COVID-19 patients; and
- A 20% surge of hospitalized COVID-19 patients would not require the region to resort to crisis standards of care as described in Oregon's Crisis Care Guidance.
    - If crisis standards of care are needed, then elective procedures should not resume or, if already restarted, be cancelled.

[3] For historical purposes, there is no Region 4 or Region 8 in Oregon.

Which regions have a Regional Resource Hospitals to help with monitoring the region's hospital bed capacity?

A regional resource hospital (RRH) is a hospital that has entered into agreement with the OHA to serve as the regional hospital bed management and transfer center for one or more regions during the COVID-19 emergency. Currently the OHA has an established agreement with the following hospitals to serve as an RRH: Salem Hospital (Region 2), PeaceHealth (Region 3), and Grande Ronde Hospital (Region 9).

Do I need to provide information to an ambulatory surgical center (ASC) with which I have a transfer agreement, so they know what the hospital capacity is?

Hospitals must immediately notify all ASCs with which the hospital has a transfer agreement if the hospital bed capacity requirements cannot be met.

For Ambulatory Surgical Centers (ASC):

Does my ASC have obligations to be in touch with hospitals in my area as a condition for resuming elective procedures?

As part of the ASC guidance for resuming non-emergent and elective procedures, each ASC must provide a point of contact to all local admitting hospitals to allow for rapid communication regarding hospital bed capacity changes.

The guidance says that an ASC must limit the volume of non-emergent and elective procedures to no more than 50% of the ASC's pre-COVID-19 non-emergent and elective procedure volume, as measured against the average volume during the fourth quarter of 2019. What if my ASC opened after the fourth quarter of 2019 began?

If an ASC opened after the start of the fourth quarter of 2019, it should calculate its pre-COVID non-emergent and elective procedure volume as the average number of procedures in the last full month of operation.

For Medical, Dental, and other Health Care Settings:

Can I provide massage therapy?

Only a setting where medical massage therapy is provided is currently permitted, unless the setting falls within one of the categories of businesses that were required to close under EO 20-12. All medical spas, facial spas, day spas and non-medical massage therapy services were closed or cancelled under EO 20-12, and must remain closed or cancelled.

Can I provide Botox® treatments?

The answer depends on the location where the services are to be provided and whether the criteria listed in the guidance for medical, dental, and other health care settings can be met.

- All esthetician practices, medical spas, facial spas, and day spas were closed under EO 20-12 and must remain closed.
- If Botox® treatments are provided in a setting not required to close under EO 20-12, they can be provided if the criteria listed in the guidance for medical, dental, and other health care settings can be met. Once an office has met the criteria for resuming non-emergent and elective procedures, it must limit its case load volume to ensure physical

distancing of at least 6 feet is maintained whenever possible and prioritize non-emergent and elective procedures based on whether their continued delay will have an adverse medical outcome for a patient.

For Veterinarian Facilities:

The following table outlines recommendations for resuming veterinarian care during the COVID-19 pandemic, including nonemergent and elective procedures:

Service	Advice
Wellness pet visits (vaccines, exams)	Conversations with clients should be over the phone or via telemedicine. Curbside drop-off should be prioritized to pets needing vaccinations.
Preventive medicine (heartworm, tick and parasiticide)	If a physical exam is needed to prescribe or refill medication, then the visit is recommended.
Dentistry	Recommended with a priority to those in immediate need of care, so long as reusable PPE is available and physical distancing is practiced.
Spay and Neuters	Recommended so long as the guidance for resuming nonemergent and elective procedures can be met, including the criteria for PPE and physical distancing.
Other surgical procedures	Recommended so long as the guidance for resuming nonemergent and elective procedures can be met, including the criteria for PPE and physical distancing. Recommend prioritizing those in immediate need of care.
Euthanasia	Can continue if clinically indicated.
Boarding and grooming	Resume slowly and it is recommended so long as physical distancing of staff is practiced.

Other Resources:

What resources are available related to resuming elective surgeries?

The American College of Surgeons has issued surgical guidelines for resuming elective surgery that can be found here: https://www.facs.org/covid-19/clinical-guidance/resuming-elective-surgery.

Enforcement:

The guidance says OHA can issue civil penalties to a facility or office for non-compliance with the guidance. How much are the civil penalties?

OHA can issue civil penalties of up to $500 per day when a facility or office is found to be out of compliance with the guidance.

Apart from civil penalties, what other actions could OHA take to enforce the guidance?

OHA can request a court to order that a facility or office close until it can comply with the guidance.

Appendix A: map of Oregon's HPP-ATAB regions