Virtual Grand Rounds

ACG Virtual Grand Rounds

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Week 6: Celiac Disease: 10 Things Every Clinician Should Know
Amy S. Oxentenko, MD, FACG
April 30, 2020 at Noon EDT

Week 7: *C. difficile* and Fecal Microbiota Transplant: The Beginnings of Microbiome Therapy
Neil H. Stollman, MD, FACG
May 7, 2020 at Noon EDT

Visit **gi.org/ACGVGR** to Register

COVID-19: A Roadmap to Safely Resuming Endoscopy

COVID-19: A Roadmap to Safely Resuming Endoscopy

An update on the latest developments and practical tips for your endoscopy center

MONDAY, APRIL 27, 8-9:30PM EDT

Introduction

ACG President Mark B. Pochapin, MD, FACG

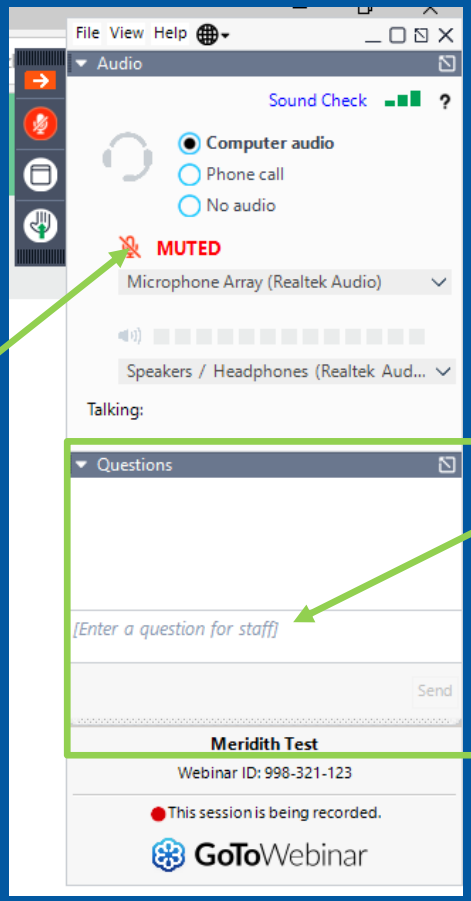
Webinar Co-Hosts & Presenters

Costas H. Kefalas, MD, MMM, FACG, ACG Trustee
Neil H. Stollman, MD, FACG, Chair, ACG Board of Governors
ACG Endoscopy Resumption Task Force

Register & Learn More gi.org/ACGVGR

Participating in the Webinar

All attendees will be muted and will remain in Listen Only Mode.



Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2020 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2021 for this activity.

ACG will submit MOC points on the first of each month. Please allow 3-5 business days for your MOC credit to appear on your ABIM account.

MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.

Virtual Grand Rounds

Disclosures:

Costas H. Kefalas, MD, MMM, FACG

Neil H. Stollman, MD, FACG

Mark B. Pochapin, MD, FACG

Sapna V. Thomas, MD, FACG

Vonda G. Reeves, MD, MBA, FACG

Harish K. Gagneja, MD, FACG

Michael S. Morelli, MD, CPE, FACG

Louis J. Wilson, MD, FACG

Melissa Latorre, MD, MS

Whitfield Knapple, MD, FACG

Jeffrey L. Nestler, MD, FACG

According to ACCME guidance, because there are no current preventive or specific treatments for coronavirus infection, there are no relevant conflicts of interest for any speakers or moderators.

Universe.gi.org

COVID-19: A Roadmap to Safely Resuming Endoscopy

Hosted by:

Costas H. Kefalas, MD, MMM, FACG
Trustee, ACG Board of Trustees

Neil H. Stollman, MD, FACG
Chair, ACG Board of Governors

And
The ACG Endoscopy Resumption Task Force

COVID-19: A Roadmap to Safely Resuming Endoscopy

ACG ENDOSCOPY RESUMPTION TASK FORCE

Co-Chairs:

Costas H. Kefalas, MD, MMM, FACG

Neil H. Stollman, MD, FACG

Members:

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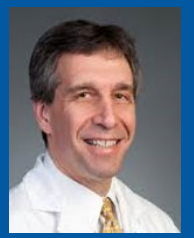

Jeffrey L. Nestler, MD, FACG

PRESENTERS

Louis J. Wilson, MD FACG
Chair, ACG Practice Management Committee

Costas H. Kefalas, MD, MMM, FACG
Trustee, ACG Board of Trustee

Vonda G. Reeves, MD, MBA, FACG
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GI Practice Survey Results and Analysis

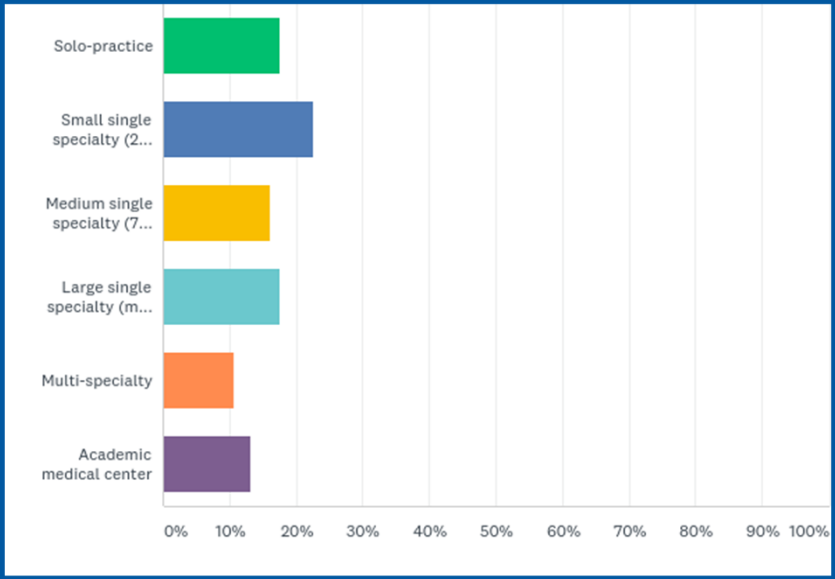
Louis J. Wilson, MD, FACG
Chair, ACG Practice Management Committee
Wichita Falls Gastroenterology Associates
Wichita Falls, TX

ACG PM Committee
COVID 19 Crisis Business Survey

- To assess the early business response by GI practices to the COVID 19 Pandemic
- Survey created April 7, 2020
- Results as of Tuesday, April 21, 2020
- This report involves first 335 Responses

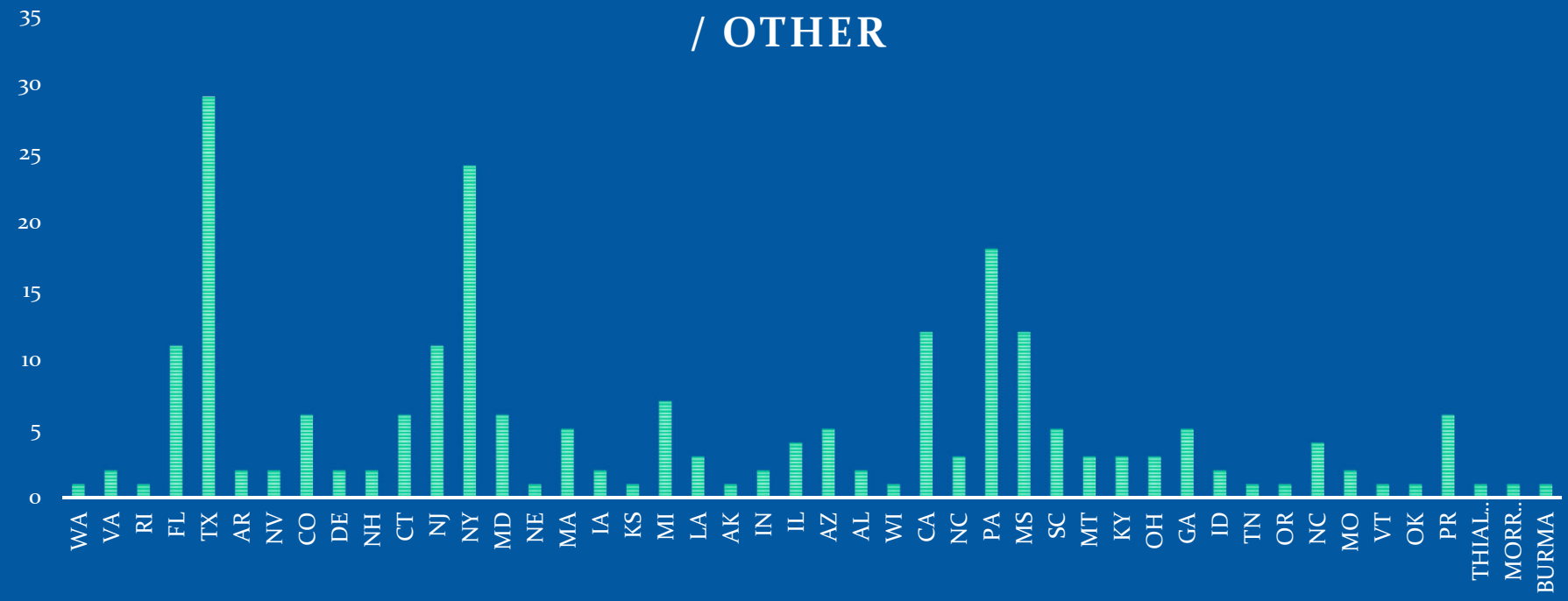
Louis J Wilson MD, FACG, PMC Chairman
Stephen Amann MD, FACG PMC Vice Chairman

Q1: What type of practice do you have?
A Broad Cross Section of Practices



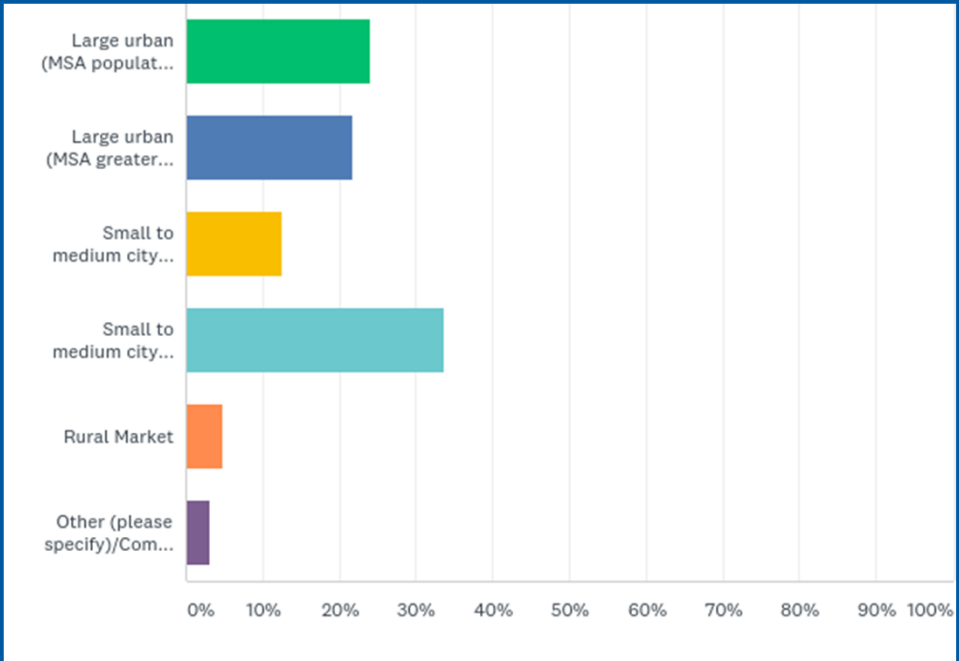
ANSWER CHOICES	RESPONSES	
Solo-practice	17.61%	59
Small single specialty (2-6 physicians)	22.69%	76
Medium single specialty (7-15 physicians)	16.12%	54
Large single specialty (more than 15)	17.61%	59
Multi-specialty	10.75%	36
Academic medical center	13.13%	44
TOTAL		335

COVID-19: A Roadmap to Safely Resuming Endoscopy



Q3: What best describes the community where you practice gastroenterology?

A Broad Cross-Section of Communities



ANSWER CHOICES	RESPONSES	
Large urban (MSA population greater than 500,000) with high COVID 19 Impact	24.11%	61
Large urban (MSA greater than 500,000) with low or moderate COVID 19 Impact	21.74%	55
Small to medium city with high COVID 19 Impact	12.65%	32
Small to medium city with low or moderate COVID 19 Impact	33.60%	85
Rural Market	4.74%	12
Other (please specify)/Comment	3.16%	8
TOTAL		253

Overview

- Reached a broad cross-section of practices and communities

FINDINGS

- Severe revenue reductions in every practice type (less impact for academic).
- Only 39% still seeing patients face to face.
- Only 33% doing endoscopy in an ASC.
- Dramatic transition to telemedicine (67% doing >75% of encounters).
- Written responses demonstrate a diversity of situations and responses.

Written Responses:

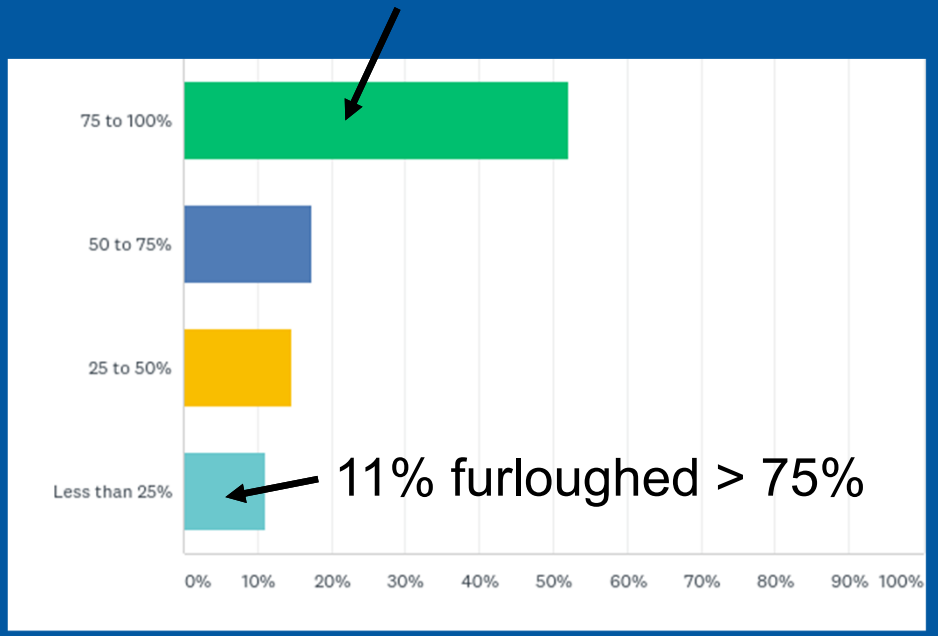
Dramatic Words

- Significantly decreased/down tremendously - 52
- "We are shut down" - 47
- "Devastated" - 34
- "Forced to furlough" our staff - 24
- No procedures/no patients – 33
- Personal financial burden -13
- No income/no physician salary - 8
- "I'm going out of business" -2

Q9: What percentage of pre-crisis staff have you retained at this time?

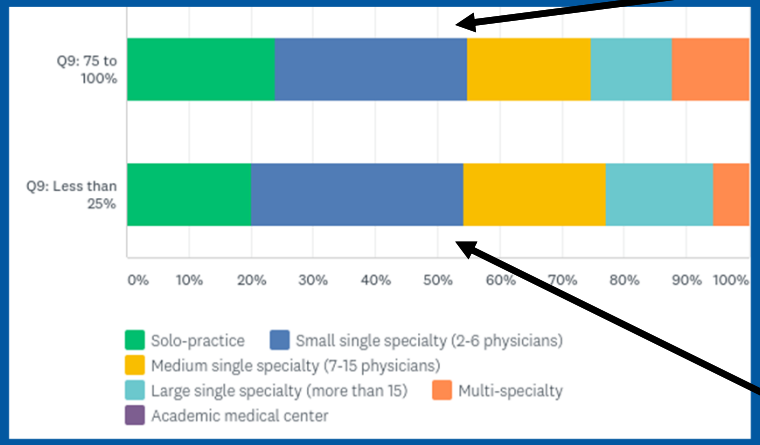
ANSWER CHOICES	RESPONSES	
75 to 100%	52.10%	174
50 to 75%	17.37%	58
25 to 50%	14.67%	49
Less than 25%	11.08%	37
TOTAL		334

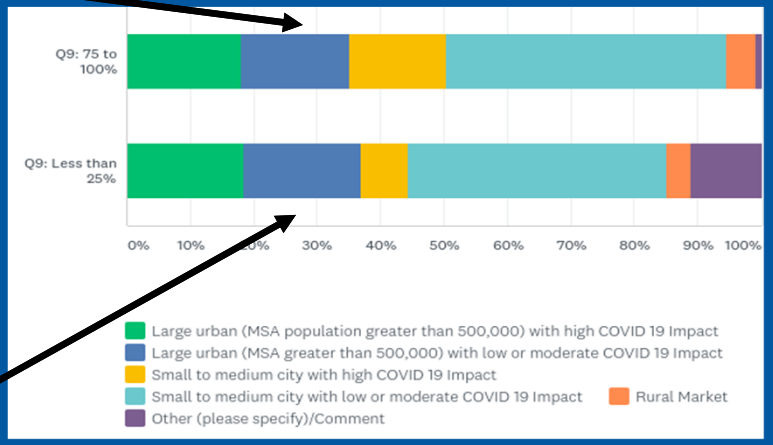
Only 52% retained at least 75% staff



Staff Retention by Practice Type: Similar Communities and Practice Types

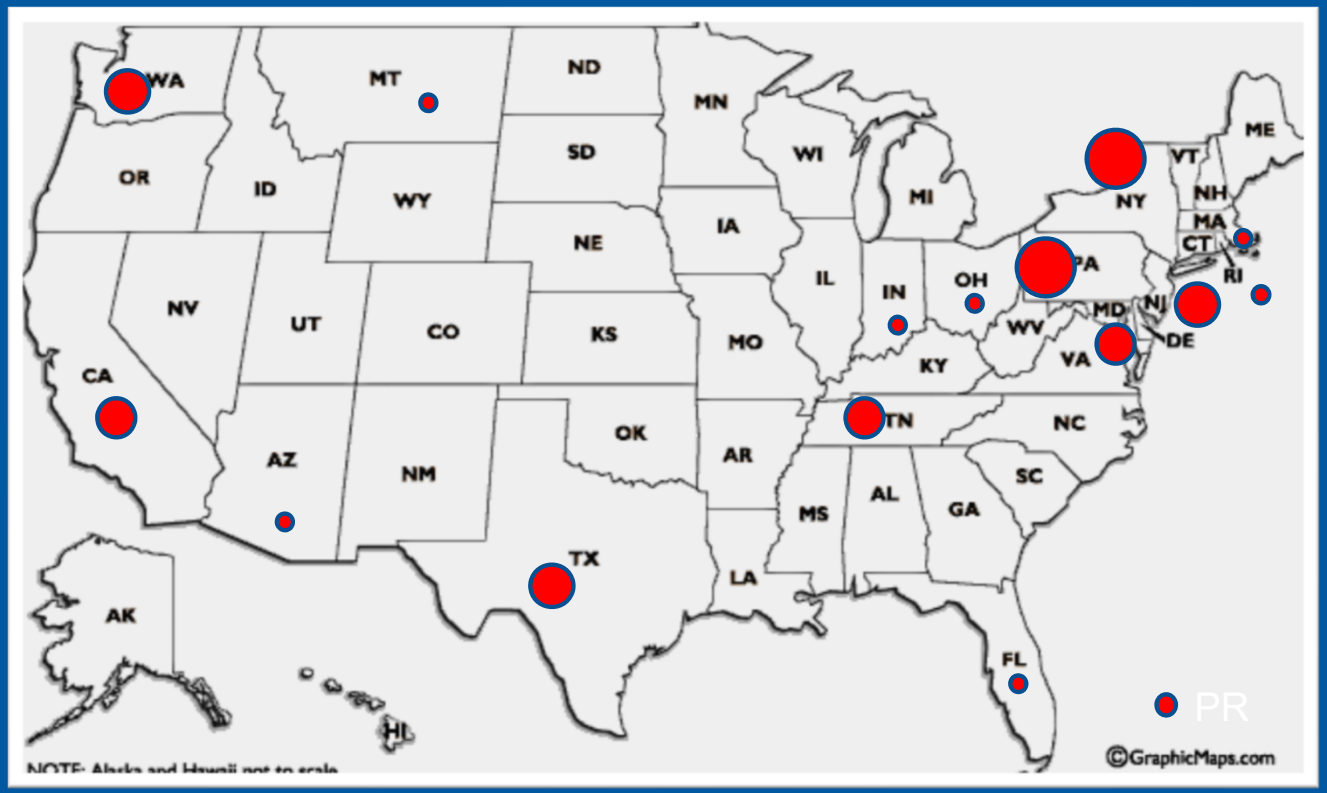
Retained 75% Staff



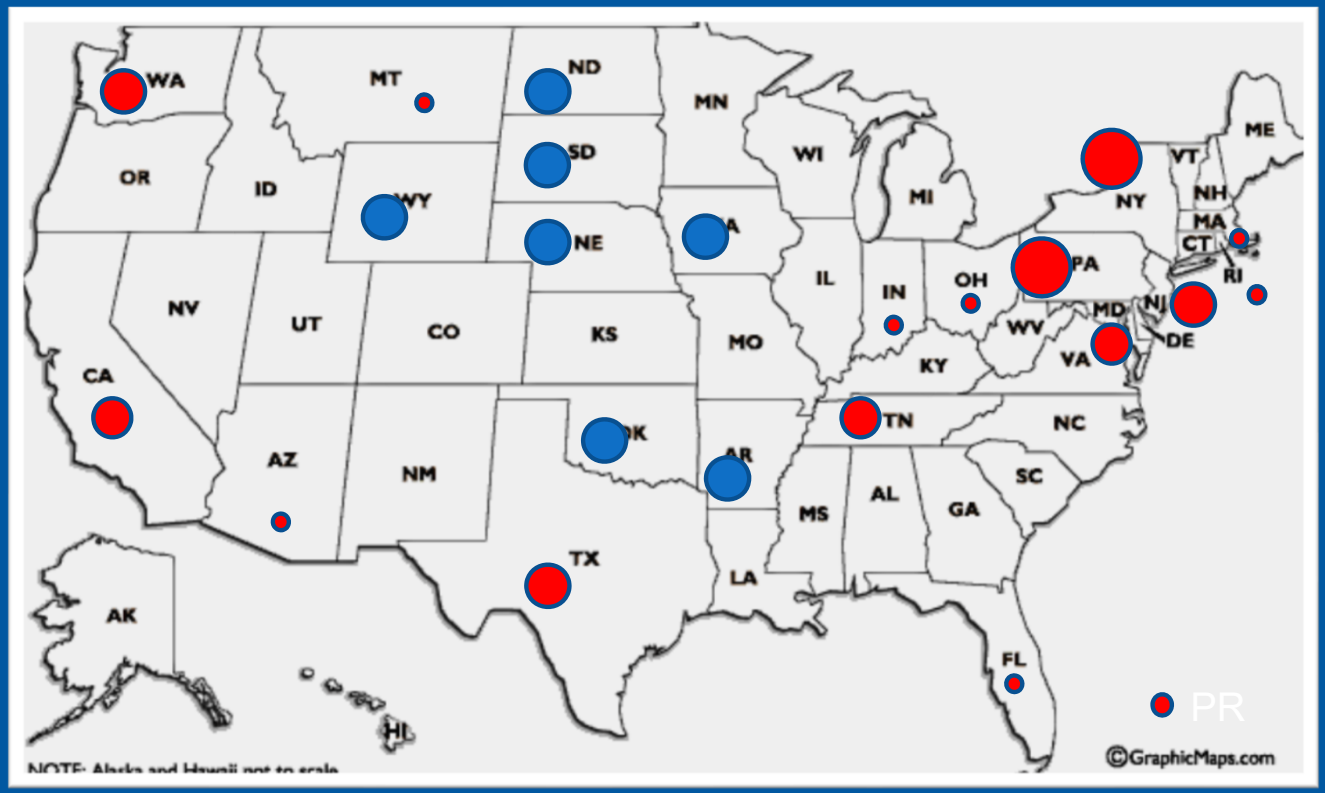


Furloughed 75% Staff

Respondents who "Shut Down" (work force at ≤ 25%):
Practice Locations



Respondents who "Shut Down" (work force at ≤ 25%):
Practice locations and "no-lockdown" states

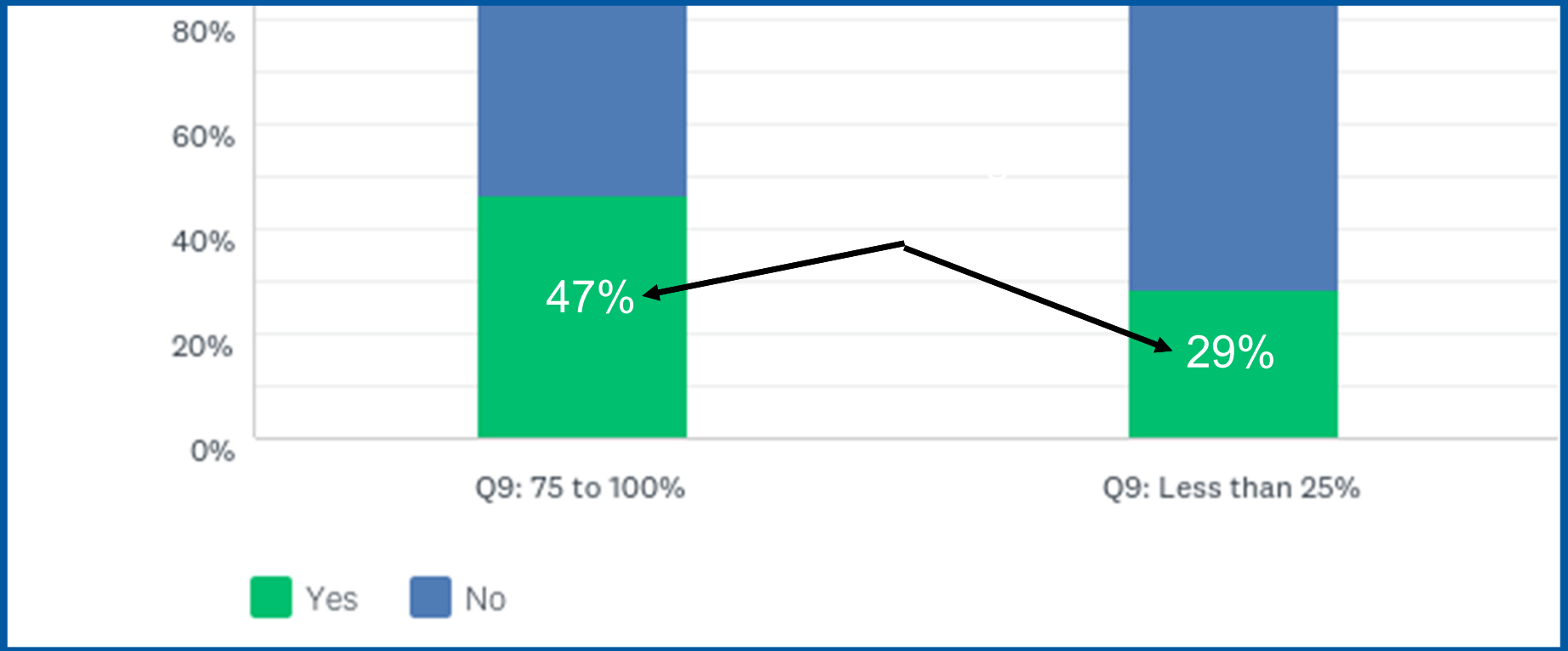


Staff Retention – A Tale of Two Responses?

Still seeing patients face to face

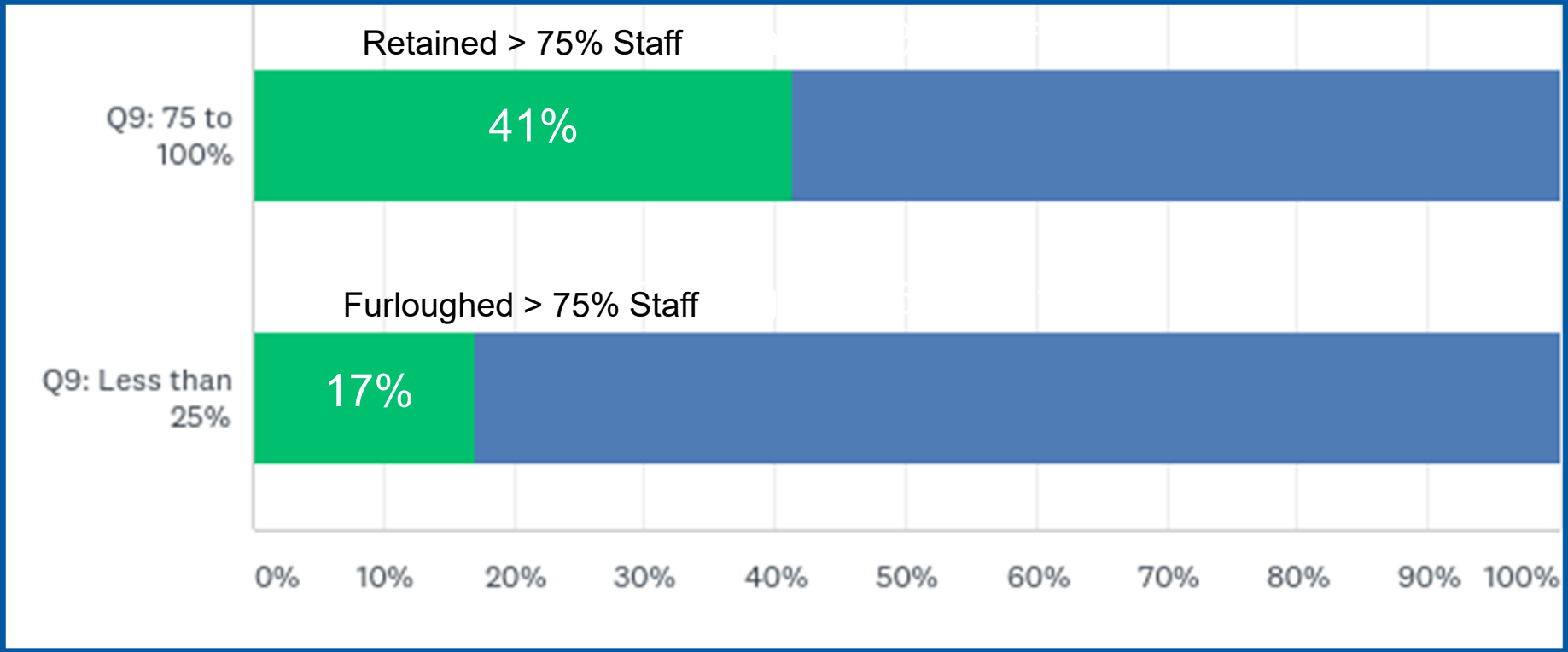
Retained > 75% Staff

Furloughed > 75% Staff

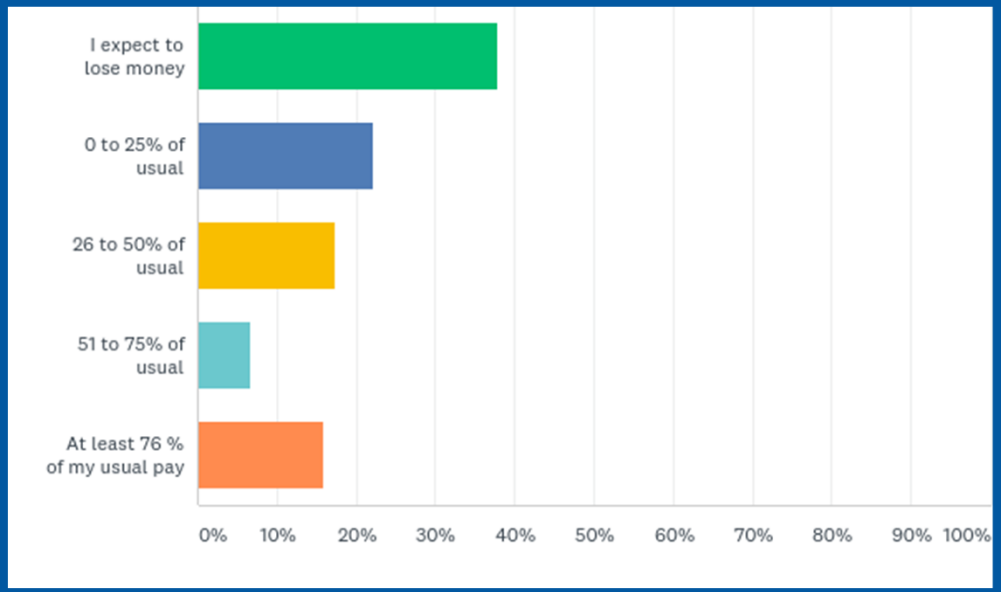


Staff Retention – A Tale of Two Responses?

Still doing endoscopy in an ASC



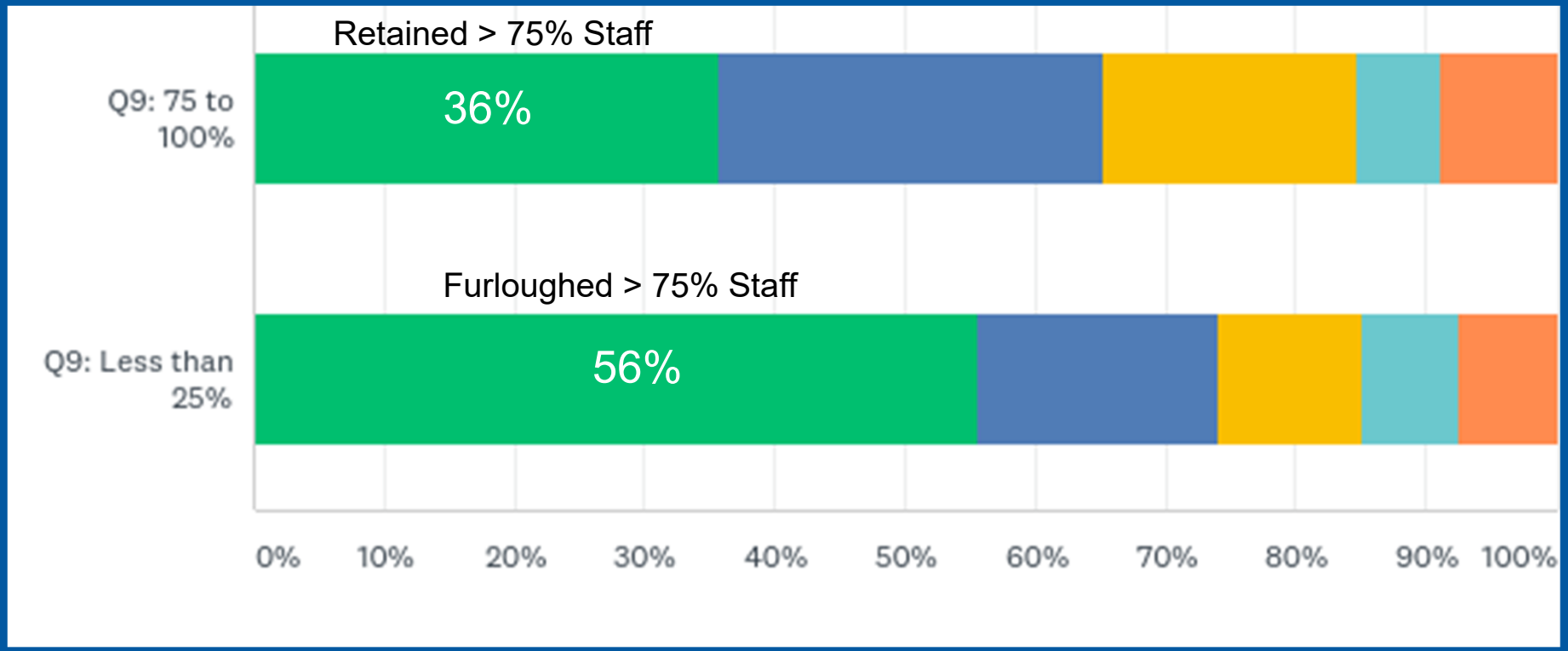
Q11: Compared to your usual pay, what are your personal pay expectations for the next two to three months?



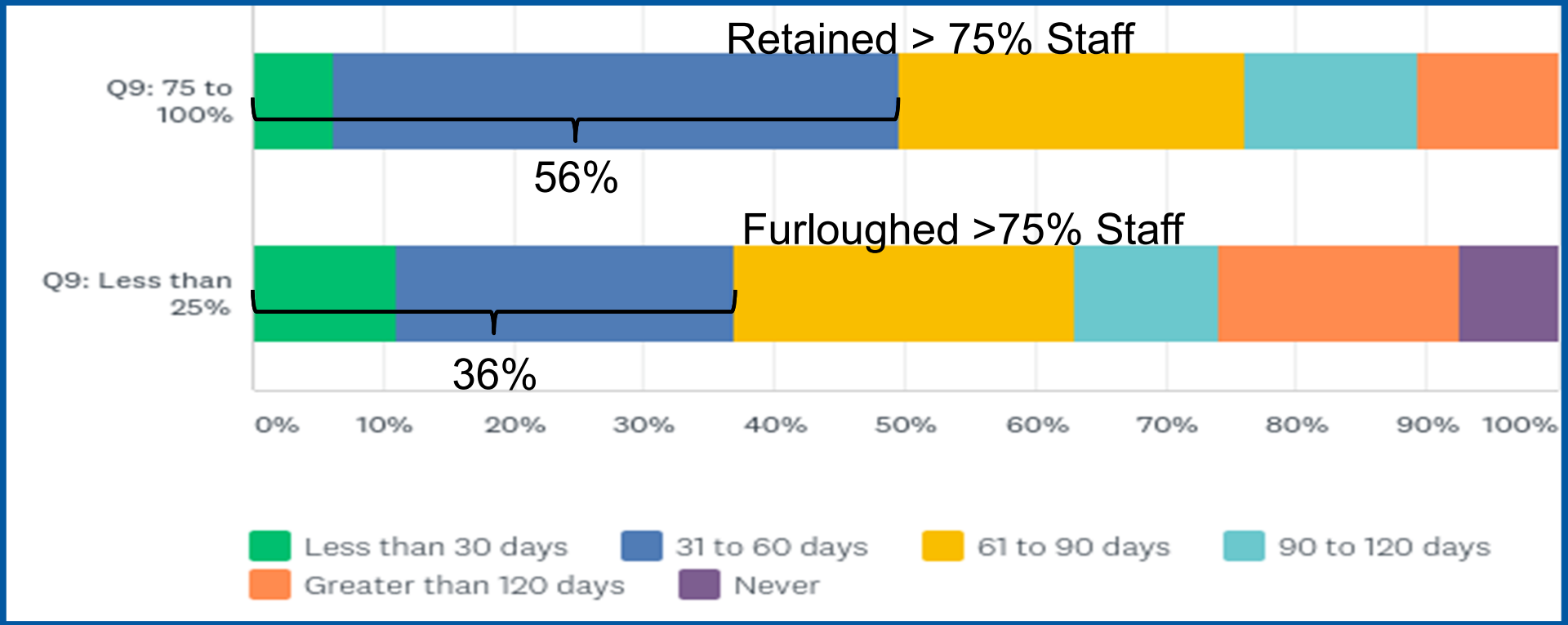
**86% Expect to make less than 50% of usual pay.
**38% expect negative income!

ANSWER CHOICES	RESPONSES	
I expect to lose money	37.94%	96
0 to 25% of usual	22.13%	56
26 to 50% of usual	17.39%	44
51 to 75% of usual	6.72%	17
At least 76 % of my usual pay	15.81%	40
TOTAL		253

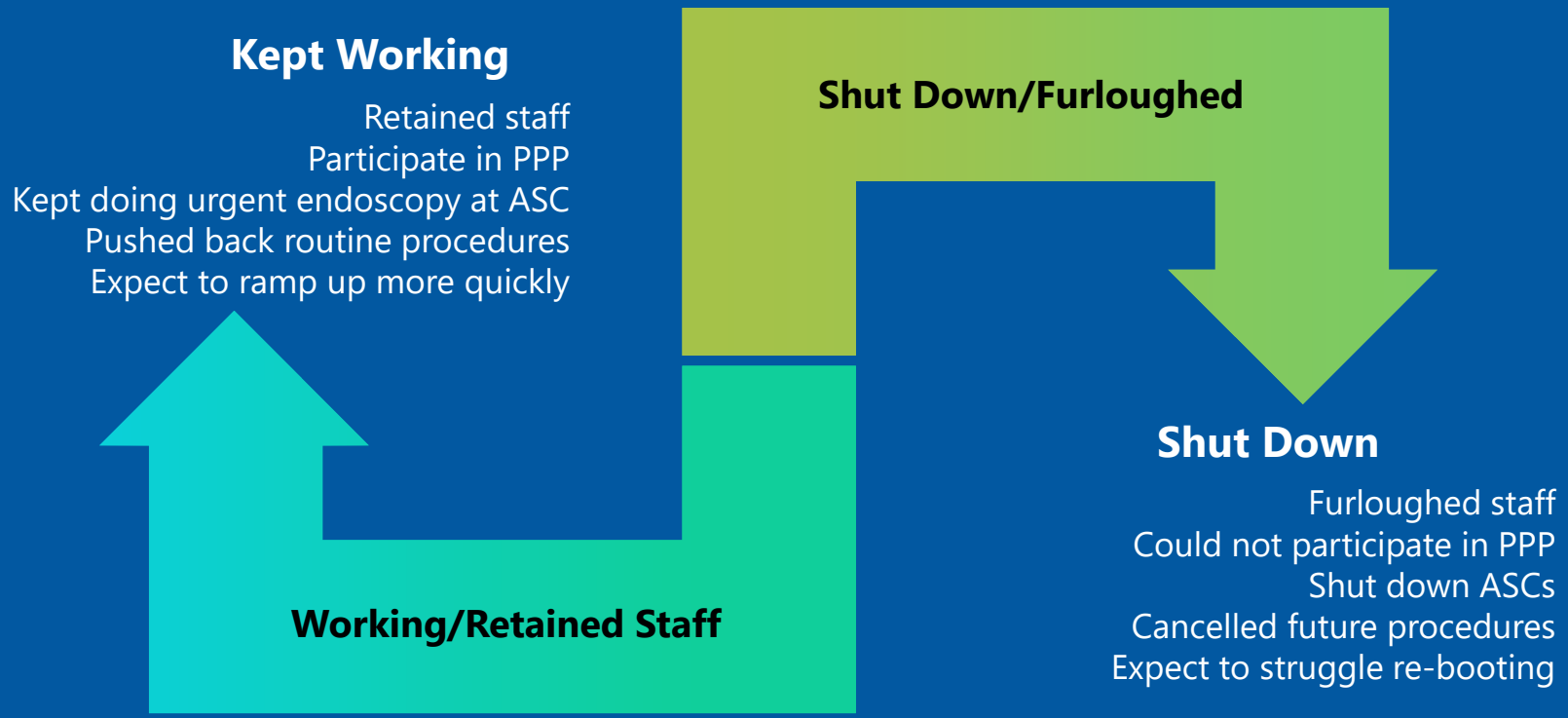
Pay Expectations:
More “shut down” groups expect negative income



Q14: When do you expect to resume full-operations at your gastroenterology practice?



A Tale of Two Responses



PMC Survey Written Responses :

Q:What are your plans to resume and advice requested?

PLANS

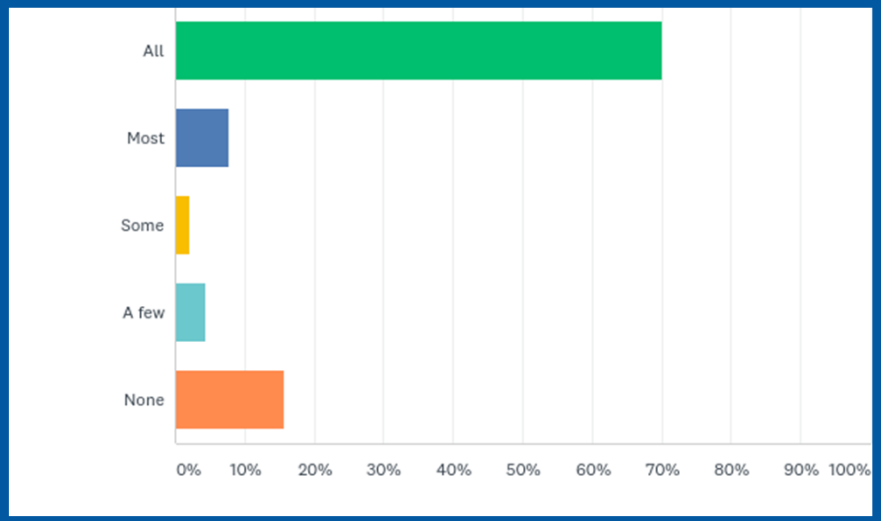
- Need to work harder/Extra days/Saturdays – 42
- Slowly rebuild - 19
- Continue telemedicine - 21
- Start back as usual - 13
- I don't know/no plan - 21
- Cost control for reduced income - 4
- Retire - 2

QUESTIONS

- How to ramp up quickly but safely - 25
- Cost mitigation/Decrease overhead - 14
- How to re-hire staff - 12
- How to do POC COVID Testing - 9
- Loans/Financial assistance needed - 7
- How to communicate/reassure Patients- 2

ACG PMC COVID 19 Business Survey - **PPE**

Q12: On what percentage of endoscopy procedures are you currently wearing N95 masks?



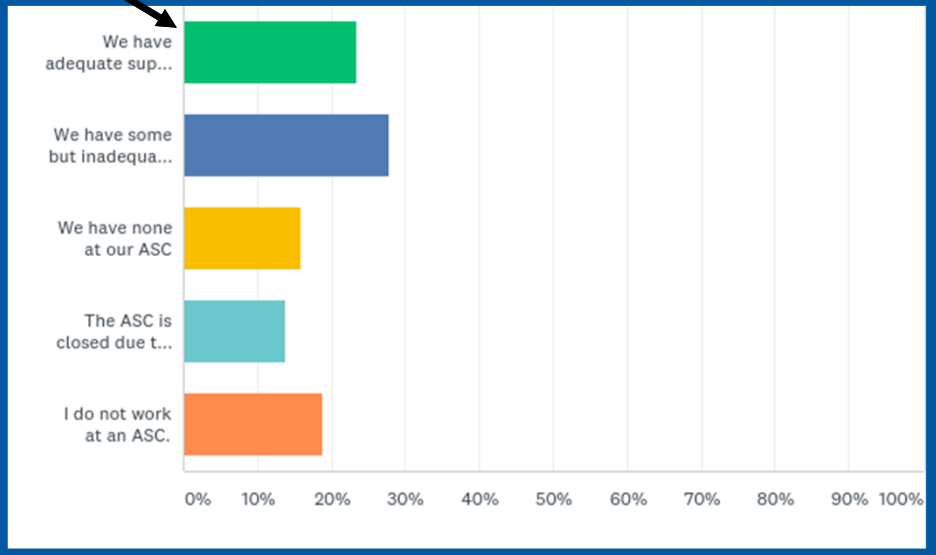
70/30

ANSWER CHOICES	RESPONSES	
All	70.04%	173
Most	7.69%	19
Some	2.02%	5
A few	4.45%	11
None	15.79%	39
TOTAL		247

Q13: If you work in an ASC, what is the current availability of N95 Masks?

Only 23.5% report adequate supply of N95 masks

ANSWER CHOICES	RESPONSES	
We have adequate supply for all procedures.	23.53%	56
We have some but inadequate supply for all procedures.	27.73%	66
We have none at our ASC	15.97%	38
The ASC is closed due to inadequate supply of N95 masks	13.87%	33
I do not work at an ASC.	18.91%	45
TOTAL		238



Conclusions

- COVID 19 has made a dramatic change in the practice of gastroenterology.
- Severe financial stress is widespread among GI practices across all practice models and communities.
- There is a widespread shortage of facial PPE.
- Practices which “shut down” or furloughed staff expect more pay reduction and to face the biggest challenges.
- Early business responses by practices may impact the challenges of re-opening.

Regulatory Guidance

Costas H. Kefalas, MD, MMM, FACG
Trustee, ACG Board of Trustees
Akron Digestive Disease Consultants, Inc.
Akron, Ohio

Regulatory Guidance – Outline

- Guidance – Professional Societies
- Opening Up America Again – The White House & CDC
- Opening Up America Again – CMS
- Opening Up America Again – State/Local Considerations

Guidelines – Professional Societies: Background

- From the onset of Corona virus pandemic, new information has been available daily or weekly
- Professional societies, including ACG, have released a number of recommendations pertinent to gastroenterologists/endoscopists
- Some of these recommendations have been ambiguous, due to the fast-changing situation, geographic differences in incidence, and availability of equipment and resources
- ACG continues to monitor this fluid situation and updated recommendations may be forthcoming

Guidance from Key Professional Societies: Summary of Documents

DATE	SOCIETIES	TITLE
March 15	AASLD/ACG/AGA/ASGE	COVID-19 Clinical Insights for Our Community of Gastroenterologists and Gastroenterology Care Providers
March 31	AASLD/ACG/AGA/ASGE	Gastroenterology Professional Society Guidance on Endoscopic Procedures During the COVID-19 Pandemic
April 1	AGA	AGA Institute Rapid Recommendations for Gastrointestinal Procedures During the COVID-19 Pandemic
April 1	AASLD/ACG/AGA/ASGE	COVID-19 Use of Personal Protective Equipment in GI Endoscopy
April 13	ASGE/SGNA/ACG/AGA/ASCRS	Management of Endoscopes, Endoscope Reprocessing, and Storage Areas During the COVID-19 Pandemic
April 17	ACS/ASN/AORN/AHA	Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic
April 17	ESGE/ESGENA	ESGE and ESGENA Position Statement on Gastrointestinal Endoscopy and the COVID-19 Pandemic
April 27	AGA/DHPA	Joint AGA and DHPA Guidance: Recommendations for Resumption of Elective Endoscopy During the COVID-19 Pandemic

Opening Up America Again – The White House & CDC: Background

- Three-phased approach based on public health experts
- Guide to assist state/local officials when reopening economies

- These Guidelines include:
  - State or Regional Gating Criteria
  - Core State Preparedness Responsibilities
  - General Guidelines for All Phases
  - Guidelines for Specific Phases

Opening Up America Again – The White House & CDC: State or Regional Gating Criteria*

SYMPTOMS	CASES	HOSPITALS
↓ trajectory of influenza-like illnesses (ILI) in 14-day period ***AND*** ↓ trajectory of COVID-like syndromes in a 14-day period	↓ trajectory of documented cases in 14-day period ***OR*** ↓ trajectory of positive tests as a % of total tests in 14-day period (flat or increasing volume of tests)	Treat all patients without crisis care ***AND*** Robust testing program for at-risk healthcare workers, including emerging antibody testing

**State/Local officials may need to tailor application of criteria to local circumstances*

Opening Up America Again – The White House & CDC: Core State Preparedness Responsibilities

TESTING & CONTACT TRACING	HEALTH SYSTEM CAPACITY	PLANS
Ability to set up safe and efficient testing sites for symptomatic individuals and trace contacts of COVID+ results	Ability to quickly and independently supply sufficient PPE and critical medical equipment for surge	Protect health and safety of workers in critical industries
Ability to test syndromic/ILI-indicated persons for COVID and trace contacts of COVID+ results	Ability to surge ICU capacity	Protect health and safety of those living and working in high-risk facilities (e.g., senior care facilities)
Ensure surveillance sites are screening for asymptomatic cases and contacts for COVID+ results are traced		Protect employees and users of mass transit
		Advise citizens regarding protocols for social distancing and face coverings
		Monitor conditions and immediately take steps to limit and mitigate any rebounds or outbreaks by restarting a phase or returning to earlier phase, depending on severity

Opening Up America Again – The White House & CDC: General Guidelines for All Phases

INDIVIDUALS	EMPLOYERS
Continue to practice good hygiene: • Wash hands with soap and water or use hand sanitizer, especially after touching frequently used items or surfaces • Avoid touching face • Sneeze or cough into a tissue or inside of elbow • Disinfect frequently used items and surfaces often • Strongly consider using face coverings while in public, and particularly when using mass transit	**Develop/implement appropriate policies, in accordance with Federal, State, and local regulations and guidance regarding:** • Social distancing • Protective equipment • Temperature checks • Sanitation • Use and disinfection of common/high-traffic areas • Business travel
People who feel sick should stay home: • Do not go to work or school • Contact and follow advice of medical provider	**Monitor workforce for symptoms; Do not allow symptomatic people to return to work until cleared by medical provider**
	Develop/implement policies and procedures for workforce contact tracing following employee COVID+ test

Opening Up America Again – The White House & CDC: Guidelines for Specific Phases

	INDIVIDUALS	EMPLOYERS	SPECIFIC EMPLOYERS
PHASE I	• **Vulnerable individuals shelter in place** • **In public, all individuals maximize physical distance** • **Avoid socializing in groups more > 10** • **Minimize non-essential travel**	• **Encourage telework** • **Return to work in phases** • **Close common areas** • **Enforce social distancing** • **Minimize non-essential travel** • **Accommodations for vulnerable personnel**	• **Elective surgeries can resume, as clinically appropriate, on an outpatient basis at facilities that adhere to CMS guidelines** • **No visits to hospitals and senior living facilities** • **Closed: schools, organized youth activities, bars** • **Open: gyms and large venues (sit-down dining, movie theaters, sporting venues, places of worship), with strict physical distancing protocols**
PHASE II	• *Vulnerable individuals shelter in place* • *In public, all individuals maximize physical distance* • *Avoid socializing in groups > 50, unless precautions observed* • *Non-essential travel can resume*	• *Encourage telework* • *Close common areas* • *Enforce moderate social distancing* • *Non-essential travel can resume* • *Accommodations for vulnerable personnel*	• *Elective surgeries can resume, as clinically appropriate, on an outpatient and in-patient basis at facilities that adhere to CMS guidelines* • *No visits to hospitals and senior living facilities* • *Open: schools, organized youth activities; large venues (sit-down dining, movie theaters, sporting venues, places of worship), with moderate physical distancing protocols; gyms, with strict physical distancing protocols; bars with diminished standing-room occupancy*
PHASE III	• *Vulnerable individuals resume public interactions; practice physical distancing* • *Low-risk populations: minimizing time in crowds*	• *Unrestricted staffing of worksites*	• *Visits to hospitals and senior living facilities can resume* • *Large venues (e.g., sit-down dining, movie theaters, sporting venues, places of worship) with limited physical distancing protocols; gyms with standard sanitation protocols; bars with increased standing room occupancy*

Opening Up America Again – CMS: Background

- CMS recognizes that:
  - Many areas have a low and stable incidence of COVID-19
  - It is important to be flexible and allow facilities to provide care for patients needing non-emergent, non-COVID-19 healthcare
  - It is important to restart care currently postponed
- If states/regions have passed White House/CDC Gating Criteria (symptoms, cases, and hospitals) announced on April 16, then they may proceed to Phase I
- Decisions should be consistent with public health information and in collaboration with state public health authorities
- Recommendations provide healthcare facilities flexibility in providing essential non-COVID-19 care to patients without symptoms of COVID-19 in regions with low incidence of COVID-19

Opening Up America Again – CMS: General Considerations

- Coordinate with state/local officials to evaluate incidence and trends for COVID-19 in area where re-starting care is considered
- Evaluate necessity of care based on clinical needs
- Prioritize surgical/procedural care, high-complexity chronic disease management, and select preventive services
- Consider establishing **Non-COVID Care (NCC) zones** to screen all patients for symptoms of COVID-19, including temperature checks; Staff would be routinely screened as well as others working in facility (physicians, nurses, housekeeping, delivery, etc.)
- Facility should have sufficient resources available across phases of care, including PPE, healthy workforce, facilities, supplies, testing capacity, and post-acute care, without jeopardizing surge capacity

Opening Up America Again – CMS: Personal Protective Equipment

- CMS recommends healthcare providers and staff wear surgical facemasks at all times, consistent with CDC
- Procedures on mucous membranes should be done with great caution, and staff should utilize appropriate respiratory protection such as N95 masks and face shields
- Patients should wear a cloth face covering that can be bought or made at home if they do not already possess surgical masks
- Conserve personal protective equipment

Opening Up America Again – CMS: Workforce Availability

- Staff should be routinely screened for symptoms of COVID-19 and if symptomatic, they should be tested and quarantined
- Staff who will be working in these **NCC zones** should be limited to working in these areas and not rotate into "COVID-19 Care zones"
- Staffing levels in the community must remain adequate to cover a potential surge in COVID-19 cases

Opening Up America Again – CMS: Facility Considerations

- In region with low incidence rate, when facility determines to provide in-person, non-emergent care, facility should create NCC areas to reduce risk of COVID-19 exposure and transmission; these NCC areas should be separate from other facilities
- Within facility, facilitate social distancing, such as minimizing time in waiting areas, spacing chairs 6 feet apart, and maintaining low patient volumes
- Prohibit visitors; if they are necessary for aspect of patient care, should also be pre-screened

Opening Up America Again – CMS: Sanitation Protocols

- Ensure established plan for thorough cleaning and disinfection prior to using spaces or facilities for patients with non-COVID-19 care needs
- Ensure equipment used for COVID-19+ patients are thoroughly decontaminated, following CDC guidelines

Opening Up America Again – CMS: Supplies

- Adequate supplies of equipment, medication and supplies must be ensured, and not detract for community ability to respond to potential surge

Opening Up America Again – CMS: Testing Capacity

- All patients and staff must be screened for potential symptoms of COVID-19 prior to entering NCC facility
- When adequate testing capability is established, patients should be screened by laboratory testing before care, and staff working in these facilities should be regularly screened by laboratory test

Opening Up America Again – CMS: Concluding Comments

- All facilities should continually evaluate whether region remains low risk of incidence and should be prepared to cease non-essential procedures if there is a surge
- By following above recommendations, flexibility can allow for safely extending in-person non-emergent care in select communities and facilities

Opening Up America Again – State/Local Considerations

- In addition to regulatory guidance/recommendations from federal level (White House/CDC and CMS), must also consider and follow specific state/local recommendations
- State/local considerations may be more restrictive than federal ones, but should be identified and followed
- There are too many various state/local recommendations to list here
- Check with your state government/department of health, state medical board, state medical association, and/or state GI society for information and specific recommendations

Regulatory Guidance – Take Home Points

- Professional societies have released numerous recommendations pertinent to re-opening/ramping-up an endoscopy center/unit
- The White House/CDC requirements must be met, prior to re-opening or ramping-up an endoscopy center/unit for elective procedures
- CMS has released general recommendations to re-open facilities; **There is flexibility in these recommendations**, as not all resources are available everywhere and to everyone
- All federal recommendations are a guidance; **state and local requirements must also be met** prior to re-opening/ramping-up an endoscopy center/unit

References

1. https://gi.org/2020/03/15/joint-gi-society-message-on-covid-19/
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BUSINESS COSTS:
Re-opening & Ramp Up

Vonda Reeves, MD, MBA, FACG
ACG Governor, State of Mississippi
ACG Practice Management Committee
Gastrointestinal Associates, P.A . Flowood, MS

How To Get Started: RO/RU

CORE RO/RU team formation:

- *Purpose*: Develop a detailed plan on RO/RU
- *Create* Phases of RO/RU: 1-3
- Make capacity *goals*.
- Structure # of rooms.
- Coordinate *staffing*.
- *Assess* supplies on-going basis.

Revised Operations: RU/RO Team

CORE MEMBERS:

- INFECTION CONTROL
- NURSE MANAGER
- ANESTHESIA
- MEDICAL DIRECTOR
- CHARGE NURSE
- OTHERS AS NEEDED

RESPONSIBILITIES:

- **WEEK** 1-3: **daily assessment** of supplies, patient flow, **staffing capacity**,
- **Track** room times and **utilization**
- Monitor all PPE usage: staff and patients
- **Train** and **re-train** staff
- **Procedure monitoring**

ENDOSCOPY Supply Management: COVID Restart

ESSENTIALS:

- GOWNS
- MASKS
- GLOVES
- FACESHIELDS
- SHOE COVERS

ADDITIONAL ESSESSENTIALS:

- PDI SANTI WIPES
- POM's
- THERMOMETERS
- IV FLUIDS
- Numerous other items

WHAT to TRACK and WHY

WHAT:

- STAFF SALARIES
- SUPPLY UTILIZATION
- RENT/MORTGAGE/LEASES
- VENDORS

WHY:

- LARGEST EXPENSE OF ASC
- RATE LIMITING FACTOR FOR PERFORMANCE AND SCHEDULING
- TRACK WEEKLY, ORDER ON SCHEDULE
- POTENTIALLY NEGOITIABLE
- EST. ALTERNATE SUPPLY CHAINS (ALLOT TO EST. CUSTOMERS)

PERSONAL PROTECTIVE EQUIPMENT BURN CALCULATOR

- CDC SPREADSHEET
- TOOL CALCULATES **AVERAGE CONSUMPTION** (BURN RATE)
- ESTIMATES **HOW LONG REMAINING SUPPLY WILL LAST**
- HELPS ASC MAKE **ORDER PROJECTIONS** FOR FUTURE NEEDS

LINK:

https//www.cdc.gov/coronavirus/2019-hco/hcp/ppe-strategy/burncalculator.html

STAFF EXPANSION: $-$$

FRONT/INTAKE:

- PRE-OP SCREENING(TIME, $$)
- LIMIT TIME OF FACE-TO-FACE ENCOUNTER
- MORE STAFF RQUIREMENTS FOR PPE:$$
- PRE-PROCEDURE CALLS: MORE DETAILS
- UPFRONT PAYMENT OF DEDUCTIBLES PRIOR TO PROCEWDURE DATE

POST PROCEDURE:

- DISCHARGE NURSE/ ESCORT PPE
- MORE FACE-TO-FACE TIOME

INTRA-PROCEDURAL:

- EXTRA PERSONNEL FOR NROOM ASSISTANCE

IMPACT OF REVISING BLOCK TIME FLOW

- **LOWER CASE LOADS=LESS REVENUE**
- MORE PPE REQUIRED-**$$**
- INCREASED PATIENT FLOW TIME TO ALLOW FOR TERMINAL CLEANING
- ALLOW **AIRFLOW EXCHANGE** FOR ASC'S WTHOUT NEGATIVE PERESSURE ROOMS
- **'TERMINAL CLEANING '** OF ROOMS-$$ (GREATER CONSUMPTION OF SUPPLIES)

LENGTHENING HOURS OF OPERATION

POSITIVES

- **INCREASES** PATIENT VOLUME
- ADDRESSES RELUCTANCE OF PATIENT TO **MISS WORK**
- ALLOWS **WEEKENDS** FOR PROCEDURES OR OFFICE VISITS

NEGATIVES

- REQUIRES 2 SHIFTS OF WORKERS
- **OVERTIME:** INCREASED STAFF SALARIES: 1.5-2X HR WAGES
- CAUSES **STAFF FATIGUE**: DOCTORS AND STAFF

CHALLENGES for FULLY vs PARTIALLY CLOSED ASC

FULLY CLOSED

- LOSS OF PATIENT CONTACT-**$$$$**
- RESTART WORKLOAD FROM WEAKENED POSITION
- LOSS OF CONTACT WITH REFERRAL SOURCES-**$$$**
- LOSS/ATTRITION OF STAFF-**$$**
- 'SUPPLY CHAIN' RENEWAL-**$$.**
- GREATER MARKETING EXPENSES-**$$$**

PARTIALLY CLOSED

- EASIER RAMP UP
- MAINTAINED 'SUPPLY CHAINS '
- MAINTAINED PATIENT CONTACT
- PRESERVES REFERRAL SOURCES
- MARKETING 'REOPENING' EASIER

** SEE DR. LOUIS WILSON'S SURVEY SLIDES

UNREALIZED EXPENSES and REVENUE: ANCILLARIES

- **INFUSION:** INCOME STREAM, BUT IV FLUIDS IN SHORTAGE
- **ESOPHAGEAL MANOMETRY** AND **BRAVO**: extra PPE, cleaning.(**$$**)
- **COLON IRRIGATION UNITS:** extra PPE, extended staff exposure time
- **PHARMACY:** SWITCH TO MAIL-OUT PRESCRIPTIONS (decreases facility traffic, decreases staff contact with patients).
- **TELEMEDICINE:** well-worth extra cost of computer support. Consider for pre-op visits, USE TO SURE-UP **PATIENT TRUST!!.**

MARKETING: REOPENING

- **UPDATE WEBSITE**: MOST IMPORTANT ACTION
- **PHONE HUB FIRST!**
- SOCIAL MEDIA BARRAGE—**ALL FORMS!!FACEBOOK, TWITTER, INSTAGRAM**
- **LETTERS** TO REFERRING PHYSICIANS, **PERSONAL CALLS**
- **LETTERS** TO PATIENTS: COVID instructions, changes to assure safety, etc.
- **PSA's**: PUBLIC SERVICE ANNOUNCEMENTS.
- **Virtual guided tour of ASC**: web site emphasis on post-COVID 19 changes. (Cheap, easy to produce)
- ***WOO YOUR PATIENTS BACK WITH CONFIDENCE AND TRUST!!***

TAKE HOME POINTS

- CREATE A **RO/RU TEAM** COMPOSED OF KEY LEADERS
- MEET DAILY FOR **FIRST 2 WEEKS**
- WELCOME **FEEDBACK, FLEXIBILITY!**
- **MONITOR** AND **PRIORITIZE** PATIENT SCHEDULING
- **TRAIN** AND **RETRAIN** STAFF!
- AVOID **OVERLOAD** OF ASC IN FIRST 2-4 WEEKS
- CONSTANTLY **MONITOR SUPPLIES**

THE PROVERBIAL ***PHOENIX*** ARISES FROM THE ASHES!!!

1. **STRONG RU/RO TEAM**
2. **TRANSPARENCY**
3. FREQUENT COMMUNICATION AND FEEDBACK WITH WORKFORCE
4. **HUGE MARKETING, REBRANDING OF PRACTICE.**
5. **FLEXIBILITY AND PATIENCE!!**

THIS, TOO, SHALL PASS!!

Safely Re-opening / Ramping-up the ASC: practical considerations

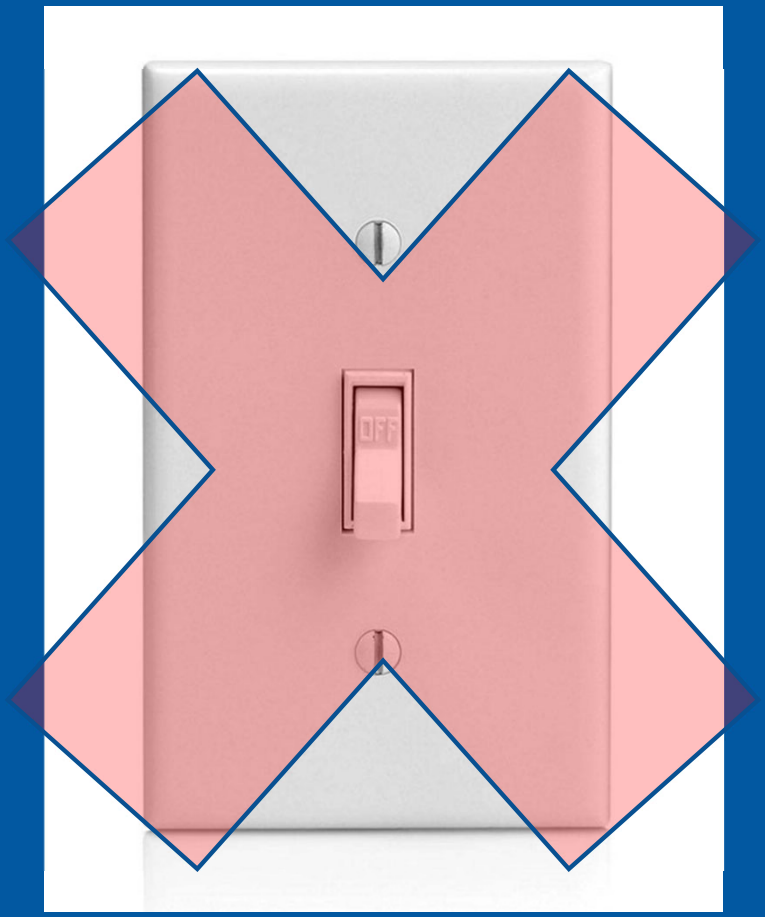
Neil Stollman MD, FACG
Chairman, ACG Board of Governors
Oakland, CA

Melissa Latorre MD, NY, NY
Whit Knapple MD, Little Rock AK

Practical Issues of SAFELY Re-Opening

- ***WHEN*** to re-open or ramp up
- ***WHO*** are the patients you're opening for
- ***WHO*** are the staff you'll need to re-open
- ***WHAT*** do you need to safely re-open
- ***WHERE*** is care given (the physical space and how to use it)
- ***HOW*** to succeed safely

COVID-19: A Roadmap to Safely Resuming Endoscopy



When to safely re-open

- Dependent on your locale's time curve (and difficult to define 'high risk' communities from 'lower risk' which evolves)
- "Open soon, but slowly"
- "Gating Criteria" (CMS 4/16/20) need to be met:
  - Phase One – OK to resume elective outpatient procedures as "clinically appropriate"
  - Downward Trajectory x 14 day in cases / deaths, hospitals not in 'crisis care'
  - State / Local Guidance generally dominates over federal
  - Testing availability will impact, not currently available for most of us

Who are we opening for? (Which patients?)

- Easy at the extremes:
  - IMMEDIATE / URGENT CASES generally hospital-based, such as GIB, foreign bodies, cholangitis should ALWAYS be done
  - TRULY ELECTIVE CASES such as screening or surveillance (colon cancer, Barrett's, IM), bariatric procedures, most motility procedures and GERD/IBS-like Sxs w/o alarm features should be deferred 3 months
- For the middle ground, adopt a triage system, write it down and adhere to it
- If large or multiple sites, consider a formal committee to review appropriateness of procedures case by case

Who are we opening for? (TRIAGE templates)

- HIGH Priority: therapeutics (stricture dilations, PEG/PEJ), early CA Rx, alarm symptom, mass on imaging
- LOWER Priority: Sxs w/o alarm features, FIT/cologuard, surveillance
- Urgent **Priority** vs Urgent **Elective**

Time-Sensitive* (within 24 hours-8 weeks)			**Non-Time Sensitive**
Threat to the patient's life or permanent dysfunction of an organ	Risk of metastasis or progression of stage of disease	Risk of rapidly worsening progression of disease or severity of symptoms	No short-term impact on patient-important outcomes
e.g. diagnosis and treatment of GI bleeding or cholangitis	e.g. work up of symptoms suggestive of cancer	e.g. management decisions, such as treatment for IBD	e.g. screening or surveillance colonoscopy, follow up colonoscopy for +FIT

AGA Institute Rapid Recommendations for GI Procedures during Covid19
In press

COVID-19: A Roadmap to Safely Resuming Endoscopy

AASLD · ACG · aga · ASGE

GASTROENTEROLOGY PROFESSIONAL SOCIETY GUIDANCE ON ENDOSCOPIC PROCEDURES DURING THE COVID-19 PANDEMIC

Released 3/31/20

Urgent/Emergent Procedures Should Not Be Delayed

1. Upper and lower GI bleeding or suspected bleeding leading to symptoms
2. Dysphagia significantly impacting oral intake (including EGD for intolerance of secretions due to foreign body impaction or malignancy (stent placement))
3. Cholangitis or impending cholangitis (perform ERCP)
4. Symptomatic pancreaticobiliary disease (perform EUS drainage procedure if necessary for necrotizing pancreatitis and non-surgical cholecystitis, if patient fails antibiotics)
5. Palliation of GI obstruction [UGI, LGI (including stent placement for large bowel obstruction) and pancreaticobiliary]
6. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
7. Cases where endoscopic procedure will urgently change management (e.g., IBD)
8. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

All Elective Procedures Should Be Delayed

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients, including surveillance for esophageal varices in patients with cirrhosis.
3. For patients needing interval endoscopy for obliteration of esophageal varices post-acute bleeding, the individual circumstances of the patient need to be taken into account to determine safety of delay (i.e., size of varices, red wale markings, CTP status of the patient, acute bleed characteristics).
4. Evaluation of non-urgent symptoms or disease states where procedure results will not imminently (within 4-6 weeks) change clinical management (e.g., EGD for non-alarm symptoms, EUS for intermediate risk pancreatic cysts)
5. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

COVID-19: A Roadmap to Safely Resuming Endoscopy

Perform always

- Acute upper/lower GI bleeding with hemodynamic instability
- Capsule/enteroscopy for urgent/emergent bleeding
- Anemia with hemodynamic instability
- Foreign body in esophagus and/or high-risk foreign body in the stomach
- Obstructive jaundice
- Acute ascending cholangitis

Case by case management – high priority

- Endoscopic treatment of high-grade dysplasia (HGD) or early intra-mucosal cancer in the esophagus, stomach, or large colonic polyps at high-risk of submucosal invasion
- Malignant stricture stenting
- PEG/PEJ/NJ tube
- Upper GI fistula/leakage
- Dysphagia or dyspepsia with alarm symptoms present
- Upper GI bleeding without hemodynamic instability
- Rectal bleeding
- Colonoscopy for melena after negative upper-GI endoscopy
- Severe anemia with no hemodynamic instability
- Tissue acquisition needed for the initiation of systemic therapy/surgery
- Colonoscopy within organized FOBT+ CRC screening programme
- Foreign body in the stomach, low-risk
- Benign stricture requiring dilation/stenting
- Radiologic evidence of mass
- Lymph node EUS sampling
- Gallstone-related pancreatitis
- Pancreatic mass/stricture
- Biliary stricture dilation
- Pancreatico-biliary stent replacement for non-urgent indication
- Necrosectomy

Case by case management – low priority

- Endoscopic treatment of esophageal or gastric low-grade dysplasia (LGD)
- Duodenal polyp
- Ampullectomy
- Band ligation/non-emergency
- Iron deficiency anemia
- Pancreatic cyst (depending on risk features)
- Biliary stricture/no urgency (no cholangitis, no jaundice, etc.)
- Submucosal lesion EUS sampling
- Achalasia (POEM, balloon dilitation)
- gFOBT/FIT+ (outside of an organized regional/ national screening program)

Postpone always

- Surveillance for
  - Barrett's Esophagus without dysplasia or Low-Grade Dysplasia or after endoscopic treatment
  - Gastric atrophy/Intestinal Metaplasia
  - Inflammatory Bowel Disease
  - Primary Sclerosing Cholangitis
- Post-endoscopic resection (including immediate endoscopy after resection), surgical resection of cancer or post-polypectomy surveillance
- Diagnosis/surveillance of Lynch syndrome and other hereditary syndromes
- Diagnosis of Irritable Bowel Syndrome-like symptoms
- Diagnosis of reflux disease, dyspepsia (no alarm symptoms)
- Screening in high risk patients for esophageal cancer, gastric cancer, colon cancer (primary screening endoscopy) or pancreatic cancer
- Bariatric GI endoscopy procedures (e.g., intra-gastric balloons, endoscopic sleeve gastroplasty)

ESGE Guidelines on Endoscopy during COVID pandemic
Published 4-17-20

Who (patients)

- Pre-procedure screening
  - Telehealth ideally, with phone checklist w/in 24-72h of appointment
  - Pre-procedure covid testing: covered later
- Day of procedure screening (patients AND staff)
  - Temp, symptom questionnaire, contacts, pulse oximetry?
- ? Additional consent for exposure risk or “mutual statement of social responsibility” outlining risks to each other and mutual notification if exposure or illness.

COVID-19: A Roadmap to Safely Resuming Endoscopy

AMSURG — COVID-19 SCREENING PROCESS

An Envision Healthcare Solution

REVISED DATE: 4/20/2020

STAFF WILL SCREEN ALL PATIENTS AND PATIENT CAREGIVERS/RIDES FOR CORONAVIRUS PRIOR TO OR AT ARRIVAL PREFERABLY OR UPON ENTRY OR WHEN SCHEDULING PROCEDURES (UNTIL FURTHER NOTIFIED).

ASK ALL QUESTIONS IN ORDER. BASED ON ANSWERS, FOLLOW THESE STEPS:
- **IF PATIENT SAYS NO TO ALL QUESTIONS, PROCEED WITH PROCEDURE.**
- **IF PATIENT SAYS YES TO ANY QUESTION, INFORM THE PATIENT THE APPOINTMENT WILL BE RESCHEDULED. COPY THE SCREENER FORM AND PLACE IT IN THE COVID-19 RESCHEDULE FOLDER.**
- **IF PATIENT SAYS YES TO BOTH SYMPTOMS AND TRAVEL/CONTACT, PATIENT IS CONSIDERED HIGH RISK. COMPLETE HIGH RISK CHECK LIST.**

1 ASK ABOUT SYMPTOMS

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- FEVER
- CHILLS/REPEATED SHAKING WITH CHILLS
- MUSCLE PAIN
- RECENT ONSET COUGH
- SHORTNESS OF BREATH
- OTHER ACUTE RESPIRATORY SYMPTOMS
- SORE THROAT
- NEW LOSS OF TASTE OR SMELL

2 ASK ABOUT TRAVEL

HAVE YOU TRAVELED WITHIN THE PAST 14 DAYS? IF SO, WHERE?

3 ASK ABOUT CONTACT

HAVE YOU BEEN IN CONTACT WITH A PERSON WHO HAS TRAVELED THE PAST 14 DAYS?

4 ASK ABOUT CONTACT

HAVE YOU BEEN IN CONTACT WITH A PERSON WHO HAS BEEN DIAGNOSED WITH COVID-19?

5 ASK ABOUT TESTING

HAVE YOU TESTED POSITIVE FOR COVID-19?

NO to SYMPTOMS; NO to TRAVEL/CONTACT; NO to POSITIVE COVID-19 TEST
OK TO SCHEDULE. OK TO COMPLETE VISIT.

This does not replace the traditional pre-procedure screening process. If in doubt, isolate or delay the procedure. More detailed guidance in available in the AMSURG COVID-19 EID Binder.

AMSURG — COVID-19 SCREENER

An Envision Healthcare Solution

REVISED DATE: 4/20/2020

COVID-19 SCREENER
COMPLETE THIS SCREENING PROCESS FOR EVERY PATIENT OR VISITOR VIA TELEPHONE AND IN-PERSON, AND PLACE IN PATIENT RECORD.

PATIENT NAME	DATE OF SERVICE
MR # (IF ANY)	**DOB**
ADDRESS	**TELEPHONE #**

TRAVEL / CONTACT QUESTIONS

The patient reported he/she has:
- ❑ traveled within the past 14 days; where?
- ❑ had contact with a person who traveled past 14 days; where?
- ❑ had contact with a person diagnosed with the COVID-19
- ❑ been diagnosed with COVID-19

SYMPTOM QUESTIONS

AND the patient reported he/she currently has:
- ❑ FEVER
- ❑ CHILLS/REPEATED SHAKING WITH CHILLS
- ❑ MUSCLE PAIN
- ❑ RECENT ONSET COUGH
- ❑ SHORTNESS OF BREATH
- ❑ OTHER ACUTE RESPIRATORY SYMPTOMS
- ❑ SORE THROAT
- ❑ NEW LOSS OF TASTE OR SMELL

- **IF PATIENT SAYS NO TO ALL QUESTIONS, PROCEED WITH PROCEDURE.**
- **IF PATIENT SAYS YES TO ANY QUESTION, INFORM THE PATIENT THE APPOINTMENT WILL BE RESCHEDULED. COPY THIS FORM AND PLACE IT IN THE COVID-19 RESCHEDULE FOLDER.**
- **IF PATIENT SAYS YES TO BOTH SYMPTOMS AND TRAVEL/CONTACT, PATIENT IS CONSIDERED HIGH RISK. COMPLETE HIGH RISK CHECK LIST BELOW.**

HIGH RISK CHECKLIST

As a result of the patient's responses above, implement the following:
- ❑ Add a high level alert in patient's chart (if any) stating "Do not schedule. Positive Coronavirus Screening on [DATE]."
- ❑ Direct patient to be evaluated by primary care provider (or emergency personnel, only if necessary).
- ❑ Advise patient or caregiver that he/she may call back to schedule no sooner than 14 days.
- ❑ Copy this form and place in COVID-19 Reschedule folder.

IF IN PERSON:
- ❑ Place a face mask on patient or caregiver immediately.
- ❑ Put on gloves and use disinfectant wipes to clean all surfaces that the patient encountered.

EMPLOYEE NAME	CONTACT NUMBER

Who are we opening with? (staff)

- Assess availability of staff: physicians, CRNAs, nursing, housekeeping, facilities. ? “comeback bonus”
- Avoid detracting from surge hospital needs, if locally relevant
- Staff scheduling considerations:
  - Those working in COVID zones or other facilities
  - Minimize number of people at the facility at any given time
  - Minimize shift changes, handoffs
  - ? A/B teams to compartmentalize potential exposures
  - Reluctant to return staff plans?
- Staff REtraining on PPE, infection control protocols etc

What do we need to re-open / ramp up?

- CHECKLISTS!! (ASCA, AmSurg templates)
- Anesthesia and medication supplies, cleaning supplies
- Adequacy of PPE (and new staff training on PPE use and infection control, and N95 fit testing)
- Ensure physical plant all working correctly including reprocessing
- Pathology (and couriers)
- Notification of reopening to local regulatory authorities, vendors of supplies and facility services, and hospital with transfer agreement
- Terminal clean center, reprocess scopes prior to re-opening (standard reprocessing acceptable)

Where: The physical space and how to use it (1)

- External screening area for Qs, temp, masking. Outside or in now unused waiting room
- No family/escorts in center unless clearly needed
- Distancing (as per prior, 6 feet etc)
- Surgical / loop masks for all (patient provided cloth ok for them)
- Buy bulk pens and discard! Wipe tablets, keyboards etc
- Face shield or physical barriers for front desk staff
- Revise patient flow in to minimize contact and maximize distancing

Where: The physical space and how to use it (2)

- Procedure room itself
  - Timing of cases and room turnover; 'flipping' rooms
  - Room 'settling' time
  - Terminal clean between all cases
  - EGD rooms vs Colon Rooms
  - Donning / doffing areas
- Post procedure, distance, recover in room?
- Exit distinct from entrance if possible and telephone sign out
- Patient follow up at X and Y days appropriate

Management of endoscopes, endoscope reprocessing, and storage areas during the COVID-19 Pandemic

- This document provides best practice recommendations with respect to endoscope handling, endoscope reprocessing, and storage area management during the COVID-19 pandemic.
- As more evidence becomes available, some of these suggestions may require subsequent updates.

DISINFECTION, HANDLING, AND ENDOSCOPE STORAGE

a. *Endoscopes*

Question: Does standard manual cleaning followed by high-level disinfection eradicate SARS-CoV-2?

Recommendation:

- Based on available evidence, standard manual cleaning followed by high-level disinfection (HLD) should be effective at eradicating SARS-CoV-2(1). At this time no changes to the reprocessing of GI endoscopes are recommended.

HOW to succeed safely

- PRACTICE: Mock trial of operations and retrain and educate staff
- RETAIN FLEXIBILITY, this ***will*** change and we'll need to change with it
  - Cessation of restrictions?
  - Resurgence requiring de-escalation
- PLAN for possible patient and staff exposures; have protocols
- PLAN for future supply needs (beyond 'normal')
- SUPPORT for staff, emotional, physical; open forum for communications

Personal Protective Equipment(PPE): Human and Environmental Safety

Michael S. Morelli MD, CPE, FACG
President Indianapolis Gastroenterology and Hepatology
Member GI Alliance

Covid-19 Transmission Routes

- Aerosolization of the virus
- Respiratory droplets
- Most prevalent exposure risk during coughing and intubation or extubation of the oropharynx
- Possible Fecal oral route
- Contact with contaminated surfaces
- Transmission can occur from both symptomatic and asymptomatic patients
- These drive the recommendations for PPE and safe practices

General PPE Use and Techniques of Infection Control in the ASC

- Proper hand washing protocols/hygiene
  - cdc.gov is an excellent resource
- Proper sequence and techniques of donning and doffing of gowns, gloves, masks, shields, etc..
- Remove all extraneous potential sources of infection/transmission
- Implementation of a work flow and process to avoid cross contamination of working stations with the staff
- Limit number of personnel working in each room and changing of personnel to conserve PPE

General PPE Use and Techniques of Infection Control in the ASC

- Ensure all patients are properly screened prior to coming to the center
  - Low risk patients would be considered those w no sxs, negative pre-procedure PCR test, no exposure to patients with Covid-19, and those living in a non hot spot or low prevalence area
- Limit patient movement in the center and avoid unnecessary contact
- Have all patients wear a surgical mask
- Social distancing in pre and post areas
- Keep all family members out of the center if possible; pick up at front door policy
- Use of procedure oxygen masks by anesthesia can be considered

COVID-19: A Roadmap to Safely Resuming Endoscopy

Filtering Face Piece Respirators and Mask Options

- Surgical masks
- N95 or equivalent performing like masks
  - KN95(Chinese) FFP2(European) P2(Australian) DS(Japanese)
- Elastomeric masks
- PAPR(Powered Air Purifying Respirators)
- Proper fitting of PPE masks is important (FIT test)
  - Hospital options
  - Private company options- can be expensive
  - Simple You tube videos are quite good and free(many available)

Filtering Face Piece Respirators and Mask Options

- Surgical masks
  - What many routinely wear now-inexpensive and prevalent
  - Should not be considered ineffective and should be acceptable protection in low risk patients especially when other masks are not available
  - Studies of surgical masks vs N95 are not consistently in favor of N95 and the extra reported benefit is not overly large but studies have methodologic flaws and are not necessarily applicable to this specific topic
  - Patient risk stratification and proper techniques are important when using these masks-if patients are screened for your center appropriately most cases should be able to be done with these masks especially if N95 and like PPE are not available
  - Can use face shields or goggles with surgical masks

Filtering Face Piece Respirators and Mask Options

- N95 or equivalent performing like masks
  - KN95(Chinese) FFP2(European) P2(Australian) DS(Japanese)
  - Filter at least 95% of airborne particles 0.3 microns diameter or greater
  - Other country versions not easily obtained
  - K95 FDA approved April 2020 of note
  - Point of caution-N95 like masks used in industry(painting for example) do not have the same performance characteristics when applied to use in health care
  - Cost generally around $1 but obviously not obtainable in many areas

COVID-19: A Roadmap to Safely Resuming Endoscopy

Filtering Face Piece Respirators and Mask Options

- Elastomeric masks
  - Same performance characteristics as N95
  - Cost in $30-$60 range
  - More easy to obtain than N95 and cheaper than PAPR
  - Non powered
  - Filters can be changed
  - Reusable and can be disinfected
  - More comfortable

COVID-19: A Roadmap to Safely Resuming Endoscopy

Filtering Face piece Respirators and Mask Options

- PAPR(Powered Air Purifying Respirators)
  - Similar performance characteristics to N95 masks
  - Expensive ranging from $800-$1300 depending on source
  - Thus more readily available
  - Good alternative when N95 masks do not fit well

Reusing Filtering Masks and Disinfecting

- Vaporized Hydrogen Peroxide
- UV light

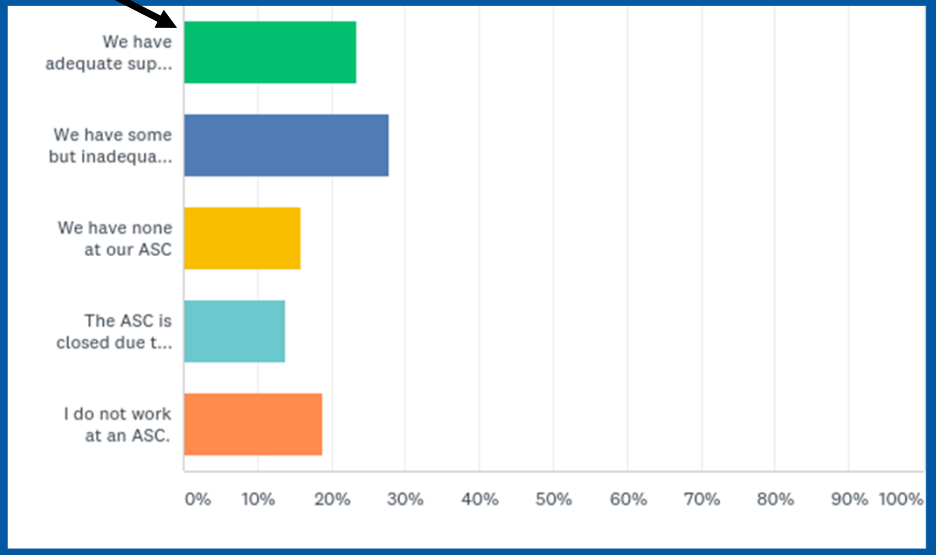
Supply Chain Process and Options

- Historical relationship and contract arrangements with health care vendors such as McKesson or Cardinal are key especially your prior allocation arrangement for N95 masks(who you know and how tied you have been to them)
- Industrial supply vendors such as 3M
- State managed emergency surge for health care(MESH) organizations
- Caution for rogue organizations that tout counterfeit products
- Approved manufacturers listed below per NIOSH-National Institute for Occupational Safety and Health
  - **https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/N95list1-a.html**

ACG STUDY RESULTS

Only 23.5% Report Adequate Supply of N95 Masks

ANSWER CHOICES	RESPONSES	
We have adequate supply for all procedures.	23.53%	56
We have some but inadequate supply for all procedures.	27.73%	66
We have none at our ASC	15.97%	38
The ASC is closed due to inadequate supply of N95 masks	13.87%	33
I do not work at an ASC.	18.91%	45
TOTAL		238



Good News from Italy: PPE Works

42 hospitals in Northern Italy

968 Health Care Workers

42 positive (4.3%),

- 6 hospitalized (0.6%)
- No Deaths
- 85.7% occurred before the introduction of safety measures (PPE/Case selection)
- 54.7% clustered in 3 centers

Only surgical masks were available for most of the procedures in Northern Italy (N95 or equivalent reserved for COVID19 infected or high risk cases)

Endoscopy News

Low risk of covid-19 transmission in GI endoscopy

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MESSAGE

Reported experience from the recent worldwide covid-19 outbreak suggests that GI endoscopy is a potential source of infection for healthcare workers (HCW); less is known about patient risk through performance of GI endoscopy as a high-risk medical procedure. Two case series from Northern Italy were recorded, one on 851 patients from one large tertiary referral centre and the other on 968 HCWs from 41 hospitals in the area. All 851 patients endoscoped in Humanitas University Hospital between 27 January and 13 March received a 2-week follow-up call; the response rate was 94.2%. Of these 802 patients, only 1 became covid-19 positive; 7 further cases developed fever and cough (3 tested negative). None of these eight cases (1.0%) required hospitalisation. In the other study, 42 hospitals in Northern Italy were invited to join a survey with regard to covid-19 positivity among HCWs, and 41 responded; centres with positive cases were interviewed in detail. Of 968 HCWs in these centres, 42 (4.3%) were tested positive for covid-19, and 6 (0.6%) had to be temporarily hospitalised (for a mean of 8 days, none on intensive care unit (ICU)). Of these 42 cases, 85.7% occurred before the introduction of safety measures, including personal protective equipment (PPE) and case selection/reduction in GI endoscopy. Clustering of HCW infection (54.7% of all cases) was observed in three centres. This data suggest that GI endoscopy appears to be relatively safe for both patients and medical personnel when using adequate protective measures.

IN MORE DETAIL

As of 31 March 2020, Italy and especially its Northern regions became the epicentre of the novel coronavirus (severe acute respiratory syndrome-CoV-2) outbreak, with more than 100 000 documented infections and a higher mortality rate than that reported in other countries. According to recent data issued by the Italian Health Authority, more than 10% of all infections in Italy have been reported among HCWs and some of them have died.[1] However, there are very few scientific data on the real incidence and risk of infection both among different categories/specialties of HCWs, as well as for patients.

Since endoscopy procedures are performed at a short physical distance to patients and also coworkers, it seems logical that both patients and HCWs in endoscopy may be exposed to significant risk for diffusion of diseases transmitted by airborne spread. In high-prevalence areas, this could be even more relevant since virus transmission can occur through asymptomatic patients. International guidelines have been proposed[2–5] to implement preventive measures. However, the effect of such protocols and the real burden of covid-19 outbreak on endoscopy patients and personnel still have to be analysed in detail.

The aim of this study was to describe incidence and outcome of infection among patients undergoing endoscopy in one tertiary referral centre in Lombardia, as well as among endoscopy personnel in the majority of hospitals located in the most affected area of Northern Italy (online supplementary figure S1).

Patients

All consecutive patients undergoing endoscopy procedures between 27 January and 13 March at the endoscopy department of the Humanitas Research Hospital Rozzano (Milan), Italy, were contacted by phone by research nurses and coordinators. A dedicated protocol with a specific list of questions (online supplementary table S1) was used to identify patients who had developed fever or respiratory symptoms or were diagnosed as covid-19 positive within 2 weeks after endoscopic procedures.

During the study period, 851 procedures were performed (online supplementary table S2). Starting with the third week of February, most of the elective procedures have been cancelled and a triage protocol has been adopted to select patients before endoscopy (time course of case numbers; see online supplementary figure S2). At the same time, protective measures for the endoscopy personnel[2] were implemented, such as reduction of cases by 80% or more to focus on emergency and immediately relevant therapies, as well as use of PPE, with gowns, googles and different masks.

Of 802 patients completing the survey, the mean age of the respondents was 57.2 years (range 22–84, 503 M). Overall, eight patients developed mild respiratory symptoms with fever (1.0 %), and one of them with cough on day 15 after lower GI endoscopy was tested positive by swab test (proven infection rate of 0.12%). None of the eight patients had to be hospitalised; details are shown in table 1. Of note, no cases of respiratory symptoms have been recorded among the 26 HCWs of the endoscopy

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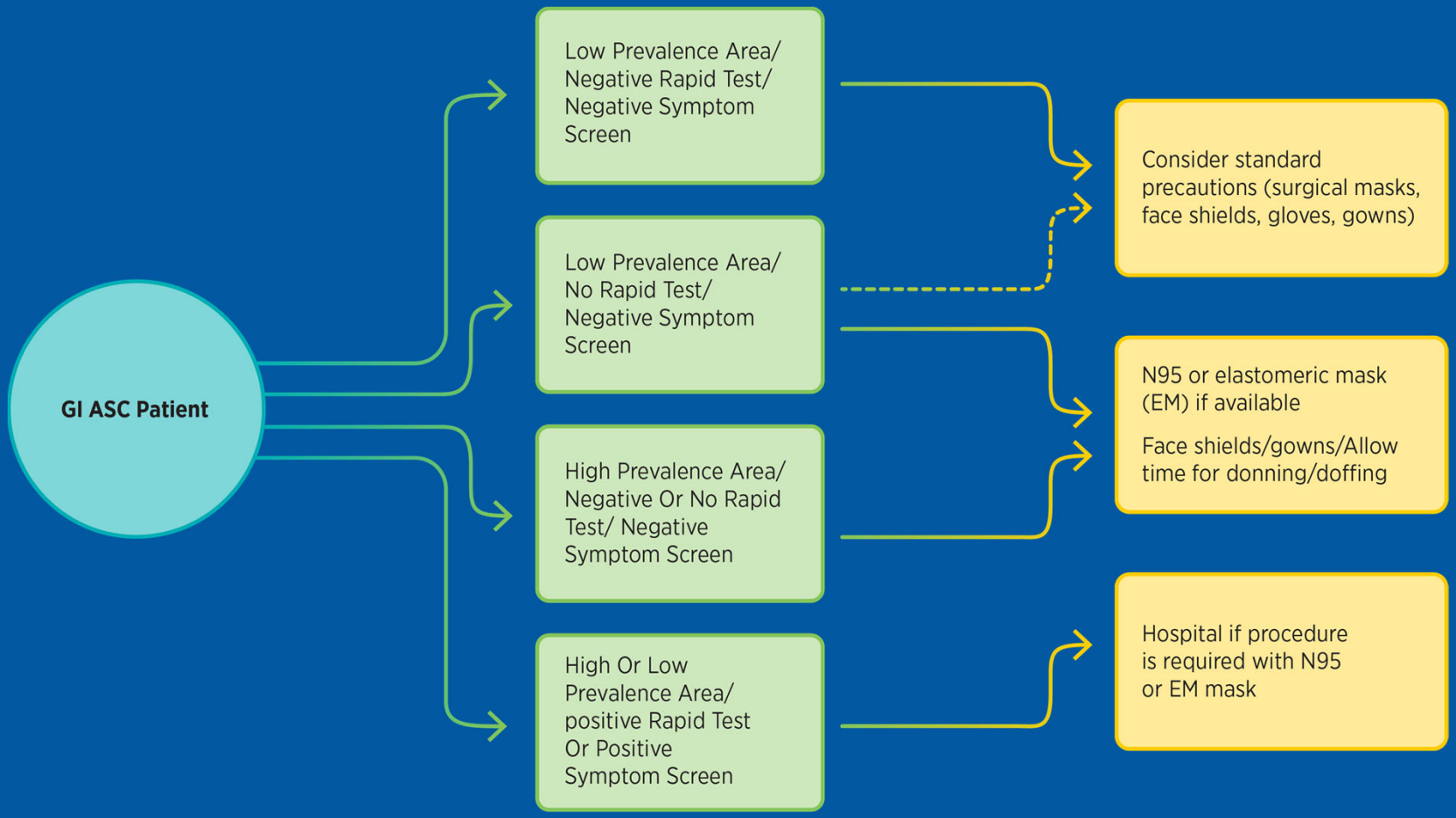
COVID-19: A Roadmap to Safely Resuming Endoscopy

PPE DECISION TREE



Summary

- Understand how Covid-19 is transmitted
- Take all appropriate pre cautions when utilizing all PPE
- The N95 masks, PAPR, and EM masks are the most protective but have different availabilities, obtainability, and cost
- We feel the best approach is to risk stratify patients according to..
  - Prevalence of disease in your area
  - Pre screening of patients as outlined. High risk and + patients should likely be done in the hospital and with use of highest PPE possible
  - Low risk patients can be done with surgical masks and shields especially in low risk procedures such as colonoscopy

COVID-19 Testing

What's Available, Who should We Test?

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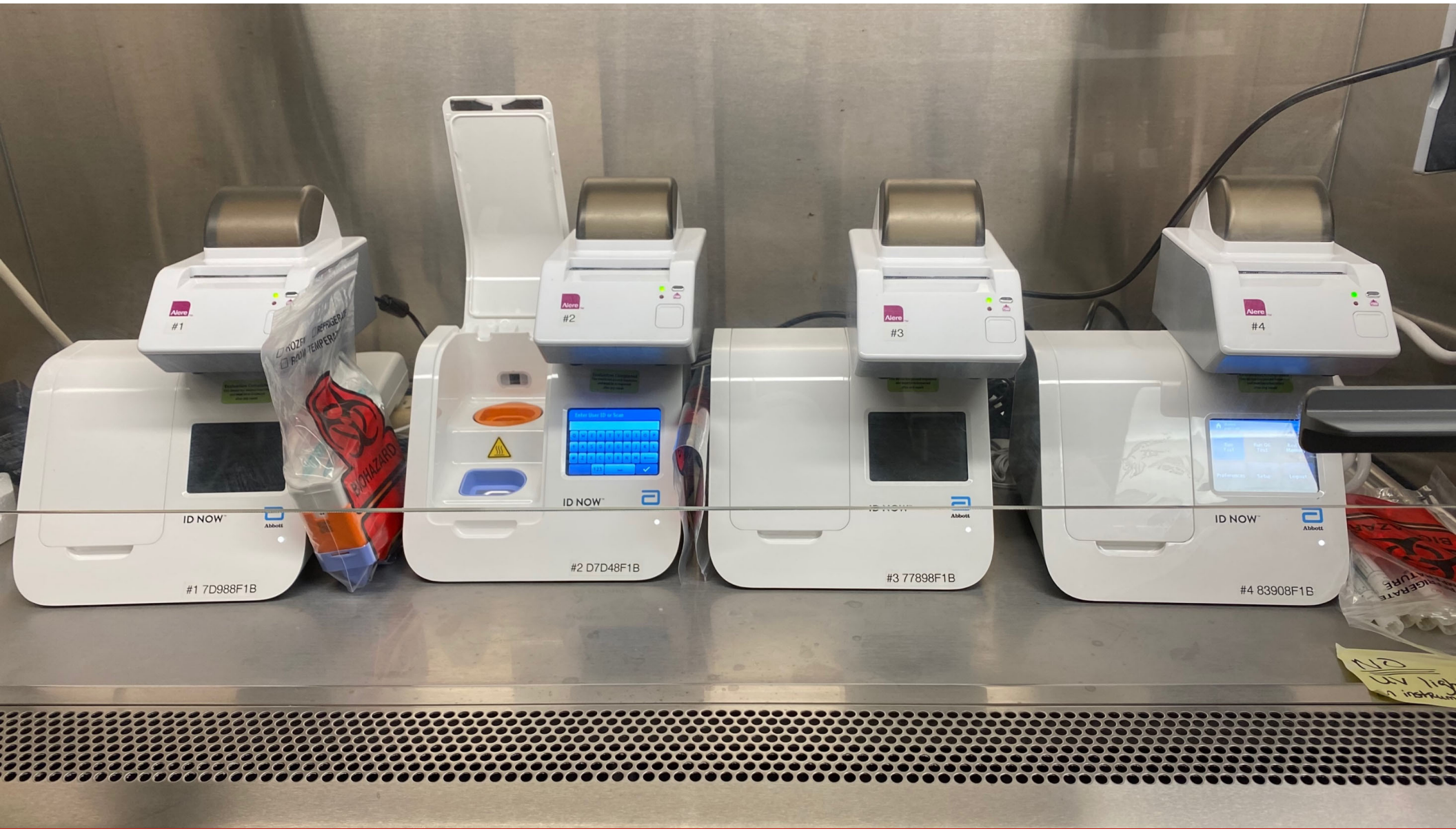
Austin Infectious Disease Consultants

COVID-19 Diagnostic Tests

- Nucleic Acid Amplification Testing (NAAT) – Most sensitive rapid diagnostic testing method
  - Polymerase Chain Reaction (RT-PCR)
    - CDC
    - Roche Cobas
    - Quidel
  - Isothermal Nucleic Acid Amplification
    - Abbott ID NOW COVID-19 (It is marketed as POC – but not really!)
- COVID-19 Antibody testing (future is here albeit in slow motion)
- COVID-19 Antigen testing (future)


#1
ID NOW
#1 7D988F1B
BIOHAZARD
#2
ID NOW
#2 D7D48F1B
#3
ID NOW
#3 77898F1B
#4
ID NOW
#4 83908F1B

ID NOW – Needs Internal Validation (Austin)

- Patient specimens with known results using prior RT-PCR platform(s)
- Samples retested on the ID NOW

Test Result	Number Concordant/ Number Tested	% Agreement [95% CI]
Positive	45/46	97.8% [88.5 – 99.9%]
Negative	58/58	100% [93.8 – 100%]

Number of Tests – Availability Question

- St. David's Medical Center (as example)
  - 4 analyzers
  - 384 tests available per week
  - 54 tests available per day
  - We received 384 tests for the first 2 weeks each and then FEMA intercepted and we didn't get any test for the next 2 weeks….AVAILABILITY IS AN ISSUE!!

Why Antibody Test Is Not Recommended?

- It should NEVER be used to make the diagnosis – First week of illness patients are most infectious and antibody test is NEGATIVE
- Appx. 50% of the patients are POS for IgM and 30% for IgG at 7 days
- Appx. 85% of the patients are POS for IgM and 70% are POS for IgG at 14 days
- False negative – missed opportunity to make a diagnosis
- False positive – disastrous consequences
- FDA Warning – "Not use serological test as the sole basis to diagnose COVID-19 but instead as information about whether a person may have been exposed"

How Would We Use COVID-19 Antibody Test?

- Help determine the prevalence of SARS-CoV-2 infection in population
- Identify individuals in the community who are immune – We don't have good data yet as per WHO press release on 4/24
- Help delineate the phase of infection
- Identify donors of therapeutic plasma
- Possible help with return to work decisions

What Should We Do? - Too Many Questions With Few (Correct) Answers

- Do we test the staff?
- Do we test all the patients prior to the elective procedures?
- It all depends upon:
  - Availability of testing (also reagents, swabs)
    - If testing – timing?
  - Availability of PPE
  - Disease prevalence in your community
  - Abbott ID NOW is not a POC test!!!!

Questions?

How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2020 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2021 for this activity.

ACG will submit MOC points on the first of each month. Please allow 3-5 business days for your MOC credit to appear on your ABIM account.

MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.