



## Department of Health

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TO: Hospitals, Ambulatory Surgery Centers, Office-Based Surgery Practices, and Diagnostic & Treatment Centers

### **Updated Guidance for Resumption of Non-Essential Elective Surgeries and Non-Urgent Procedures in Hospitals, Ambulatory Surgery Centers, Office Based Surgery Practices and Diagnostic and Treatment Centers**

On June 8, 2020, New York City was deemed eligible to resume elective surgery. As such, Hospitals, Ambulatory Surgery Centers (ASC), Office Based Surgery Practices (OBS) and Diagnostic and Treatment Centers (DTC) in all counties of the State may resume non-essential elective surgery and non-urgent procedures. Please note, eligibility requirements may be adjusted based on the prevalence of COVID-19 in a region or a county, and these surgeries and procedures may be suspended if there is a significant increase in community spread and/or hospitalization rates.

This guidance is an update to the April 29, 2020 directive issued to hospitals by the New York State Department of Health (Department), as established by Executive Order No. 202.25, as well as guidance issued on May 19, 2020 to ASCs, OBS and DTCs.

#### **I. Updated Guidance for Hospitals**

This guidance updates the April 29, 2020 directive, "COVID-19 Directive Regarding the Resumption of Elective Outpatient Surgeries and Procedures in General Hospitals in Counties and Facilities Without a Significant Risk of COVID-19 Surge", available at [https://coronavirus.health.ny.gov/system/files/documents/2020/05/elective-surgery-notification\\_4\\_29\\_20.pdf](https://coronavirus.health.ny.gov/system/files/documents/2020/05/elective-surgery-notification_4_29_20.pdf).

Hospitals in all counties may resume non-essential elective surgeries and non-urgent procedures in both inpatient and outpatient settings. Waivers are no longer required. Hospitals that have already submitted the attestation included with the April 29 directive do not have to re-submit it. By submitting that attestation, hospital leadership is affirming that the hospital meets the requirements on pages 3 and 4 of the April 29 directive within the section titled, "Requirements for All Eligible General Hospitals Performing Non-Essential Elective Surgeries and Non-Urgent Procedures", as updated in this guidance. Hospitals are not required to attest to the eligibility requirements in the April 29 directive, including hospital inpatient capacity, ICU capacity, and COVID-19 hospitalization rate.

Updated requirements from the April 29 directive are summarized below; updates and clarifications are indicated in **bold**.

- The April 29 directive required hospitals to meet thresholds for total bed capacity, ICU bed capacity, and COVID hospitalization rate based on the HERDS survey data submitted for the period April 17 through April 27. **These thresholds are no longer used to qualify hospitals to resume and continue to perform non-essential elective surgeries and non-urgent procedures. However, hospitals should continue to carefully monitor their bed capacity, hospitalization, and other metrics, such as rate of transmission, and make adjustments to capacity and operations as needed.**

- The April 29 directive included a requirement that hospitals establish a prioritization policy committee consisting of surgery, anesthesia, and nursing leadership to develop a prioritization strategy for elective surgery and procedures, to include case prioritization, safe and appropriate care, and availability of post-operative recovery and rehabilitation settings. **This committee must address the prioritization of both inpatient and outpatient elective procedures and should be responsible for monitoring the Regional Reopening metrics indicated above. Prioritization policies should be reviewed regularly and adjusted based on fluctuations in demand as measured by these metrics.**
- The April 29 directive included a requirement that hospitals test all patients receiving elective surgeries and procedures for COVID-19 and patients must test negative for COVID-19 using a molecular assay for detection of SARS-CoV-2 RNA prior to any such surgery or procedure. **The requirement to administer the test has been revised from three days prior to the elective surgery or procedure, to five days prior to the elective surgery or procedure, and this requirement extends to include both inpatients and outpatients. Test results must be received and reviewed before conducting the surgery or procedure. The only exception would be a non-scheduled emergent procedure, where testing prior to surgery may not be feasible. In this case, a thorough screening and history should be taken, as well as other appropriate precautions. A test should be performed as soon as possible and if positive, may result in the need for health care worker exposure protocols to be followed. Hospitals do not have to perform the test; it is allowable to accept a third-party test, provided it is a viral molecular assay as described above and is performed by a laboratory with any required permits and approvals.**
- The requirement in the April 29 directive for hospitals to counsel patients regarding social distancing, wearing facemasks, minimizing contact with others for the 14 days before the surgery or procedure, and for patients to be questioned about symptoms or any potential contacts with symptomatic persons prior to the surgery or procedure **is extended to patients being admitted for inpatient elective surgery.**
- There has been no change to the requirement for hospitals to have adequate personal protective equipment (PPE) and medical and surgical supplies appropriate to the number and type of procedures to be performed. Adequate PPE means that a hospital has at least a seven-day supply of PPE on hand and the hospital's supply chain can maintain that level **to support both inpatient and outpatient surgeries and procedures** without resorting to contingency or crisis capacity strategies. **To prepare for a potential future surge, hospitals should be working towards having immediate access to a 90-day supply of PPE.**
- There has been no change to the requirement for hospitals resuming elective surgeries and non-urgent procedures to ensure sufficient staffing, and to take into consideration the time needed to reassign staff as needed, including the needs of staff returning from direct care related to surge activities for downtime and emotional support.
- The April 29 directive included a requirement for hospitals resuming non-essential elective surgeries and non-urgent procedures to submit information about the types and numbers of surgeries and procedures to the Department on a monthly basis. **There is no longer a requirement to submit this data; however, hospitals should have a mechanism to report this information to the Department if requested in the future.**

## II. Update to May 19 Guidance for ASC, OBS and DTC Providers

This guidance updates the May 19, 2020 guidance, “COVID-19 – Resumption of Elective Outpatient Surgeries and Non-Urgent Procedures (Deferred Procedures) in Ambulatory Surgery Centers, Office-Based Surgery Practices and Diagnostic and Treatment Centers in Counties Without a Significant Risk of COVID-19 Surge”, available at

<https://coronavirus.health.ny.gov/system/files/documents/2020/05/guidance-for-elective-surgery-and-non-urgent-procedures-in-ambulatory-settings.pdf>.

- The May 19 guidance for ASC, OBC and DTC regarding testing has not changed except for the following update. **The test period may now be extended from three days to five days prior to the surgery or procedure. Test results should be received and reviewed before conducting the surgery or procedure. The only exception would be a non-scheduled emergent procedure where testing prior to surgery may not be feasible. In this case, a thorough screening and history should be taken as well as appropriate precautions. A test should be performed as soon as possible, and if positive, may result in the need for health care worker exposure protocols to be followed. Providers do not have to perform the test; it is allowable to accept a third-party test provided it is a viral molecular assay as described above and is performed by a laboratory with any required permits and approvals.**
- The May 19 guidance for ambulatory facilities to maintain ongoing confirmation of local hospital capacity (bed census, ICU census, and ventilator availability) is clarified. **The intention of this guidance is for ASC, OBS, and DTC providers to monitor capacity at the hospitals to which they would normally be transferring to and/or recommend patients visit post procedure, if necessary. Providers should establish their own policies for frequency of monitoring and may monitor local hospital capacity by region at the following link:** <https://forward.ny.gov/early-warning-monitoring-dashboard>.
- There has been no change to the requirement for ASCs, OBSs and DTCs to have adequate PPE and medical and surgical supplies appropriate to the number and type of procedures to be performed. Adequate PPE means that an ambulatory provider has at least a seven-day supply of PPE on hand, and the provider’s supply chain can maintain that level to support outpatient surgeries and procedures without resorting to contingency or crisis capacity strategies. To prepare for a potential future surge, providers should be working towards having immediate access to a 90-day supply of PPE.

## III. Updated Guidance for All Providers

Providers have requested additional guidance for the type of PPE recommended when performing high risk (e.g., aerosolizing) procedures. In general, procedures performed on mucous membranes, including the respiratory tract, pose a higher risk of aerosol transmission. They should be performed with caution and healthcare staff should utilize appropriate respiratory protection such as N95 masks and face shields. Please refer to CMS Guidance: Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase 1, available at <https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf>.

In addition, as guidance for types of surgery procedures by site:

- Above the clavicle, high-risk procedures (e.g., intubation, chest tubes, tracheostomy, EGD, use of high flow O2 delivery and open suction of airways), use of full PPE and isolation garments are recommended (FDA approved N95 masks, face shield, isolation garments/gowns, gloves).

- Below the clavicle procedures, use of an N95 mask or surgical mask, eye protection, traditional surgical gowns, and gloves are recommended.

Sources: <https://www.plasticsurgery.org/for-medical-professionals/covid19-member-resources/resumption-of-elective-surgery> and [https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take\\_precautions](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take_precautions).

Please note that the Department has issued general guidance. Providers should adopt and follow professional standards of care which, at a minimum, should be based on specialty specific COVID-19 recommendations. An example of a relevant recommendation, in addition to other resources mentioned in this document, is the guidance published by the American College of Surgeons on resuming elective surgeries, available at <https://www.facs.org/covid-19/clinical-guidance/resuming-elective-surgery>.

Another helpful resource is the Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic, released by the American College of Surgeons, the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses, and the American Hospital Association, available at <https://www.asahq.org/about-asa/newsroom/news-releases/2020/04/joint-statement-on-elective-surgery-after-covid-19-pandemic>.