ACG Virtual Grand Rounds

COVID-19 Management: Pearls for the Gastroenterologist

Endoscopy Resumption Task Force discusses top 5 GI consults for COVID-19 complications, top 5 updates on COVID-19 therapeutics, and top 5 common COVID-19 vaccination questions for gastroenterologists

TUESDAY, FEBRUARY 9th, 8 to 9:30 PM EST
Moderator: Francis A. Faraye, MD, MSc, MACG
Speakers:
  - Freddy Caldera, DO, MS
  - Harish K. Gagneja, MD, FACP
  - Melissa Latorre, MD, MS

Register & Learn More gi.org/ACGVGR

Visit gi.org/ACGVGR to Register

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.
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.
ACG Endoscopy Resumption Task Force/Practice Management Committee

Physicians Survey

Louis J Wilson, MD, FACG
Wichita Falls, Texas

Survey Team

Stephen Amann, MD, FACG
Melissa Latorre, MD MS
Tamara Brodsky, MD MBA
ACG Endoscopy Resumption Task Force/Practice Management Committee Physicians Survey

“What Just Happened!?"
ACG Task Force Surveys

Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC

Survey 1 – April 7-21
Survey 2 – June 8 to 23
Survey 3 – Jan 5-19

State and Local “Lockdowns”

ACG Endoscopy Resumption Task Force Webinars

Three ACG COVID 19 Crisis Surveys

April 7 to 21, 2020
- 16 Qs
- 335 R
- 42 & PR

June 8 to 23, 2020
- 29 Qs
- 315 R
- 47 & PR

January 5 to 19, 2021
- 40 Qs
- 435 R
- 46 & PR
Task Force/Practice Management Physicians Survey Areas

Effect of the COVID 19 Pandemic on:
1. Practice Characteristics
2. Endoscopy Practice
3. Outpatient/Clinic Practice
4. Hospital Practice
5. Financial Outcomes

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practice/physician-owned</td>
<td></td>
</tr>
<tr>
<td>Single specialty physician-owned/traditional private practice</td>
<td></td>
</tr>
<tr>
<td>Single specialty platform company/private equity-affiliated private practice</td>
<td></td>
</tr>
<tr>
<td>Multi-specialty physician-owned/private practice</td>
<td></td>
</tr>
<tr>
<td>Hospital or health system-based/employed</td>
<td></td>
</tr>
<tr>
<td>Traditional academic practice</td>
<td></td>
</tr>
<tr>
<td>Veterans Administration/government/military employed</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

American College of Gastroenterology
Do you usually perform outpatient endoscopy at an ambulatory surgery center?

Who is performing endoscopy at an ASC?

- Private Practice versus Hospital Employed
  - Q1: Single specialty...
    - 91%
  - Physicians in PP are 75% more likely to work in an ASC
  - Q1: Hospital or health...
    - 52%
EARLY RESPONSE: What best describes the EARLY response in your outpatient endoscopy practice to the COVID 19 Pandemic?

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never shut down outpatient endoscopy completely.</td>
<td>22.47%</td>
</tr>
<tr>
<td>Shut down outpatient endoscopy briefly but resumed within 2 weeks.</td>
<td>14.90%</td>
</tr>
<tr>
<td>Shut down for longer than 2 weeks but have resumed now.</td>
<td>57.83%</td>
</tr>
<tr>
<td>Previously opened but are currently shut down for outpatient endoscopy again.</td>
<td>2.78%</td>
</tr>
<tr>
<td>Closed our outpatient endoscopy practice and never reopened.</td>
<td>0.51%</td>
</tr>
<tr>
<td>This issue does not apply to my practice.</td>
<td>1.52%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>396</td>
</tr>
</tbody>
</table>
What best describes your current outpatient endoscopy practice?

- Urgent and emergent cases only: 6.6%
- All cases (urgent and elective): 91%

N95 Mask Usage and Availability: The PPE gap has closed

- April: 23.5%
- May: 70%
- August: 77%
- October: 73%
- January: 87%
- December: 83%
What best describes the pre-procedure COVID 19 screening for PATIENTS scheduled for outpatient endoscopy at this time?

- Clinical screening: questions +/- temp checks
- COVID 19 antigen testing
- COVID 19 PCR testing
- Other (please specify)

PATIENT SCREENING: PP versus Hospital employed

<table>
<thead>
<tr>
<th></th>
<th>CLINICAL SCREENING WITH RISK-QUESTIONS AND/OR TEMPERATURE CHECKS BEFORE OUTPATIENT ENDOSCOPY.</th>
<th>TESTING FOR COVID 19 BY PCR IS REQUIRED PRIOR TO OUTPATIENT PROCEDURES.</th>
<th>COVID 19 ANTIGEN TESTING IS REQUIRED PRIOR TO ALL OUTPATIENT PROCEDURES.</th>
<th>I DON'T KNOW</th>
<th>THIS ISSUE DOES NOT APPLY TO MY PRACTICE.</th>
<th>OTHER (PLEASE SPECIFY)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: Single specialty physician-owned/traditional private practice</td>
<td>55.00% 77 34.29% 48</td>
<td>4.29% 6</td>
<td>0.00% 0</td>
<td>1.43% 2</td>
<td>5.00% 7</td>
<td>59.83% 140</td>
<td></td>
</tr>
<tr>
<td>Q1: Hospital or health system-based/employed</td>
<td>18.09% 17 67.02% 63</td>
<td>9.57% 9</td>
<td>0.00% 0</td>
<td>2.13% 2</td>
<td>3.19% 3</td>
<td>40.17% 94</td>
<td></td>
</tr>
<tr>
<td>Total Respondents</td>
<td>94 111</td>
<td>15 0 4 10 234</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital employed are 97% more likely to require COVID testing by PCR than PP physician.
PROVIDER SCREENING: How are YOU and other endoscopy staff members screened for COVID 19 prior to performing endoscopy at this time?

No testing

Periodic PCR or antigen testing 4.5%

Clinical screening: questions +/- temp checks

More hospital employed physicians report no provider screening by any method.
PROVIDER SCREENING: How are YOU and other endoscopy staff members screened for COVID 19 prior to performing endoscopy at this time?

ASC Versus Hospital Based

ASC

Clinical screening

Q32: No

Hospital

No testing

There is very little difference in requirement for provider setting in the hospital versus the ASC setting.

VOLUME EXPECTATIONS: What best describes the expected patient volume at your gastroenterology practice?

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or above full volume now</td>
<td>40.55%</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in 31 to 60 days</td>
<td>16.88%</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in 61 to 90 days</td>
<td>12.59%</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in greater than 90 days</td>
<td>22.67%</td>
</tr>
<tr>
<td>Never expect to back to my pre-crisis volume</td>
<td>6.30%</td>
</tr>
<tr>
<td>Does not apply to my practice</td>
<td>1.01%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
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</table>
VOLUME EXPECTATIONS: What best describes the expected patient volume at your gastroenterology practice?

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<th>ANSWER CHOICES</th>
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</thead>
<tbody>
<tr>
<td>At or above full volume now.</td>
<td>40.55% 161</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in 31 to 60 days.</td>
<td>16.88% 67</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in 61 to 90 days.</td>
<td>12.59% 50</td>
</tr>
<tr>
<td>Below normal volume but expect to be back at full volume in greater than 90 days.</td>
<td>22.67% 90</td>
</tr>
<tr>
<td>Never expect to back to my pre-crisis volume.</td>
<td>6.30% 25</td>
</tr>
<tr>
<td>Does not apply to my practice.</td>
<td>1.01% 4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>397</td>
</tr>
</tbody>
</table>

PPE AT THE OFFICE: What best describes the current PPE requirements for providers and staff at your office practice?

- N95 required: 13%
- Surgical mask required: 70%
- Any face covering: 15%
- Not applicable: 100%
Prior to the pandemic were you using telemedicine at your practice?

- Yes: 91%
- No: 9%
- Does not apply to my practice: 0%

Using Telemedicine Now

- More than 75% of Encounters: 67%
- 30% to 50%: 26%
- 10% to 30%: 19%
TELEMED REIMBURSEMENT: Which best describes how well your practice has been reimbursed for telemedicine services during the COVID 19 pandemic?

- 22% Poor reimbursement (Many denials, services not paid)
- 65% Good reimbursement (Most paid at expected rates)
- 11% Does not apply to my practice

FUTURE PLANS FOR TELEMED: What are your expectations for the use of telemedicine after the COVID 19 pandemic?

- 86% expect to continue if rates maintained
- 21% Continue regardless of payment
- 11% Will not continue
- Does not apply

American College of Gastroenterology
How many of your staff members do you believe have contracted COVID 19 infection due to exposure at work?

*40% of practices have also had a physician with COVID (25% at work)*

Have you already received vaccination for COVID 19?

93% Yes

American College of Gastroenterology
Have COVID-19 vaccinations become available for your staff members?

- 82% Yes
- 18% No

What best describes the practices policy concerning COVID-19 vaccination for staff members at your practice?

- 70% We do not have a practice policy for COVID-19 vaccination.
- 10% Vaccination is recommended but not verified or tracked.
- 10% Vaccination is required and verified or tracked.
- 10% Vaccination is not required, but is recommended and tracked.
Have COVID 19 vaccinations become available for your staff members? Private Practice versus hospital employed

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single specialty...</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Hospital or health...</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

FINAL MESSAGE

Despite persistent disruption in the practice of gastroenterology there are encouraging trends suggesting the resilience of GI practices in the face of COVID 19 pandemic.
Federal Update

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

Topics

• Paycheck Protection Program (PPP)
• CMS Accelerated and Advanced Payment Program
• CARES Act Provider Relief Fund
• Other Programs
• Consolidated Appropriations Act (CAA)
• Outlook
Paycheck Protection Program (PPP) – 1

- Created by Congress as part of the $2 trillion CARES Act
- **Who:** Small businesses < 500 employees, self-employed individuals or independent contractors
- Covers payroll, healthcare benefits, rent, utilities, mortgage interest
- Loan administered by Small Business Administration via local bank
- Up to $10 million per entity, based on average monthly payroll from prior year
- Loan forgiveness based on employer maintaining or rehiring employees and maintaining salary levels; forgiveness will be reduced if full-time employees or salaries and wages decrease
- Program closed to new applications on August 8, 2020 but reopened January 11, 2021 for first time applicants to the First Draw PPP Loan

Paycheck Protection Program (PPP) – 2

- Loans have an interest rate of 1%
- Loans issued before June 5 have a maturity of 2 years; Loans issued after June 5 have a maturity of 5 years
- Loan payments will be deferred for borrowers who apply for loan forgiveness until Small Business Administration remits borrower’s loan forgiveness amount to lender
  - If borrower does not apply for loan forgiveness, payments are deferred 10 months after end of covered period for borrower’s loan forgiveness (either 8 weeks or 24 weeks)
- No collateral or personal guarantees are required
- Government and lenders will not charge small businesses any fees
Paycheck Protection Program (PPP): Second Draw

- Eligible borrowers that previously received PPP loan may apply for a Second Draw PPP Loan
- Same general loan terms as First Draw PPP Loan
- Can be used to fund payroll costs, including benefits, mortgage interest, rent, utilities, worker protection costs related to COVID-19, uninsured property damage costs caused by looting or vandalism during 2020, and certain supplier costs and expenses for operations
- For most borrowers, maximum loan amount of Second Draw PPP Loan is 2.5x average monthly 2019 or 2020 payroll costs up to $2 million
- Borrower generally eligible for a Second Draw PPP Loan if:
  - Previously received First Draw PPP Loan and will or has used full amount only for authorized uses
  - Has no more than 300 employees; and
  - Can demonstrate at least 25% reduction in gross receipts between comparable quarters in 2019 and 2020
- How and when to apply:
  - Apply for Second Draw PPP Loan from January 13, 2021, until March 31, 2021
  - SBA is accepting Second Draw PPP loan applications from participating lenders
  - All Second Draw PPP Loans will have same terms regardless of lender or borrower


CMS Medicare Accelerated and Advanced Payment Program

- Who: Part A or Part B providers and suppliers: Hospitals, physicians, ASC facility fees, infusion fees, pathology, durable medical equipment suppliers, etc.
- Advanced payment (loan) from CMS; must be repaid to CMS
- Must have billed Medicare for claims within 180 days, not in bankruptcy, not under medical review/investigation, no outstanding delinquent Medicare overpayments
- Funds received are 3-month estimate of usual earnings based on historical data
- Repayment now delayed until 1 year after payment was issued
- After 1st year, CMS will automatically recoup 25% of Medicare payments owed to provider for 11 months; at the end of the 11-month period, recoupment will increase to 50% for another 6 months; if provider is unable to repay total amount of payment during this time-period, CMS will issue letters requiring repayment of outstanding balance, subject to 4% interest rate
- CMS has paid out over $100 billion in AAPP loans
- CMS stopped accepting AAPP loan applications on 10/8/2020
- Extended Repayment Schedule for those experiencing financial hardship

CARES Act Provider Relief Fund (PRF) – 1

- **Who**: Providers and all facilities (ASCs) that received Medicare fee-for-service payments in 2019
- Employed providers will not receive funds; funds will go to employer organization
- Funds for group practice or solo physicians deposited to organization’s TIN
- **Grant** that does not require repayment
- Automatic payment from HHS/CMS administered by UnitedHealth Group
- Electronic deposit from Optum Bank with description “HHSPAYMENT” (or paper check in mail)
- May be used for health care related expenses or lost revenue due to COVID
- Within 90 days of receiving payment, providers must sign attestation confirming receipt of funds and agreement to terms and conditions
- Does not require repayment, but recipients may be subject to recoupment if funds are not fully expended on permissible expenses or to cover lost revenue

https://www.hhs.gov/coronavirus/cafes-act-provider-relief-fund/for-providers/index.html#what-is-the

CARES Act Provider Relief Fund (PRF) – 2

- Providers receiving more than $10,000 in aggregate payments are required to report on increased health care related expenses and lost revenues attributable to COVID-19
- **Two step process** for applying these funds to COVID Expenses and Lost Revenues:
  1. PRF payments applied to healthcare related expenses attributable to coronavirus over and above what has been reimbursed by other sources
     - General & Administrative expenses
     - Other healthcare related (i.e., operating) expenses
  2. Remaining PRF payments are then applied to patient care lost revenues
     - Payment applied based on the lost revenue calculation approach:
       - Actual-to-Actual
       - Budget-to-Actual
       - “Any Reasonable Method”
- Reporting Deadline for 2020 has been extended (date TBD)
- Current reporting periods include calendar year 2020 and January-June 2021

https://www.hhs.gov/coronavirus/cafes-act-provider-relief-fund/for-providers/index.html#what-is-the
Other Programs

- Economic Injury Disaster Loans (EIDL) and Loan Advance
  - Loan, required repayment, 3.75% interest
  - Must demonstrate substantial economic injury from declared disaster
- FCC Funds for COVID 19 Telehealth Program
  - For eligible providers to purchase telecommunications, devices, broadband connections for telehealth
  - Program closed to new applications June 25, 2020
- Federal Student Loan Deferment of Payments
  - Suspension of Payments to Dept. of Education from March 13 – December 31, 2020

https://www.fcc.gov/covid-19-telehealth-program
https://studentaid.gov/manage-loans/lower-payments/get-temporary-relief

Consolidated Appropriations Act (CAA), 2021

- $1.4 trillion bill, $900 billion of which is COVID relief
  - Establishes surprise billing fix
  - Extends suspension of Medicare sequestration until 4/1/2021
- Changes to key funding sources:
  - PPP: $284 billion refill (increasing total to $943 billion) and extends program to 3/31/2021
    - Several policy changes implemented, including (1) reopening PPP for second draws (2) expanding types of eligible expenses and (3) corrects tax liability issues
  - Emergency EIDL Grants: $20 billion (increasing total to $40 billion)
  - PRF: $3 billion (increasing total to $178 billion)
    - Two key policy changes: (1) additional flexibility to calculate lost revenues and (2) additional flexibility for parent entities to transfer Targeted Distributions

President Biden Issues COVID-19 Executive Orders

- Executive Order on Establishing the COVID-19 Pandemic Testing Board and Ensuring a Sustainable Public Health Workforce for COVID-19 and Other Biological Threats
- Executive Order on Protecting Worker Health and Safety
- Executive Order on Ensuring an Equitable Pandemic Response and Recovery
- Executive Order on a Sustainable Public Health Supply Chain
- Memorandum to Extend Federal Support to Governors’ Use of the National Guard to Respond to COVID-19 and to Increase Reimbursement and Other Assistance Provided to States
- Executive Order on Ensuring a Data-Driven Response to COVID-19 and Future High-Consequence Public Health Threats
- Executive Order on Improving and Expanding Access to Care and Treatments for COVID-19
- Executive Order on Strengthening Medicaid and the Affordable Care Act
CMS Update

- Due to ongoing public health emergency (PHE), telehealth continues to be reimbursed by CMS and insurers
- CMS has indicated that it will extend COVID-19 PHE until end of CY 2021, but nothing official yet
- MIPS requirements have been loosened due to the pandemic

https://qpp.cms.gov/resources/covid19#:~:text=Due%20to%20the%20anticipated%20need,the%20MIPS%202021%20performance%20period

U.S. Department of Labor Issues
Stronger Workplace Guidance – 1/29/2021

- Guidance recommends:
  - Conduct a hazard assessment
  - Identify control measures to limit virus spread
  - Adopt non-punitive policies for employee absences, to encourage potentially infected workers to remain home
  - Ensure that coronavirus policies and procedures are communicated to both English and non-English speaking workers
  - Implement protections from retaliation for workers who raise coronavirus-related concerns
- Details key measures for limiting coronavirus’s spread, including: (1) ensuring infected or potentially infected people are not in the workplace (2) implementing and following physical distancing protocols and (3) using surgical masks or cloth face coverings
- Provides guidance on use of personal protective equipment, improving ventilation, good hygiene and routine cleaning
- Not a standard or regulation, and it creates no new legal obligations; contains advisory recommendations and descriptions of existing mandatory safety and health standards

https://www.dol.gov/newsroom/releases/osha/osha20210129
Outlook 2021

- Biden seeking COVID-19 relief package that currently faces roadblocks
- Confirmation hearings have been delayed; still no announced CMS Administrator
  - These are important for setting the Biden Administration’s regulatory agenda
- Potential additional changes to PRF under Biden Administration
- ACA lawsuit (decision expected June, but could be earlier)
  - Will Congress act in advance?
- Currently unclear how telehealth will be addressed as a more permanent fix beyond COVID-19 PHE
- Unclear how active Biden Administration will be on alternative payment models (APMs) and with respect to MIPS/A-APMs

Pre-Procedure Covid-19 Testing

Jeffry Nestler MD, FACP

ACG Governor – Connecticut
President, Connecticut GI PC
Director, Division of Gastroenterology Hartford Hospital
Co-Director, Digestive Health Center Hartford Healthcare
Associate Clinical Professor, University of Connecticut
Pre-Procedure Covid-19 testing

To test or not to test, that is still the question

Types of Testing

• Nucleic Acid Amplification Testing (NAAT)
  • Polymerase Chain Reaction (RT-PCR)
  • Other Nucleic Acid Amplification Tests
• Covid-19 Antigen testing – “rapid”
• Antibody testing – IgG, IgM; prior infection
Sensitivity and Specificity

- RT–PCR – most sensitive (91-97%)
- Other NAATs – high sensitivity
- Rapid Antigen – variable sensitivity; lower sensitivity in asymptomatic patients (40-50%)
- Specificity is high with all tests (95-98%)
- The higher the prevalence; the greater the positive predictive value of the test
- The lower the prevalence; the lower the positive predictive value of the test

Who to Test?

- Staff – How often? Which test
- Providers – How often? Which test
- **Patients** - How many days prior to procedure? The closer to the procedure - the better (<72 hours)
Barriers to Testing

• Testing availability
• Logistics/Turnaround time
• Cost (test and personnel)
• Insurance coverage
• Patient acceptance

Be prepared for increased cancellations in your ASCs!

Pre – Procedure COVID Testing Recommendations

• Federal – none
• State/County – varies
• Hospital system – varies
• Joint venture partner – varies
• Professional Societies – varies
Pre-Procedure COVID-19 Testing
ASC Prevalence

- Asymptomatic patients
- Range of positivity - .14% To 2.44%
- Low overall positivity rate
- Positivity rate increases with prevalence
- Connecticut GI (unpublished data) – May thru Dec - 63/25642 (.24%)
- Our weekly range - 0% - .93%; correlates to overall prevalence

Forde JJ et al. Gastro 2020 159:1538
Kidambi TD et al Gastro 2020
### ACG Survey

#### Who is performing testing?

<table>
<thead>
<tr>
<th>Clinical Screening</th>
<th>Testing for COVID 19 by PCR is Required Prior to Outpatient Procedures</th>
<th>COVID 19 Antigen Testing is Required Prior to All Outpatient Procedures</th>
<th>I Don’t Know</th>
<th>This Issue Does Not Apply to My Practice</th>
<th>Other (Please Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC</td>
<td>45.26%</td>
<td>6.32%</td>
<td>0.35%</td>
<td>0.70%</td>
<td>2</td>
</tr>
<tr>
<td>Hospital</td>
<td>72.37%</td>
<td>10.53%</td>
<td>0.00%</td>
<td>2.63%</td>
<td>2</td>
</tr>
</tbody>
</table>

| ASC                | 120                                                        | 18                                                       | 1           | 4                                      | 15                     |
| Hospital           | 184                                                        | 26                                                       | 1           | 4                                      | 15                     |

### ACG Survey

#### Independent versus Hospital employed

<table>
<thead>
<tr>
<th>Q1: Single specialty physician-owned/ traditional private practice</th>
<th>Clinical Screening with Risk Questions and/or Temperature Checks Before Outpatient Endoscopy</th>
<th>Testing for COVID 19 by PCR is Required Prior to Outpatient Procedures</th>
<th>COVID 19 Antigen Testing is Required Prior to All Outpatient Procedures</th>
<th>I Don’t Know</th>
<th>This Issue Does Not Apply to My Practice</th>
<th>Other (Please Specify)</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDEPENDENT</td>
<td>34.29%</td>
<td>4.29%</td>
<td>0.00%</td>
<td>1.43%</td>
<td>5.00%</td>
<td>7</td>
<td>59.83%</td>
</tr>
<tr>
<td>EMPLOYED</td>
<td>36.00%</td>
<td>4.29%</td>
<td>0.00%</td>
<td>1.43%</td>
<td>5.00%</td>
<td>7</td>
<td>59.83%</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>111</td>
<td>15</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>234</td>
<td></td>
</tr>
</tbody>
</table>

Q1: Single specialty physician-owned/ traditional private practice
AGA Recommendations

Recommendation 1
Asymptomatic prevalence - Intermediate (0.5% - 2%)
Consider pre-procedure testing; May affect PPE decisions

Recommendation 2
Asymptomatic prevalence – Low (<.5%) - Against pre-procedure testing
High false positive rate; PPV is low

Recommendation 3
Asymptomatic prevalence – High (>2%) or “hot spot” – Against pre-procedure testing
PPE use would not be affected because of high false negative rate

Sultan, S et al; Gastro 2020;159:135-1948
Prevalence tool - https://gastro.org/news/use-this-tool-to-determine-your-pre-testing-strategy-prior-to-endoscopy

Psychological Impact

• Pre-procedure testing is low yield but high impact on staff anxiety
• Additional reassurance to staff and patient for a COVID safe environment
• False sense of security
• Difficult to stop once you start
Good News

- Low transmission rate in endoscopy without testing (Gagneja et al)
- Connecticut GI had only 1 possible procedure related transmission since March
- Symptom screening works
- Appropriate PPE works
- POC ("the COVID-19 pregnancy test") maybe a reality soon
- Vaccines are here and will need to be considered in any future strategy

Pre-procedure Covid-19 Testing

Take Home

- ASC Covid-19 positivity rates increase as community prevalence increases
- The use of pre-procedure testing should be dictated by prevalence, availability of testing and PPE
- Transmission rates in ASCs are low with or without testing
- No true accurate point of care Covid-19 test available (the COVID "pregnancy test")
- Rapid antigen sensitivity in asymptomatic patients is low – Need to use NAATs
- Logistics and resources are problematic for NAAT/RT-PCRs
- Potential psychological benefit
- Ask yourself will it change my use of PPE?
- Final question - will vaccines change the use of pre-procedure COVID testing?

Don’t forget about symptom screening!
Patient and Environmental Safety: What has Changed?

Sapna Thomas MD, FACG
Medical Director, West Region – Digestive Health Institute
University Hospitals of Cleveland
ACG Governor – Northern Ohio
President - Ohio Gastroenterology Society

Should the room turnover be determined by the air changes/hour (ACH)?

Current data suggests that SARS-CoV-2 is predominately transmitted by close-range aerosolized large droplets that may be inhaled or in contact with eyes, nose, mouth of persons nearby.

There is evidence that aerosols may be responsible for the airborne transmission of SARS-CoV-2 beyond 6 feet from the source.

No conclusive studies have been conducted on differentiating between the modes of transmission of virus via droplets or aerosols.
Safeguards Against Transmission of Droplets and Aerosols

• Facial Mask
  • Surgical Mask - approximately 20-30% leakage of droplets and ineffective in preventing of aerosols transmission
  • N95 and elastomeric respirators – approximately 5% leakage of droplets, limit aerosol transmission
    • Must be fitted correctly
    • Avoid contamination
  • Face Shield/Safety Goggles

This unresolved issue on the transmission of virus-laden aerosols has lead to recommendations for HCW to use N95/respirators and eye protection

• Aerosol Generating Procedures - Endoscopy
CDC Recommendations for Ventilation

• Layered strategy to reduce exposures to SARS-CoV-2
  • When indoors, HVAC ventilation mitigation strategies
    • Increase outdoor air ventilation when possible
    • Disable demand-controlled ventilation (DCV)
    • Eliminate/Decrease Re-circulation –weather based
    • Improve central air filtration to highest compatible with filter rack and seal edges to limit bypass
    • Keep systems running longer hours
    • Consider portable room “air scrubbers” with HEPA filters – can alter humidity and temperature
  • Use fans to increase effectiveness of open windows
  • Decrease occupancy when outdoor ventilation cannot be increased

Air Purification System
- $1000 - $5000 + filter

Air Scrubber
- Increase ACH by 4-6 depending on room size
- $1000- $2000
Continue Measures for Source Control

- Ensure face covering for everyone
  - Surgical mask if available for patients, attendants, staff, etc
  - N95/respirator - protection against exposure to splashes and sprays if infectious material from others
  - Face Shield/ Safety Goggles – eye protection (in addition to mask)
- Consider POM mask for EGD
- Covering of orifices
- Continue Social Distancing
  - The inter-personal distance of 6ft can be considered reasonably effective protection if everyone wears face mask in daily activities
- Continue Surface Cleaning
  - Studies have shown SARS-CoV-2 can remain on surfaces for hours
- Handwashing

Surface Cleaning/Disinfection

- Surface cleaning and disinfection – high touch surface – EPA List N
- Germicidal Ultraviolet (GUV)
  - UV-C – wavelength in the spectrum 200-280 nm – optimal 265nm
  - Effective against SARS-CoV2 under laboratory conditions
  - CDC – considered a supplement to help inactivate SARS-CoV-2 especially if options for increasing room ventilation are limited
  - Location
    - Upper Room GUV – disinfection zone of UV energy focused up and away from people. Fixtures mounted on walls and ceilings to disinfect air as it circulates
    - In-Duct – installed within the HVAC system
    - Far-UV – wavelength 222nm – safe exposure to UV light
  - Risks
    - Direct Exposure to skin and eyes
    - Some UV-C lamps can generate ozone which can cause airway irritation
    - UV-C can degrade certain materials: plastics, polymers, dyed textiles
    - Some UV-C lamps contain mercury – risk if broken, disposal
Portable Industrial Far UV Sanitation Light
- approx. 500 SqFt room – 30min
- $12,000

In-Duct Germicidal UV light
- Installed within HVAC system
- $900/unit

How will COVID-19 vaccination impact your recommended use of PPE?

- 75%
- After vaccinated, providers and staff may return to pre-COVID standards...
- No impact, we will continue full PPE indefinitely.
- I don't know
- Other (please specify)
Summary

SARS CoV-2 is spread by large droplets as well as small aerosols

- Layered Strategy Approach
  - PPE
    - Mask – use correctly
    - Face shield, eye protection
    - Patient Source Control
  - Ventilation
    - Work with HVAC/Ventilation Engineer to optimize current system
    - Consider external Air Purification/Air Scrubber
    - Consider alternative disinfection – UV-C light
    - Limit Occupancy
  - Vaccination

COVID-19: Considerations for keeping our practices open and solvent

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The old normal

Before 3/2020

3/2020-present

2021 ........

Our (professional) future

Can we get back?

It is always wise to look ahead, but difficult to look further than you can see.

Winston Churchill
Keeping our practices open: pay attention to....

- **The back office**: financial concerns
- **The front line**: our teammates
- **The physical space**: keeping everyone safe
- **Our mission**: bringing our patients back

Financial performance remains in flux: volume expectations are actually back where we started (we’re optimistic...but wrong)
Compared to your usual or expected pay, what best describes your income in 2020?

Over 1/3 (36%) lost at least 25% of prior income
Over 90% of respondents lost ‘some’ income

Income by Practice Type: not a uniform impact

5x as many independent MDs had neg or >50% lost income (43% vs 8%)
10% of employed MDs made more this year (vs <3% of independent MDs)
Break-Even Analysis (BEA)

- BEA: the number of patients that must be seen (for the practice) or procedures performed (for the endoscopy unit) to at least cover your costs
- One can ↑ volume or reimbursement or ↓ costs
  - Practically speaking, costs are up due to increased PPE costs, need to ‘hoard’ supplies when available and increased staff
  - Volume may be limited by distancing measures and patient reluctance but may also increase after vaccination, with pent-up demand and age 45 exams
  - Reimbursement certainly not going up but some grants still being disbursed

Keeping everyone safe

- Infection control measures are here to stay in some way for long term, including distancing, hand hygiene, barriers etc
- Increasing attention on ventilation and airspace than surface decontamination
- Avoid “Hygiene Theater” that may be wasteful and falsely reassuring (ie NYC subway car spray disinfection vs masking in Tokyo subway)

How many of your staff members do you believe have contracted COVID 19 infection due to exposure at work?

- None
- 1 or more work-related infections
- 2 or more work-related infections
- Exposure outside of work

Co-worker risk (It’s not just patients!)

- Call center in S. Korea
- 50% positive rate nearby
- <5% rest of floor
- <1% rest of building
  - Elevators, door handles unlikely
- Staff / break / lunch rooms are problem spaces
- Staff meetings will be “fewer, smaller, and shorter”

Your team may need to be bigger

- Intermittent absences (childcare, quarantine) will remain common, and your admins need permission to upstaff/hire.
- Prioritize cross-training and staff rotations.
- Restrict hours rather than FTEs to improve productivity rather than staff numbers.
- Recognize efforts and sacrifices by staff, address career development, ‘battlefield promotions’ and bonuses.

What best describes the impact of the pandemic on current staffing at your practice? (choose all that apply)

- No impact: 55%
- Additional staff hired: 25%
- Staff overtime required: 14%
- Services reduced 2/3 staff shortages: 13%

25% have UPSTAFFED (despite incomes down) and 14% required ‘considerable overtime’. 13% reported reduced services due to staff shortages.
HR SOUP: Family and medical leave act (FMLA) plus FFCRA (COVID specific) and State specific policies too!

“All politics is local…..”

- Regulations and plans are now hyper-local and vary county by county; talk to ‘your’ people
- Work with your hospital; some ASCs are able to be a temporary outlet / alternative to hospital OPD
Reassuring our patients: Key concepts

- Make a plan, communicate it (website, emails, videos etc), and then DO IT!
- Be clear, consistent and engage staff to “model” what you recommend
- HCWs are viewed favorably and patients generally have trust and gratitude...we can leverage that trust and strive to make our offices one of the few places they CAN feel safe and provide a positive experience. No mask drama here!
- Physician may need to be personally involved to have patients feel secure
- Start with the initial telehealth visit. Routinely and proactively address potential concerns; don’t wait to be asked! Re-emphasize during pre-procedure calls
- Upgrade your digital game (everyone else is, need to stay relevant)

Top tips to keep your ASC and practice open

- Financial analyses often! We used to live in a steady state world, but not anymore....flux is the new normal.
- Continue smart efforts to keep staff and patients virus safe
- Upstaff, cross train, and love ‘em all
- HR issues in the COVID world are different; know the regs (or have an HR consultant who does)
- Engage locally, that’s where the action is for regs, vax etc
COVID-19 Positive Patients and Staff: Implications For Your Endoscopy Unit and Practice

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

Overview

• What to do when one of your scheduled cases tests + for, has symptoms of, or exposure to COVID-19?
• What to do when endo staff tests + for COVID-19?
  • When can staff return?
  • What are the criteria for returning?
• What to do regarding patients with prior + COVID results?
  • When can “recovered” patients come to the center?
  • What are the criteria for returning?
• Follow up after patients leave your center
Scheduled Cases Test + For COVID-19 or Has Symptoms or Exposures

- If case is elective cancel and reschedule in your center at a time to be determined
  - details to be discussed

- If semi-urgent redirect the case to the hospital
  - notify them ahead of time
  - make all the appropriate plans to care for the patient and protect yourself and all the participating personnel

Staff Tests + For COVID-19 or Has Exposure or Symptoms

- Positive testing in one of your staff members
- Exposure from a known + patient
- Vague situations
  - Limited exposure from a known contact
  - Exposure to a contact of a known + case
Staff Tests + For COVID-19

- Staff should take appropriate isolation precautions as per CDC guidelines
- Seek medical care if concerning symptoms are present
- Stay in a separate room from other household members and use a separate bathroom, and avoid all contact if possible
- Wear a mask when around other people

When can staff safely return to work?
- At least 10 days since sx fist appeared/24 hrs no fever
- AND other symptoms of COVID-19 are improving
  - does not include loss of taste and smell
- If you had severe illness from COVID-19 may need to consider isolation up to 20 days
  - (defined as in the hospital and or required oxygen)
Staff Tests + For COVID-19

- Should staff get re-tested prior to return to work?
  - Not recommended
    - Test may stay positive for up to 3 months or longer without being contagious to others
  - Only be re-tested if develop new symptoms to suggest COVID-19 re-infection

Staff Had Close Contact To a Known + Case

- Definition of close contact
  - Within 6 feet of someone who had COVID-19 for a total of 15 min or more over a 24-hour period
  - Patient sneezed or coughed on you
  - You hugged a COVID-19 positive patient
Staff Had Close Contact to a Known + Case

• Options
  • Stay home in quarantine for 14 days from time of exposure and monitor for sxs

• Efforts can be made to reduce the length of quarantine
  • Local public health authorities often make this final decision based on local conditions and need
    • Lessen the number of days to 10 is an option
    • Staff can get tested no sooner than day 5 from exposure (due to false negative rate from testing too soon) and if negative go back to work

When Can Patients Who Had COVID-19 Return Safely To Your Center?

• Same rules apply to patients and staff members with some caveats based on risk stratifications

  • Asymptomatic persons with healthy immune systems may have procedure 10 days after a + test

  • Symptomatic persons with healthy immune systems may have procedure 10 days after symptoms are gone and temp below 100 F
When Can Patients Who Had COVID-19 Return Safely To Your Center?

- Asymptomatic patients with severely compromised immune systems may have a procedure 20 days after a + test.

- Symptomatic persons with severely compromised immune systems may have a procedure 20 days after symptoms are gone and if temp is below 100.

Follow Up on Patients After They Leave Endo Center

- Various protocols from practice to practice ranging from day 1 to day 14.

- Goal is to identify those who have tested + since being seen in your center and screen staff who have had exposure to that patient.
Follow Up on Patients After They Leave Endo Center

• Issues with this approach
  • Patients could have gotten COVID-19 after they left your center so there has been no true risk to your staff
  
  • Patient contact was unlikely to have met CDC criteria for being considered an exposure
  
  • If staff is asymptomatic and it has been 7 days is it worth testing?
    • House of cards effect

Summary

• Continue proper protocols to protect patients and staff

• Cases on COVID-19 + patients should be done in the hospital setting if acutely necessary with appropriate PPE

• Cases on COVID-19 + patients that can be delayed should be brought back to your center as per CDC guidelines
  • Repeat testing is unnecessary and often misleading
Summary

• Positive staff members can be brought back to work as per CDC guidelines approximating the criteria for patients

• Value of calling patients post procedure inquiring about COVID-19 status is debatable and certainly has costs

References

• 1. Center for Disease Control and Prevention guidelines on COVID-19
Questions & Answers

Thank you!

- Next Webinar

**COVID-19 Management: Pearls for the Gastroenterologist**

Endoscopy Resumption Task Force discusses top 5 GI consults for COVID-19 complications, top 5 updates on COVID-19 therapeutics, and top 5 common COVID-19 vaccination questions for gastroenterologists.

**TUESDAY, FEBRUARY 9th, 8 to 9:30 PM EST**

Moderator
Francis A. Farrey, MD, MSc, MACG

Speakers
Freddy Caldera, DO, MS
Harish K. Gagneja, MD, FACG
Melissa Latore, MD, MS

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