ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!

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

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.
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, FACC

Webinar Co-Hosts & Presenters
Costas H. Kefalas, MD, MMM, FACC, ACG Trustee
Neil H. Stollman, MD, FACC, Chair, ACG Board of Governors
ACG Endoscopy Resumption Task Force

Register & Learn More gi.org/ACGVGR
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:
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

American College of Gastroenterology
COVID-19: A Roadmap to Safely Resuming Endoscopy

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
ACG Governor for Mississippi

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

Michael S. Morelli, MD, CPE, FACG
ACG Public Policy and Legislative Task Force

Harish K. Gagneja, MD, FACG
ACG Governor for Southern Texas
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 the first 335 responses

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

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

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo-practice</td>
<td>17.61%</td>
</tr>
<tr>
<td>Small single specialty (2-6 physicians)</td>
<td>22.69%</td>
</tr>
<tr>
<td>Medium single specialty (7-15 physicians)</td>
<td>16.12%</td>
</tr>
<tr>
<td>Large single specialty (more than 15)</td>
<td>17.61%</td>
</tr>
<tr>
<td>Multi-specialty</td>
<td>10.75%</td>
</tr>
<tr>
<td>Academic medical center</td>
<td>13.13%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>
COVID-19: A Roadmap to Safely Resuming Endoscopy

SURVEY RESPONSE NUMBER VS LOCATIONS BY STATE / OTHER
Q3: What best describes the community where you practice gastroenterology?

A Broad Cross-Section of Communities

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large urban (MSA population greater than 500,000) with high COVID 19 Impact</td>
<td>24.11%</td>
</tr>
<tr>
<td>Large urban (MSA greater than 500,000) with low or moderate COVID 19 Impact</td>
<td>21.74%</td>
</tr>
<tr>
<td>Small to medium city with high COVID 19 Impact</td>
<td>12.65%</td>
</tr>
<tr>
<td>Small to medium city with low or moderate COVID 19 Impact</td>
<td>33.60%</td>
</tr>
<tr>
<td>Rural Market</td>
<td>4.74%</td>
</tr>
<tr>
<td>Other (please specify)/Comment</td>
<td>3.16%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
</tr>
</tbody>
</table>
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:

- 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?

Only 52% retained at least 75% staff

11% furloughed > 75%
COVID-19: A Roadmap to Safely Resuming Endoscopy

Staff Retention by Practice Type:
Similar Communities and Practice Types

Retained 75% Staff

Furloughed 75% Staff

American College of Gastroenterology
Respondents who “Shut Down” (work force at \( \leq 25\% \)):

**Practice Locations**
Respondents who “Shut Down” (work force at ≤ 25%):

Pract ice locations and “no-lockdown” states

[Map showing practice locations and states with "no-lockdown"]
COVID-19: A Roadmap to Safely Resuming Endoscopy

Staff Retention – A Tale of Two Responses?
Still seeing patients face to face

Retained > 75% Staff
- 47%

Furloughed > 75% Staff
- 29%

Q9: 75 to 100%
Q9: Less than 25%

Yes
No

American College of Gastroenterology
Staff Retention – A Tale of Two Responses?
Still doing endoscopy in an ASC

- Retained > 75% Staff: 41%
- Furloughed > 75% Staff: 17%
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!

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I expect to lose money</td>
<td>37.94%</td>
</tr>
<tr>
<td>0 to 25% of usual</td>
<td>22.13%</td>
</tr>
<tr>
<td>26 to 50% of usual</td>
<td>17.39%</td>
</tr>
<tr>
<td>51 to 75% of usual</td>
<td>6.72%</td>
</tr>
<tr>
<td>At least 76% of my usual pay</td>
<td>15.81%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>253</td>
</tr>
</tbody>
</table>
Pay Expectations:
More “shut down” groups expect negative income

- Retained > 75% Staff: 36%
- Furloughed > 75% Staff: 56%
Q14: When do you expect to resume full-operations at your gastroenterology practice?

- Retained > 75% Staff: 56%
- Furloughed >75% Staff: 36%
A Tale of Two Responses

**Kept Working**
- Retained staff
- Participate in PPP
- Kept doing urgent endoscopy at ASC
- Pushed back routine procedures
- Expect to ramp up more quickly

**Shut Down/Furloughed**
- Furloughed staff
- Could not participate in PPP
- Shut down ASCs
- Cancelled future procedures
- Expect to struggle re-booting

**Working/Retained Staff**
# 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**

<table>
<thead>
<tr>
<th>Choice</th>
<th>Percentage</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>70.04%</td>
<td>173</td>
</tr>
<tr>
<td>Most</td>
<td>7.69%</td>
<td>19</td>
</tr>
<tr>
<td>Some</td>
<td>2.02%</td>
<td>5</td>
</tr>
<tr>
<td>A few</td>
<td>4.45%</td>
<td>11</td>
</tr>
<tr>
<td>None</td>
<td>15.79%</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>247</td>
</tr>
</tbody>
</table>
Q13: If you work in an ASC, what is the current availability of N95 masks?

Only 23.5% report adequate supply of N95 masks.
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 the 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

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

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

*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

<table>
<thead>
<tr>
<th>TESTING &amp; CONTACT TRACING</th>
<th>HEALTH SYSTEM CAPACITY</th>
<th>PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to set up safe and efficient testing sites for symptomatic individuals and trace contacts of COVID+ results</td>
<td>Ability to quickly and independently supply sufficient PPE and critical medical equipment for surge</td>
<td>Protect health and safety of workers in critical industries</td>
</tr>
<tr>
<td>Ability to test syndromic/ILI-indicated persons for COVID and trace contacts of COVID+ results</td>
<td>Ability to surge ICU capacity</td>
<td>Protect health and safety of those living and working in high-risk facilities (e.g., senior care facilities)</td>
</tr>
<tr>
<td>Ensure surveillance sites are screening for asymptomatic cases and contacts for COVID+ results are traced</td>
<td></td>
<td>Protect employees and users of mass transit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise citizens regarding protocols for social distancing and face coverings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
</tr>
</tbody>
</table>
# Opening Up America Again – The White House & CDC: General Guidelines for All Phases

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

<table>
<thead>
<tr>
<th>PHASE</th>
<th>INDIVIDUALS</th>
<th>EMPLOYERS</th>
<th>SPECIFIC EMPLOYERS</th>
</tr>
</thead>
</table>
| 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 areas 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 face masks 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
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

8. https://contentsharing.net/actions-email_web_version.cfm?ep=ZOpdhAdHlo3ucGPNUnkQG6Djd36EFMjYoHV5EMSum_mtSTfSEQFhdidy_rCejbFEobVD77RItokUqIlCcpXvhEBbMYechnb5-y4OidsZtPNQ4u9ZBBvRbpynvM4pqTK
9. https://www.whitehouse.gov/openingamerica/#criteria
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 ongoing 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 retrain staff
- Procedure monitoring
ENDOSCOPY Supply Management: COVID Restart

ESSENTIALS:
- GOWNS
- MASKS
- GLOVES
- FACE SHIELDS
- SHOE COVERS

ADDITIONAL ESSENTIALS:
- 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 NEGOTIABLE
- 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:
# STAFF EXPANSION: $$\rightarrow$$

**FRONT/INTAKE:**
- PRE-OP SCREENING (TIME, $$)
- LIMIT TIME OF FACE-TO-FACE ENOUNTER
- MORE STAFF REQUIREMENTS FOR PPE: $$
- PRE-PROCEDURE CALLS: MORE DETAILS
- UPFRONT PAYMENT OF DEDUCTIBLES PRIOR TO PROCEDURE DATE

**POST PROCEDURE:**
- DISCHARGE NURSE / ESCORT PPE
- MORE FACE-TO-FACE TIME

**INTRA-PROCEDURAL:**
- EXTRA PERSONNEL FOR ROOM ASSISTANCE
COVID-19: A Roadmap to Safely Resuming Endoscopy

IMPACT OF REVISING BLOCK TIME FLOW

- LOWER CASE LOADS—LESS REVENUE
- MORE PPE REQUIRED—$$
- INCREASED PATIENT FLOW TIME TO ALLOW FOR TERMINAL CLEANING
- ALLOW AIRFLOW EXCHANGE FOR ASC’S WITHOUT NEGATIVE PRESSURE ROOMS
- ‘TERMINAL CLEANING’ OF ROOMS—$$ (GREATER CONSUMPTION OF SUPPLIES)
LENGTHENING HOURS OF OPERATION

POSITIVES

- INCREASES PATIENT VOLUME
- ADDRESSES RELUCTANCE OF PATIENTS 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 SHORE 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.
- **PSAs**: PUBLIC SERVICE ANNOUNCEMENTS
- **Virtual guided tour of ASC**: website emphasis on post-COVID-19 changes (cheap, easy to produce)
- **WOO YOUR PATIENTS BACK WITH CONFIDENCE AND TRUST!!**
TAKE HOME POINTS

- CREATE AN **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!*
COVID-19: A Roadmap to Safely Resuming Endoscopy

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

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

<table>
<thead>
<tr>
<th>Time-Sensitive* (within 24 hours-8 weeks)</th>
<th>Non-Time Sensitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat to the patient's life or permanent dysfunction of an organ</td>
<td>Risk of metastasis or progression of stage of disease</td>
</tr>
<tr>
<td>e.g. diagnosis and treatment of GI bleeding or cholangitis</td>
<td>e.g. work up of symptoms suggestive of cancer</td>
</tr>
</tbody>
</table>

AGA Institute Rapid Recommendations for GI Procedures during Covid19
In press
COVID-19: A Roadmap to Safely Resuming Endoscopy

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/JJ 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 dilatation/stenting
- Radiologic evidence of mass
- Lymph node EUS sampling
- Gallstone-related pancreatitis
- Pancreatic mass/stricture
- Biliary stricture dilation
- Pancreato-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
- Ampulectomy
- 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 dilation)
- 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 gastropasty)

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.
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
- 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 with no symptoms, 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
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
COVID-19: A Roadmap to Safely Resuming Endoscopy
COVID-19: A Roadmap to Safely Resuming Endoscopy

Reusing Filtering Masks and Disinfecting

- Vaporized Hydrogen Peroxide
- UV light
COVID-19: A Roadmap to Safely Resuming Endoscopy

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](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

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have adequate supply for all procedures.</td>
<td>23.53%</td>
</tr>
<tr>
<td>We have some but inadequate supply for all procedures.</td>
<td>27.73%</td>
</tr>
<tr>
<td>We have none at our ASC</td>
<td>15.97%</td>
</tr>
<tr>
<td>The ASC is closed due to inadequate supply of N95 masks</td>
<td>13.87%</td>
</tr>
<tr>
<td>I do not work at an ASC</td>
<td>18.91%</td>
</tr>
</tbody>
</table>
| TOTAL                                                    | 238       

The bar chart shows the distribution of responses among the 238 participants. The percentage of participants who report having adequate supplies of N95 masks is the highest, followed by those who have some but inadequate supplies. A significant portion of participants report having none at all or their ASC closed due to inadequate supplies.
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)

Gut Published Online First: 22 April 2020. doi: 10.1136/gutjnl-2020-321341
COVID-19: A Roadmap to Safely Resuming Endoscopy

PPE DECISION TREE

GI ASC Patient

- Low Prevalence Area/ Negative Rapid Test/ Negative Symptom Screen
  - Consider standard precautions (surgical masks, face shields, gloves, gowns)

- Low Prevalence Area/ No Rapid Test/ Negative Symptom Screen
  - N95 or elastomeric mask (EM) if available
    - Face shields/gowns/Allow time for donning/doffing

- High Prevalence Area/ Negative Or No Rapid Test/ Negative Symptom Screen

- High Or Low Prevalence Area/ positive Rapid Test Or Positive Symptom Screen
  - Hospital if procedure is required with N95 or EM mask
Summary

- Understand how Covid-19 is transmitted
- Take all appropriate precautions 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
  - Prescreening 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?

Harish K. Gagneja, MD, FACG
ACG Governor for Southern Texas
Austin Gastroenterology, PA
Austin, TX

Acknowledgement: Brian Metzger, MD, MPH
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)
ID NOW – Needs Internal Validation (Austin)

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

<table>
<thead>
<tr>
<th>Test Result</th>
<th>Number Concordant/Number Tested</th>
<th>% Agreement [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>45/46</td>
<td>97.8% [88.5 – 99.9%]</td>
</tr>
<tr>
<td>Negative</td>
<td>58/58</td>
<td>100% [93.8 – 100%]</td>
</tr>
</tbody>
</table>
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.