PHOENIX CHILDREN'S | COVID-19

Dear Colleagues,

Phoenix Children's Hospital has received approval from Arizona Department of Health Services to resume elective surgery. There were several requirements required by the Governor's office to receive an exemption to begin elective surgery, one of which includes preoperative testing for SARS-CoV2. In preparation for reopening the hospital for elective procedures, we have been developing a process for preoperative testing.

As we communicated previously, we have set up a testing site in the old emergency room for outpatients. We initially used this site for testing symptomatic employees and this allowed us to vet or test our process and workflow.

The time frame for getting tests completed will be a bit narrow prior to the procedure. There is no real good evidence on exactly when the testing needs to be performed. It is important to remember that we are testing asymptomatic patients. We have been in communication with other children's hospitals on their practices to try and determine best practice. We are limited by not being able to complete all of this testing in-house at this time. We are only doing in-house testing prior to surgery on patients who are either inpatient or in the Emergency Department. The ED providers will be ordering the SARS-CoV-2 testing to avoid delays. However, patients transferred as direct admits for surgery will require the attending to order testing.

The real question is whether you can rely upon a negative test result when the surgery is performed. We are all aware that a negative SARS-CoV-2 test performed some time ago may turn positive if the patient had recent exposure. As everyone is aware, COVID + patients can remain asymptomatic. We have elected, with consultation with Infectious Disease Medical Directors, to perform testing no later than 72 hours before surgery. It is a rather tight window, particularly with getting turnaround from our labs on results from these tests. Keep in mind that pre-procedural testing is likely going to be needed for the next 18 months until there is a vaccine widely available. For outpatient pre-procedural testing, we have developed a protocol standing order for SARS-CoV-2 testing. For PCMG providers, the orders will be sent thru SCM for signature. For non-PCMG providers, we have developed a written order form that will be scanned and sent to providers by HIM for later signature.

We have extended the testing window for some CCBD patients. Many of these patients have frequent procedures and because of the nature of their disease and immune-compromised state, most of them essentially shelter in place and are self-quarantined. As long as these patients remain free of symptoms and have had no known exposure, we might not need to re-test them for procedures if they are done on a weekly basis. We will also evaluate inpatients with prior negative tests during their hospital stay. Available data suggests that it is rare for an inpatient to become positive during their stay after an initial negative test (assuming no new clinical symptoms that warrant testing).

It is imperative that patients show up for their testing when scheduled. If they miss their initial appointment, we will try to reschedule the next day. However, if the test cannot be completed that day, we cannot plan to attempt rescheduling the day before surgery. That may change in the future if we have very reliable rapid turnaround time for test results. We have an entire team working on the scheduling process for these tests. They are coordinating with all of our procedural areas: Main OR, Aerodigestive, Ambulatory Surgery, CCBD, Radiology, etc. IT has developed a dashboard that will allow us to track the procedures scheduled, SARS-CoV-2 testing appointments and test results. This will be very helpful in allowing us to manage the OR/procedure schedules efficiently.

We are evaluating opening other PCH run testing locations. This will be communicated to everyone if/when that is available. We recognize that families

will be requesting testing closer to their home. We will only consider this on a case-by-case basis, particularly families that are coming from long distance or out of state, but we are not encouraging that for people who live in the Phoenix metro area. The reason we are reluctant to refer patients to other commercial sites is that testing turnaround can be prolonged. It really complicates the process of knowing when the test was performed and whether it can be completed in our required timeframe. It is also more difficult for us to obtain the test report so that we are certain of the result. We need to have documentation of the test results, not just a verbal confirmation from the family. The other variable is the type of swab used for testing. We are continuing to recommend only nasopharyngeal swabs at this time as that method provides the best reliability.

One issue that will difficult to manage will be the scheduling of "urgent" cases. We will need clear criteria on what would be considered urgent and we recognize that can be difficult to define. From our standpoint, it would be a case that if not performed soon could adversely affect the patient outcome. Urgent does not mean adding a patient to the schedule just because the patient is from out of town or the family is insistent on getting the procedure done quickly. We still need to do the SARS-CoV-2 testing in advance of the procedure date. This is clearly necessary for those procedures requiring general anesthesia airway manipulation. Lack of test results would then require different PPE if the test has not been resulted. PPE is still in short supply and conversation is necessary. More importantly, performing the procedure in absence of testing places our providers and staff performing the procedure at increased risk. This is particularly true for high risk cases e.g. airway surgery, colonoscopies. As noted above, true emergent cases can be tested in-house. Even in some of these cases, the test result may not be available, but would be known shortly after surgery. The Pathology department is increasing the number of times per day that they will run the PCR test.

If the family refuses testing or fails to show up for the testing appointment, the clinical team will be notified. They will have to make a decision on whether to proceed without a test result. As noted above, we would like to avoid this except for emergent cases. This will provide the most protection for our staff and providers.

One last thing that needs to be addressed is the self-screening that is done by providers and staff before they come into the hospital. Those who are employed by PCH have to document this in the employee portal. Non-PCMG providers have not been required to perform self-screening. We are looking to implement thermal screening with cameras on entry to the hospital, but it will likely be a few weeks before it is implemented. Our non-PCMG providers who do procedures in our facility or enter our facility for other patient should also do self-screening (monitoring temperature and any signs/symptoms of COVID-19). Anyone can have their temperature taken at the employee entrance sites in the East building and south employee entrance. We will be developing a process to have non-PCMG providers confirm that they have had a negative self-screen when they arrive at the procedural areas.

As you have witnessed, this is a fluid and evolving situation. We will continue to do our best to keep everyone informed. Thanks for your patience as we have worked to obtain the necessary resources and develop this process.

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