Atrium Health

DIVISION OF ACUTE CARE SURGERY

Department of Surgery COVID-19 Activation and Response Plan

Activation	Threshold for activation/Possible ACS Impact	Surgery Department Response	Recommended Facility Response
ACS Level : Alert Atrium Incident Command Priority 1	• Pandemic level, increasing prevalence throughout the country • Potential impact to facility and system • Full Surgery Compliment • Peri-operative staffing normal • School closing in community with impact on staff availability	**Dept:** • Contact patients prior to visits to clinic and/or OR to delay surgery if elective and have COVID-19 high risk features • Have clinic nurses screen patient for must see and urgent visits to present to clinic, all other managed with calls or telehealth evaluation • Stay home if sick • All personnel in QI, Research, etc without direct patient care to start working from home • Prioritize cases for CV, cancer, urgent and emergent status • Begin cycling faculty/APP/residents on 5-7 day cycles to minimize exposure • APP with no change in role • Non-essential surgery can continue **ACS:** • Maintain current staffing model • May need switching to maintain core service lines as faculty become infected and require quarantine • ACS obtain faculty privileging at all Atrium Metro Facilities and VCC ability	**Facility** • Focus on avoiding patient presentation to hospital for testing • Minimize routine, non-urgent clinic appointments • Focus on virtual visits • Restriction of visitors to immediate families **Transfer Criteria** • Limit non-emergent transfer to CMC Main **Operating Rooms** • Normal Operations **NORA** • Limiting to emergent cases only when COVID-19 positive or expected • All procedures done at patient bedside or in OR when at all possible • Cases that must be done in procedure areas: pediatric septoplasty, pediatric pacemaker, PDA stent, Cerebral angiography, Code Stroke, Pediatric CT and Code Stemi

		• Services: EGS, STICU Low, STICU High, Trauma Floor, Day Call, Night Call	

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ACS Level 2 Atrium Incident Command Priority 1	• First confirmed case Inpatient case • Potential impact on facility and system • <20% hospital bed availability • <25% ICU bed availability • <3 ACS faculty out • Reduction in PeriOp staff by 10% due to illness • Decreased blood bank supply due to social distancing	**Dept:** • **Goal Reduce elective case volume by 50%** with non-essential cases cancelled for at least 2 weeks (focus on required cancer and CV cases) • Non-essential cases to not reschedule for 3 months • Sub-acute cases (need in <3months) able to proceed • High risk patients (age >60, DM, HTN, smoking hx, COPD CHF, CAD) discuss with patient and cancel if can wait • Pooling of non-ACS surgeons for system general surgery coverage • **Reallocation of elective rotation surgical residents**, research residents, to EGS, ICU, and trauma rotations as drawdown on elective cases proceed • Non-ACS APP to flex to ACS or medical service lines • All CC credentialed APP to flex to ICU services **ACS:** • Maintain current weekday staffing model • Cohort EGS service to cover just ICU EGS/ED patients	**Facility** • Daily SITREP huddles with COVID-19 Taskforce leaders • Subsequent daily sitrep with ACS stakeholders and providers • Nursing reassignments, expanded patient ratio • Expanded Patient cohorting • Start aggressive discharge of all non-critical patients to ANY discharge destination. • Delayed Tracheostomy protocol in effect for COVID patients, • Trach/ENT case COVID screening • Triage criteria initiated for ECMO cannulation. Institute virtual clinic visits for all ACS clinics unless urgent problem. • Limit visitation to 1 per patient in ICU, none floor **Transfers** • Institution of SCC Quarterback with knowledge of sitrep, IC level, and resource availability for all surgical/SCC/trauma consults, vets all transfer requests after service • Limit non-emergent transfer to main • Urgent/Emergency cases with surgeon capability at outlying facility should be triaged to stay at that facility • Emergent cases with critical care needs prioritized to CMC Main • Only urgent/emergent trauma transfers will be accepted with needs for specialized care **Operating Rooms** • CMC and ODS - Per service line decrease number of elective cases by 50%- non-essential cancelled;

		• General surgery to cover floor EGS • ACS Services: ICU EGS, STICU Low, STICU High, Trauma Floor, Day Call, Night Call	prioritizing surgical urgency and canceling high risk patients **NORA** • As per Alert status

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ACS Level 1 Atrium Incident Command Priority 1	• Facility at ≥100% capacity • ICU capacity ≥90% • 5-20 confirmed admitted cases • Dwindling resources of facility • Significant impact on the system • Denial of discharges from SNF, rehab, or other discharge dispositions • 3-6 ACS Faculty out • Reduction in PeriOp staff by 25% due to illness • Severely decreased blood bank supply	**Dept:** • **All non-essential surgery cancelled**, consider cancelling invasive CV and cancer if high risk factors (age >60, DM, HTN, smoking hx, COPD CHF, CAD). • Permission to perform any non-urgent (needed in less than 2 weeks) case requires Chairman/Chief approval. • Temporize urgent cases using non-operative means and discharge patient's home at increasing rates • General surgery trained faculty are employed to consult and manage EGS Tier 1: General Surgery, HPB, Transplant, GI Onc, Bariatric, Colorectal, MIS, PGY5, Fellows Tier 2: All other General Surgery trained attendings • General surgery pool cover Main and system EGS/general surgery needs • All residents redistributed to ICU, EGS, trauma rotations • All CC APP flex to cover surgical and non-surgical ICU covered by ACS faculty **ACS:** • SCC faculty taking non-surgical ICU admissions. • ACS faculty responsible for STICU all patients and trauma • Increase proportion of available surgical critical care intensivist to care for COVID-19 ICU teams • Older faculty focused toward trauma population and virtual care	**Facility** • Daily SITREP huddles with COVID-19 Taskforce leaders • Subsequent daily sitrep with ACS stakeholders and providers • ICU Expansion: Progressive care, monitored beds, PACU overflow • Two ICU beds per ICU room • Prepare Two hospital beds per hospital room • No patient visitation **Transfers** • SCC with knowledge of sitrep, IC level, and resource availability for all surgical/SCC/trauma consults, vets all transfer requests after acceptance • Urgent cases to stay at that facility and every effort to discharge them with non-operative means • No non-emergent transfer to main • Emergency cases with surgeon capability at outlying facility will stay at that facility • Emergent cases with critical care needs prioritized to CMC Main or nearest available facility with an ICU and surgeon • Exhaust non-operative interventions • ECMO needs patients prioritized with consultation of ECMO team given scarce resources • All trauma transfer requests must be vetted through and ACS staff, only emergent or needs for acute specialized care will be transferred • Virtual and telephone management of urgent needs **Operating Rooms** • Reduce rooms running by 1/2 • Urgent and emergent surgical cases only • CMC OR 20 rooms (1 Trauma, 1 Transplant, 4 General Surgery, 2 Ortho, 2 CT, 1 Cysto, 1 Hybrid, 1 Robotic, 1 GYN, 2 Peds, 2 Neuro, 1 Plastics, 1 ENT)

	due to social distancing	• ICU EGS transitioned to fellow, PGY-5, general surgery coverage • SCC fellow's battlefield promotion to junior faculty for ICU and trauma coverage • ACS Services: STICU Low, STICU High, PACU ICU, Virtual Critical Care, 12 hour trauma call.	• ODS 5 rooms will be available appropriate cases to be moved from CMC **NORA** • As per Alert status

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ACS Condition Zero Atrium Incident Command Priority 1	• Facility at >125% capacity • ICU capacity ≥100% • >20 confirmed admitted cases • Expected exponential increase in admissions • Catastrophic Exhaustion of facility and system resources • 6-9 ACS Faculty Out • Reduction in staff by 40% due to illness • ICU Bed Capacity over maxed • Blood availability scarce	**Dept:** • **All non-emergent (need in <2days) cases cancelled. Urgent cases transfer to outlying facilities.** Pursue all non-operative options for emergent and urgent patients. • **Import trauma experienced system surgeons for trauma call** • General surgeons to assist with trauma coverage, only Tier 1 to cover trauma if needed Tier 1: General Surgery, HPB, Transplant, Gi Onc, Bariatric, Colorectal, MIS, PGY5, Fellows Tier 2: All other General Surgery trained attendings • Tier 2 to cover Medical patients when needed • **All staff, residents, fellows, and APP possible need to flex to cover non-surgical patients** • Advancement of PGY 5 and Fellows to junior attending status. Creation of PGY5 service for COVIID/trauma/EGS, able to take trauma call in attending role with ACS faculty backup. Run floor, consults, and if needed ICU level of care. • PGY-4 to take position as acting fellow for EGS, trauma, ICU, able to act independently for extension of attending run services for COVID-19 patients • Battlefield promotion of all subspecialty fellows to junior attending status for running of own COVID-19 service • Triage criteria for emergency operations and trauma patients. Triage criteria for mechanical ventilation. • Futility policy for Code Blue Activation in COVID patients. Futility policy for trauma activations and admissions. **ACS:**	**Facility** • Daily SITREP huddles with COVID-19 Taskforce leaders • Subsequent daily sitrep with ACS stakeholders and providers • OR conversion to 4 ICU beds • Anesthesia reassigned to critical care • Physicians assigned to areas outside of expertise for patient care • Tandem ventilator and/or novel ventilators from RT equipment • Possible intubation with family manual ventilation (BVM) on case by case basis • Need for increased cohorting of COVID+ providers in hospital still on duty **Transfers** • SCC Quarterback with knowledge of sitrep, IC level, and resource availability for all surgical/SCC/trauma consults, vets all transfer requests • Urgent cases to stay at that facility and every effort to discharge them with non-operative • Urgent and emergent cases at main to transfer to Mercy and other facilities to prioritize severely ill, sever trauma, critical care needs EGS and other surgical patients • No non-emergent transfer to main • Emergency cases with surgeon capability at outlying facility will stay at that facility • Emergent cases with critical care needs with advanced triage criteria • Exhaust non-operative interventions • ECMO advanced triage criteria • Trauma transfers with advanced triage criteria • Virtual and telephone management of urgent needs **Operating Room**

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		• Remaining ACS faculty transition to focus on ICU solely • Complete ACS allocation toward ICU patients • (Trauma volume expected to decrease and transition to general surgery trained faculty) • Chief resident to take trauma floor • ACS Services: STICU Low, High, PACU ICU, 24-hour trauma call for ICU	• Only Emergent (need in <2days) cases **NORA** • As per Alert status