Editorial

COVID-19 Guideline Modifications as CMS Announces “Opening Up America Again”: Comments from the Society of Surgical Oncology

By James R. Howe, MD,1 David L. Bartlett, MD,2 Douglas S. Tyler, MD,3 Sandra L. Wong, MD,4 Kelly K. Hunt, MD,5 and Ronald P. DeMatteo, MD6 for the Society of Surgical Oncology*

1University of Iowa Hospitals and Clinics, Iowa City, IA; 2University of Pittsburgh Medical Center, Pittsburgh, PA; 3University of Texas Medical Branch, Galveston, TX; 4Dartmouth-Hitchcock Medical Center, Lebanon, NH; 5University of Texas MD Anderson Cancer Center, Houston, TX; and 6Hospital of the University of Pennsylvania, Philadelphia, PA.

Corresponding Author:
James R. Howe, MD
Email: james-howe@uiowa.edu

*Note. Authors are members of the 2020-2021 Executive Committee of the Society of Surgical Oncology.

Disclosures: Dr. Kelly K. Hunt reports medical advisory board support from Armada Health and Merck & Co.; research funding to her institution from Endomagnetics, Luminell, and OncoNano. All other authors report no conflicts.
On 4/19/20, the Center for Medicare & Medicaid Services (CMS) released a document entitled “Opening Up America Again: Centers for Medicare & Medicaid Services (CMS) Recommendations for Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I.” CMS recognizes that some areas of the United States have low and/or stable numbers of COVID-19 patients, and that there should be greater flexibility for healthcare facilities to deliver care that was being deferred due to the pandemic, including surgical procedures. Regions must fulfill what the White House has defined as Gating Criteria in order to move to phase 1 of re-opening. These include:

1. Downward trajectory of influenza-like illness or COVID-like symptoms cases within 14 days
2. Downward trajectory of documented COVID-19 cases or positive tests (as % of total tests) within 14 days
3. Hospitals are treating patients without crisis care
4. Robust testing programs are in place for at-risk healthcare workers

Phase 1 of re-opening would allow resumption of elective surgeries as clinically appropriate, on an outpatient basis at facilities that adhere to CMS guidelines. If a region shows no rebound in the number of cases and satisfies the 14-day gating criteria a second time, it can then move to Phase 2, where “elective surgery can resume, as clinically appropriate, on an outpatient and in-patient basis at facilities that adhere to CMS guidelines.” Then, If a region shows no rebound in the number of cases and satisfies the 14-day gating criteria a third time, it can then move to Phase 3, where surgery can fully resume, and other social restrictions can be relaxed (like unrestricted staffing of worksites, limited physical distancing in large venues).

The CMS document suggests that “providers should prioritize surgical/procedural care and high/complexity chronic disease management.” This would require testing capacity, a healthy workforce, adequate personal protective equipment (PPE), and post-acute care that would not jeopardize the facility’s capacity to respond to another surge in COVID-19 cases. Facilities should also continue to take steps to reduce transmission (distancing, separation of COVID-19
free spaces, prohibiting visitors, increased sanitation protocols), and all patients should be screened for symptoms, and by laboratory testing “before care” (presumably this includes surgery). Healthcare workers should also be regularly screened by laboratory testing when “adequate testing capability is established.”

To summarize, the White House and CMS documents suggest that facilities with downtrending numbers of COVID-19 cases, that have adequate testing abilities, and do not have shortages of PPE, ICU beds, ventilators, and healthcare workers may be able to resume elective surgeries, which would reasonably include all cancer cases. The first phase of recovery as described by the White House document would allow for outpatient procedures for cancer patients which had been deferred due to lower priority during the pandemic phase of care. Phase 2 would then allow for cases requiring inpatient care as well as outpatient procedures. The American College of Surgeons (ACS) has also given detailed suggestions of what facilities should do to prepare for the ramping up to start doing elective surgeries in their document “Local Resumption of Elective Surgery Guidance.”

The ACS recently updated their cancer triaging suggestions during COVID-19 to include a recovery phase in a document entitled “ACS Guidelines for Triage and Management of Elective Cancer Surgery Cases During the Acute and Recovery Phases of Coronavirus Disease 2019 (COVID-19) Pandemic.” This document breaks down the COVID-19 outbreak into the pandemic phases, for which the Society of Surgical Oncology (SSO) and the ACS had already posted guidelines for triaging cancer cases (on 3/24/20), and now includes two recovery phases. The early recovery phase is when there are fewer COVID-19 cases each day, and greater availability of limiting resources such as PPE, healthcare workers, ventilators and ICU beds, and testing is available. In the late recovery phase, the facility is >14 days beyond their peak, and resources are at near normal levels. The ACS document specifically gives suggestions for prioritizing cancer cases in the acute and late recovery phases for patients with breast cancer, colorectal cancer, thoracic malignancies, pancreatic and periampullary cancers, soft tissue sarcoma, and melanoma.
Although the release of these documents from the White House and CMS\textsuperscript{1,2} are encouraging for surgeons to be able to resume elective surgeries soon, all regions of the country and even specific hospitals within the same region will have unique challenges in meeting these proposed criteria. Some confusion may result from the fact that Phase I of recovery just mentions performing outpatient procedures, and that individual states may have different criteria mandated by their governors. Therefore, surgeons must work closely with their hospital leadership and local authorities to determine whether they fall within the pandemic or recovery phases, and whether they meet gating criteria, CMS, and state guidelines. If these standards are met, then it would be reasonable to resume elective surgeries for cancer patients which could apply to both inpatient or outpatient procedures, since few cancer cases would be considered as being truly elective.\textsuperscript{7} The updated ACS guidelines for triage give detailed suggestions on how to prioritize cancer cases that have been deferred in these 5 disease sites.\textsuperscript{4} A general principle that emerges from these suggestions is to review the priority of cancer cases suggested in the pandemic phases, and begin by performing the more urgent cases that were delayed, followed by the semi-urgent. Then, other cancer cases can follow based upon prioritization as to which patients are most likely to have compromised outcomes with further delays. It is important to be aware that there could be a resurgence of COVID-19 cases related to seasonal changes (in the fall or winter), as social distancing practices are relaxed, or due to other currently unforeseen factors. Should this happen, this could again lead to severe restrictions in cancer care delivery, and we may need to once again return to these triage guidelines for cancer patients. All guidelines will also need to be periodically updated as both COVID-19 PCR and antibody testing become more universally available, effective drugs are identified, and/or an effective vaccine is developed.

*Readers might also be interested in how the COVID-19 pandemic is affecting the academic mission in Surgical oncology\textsuperscript{8} and a detailed example of how one medical center has navigated the issues surrounding COVID-19.\textsuperscript{9}*
References


criteria


/media/files/covid19/acstriage_and_management_elective_cancer_surgery_during_acute_and_recovery_phases.ashx.


