



Roadmap for Resuming Elective Surgery at CommonSpirit Health Hospitals

Revised May 18, 2020

Note: Revisions from the previous version are underlined.

COVID-19 has changed our lives and healthcare delivery system in ways we never imagined. We will continue to evolve our healthcare delivery system as we adjust to the new presenting information. To support the hospitals and ambulatory care settings in their phased in approach to resuming elective surgeries, the CommonSpirit Health (CSH) team in the National Office has used the Joint Statement from the American Hospital Association released on April 17, 2020 as the framework for further guidance. This toolkit compliments the simultaneous release of “Resumption of Elective Surgeries: A Phased Approach” from Dr. Robert Wiebe, Chief Medical Officer at CSH.

In this toolkit, Division leaders will find the actual Joint Statement from the American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, and the American Hospital Association (see Contents 1-8). Following each of their eight sections, there is a section (a magenta box) where the CSH National Team has prepared a list of considerations that are presented in a “checklist” style. More in depth details can be found on either the CHI or Dignity Health SharePoint sites, in the appendices or other provided link. Our hope is that the design of this toolkit will assist you in your “jumpstart” efforts to resume your elective surgeries and other procedures.

If you have specific questions on the toolkit content, you are welcome to reach out to your local leaders for Communications, Environmental Services, Human Resources, Infection Prevention, Quality/Safety, and Supply Chain. If the toolkit is revised, you will find the latest revision in the COVID Daily Bulletin and on the CHI / Dignity Health SharePoint sites.

We appreciate your partnership and serving our patients.

Distributed by Patient Safety in the National Office in partnership with the teams in Advocacy (Shelly Schlenker), Communications (Anissa Routon), Environmental Services (Tim Livesay), Food and Nutrition Services (Diesell Martinez), Human Resources (Annette Lorenzi, Shelli Hofmann), Laboratory Service (Karen Smith), Patient Care Services (Brian Dawson), and Supply Chain (Dan DeLay, Kathy Carpenter and Alex Aliberto).

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1. Timing for Reopening of Elective Surgery

Principle: There should be a sustained reduction in the rate of new COVID-19 cases in the relevant geographic area for at least 14 days, and the facility shall have appropriate number of intensive care unit (ICU) and non-ICU beds, personal protective equipment (PPE), ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care.

Considerations:

- a. Timing of resumption: there must be a sustained reduction in rate of new COVID-19 cases in the relevant geographic area for at least 14 days before resumption of elective surgical procedures¹⁻⁴
- b. Any resumption should be authorized by the appropriate municipal, county and state health authorities
- c. Facilities in the state are safely able to treat all patients requiring hospitalization without resorting to crisis standards of care
- d. Does the facility have appropriate number of ICU and non-ICU beds, PPE, ventilators, medications, anesthetics and all medical surgical supplies?
- e. Does the facility have available numbers of trained and educated staff appropriate to the planned surgical procedures, patient population and facility resources? Given the known evidence supporting health care worker fatigue and the impact of stress, can the facilities perform planned procedures without compromising patient safety or staff safety and well-being?

CSH Considerations to “Jump-Start”

Clinical Consideration:

- Identify either two consecutive weeks of declining new COVID-19 infections in the community based on County-level reports or two consecutive weeks of Low-Moderate to Minimal Influenza-Like Illness (ILI) activity in the State as reported to ILINet (CDC updates and presents ILI activity every week on its website)
- Ensure at minimum 20% availability of beds and other medical equipment needed
- Determine anesthesia coverage (work with local anesthesia leadership to ensure anesthesia coverage for increased surgical workload – may need locum tenens anesthesia providers)
- Determine Operating Room resources (e.g., have you repurposed any pre-op or postop areas for additional beds?)
- Establish Length of Stay process (discharges and transfers by 11am by hospitalists and intensivists)

- Establish the use of COVID-19 Patient Education technology prior to surgery (e.g., EMMI)
- Clinical Data Science will be supplying forecasting informing to the timing and the level of admissions of COVID+ patients that will occur by geography after social distancing is reduced (refer to Appendix K for example of illustrative graphical information)

Human Resources (HR) Considerations:

- Ensure adequate trained and educated staff are available
 - Work with local HR to determine options for expedited hiring if needed
 - Provide existing online education to support employees and leaders around topics such as Resiliency, and Virtual Meetings
 - Collaborate with clinical education department to ensure adequately trained staff

2. COVID-19 Testing within a Facility

Principle: Facilities should use available testing to protect staff and patient safety whenever possible and should implement a policy addressing requirements and frequency for patient and staff testing.

Considerations: Facility COVID-19 testing policies should account for:

- a. Availability, accuracy and current evidence regarding tests, including turnaround time for test results.
- b. Frequency and timing of patient testing (all/selective)
 1. Patient testing policy should include accuracy and timing considerations to provide useful preoperative information as to COVID-19 status of surgical patients, particularly in areas of residual community transmission.
 2. If such testing is not available, consider a policy that addresses evidence-based infection prevention techniques, access control, workflow and distancing processes to create a safe environment in which elective surgery can occur. If there is uncertainty about patients' COVID-19 status, PPE appropriate for the clinical tasks should be provided for physicians and nurses.
- c. Health care worker testing
- d. How a facility will respond to COVID-19 positive worker, COVID-19 positive patient (identified preoperative, identified postoperative), "person under investigation" (PUI) worker, PUI patient?

CSH Considerations to “Jump-Start”

- Initiate COVID-19 testing for all procedures and surgeries that may generate aerosols using in-house or externally-sourced molecular/PCR. This includes procedures where reasonable anticipation of aerosol generating procedures will occur such as conscious sedation which might require supplemental O₂ therapy (refer to Appendix A)
 - Utilize standard PPE requirements for surgery if patient tests negative for COVID-19
 - Health care worker molecular testing may commence when testing capacity is increased
 - Only use a nasopharyngeal swab when testing an asymptomatic patient or health care worker
- Review turnaround time (TAT) of existing testing capability and established workflow to ensure testing occurs as close as possible to surgery date
 - If TAT is greater than four days, please work with local lab leadership to identify alternatives. If no alternatives are available please contact Karen Smith, System VP of Laboratory Services at Karen.Smith@DignityHealth.org to review other options (refer to Appendix A)
- Educate the patient to remain home (shelter in place) after testing until surgery date to limit potential exposure prior to surgery (refer to Patient Education materials in CHI/Dignity Health SharePoint site)
- Create a process to determine next steps if patient testing is not available or test results have not come back by date of surgery

3. Personal Protective Equipment

Principle: Facilities should not resume elective surgical procedures until they have adequate PPE and medical surgical supplies appropriate to the number and type of procedures to be performed.

Considerations: Facility policies for PPE should account for the following:

- a. Adequacy of available PPE, including supplies required for potential second wave of COVID- 19 cases
- b. Staff training on and proper use of PPE according to non-crisis level evidence-based standards of care
- c. Policies for the conservation of PPE should be developed (e.g., intubation teams) as well as policies for the extended use and reuse of PPE per CDC guidelines

CSH Considerations to “Jump-Start”

- Determine if facility has adequate inventory of PPE
 - Minimum four days on hand (utilize CRISIS application for analysis)
 - Projection of new inventory arrival for the next two weeks
 - Utilize your supply chain resources within your division for inquiries
- Evaluate approved options for reprocessing PPE established by the national office
- Establish universal source control at point of entry for all health care workers, visitors, and patients as recommended by the CDC (e.g., masking all individuals entering the facility, symptom check for fever and respiratory illness)
- Maintain visitor and student restrictions for two weeks after reopening for elective surgeries. A continued downward trend in geographical cases must be observed

4. Case Prioritization and Scheduling

Principle: Facilities should establish a prioritization policy committee consisting of surgery, anesthesia and nursing leadership to develop a prioritization strategy appropriate to the immediate patient needs.

Considerations: Prioritization policy committee strategy decisions should address case scheduling and prioritization and should account for the following:

- a. List of previously cancelled and postponed cases
- b. Objective priority scoring (e.g., MeNTS instrument)⁵ (refer to Appendix B)
- c. Specialties’ prioritization (cancer, organ transplants, cardiac, trauma)^{6,7}
- d. Strategy for allotting daytime “OR/procedural time” (e.g., block time, prioritization of case type [i.e., potential cancer, living related organ transplants, etc.])
- e. Identification of essential health care professionals and medical device representatives per procedure
- f. Strategy for phased opening of operating rooms
 1. Identify capacity goal prior to resuming 25% vs. 50%
 2. Outpatient/ambulatory cases start surgery first followed by inpatient surgeries
 3. All operating rooms simultaneously – will require more personnel and material
- g. Strategy for increasing “OR/procedural time” availability (e.g., extended hours before weekends)
- h. Issues associated with increased OR/procedural volume

1. Ensure primary personnel availability commensurate with increased volume and hours (e.g., surgery, anesthesia, nursing, housekeeping, engineering, sterile processing, etc.)
2. Ensure adjunct personnel availability (e.g., pathology, radiology, etc.)
3. Ensure supply availability for planned procedures (e.g., anesthesia drugs, procedure-related medications, sutures, disposable and non-disposable surgical instruments)
4. Ensure adequate availability of inpatient hospital beds and intensive care beds and ventilators for the expected postoperative care
5. New staff training

CSH Considerations to “Jump-Start”

- The objective priority scoring (MeNTS instrument) from ACS is attached in appendix B
- Review the CommonSpirit Health in of COVID-19 Elective Surgery Backlog Calculator (refer to Appendix C) to understand how many cases are in your backlog based on your historical volume data and how much time you should expect to need to address that backlog. Your resource assessment will inform calculator inputs such as:
 - Beds to accommodate elective inpatient cases
 - Ability to run rooms in the evenings or on weekends
 - Conversion of any rooms to OR's (procedure rooms or Endo suites)
 - OR rooms or PACU bays that are set aside specifically for COVID-19 patients
 - Need to supplement nursing and anesthesia staff resources with travelers
 - Impact of surgeons with privileges at other facilities on your backlog
- Meet with the corporate Perioperative Services team as needed to validate the inputs and levers of the backlog calculator, and/or to discuss considerations for block policy, appointment book maintenance, and case backlog prioritization
- Schedule and conduct a meeting with your surgical governance committee (multi-disciplinary team to include nursing, surgery, anesthesiology, lab, radiology, EVS), to address:
 - Short term changes to block policy, if needed, to handle recovery period (refer to Appendix D)
 - Review Backlog Calculator
 - Discuss plan for market development post-COVID-19 rounding with physician offices (via phone, in-person, etc.)
 - Determine ongoing meeting cadence

- Once you have a date when your OR's will re-open, work with Market Development representatives to communicate to surgeon offices
 - Refer to Appendix E - Physician Outreach templates
 - MDR's to assist with patient messaging and communication needs (procedure prioritization, testing policies, counseling, safety for patients and healthcare workers, PPE use, patient family/visitor guidelines, post-discharge care, advance directives)
- Once you have a date when your OR's will re-open, begin the process of rescheduling cancelled cases in the backlog
 - OR schedulers should start reaching out to offices to schedule cancelled procedures. Periodically, run the COVID-19 Cancelled Case report to refresh your list
- Review the schedule for the first week that you are open. Continue to assess your resources and make any changes to the schedule based on any new resource constraints
 - Continuously evaluate unfilled surgeon block time so all unused time is released to 'First Come, First Served' time slots
- Start planning for additional phases of ramp up period
 - If you don't expect to re-open at 100% capacity start planning your ramp-up timeline to get back to full operations
 - Ensure safe, high quality high value care of surgical patients across the five phases of surgical care (use risk adjusted data)

5. Post-COVID-19 Issues for the Five Phases of Surgical Care

Principle: Facilities should adopt policies addressing care issues specific to COVID-19 and the postponement of surgical scheduling.

Considerations:

Facility policies should consider the following when adopting policies specific to COVID-19 and the postponement of surgical scheduling:

a. Phase I: Preoperative

1. Guideline for preoperative assessment process
 - Patient readiness for surgery can be coordinated by anesthesiology-led preoperative assessment services.
2. Guideline for timing of re-assessing patient health status
 - Special attention and re-evaluation are needed if patient has had COVID-19-related illness
 - A recent history and physical examination within 30 days per Centers for Medicare and Medicaid Services (CMS) requirement is

necessary for all patients. This will verify that there has been no significant interim change in patient's health status

- Consider use of telemedicine as well as nurse practitioners and physician assistants for components of the preoperative patient evaluation
- Some face-to-face components can be scheduled on day of procedure, particularly for healthier patients
- Surgery and anesthesia consents per facility policy and state requirements
- Laboratory testing and radiologic imaging procedures should be determined by patient indications and procedure needs. Testing and repeat testing without indication is discouraged
- Assess preoperative patient education classes vs. remote instructions
- Advanced directive discussion with surgeon, especially patients who are older adults, frail or post-COVID-19
- Assess for need for post-acute care (PAC) facility stay and address before procedure (e.g., rehabilitation, skilled nursing facility)

b. Phase II: Immediate Preoperative

1. Guideline for pre-procedure interval evaluation since COVID-19-related postponement
2. Assess need for revision of nursing, anesthesia, surgery checklists regarding COVID-19

c. Phase III: Intraoperative

1. Assess need for revision of pre-anesthetic and pre-surgical timeout components.
2. Guideline for who is present during intubation and extubation
3. Guideline for PPE use
4. Guideline for presence of nonessential personnel including students

d. Phase IV: Postoperative

1. Adhere to standardized care protocols for reliability in light of potential different personnel. Standardized protocols optimize length of stay efficiency and decrease complications (e.g., ERAS)

e. Phase V: Post Discharge Care Planning

1. PAC facility availability
2. PAC facility safety (COVID-19, non-COVID-19 issues)
3. Home setting: Ideally patients should be discharged home and not to a nursing home as higher rates of COVID-19 may exist in these facilities

CSH Considerations to “Jump-Start”

- Complete a terminal cleaning of all areas prior to reopening and at the end of each day
- Establish engineering controls to facilitate social distancing, such as minimizing time in waiting areas, spacing chairs at least 6 feet apart, and maintaining low patient volumes
- Consider postponing surgery or scheduling for the last case of the day if the patient is COVID-19 positive
 - Weigh impact of postponing surgery to patient outcome
 - Consider excluding staff in collaboration with HR that are at greater risk for adverse outcomes per CDC recommendations (e.g., pregnant, chronic respiratory condition, etc.)
 - Recover the patient in the OR suite
- Identify patient path of travel from pre-op to postop to limit interaction with other patients and ancillary staff
- Identify vendors who would need to participate in the cases, limit the number of personnel. Develop a process to communicate and notify the vendor of existing protocols
- Limit OR traffic within the surgical suite
- Consider designating recovery locations that are separate from known areas with positive COVID-19 or PUI patients
- Review room turnover procedure with environmental services (EVS)
 - Specifically delineate the responsibilities of room cleaning with OR and EVS staff
 - Review daily terminal cleaning logs to ensure completion
- Consider discharge location requirements (e.g., SNF, LTAC) for patients with known and unknown COVID-19 status
 - Be aware some discharge locations require two negative COVID-19 tests prior to accepting patient regardless of original test result during pre-op

6. Collection and Management of Data

Principle: Facilities should reevaluate and reassess policies and procedures frequently, based on COVID-19 related data, resources, testing and other clinical information.

Considerations: Facilities should collect and utilize relevant facility data, enhanced by data from local authorities and government agencies as available:

- a. COVID-19 numbers (testing, positives, availability of inpatient and ICU beds, intubated, OR/procedural cases, new cases, deaths, health care worker positives, location, tracking, isolation and quarantine policy)
- b. Facility bed, PPE, ICU, ventilator availability
- c. Quality of care metrics (mortality, complications, readmission, errors, near misses, other – especially in context of increased volume)

CSH Considerations to “Jump-Start”

- Monitor daily COVID-19 statistics by utilizing the CRISIS application
- Work with local and division Supply Chain leadership on a daily basis to review inventory levels of related surgical supplies (e.g., ventilator circuits, custom packs)
- Develop a process to monitor and manage key perioperative supplies to improve supply efficiency refer to John Frye, System VP, Supply Chain Operations at JohnFrye@catholichealth.net for further input

7. COVID-related Safety and Risk Mitigation surrounding Second Wave

Principle: Facilities should have and implement a social distancing policy for staff, patients and patient visitors in non-restricted areas in the facility which meets then-current local and national recommendations for community isolation practices.

Considerations:

- a. Each facility’s social distancing policy should account for:
 - 1. Then-current local and national recommendations
 - 2. The number of persons that can accompany the procedural patient to the facility
 - 3. Whether visitors in periprocedural areas should be further restricted

CSH Considerations to “Jump-Start”

- Revise surge plan to identify different areas for a surge once the repurposed units (e.g., COVID-19 units) go back to normal operations
- Identify feasibility of initiating rapid mitigation strategies
 - Reactivate visitor, student, and dietary service restrictions, single point of entry, and designation of inpatient COVID-19 units
- Initiate existing HR developed measures that support social distancing
 - Review the Temporary Teleworker Policy
 - Consider implementing portions of New Employee Orientation electronically rather than in person while social distancing continues to be necessary

- Encourage the use of video and/or telephone interviews when possible. If in-person interviews are necessary, consider scaling down the number of employees involved in the interview process to ensure proper distance is maintained
- Review established employee assistant programs (e.g., employees who are concerned about potential exposure to their families may be able to access no- or low-cost accommodations). Additional information about organizations and/or hotel chains offering such accommodations can be obtained by contacting your local HR office

8. Additional COVID-19 Related Issues

Note: This is the “other section” from the joint statement from AHA and others and many of these sections are also included in the magenta boxes of previous sections.

- a. Healthcare worker well-being: post-traumatic stress, work hours, including trainees and students if applicable
- b. Patient messaging and communication (refer to Appendix F)
- c. Case scheduling process (refer to Appendix C and D)
- d. Facility and OR/procedural safety for patients
- e. Preoperative testing process
 1. For COVID-19-positive patients
 2. For non-COVID-19-positive patients
 3. Environmental cleaning
- f. Prior to implementing the start-up of any invasive procedure, all areas should be terminally cleaned according to evidence-based information.
- g. In all areas along five phases of care (e.g. clinic, preoperative and OR/procedural areas, workrooms, pathology-frozen, recovery room, patient areas, ICU, ventilators, scopes, sterile processing, etc.):
 1. Regulatory issues (The Joint Commission, CMS, CDC)
 2. Operating/procedural rooms must meet engineering and Facility Guideline Institute standards for air exchanges
 3. Re-engineering, testing, and cleaning as needed of anesthesia machines returned from COVID-19 and non-COVID ICU use

CSH Considerations to “Jump-Start”

- Maintain cafeteria, visitor and student restrictions for a minimum of two weeks after reopening for elective surgeries. A continued downward trend in geographical cases must be observed
- More than ever, it is important to recognize and prioritize our employees’ well-being, as they continue to provide much-needed care, treatment, and

support. Recognizing the personal impact of the current crisis is a vital step for employees to continuing to support their own and their colleagues' well-being. CommonSpirit Health has developed information and resources to support employees' physical, emotional, social, financial, and spiritual well-being. We will continue to update these resources. Click here for the Employee COVID-19 Resilience and Well-Being Resources - <https://dignityhealth.box.com/v/COVID19-Resources-CSH>

9. Communications Plan

Principle: Facilities should have a comprehensive communications plan to provide clear information to staff, patients, physicians, and the community. Communications should describe the criteria we are using to resume procedures, the steps we are taking to safely provide care, and the expectations that staff and patients should have.

Considerations: Communications to our key audiences should be coordinated and consistent. Communications should place a particular emphasis on earning trust from our physicians, staff, and patients that it is safe to provide and receive care at our facilities.

Recognizing that each division and community may have a different timeframe and approach for resuming procedures, communications should be customized and specific to the local circumstances and approach.

CSH Considerations to “Jump-Start”

A suite of communications resources has been developed to support our division teams. Those resources may be found in *Communications Resource needed from Dan* (refer to Appendix F)

- Key messages:
 - We are preparing to safely and gradually resume some elective procedures at our care sites, following guidance from national health officials
 - We will continue to take significant steps to make sure it is safe to be treated at our care facilities. We have a careful and detailed approach to determine which procedures can safely be performed, where they can be performed, and when they can be performed

- Serving our communities is our calling, and safely resuming these procedures is one of the most important ways we can help our communities heal
- Communications tactics:
 - Consider a proactive approach to communicating with staff, patients, physicians, and the community. Recognize the significant interest and questions from our key audiences
 - Use internal memos, FAQs, patient communications, and media statements to share our message
 - Consider reinforcing messages through Huddles, calls or meetings with employees and physicians, and community outreach

References

1. Gottleib S, McClellan M, Silvis L, Rivers C, Watson C. National coronavirus response: A road map to reopening. American Enterprise Institute website. <https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/>. March 29, 2020. Accessed April 17, 2020.
2. Wall Street Journal. <https://www.wsj.com/podcasts/the-journal/dr-anthony-fauci-on-how-life-returns-to-normal/>. April 16, 2020. Accessed April 17, 2020.
3. COVID-19 Projections—Illinois. Institutes for Health Metrics and Evaluation. <https://covid19.healthdata.org/united-states-of-america/illinois>. Accessed April 17, 2020.
4. COVID-19 Hospital Impact Model for Epidemics (CHIME). UPenn Medicine. <https://penn-chime.phl.io>. Accessed April 17, 2020.
5. Prachand V, Milner R, Angelos P, et al. Medically-Necessary, Time-Sensitive Procedures: A scoring system to ethically and efficiently manage resource scarcity and provider risk during the COVID-19 pandemic. JACS in press. [https://www.journalacs.org/article/S1072-7515\(20\)30317-3/pdf](https://www.journalacs.org/article/S1072-7515(20)30317-3/pdf).
6. American College of Surgeons. COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures. <https://www.facs.org/COVID-19/clinical-guidance/triage>. March 17, 2020. Accessed April 17, 2020.
7. American College of Surgeons. COVID-19: Recommendations for Management of Elective Surgical Procedures. <https://www.facs.org/covid-19/clinical-guidance/triage> March 13, 2020. Accessed April 17, 2020.

Appendices

A. COVID-19 Testing Made Easy



Overview of
COVID-19 Testing M

<https://dignityhealth.box.com/s/qniww1xs23mmusttc424f6y5mjpfrqkp>



COVID 19 Testing
for Resuming Electiv

<https://dignityhealth.box.com/s/ohsn8pmfumr0nbyoppoghqbq82za1qgvi>



CSH Clinical Mgmt
Guidelines

<https://dignityhealth.box.com/s/ubsde6p1gan3yd0nboq9b3vqpai4nhfi>

B. MeNTS OR Procedure Prioritization Worksheet



MeNTS OR
Procedure Prioritizat

<https://dignityhealth.box.com/s/146wkufxlx41schk9ov4692wdw1rlqmt>

C. Elective Backlog Calculator



CSH COVID-19
Elective Surgery Backl

<https://dignityhealth.box.com/s/hhw6st3s5wftvqsznpfyzobl6x277mc1>

D. Block Policy, Appointment Book Maintenance, and Prioritization Considerations



Block Policy-Appt
Book Maint-Prioritizat

<https://dignityhealth.box.com/s/f8i1zjir8kr8q8in5krppcx62kc352k1>

E. Physician Outreach Templates



Physician Outreach
Template CHI DRAFT.c

<https://dignityhealth.box.com/s/qh1ca093dk5jt7ui2y/g6cd80nbu7c7p>



Physician Outreach
Template DH DRAFT.c

<https://dignityhealth.box.com/s/lbcgyuiy22ief4b79csvmbvj4nuwd1ws>

F. Communications Resources

<https://dignityhealth.box.com/s/usqlj8fu0m3j296p46l1z1iyhooorj3n>

G. Joint Statement from AHA ACS ASA AORN



AHA ACS AORN Joint
Statement.pdf

<https://dignityhealth.box.com/s/h5g04hwwb589uxurc2i3n35iaayyg1mt>

H. ACS Statement



ACS Statement

<https://dignityhealth.box.com/s/s62wudjq7kv6b6fwtbomdla6b9dov7bo>

I. White House Plan



Opening Up America
Again - The White Ho

<https://dignityhealth.box.com/s/ooi3jv980m8x1ugy4xnse5bdebdostv>

J. CMS Reopening Guidelines Phase One



CMS
covid-flexibility-reope

<https://dignityhealth.box.com/s/ltj8mufdjnr5994kl01sqqd7ei86ul9w>

K. COVID-19 Recovery Planning



COVID-19 Recovery
Planning

<https://dignityhealth.box.com/s/cbo7bymt81jct5uo6un7yvxwfjmmw4wa>