

## Restarting the Health Care System Amid COVID-19 with Dr. Frank Opelka – Hospitals In Focus Transcript

Chip Kahn ([00:00](#)):

Hello and welcome to another edition of Hospitals and Focus. I'm your host, Chip Kahn. Hospitals, physicians and other caregivers are focused like a laser beam on the challenge of the coronavirus. One side effect of the pandemic has been the scheduled and routine procedures, diagnostics and other treatments have been postponed or canceled. In COVID hotspots around the country, hospital beds have been filled. But in low impact areas, hospitals are close to empty while doctor's offices and other health facilities are either closed or seeing only the sickest patients. So for all those patients beyond COVID, there is a need to get the system started again. But this is not so simple, both because covert is not going away totally, even if it's peaked in some places. And the fact that healthcare facilities, once shuttered, cannot just get going again from a standing start. Today, we're going to talk about the effort to restart the system with all those complexities and the COVID overlay, a threat that will remain with us, unfortunately. We have the perfect guest for the issue. Dr. Frank Opelka, the medical director at the American College of Surgeons. How are you doing Frank?

Dr. Frank Opelka ([01:32](#)):

Hi Jeff, it's great to connect with you again. Sorry we're so socially isolated. Chip, it's a real pleasure for me to get to reach out to the members. As you know, my career began some time ago, first in the military as a military surgeon for over a decade and then I rolled into academic medicine in New Orleans at the Ochsner Clinic and as an academic in the Harvard Medical System and then returning to New Orleans again at Louisiana State University. Along that career path, I've always touched base with the American College of Surgeons on the policy, the legislative and regulatory front. And as my career clinically began to wind down, we at the College of Surgeons, ramped up our Washington office where I lead a group in policy development, policy assessment, moving into the regulatory aspects and legislative aspects. And all of that is pretty much come to play as we've played out this pandemic and with COVID.

Chip Kahn ([02:47](#)):

Frank, so could you begin by telling us why the government at the federal and state levels chose to shut down so much healthcare activity and what the effect of that has been?

Dr. Frank Opelka ([03:01](#)):

That's a great question. As all of us, I think considered the models that we're moving forth with, what had happened in China, what was going on in Italy and the modeling that our experts in the U.S had created for a COVID infestation across the country, it presented a looming picture of how to prepare for this. And I think the government, at the federal level and pushed down to the individual States and governors and the mayors in different cities, began looking for ways to prepare to get ready for COVID infection crisis, a pandemic. And so the effort was to realize the projected needs of a healthcare system, which was not ready to flex up for a pandemic. And it meant that we were going to have to take down an enormous amount of our current services and prepare for what was going to be quite a horrific onslaught from the challenges that patients have with COVID once they're infected.

Dr. Frank Opelka ([04:19](#)):

There was a lot of unknowns. How much of the population is already infected and how quickly this virus spreads, how contagious it is, its motive spread and so forth and so on. The amount of ventilators that were going to be required in ICUs were all modeled and projected. So there was an approach the government took and the governors in each state took to voluntarily seek all of us to shut down. And

## Restarting the Health Care System Amid COVID-19 with Dr. Frank Opelka – Hospitals In Focus Transcript

then in some instances, it was more than voluntary, it was mandated. Those shutdowns, they were broad-scale reaching across all elements of all counties, all cities when the virus was actually projected to track differently in those environments. And the impact it had on the medical infrastructure, on patients who needed some of the more routine care, has been significant.

Dr. Frank Opelka ([05:20](#)):

The clinical needs of patients, the resources, the business models that sustain the health sector have been completely turned off. And people then turn their attention to preparing for what was COVID and what are the crash courses that were needed in retooling the entire workforce and what aspects of the workforce were needed. It was a call to arms, it was an all hands on deck approach and it was an incredible exercise, but it's overall implications both clinically and in resources and overall financial impact on the sector, we're not going to know the overall effect for years to come. But every indication is that we have a lot to think about in preparing for the next pandemic given what's gone on with this one.

Chip Kahn ([06:15](#)):

So Frank, can we elaborate a little bit in terms of comparing that we now have hotspots? What it's like in a New York or areas around there where we have heavy penetration in the hospitals to areas in other parts of the country where we have a low COVID effect. In terms of hospitals and the surgeons and other physicians who work in hospitals and other care givers, what's been the difference between the two and obviously what's the effect has that had on patients?

Dr. Frank Opelka ([06:50](#)):

You've probably seen and I imagine others have seen all the different heat maps from county to county or city to city that play out COVID. And it's not just the big national flattening of the curve, each city, each county has its own curve and the risks involved in each city in each county are different given the social dynamics and how people live. A whole area where people are acres apart from one another, it's a virus that spreads through social contact that we're not going to see it there. What are the opportunities in some of those communities to have enough wherewithal with protective gear and social isolation and how they practice that they could sustain the ability to take care of some of the necessary other conditions patients are faced with. So it presented a problem to think of a one size fits all COVID curve that would temporarily sequence around different hotspots in the country. We didn't really see that play out. That kind of modeling for preparedness turned out to be problematic for the clinical wellbeing of patients with lots of other conditions.

Dr. Frank Opelka ([08:12](#)):

So we've seen that we've got solo, small group practices, rural critical access surgeons, employed surgeons, community surgeons, academic surgeons, all playing out differently with the types of needs of patients in their community and different COVID environments in each one. But we put down one formula for all as a management tool and that's had repercussions. People who've got need for dialysis and need dialysis catheters or other limb preserving operations or significant musculoskeletal or gastrointestinal conditions or cancers. All those other conditions that we face with our patients were put on hold while we walk through a one size fits all pandemic approach and the impact of that, we still don't know. And as we then move into this surging through COVID, and we start to rethink things, we've got to retool our entire system and how we approach things. But we can get more into that and in a later conversation today, I'm sure.

## Restarting the Health Care System Amid COVID-19 with Dr. Frank Opelka – Hospitals In Focus Transcript

Chip Kahn ([09:34](#)):

Frank, I guess this is sort of an academic question now because the shutdowns tended to be so severe in terms of this care beside the ramp up to COVID and the care for COVID patients. But back a number of weeks ago, the college worked up a set of criteria for what care should be maintained during this period. And I know you then worked with CMS to try to integrate your criteria into policy they were developing. What did you all propose back then in terms of what should have been kept going as we proceeded into the COVID crisis, the COVID overlay?

Dr. Frank Opelka ([10:20](#)):

When we think about elective surgical care, it's more than elective care, it's not that we're doing something cosmetic for a patient. These surgical care for the most part, most invasive procedures that any patient receives from any medical or surgical specialty, that's usually the cord of last resort. People want simple noninvasive therapies if that will return and restore their health. So when we come to the point of needing urgent and emergent care, there's a real need for patients to undergo these procedures. The College tried to look at the COVID environment that CMS was thinking about as they try to bring down the amount of elective surgery so that we could prepare for COVID. How do we establish and define a triage methodology that helps provide guidance to the local community? Provide guidance to the hospital leadership, the administrative team, the credentials committees, the operating room staff, the entire surgical community for them to look at patients, prioritize those patients, consider the needs of those patients, and whether or not they should move forward with surgical care during a COVID pandemic.

Dr. Frank Opelka ([11:49](#)):

Some of those decisions early on were made based on the need to prepare for COVID. But as our understanding of the COVID environment advanced, it also took into consideration how many patients were asymptomatic and yet infected and would be at risk if brought into a COVID environment? Or how many patients were not infected at all and would be at risk if brought into a COVID environment? So what surgical procedures for the various conditions patients faced from vascular conditions, cardiac, musculoskeletal, complex GI, oncologic, a whole array of procedures to think about in a COVID environment where our knowledge of COVID was emerging right in front of us and the risk benefit ratios had to be put forth to the local community. Guidance we provided to CMS and guidance we provided to the medical community at large, went to the administrators of these facilities as well as to the surgeons, anesthesia and everyone involved and use their better judgment based on available knowledge.

Dr. Frank Opelka ([13:06](#)):

We also tried to provide updated knowledge resources on a weekly basis and publishing those. So all of those making these decisions could see the literature vetted through our own experts, as trusted and reliable, as best as possible. With most of this not being randomized controlled trials, but observational data that was coming out of China that was coming out of Spain, out of Italy, out of the rest of Europe, and from our own experience in the States, particularly in New York city and new Orleans and Detroit, some of the initial hotspots. So how do you synthesize all of that together as a living management of the pandemic and the surgical services that were needed? That was our effort with CMS, with the government at large, and we tried to make that available and continue it as a living document today.

Chip Kahn ([14:02](#)):

## Restarting the Health Care System Amid COVID-19 with Dr. Frank Opelka – Hospitals In Focus Transcript

So Frank, now with all that knowledge and with beginning to understand how much PPE, the special equipment, and how much testing we now have or that we'll need, where are you and the college on your prep for returning, at least in those low impact areas, to full service or something closer to full service? And what has to happen to get us there and how are surgeons and other physicians planning for that?

Dr. Frank Opelka ([14:39](#)):

When to begin to ramp up? How do we actually move from where we are to where we need to go?? In many respects, I draw a comparison. I remember tragedy of 9/11 and after 9/11 we redesigned the airline industry and we moved forward with TSA and all these other security functions so that we had a trusted airline system after 9/11. We are going to have to change this entire healthcare sector in much the same way in the post COVID era until we've actually gotten to the point where we've got adequate secure herd immunity and safe, trusted care, again, including surgical care.

Dr. Frank Opelka ([15:26](#)):

So what changes will we need to make as first of all, we begin to reopen surgery? How do we move from emergency surgery to urgent surgery to starting to take down the backlog and starting to help and prioritize those patients? Ideally, it would be to have trusted testing, which has still been a challenge for us as a nation. But having that trusted testing in all environments for all invasive care would be helpful to the work, the healthcare workers, the surgeon, the anesthesiologist, and to the patients and their families and the protections they need. So trusted testing is a crucial step.

Dr. Frank Opelka ([16:14](#)):

We also put forth the need to understand where you are in the COVID surge. Where does your community curve, where is it? Are you 14 days past that period of peak involvement of the virus? Are you seeing that you're starting to get lower down in incidents so that it is a representation that the virus has somewhat moved through your community? That has to be a local assessment that's performed in conjunction with the local population health experts and epidemiologists in your area that gives you a read on your community and what's involved. We think there's a real need for patient communication and understanding the risk benefit ratios of being operated on in a COVID environment. Surgery is its own stress and some surgery has more stress on the body than others. It may be that simple procedures can be performed in outpatient environments as the White House reveals in its early phase. But we still want all those necessary universal precautions, proper protection, assumption of illness, of COVID exposure unless we've got complete and secure testing. So a note of caution as we reopen, but thoughtful tracking is important.

Dr. Frank Opelka ([17:41](#)):

Finally, we've put together an ACS COVID registry. We do a lot of work with registry and data as a data driven organization. So we've put together a hospital, a free service as a COVID registry to track this. It's got about 50 or 60 data elements that allow us to actually have an educated return. How do we know we're protecting our workforce, protecting all of those involved anesthesia, surgery, patients and family? We can only know that if we actually use the data that's necessary to track a virus like this that is so contagious. We think that is a crucial step to secure a safe return. But it's not going to be a switch we just turn back on. It's going to be a thoughtful rethinking of all the workflows in the care of patients and how we protect them in a COVID environment.

## Restarting the Health Care System Amid COVID-19 with Dr. Frank Opelka – Hospitals In Focus Transcript

Chip Kahn ([18:42](#)):

Let me close with one I guess bit of concern, Frank. There is discussion among the scientists that we may get a resurgence in the fall or I guess into the winter. Can you visualize the effect that might have on a return to care, or do you think we're going to build that return in such a way that we're going to be able to continue regular care besides fighting COVID?

Dr. Frank Opelka ([19:18](#)):

Yeah, it's a question I think we're all asking. And being a surgeon, I'm dangerous to opine on virology and it's incidence and its recurrence, so I rely on the experts to educate us. But I think we've got to take what we've learned from this first wave. If the experts tell us the second wave is coming, how do we more smartly prepare? How do we actually turn up, turn down, flex up, flex down, and create the ability to early identify those people who are involved and avoid unnecessary exposure for those individual patients? Maybe delay their care that they need until such time as their over the event. Also, have better capability of treating this condition. So not only identifying it, we still have a lot of work to do in working forward the best way to manage these patients. So early diagnosis, surveillance and screening, early intervention, avoidance of unnecessary care and ultimately managing the virus. And then finally in probably the next year, start to see the ability to vaccinate and protect the population against this.

Dr. Frank Opelka ([20:41](#)):

So as we see that second wave, we've got to be more thoughtful. We don't need to do the broad scale shuttering. We need to be able to be more flexible in how we flex up and flex down in different communities and manage the population now that we have more understanding. So how do we use all the knowledge we've gained to go forward? And that's a question for all of us.

Chip Kahn ([21:06](#)):

Frank, this has really been terrific, I just so appreciate you taking time. And also, we deeply appreciate all the work that you're doing at the American College of Surgeons to help us both deal with COVID and get our healthcare system started again for all the patients.

Dr. Frank Opelka ([21:25](#)):

Thanks Chip. Thanks for all you're doing and for your organization. We look forward to continuing our ongoing relationship and hope everyone stays safe as we get through this.

Chip Kahn ([21:36](#)):

Join us next time as we speak with experienced leaders on new ideas about healthcare delivery and financing. Please listen, rate and subscribe wherever you get your podcasts. And if you haven't already, you can follow the Federation on social media at FH hospitals and me at Chip Khan. This was Hospitals in Focus. I'm Chip Kahn. Thanks again for listening.