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Commentary

The Other Side of the COVID-19 Curve: A Model for the Safe Reintegration of Elective Interventional Pain Procedures

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Background: Throughout the COVID-19 pandemic, clinicians have had to think quickly, adapt to changing recommendations sometimes on a daily basis, and have often had to rely on trial-and-error-based treatment protocols under various conditions. As we move on past the apex of the COVID-19 curve, new treatment protocols for the safe reintegration of elective interventional pain procedures into chronic pain practice are needed.

Methods: Literature review and description of a model for the safe reintegration of interventional pain procedures.

Limitations: A narrative review with paucity of literature.

Discussion: Herein we describe one such model in the hopes that through similar knowledge sharing, we can draw on others experiences to reach a collective conclusion on the safest, most effective, and efficient way(s) to move forward.

Key words: COVID-19, interventional pain procedures, safety

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One of the many consequences of the COVID-19 pandemic were the state and federal government-imposed restrictions on elective surgical procedures. Interventional-based pain practices were disproportionately affected by these restrictions as they required such practices to cancel/postpone all prescheduled interventional pain procedures.

Over the last 3 months, many pain practices, including our own, have struggled to continue providing much needed pain management services to an ailing patient population without the use of interventional therapies, and while adhering to social distancing measures, respecting self-quarantine protocols, and ensuring safety to patients, clinicians, and office support staff alike. The role of telemedicine in chronic pain management has been previously discussed in the literature and employed in clinical practice, but had not been regarded as the standard of care (1,2). With little guidance, technological acumen, and in some cases without the necessary tools (webcams, microphones, telehealth platforms), pain practices had to rapidly integrate virtual health care into their practices and endure the arduous process of transitioning from conventional live patient visits to exclusively telehealth medicine (3).

The Montefiore Multidisciplinary Pain Program (MMPP) is a 13 physician primarily interventional and largely nonopiate-based chronic pain practice affiliated with Montefiore Health Systems, serving a highly appreciative and diverse patient population in Bronx, New York. MMPP is home to the largest physical medicine and rehabilitation–based ACGME-accredited pain medicine fellowship training program in the United States and one of the largest pain medicine training programs in New York State. During the COVID-19 pandemic, > 75% of the MMPP clinician staff were repurposed to COVID-19 wards, step down units, and intensive care

units, leaving behind a skeleton staff of only 3 clinicians. On March 7, 2020, Governor Andrew Cuomo issued the Executive Order 202.10 authorizing the Commissioner of Health to direct all general hospitals, ambulatory surgery centers, office-based surgery practices, and diagnostic and treatment centers to increase the number of beds available to patients, including by canceling all elective surgeries and procedures (4). In compliance with these orders, our practice postponed approximately 200 pain procedures until further notice. Our practice did, however, continue to operate during the pandemic by providing pain management services via telehealth. During this period, in addition to conservative and pharmacotherapeutics, our clinicians continued to offer patients pain procedures albeit with the preface that it could be months before the procedures are actually scheduled.

There is currently no clinically proven working vaccine (5) against or evidenced-based effective treatments for COVID-19 (6), but we are witnessing a gradual and encouraging flattening of the "curve" across the United States and in most parts of the world. As many states, including New York, begin the reopening process and lift restriction of elective surgical procedures, our practice, along with guidance and assistance from hospital administrators, was tasked with devising a safe and social distancing friendly working model for the reintegration of interventional pain procedures into our clinical practice.

We are sharing the following untested reintegration protocol in hopes that others will share similar early experiences and together as a pain community devise safe and effective protocols to allow us to continue to offer patients interventions in these uncertain times.

Workflow

1. Scheduling: Patients will be individually contacted by secretarial staff and asked if they are still interested in receiving the previously planned injection.
   a. If they are no longer interested in scheduling a procedure, the reasons will be document and patients will be offered a follow-up telehealth visit.
   b. If patients are interested in proceeding with scheduling, patients will be offered a date and time for the procedure.
2. Mandatory Prescreening: 48 hours or less prior to any scheduled injection, patients will be required to have a COVID-19 polymerase chain reaction test.
   a. Nursing staff will call patients 1 day prior to the injection appointment to ensure patients have been properly screened.
      i. Any patient that tests positive for COVID-19 will be instructed to enter self-quarantine for 14 days and will not be rescheduled without clearance from their primary care doctor.
      ii. Patients who test negative will be further screened by telephone for fever, chills, dry cough, malaise, body aches, anosmia and dysgeusia, and any recent sick contacts.
      iii. After screening negative for items i and ii, patients will be given permission to arrive for the injection.
3. Social Distancing: Under normal circumstances, our facilities are equipped with 3 fluoroscopy suites and an 8-bed recovery area. Our normal workflow can accommodate 3 practitioners allowing each to have 2 injection slots per hour between the hours of 8 AM to 4:30 PM, excluding 12:00 PM to 1:00 PM recess for lunch (assuming 100% show rate, 42 total injections per day). To strictly adhere to social distancing protocols the following limitations will be imposed:
   a. A maximum of 2 clinicians will be allowed to schedule injections per day.
   b. Injections will be restricted to 1 per hour, per clinician, such that no more than 2 patients will be in the recovery area or in the waiting area at any given time.
   c. A family member will only be permitted to accompany patients if the patient requires assistance with ambulation, or if an escort is required in cases in which patients are given sedation for an injection.
4. Patient Arrival:
   a. Before entering our facility, patients will be screened for fever using a contactless thermometer, required to sterilize their hands using hand sanitizer, and provided with a surgical mask.
   b. Patients will be instructed to arrive 30 minutes prior to scheduled appointment.
   c. Late patients will be handled on a case-by-case basis. If social distancing cannot be reasonably accommodated due to backlog of patients, the late patient will be rescheduled without any grace period.
5. Recovery Area: Only 4 of the 8 (odd or even numbers) beds will be occupied at any given time to allow for adequate spacing between patients in the preprocedure/recovery area.

   a. A maximum of 4 patients will be allowed into the preprocedure/recovery area at once: 2 beds will be used for patients waiting for injections, and the 2 remaining beds will be held for patients returning from ongoing injections.
   b. All beds will be sterilized using hospital-grade disinfectant wipes between patient use.
   c. Assuming patients are in good condition postprocedure (no postprocedure complications) patient will be promptly asked to leave the facility on discharge.
6. Fluoroscopy Suite:
   a. Suites will be sterilized with hospital-grade wipes between each patient use.
7. Personal Protective Equipment:
   a. All providers will continue to be required to wear hospital scrubs in the preprocedure/recovery area and the fluoroscopy suites.
   b. All providers will be required to wear N95 masks with a superimposed surgical mask, which will be disposed between injection cases.
   c. Providers will wear protective eyewear during procedures.
   d. Providers will not be required to wear surgical gowns during procedures but will be required to sterilize the lead aprons in-between cases with hospital-grade disinfectants.
8. Discharge Instructions:
   a. Patients will be given discharge instructions, including the office scheduling telephone number, and will be asked to call to schedule a follow-up visit rather than stopping to do so at the front desk prior to exiting the facility.
   b. Patients will be encouraged to schedule telehealth visits for follow-up, rather than in-person visits, when possible.

Conclusions

Although we have not tested the earlier described workflow, we anticipate these measures will provide our patients, clinicians, and support staff the extra added safety precautions necessary to resume providing elective pain procedures without significantly increasing the risk of exposure to COVID-19. Furthermore, given the high demand for pain procedures, as the proposed workflow becomes routine, we hope to gradually alter these protocols to allow for increased patient volumes.

With the advent of COVID-19, clinicals have had to think quickly, adapt to changing recommendations, sometimes on a daily basis, and more than ever in recent history have to rely on trial-and-error-based treatment protocols. We hope that through similar knowledge sharing, we can draw on others experiences and collectively devise safe, efficient, and effective working protocols for the reintegration of much needed interventional pain procedures as we continue to move on past the apex of the COVID-19 curve.

Disclaimer

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Conflict of interest

Each author certifies that he or she, or a member of his or her immediate family, has no commercial association (i.e., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted manuscript.

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