

Road Map to Re-Opening Your Closed ASC and Resuming Elective Surgeries

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Disclosures relevant for this presentation

I am the National Medical Director (CMO) for HCA Healthcare's 143 ASCs that operate in 16 States and 39 markets representing over 800K procedures annually

Take home messages from tonight

- The COVID-19 pandemic continues – adaptability and resilience will be required for some time
- Your re-engagement strategy must be thoughtful, programmed, agile and rigorously applied to be resilient. Resiliency ensures a continually safe environment capable of effective and efficient care
- There are many tools and resources available to assist you
- The “new normal” may not be like the “old normal” for a while, if ever
- People need to feel safe to engage; it’s our responsibility to be safe so they can feel safe and their trust in us is justified

Disclaimer: This presentation is not a detailed “road map” but a discussion of general themes for you to consider as you reopen your ASC and we collectively reopen society

Procedural Care in America – Current State

Decreases in procedural volume have resulted from pandemic

- Fear of being infected
- Risk of contributing to virus spread
- Desire to create hospital capacity for COVID-19 patients (beds, vents, clinicians)
- Need to preserve PPE
- Government restrictions

Procedural Care in America – Current State

While appropriate, the decrease in procedural care has led to

- Disruptions in scheduled procedural care
- Backlogs of cases leading to increased demand for return
- Ambiguity over appropriateness, timing and case selection
- Confusion about when, how and under what circumstances scheduled care can resume/accelerate
- Ambiguous, contradictory, and sometimes absent guidance from trusted entities (government, regulators, professional societies and individuals)
- Devastating financial ramifications for health systems, ASCs, caregivers

Uncertainty and fear are the result

CMS Guidance, Opening Up America

- [CMS released recommendations](#) on re-opening facilities to provide non-emergent non-COVID-19 healthcare
- States or regions that have passed Gating Criteria (symptoms, cases, and hospitals) may proceed to Phase I
- ASCs should consider alignment with other in-market facilities (“community standard”)



Proposed State or Regional Gating Criteria

(Satisfy Before Proceeding to Phased Opening)

SYMPTOMS

Downward trajectory of influenza-like illnesses (ILI) reported within a 14-day period

AND

Downward trajectory of covid-like syndromic cases reported within a 14-day period

CASES

Downward trajectory of documented cases within a 14-day period

OR

Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)

HOSPITALS

Treat all patients without crisis care

AND

Robust testing program in place for at-risk healthcare workers, including emerging antibody testing



OPENING UP AMERICA AGAIN

Centers for Medicare & Medicaid Services (CMS) Recommendations Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I

The United States is experiencing an unprecedented public health emergency from the COVID-19 pandemic. Healthcare facilities in some areas are stretched to their limits of capacity, and surge areas have been needed to augment care for patients with COVID-19. To expand capacity to care for these patients and to conserve adequate staff and supplies, especially personal protective equipment (PPE), on March 18 the Centers for Medicare & Medicaid Services (CMS) recommended [limiting non-essential care](#) and expanding surge capacity into ambulatory surgical centers and other areas. However, CMS recognizes that at this time many areas have a low, or relatively low and stable incidence of COVID-19, and that it is important to be flexible and allow facilities to provide care for patients needing non-emergent, non-COVID-19 healthcare. In addition, as states and localities begin to stabilize, it is important to restart care that is currently being postponed, such as certain procedural care (surgeries and procedures), chronic disease care, and, ultimately, preventive care. Patients continue to have ongoing healthcare needs that are currently being deferred. Therefore, if states or regions have passed the Gating Criteria (symptoms, cases, and hospitals) announced on April 16, 2020, then they may proceed to Phase I. The Guidelines for Opening Up America Again can be found at the following link: <https://www.whitehouse.gov/openingamerica/#criteria>

Maximum use of all telehealth modalities is strongly encouraged. However, for care that cannot be accomplished virtually, these recommendations — the first in a series of recommendations — may guide healthcare systems and facilities as they consider resuming in-person care of non-COVID-19 patients in regions with low incidence of COVID-19 disease.

Non-COVID-19 care should be offered to patients as clinically appropriate and within a state, locality, or facility that has the resources to provide such care and the ability to quickly respond to a surge in COVID-19 cases, if necessary. Decisions should be consistent with public health information and in collaboration with state public health authorities. Careful planning is required to resume in-person care of patients requiring non-COVID-19 care, and all aspects of care must be considered — for example:

- Adequate facilities, workforce, testing, and supplies
- Adequate workforce across phases of care (such as availability of clinicians, nurses, anesthesia, pharmacy, imaging, pathology support, and post-acute care)

The following recommendations aim to give healthcare facilities some flexibility in providing essential non-COVID-19 care to patients without symptoms of COVID-19 in regions with low incidence of COVID-19. Healthcare systems or clinicians have flexibility to re-start clinically necessary care for patients with non-COVID-19 needs or complex chronic disease management requirements in accordance with the following general considerations:

General Considerations

- In coordination with State and local public health officials, evaluate the incidence and trends for COVID-19 in the area where re-starting in-person care is being considered.
- Evaluate the necessity of the care based on clinical needs. Providers should prioritize surgical/procedural care and high-complexity chronic disease management; however, select preventive services may also be highly necessary.

CMS Guidance, Opening Up America

States or regions that have passed Gating Criteria (symptoms, cases, and hospitals) may proceed to Phase I with the following expectations per CMS Guidelines:

- Screen all patients for symptoms of COVID-19 and conduct temperature checks
- Sufficient resources should be available without jeopardizing surge capacity
- Universal masking should be in place
- Staff should utilize N95 masks for aerosolizing procedures
- PPE conservation efforts should be in place
- Staff should routinely be screened for COVID-19
- Social distancing measures should be in place in common areas
- Visitors should be limited and screened upon entry
- Adequate supplies and equipment should be available
- When adequate testing is available, test patients before care and staff routinely
- Elective care should cease if there is a surge

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SAMBA's leadership in reopening ambulatory anesthesia



Outpatient • Office Based • Non-Operating Room

Society for Ambulatory Anesthesia (SAMBA) Statement on Resuming Ambulatory Anesthesia Care as Our Nation Recovers from COVID-19
4/18/2020



The Federal Government has just issued "[The White House Guidelines for Opening Up America Again](#)" in which resuming elective surgeries was mentioned more than once. Anesthesiologists and medical directors play an essential role in maintaining quality and safety for patients and staff at ambulatory surgery centers (ASCs) and other outpatient surgical facilities, hospitals, and office-based practices. Thus, The Society for Ambulatory Anesthesia (SAMBA) is offering this guidance to our member facilities and members.

SAMBA supports the federal call to resume care of patients for postponed time-sensitive and elective surgeries as appropriate, with priority given to the former. SAMBA advocates for a stepped approach when reopening ASCs and other facilities where these surgeries are performed. Elective surgeries should begin only in areas where local, state and federal officials have authorized the resumption. Therefore, this is expected to take place only in communities where there is a low incidence of COVID-19 admissions to hospitals, a trending decrease in positive cases, and adequate supply of PPE.

ASCs specialize in outpatient surgery. They are not only suited for low to moderate risk procedures, but also care for higher risk patients having increasingly complex surgeries. We need to be cautious in performing surgeries that have the potential of patients needing transfer to a higher level of care. Hospitals may still need to care for COVID-19 patients should

resurgence occur. Therefore, SAMBA recommends gradually starting with low risk, shorter procedures and then moving to more advanced ones as the pandemic is monitored. SAMBA recommends exploring options for anesthesiologist-led remote preoperative patient evaluation utilizing telemedicine platforms to minimize patient visits.

SAMBA strongly endorses testing all patients before elective procedures as feasible. Every person who has not tested negative is considered a potential carrier of the virus. We thus strongly recommend maintaining standards as expressed by the CDC, ASA, and APSF:

1. Maintain safe distancing between patients and visitors.
2. Continue screening patients for symptoms and measuring temperature.
3. Limit visitors to either none or only one individual per patient.
4. Avoid crowding in waiting areas by removing and separating chairs 6 feet apart.
5. Strongly encourage the use of level I masks in all public areas within the facility.
6. Strongly encourage the use of level 3 masks in clinical areas.
7. PPE, including N95 masks, should continue to be worn for aerosolizing procedures, such as airway management, upper endoscopy, bronchoscopy, and ENT procedures.
8. Schedule procedures to allow time for droplets to settle during aerosolizing procedures and for proper cleaning.

Medical directors need to be engaged with the administrative leadership to:

1. Maintain a sufficient supply of PPE for safety of patients and staff.
2. Maintain sufficient supplies of medications necessary for clinical care.
3. Implement extra environmental cleaning (e.g., elevator buttons, doorknobs, waiting areas).

SAMBA recently hosted a [webinar](#) on infection control at ASCs which can be found on our [website](#). We urge you to view this [webinar](#) to review best practices for infection prevention, such as proper handwashing, and other strategies in the prevention checklist.

Minimal staff are recommended to return to currently closed facilities in sufficient time ahead of service start dates to perform preparatory steps including but not limited to:

1. Proper cleaning of the facility
2. Resterilization of equipment
3. Adequate inventory of medications and supplies
4. Inspection of facility functionality and maintenance of back-up generators and medical gas supplies
5. Checking expiration date on medications, disposables and implants

Staffing should be adjusted according to surgical demand, as the recommended return to service is gradual. It remains unknown whether the economic impact of the pandemic shut down will impact elective surgical volumes, and the lingering fear of infection may impact patients' desire to have totally elective surgeries in the early stages of resuming care.

In conclusion, SAMBA supports the federal call to resume care of patients for time-sensitive and elective surgeries, as appropriate, in collaboration with local and federal health authorities. Return to service should be done in well-planned endeavors considering safety of patients and staff, wellbeing of our communities and the good of our nation.

Basem Abdelmalak, MD, FASA
SAMBA President

Leopoldo Rodriguez MD, FASA
SAMBA President-Elect

BobbieJean Sweitzer MD, FACP
SAMBA Vice-President



CHANGING THE FRAME FOR HEALTHCARE

Tools – Reopening Checklists

	A	B	C	D
		Yes	No	Limitations or further comments
1	If the ASC has been closed, consider the following below before reopening to provide normal services:			
2	Administration			
3	Has there been a downward trajectory in the rate of new COVID-19 cases in the relevant geographic area for at least 14 days before resumption of elective procedures?			
4	Has any resumption of elective procedures been authorized by the appropriate municipal, county and state authorities?			
5	If the facility enrolled as a hospital, and the public health emergency (PHE) has not been lifted at the federal level, did you notify your MAC in writing of your plan to revert back to an ASC prior to the end of the PHE period (Note: If the PHE is over, facilities will automatically revert back to ASCs).			
6	If the ASC contracted with local healthcare system(s) to provide hospital services and you plan to stop before the PHE is over, did you notify the hospital and terminate any agreement?			
7	Has the ASC notified the state licensing entity of the reopening date?			
8	If applicable, has the ASC's accrediting organization been notified of the reopening date?			
9	Has the ASC's Governing Board determined if the ASC will reopen in phases or at once based on information provided by the appropriate municipal, county and state authorities?			
10	Have the below been notified of the reopening date and hours/days the ASC will be open:			
11	- medical staff			
12	- staff			
13	- anesthesia			
14	- physicians' offices/schedulers			
15	- vendors			
16	Has the ASC verified the local/transfer hospital is able to accept emergency transfers?			
17	Has accurate and complete information regarding a reopening date and any changes in the normal operations of the center been provided on the ASC's website?			
18	Has the list of canceled procedures to determine re-scheduling priority been evaluated? (Some non-essential procedures may now be essential due to time or change in the patient's health status.)			
19	Based on the priority list, does the ASC have the necessary staff required for these procedures?			
20	Do any ASC staff have childcare/family care concerns?			
21	Has the ASC communicated goals with staff, listened to their concerns and established a safe environment where staff can verbalize fears, questions and concerns in the future?			
22	Does the ASC have the appropriate anesthesia coverage for these cases?			
23	Have scheduled patients been contacted to ensure they can travel safely to/from the ASC?			
24	Has the ASC considered creating a letter to patients to reassure them that the ASC has conducted extensive cleaning, training, etc., to serve them in a safe sanitary environment? (Consider posting			

ASCA [Checklist](#) to Help Reopen Your ASC

	A	B	C	D
	Task	Designated Employee	Date of Completion	Comments
1	or in need or changed			
58	Operating Rooms			
59	Ensure all equipment lights and flat surfaces are dusted prior to first case.			
60				
61	Have sterile supplies stored in the OR's been inspected for damage or exposure?			
62				
63	If supplies were damaged/exposed, has action been taken and completed? (i.e. replacement, reprocessing etc.)			
64				
65	Has an evaluation for electrical hazards been conducted?			
66				
67	Are the scrub sinks functioning properly? (this includes water running at appropriate temperatures)			
68				
69	Are there enough air exchanges per hour?			
70				
71	If necessary, has your ASC implemented new processes for intubation/extubation?			
72				
73	Have you taken precautions for filtering (CO2)			
74	Business Office/Scheduling			
75	Identify backlog of cases			
76				
77	Has center started scheduling cases			
78				
79	Has center contacted physicians offices for restart date			
80				
81	Have cases been pre-certified			
82				
83	Are you planning extended days? Saturdays?			
84				
85	Plan for scheduling low and high risk cases			
86				
87	Do you have a plan to help find space for surgeons from closed/limited availability competitors?			
88	Has a detailed report of expenses incurred due to the COVID-19 crisis been maintained by the ASC?			
89				
90	Have all computers and telephone systems been checked to ensure they are working properly?			
91				
92	Update phone message to reflect opening			
93				
94	Ensure Vivify- GO has been set up and is in use			
95				
	Check OMP for updates. If necessary, email Patti McCreddie to turn on OMP auto prompts for your ASC.			

Health System Opening Checklist

Tools – Reopening Checklists

Checklist items include:

- Initial tasks – surveying pandemic infection, check State and local govt., notify staff/vendors
- Central Sterile Processing/high level disinfection – retest equipment, HVAC, check supplies
- Procedure rooms - check air exchanges, clean all surfaces, check supplies, check gas lines
- Business Office/Scheduling – identify case backlog, check adequacy of scheduling, discuss extended hours
- Pharmacy – assess current inventory, reactivate badge access, review med ordering
- Radiology – ensure equipment inspected and functioning
- Patient Care Areas – clean and disinfect surfaces, medical gas; proper spacing of beds
- Risk/Safety-IC – update emergency plan, remove high-touch items; develop new P&P with approvals
- Facilities – check generator, relight pilots on heaters, check drains, “out of service” items like anes machines
- HR/Staff Training – COVID & PPE training, test staff?, N95 fit testing
- Expiration Checks – meds, implants
- Supply Ordering – strategy and implementation for new par levels
- Consignment - notify vendors of reopening, training for COVID P&P, restrictions on ASC visits
- Credentialing/EDHP – check for expirations, new applicant processing

Policies, Procedures and other documentation

- Relevant P&P areas to add/edit include
 - Screening/monitoring of patients, staff
 - Staff self-monitoring and reporting
 - PPE use
 - Distancing (physical and barriers like Universal Masking)
 - Enhanced Disinfection/cleaning (if needed)
 - Patient testing and medical clearance
- Use an available checklist or crosswalk
 - Once again, AAAHC has an excellent one



ASCA COVID-19 Recommendations for ASCs and AAAHC Standards Crosswalk

Amidst the COVID-19 pandemic, the Ambulatory Surgery Center Association (ASCA) recently released ten recommendations for Protecting Patients, Families and Staff During Necessary Surgeries. These ten recommendations provide sound guidance for infection control and prevention that align with your AAAHC Accreditation Standards.

We encourage you to consider these recommendations and the Centers for Disease Control and Prevention (CDC) references when reviewing, developing, implementing, and evaluating your emergency preparedness plan and infection control processes. The grid crosswalks the Standards with the ten recommendations and will support your efforts in conducting a gap analysis.

AAAHC's *1095 Strong, quality every day* philosophy stresses the provision of accreditation tools, resources, and relevant education that promotes patient safety and improves the quality of health care.

ASCA Recommendation	AAAHC 2018 Accreditation Handbook for Ambulatory Health Care	AAAHC 2017-18 Accreditation Handbook for Medicare Deemed Status Surveys
<p>1. Pre-screen all patients for symptoms or high-risk exposure prior to their visit, beginning at the physician's office and during any pre-admission phone calls or other remote methods. Inform the patient to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, fever).</p> <p>www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html</p>	<p>5.I.A.1. The written risk management program and/or policies address methods by which a patient may be dismissed from care or refused care.</p> <p>7.I.A.2. The written infection prevention and control program is relevant to the organization as demonstrated by a formal, documented infection prevention risk assessment.</p> <p>7.I.B. The written infection prevention and control program describes how infections and communicable diseases are prevented, identified and managed.</p> <p>7.I.B.1. The program requires immediate implementation of corrective and preventive measures when problems are identified.</p> <p>7.I.F. Safeguards are in place to protect patients and others from cross-infection. At minimum, the organization has written policies and procedures that ensure:</p> <p>7.I.F.1. The isolation or immediate transfer of patients with communicable diseases.</p>	<p>5.I.A.1. The organization's governing body approves a written risk management program and/or policies that address methods by which a patient may be dismissed from care or refused care.</p> <p>7.I.B. The written infection prevention and control program is: [416.51(b) Q-0242]</p> <p>7.I.B.5. In compliance with all applicable state and federal requirements.</p> <p>7.I.B.6. Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. [416.51(b)(3) Q-0245]</p> <p>7.I.B.7. Focused on direct intervention to prevent infection, as needed.</p> <p>7.I.B.8. Consistent with and adheres to professionally acceptable standards of practice. [416.51(a) Q-0241]</p> <p>7.I.B.9. The result of a formal, documented infection prevention risk assessment to ensure that the program is relevant to the organization.</p> <p>7.I.H. Policies are in place for the isolation or immediate transfer of patients with a communicable disease.</p> <p>10.I.G.1. Provisions have been made for the isolation or immediate transfer of patients with a communicable disease.</p>

Workflows and Efficiencies

- Strongly suggest simulations (real or tabletop exercises) to identify constraints/opportunities and workflow modifications
- Screening, distancing, PPE, care protocols will impair “normal” throughput
 - Patient preparation
 - Room turnovers with intubation/extubation, cleaning etc.
 - Capacity constraints (lobby, PACU/phase II bed spacing)
 - Discharge logistics with limited visitor policies
- Patient follow-up
 - Discussed more fully later but in short, we don’t know much about this disease and its effects on patients undergoing procedural care
- Consider scheduling patterns and case assignments
 - High risk cohorting, room flipping, extended hours, etc.
 - Creativity will serve you well

Workflows and Efficiencies (cont.)

- Expect different financial performance
 - Cases likely longer -> fewer cases/day (increased labor costs)
 - Supply costs likely up (e.g. N95 cost vs. Level 3 or 1)
 - Cancellation rate possibly up
- Tension between old financial performance and new reality
 - Pressure to achieve former budget and production goals could lead to breaches in infection prevention, etc.
 - Safety of patients and staff must remain the priority

Safety – Physical and Psychological

Two relevant perspectives

- Physical
 - Rigorous infection prevention, patient and staff screening, universal masking, physical distancing, testing, etc.
- Psychological
 - People want and need to feel safe
 - Concept of psychological safety always applies to patient safety
 - Is even more important now

“Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes.”



Amy Edmondson
Harvard Business School Professor



COVID-Free vs. COVID-Safe

Until there is much better point of care testing, a great vaccine or herd immunity it is impossible for us to guarantee a COVID-free environment

However, we can strive for a COVID-Safe environment

Creating Safety for Resumption of Routine Patient Care:

Universal Protection Framework Development

Universal Protection: A new standard that promotes patient safety & confidence across all sites of care



Infection Prevention

- Areas of Focus:
 - Universal Masking
 - Personal Protective Equipment
 - Policies & Procedures



Access Control

- Areas of Focus:
 - Separate Entrances
 - Screening: Colleagues & Patients
 - Visitation Policies



Distancing

- Areas of Focus:
 - Social Distancing
 - Patient Cohorting



Patient Flow

- Areas of Focus:
 - Workflow
 - Wayfinding & Signage

Comprehensive Communications & Marketing Strategies Across All Sites of Care

COVID-19 Safe Environment

We are taking an abundance of caution to ensure the safety of our patients, families, caregivers and visitors.



Enhanced Screening

We are screening everyone for COVID-19 before entering our facility through daily temperature, signs and symptoms checks.



Masks for All Visitors

Everyone who enters our facility will be required to wear a mask. If you have a mask at home, please wear it to your visit. Otherwise, we will provide one for you and your visitor to wear throughout your stay.



Infection Prevention

We have removed frequently touched items such as magazines, toys, vending machines, coffee and snacks.



Heightened Disinfection

We have increased the cleaning frequency of patient rooms, public and common areas, restrooms, waiting areas and any commonly touched surfaces. Our disinfectants are effective in killing the virus that causes COVID-19 and other pathogens.



Social Distancing

We are adhering to social distancing, and our lobby is marked, so you will know where to stand and sit. This will also be factored in throughout all phases of care during your stay. If you prefer to wait in your car, please feel free to do so.



Personal Protective Equipment for Colleagues

We have an adequate supply of PPE for our colleagues and physicians. This helps protect you, the patient, and our team from COVID-19 transmission.



Hand Hygiene

Hand hygiene is always a priority for us. Hand sanitizer and hand washing stations are available throughout our facility.



Visitors

To reduce overall exposure, we are currently limiting visitors to one per patient. For pediatric patients, two visitors may come to the facility.



Following Safety Protocols

We are following Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS) and appropriate state guidelines for performing COVID-19 safe surgeries.

The Testing Conundrum

Value of testing is dependent on

- Availability
- Accuracy
- Likelihood that result remains true when needed (a moment in time)

What do test results provide?

- Value of a positive test?
- Value of a negative test?
 - Decaying value of a preop test relative to dates of test and procedure
 - Quarantine patient and family following test, how many days before test and after, etc.?

Will only cease as an issue when POC testing available prior to procedure

What about the ASC physicians and staff? No risk assumed from them?

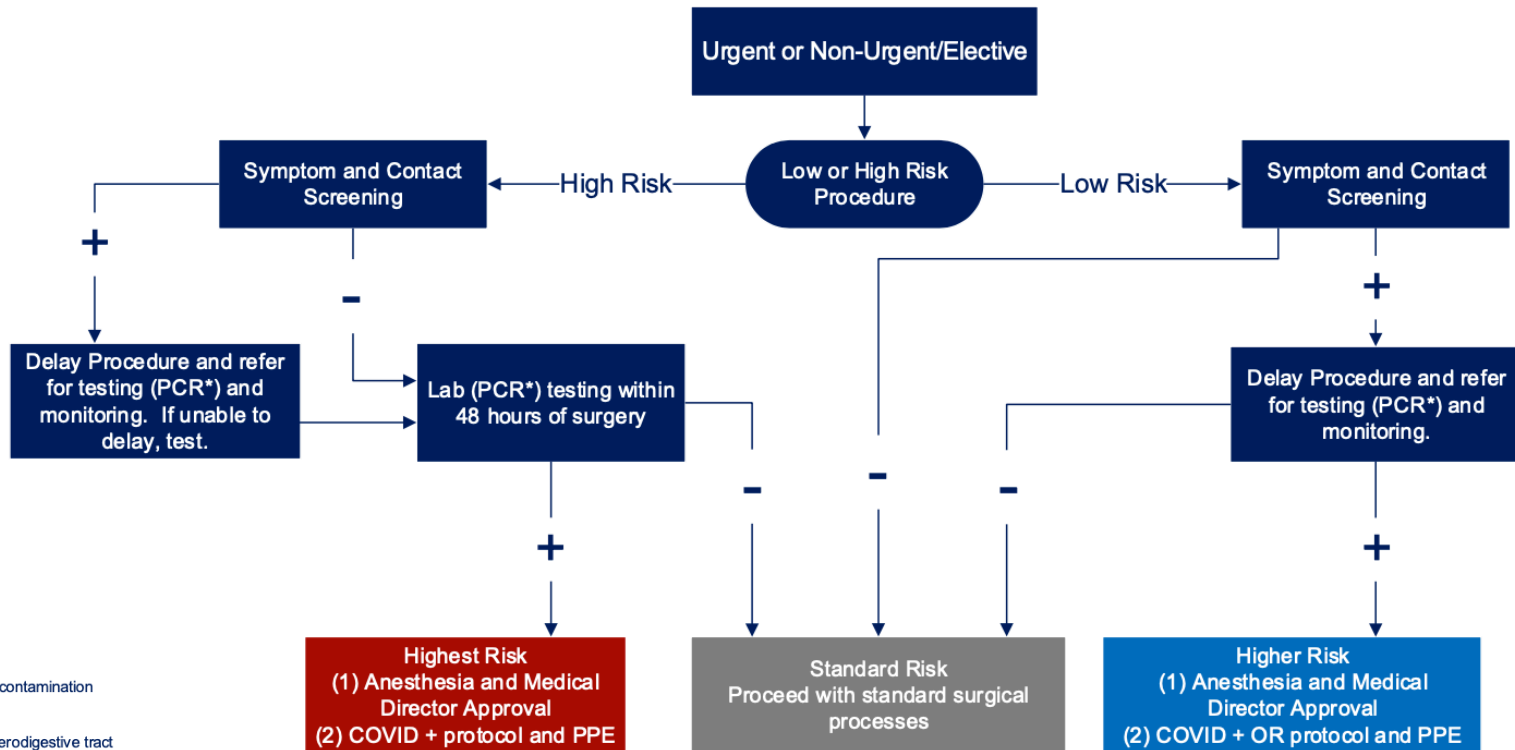
The Testing Conundrum (cont.)

Testing strategies

- Test every patient
 - How and when
 - Gap between test and date of service, other issues as mentioned
- Test selected patients
 - High risk patients
 - High risk procedures (AGP, airway cases, etc.)
- Test no one
 - Maximize screening

Regardless of strategy, until there is a highly accurate POC test we should assume everyone is a potential carrier and follow Universal Protection approaches

A sample ASC testing algorithm



High Risk Procedures:

Lung/bronchoscopy
Surgery of the bowel with gross contamination
Nasopharyngeal/ENT
Endoscopy of the GI tract
Other open procedures on the aerodigestive tract

Patients with delayed procedures due to positive symptoms or COVID tests should be enrolled in VivifyGo monitoring program

Other patient testing to screen for COVID based on the risk of performing surgery in a potentially infected, asymptomatic patient will be at the discretion of the treating physician.

*PCR = Polymerase Chain Reaction

Professional Collaboration and Consensus



Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic

American College of Surgeons
American Society of Anesthesiologists
Association of periOperative Registered Nurses
American Hospital Association

Introduction:

In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS), the U.S. Surgeon General and many medical specialties such as the American College of Surgeons and the American Society of Anesthesiologists recommended interim cancellation of elective surgical procedures. Physicians and health care organizations have responded appropriately and canceled non-essential cases across the country. Many patients have had their needed, but not essential, surgeries postponed due to the pandemic. When the first wave of this pandemic is behind us, the pent-up patient demand for surgical and procedural care may be immense, and health care organizations, physicians and nurses must be prepared to meet this demand. Facility readiness to resume elective surgery will vary by geographic location. The following is a list of principles and considerations to guide physicians, nurses and local facilities in their resumption of care in operating rooms and all procedural areas.

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: Facilities should evaluate the following before resuming elective surgery:

- Timing of resumption: There should 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 procedures.^{1,2,3,4}
- Any resumption should be authorized by the appropriate municipal, county and state health authorities.
- Facilities in the state are safely able to treat all patients requiring hospitalization without resorting to crisis standards of care.
- Does the facility have appropriate number of ICU and non-ICU beds, PPE, ventilators, medications, anesthetics and all medical surgical supplies?
- 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?

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:

- Availability, accuracy and current evidence regarding tests, including turnaround time for test results.
- Frequency and timing of patient testing (all/selective).
 - 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.
 - 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'



100+ years

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

Local Resumption of Elective Surgery Guidance

Introduction

In order to focus local resources on managing the new coronavirus (COVID-19) pandemic, “elective” surgery has been largely postponed and stopped. As the COVID-19 rates have already reached their peaks, or will do so over the next week or two (depending on location), the current focus for an increasing number of facilities is toward “ramping up” to prepare for elective operations.

The current document offers a set of principles and issues to help local facilities plan for resumption of elective surgical care.

While the effect of the COVID-19 pandemic on local communities or facilities is a spectrum, we suggest facilities use this checklist as a guide to ensure issues have at least been considered. Understanding both the local facility capabilities (e.g., beds, testing, operating rooms [ORs]) as well as potential constraints (e.g., workforce, supply chain), while keeping an eye on potential subsequent waves of COVID-19 will continue to be important.

Within the categories of I. COVID-19 Awareness, II. Preparedness, III. Patient Issues, and IV. Delivery of Safe High-Quality Care, there are 10 distinct issues to be addressed locally before elective surgery may be safely reinstated. Evaluating and addressing each of these 10 issues will help facilities to not only optimally provide safe and high-quality surgical patient care, but also to ensure that surgery resumes, and doesn't stop again.

PPE Considerations

- Usage rates increased over historical levels
 - Likely higher than most think even after planning
 - Tight controls needed, continual planning for need
- Likely further changes in guidance surrounding reuse, reprocessing and return to single patient only
 - Key question is how long relaxation of normal usage rules remain in effect (i.e., single patient only use) in an increasingly elective procedural environment
- Clinician acceptance
 - Include all constituents in discussions to determine appropriate use
 - Know how to deal with requests for PPE not supported by evidence
 - What if it threatens your ASC's business?

Supply Chain Considerations

- Tight coordination with your supply chain partners is a must
 - Allocations are typically driven by historical usage, can make procurement an issue
 - Ensure that you are anticipating supply needs with adequate lead time to adjust
- Many common anesthesia medications are also in short supply now
- PPE use must be driven by safety priorities
- Resist efforts to allow PPE supplies to influence safe deployment

Finally, Potential Clinical Anesthesia Concerns

The ultimate long-term effects of Coronavirus and its disease – COVID-19 – remain to be fully appreciated

We know it

- Presents clinically in several ways
- Frequently is asymptomatic
- Is highly infectious
- It currently is difficult to treat

However, we don't know

- If there are lasting physiological effects
- If infection renders immunity
- If it will have seasonal reappearance
- If a vaccine will work
- If there are interactions with anesthetic agents

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JID: ECLINM [m5G; April 4, 2020; 9:41]

EclinicalMedicine 000 (2020) 100331

Contents lists available at ScienceDirect

EclinicalMedicine

journal homepage: <https://www.journals.elsevier.com/eclinicalmedicine>

Research Paper

Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection

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ARTICLE INFO

Article History:
Received 14 March 2020
Revised 18 March 2020
Accepted 18 March 2020
Available online xxxx

Keywords:
COVID-19
SARS-CoV-2
Surgery
Incubation period

ABSTRACT

Background: The outbreak of 2019 novel coronavirus disease (COVID-19) in Wuhan, China, has spread rapidly worldwide. In the early stage, we encountered a small but meaningful number of patients who were unintentionally scheduled for elective surgeries during the incubation period of COVID-19. We intended to describe their clinical characteristics and outcomes.

Methods: We retrospectively analyzed the clinical data of 34 patients who underwent elective surgeries during the incubation period of COVID-19 at Renmin Hospital, Zhongnan Hospital, Tongji Hospital and Central Hospital in Wuhan, from January 1 to February 5, 2020.

Findings: Of the 34 operative patients, the median age was 55 years (IQR, 43–63), and 20 (58.8%) patients were women. All patients developed COVID-19 pneumonia shortly after surgery with abnormal findings on chest computed tomographic scans. Common symptoms included fever (31 [91.2%]), fatigue (25 [73.5%]) and dry cough (18 [52.9%]). 15 (44.1%) patients required admission to intensive care unit (ICU) during disease progression, and 7 patients (20.5%) died after admission to ICU. Compared with non-ICU patients, ICU patients were older, were more likely to have underlying comorbidities, underwent more difficult surgeries, as well as more severe laboratory abnormalities (eg, hyperleukocytemia, lymphopenia). The most common complications in non-survivors included ARDS, shock, arrhythmia and acute cardiac injury.

Interpretation: In this retrospective cohort study of 34 operative patients with confirmed COVID-19, 15 (44.1%) patients needed ICU care, and the mortality rate was 20.5%.

Funding: National Natural Science Foundation of China.

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1. Introduction

In December 2019, an outbreak of the 2019 novel coronavirus disease (COVID-19) caused by the SARS coronavirus 2 (SARS-CoV-2) occurred in Wuhan, China [1,2]. It has spread rapidly to other areas in China and worldwide. [3,4] The most common manifestations of COVID-19 included fever, dry cough, dyspnea, myalgia, fatigue, hypolyphaemia, and radiographic evidence of pneumonia. Complications (eg, acute respiratory distress syndrome [ARDS], arrhythmia, shock, acute cardiac injury, secondary infection, and acute kidney injury) and death may occur in severe cases. [2,5–7] The course of the COVID-19 is long, and COVID-19 is highly contagious even during the incubation period. [8] Furthermore, asymptomatic carrier of SARS-CoV-2, accounting for 1% of the laboratory confirmed cases of SARS-CoV-2 infection, [9] may potentially transmit the virus during incubation time. [10] which makes the identification and prevention of COVID-19 infection highly challenging. During the early phase of the COVID-19 outbreak, we encountered a small number of asymptomatic patients who underwent elective surgeries during the incubation period of COVID-19 infection, but the clinical manifestations and prognosis of these patients were beyond our expectation. It is our belief that these represent a specific surgical patient population that deserves our attention.

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<https://doi.org/10.1016/j.eclim.2020.100331>
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Please cite this article as: S. Lei et al., Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection, EclinicalMedicine (2020), <https://doi.org/10.1016/j.eclim.2020.100331>

General Industry Thoughts as We Move Forward...

- As the pandemic continues, there will be bumps in the road with surges, supply shortages, and changing staff and patient concerns
- The American health system is stressed beyond comprehension – expect thoughtful leaders to consider changing current business, delivery and payment models as well as abandoning historical relationships. The current financial stress provides both opportunity and political cover to do so
- There is the time to demonstrate that what we do with ambulatory procedural care in ASCs is not only safe and efficient but the right place for safe, effective and efficient care in the future

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What Comes After the Coronavirus Storm?

We'll eventually get to a safe harbor, but we'll find we're a changed country.



By [Peggy Noonan](#)

April 23, 2020 7:32 pm ET

WSJ | OPINION

No one is certain what to do. Everyone's acting on insufficient information. No plan will come without cost. A lot will become clear in retrospect. The bias should be opening as soon as possible as safely as possible. Don't sacrifice safe for soon. Have a solid, sophisticated, mature definition of "safe."

Acknowledgements and Thanks

This presentation relies on significant contributions from my colleagues at HCA Healthcare including

- Ambulatory Surgery Division leadership
- Patient Safety and Quality team and the ASD Pharmacy team
- ASD Medical Directors
- Clinical leadership from HCA's enterprise Clinical Services Group and Operations & Service Line Group