Ambulatory Surgery Centers: Reopening Following the COVID-19 Pandemic

Across the nation, Ambulatory Surgery Centers (ASCs) and other ambulatory procedural settings have been affected by COVID-19. With many or all centers closed and some having been repurposed for COVID-19 care, reopening ASCs to begin elective procedures again while limiting the spread of remaining COVID-19 presents a challenge. Prudent and safe plans balance the needs for patient care with the risks to providing care. The national plan for reopening in the United States shared in late March 2020 provides a general framework of considerations about reopening services . Until such time as ASCs are allowed to resume operations that include elective procedures, guidelines and recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Surgeons should be followed.

Public health care leaders, health-care service organizations, and professional organizations are fairly consistent in their recommendations about the approach to reopening services as of the date at the top of this document. Any resumption should be authorized by the appropriate municipal, county, and state health authorities. Following the communication of reopening guidelines by the Centers for Medicare and Medicaid Services (CMS) in April, the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses, and the American Hospital Association published a comprehensive "Roadmap to Resuming Elective Surgery" that may be found at https://www.facs.org/covid-19/clinical-guidance/roadmap-elective-surgery. Other organizations, including the Ambulatory Surgery Center Association, also offer resources to support decision-making and operations related to reopening.

Every ASC and procedural setting should assess readiness and risk based on the full review of the resources listed at the close of this document, including any future updates that are provided. Key points are compiled below for your rapid review and consideration, followed by examples of verbiage that might be used in organizational communication.

Key considerations

1. Community readiness
    a. COVID-19 must be low or declining (sustained and declining for fourteen days preferred)
        i. Authorization of local and state health authorities
        ii. Sufficient bed capacity to accommodate potential needs of COVID-19 patients without crisis standard of care
        iii. Sufficient personal protective equipment (PPE) supplies to accommodate the potential needs of COVID-19 patients, including a potential second wave

iv. Sufficient medications and medical–surgical supplies for the community
v. Sufficient staff available to safely provide care considering fatigue and stress

2. Ongoing patient safety and prevention of spread
    a. Policies and practices supporting the safety of patients and the broader community can be guaranteed, and spread of the virus prevented
        i. Testing of patients and staff and a plan to manage positive results
        ii. Preoperative screening for COVID-19 before visits
            1. Consider test availability, accuracy, and turnaround time
        iii. Preoperative monitoring of health prior to starting surgery
        iv. Staff self-monitor and screen for viral symptoms daily
        v. Consistent use of PPE according to CDC recommendations for all procedures, including COVID-19 CDC PPE recommendations if patient status is uncertain
        vi. Conservation and reuse of PPE according to CDC guidelines
        vii. Addressing COVID-19-positive patients identified postoperatively
        viii. Waiting room spacing for social distancing, face masking, and other recommended procedures for patients and visitors
        ix. Heightened disinfection practices
        x. Medical clearance by primary care provider if applicable
        xi. Staff training/retraining completed and documented for workflow changes and infection prevention measures
3. Organizational factors
    a. Geographical considerations is based on state-by-state COVID-19 trends
    b. Patient prioritization begins with patients who have low comorbidities and surgical risk
        i. Patient prioritization committee in place and strategy developed (nursing leadership, physician, anesthesia)
            ii. Priorities based on objective priority scoring (e.g., medically necessary time-sensitive [MeNTS] instrument; see MeNTS prioritization article from American College of Surgeons currently in press https://www.journalacs.org/article/S1072-7515(20)30317-3/pdf)
        iii. Procedure for assigning day/time based on patient risk versus “block” scheduling
        iv. Essential staff identified, including position on medical device representatives for each procedure
    c. Case volume depends on the following conditions:
        i. Phase opening (25–50%)
        ii. Pent-up demand—with a plan to meet increased volume
        iii. Longer hours
        iv. Weekend hours
    d. Procedure types—begin with patients who have the following:
        i. Lower risk with regard to airborne transmission
        ii. Minimal risk of unintended hospital admissions

iii. Need for post-acute care (PAC) facility stay addressed before procedure

e. Consider COVID-19 testing preoperatively
    i. Is it feasible?
    ii. Would it change the decision to proceed with the procedure?
f. Implement checklists, time-out, and practices
    i. Revise nursing, anesthesia, and physician checklists
    ii. Consider revising time-out procedures to include COVID-19 information and prevention
    iii. Utilize required staff only for intubation
g. Monitor quality of care metrics (mortality, complications, readmission, errors, near misses, other—especially in context of increased volume)
h. Ensure environmental cleaning
    i. Terminal cleaning prior to start-up of procedures
    ii. Management of anesthesia machines returned from use for COVID-19 or non-COVID-19 patients
i. Review visitor policies
    i. Consider limit to number of visitors accompanying patient
    ii. Determine lobby-only versus preoperative and postoperative areas

Sample verbiage to consider for use in organizational documents, communication, and scripting

1. We are unable to identify all COVID-19 active in people around you and in our workforce. We are taking every precaution to screen people entering our facility (staff, patients, and visitors) for fever, cough, and other COVID-19 symptoms and determining their recent contact with persons who have been ill. Any person who screens positive will not be allowed into our facility.
2. We are providing appropriate PPE for staff and patients according to CDC guidelines. This is a *must*. Social distancing will be enforced in all areas, including waiting areas. Limited visitor waiting space should be anticipated.
3. We are implementing frequent cleaning practices in all areas of our facility consistent with CDC guidelines. Cleaning practices in our operating rooms and recovery areas occur between each patient use and according to CDC guidelines.
4. Patients requiring airway intubation will be required to be evaluated by the anesthesia provider to determine whether there are any safe alternatives. If intubation is required, management of the patient will occur in the operating room with minimally essential personnel present during intubation. If airway management may be challenging, or prolonged time to extubation is expected, the patient should likely not be cared for in the ambulatory surgery area.
5. We have added some physical barriers to minimize contact between people in care areas and reception areas. PPE will be utilized by all persons including masks being required for all visitors while in the facility.

6. Age-related risk (over age sixty) and those with comorbidities should be aware of their increased general risk should they contract COVID-19 infection.
7. Staff training has been conducted to reduce risk related to COVID-19 and for new procedures and practices necessary at the facility. The safety of everyone in the surgical/procedural environment and prevention of the transmission of COVID-19 are our top priorities.

Resources

These resources provide more extensive discussions related to reopening of ASCs.

* = KEY RESOURCES

American College of Surgeons. (March 17, 2020). COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures. https://www.facs.org/COVID-19/clinical-guidance/triage. Accessed April 27, 2020.

American College of Surgeons. (March 13, 2020). COVID-19: Recommendations for Management of Elective Surgical Procedures. https://www.facs.org//media/files/covid19/guidance_for_triage_of_nonemergent_surgical_procedures.ashx. Accessed April 27, 2020.

*American College of Surgeons et al. (April 17, 2020). Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic. https://www.facs.org/covid-19/clinical-guidance/roadmap-elective-surgery. Accessed April 27, 2020.

American Society of Anesthesiologists. (2020). COVID-19 Information for Health Care Professionals: Recommendations. https://www.asahq.org/about-asa/governance-and-committees/asa-committees/committee-on-occupational-health/coronavirus. Accessed April 27, 2020.

Ambulatory Surgery Center Association. (April 20, 2020). CMS Releases Recommendations for Reopening Healthcare Facilities https://www.ascassociation.org/resourcecenter/latestnewsresourcecenter/covid-19-cms-recommendations-for-reopening. Accessed April 27, 2020.

Ambulatory Surgery Center Association. (April 17, 2020). Statement on Resuming Elective Surgery as the COVID-19 Pandemic Recedes. https://www.ascassociation.org/asca/resourcecenter/latestnewsresourcecenter/covid-19/covid-19-statements-on-resuming-elective-surger/covid-19-asca-statement-on-resuming-elective-surgery. Accessed April 27, 2020.

Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. (April 13, 2020). https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize. Accessed April 27, 2020.

*Centers for Medicare and Medicaid Services. (April 19, 2020). Opening Up America Again: Centers for Medicare & Medicaid Services (CMS) Recommendations—Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I. https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf. Accessed April 27, 2020.

*Forrester, JD, et al. (April 3, 2020). Precautions for Operating Room Team Members during the COVID-19 Pandemic. *Journal of the American College of Surgeons*. https://www.journalacs.org/article/S1072-7515(20)30303-3/fulltext. Accessed April 27, 2020.

Gottlieb S, McClellan M, Silvis L, Rivers C, Watson C. National coronavirus response: A Road Map to Reopening. (March 29, 2020). American Enterprise Institute website. https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/. Accessed April 27, 2020.

*Prachand VN, Milner R, Angelos P, Posner MC, Fung JJ, Agrawal N, Jeevanandam V, Matthews JB. (2020 in press). Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic. *Journal of the American College of Surgeons.* doi: https://doi.org/10.1016/j.jamcollsurg.2020.04.011. Accessed April 27, 2020, at https://www.journalacs.org/article/S1072-7515(20)30317-3/pdf.