SAME-DAY SURGERY

THE TRUSTED SOURCE FOR HOSPITALS, SURGERY CENTERS, AND OFFICES

JUNE 2020 Vol. 44, No. 6; p. 61-72

INSIDE

RELIAS MEDIA

Surgery Centers, Experts Search for Answers on Reopening

As COVID-19 spread across the United States, some surgery centers stopped most elective surgeries, sometimes repurposing their space to take emergent cases or turning operating rooms into critical care units to accept overflow from nearby hospitals. Others did what they could to survive during the pandemic.

Now that many places have gone through a surge of COVID-19 cases and some governors have begun to lift stay-at-home orders, the question for surgery center leadership is: When and how should we resume normal operations? The answer varies according to the facility's location and needs of the local healthcare system. Hospital-based and ambulatory surgery centers also can follow the April 19, 2020, guidance, issued by the Centers for Medicare and Medicaid Services, "Opening Up America Again." *(https://go.cms.gov/2y6eYzB)*

"To date, we've been very fortunate that the treatment needs of COVID-19 cases have not exceeded hospital capacity in most places," says **Bill Prentice**, chief executive officer of the Ambulatory Surgery Center Association. "Ambulatory surgery centers remain ready to help where needed while also preparing to resume performing postponed surgeries in states that are reducing restrictions based upon reductions in COVID-19 cases."

Determining when an area is seeing an end to COVID-19 cases is challenging, according to infectious diseases physicians and scientists. For example, by mid-April, Seattle had been combating COVID-19 for more than eight weeks. Washington was the first U.S. state hit hard by COVID-19. Seattle and surrounding areas prepared and built capacity, basing their plans on what was happening in China, South Korea, and Italy.

Still, weeks after shutting down most of its public life, tackling the pandemic through ramped-up testing, and drawing on its experienced healthcare and public health experts, Seattle still had a way to go to end the crisis.

"As we work through this pandemic in a way that's ahead of the curve than most of the country, we continue to see significant gaps. We see outbreaks in vulnerable communities and still

Financial Disclosure: Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Author **Melinda Young**, Author **Stephen W. Earnhart**, RN, CRNA, MA, Physician Editor **Steven A. Gunderson**, DO, FACA, DABA, CASC, RN, CRNA, MA, Consulting Editor **Mark Mayo**, CASC, Editorial Group Manager **Leslie Coplin**, and Nurse Planner and Accreditations Director **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

SAME-DAY SURGERY

Same-Day Surgery (ISSN 0190-5066) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Same-Day Surgery*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

SUBSCRIBER INFORMATION
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

ACCREDITATION
Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 1.75 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.75] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 36 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
NURSE PLANNER, ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

disjointed access to testing," said **John B. Lynch**, MD, MPH, an associate professor in the department of medicine, division of allergy & infectious diseases, at the University of Washington. Lynch spoke about COVID-19 at an April 17 virtual media briefing hosted by the Infectious Diseases Society of America.

Lynch is one of many experts who have spoken about the COVID-19 pandemic to media and peers in numerous virtual events since March. *Same-Day Surgery* has attended more than a dozen of these events and also spoke with infectious disease and surgery center experts. These insiders have painted a picture about what is happening as the pandemic matured and surgery centers decided how and when to resume normal operations.

Here is a look at what these experts are saying and how it might affect surgery centers:

• **Even the earliest outbreaks are not ending as quickly as hoped.** "Gov. Jay Inslee [of Washington] was early to getting Seattle to social distancing work, and that was really important to slowing down the epidemic," Lynch said. "We still have yet to see a decrease in hospitalized cases, even now, two months into this work." Two barriers remain: lack of enough test kits, and a public health sector that is not a strong as it was during the last pandemic: AIDS. "We have incredible public health people here, but they were overwhelmed because of years and years of underfunding," Lynch said. "They have a long way to go to coordinate testing." Seattle also tested tens of thousands of people for COVID-19. The city has access to an experienced clinical virology lab that can perform 5,000 tests per day, he added. "We're still woefully undertesting," Lynch noted. "Moving forward, we need 10,000 to 20,000 tests per day, and we're going to need a several-fold higher capacity for testing, in addition to access. There is still a long way to go to get to that point."

SARS-CoV-2, the virus that causes COVID-19, also appears to be resilient as it spreads around the globe. Hong Kong, South Korea, Taiwan, and other areas appeared to have successfully ended their outbreaks, only to see a resurgence weeks later. In Hong Kong, the public had begun wearing masks and staying at home early on. They appeared to have defeated the viral spread. But in late March, COVID-19 cases resurged.

• **There are minimal tactics for resuming elective surgeries.** "Unless we go about this with a well-planned,

EXECUTIVE SUMMARY

Some surgery centers chose to pause elective surgeries during the COVID-19 pandemic. With certain areas gradually reopening public life, how can surgery centers resume routine business?

- Seattle and surrounding areas were the first to cope with COVID-19, starting in late January. But after weeks of battling the virus, recovery was slow, and hospitalizations remained high.
- Before reopening, surgery centers should develop a plan that includes its environment readiness, supply availability, staffing, scheduling, and regulatory issues.
- Defeating the virus and economic recovery likely will take time.

organized effort, we will see chaos in the operating room," warned **Linda Groah**, MSN, RN, CNOR, NEA-BC, FAAN, chief executive officer and executive director of the Association of periOperative Registered Nurses (AORN). Groah spoke at an AORN web conference about leadership and COVID-19 on April 14.

The first step in reopening a surgery center likely will depend on the center's state regulations and specific COVID-19 guidance. Areas that reopen should have a sustained reduction in COVID-19 cases for at least two weeks, and their hospitals must be able to safely treat all hospitalized patients without resorting to a crisis mode.

These states also should be able to test everyone with COVID-19 symptoms and provide contact tracing, monitoring, and testing. Testing is the key barrier. "Testing is not readily available for all people who want to be tested right now," Groah said.

Once a state can reopen after the pandemic, surgery centers should create a pathway forward to resume surgery, she added. The pathway should address these considerations: environment readiness, supply availability, staffing, scheduling surgery, and regulatory issues. "This is about managing your supplies, and not just personal protective equipment," Groah explained. "It's all [about] supplies. We know there may be a shortage of drugs from the anesthesia perspective." Disposable supplies and N95 masks might be in short supply for a while longer. "How do we bring staff back in for work?" Groah asked. "Some people are working in other areas of a hospital and are being retrained." Surgery centers should manage schedules, following an order and guidelines on how to determine which surgeries are the highest priority and should be performed first, she added. Finally, surgery centers need to consider testing patients and staff for COVID-19 for some period after their area's pandemic surge eases.

• COVID-19 vaccines and cures will not be ready for some time. "A vaccine — if everything goes well, we're probably looking at about a year to a year and a half," said **Sumit Chanda**, PhD, director and professor of the immunity and pathogenesis program at Sanford Burnham Prebys Medical Discovery Institute in La Jolla, CA. Chanda spoke at a COVID-19 web media conference on April 2. "In the meantime, what we're looking to do is develop existing therapeutics and see if they have any efficacy against the virus," Chanda reported. "Right now, there are several exciting compounds that are in clinical trials."

Two possibilities are remdesivir and favipiravir, similar antiviral agents developed to treat other viruses. Researchers are testing their efficacy against COVID-19. "Typically, a drug discovery effort takes five to 10 years," Chanda noted. "I think our best shot now, to get something to market and into patients quickly, is to take old drugs and see if they work against the current coronavirus that is circulating."

• Economic recovery also will be slow. "I think it's going to be a long period of economic recovery, and things are going to get worse before they get better," said **Bernard Weinstein**, PhD, associate director of the Maguire Energy Institute at Southern Methodist University in Dallas. Weinstein spoke at a COVID-19 media web conference on April 9.

"There have been some forecasts that we could see the gross domestic product contract by as much as 25% in the second quarter, and that's unprecedented — at least it's unprecedented since 1930," Weinstein said. "It's not just us, it's the rest of the world. There is some evidence that China's economy is starting to open up, but already we're seeing that the recovery process in China is very slow."

China's economy is held back because domestic consumers are using caution and because the rest of the world is not buying what China produces, Weinstein explained. "The next six to 12 months will have some evidence, but I really think it's going to be a pretty long and hard slog," he predicted. "It's not like we can flip on a switch and get the recovery revved up quickly." There likely will be a U-shaped recovery, starting in the middle of the summer of 2020, assuming the virus is brought under control, Weinstein added. ■

New York City Chief Surgeon Describes How COVID-19 Changed Work, OR Function

At the Hospital for Special Surgery (HSS) in New York City, everything changed around mid-March, when the facility closed because of the COVID-19 crisis.

"The decision for us to close down was, initially, to make sure we could help out by sending over as many personal protective equipment [PPE] as possible to other New York hospitals," says **Bryan Kelly**, MD, MBA, surgeon-in-chief and medical director of HSS.

New York City was among the hardest hit cities during the pandemic's first wave. By the third week of April, the city's coronavirus death toll was more than 13,600 and hospitalized COVID-19 patients reached close to 35,000. "We're an all-orthopedic surgery hospital, and we typically do 130 to 140 orthopedic surgeries per day," Kelly says.

Ten of the more than 50 operating rooms (ORs) are at ambulatory surgery centers (ASCs) in three different locations, he adds. "We have only four critical care beds for patients who have complications," Kelly says.

The first four weeks since HSS closed to elective surgeries were a time of dizzying change. First, Kelly and other HSS leaders realized that New York City hospitals were overwhelmed with COVID-19 patients. HSS began to accept transfers of non-COVID-19 patients. "We converted one of our ASCs into an orthopedic triage center, an urgent care center," Kelly says.

Orthopedic emergency cases from all other hospitals in the area were diverted there to keep these non-COVID-19 patients away from emergency rooms that were filling with COVID-19 patients. At first, it seemed as though the surgery center would fill with non-COVID-19, orthopedic trauma cases. But it did not work out that way. "There was not that much trauma because everyone was quarantined, and not that many were COVID-negative," Kelly says.

"We converted the ninth floor OR into an intensive care unit [ICU] with 30 ICU beds," he explains. "We have about 20 COVID-positive ICU bed patients. We're an orthopedic hospital and are not designed for this."

HSS changed two inpatient floors to keep COVID-19 patients who are not on ventilators. "All of this requires us to reconfigure the space," Kelly says. "All had to be converted into negative pressure rooms."

The building created safe spaces for staff, and filled up with 140 patients, including 20 orthopedic patients. The rest were COVID-19 patients. "We have an anesthesia department with 70 anesthesiologists, and we created a tiered system where a critical care specialist oversees the entire group of ventilated patients," Kelly reports. "Patients have an anesthesiologist, internal medicine physician, resident, fellows, physician assistants, and nurses all staffing it — overseen by critical care people."

Everyone at HSS is handling work they are not used to. For instance, post-anesthesia care unit (PACU) nurses began working as ICU nurses. "This has been a hard transformation," Kelly says.

Physicians, nurses, and other staff were asked to perform duties that are quite different from what they were handling the previous month. "Now, we have orthopedic surgeons acting like floor interns in the ICUs to support the internists," Kelly says. "It's been an amazing team effort by all of the staff." By adapting as the pandemic evolved, HSS avoided furloughing staff.

"We're doing everything we can to protect our staff, whether with PPE or jobs," Kelly says. "There are 6,000 employees in our institution, and 3,000 are clinical."

Before March 15, HSS had 200 people working virtually from home. "Now, we have 2,000 people working from home, and we've implemented a telemedicine program that we were planning to roll out in 2020, but hadn't started it," Kelly explains. "We had zero virtual consultations on March 15. Now, [in mid-April], we have 800 per day, and we're shooting for 1,000 per day. We also have nine satellite locations that all were converted into urgent orthopedic care clinics."

HSS converted its space for COVID-19 patients in the span of one week, Kelly says. "It was a lot of long days," he notes. "It's not what the hospital was designed for, but the staff and physicians here are incredible people. They dived into this problem, wanting to do everything we can to help the city get through this crisis."

Since HSS revenue is generated through orthopedic surgery, most of these procedures were put on hold — except for emergency traumas, Kelly notes. "Our feeling is we have to try to figure out how we can help with the COVID-19 crisis and maintain our ability to take care of typical orthopedic patients," he says. "Our patients would love for us to get back to where we were."

HSS physicians, nurses, and other staff have been bombarded with multiple stressors, including learning new skills on the fly, avoiding illness and knowing people who have become ill,

financial pressures, and family issues, Kelly observes.

More than 50 employees tested positive for COVID-19. While most exhibited minor symptoms, a few were hospitalized. As of mid-April, none of the staff became critically ill, and none had died.

"It's stressful. We brought in a crisis management specialist, and we have a team of people working on crisis management stress reduction and anxiety," Kelly says. "There are resources and access to emotional and psychological support."

Everyone is concerned about when their surgical work can return to normal, but no one knows what the new normal will look like. "What impresses me is when you go up on the floors now, they're working away as they would under normal circumstances. They seem to be managing it well," Kelly observes. "But we worry about stress on the other side of it as well. Data from China show healthcare workers having long-lasting issues with anxiety and post-traumatic stress disorder. We want to make sure we have resources for that."

Lessons learned, from a surgery center perspective, include the practicality of telemedicine.

"Patients don't mind telemedicine visits. It's more convenient for them," Kelly notes. "We'll have more than 200 people working from home on the other side of this — maybe not 2,000. With regard to social distancing, we'll make some modifications in how we do it."

For instance, patients and healthcare workers will continue to wear masks for a period. The facility will implement COVID-19 testing.

Returning to a new normal will not be easy, Kelly notes. "As hard it was to create all of these changes, unraveling them will be a bit of a puzzle, as well," he acknowledges. "We're trying to figure out the best way to unravel them in a way that is safest for staff, patients, the institution, and the community around us as well." ■

Q&A Part 1: How Did COVID-19 Affect Surgery Centers?

As the first cases of COVID-19 started emerging across the United States, surgery center leaders had to make tough choices about whether to close, carry on as normal, or modify operations to help treat an expected surge in infected patients.

Same-Day Surgery: *How have your surgery center's operations changed during the crisis?*

Young: Our surgery center moved from normal operations to urgent emergent cases for only one week. Then, we stopped performing all elective surgery.

Millsap: After careful consideration and deliberation with local experts and the county health department, MPSC made the determination in March to only perform "time-dependent" cases and [extended] this policy through the end of April. "Time-dependent" cases are identified as either tier 1 (necessary to be performed in seven to 10 days) or tier 2 (necessary to be performed in 30 to 45 days). As a result, MPSC is temporarily closing several locations and consolidating cases to be performed at one facility. This is done in an effort to limit patient risk of exposure, and allows

PANDEMIC IMPACT REPORT

In this three-part question and answer (Q&A) series, dozens of surgery center administrators and directors from across the United States were asked about their facilities' experiences during the COVID-19 pandemic's early weeks. The leaders talked candidly about their region's outbreaks, their decisions, and how COVID-19 affected their work and operations:

- **Gregory P. DeConciliis**, PA-C, CASC, administrator, Boston Out-Patient Surgical Suites; Eastern Massachusetts Surgery Center, Waltham, MA
- **Alfonso del Granado**, BHCM, CASC, administrator, Covenant High Plains Surgery Center, Lubbock, TX
- **Joleen Harrison**, RN, BSN, CASC, administrative director, Mankato Surgery Center, Mankato, MN
- **Terri Mahoney**, BN, CNOR, CASC, administrator, Bluffton Okatie Surgery Center, Okatie, SC
- **Carrie Millsap**, chief operating officer, Monterey Peninsula Surgery Center (MPSC), Monterey, CA
- **Michael J. Patterson**, FACHE, president and chief executive officer, Mississippi Valley Health, Davenport, IA
- **Cindy Young**, BSN, RN, CASC, administrative director, Surgery Center of Farmington, Farmington, MO

MPSC to treat those patients who need immediate intervention.

del Granado: Our centers suspended what I call "discretionary" elective cases several days before Texas Gov. Greg Abbott issued an executive order that perfectly matched the policy I had put into effect. This has caused a 90% drop in cases. While we could have closed, we are in a joint venture with the local hospital system. We worked closely with them to ensure that we would remain open to take care of necessary cases at our centers so they would not have to be done at the hospital.

At the same time, our national management company, which is also a JV partner, provided us with additional personal protective equipment (PPE) and, more importantly, policies and guidance for exposure risk reduction. They also put in place "quarantine pay" policies to protect the staff if exposed.

Mahoney: Upon the recommendation from the governor, we are only doing urgent cases. Our physicians attest to the necessity of the case. Even prior to this, we went into conservation mode. Beside the significant financial impact, the reduction of cases has [affected] our facility [and] the impact on our staff has been great — the uncertainty of continued employment, financial impact, the stress of the unknown.

DeConciliis: The COVID-19 crisis impacted surgery centers across the nations differently. I've heard so many great stories of repurposing ASCs and offering much-needed support during these critical moments.

In our area, we are fortunate to have some of the best hospitals in the country that have exhibited their strength, once again, with handling the COVID-19 surge. Through conversations with [department of public health officials] and some hospital systems, I have tried to assist with medicine procurement, various sorts of PPE, and made requests for staff repurposing. Much of the crisis in our area has centered around the nursing homes, so assistance was needed there the most.

In terms of how we are contributing, we have ensured our staff and patient population is highly screened before entering the facility. We have limited personnel and family members. By creating this "clean" environment, we have marketed ourselves to local primary care providers and surgeons as a viable option to perform their essential surgical procedures in a safe and effective environment. We offered our services to our local hospital as a triage from the emergency room for urgent procedures to allow hospital operating room staff to be available for repurposing and to preserve resources.

Harrison: As a multispecialty ambulatory surgery center [ASC], we are performing essential surgeries only specified by Gov. Tim Walz of Minnesota. We are 50% owned by a multispecialty and orthopedic clinic, so we are helping each other with PPE needs if we can. We are working with the state ASC association to give more information to [Gov. Walz] on options for our surgery centers in Minnesota.

Patterson: We closed our endoscopy facility based on national recommendations. Our multispecialty ASC remained open to provide necessary surgery to those patients in need. We developed a screening process and worked with our physician-led board of directors and our medical director to interpret guidelines and review each case to ensure appropriateness for surgery. We have reduced our volume by over 90%, but remain open to provide surgery two days per week. ■

Q&A Part 2: Some Surgery Centers Closed, Others Helped Local Hospitals

After deciding what their operating model would look like during the COVID-19 crisis, surgery center leaders had to determine appropriate staffing levels — furloughs, layoffs, or fewer hours. Additionally, administrators had to decide whether to ration precious personal protective equipment (PPE) and other supplies, or loan this materiel to frontline facilities in desperate need.

***Same-Day Surgery*:** *Did your surgery center close or move to only emergency surgical procedures? If it closed, how did that affect you and surgery center staff? Were personal protective equipment donated to the local hospital?*

Harrison: We have limited amounts of PPE, and any PPE we have we need for the "essential" cases we are doing.

Patterson: We have worked closely with our Unity Point Health System partner to develop plans for overflow care of patients needing surgery in the event the hospital becomes full with regular inpatients or COVID patients. It really has been a community effort to ensure patients continue to get the care they need in the appropriate setting. PPE is being managed based on need, and we

are working with our county health department to ensure resources are available where they are needed.

Young: It was decided our number of urgent/emergent cases would be so small financially it was best we furloughed all of our staff. We did keep two administrative staff to take care of day-to-day functions as well as work all accounts. We worked with the hospital, loaning them our anesthesia machines, stretchers, IV poles, and patient monitors. This was done through a legal loan agreement. We did allow the hospital to obtain our PPE with the understanding they would replace what was obtained when we opened back up. My nursing staff was offered first priority from the hospital to hire them for [pro re nata] work to assist their staff during COVID-19.

del Granado: Our 46 physician partners, plus the hospital and management company, voted unanimously to continue to provide at least 80% income to the staff as well as maintain their full benefits and deferring their dividends to ensure that we maintained enough cash on hand.

The staff, in turn, elected to reduce their hours further than asked, down to 50%, opting to take part-time jobs or apply for unemployment to help the company preserve its financial viability. This was an impressive and, frankly, moving display of solidarity. I'm proud to be part of this organization.

With regards to PPE, we inventory it twice weekly and keep it always locked up, issuing gear under Centers for Disease Control and Prevention [CDC] protocols for extended and reuse. We have enough to continue operating at our current reduced volume almost indefinitely, and we have donated surplus to the hospital as well. Having said that, we would be unable to sustain more than three weeks of normal operations, so we are on a constant hunt for as much as we can get until the market shortfall is cured.

Millsap: MPSC is working closely with local hospitals to ensure they have the supplies needed to successfully combat the pandemic and treat affected patients. This includes donating surplus medical supplies, PPE, and loaning anesthesia equipment should a shortage of ventilators occur.

***Same-Day Surgery*:** *How do you believe this pandemic will change the way same-day surgery centers operate in the future? For instance, what are some aspects of your facility's disaster planning that you wish had been different before COVID-19?*

Patterson: COVID-19 will most likely have a material impact on how healthcare systems and facilities operate, in general, in the coming months. We will need to develop solid screening processes to ensure we are protecting staff, patients, providers, and visitors.

We may hit the peak in the coming months, but that doesn't mean that COVID-19 won't exist in our communities for a significant period of time following that peak. We will need to develop solid screening processes, and will look for rapid technology gains to assist with quick detection of the virus, along with appropriate PPE utilization to ensure we continue to provide high-quality, safe surgical care to patients.

Young: I feel we are going to need to perform COVID-19 clearance of patients prior to surgery, just as we perform glucometer checks. At our facility, we perform cataract surgery and ENT [ear, nose, and throat] procedures. COVID-19 lives and thrives in these [patient populations]. If we perform surgery on a patient who is active with COVID-19, but not showing symptoms, we could infect our staff and expose other patients. Testing of staff for COVID-19 antibodies will be vital in the future as well.

Millsap: MPSC follows CDC and CDPH [California Department of Public Health] guidelines to ensure continued quality patient care. MPSC adheres to the highest infection control standards and maintains an infection rate that is among the lowest in the nation. Our equipment sterilization, environmental cleaning, disinfection, and air filtration systems meet national standards. MPSC's physicians and staff perform optimal hand hygiene practices before and after any patient contact. Additionally, MPSC makes available hand sanitizer dispensers throughout our facilities. Prior to admission to the surgery center, all incoming patients are screened for symptoms of any illness, including those related to COVID-19. Patients are requested to disclose any significant travel history to one of the affected areas in the last 14 days, or if they have known direct contact with a COVID-19 patient. Upon arrival and prior to admission, all patients are screened for fever, cough, [and] shortness of breath. Patients experiencing symptoms or exposure will be required to postpone their procedure until their condition is resolved.

While these reactive measures are proving effective, MPSC is gaining further insight on how to proactively address future widespread crisis. The COVID-19 crisis has clear lessons for what we can do now to stop a future global health emergency. National and international experiences reflect the importance of anticipating and preparing for crisis situations, which includes efficiently implementing government recommendations

and organizational response plans, maximizing patient and staff safety in the outpatient surgical environment, and effectively making key clinical management considerations supporting the economic health of our local community.

Mahoney: During this time, I found our staff were amazingly understanding. They were incredibly supportive of each other and came together even more than usual. I felt like our management team went into survival mode. [We asked ourselves] what do we need to do to get through this so we can continue providing care in the future to our patients and to help our staff feel confident that this will pass and we will make it?

del Granado: I believe there will be a continuing reduction in certain types of cases until either a vaccine is developed or enough healthcare personnel are exposed and recover. Several of the physicians, whose specialties include an elevated risk for exposure to aerosolized coronavirus, have expressed their intention to limit their practices to the most necessary cases only. There also will be more patients willing to live with discomfort or accept some limited mobility rather than face the risk of exposure.

Over time, this fear will ease if not fully dissipate. I believe ASCs will return to their upward growth trend sooner rather than later. We've modeled several scenarios, and the most pessimistic have us recovering by December 2021, but we believe [sooner] is more realistic.

During that recovery period, and for the foreseeable future, we will continue to equip anesthesiologists and circulators with N95s and face shields, and will continue our current policy of having other staff exit the room during intubation/extubation and for three minutes thereafter until enough N95s are available for everyone. Again, in time, I suspect that a combination of vaccines and herd immunity will diminish the need for some of these cumbersome practices.

DeConciliis: We have planned for, and have policies for, every emergency and disaster possible. We always hope we never have to use them. With a disaster such as this, we have all been forced to make rapid changes in real time, and often on the fly, to adapt and survive. I believe the most prepared ASCs, with strong management and committed surgeons and staff, have adapted the best.

But if a particular ASC has not adapted well, there still is time to act. Preparing for the resumption of operations is something that must start now. ASCs were made for this kind of resurgence. Our "clean" environment, efficiencies, and commitment to our staff and patients will allow us to handle this surge in volume effectively. We should prepare to land on our feet in a much better position. If they haven't already, patients and surgeons will choose ASCs for their procedures ... We must continue to do our part to assist the hospitals and health systems with the pandemic in every way possible, and, most importantly, stay positive and prepare our facility for the busy road ahead.

Harrison: Hopefully, the states and federal government will understand what a surgical center is and plan for the ASCs to be in all regional planning phases of their emergency planning. We could never have planned or have imagined being ready for such magnitude of a pandemic in any facet of healthcare. I feel our emergency planning team, our board of directors, have responded and executed according to what we knew, moment by moment. We have stayed in contact with our state ASC association for guidance, and stayed connected to our governor's office weekly.

One item of focus is to understand what exactly our "burn rate" of supplies is: taking a closer look at inventory on hand, and seeing where the basic supply chain was in back orders and allocations. It is difficult to understand what we need on a detailed basis. Another thing to know is when items expect to resume our regular par level. It is a fine balance between having just-in-time inventory and hoarding supplies we don't need or could [expire]. ■

Q&A Part 3: Improving Communication on List of Lessons Learned

Facing the crucible of the COVID-19 crisis has been an unprecedented challenge, but it also has allowed surgery center leaders to take a closer look at areas for improvement so they can handle future emergencies better.

Same-Day Surgery: *Are there any other personal or professional lessons learned from the pandemic and its impact on you and your facility? What might you do differently in the future?*

Mahoney: I feel we could have improved our communication to our medical staff during the earlier

stages. Many things were happening in other parts of the country, and we weren't there yet. We could have communicated our plan to them earlier.

We also were going through something we had never experienced before. So much was uncharted waters. New information was coming out daily.

Patterson: We need effective ways to communicate what is going on in real time. There was so much information coming out, and interpreting how to respond appropriately was a challenge since things were sometimes changing each hour. We were fortunate to have processes in place to communicate with employees and providers but feel that always could be improved.

In addition, we have actively participated in our community disaster preparedness drills, which was very beneficial for our team. We knew the players and how to get in touch with the respective parties, which helped us understand what the community impact was going to be.

I think the after-action report process will be imperative to learn what could have been done better as a community.

Millsap: ASCs [ambulatory surgery centers], like MPSC, are proving to be a valuable resource during the COVID-19 crisis. The impact of this pandemic on hospitals is expected to be severe, and U.S. hospitals typically operate at or near full capacity.

ASCs are well positioned to rapidly increase available healthcare services by accepting overflow patients from local hospitals. MPSC is expanding service lines while maintaining our high-quality standard of care. We are in close and consistent communication with our hospital partners to ensure quality service to our community. MPSC's physicians and staff are collaborating to bring innovative, effective treatment and support to our patients during this crisis. For example, MPSC is considering establishing a pandemic preparedness committee, which would include representatives of all clinical and support departments, as well as senior administrators.

We also are speaking with neighboring hospitals and local public health agencies to determine if a healthcare coalition would benefit our community.

These committees would be responsible for monitoring the market for potential issues; keeping abreast of innovations in planning, testing, and treatments; and sharing this knowledge with colleagues.

Forming dedicated institutions both within our facility and beyond our ORs [operating rooms] ensures our ability to successfully integrate systemwide planning and preparedness.

Harrison: Right now, I cannot venture a forecast for a specific change in same-day surgery center operations, other than every touchpoint of healthcare, as we knew it, will change. This includes the way we do traditional office visits, history, and physical screening prior to surgery, and the reopening of the ASCs that closed during this pandemic.

The lesson is: We are never certain of anything in healthcare. We know we need it. We will all be watching closely as the face of healthcare changes.

del Granado: It is quite simply impossible to plan for every contingency. Larger organizations and governments were caught flat-footed, and it would be the height of hubris to presume to be able to do better.

Instead, we had two factors in our favor. First, we always maintain enough resources to ride out a 100-year storm. Second, we have been able to continue running through a challenging and constantly shifting landscape without missing a step, not because we prepared countless exhaustive plans for every possible scenario, but rather because the staff, physicians, and partners stuck together with resilience and levelheadedness.

We stuck to the facts and ignored the wild speculation on both sides, we remained forward-looking, and anticipated each development so we could prepare in advance and adapt to the necessary changes.

Every move we made — policy changes and contingency plans — came out ahead of everyone else because we stayed on top of things and prepared the team, communicating constantly and openly, so that when challenges came our way the team was ready for them.

That really distills the essence of my advice: Stay vigilant, flexible, resilient, gritty, and, most important, stay together. ■

COMING IN FUTURE MONTHS

- Small surgery center describes how it survived COVID-19
- Research on how surgery centers performed during COVID-19
- Arteriovenous fistula creation in ambulatory surgery setting
- Ambulatory laminectomy outcomes

The CARES Act: What Surgery Centers Need to Know

The CARES Act Provider Relief Fund Payment Attestation Portal, signed into law on March 27, provides $100 billion in relief funds to healthcare providers on the front lines of the COVID-19 pandemic.

The funds can be distributed to any provider that received Medicare fee-for-service (FFS) reimbursements in 2019. *(For more information about the fund, please visit this online resource: https://bit.ly/3cDvvK8)*

The CARES Act also updated federal confidentiality protections, making changes to 42 CFR Part 2. "Specifically, the CARES Act includes a provision to permanently align Part 2 with HIPAA [Health Insurance Portability and Accountability Act] for purposes of treatment, payment, and healthcare operations, with initial patient consent," says **Kathryn Spates**, executive director of federal relations for The Joint Commission.

"As a member of the Partnership to Amend 42 CFR Part 2, a coalition of nearly 50 healthcare organizations that has worked to align Part 2 with HIPAA, The Joint Commission applauds the inclusion of the provision in the CARES Act," Spates says. "This provision will help to reduce unintended treatment errors and ensure their substance use disorder patients receive safe, coordinated care."

The CARES Act also carries a provision that requires the Department of Health and Human Services (HHS) to issue guidance on the sharing of protected health information during the COVID-19 crisis.

The Office for Civil Rights recently issued guidance for HIPAA-covered entities and associates on sharing protected health information during the public health emergency. Spates says both pieces of guidance will be helpful.

As Congress and the Trump administration consider future COVID-19 relief bills, it will be important to address the unique needs of rural healthcare facilities, Spates says.

"Prior to the coronavirus pandemic, rural healthcare facilities struggled with adequate staffing, medical equipment, and other medical supply needs," she observes. "These resources are exacerbated by the coronavirus."

For instance, rural hospitals might experience COVID-19 surges that result in these facilities receiving patient loads at a higher volume than they are accustomed. In turn, these facilities might not be able to deliver care to non-COVID-19 patients, which would reduce their revenue, Spates explains. "Future legislation must also address funding for the many challenges that skilled nursing facilities continue to face as they deal with the coronavirus," Spates says. "Adequate supplies of personal protective equipment [PPE] is an issue for these facilities. Prior to the outbreak, they had the least PPE supplies relative to their patient populations."

Rural facilities also do not have the resources, including appropriate experts, to handle major infectious disease outbreaks.

"Any future legislation must address maintaining a reserve of at last 60 days of supplies, including PPE, ventilators, and diagnostic supplies, so that healthcare facilities have resources to manage a second wave of coronavirus," Spates argues. "The Joint Commission is advocating for future legislation to include funding a comprehensive, cross-facility, level-of-care, after-action report. Emergency preparedness experts consider it essential to conduct after-action reports to obtain lessons learned."

An after-action report helps stakeholders avoid repeating future missteps and to incorporate best practices for dealing with similar disasters, she adds.

"Lastly, it will take a long time for the healthcare system to get back to business as usual," Spates says. "There will be a backlog of surgical procedures and medical evaluations that will need to be scheduled, while the healthcare system continues to prepare for a potential second wave of the coronavirus. Healthcare organizations will need assistance during the tail end of the outbreak to recover to their normal operations and to deal with the backlog of deferred surgeries and other care." ■

CME/CE OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

The Winds of Change

By Stephen W. Earnhart, RN, CRNA, MA
CEO, Earnhart & Associates, Austin, TX

What a historic year 2020 has turned out to be so far. I was so optimistic about this new year and decade, but little did any of us know what was ahead. It is going to be interesting how history categorizes this incredible event. During our lifetime, other events have happened that changed the world, including:

• The fall of the Berlin Wall in 1991.

The obvious change was the unification of Germany, but it also marked the end of the Cold War, and ultimately the fall of the Soviet Union.

• The terrorist attacks of Sept. 11, 2001.

This event triggered the global war on terrorism, of which we are still feeling the effects.

The COVID-19 pandemic has exposed global vulnerability in our healthcare system and showed how unprepared the world was and is for emergencies of this magnitude.

In the United States, the way we handle more than 50 million surgical procedures annually is bound to transform after the pandemic ends. We are poised to see sweeping changes, and all of us need to be ready. From multiple sources, there are great ideas that we can list here. However, the mostly likely source of sweeping changes is going to come from the Centers for Medicare & Medicaid Services (CMS).

Each year, CMS dictates the types of surgeries that can be performed in ambulatory surgery centers (ASCs), and what procedures must be performed in hospitals. There are thousands of procedures CMS allows in an ASC, and the agency adds more each year.

There are many other procedures that could be moved from hospitals and hospital outpatient departments into ASCs. I expect this development once we move past the COVID-19 crisis. How can your facility prepare?

• Look within. Do you have the time slots available to add to your block time? Do you have the space to expand? Do you employ enough staff? Most ASCs have laid off staff to save costs during the pandemic. Keep in touch with these employees, and be ready to bring them back. Also consider whether you can expand the hours of operation to include an evening schedule and a Saturday block.

• Spread the word. Let your surgeons know you are interested in new cases and specialties. Surgeons only make money when they operate, and they are struggling right now to find places to work.

Notify the director of surgery at the local hospitals that you have capacity and can handle their elective surgeries. Reopening their own surgical program puts elective cases at the end of the process, and they are looking for ways to accommodate their patients and surgeons.

Make yourself available for interviews with your local TV and radio stations. Let them know you are ready to put elective cases back on the schedule.

• Follow protocol. Secure permission, in writing, from your governing board indicating all members agree with your plans. Notify your accreditation agency and let them know your intentions, too. Most ASCs allow new surgeons immediate 90 days privileges to handle cases with a phone call and some paperwork. Review your policies and procedures on how to make it happen.

Start looking at an equipment budget for more intensive procedures from your governing body. Be sure to check state regulations and stay in compliance.

• Bring in cases — and keep them. Welcoming cases through your door should be relatively easy, but keeping them might be a challenge after the pandemic crisis passes. Market yourself accordingly, and be prepared to offer equity to new users.

Look for the best staff to accommodate new procedures when they happen. Be wary of purchasing new equipment and supplies and hiring staff for surgeons who do not want to purchase equity.

No one wants to capitalize over the loss of life, the pain and suffering, and economic tragedy of the COVID-19 pandemic, but these changes are overdue and need to happen. There is no reason why you should not be involved in the transformation of the industry. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Address: 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com. Instagram: Earnhart.Associates.)

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **Once states reopen after the COVID-19 pandemic, surgery centers can be ready to resume elective surgeries if they have taken time to create a plan or pathway. Which must be a major focus of the pathway?**

   a. Asking hospitals to return loaned supplies, equipment
   b. Environment readiness
   c. Completing accreditation survey
   d. Finishing abandoned quality improvement projects

2. **Some states lifted barriers to full utilization of nurse anesthetists during the COVID-19 pandemic. What changes did states make through executive action?**

   a. They allowed nurse anesthetists to cross state lines freely to provide their services.
   b. They allowed nurse anesthetists to replace anesthesiologists in surgeries for COVID-19 patients.
   c. They made a permanent change to the duties and privileges of nurse anesthetists.
   d. They temporarily changed their requirement for physician supervision of nurse anesthetists.

3. **How did the Hospital for Special Surgery (HSS) in New York City handle COVID-19?**

   a. HSS stopped its elective surgeries, shared personal protective equipment (PPE) with local hospitals, handled emergency orthopedic surgeries, and repurposed operating rooms and other space to provide critical care.
   b. HSS closed its operations for three months, furloughing staff.
   c. HSS continued about half of its usual elective surgery schedule, but directed staff to wear PPE and sanitize all spaces after every patient.
   d. HSS sent its nursing and physician staff to local hospitals to help with their COVID-19 patients.

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

COVID-19 Pandemic Led to Revised Accreditation Procedures

The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care (AAAHC) added some flexibility to the accreditation process in response to the COVID-19 crisis.

TJC suspended all regular surveying as of March 16. Surveys for high-risk situations might continue, and no restart date was set. *(Read more: https://bit.ly/3bmVIMu.)*

One day later, AAAHC announced all accredited organizations will remain accredited during the remainder of pandemic, regardless of their anniversary or expiration dates. The organization postponed all non-emergency surveys that were scheduled to occur between March 18 and May 15. *(Read more: https://bit.ly/2KiITaq.)*

High-priority AAAHC emergency surveys may be completed, depending on surveyor availability, organizational access restrictions, travel limitations, and other factors. Also, the AAAHC change notification is waived, until further notice, for temporary closures, suspensions, and expansion of services directly related to the COVID-19 pandemic. "Priority surveys include immediate jeopardy complaint surveys and initial surveys," says **Therese Poland**, RN, BSN, MSN, senior vice president of accreditation services at AAAHC.

AAAHC is calling on organizations, within their survey window, to verify the organization's hours of operations, procedures, and to find out if there have been any confirmed or suspected cases of COVID-19.

"As a reminder, personal protective equipment [PPE] should be made available to all surveyors during this time," Poland says. "AAAHC believes that facilities should be survey-ready all 1,095 days of the accreditation term. Should AAAHC conduct an onsite survey during this time, although the survey will proceed in accordance with the standard scheduled, there will be a heightened focus on infection control."

The Centers for Medicare & Medicaid Services (CMS) survey process also has changed. *(Read more online at: https://go.cms.gov/2ywM0ZA.)* CMS will prioritize any immediate jeopardy situations for surveys and delayed revisit surveys, said **Michelle McDonald**, RN, MPH, CJCP, executive director of government regulations & advisory services at TJC. McDonald spoke about CMS' revisions during a webcast on April 15.

"Federal surveyors will perform targeted infection control surveys of facilities in those areas in most need of additional oversight," McDonald added.

CMS surveys that are not authorized include standard surveys for hospitals, long-term care facilities, home health agencies, hospices, and immediate care facilities for individuals with intellectual disabilities, according to **Kathryn Spates**, JD, ACNP-BC, executive director of federal relations for TJC. Spates also spoke during the April 15 webcast.

Since the pandemic started, CMS issued guidance that allows ambulatory surgery centers (ASCs) to enroll as hospitals and provide inpatient and outpatient hospital services to help expand hospital capacity. *(Read more at: https://go.cms.gov/3bmjyIq.)*

In its April 3 memo, CMS wrote, "Any Medicare-certified ASC wishing to enroll as a hospital during the COVID-19 public health emergency should notify the Medicare administrative contractor that serves their jurisdiction of its intent."

ASCs have to sign an attestation statement. Also, they cannot be certified and enrolled as both an ASC and hospital concurrently. Further, onsite surveys are not required for approval.

"Note that once there is no longer a need for the ASC to be a hospital under their state's emergency preparedness or pandemic plan, the ASC should come

back into compliance with all applicable ASC federal participation requirements, including the conditions for coverage," the guidance reads.

As some parts of the country reopen public activities and elective surgeries return, surgery centers should follow the rules established by their accrediting organization. For instance, surgery centers accredited by AAAHC should continue to submit their application for survey, regardless of whether COVID-19 affected operations, according to Poland. "Organizations with completed applications on file will remain accredited until the next accreditation decision is rendered," she added. "Once normal operations resume across the country, AAAHC will schedule surveys through a catch-up process."

When a surgery center suspects a case of COVID-19 on site and is within a survey window, or it is within 14 days after a survey, the organization must notify AAAHC by calling (847) 324-7485, Poland said. "There is no need to report community outbreaks, just cases in your organization," she explained. If a primary contact changes during the COVID-19 crisis, the surgery center should send an email to AAAHC at notify@aaahc.org, Poland reported.

Once the COVID-19 surge passes and the state lifts shelter-in-place orders and other restrictions, the AAAHC may schedule a survey. AAAHC will develop a plan for prioritizing surveys with consideration to the anniversary/expiration date, program type, state and contract requirements, and other considerations, Poland explained. "The status of each state regarding shelter in place and travel orders will also be factors considered," she added.

Surgery center administrators should remember that AAAHC officials understand compliance with all requirements might be challenging during the pandemic, Poland noted.

"AAAHC acknowledges that these are unprecedented times and that there are several variables that may impact an organization's ability to maintain full compliance of certain requirements," Poland offered. "For example, an organization's decision to temporarily close or change status may impede existing QI [quality improvement studies. They may be required to implement crisis strategy for management and use of PPE, or they may even be utilizing staff with expired ACLS [advanced cardiac life support]," Poland says. "AAAHC will soon be releasing guidance that aims to address such questions."

As the pandemic continues, AAAHC noted ASCs could contract with a local hospital to provide that facility overflow space. As a last resort, ASCs may choose to close shop for the duration. If an ASC chooses this route, AAAHC suggests leaders could sell or lease equipment and other critical supplies to local hospitals in need. *(Read more at: https://bit.ly/3bwFv7x)* ■

More States Lift Barriers for Nurse Anesthetists During COVID-19

The American Association of Nurse Anesthetists (AANA) has asked for states to lift barriers to full utilization of nurse anesthetists. The COVID-19 crisis gave the AANA an opportunity to show the benefits of lifting physician supervision statutes, as a dozen states made temporary changes during the pandemic.

"The vast majority of states in this country have no physician supervision in statute," says AANA CEO **Randall Moore**, DNP, MBA, CRNA. Twelve additional states changed their requirement for physician supervision of nurse anesthetists through an executive action that is temporary.

"They made the decision that with COVID-19, there is a significant concern around the surge of patients and ensuring we have enough providers to take care of patients," Moore explains. "While it is an executive action, we think it is obviously the right thing to do."

Governors in New York, Michigan, Maine, and West Virginia removed physician supervision for certified registered nurse anesthetists (CRNAs). Governors in Alabama, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Tennessee, and Wisconsin also temporarily removed other aspects of physician involvement with CRNAs, says **Anna Polyak**, RN, JD, senior director of state government affairs for AANA. "CRNAs can play an important role in providing life-saving critical care management for patients impacted by the COVID-19 virus in their advanced practice registered nurse [APRN] role," she says.

There are 33 states with no supervision of CRNAs in state laws. "There is no evidence that anesthesia care in states that do not require supervision is in any way inferior to anesthesia care in states that require supervision," Polyak notes. "CRNAs provide high-quality anesthesia care, regardless of whether the state in which they are working requires supervision."

Even before COVID-19, there was evidence that antiquated rules and regulations regarding CRNAs did nothing to improve

safety, Moore says. States with these restrictions typically require a physician to be physically present and sign charts for nurse anesthetists. This increases inefficiency and cost, he adds.

Removing physician supervision of CRNAs is a top priority for AANA.

"We're focused on removal of barriers for full utilization of nurse anesthetists," Moore says. "We work with state chapters/associations, advocating at the state level, and we also work at the federal level."

Restrictions on CRNA practice are contrary to the national trend, which is allowing each practitioner to practice to the full extent of his or her education and training, Polyak says. "The excellent safety record of CRNAs is reflected in a landmark national study conducted by RTI International," she explains. "It determined that there were no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians." *(Read more: https://bit.ly/3eLkRCH.)*

Polyak also says CRNAs provide essential medical care, such as anesthesia for women in labor, in many underserved communities, as well as support for many members of U.S. armed forces.

After the COVID-19 pandemic ends, AANA leaders will meet with legislators to discuss advantages to lifting supervision restrictions on CRNAs' practice, Moore says.

"Hopefully, when we see this thing in our rearview mirror, we'll start having conversations about what we have learned about the healthcare in the states [with temporary orders]," Moore offers. "We'll see what needs to be evaluated with these executive orders, and see how these had a material impact on increasing access to care." ■

The Challenges of Infection Control in the Age of COVID-19

Infection prevention likely will be a higher priority activity and quality improvement project for surgery centers as the COVID-19 pandemic continues to flare over the next year. One place to start is the interim infection prevention and control recommendations from the Centers for Disease Control and Prevention (CDC), which address COVID-19 in healthcare settings. *(Read more at: https://bit.ly/3eGrKW1.)*

"The CDC regularly updates their infection control guidelines for the management of COVID-19 patients," says **Therese Poland**, RN, senior vice president of accreditation services at the Accreditation

Association for Ambulatory Health Care (AAAHC). "All organizations should visit the CDC website, and update their policies and procedures to reflect essential practice."

For instance, surgery centers could start with reducing risk through early identification, which they can achieve through implementation of a rigorous prescreening process, Poland offers.

"Consider calling patients ahead of time and conducting phone screens and, then, screening again at check-in," she suggests. "This could lead to immediate isolation of symptomatic patients with separate waiting areas or rooms with dedicated trained staff and equipment."

Surgery centers also should inform authorities of any identified infections. "Organizations should review their standard and transmission-based precautions, and actively monitor provider and staff adherence," Poland says. "This includes heightening focus on hand hygiene and use of personal protective equipment [PPE]."

Infectious disease physicians and scientists have addressed some of the challenges related to infection prevention in the era of COVID-19 in twice-weekly virtual media conferences about the pandemic.

One challenge is the complete novelty of the virus. When the first cases were reported, clinicians did not know COVID-19 was infectious during a presymptomatic period that could last up to four days, noted **Jeanne Marrazzo**, MD, MPH, FIDSA, director of the division of infectious diseases at the University of Alabama at Birmingham. Marrazzo spoke during an April 10 virtual media briefing hosted by the Infectious Diseases Society of America. There also are many more symptoms associated with COVID-19 than initially believed. "We were treating it like a classic respiratory infection. A lot of people refused testing because they didn't fit the classic symptoms of the syndrome," Marrazzo said. "Now, we know the range of symptoms is quite expanded, like a loss of smell ... which is specific to this infection."

IF A SURGERY CENTER NEEDS MORE OPTIONS FOR PPE ACCESS, CONSIDER IMPLEMENTING A LIMITED-USE FACE MASK POLICY, USING THE CDC'S BURN RATE CALCULATOR AS A GUIDE.

This means surgery centers and other healthcare facilities will need to protect against the spread of COVID-19, even among nonsymptomatic patients. Even a negative COVID-19 test is not a guarantee the patient is free from infection. Researchers recently discovered one company's COVID-19 test produced about a 15% false-negative rate. *(Editor's Note: This research has not yet undergone the peer review process, nor has it been published in a peer-reviewed journal. The company that developed the test stands by the reliability of its device. Read much more at: https://n.pr/3bt3u7G.)*

Scientists also have found that the virus is detectable in aerosols for up to three hours and can live up to 24 hours on cardboard and two to three days on plastic and stainless steel. *(Read more about this online at: https://bit.ly/2Kpqc4Y.)*

For these reasons, some surgery centers might choose to direct all staff, patients, and visitors to wear masks or PPE while on site. Even when there are reliable antibody tests, clinics might choose to stick with masks until COVID-19 is gone.

"There has been talk of testing healthcare workers to see who has been exposed or not exposed, but we still do not have enough trust in what exposure means," says **Kimberly E. Hanson**, MD, MHS, an associate professor of internal medicine at the University of Utah. "We will all still have to wear our PPE, and that won't change."

When organizations experience PPE shortages, they may need to consider crisis capacity techniques. "A carefully planned crisis strategy prioritizes the use of PPE for selected patient care activities, such as sterile gloves and gowns for urgent sterile surgical procedures, or procedures where splashes and sprays are anticipated," Hanson explains. "Expired PPE may be considered for other types of patient care activities."

If a surgery center needs more options for PPE access, leaders could consider implementing a limited-use face mask policy, using the CDC's burn rate calculator as a guide to preserve supplies. *(Read more at: https://bit.ly/2XWJDtx.)*

"These are challenging times. We may have to learn new behaviors and use new tools to ensure employee and patient safety is maintained throughout the emergency," Poland says. "AAAHC will continue to provide updated information relating to COVID-19." ■