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

**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
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
CMS Guidance, Opening Up America

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- **When adequate testing is available, test patients before care and and staff routinely**
- **Elective care should cease if there is a surge**
SAMBA’s leadership in reopening ambulatory anesthesia

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

Supported by:

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 resuming 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 crowd/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. Redeployment 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.

Rusen Abdelmalak, MD, FASA
SAMBA President

Leopoldo Rodriguez MD, FASA
SAMBA President-Elect

Bobbie-Jean Sweitzer MD, FACP
SAMBA Vice-President
### ASCA Checklist to Help Reopen Your ASC

1. **If the ASC has been closed, consider the following before reopening to provide normal services:**
   - Yes
   - No
   - Limitations or further comments

2. **Administration**
   - 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?
   - Has any resumption of elective procedures been authorized by the appropriate municipal, county, and state authorities?
   - 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.)
   - If the ASC contracted with local healthcare system(s) to provide hospital services and you plan to step before the PHE is over, did you notify the hospital and terminate any agreement?

3. **Has the ASC notified the state licensing entity of the reopening date?**
4. **If applicable, has the ASC’s accrediting organization been notified of the reopening date?**
5. **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?**
6. **Have the below been notified of the reopening date and hours/days the ASC will be open:**
   - Medical staff
   - Vendors
   - Anesthesia
   - Physicians’ offices/schedulers

7. **Has the ASC verified the local/transfer hospital is able to accept emergency transfers?**
8. **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?**
9. **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.)**
10. **Based on the priority list, does the ASC have the necessary staff required for these procedures?**
11. **Do any ASC staff have child-care/family care concerns?**
12. **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?**
13. **Does the ASC have the appropriate anesthesia coverage for these cases?**
14. **Have scheduled patients been contacted to ensure that they can travel safely to/from the ASC?**
15. **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 ASTA Checklist)**

### Health System Opening Checklist

<table>
<thead>
<tr>
<th>Task</th>
<th>Assigned Responsibility</th>
<th>Date of Completion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure all equipment, lights and flat surfaces are cleaned prior to first case.</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Have sterile supplies stored in the OR’s been inspected for damage or exposure?</td>
<td></td>
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<tr>
<td>3</td>
<td>If supplies were damaged/expired, has action been taken and documented? (e.g. replacement, reprocessing, etc.)</td>
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<tr>
<td>4</td>
<td>Has an evaluation for electrical hazards been conducted?</td>
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<tr>
<td>5</td>
<td>Are the scrub sinks functioning properly? (This includes water running at appropriate temperature)</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Are there enough staff exchanges per hour?</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>If necessary, has your ASC implemented new protocols for PPE/mediation?</td>
<td></td>
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<tr>
<td>8</td>
<td>Have you taken precautions for filing (COSO)</td>
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<tr>
<td>9</td>
<td>Business Office/Booking</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>Identifies backlog of cases</td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Has center started scheduling cases</td>
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<td></td>
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<tr>
<td>12</td>
<td>Has center contacted physicians’ offices for recent data</td>
<td></td>
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<tr>
<td>13</td>
<td>Issue cases been pre-certified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are you planning extended days? Saturday?</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>Fax for scheduling low and high-risk cases</td>
<td></td>
<td></td>
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<tr>
<td>16</td>
<td>Do you have a plan to help find space for surgeons from closed/unlimited availability competitors?</td>
<td></td>
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<tr>
<td>17</td>
<td>Has a detailed report of expenses incurred due to the COVID-19</td>
<td></td>
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<tr>
<td>18</td>
<td>Other should be emphasized by the ASC?</td>
<td></td>
<td></td>
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<tr>
<td>19</td>
<td>Have all computers and telephone systems been checked to ensure they are working properly?</td>
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<tr>
<td>20</td>
<td>Update phone message to reflect opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Ensure IV fluids have been set up and in use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Check IMPA updates. If necessary, email IMPA McKee to turn on IMPA auto prompts for your ASC.</td>
<td></td>
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</tbody>
</table>
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
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 boney 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 VirtlyGo 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 recommend intermittent 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 non-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 working principle and a set of recommendations for physicians, nurses and local facilities in their resumption of care in operating rooms and all procedural areas.

1. Timing for Resuming Elective Surgery
   - The health care organization should consider 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 returning to a crisis standard of care.

2. COVID-19 Testing within a Facility
   - Facilities should use available testing to protect staff and patient safety when possible and should implement policies addressing requirements and frequency for patient and staff testing.

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 are at least being considered. Understanding both the local facility capabilities (e.g., beds, testing, operating rooms [OR]) 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 restarted. 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?
Supple 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
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.

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