Adapting to Serve
Exploring COVID-19 Hospital Status
April 2020

ASCs adapting to Hospitals without Walls
Improving health care quality through accreditation

- 1095 Strong, quality every day is a transformational call-to-action that equips ambulatory leaders with the best of what they need to operationalize quality practices
- 1095 Strong centers on providing accreditation tools, resources, and relevant education to bring meaningful value to help you adapt in this evolving COVID-19 environment
- We are committed to delivering an exceptional 1095 Strong experience by improving health care quality through accreditation

Objectives
- Understand administrative options for ASCs including temporary closure and conversion to a hospital
- Review applicable CMS Conditions of Participation requirements and learn about waivers
- Examine how to optimize patient flow with increased acuity and mixed skilled workforce
What options are available to support today’s emergency?

Temporary closure or limited operations

Enroll as a hospital

Contract with a hospital

1. Temporary closure with no activity
2. Reach out to state department of health
3. Lease or sell equipment and supplies
   - Equipment Lease Agreement
4. Temporary closure with limited activity
5. Providing emergency treatment or appointments
6. Post notice at business; on website / social media

CMS will not view temporary closure as cessation of business

- Temporary closure with no activity
- Reach out to state department of health
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ASCs may enroll as a hospital if consistent with state’s emergency plan

- 1st notify and submit a signed attestation statement to Medicare administrative contractor (MAC)
- CMS region will evaluate compliance with standards; No Immediate Jeopardy’s (IJ) in last 12 months
- ASC billing privileges will be deactivated while enrolled and reimbursed as a hospital
- Attestation approval: 2 days if eligible
- Revert back to an ASC at anytime
- Hospital billing privileges deactivated
- ASC billing privileges reinstated
ASCs may contract with a hospital

- Start with reviewing ASC’s lease agreement and malpractice coverage
- Clarity on role, scope and length of agreement
- Logistic supply lines
  - Medication
  - Equipment
  - Supplies
- Access to patients, transportation, escalation of care
- Providers and staffing
- Access to policies and protocols
- Governing Board Approval
Quick Reference Crosswalk

<table>
<thead>
<tr>
<th>COP 482.</th>
<th>AAAHC Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 12 Governing Body</td>
<td>• 2.1 Governance</td>
</tr>
<tr>
<td>• 21 QAPI</td>
<td>• 5 Quality Management</td>
</tr>
<tr>
<td>• 22 Medical Staff</td>
<td>• 2.II &amp; III Governance</td>
</tr>
<tr>
<td>• 23 Nursing Services</td>
<td>• 3 Nursing (MDS)</td>
</tr>
<tr>
<td>• 24 Medical Records</td>
<td>• 6 Clinical Records</td>
</tr>
<tr>
<td>• 25 Pharmaceuticals</td>
<td>• 11 Pharmacy</td>
</tr>
<tr>
<td>• 42 Infection Control</td>
<td>• 7 Infection Control</td>
</tr>
<tr>
<td>• 26 Radiology</td>
<td>• 13 Diagnostic Imaging</td>
</tr>
<tr>
<td>• 27 Laboratory</td>
<td>• 12 Pathology</td>
</tr>
</tbody>
</table>

Now the ASC is a hospital...what next?

Which Conditions of Participation (CoP) apply?

• Attestation required for the following CoPs:
  • Nursing
  • Pharmaceutical
  • Infection control
  • Respiratory services
  • Other CoPs not waived under Section 1135 waivers

Nursing Services

Refer to AAAHC MDS Standards Chapter 3

• 42 CFR 482.23 Condition of Participation
• Adequate number of licensed registered nurses
• 24 hours of nursing services
• Drug and pharmaceutical administration
Pharmacy Services

Refer to AAAHC Standards Chapter 11

- 42 CFR 482.25 Condition of Participation
- Pharmacy is directed by a registered pharmacist or competent supervision
- Full/part-time pharmacist and adequate staff
- Schedules II, III, IV and IV are locked within a secure area

Infection Control and Antibiotic Stewardship

Refer to AAAHC Standards Chapter 7

- 42 CFR 482.42 Condition of Participation
- Qualified Infection Control Professional is appointed
- Prevention and control of transmission
- Surveillance plan to control Infections
- Hospital-wide antibiotic stewardship program

Respiratory Services

- 42 CFR 482.57 Condition of Participation
- Director of respiratory care services
- Adequate number of therapists and technicians
- Services delivered in accordance with medical staff directives
Waivers

CMS issued a nationwide Stark Law waiver; applies if arrangement is for COVID-19-related purposes

No waivers have been issued for federal and state fraud and abuse laws such as the Anti-Kickback Statute

Physician-owners permitted to refer patients to converted ASCs

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- No waivers have been issued for federal and state fraud and abuse laws such as the Anti-Kickback Statute

* Some waivers may only be implemented so long as it is not inconsistent with a state’s emergency preparedness or pandemic plan

What CoPs have been waived?

- Emergency Medical Treatment & Labor Act *
- Reporting Requirements which require that hospitals report patients in an intensive care unit whose death is caused by their disease
- Patient Rights: provision of medical records; patient visitation; seclusion
- Flexibility in Patient Self Determination Act Requirements (Advance Directives)
- Physical environment *

* Some waivers may only be implemented so long as it is not inconsistent with a state’s emergency preparedness or pandemic plan
Provider Waivers

- Medical staff with expired privileges
- Telemedicine with agreement through offsite hospital
- Physician services requirement for patients to be under care of a physician *
- Anesthesia services related to supervision of CRNAs to be at discretion of hospital *
- Verbal order read back verification and documentation

*Nursing and other services

- Nursing care plans and detailed information and sharing for discharge planning *
- Therapeutic diet approved by dietitian *
- Written requirement for personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures *
- Medical record staffing; form and content; record retention and completion within 30 days of discharge *

Conversion from ASC to Hospital
Brainstorm

1. Determine scope of services
   - Specialty, general, surgical, other
   - Agree on accepted level of acuity
2. Gap assessment: staffing, hygiene, diet, supplies, policies, security, sterilization, telemedicine
3. Space Planning: layout of building, ORs, patient flow, space, storage (e.g., supplies, medical gasses), emergency plan, laundry
4. Identify key personnel and roles

Scope and Services

Identify needs of state and local hospital; examine capacity to meet need

- Governing body (AAAHC Standards Chapter 2)
- Contact state and meet with local hospital
  - Examine internal capacity (e.g., staffing, space, equipment, supplies) to meet need and additional resources that may be required or may be sourced through partnership
- Agreements or contracts
- Referral mechanisms
- Transfer hospital for deteriorating patients
- Emergency medical service notification
Decide on scope and services

- Scope of service
  - Specialty hospital, e.g. stay with orthopaedics but increase complexity and acuity
  - Medical hospital for stabilization and management of non-COVID-19 patients
  - Dedicated maternity hospital / birthing center
  - Level of acuity: stable, urgent, emergent

Clinical policies based on type of service and level of acuity

- Pre-screening and assessments
- Triage routine vs. critical care
- Emergency Severity Index (ESI)
- Respiratory care
- Wound care (dressing and compression bandage)
- Diabetic care (waived testing and medication)
- Mobilization and physical therapy
- Management of drains; IV cannulation, PIC lines, central lines
- Pain management (IV pumps, medication)

Gap Assessment
Complete a gap assessment to determine strategy

- Clinical policies
- Providers, telemedicine
- Nursing and other services e.g. respiratory
- Hygiene and nutrition
- Sterilization
- Blood and blood products
- Medication and medical gasses
- Equipment, supplies and storage
- Security and emergency management

Determine Workforce development needs

- Licensure status: inactive, expired, cross-state
- Orientation and training (AAAHC Standards Chapter 3)
  - Develop brief orientation
  - Competency checklist
  - Buddy system
- Organization of workload and staff schedule
  - Based on skill/competency and patient acuity
- Operating Schedule
- Labs and diagnostic imaging (AAAHC Standards Chapter 13)

Space Planning
Optimize patient flow with limited space while increasing capacity

- Reuse of space
- Patient flow: reception, admission, procedure, PACU, discharge
- Bed turn over timeframes and process to effectively manage capacity
- Escalation of care: transfer criteria and process
- Discharge criteria and process (AAAHC Standard10.Q)
- Sterilization: separation of clean and dirty (AAAHC Standards Chapter 7.1)

Assess your Facility and Environment

- Equipment cleaning (AAAHC Standard Chapter 7.I.F.4.b)
- Environmental cleaning: OR; turn-over, chemicals
- Training new personnel on cleaning policies (AAAHC Standard 3.E.2.c)
- PPE (What is available for use)
- Waste management
- Laundry management (AAAHC Standard 10.I.K.a-b)
- Maintenance of equipment

Manage your Supplies

- Supply management: ordering, requesting, issuing and restocking
- Supply sign in and sign out
- Personal Protective Equipment (PPE) Burn Rate Calculator (CDC)
- Supply storage: increased supplies of stock and medical gasses, input from engineering
- FEMA control of supply chain
Optimizing PPE

- Conventional capacity
- Contingency capacity
  - Remove facemasks for visitors in public areas
  - Implement extended use of facemasks
  - Restrict facemasks to use by HCP, rather than patients for source control
- Crisis capacity
  - Implement limited re-use of facemasks
  - Prioritize facemasks for selected activities
  - No facemasks available: consider cloth masks

Key Roles

- Medical director
- Charge nurse
- Infection control professional
- Director of respiratory care services
- Pharmacist
- Primary liaisons for notifications
Charge Nurse Responsibilities

Refer to AAAHC MDS Standards Chapter 3

- Coordination for 24/7 staffing
- Roster and assignments acuity/experience, availability
- Clinical supervision, orientation, training
- Ward routine: hygiene, meals, medication, other
- Policy development and adherence
- Shift handoff
- Schedule drug security and management
- Supply management (drugs and other)

Infection Control Professional

Refer to AAAHC Standards Chapter 7

- Develop hospital wide Antimicrobial Stewardship program in accordance with national standards
- Prevent cross-infection between patients and providers
- Develop Infection Control Surveillance plan to control Healthcare Acquired Infections
- Train and monitor staff adherence to infection control policies, hand hygiene and PPE

Primary liaison(s) for official communication and notifications

- State health department
- State emergency plan discussions
- State reporting requirements for COVID-19
- Regional MAC
- Health plans
- Local hospitals and primary care providers to other locations of care increased communication is key
- EMS - Expanded range of transfer capability for Ambulances in now available to transport patients in geographic areas
Resources

AAAHC Webinar: COVID-19 Identify, Isolate, Notify
http://www.aaahc.org

Conditions of Participation
http://federal.elaws.us/cfr/title42.part482

State Operations Manual (SOM) Appendix A
https://www.cms.gov/media/423601

CMS Memo’s

Centers for Disease Control and Prevention (CDC)

ASCA website
https://www.ascassociation.org/asca/resoursecenl/latestnews/resourccenter/covid-19

FAQs

• Is there an initial certification survey if we enroll as a hospital?
  No. The initial certification survey is waived.

• Which agency has oversight if we contract with or become a hospital?
  The state assumes jurisdiction.

• How quickly can I get providers enrolled with Medicare?
  CMS MACs have access to a toll-free hotline and waivers have been applied to expedite enrollment.

• Can we operate concurrently with hospital and ASC patients?
  Once the hospital CCN is assigned to the ASC, its ASC CCN and billing privileges will be temporarily deactivated.

• What is the effective date of hospital enrollment?
  The effective date of the ASC’s hospital enrollment is the date the attestation is accepted by the MAC (typically 2 day approval.)

• What happens when I convert back to an ASC?
  At the end of the public health emergency, ASCs will have their hospital CMS certification numbers terminated, their hospital billing privileges deactivated, and their ASC billing privileges reinstated.

Questions?