



CHA Recommendations for Hospital Surge Preparations— Fall 2020/Winter 2021

11/10/20

It's not a matter of *if*, but *when* hospitals will experience the next COVID-19 surge. Experience has shown that two weeks after the number of cases rises in California, so does the number of hospitalizations. The recent increases in COVID-19 cases and hospitalizations statewide mean we must ready ourselves for surges of patients in need of care.

In preparation, CHA recommends the California Health and Human Services Agency (CHHS) take the following actions. CHA would like to meet with state officials from CHHS to resolve these critical issues as quickly as possible.

Patient Transfers and Discharges

- 1) **Leverage and build upon the state's Patient Movement Plan.** As outlined in the state's [Patient Movement Plan](#): if there is patient movement within the operational area, designate the Medical Health Operational Area Coordinator (MHOAC) to coordinate that movement; if the MHOAC is unable to meet the demand for movement, the Regional Disaster Medical Health Coordinator (RDMHC) takes over, and so on. During the Imperial County surge, there was much confusion about who was the Emergency Medical Services Authority's vendor — the All-Access Transfer Center— as well as how they decided which hospital to call and where to eventually send a patient. In addition, there seemed to be a lack of communication or coordination with both the MHOACs and RDMHCs. To provide a standardized, statewide approach, the state's Patient Movement Plan should be implemented, in addition to related processes. Until the current plan is updated to include the responsibilities of receiving hospitals (the plan is currently silent on that issue), an interim plan should be provided.
- 2) **Issue the CDPH All-Facilities Letter in development on skilled-nursing facility (SNF) admissions.** The California Department of Public Health (CDPH) should provide statewide direction to support safe and timely hospital-to-SNF transfers by issuing the All-Facilities Letter on this topic that it is currently developing in coordination with CHA and the California Association of Health Facilities. Additionally, CDPH should direct local health departments to build on this guidance to develop regional surge plans that include consideration of SNF capacity and access, as well as hospital-to-SNF transitions. Regional plans should be developed in consultation with area hospitals and SNFs.
- 3) **Support implementation of Hospital@Home models.** CDPH should encourage additional implementation of Hospital@Home models by providing on its website information about CDPH requirements and a template agreement, and ensuring that CDPH Licensing and Certification Program district offices are familiar with the program and where it has been implemented.

Staffing

- 1) **Reinstate the statewide nurse staffing ratio waiver that was in effect between March and June of this year.** With hospitals across the country experiencing increasing patient surges, nurse staffing registries will not be able to meet the national demand. California hospitals will, therefore, be unable to obtain the nursing staff required by the strict and static ratio regulations. Currently, CDPH requires that ratio waivers be issued on a hospital-by-hospital basis. This time-consuming process will take hospital staff away from the bedside to instead focus on providing paperwork to CDPH at the very time that patient needs have surged. A statewide waiver is necessary to provide the flexibility hospitals will need to care for patients. The best way for this to happen is for CDPH to reinstate its previous statewide waiver. Alternatively, CDPH could undertake a combination of the following options to provide relief to hospitals:
 - Issue a statewide waiver of the “at all times” requirement so that a nurse can take a 10-minute break without another nurse filling in — which is allowed in every other state in the country.
 - Issue a statewide waiver of the nurse staffing ratio requirement for every hospital at an appropriate threshold percent of bed capacity or higher.
 - Issue a statewide waiver of the nurse staffing ratio requirement for hospitals in the state’s purple tier under the [Blueprint for a Safer Economy](#).

Testing

- 1) **Clearly prioritize testing given testing reagent shortages and persistent testing challenges.** The hospital field and local health departments need clear direction from CHHS on how to prioritize competing and increasing testing demands. Currently, there are no prioritized groups, as a result of the [September 22 updates to the state’s prioritization guidance](#). Hospitals are also being asked — or required — to test asymptomatic individuals as a result of local health orders, such as in Santa Clara County. The PerkinElmer lab will be an important resource, but additional prioritization is needed, as demand will only increase for testing.
- 2) **Postpone CDPH draft guidance recommending weekly testing of asymptomatic, non-exposed hospital health care personnel.** CDPH is proposing broad-based testing requirements of hospital health care personnel at a time when testing supplies, particularly reagents, remain in short supply. Given that increased COVID-19 cases will require increased testing, and augmented testing capacity has not yet materialized, CHA requests that CDPH postpone any new screening recommendation for hospitals. Hospitals share the goal of preventing COVID-19 transmission and are already taking many steps, including testing health care personnel who have signs and symptoms and have had an exposure, testing patients admitted to the hospital, testing patients before they undergo surgical procedures, cohorting positive patients in COVID-19 care units, limiting visitors, and using appropriate PPE.

CHA estimates that at least 270,000 employees work in patient care units statewide (including direct patient care and support staff such as unit clerks, environmental services employees, transporters,

and others) and would be subject to the draft weekly testing recommendation. That would be nearly a one-third increase *statewide* in the number of tests most recently [reported by the Testing Task Force](#) (901,000 for Oct. 18-24). This proposed recommendation is also inconsistent with CDC guidance, which does not recommend such screening of asymptomatic health care personnel in the hospital setting (see [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#)).

Personal Protective Equipment (PPE)

- 1) **Improve PPE inventory, access, and transparency in state and county stockpiles.** For state inventories, current PPE needs include N95s approved for surgical purposes, N95s for small face sizes, PAPR parts, and nitrile gloves — and these needs will continue to grow, especially as hospitals experience patient surges. With the Salesforce system, CDPH has a new mechanism for understanding the requests being elevated to the state and potentially why a resource request has been denied by the MHOAC or RDMHC. Hospitals need to understand those decisions as well, so they can plan accordingly. Hospitals also need transparency from counties about inventory and allocation; they regularly report they don't always know what the county has and could provide to protect their patients and staff.
- 2) **Work with the Labor & Workforce Development Agency on Cal/OSHA enforcement of the aerosol transmissible disease (ATD) standard and other regulatory requirements.** Health care employers continue to face challenges in obtaining necessary PPE and keeping up with constantly changing guidance. To further the interests of employee safety, the state should focus on compliance assistance that takes into account the realities of this dynamic environment, rather than punitive enforcement activity. CHA requests that CHHS work with the Labor & Workforce Development Agency toward this end. Specifically, in August, Cal/OSHA revised its guidance on the use of N95 respirators, limiting permissible conservation strategies on the conclusion that shortages had been sufficiently resolved. Unfortunately, shortages continue to exist, and health care providers need the flexibility to use all conservation strategies approved by the Centers for Disease Control and Prevention (CDC).

Additionally, Cal/OSHA has not yet clarified what other regulatory requirements (e.g., annual fit testing, annual workplace violence prevention training, etc.) may be postponed. Finally, recent legislation requires hospitals to have a 90-day stockpile of specified PPE by April 1, 2021. Given the current environment, efforts to comply with this requirement will put a further strain on the PPE supply needed by a variety of sectors. We urge CHHS to work with sister agencies and stakeholders — including the Governor's Office of Emergency Services, the Labor & Workforce Development Agency, hospitals, other employers, organized labor, distributors, and others in the supply chain — to assess the impact of this new law.

Alternate Care Sites

- 1) **Provide transparency on reopening of state alternate care sites.** Hospitals need transparency about the three state alternate care sites — Sleep Train, Fairview, and Porterville — such as when the state will reopen the sites, what the admission criteria are, and how to request a transfer to one of the alternate care sites.

- 2) **Establish a plan to identify/develop behavioral health alternate care sites.** CHHS should coordinate an actionable regional plan to serve individuals requiring inpatient levels of care with comorbid psychiatric and COVID-19-positive needs. Options to consider include dedicated units within existing state-established alternate care sites and partnering with acute psychiatric hospitals to establish COVID-19-dedicated units. For non-COVID-19 patients requiring involuntary crisis services, county-based crisis care destinations should be identified to significantly reduce or eliminate the use of hospital emergency department 5150 drop offs.

Coordination and Planning with Hospitals

- 1) **Partner with CHA to remind hospitals to review and update, as needed, their surge plans.** Hospital plans for expanding capacity might need to be revised for the current season and weather. Hospitals would benefit from a reminder on what resources are available to them as they review and update their surge plans for winter. CHA has developed [a checklist](#) that can be re-circulated and that notes these additional resources from the federal level, which could be highlighted: [Hospital Surge Evaluation Tool](#), [Medical Surge Capacity and Capability Handbook Chapter 1: What is Medical Surge?](#), and ASPR TRACIE's [Considerations for the Use of Temporary Surge Sites for Managing Seasonal Patient Surge](#).

Maintaining Telehealth and Other Flexibilities

In addition to these requests for an anticipated surge, it is important to recognize that COVID-19 will be with us for some time to come. The state and federal flexibilities, as well as reimbursement parity (such as for telehealth), extended during the public health emergency have supported health care professionals, in and outside of our hospitals, in providing vital primary and specialty care. Those flexibilities and reimbursement parity should be extended for the duration of the pandemic.