

# IMMEDIATE STATE STEPS TO SUPPORT HOSPITAL CARE IN THIS COVID CRISIS 12/13/2020

Following are concrete steps the state can take immediately to maximize the ability to treat the expected, unprecedented surge of patients needing acute and intensive care due to COVID-19.

The steps are in four areas:

- Supplies
- Coordination
- Hospital Decompression
- Regulatory Flexibility

## **SUPPLIES**

1) **Mobile Liquid Oxygen Tanks.** COVID-19 patients are increasingly being treated with high flow oxygenation, rather than ventilators. The outcome of this treatment is better for patients than the weakening effects of making them dependent on a breathing machine. Some hospitals report that unusually high use of oxygen pipes in the hospital is resulting in O2 pipes freezing - shutting down their oxygen capabilities. Backup mobile oxygen tanks will be critical. Need to be matched to hospital O2 systems.

2) **Systematic Approach to Identify Other Emerging Resource Needs.** The state should ask MHOACs to report the Resource Requests they are receiving. Many of these equipment and supply needs and emerging trends in those needs might not be visible to the state if the MHOAC is not elevating them to the state for fulfillment by the state stockpile.

3) **Secure COVID Lab Testing Supplies.** Many of the lab testing sites in California hospitals use platforms for which there is a shortage of testing supplies. In addition, some hospitals in more rural locations have longer-than-expected testing turnaround times. Use CalOES purchasing power to create a reserve of lab testing supplies for multiple testing platforms. Create a clear process by which hospitals can access those supplies.

4) **Immediately Prioritize and Simplify Use of Valencia Branch Lab for Hospitals.** Make use of the state lab free or low cost and easy to use for hospitals. Create a clear, expedited process by which hospitals can access the Valencia Branch testing capability. While a fast track option has been given to hospitals, it still requires several layers of review with limited interface to the hospital's patient care record. Communicate widely the ability for hospitals to use the lab.

5) **State Stockpile Transparency.** Immediate Personal Protective Equipment needs include:

3M N95 Model 1860 Respirators. Coordinate with the federal government to create product-specific access for California to the Strategic National Stockpile. The California Hospital Association (CHA) was contacted by federal officials offering specific contents of the Strategic National Stockpile (SNS). They said the state of California may access the SNS for specific brands of personal protective equipment not available in the state stockpile. The brands available in the state stockpile are difficult to fit for many hospital workers. Ensure successful fit testing and health care worker protection by coordinating now to secure access as needed to 3M N95 Model 1860 masks for California hospital workers. In addition, know the state has some 176 million N95 masks in inventory. Sharing detail about those masks (brand, sizes if applicable) is essential for supply planning.

Nitrile Gloves. COVID-19 vaccination will begin this week and the ancillary kits from the federal government do not include gloves. This will increase demand for the gloves, at a time when there is a worldwide shortage of exam gloves due to limited supplier sources. Know the state has some 159 million in inventory. Sharing detail about those gloves (numbers in inventory by size and brand) is essential for supply planning. In addition, anything the state can do to access gloves through the SNS or otherwise would be helpful.

Process to Increase State Stockpile Transparency. Tomorrow (Monday, Dec. 14), CHA staff are meeting with CHHS (Liz Basnett) to follow up on previous discussions of specific ways to increase transparency of PPE in the state stockpile for hospitals. Accelerating these efforts will be critical:

- Coordinate with CalOES to provide CHA a granular breakdown of brands and sizes within the PPE stockpile.
- Provide to CHA a frequent update on the proportion of PPE given to facilities (by type - e.g. hospital, nursing home), the medical community, for public health uses and other essential workers
- Ask MHOACs to provide greater transparency and clear rationale about resource requests - clear reporting of status of requests in process, and reasons for denials or only partial approvals. Increased and more detailed communication from MHOACs in the short term; potential new features to the Salesforce system in the longer-term
- Joint CHA-CHHS communication prioritizing PPE access for hospitals and other medical providers, detailing what is available in the state stockpile, and reminding how the resource request process, beginning with the MHOAC, works.

## **COORDINATION**

1) **Ensure Alignment of County and State Public Health Policy.** Alignment is critical on issues including the provision of essential hospital services, worker testing and vaccine administration. Ensure that all counties follow the lead of the state on these key matters and enact policies no more restrictive than the guidance provided by the state. Consistency of policy across counties is key to ensuring equity of care delivery.

2) **Discontinue Use of the State All-Access Transfer Center.** This hybrid patient transfer system – EMSA using the All-Access Transfer Center - layered on top of the existing mutual aid system has caused confusion and delays. In a surge of the current proportion, moving patients outside of a county or regional area to other parts of the state equally challenged for staff and other resources is dangerous. EMSA must discontinue its use while continuing to develop appropriate principles for the transfer of patients out of a county or region, triggers for when broader, statewide transfers should be considered, and conditions under which longer-distance statewide transfers should and should not be used.

3) **Crisis Care Guidelines.** Resend these guidelines to hospitals via an All-Facilities Letter from CDPH and encourage all to be ready to implement as necessary. CDPH should also educate the public that these steps may be necessary.

## **HOSPITAL DECOMPRESSION**

1) **SNF Admissions.** Require SNFs to report bed capacity (COVID+/red, exposed in quarantine/yellow, COVID- or recovered/green) to counties. Work with local health officers to preclude local health orders that would limit admissions from hospitals to skilled-nursing facilities. Convene SNF and hospital leaders by county to smooth the transition from hospital to SNF, ensuring consistency of admission criteria, testing criteria and surge planning.

2) **Assisted Living Facilities.** Licensed residential care facilities for the elderly (RCFE) are not licensed by CDPH. There are cases where COVID+ residents have been inappropriately taken to hospitals without need for acute care. Engage the Department of Social Services (DSS) to ensure that these facilities adhere to public health guidance regarding admission and care for their residents, including DSS field office support for re-location of residents to other RCFEs when needed.

3) **State-Run Alternate Care Sites.** Alternate Care Sites (ACS) were developed during the last surge but underutilized. There will be need for support for hospitals. Specifically, ACSs should be used to accept patients no longer needing acute care but still in need of lower-level care. That means to be most useful, ACSs must take COVID positive patients and focus on providing post-acute level care. If skilled nursing facilities are unable or unwilling to take post-hospitalization

patients, ACSs will be critical to completing the care continuum. CDPH released admission criteria for the state-run ACSs on December 7 (in All-Facilities Letter 20-48.2). However, the admission criteria may vary from site to site, making it confusing. More important, the admissions criteria should be far less restrictive than included in the AFL if these sites are to be helpful in this surge. Clarity, through a revised AFL is needed.

**4) Increasing Hospital Bed Capacity Where Staff Are Available.** Where space is an issue, but staff is available, CHHS, with EMSA and CDPH, should continue to build out capacity at hospitals through county-run Alternate Care Sites (ACS), Federal Medical Stations (FMS) and using beds provided directly to hospitals. If the resources exist, make these options more widely available to hospitals that can take on greater numbers of patients.

**5) Improve Insurance Practices:** DMHC is drafting an All-Plan Letter that seeks to direct plans to remove unnecessary barriers to hospital admission, transfer, and/or discharge. This is especially important during this surge as we seek to expedite the care for COVID-19 patients. The draft should be much more directive by 1. Suspending the ability of plans to require prior authorization for inpatient admission; 2. Compelling plans to act to ensure timely post-acute care transitions; and 3. Ensuring timely reimbursement of services.

## **REGULATORY FLEXIBILITY**

**1) Provide Expedited Waivers to Use Team Nursing Models.** Given significant shortages of critical care nurses, many acute care hospitals will turn next to employ a team nursing approach - one that has a specialized or experienced RN leading a team of patient extenders (e.g. RNs, LVNs, and CNAs) to maximize the number of patients who can be cared for in the ICU and other affected units. CDPH should augment the new expedited process for nurse-staffing ratio waivers by adding a provision for the most common structures of team nursing. CHA can help to identify specifics of those team nursing models to be used most widely.

**2) Reinstate Suspension of Certain CDPH State Licensing Requirements:** Except for the nurse-staffing ratio requirement at this time, CDPH should reinstate the original version of AFL 20-26, which waived all hospital licensing requirements for four months (such as routine, on-site surveys) with specified exceptions (such as the requirement to report adverse events and unusual occurrences). This will allow hospitals during this surge to focus on patient care rather than paperwork.