CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Planning for COVID-19 Resurgences: Recommendations

6/5/20

SUMMARY: The California Hospital Association (CHA) has been working with its members to develop these recommendations to the California Health and Human Services Agency on future health care delivery system responses to resurgences of COVID-19. This is informed by the experience from the initial response in the Spring 2020, as well as the more recent surge of patients in Imperial County.

Based on these discussions, it is clear that the Spring 2020 approach of halting care for non-COVID-19 patients to prepare for projected COVID-19 patients will only reduce access to care for Californians. It will do so in the short term by delaying medically necessary procedures, which may result in patient harm. And in the long term, it will take what a report by the California Care Foundation recently referred to as a "financial shock" to California hospitals and push them over the brink, resulting in hospital and health system reductions in services and even closures.

Instead, these recommendations propose a different approach, in which hospitals work with counties in developing Local Area Surge Plans based on California Department of Public Health guidelines, hospitals surge in real time to care for additional COVID-19 patients, and the state funds a COVID-19 Surge Facilities Network to provide the additional care California will need in its response to COVID-19. This approach would ensure that all Californians, whether they have COVID-19 or other medical conditions, can access the care they need.

So that hospitals can surge their capacity to care for additional COVID-19 patients in real time, this document includes an attachment with the state regulatory waivers that must be maintained. These include the COVID-19 State of Emergency, key Executive Order provisions, and specific state waivers and guidance. Given the forecasted COVID-19 resurgences and seasonal Influenza during Fall and Winter, these need to be continued through the end of March 2021. Where hospitals only utilize waivers during patient surges and staffing shortages, those are proposed to be triggered only during those situations.

BACKGROUND: Planning for future health system responses to COVID-19 resurgence will require different approaches based upon the learnings from the initial response in Spring 2020. Critical planning elements should include mechanisms to:

- Resolve the "Limiting Factors" experienced in Spring 2020
    - Testing availability (on-site, RNA [aka PCR] and serology)
    - Personal protective equipment (PPE) and critical equipment needs and availability
    - Improved accuracy around estimated community demand and forecast health care capacity impacts
    - Barriers to utilization of alternative care sites
    - Ensuring access to post-hospital skilled-nursing facility (SNF) care for patients with confirmed or suspected COVID-19

  - Prevention and mitigation of COVID-19 outbreaks in high-risk populations

- "Mitigate" demand in future surges
  - Access to new therapeutic agents, e.g., Remdesivir, and adoption of evolving clinical guidelines, including ambulatory and home interventions, patient cohorting, infection prevention and ventilator utilization
  - Influenza vaccination programs
  - Contact tracing and community disease transmission monitoring
  - Dynamic implementation of Non-Pharmaceutical Interventions (NPIs), e.g., physical distancing, stay-at-home orders

RECOMMENDATIONS:

A. GUIDING PRINCIPLES

Future responses to COVID-19 resurgence should follow a set of clear "*guiding principles:"*

1. Do what is in the best interest of all patients (COVID-19 and non-COVID-19).
2. Meet the surge demand for COVID-19 without unnecessarily diminishing care for non-COVID patients. This will require augmenting existing hospital capacity with the addition of dedicated, state funded, COVID-19 facilities that provide acute and skilled nursing levels of care known as the COVID-19 Surge Facilities Network.
3. Develop solutions that are state guided, county (or regionally) partnered and health care facility based.
4. Develop solutions as close to unique local conditions as possible.
5. All hospitals in an area should take an active role in responding to COVID-19 patient care needs (e.g., this is a shared public health responsibility).
6. Hospitals and SNFs should partner with the state to operate the state funded COVID-19 Surge Facilities Network.
7. Surge management related data should be transparent to all hospitals included in a specific Local Area Surge Plan (see definition of "Local Area" in Section C.2 below).

B. DEMAND FORECAST

It is essential that we do not delay necessary medical services in order to create "reserved" capacity for *potential* COVID-19 volumes. Future COVID-19 response plans must be built to accommodate the combined demand for regular medical services, the annual influenza season, and future COVID-19 outbreaks. In the spring of 2020, COVID-19 hospital census (confirmed and suspected) peaked at just under 6,000 patients per day, with approximately 30% in the ICU. Hospitals' census typically runs below full licensed-bed capacity, suggesting that influenza demand – and many COVID-19 patients – can be accommodated in the existing health care infrastructure and by supplementing this capacity with a dedicated network of COVID-19 facilities, e.g. a "COVID-19 Surge Facilities Network", dispersed regionally across the State. Facilities that could be appropriate for the COVID-19 Surge Facilities Network (hospitals, skilled nursing facilities, etc.) would be identified as part of "Local Area" (a county or a regional collection of counties) surge planning efforts described below. By including COVID-19 skilled nursing level care sites in the COVID-19 Surge Facilities Network, patient flow across the

continuum can be improved which will decrease acute care lengths of stay and increase acute care capacity to treat patients (COVID-19 and non-COVID-19).

C. APPROACH

1. Overview

The Spring 2020 initial response to COVID-19 involved emptying California's hospitals to make capacity for a *projected* surge in COVID-19 patients of up to 35,000 patients daily. A secondary component included the deployment of COVID-19 dedicated alternative care sites originally targeted at generating another 20,000 beds daily. However, hospital COVID-19 census peaked at 6,000 and there was very little actual patient census in the alternative care sites network. Challenges with the alternative care sites included narrow clinical admission criteria, a lack of patient and transferring physician acceptance, and an overall lack of demand due to the capacity generated in acute care hospitals.

Hospitals demonstrated that they could quickly create capacity through the delay of non-urgent procedures and treatments. Throughout the state, hospital census was reduced by 40-50%. This was effective in meeting the goal of creating capacity but was too expansive and ultimately not needed at that scale. Further, the approach resulted in significant delays in treatment and in chronic and preventive care. Finally, the response has been financially devastating for California's health care system of hospitals and physicians. A similar approach to future COVID-19 resurgences is not viable.

Instead, hospital capacity should be adjusted "real time" through dynamic surge plans developed collaboratively between hospitals and counties or regional collections of counties according to guidelines set by the California Department of Public Health (CDPH). Additionally, it is critical to effectively minimize the potential impacts of influenza and COVID-19 resurgence volumes through: 1) a very aggressive CDPH-led seasonal influenza vaccine public education campaign (and consideration of thoughtful requirements and/or incentives to encourage vaccination), and 2) rapid identification of COVID-19 outbreaks and corresponding activation of more restrictive non-pharmaceutical interventions (NPIs).

2. "Local Area" (County or Regional as Appropriate) Surge Plans

Local health officers would be responsible for convening "Local Area" planning groups consisting of key stakeholders including local hospitals. The critical outputs of the planning groups are:

- Determining if their Local Area Surge Plan will be focused on a single county or on a regional collection of counties (and providers).
- Developing, in partnership with local hospital providers, a Local Area Surge Plan in alignment with CDPH guidelines. Critical elements of the Local Area Surge Plan would include:
    a) Community disease prevalence determination (diagnostic testing) and contact tracing
    b) Triggers for advancement of non-pharmaceutical interventions

c) Determination of *minimum* local inventory targets for local PPE and critical equipment
d) Process for escalation of requests to the state for access to state stockpile inventories to supplement local supplies as necessary
e) Monitoring of Local Area hospitals' individual surge status and Local Area triggers for activation of the COVID-19 Surge Facilities Network and local adjustments to NPIs (see "surge status levels" below)

- Identifying and making available to the state a list of potential facilities (acute care, SNFs, and alternative care sites) that are felt appropriate for potential inclusion in the COVID-19 Surge Facilities Network.
- Local Area Surge Plans should require a letter of support from hospitals in the area.

Local Area Surge Plans would be submitted to CDPH no later than July 31, 2020.

3. Hospital-Specific Surge Plans

Each hospital would update their individual surge plans to incorporate responses to the impacts of COVID-19. These facility specific plans would include consideration of:

a) Clinical volumes (inpatient, surgical and emergency department)
b) Staffing and staffing contingency plans
c) Adequate PPE levels and supply chain contingencies
d) Clinical Prioritization policies around elective procedures and treatments
e) Facilities and operational modifications necessary for effective social distancing, infection control and patient cohorting in their specific healthcare environment.
f) Triggering conditions related to individual hospital specific surge status (green, yellow, orange, red).
g) Mechanisms to flex from historical average census levels by 10% and 20% in existing bed space (while minimizing impact to necessary care for non-COVID patients) and plans for creation of on-site alternative capacity activation as per the definition of Surge Status 4 (Red) below.

Individual hospitals would have responsibility for determining, updating and communicating to their county their surge status. Likewise, the county (or region) would have responsibility for determining the aggregate surge status for the local area based upon the aggregate status of conditions in the local area.

4. COVID-19 Surge Facilities Network

The dynamic surge plans developed in conjunction with counties and hospitals should be augmented by a State of California developed and sponsored network of dedicated COVID-19 treatment facilities that encompass acute care, skilled nursing, and alternative care sites. The network should accommodate up to 3,000 patients per day and be regionally dispersed across the state, aligned with projected demand forecasts.

The COVID-19 Surge Facilities Network needs to be developed in advance of September 30, 2020 due to the anticipated start of the seasonal Influenza period. The network should prioritize the utilization of "traditional" healthcare assets (versus hotels or convention

centers) and should focus on traditional assets that are operating significantly below capacity, or that have been recently closed / converted to non-acute use (perhaps as a result of seismic status). Both hospital and SNF facilities are needed in the COVID-19 Surge Facilities Network. Suggestions for facilities would be sent to the state via the Local Area Surge Plans submitted by July 31, 2020 and the state would then evaluate and finalize the COVID-19 Surge Facilities Network by September 30, 2020.

Given the recent challenges experienced with placement of patients in Imperial County, the likelihood of a resurgence earlier than the fall due to re-opening – coupled with current civil unrest – and challenges experienced this spring in placement of COVID-19 patients requiring skilled nursing levels of care and dialysis treatments, it is expected that there would be strong demand for these facilities. As such, some of these facilities might be operated on an ongoing basis over the next two years (until a vaccine or herd immunity is reached) and others opening as necessary as part of Local Area Surge Status 3 (orange) and higher.

Given that the state does not routinely operate acute care or SNFs (with the limited exception of the California Department of Veterans Affairs' operation of Veterans Homes), it may be most effective to have the state contract with existing hospital or SNF operators to operate facilities in the COVID-19 Surge Facilities Network. The benefit of that approach is that operations of the surge facilities could be more seamlessly integrated into the operational, staffing and IT infrastructure of the operating entity, thus making intermittent deployment more feasible. This approach may also facilitate the ability to bill and be reimbursed for services rendered to patients through existing Medicare provider numbers. The network could also utilize some of the sites developed as part of the Spring 2020 Alternative Care Network, particularly give more time for advance planning and outfitting. These potential sites could include Los Angeles Surge Hospital, Sleep Train Arena in Sacramento, Seton Medical Center, Porterville and Fairview Developmental Centers, and be augmented by others as identified.

A critical element of the COVID-19 Surge Facilities Network would be the ability to staff the facilities completely and effectively. While these facilities may be operated by existing healthcare operators, staffing will likely need to include registry, travelers and the continued availability of staffing through the California Health Corps as essential elements.

5. Hospital Surge Status Levels

Surge status for an ***individual hospital*** would be determined by hospital leadership at that facility related to individual facility capabilities and conditions. A variety of factors (and the confluence of different factors) influence hospital surge status. Some elements for consideration may include the following:

Hospital Level Surge Indicators	Surge Status 1 (Green)	Surge Status 2 (Yellow)	Surge Status 3 (Orange)	Surge Status 4 (Red)
Volume				
% increase from average Census	<10%	10-20%	20-30%	30%+
Available Beds Occupancy Rate	<80%	80-90%	90-95%	95%+
Bed Flex Usage Rate (med/surg to ICU)	<10%	10-20%	20-30%	30%+
Staffing				
Nurse Staffing Ratios	Normal	+1-10%	+10-20%	>20%
Travelers / Registry (% of nursing staff)	<5%	5-10%	10-15%	15%

6. Local Area Surge Status Levels

At a ***Local Area*** level, local health officer(s) and Medical Health Operational Area Coordinator(s) (MHOAC(s) would determine aggregate surge status for the aggregate facilities in the Local Area and community disease prevalence and trajectory.

The following are suggested general definitions for Local Area surge status:

Surge Status 1 (Green)
Hospitals are able to accommodate volumes with existing beds; however, they may need to utilize bed classification regulatory flexibility (ICU/TCU/Med Surg) so as to increase ICU capacity as necessary. ICU beds may need to flex from historical levels of approximately 10% of beds to 30% of beds. All facilities accept COVID-19 patients. Public health indicators such as disease transmission rates are within manageable levels for aggregate Local Area hospital and SNF capacity. It is expected that hospital capacity will be able to flex up by 10% over historical average daily census as is normally done to accommodate seasonal influenza and other patient care needs (Note: As a frame of reference, over the last three years, the hospital census peak in the winter months has been approximately 5% over the other census periods.)

Surge Status 2 (Yellow)
In Surge Status 2, individual hospitals may reach capacity and need to divert COVID-19 patients in order to maintain care for non-COVID patients. The Local Area MHOAC(s) beings to direct patients to other hospitals (if any) in the Local Area that have capacity to care for COVID-19 patients. Counties re-activate some NPI policies (specific actions to be determined in the local surge plan). As aggregate “traditional” acute care capacity is exhausted, hospitals will begin to curtail elective surgery and non-urgent procedural volumes real time as needed to accommodate urgent case volumes within the combined capacity of hospitals in the Local Area, flexing by up to 20% over historical average daily census.

Surge Status 3 (Orange)

Local Area existing hospital capacity is exhausted without limiting medically necessary and time sensitive care for non-COVID-19 patients. Additional capacity is activated (on a regional basis as needed) through the COVID-19 Surge Facilities Network dedicated facilities (acute and SNF) for COVID surge capacity. Hospitals transfer stable COVID-19 patients to the COVID-19 Surge Facilities Network through the *All Access State-wide Transfer Center* that was established in Spring, 2020. At the discretion of Local Area Surge Plans, the EMS system may begin to direct patients (COVID-19 positive or suspected) to the COVID-19 Surge Facilities Network. Local health officers further curtail public activities through more restrictive NPI deployment (specific actions to be determined in the County / Regional surge plan). Through the combined effects of hospital surge plans and the COVID-19 Surge Facilities Network, hospital capacity is flexed by 30%+ over historical average daily census.

Surge Status 4 (Red)

Hospitals deploy additional on-site hospital-based surge capacity as necessary. This includes conversion of hospital public spaces into treatment capacity (auditoriums, cafeterias, parking structures/tents, etc.). The state makes available through the MHOAC program stockpiles of PPE and emergency equipment and supplies obtained for the alternative care sites and federal medical stations in the spring of 2020 (not already deployed into the COVID-19 SNF Network). The state should also provide financial support to hospitals to cover the costs associated with the deployment of the additional on-site surge capacity necessary for Surge Status 4 (red). Local health officers re-activate full NPIs (which may include shelter in place orders for non-essential workers and business closures, as determined by the local health officer). Through these efforts, hospital capacity is flexed by 35%+ over historical average daily census.

D. NEXT STEPS TO IMPLEMENT THIS APPROACH

1. CDPH Guidelines for Local Health Departments and Health Care Facilities on Surge Plans

   CDPH would issue guidelines for local health departments, MHOACs, hospitals, and SNFs to use as they develop Local Area Surge Plans. Local Area Surge Plans should be submitted to CDPH no later than July 31. 2020.

2. Local Area Surge Planning

   Local health officers and MHOACs would determine surge planning geographic areas (a county or a regional group of counties) and develop Local Area Surge Plans (county or regional) in collaboration with local hospital and SNF providers.

3. Active Participation by Hospitals in Local Area Surge Planning

   Hospitals would partner with counties or regional groups of counties to create Local Area Surge Plans and submit letters of support for these plans, if they agree with the Local Area Surge Plan.

4. Health Care Delivery System Provides the Majority of Clinical Care for COVID-Patients and Care for Normal Patient Volumes

The traditional health care delivery system will continue to provide the majority of clinical care including care for COVID-19 patients not treated in the COVID-19 Surge Facilities Network. Hospitals should implement clinically based "resumption of care" plans to minimize the negative impacts of delayed care from Spring 2020. The health care delivery system must ensure the ability to treat normal patient volumes, the annual influenza surge and a significant portion of expected COVID-19 surge. Hospitals would update hospital-specific surge plans to incorporate COVID-19 responses including plans for Surge Status 4 (red) emergency on-site capacity plans.

5. Extend State Waivers to Ensure Effective Hospital Response

   Specifically, the state must extend the regulatory waivers listed in the attached document "***State Waivers Needed to Ensure Effective Hospital Response****."* These include:
   a) maintaining the COVID-19 State of Emergency and key Executive Order provisions
   b) extending regulatory waivers and guidance
   c) revising and extending regulatory waivers and guidance that would be operative when a health care facility experiences a patient surge or staffing shortage.

   All of these regulatory supports are needed through the end of March 2021, given the forecasted combined disease burden of both COVID-19 and seasonal Influenza.

6. State to Stockpile PPE and Critical Equipment

   The state is best positioned to respond to requests for extraordinary amounts of PPE, equipment and emergency staffing that may be needed to respond to local flare-ups in the incidence of COVID-19. This should also include the storage and deployment of equipment and supplies purchased by the state to support the initial establishment of alternative care sites. It is acknowledged that health systems may also have policies in place for PPE stockpiles and may play a role in supporting the individual facilities in their system through centralized supply chain efforts.

7. State Support of COVID-19 Surge Facilities Network, All Access Transfer Center, and California Health Corps

   The state should develop and provide financial support as necessary for the COVID-19 Surge Facilities Network and maintain the All Access Transfer Center to coordinate patient movement to the COVID-19 Surge Facilities Network. The state should also provide financial support to hospitals to cover the costs associated with the deployment of the additional on-site surge capacity necessary for Surge Status 4 (red). The California Health Corps should continue to be directed at staffing stabilization for SNFs and other long-term care sites as well as available for more permanent staffing of the COVID-19 Surge Facilities Network.

8. Continue Ramping Up PCR Testing

The California COVID-19 Testing Taskforce should drive testing capacity to a target whereby specific prioritization can be given to rapid testing of health care patients and staff as necessary to limit unnecessary PPE utilization and assist in patient cohorting. This includes the ability to do screening of all patients upon admission to acute or SNF facilities (for both inpatient admissions and outpatient procedures).

9. CDPH-Led Flu Vaccine Public Health Campaign and Consideration of New Flu Vaccine Requirements

   CDPH should, in partnership with the local health officers, develop and launch an aggressive flu vaccine public campaign for Fall 2020. In addition, CDPH and local health officers should consider new flu vaccination requirements or incentives to drive increased vaccination rates. A reduction in seasonal influenza could significantly bend the curve in terms of the overall need for patient care this coming fall and winter.

10. Responsibilities of County/Regional Collaboration Between Counties

    The deployment of CDPH guidelines occurs at the county or regional level (depending upon demographic, geographic and employment patterns in a particular area) and should be incorporated into Local Area Surge Plans. Counties and local health departments should also be responsible for:
    - Conducting community-wide disease tracking and contract tracing
    - Monitoring public health indicators and determining surge status at the county/ regional level
    - Providing infection control, admission criteria and cohorting policies for SNF/long-term care facilities in partnership with CDPH
    - Overseeing the local EMS system and the MHOAC emergency response systems
    - Determining local area (county or regional) public health guidelines, e.g., determining levels of NPIs in force associated with various surge levels

E. TIMELINE

June – July
- CDPH issues guidelines on Local Area Surge Plans
- Local health officers and MHOACs determine which Local Area Surge Plans will be county-specific and which surge plans will be regional with counties working together
- Complete surge plans aligned with CDPH guidelines and with letters of support from hospitals
- Identification of facilities for inclusion in the COVID-19 Surge Facilities Network
- Determine local inventory levels and state-level stockpile inventory levels for PPE and critical equipment
- State extends waivers needed to ensure an effective hospital response during COVID-19 resurgences

August – September
- Refine and operationalize the COVID-19 Surge Facilities Network (as identified by the state and in the Local Area Surge Planning efforts)

October-November

- CDPH launch of public health campaign encouraging flu vaccinations, in partnership with local health officers

Attachment: State Waivers Needed to Ensure Effective Hospital Response

Planning for COVID-19 Resurgences: State Waivers Needed to Ensure Effective Hospital Response

6/5/20

1. **<u>Executive Orders:</u> The governor's proclamation of emergency must remain in place to authorize the regulatory flexibility hospitals need to respond effectively to patient surges.** With such a proclamation in place, the governor and state agencies can act quickly in changing circumstances to provide flexibility and direction to the health care system as needed to facilitate the provision of high-quality health care for all Californians. **The proclamation of emergency must continue through the end of March 2021, the likely end of California's influenza season. In January, a reassessment should be undertaken, based on conditions and incidence of influenza, on whether the necessary authorities and waivers should be further extended.**

   Specifically, the following Executive Order (EO) provisions must remain in place:

   - Grant of authority to the California Department of Public Health to waive health facility licensing and staffing requirements. (Proclamation of Emergency, 3/4/20; EO N-39-20, 3/20/20)

   - Telehealth waivers. (EO N-43-20, 4/3/20)

   - Direction to the Division of Occupational Safety and Health (Cal/OSHA), the California Department of Public Health, and the Department of Social Services for staff to focus on providing technical assistance and support to health care facilities; to focus enforcement activities where there are allegations of the most serious violations impacting health and safety; and to allow asymptomatic health care workers to continue to work with precautions to prevent transmission. (EO N-27-20, 3/15/20)

   - Grant of authority to the Department of Consumer Affairs, California Department of Public Health, and Emergency Medical Services Authority to waive professional licensure, certification and training requirements and amend scope of practice for health care professionals. Authorizes Emergency Medical Services Authority to allow emergency medical technicians and paramedics to practice in hospitals. (EO N-39-20, 3/30/20)

   - Grant of authority to Emergency Medical Services Authority to authorize out-of-state medical personnel to practice in California; to let paramedics transport patients to facilities other than acute care hospitals. (Proclamation of Emergency, 3/4/20)

   - Waiver of Health and Safety Code Section 123148(b)(1) to allow disclosure of COVID-19 test results electronically to patients before the test is reviewed by the ordering professional, under certain circumstances. (EO N-52-20, 4/16/20)

2. **<u>State Agency Waivers and Directives:</u> In addition to the Governor's proclamation of emergency and executive orders referenced above, certain state agency waivers and guidance documents must remain in place through the end of March 2021.** Other state agency waivers are needed only

when a health care facility experiences a patient surge or staffing shortage. These groups of waivers are described below.

One of the learnings from the COVID-19 response was the effectiveness of statewide blanket waivers, as opposed to facilities submitting individual program flexibilities to state departments. This allowed hospitals to make changes to their operations swiftly. For all of these state waivers, a similar approach of statewide blanket waivers will be important. And as mentioned, when only needed during a patient surge or staffing shortage, those would only be operative for a facility during those situations.

a. **Waiver and Guidance Extensions:** State agency waivers and guidance that must stay in place through the end of March 2021 include:

- California Department of Public Health
  - The current waiver of Title 22 hospital and skilled-nursing facility (SNF) physical space and bed classification requirements (and related application requirements) must remain in effect. This waiver allows hospitals to reconfigure space as needed to separate potentially contagious patients from non-contagious patients, protect staff, and accommodate patient surges. Examples include using surgical suite/PACU space as ICU space, placing acute-care patients in psychiatric beds; and using tents in parking lots. Hospitals should be allowed to keep these configurations in place rather than repeatedly taking them down and setting them back up when needed.
  - Hospitals may again need to suspend scheduled procedures in anticipation of a patient surge. This requires an ongoing waiver of the detailed notification requirements of Health and Safety Code §§ 1255.1-1255.25. Such a waiver will also allow hospitals the flexibility to add capacity and then revert to normal capacity in a timely manner.
  - Ongoing waivers are needed for SNF regulations that limit social distancing and patient cohorting by disease status, such as requirements related to roommate choice, group activities, and visitors.

- Division of Occupational Safety and Health (Cal/OSHA)
  - The current guidance originally released March 28, and as amended April 2, that provides guidance on use of PPE when there are shortages.
  - Direct staff to focus on providing technical assistance and support to health care facilities; to suspend nonessential documentation and reporting requirements, audits, surveys, and other administrative burdens that divert health facility staff from patient care activities; and focus enforcement activities where there are allegations of the most serious violations impacting health and safety.

- Board of Pharmacy.
  - Current waivers related to PPE and sanitizer shortages must be extended until the shortages are resolved.

- The following administrative waivers must remain in place: (1) allow sterile compounding without license renewal; (2) allow receipt of drugs/devices from an out-of-state pharmacy, wholesaler, or third-party logistics provider even if not licensed in California; and (3) allow pharmacists to supervise one additional intern/technician.
- To protect pharmacy staff and patients, the current limited waiver of the pharmacist's duty to provide oral consultation must remain in place.

- Departments of Insurance and Managed Health Care:
  - Continue to require insurers and health care service plans to reimburse health care providers for telehealth services at same reimbursement and cost-sharing amounts as in-person services pursuant to Commissioner Lara's March 30, 2020 Notice and the Department of Managed Health Care's All Plan Letters 20-009 and 20-013.

- Emergency Medical Services Authority:
  - Current waivers of professional licensing requirements must be extended to (1) allow out-of-state health care practitioners to practice in California, including through the use of telehealth technology; (2) allow paramedics to take patients to facilities other than acute care hospitals as appropriate; and (3) allow emergency medical technicians and paramedics to practice in hospitals.

b. **Triggered Waiver and Guidance Extensions:** State agency waivers that are needed only when a health care facility experiences a patient surge or a staffing shortage, and thus must be extended through the end of March 2021, but can be revised to only be operative when triggered, include:

- California Department of Public Health: Guidelines issued by the department on the criteria for health care facilities to consider in determining whether to invoke these flexibilities would provide important direction to the health care delivery system. Trigger criteria could include, but not be limited, to when a hospital is in Surge Status 2 (Yellow), Surge Status 3 (Orange), or Surge Status 4 (Red), and during staffing shortages. In addition, so that the California Department of Public Health could track this usage, notification could be provided by a health care facility to the department's District Office or Central Applications Branch.
  - Suspend Title 22 hospital and SNF staffing requirements, including minimum nurse-to-patient ratios, minimum direct care hours, and detailed documentation of care plans.
  - Suspend requirements for acute care facilities to complete detailed discharge planning documentation as well as requirements to provide non-medical services to homeless individuals pursuant to Health and Safety Code Section 1262.5.
  - Suspend medical record completion timelines in Title 22, California Code of Regulations, Sections 70751(g) and 71551(g) so that clinicians are not diverted from patient care tasks to complete relatively unimportant paperwork.

  - Direct staff to focus on providing technical assistance and support to health care facilities; to suspend nonessential documentation and reporting requirements, audits, surveys, and other administrative burdens that divert health facility staff from patient care activities; and focus enforcement activities where there are allegations of the most serious violations impacting health and safety.

- Board of Pharmacy: Waive requirements to allow: (1) pharmacists to supervise an additional intern/technician; (2) general rather than direct supervision of pharmacist interns; and (3) prescribers to dispense bronchodilators to emergency room patients.

- Department of Consumer Affairs: Suspend: (1) the cap on the number of physician assistants, nurse practitioners, and certified nurse midwives that a physician may supervise must be in place; and (2) the requirement for a physician assistant to have a written practice agreement with a specific physician.