HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

RECOMMENDED MANAGEMENT ACTIONS TO PREPARE HOSPITALS FOR OVERFLOW SITUATIONS

2005 – 2006 WINTER SEASON

WHITE PAPER

REVISED OCTOBER 2005

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SECTION I - INTRODUCTION

For hospitals, the winter season is routinely characterized as the time of high volume and taxing demand. Although we have dodged the bullet over the last several years, even a mild season could have a significant impact. The 2005-06 winter season brings with it increased concern over the potential for an outbreak of avian influenza.

All the preplanning in the world will not eliminate the severe overcrowding that comes with the winter season, but preparation can ease the burden on hospital personnel, medical staff and administration. In order to assist hospitals to better prepare for and cope with region-wide overflow situations, the Hospital Association of Southern California (HASC) developed a list of Recommended Management Actions to Prepare Hospitals for Overflow Situations.

Please note - the Regulatory Flexibility section in the 2005 edition has been revised**.** To make recommendations for future updates please contact Mark Gamble, Regional Vice President, Greater Los Angeles, HASC. Phone: 213/538-0702; email: mgamble@hasc.org.

SECTION II - RECOMMENDED MANAGEMENT ACTIONS: PRE-PLANNING

1. Educate staff on how they can stop the spread of germs at the work place. (See CDC Document -- Attachment 1.)
2. Place "respiratory etiquette" posters and signs in high traffic areas.Signs are available from the Los Angeles County Department of Health Services - Acute Communicable Disease Control Program. Contact Manuel Cruz, health education assistant at 213-240-7941. For more health education information and materials visit online at lapublichealth.org/acd
3. Have boxes of facial tissue, with appropriate trash receptacles, available and placed throughout the ED and holding/waiting areas.
4. Install hand hygiene dispensers, such as alcohol-based hand washing gel, in patient rooms, the ED, holding/waiting areas and other high traffic locations.
5. Based on current and future supply of influenza vaccine, hospitals should consider immunization programs for high risk patients upon discharge; the local community; staff members and physicians (as well as their household members).
6. Hospitals should consider year-round pneumococcal immunization programs for high risk patients upon discharge.
7. Consider the use of antiviral medications as a possible prophylaxis for workers who are unvaccinated and exposed to cases of influenza (See CDC Document – Attachment 2.)
8. Consider the use of FluMist® (a live attenuated influenza vaccine manufactured by MedImmune and licensed for use in well persons ages 5-49) as a possible alternative to the injectable inactivated vaccine. (See CDC Document -- Attachment 3.)
9. Review and update high census procedures prior to the seasonal influx of patients.
10. Pre-plan for flexible use of space within the facility.
11. Develop joint contingency plans with physicians, IPAs, urgent care centers and community clinics, which may include extended and weekend hours.
12. Ensure there are effective procedures for expediting admissions and discharges of patients with the critical care and step down unit’s medical directors, case managers and charge nurses.

SECTION II – CONTINUED…

13. Access the influenza section of CDC website on a regular basis for related updates and information - http://www.cdc.gov/flu/.
14. Access the Los Angeles County Public Health Immunization Program's webpage http://lapublichealth.org/ip/index.htm for further information and materials that may supplement the CDC's - one of which is the newly posted schedules for County flu outreach clinics for Oct 24th - Dec 11th.

SECTION III - RECOMMENDED MANAGEMENT ACTIONS: MEDICAL SERVICES AND EQUIPMENT

1. Consider limiting or postponing elective procedures.
2. Appoint a registered nurse officer to manage patient flow in the ED.
3. Utilize a physician in the ED for rapid medical evaluation (in addition to, or in place of a nurse triage manager.)
4. Work with medical staff and medical groups to extend office hours and ensure that they have adequate call-panel physicians.
5. Increase the number of allied health practitioners at the facility and/or on-call during peak periods.
6. Consider utilizing a separate holding/waiting area for patients presenting with possible flu like symptoms such as fever, upper respiratory complaints, and fatigue.
7. Consider distributing masks to patients who present with flu-like symptoms.
8. Consider utilizing a separate area for patients awaiting admission.
9. Work with medical staff to achieve the most effective allocation of beds.
10. Encourage physicians to discharge patients in the morning instead of the afternoon.
11. Arrange transportation for patients being discharged.
12. Consider utilizing available space to create a “discharge lounge” where discharged patients could await transportation home.
13. Consider alternative resources for high demand equipment such as respirators, gurneys and supply carts, utilizing ReddiNet to query other hospitals regarding availability.

SECTION IV - RECOMMENDED MANAGEMENT ACTIONS: STAFFING CONSIDERATIONS

1. Establish vacation and on-call policies that consider staffing needs during peak seasons.
2. Encourage essential personnel to delay jury duty for the maximum allowable time.
3. Make arrangements with the local colleges and universities that allow for the utilization of additional nursing students during over-flow situations to assist in-patient care areas with non-nursing tasks.
4. Consider clinical use of registered nurses serving in administrative positions.

SECTION V - REQUESTING REGULATORY FLEXIBILITY

It is recommended that the appropriate hospital personnel discuss Title 22 flexibility with the local DHS office *prior* to the winter season. The individuals in the Los Angeles DHS office are:

- Eric Stone, Supervisor – (323) 869-8205
- Beverly Williams, Program Manager – (323) 869-8504
- Facsimile – (323)-890-8753

If an overflow situation occurs after normal business hours, the hospital should handle the crisis in the most appropriate fashion and notify Health Facilities Division at the start of the next business day.

You may be able to expedite Health Facilities Division action on your request by being prepared to address the following issues:

1. Registry has been called and is not available.
2. Transfer opportunity has been sought and is not available.
3. CEO has been notified and all alternative resources have been exhausted.
4. Transfer of lower acuity patients from ICUs and acute areas to appropriate treatment areas.
5. Curtailment of elective surgical and diagnostic procedures.

Earlier editions of the Winter Season White Paper referenced Title 22, Section 70129 as the mechanism for requesting program flexibility. In January 2005 the Department of Health Services, Licensing and Certification clarified the department's position on program flex in a memo from Brenda Klutz. A copy of the memo and the worksheet to request temporary flexibility are in Attachment 4.

SECTION VI - COMMUNITY WIDE COORDINATION AND CONTROL LOS ANGELES COUNTY EMS, PUBLIC HEALTH AND HASC

As part of an overall preparedness plan for dealing with periods of excess demand on emergency services the Department of Health Services, in cooperation with HASC, may implement the following actions:

1. Initiate a tracking system for trending the impact of the winter season on hospitals.
2. If the trend indicates a region-wide crisis and there is no value in diverting ambulances away from emergency departments, the Director of Emergency Medical Services may require all hospitals to maintain an "open" emergency department and no emergency department diversions will be honored. Re-evaluation of this policy would take place every 24 hours until the crisis is over.
3. Public Health may issue advisories regarding the crisis and the appropriate use of emergency departments versus clinics/urgent care centers.
4. As in previous years, HASC may issue press releases to the media in order to disseminate the appropriate messages to the public.
5. EMS may assist in the coordination, transportation and use of supplies/equipment from one hospital to another through the Medical Alert Center via ReddiNet
6. EMS may permit BLS ambulances to honor Emergency Department diversion and transport patients to the next closest facility.
7. HASC, EMS, Public Health, Los Angles County Medical Association, Los Angles County Emergency Medical Directors Association, Community Clinic Association of Los Angeles County and other stakeholders will participate in weekly conference calls to assist in the development of appropriate coordination and response planning to the crisis.
8. HASC will work through established lines of communication with local and state DHS offices, the Board of Supervisors, CHA and all other appropriate stakeholders to assure the best possible coordinated response.

SECTION VII - CONCLUSION

It has been a number of years since Los Angeles County has experienced a major flu season. Unfortunately, the capacity within the health care delivery system has declined to the point where it often seems like a crisis despite the absence of a true event. Should a truly severe winter season occur, all stakeholders will have to collaborate as much as possible to assure the best achievable coordination and outcome for the patients and their families.

HASC would like to acknowledge the countless number of individuals who have provided input and guidance into these recommended management actions, which have been developed with broad input over the past seven years. This is a "living document" and continues to be updated annually and new recommendations are appreciated.

If you have any additional recommendations or questions regarding this White Paper, please contact Mark Gamble, Regional Vice President, Greater Los Angeles, HASC. Phone: 213/538-0702; email: mgamble@hasc.org.

SECTION VIII - ADDITIONAL RESOURCES

1. Centers for Disease Control and Prevention (CDC) web site -- http://www.cdc.gov/flu/
2. Los Angeles County Department of Health Services - Public Health web site -- http://lapublichealth.org
3. California Department of Health Services Division of Communicable Disease Control web site -- http://www.dhs.ca.gov/ps/dcdc/dcdcindex.htm
4. New Jersey Department of Health and Senior Services: Influenza Surge Capacity Guidance for General Hospitals web site -- http://www.njha.com/qualityinstitute/files/1110200432816PM72.pdf

Attachment 1

INFLUENZA (FLU)

Stopping the Spread of Germs at Work

How Germs Spread

Illnesses like the flu (influenza) and colds are caused by viruses that infect the nose, throat, and lungs. The flu and colds usually spread from person to person when an infected person coughs or sneezes.

How to Help Stop the Spread of Germs

Take care to:

- Cover your mouth and nose when you sneeze or cough
- Clean your hands often
- Avoid touching your eyes, nose or mouth
- Stay home when you are sick and check with a health care provider when needed
- Practice other good health habits.

Cover your mouth and nose when you sneeze or cough

Cough or sneeze into a tissue and then throw it away. Cover your cough or sneeze if you do not have a tissue. Then, clean your hands, and do so every time you cough or sneeze.

Clean your hands often

When available, wash your hands -- with soap and warm water -- then rub your hands vigorously together and scrub all surfaces. Wash for 15 to 20 seconds. It is the soap combined with the scrubbing action that helps dislodge and remove germs.

When soap and water are not available, alcohol-based disposable hand wipes or gel sanitizers may be used. You can find them in most supermarkets and drugstores. If using a gel, rub the gel in your hands until they are dry. The gel doesn't need water to work; the alcohol in the gel kills germs that cause colds and the flu. *

*Source: FDA/CFSAN Food Safety A to Z Reference Guide, September 2001: Handwashing (http://www.cfsan.fda.gov/% 7Edms/handwashing).

Avoid touching your eyes, nose, or mouth

Germs are often spread when a person touches something that is contaminated with germs and then touches their eyes, nose, or mouth. Germs can live for a long time (some can live for 2 hours or more) on surfaces like doorknobs, desks, and tables.

Stopping the Spread of Germs at Work
(continued from previous page)

Stay home when you are sick and check with a health care provider when needed

When you are sick or have flu symptoms, stay home, get plenty of rest, and check with a health care provider as needed. Your employer may need a doctor's note for an excused absence. Remember: Keeping your distance from others may protect them from getting sick. Common symptoms of the flu include:

- fever (usually high)
- headache
- extreme tiredness
- cough
- sore throat
- runny or stuffy nose
- muscle aches, and
- nausea, vomiting, and diarrhea, (much more common among children than adults).

Practice other good health habits

Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food. Practicing healthy habits will help you stay healthy during flu season and all year long.

More Facts, Figures, and How-To Ideas

CDC and its partner agencies and organizations offer a great deal of information about handwashing and other things you can do to stay healthy and avoid the germs that cause flu, the common cold, and other illnesses. See Other Resources (http://www.cdc.gov/germstopper/resources.htm) and Posters (http://www.cdc.gov/germstopper/materials.htm) on this Stop the Spread of Germs site for a select listing of Web sites, materials, and contact information.

For more information, visit www.cdc.gov/flu, or call the CDC Flu Information Line at (800) CDC-INFO.

Attachment 2

INFLUENZA (FLU)

GUIDELINES & RECOMMENDATIONS

Influenza Antiviral Medications: 2004-05 Interim Chemoprophylaxis and Treatment Guidelines

October 18, 2004

Influenza antiviral medications are an important adjunct to influenza vaccine in the prevention and treatment of influenza. In the setting of the current vaccine shortage, CDC has developed interim recommendations on the use of antiviral medications for the 2004-05 influenza season. These interim recommendations are provided, in conjunction with previously issued recommendations on use of vaccine, to reduce the impact of influenza on persons at high risk for developing severe complications secondary to infection. The recommendations are not intended to guide the use of these medications in other situations, such as outbreaks of avian influenza. These interim recommendations may be updated as more information on the supply of influenza vaccine and antiviral medications becomes available.

Background
Influenza antiviral medications have long been used to limit the spread and impact of institutional influenza outbreaks. They also are used for treatment and chemoprophylaxis of persons in other settings. In the United States, four antiviral medications (amantadine, rimantadine, oseltamivir, and zanamivir) are approved for treatment of influenza, though limited supplies of zanamivir are currently available. When use for treatment within the first two days of illness, all four antiviral medications are similarly effective in reducing the duration of illness by one or two days. Only three antiviral medications (amantadine, rimantadine, and oseltamivir) are approved for chemoprophylaxis of influenza. **More detailed information about each medication, including dosage and approved persons for use, may be found at http://www.cdc.aov/flu/professionals/treatment.**

2004-05 Antiviral Medications Usage Guidelines
CDC is issuing interim recommendations for the use of antiviral medications during the 2004-05 season. Local availability of these medications may vary from community to community, which could impact how these medications should be used.

1) CDC encourages the use of **amantadine or rimantadine for chemoprophylaxis** and **use of oseltamivir or zanamivir for treatment** as supplies allow, in part to minimize the development of adamantane resistance among circulating influenza viruses.

2) People who are at high risk of serious complications from influenza may benefit most from antiviral medications. Therefore, in general, people who fall into these high risk groups should be given **priority for use of influenza antiviral medications:**

Treatment

- Any person experiencing a potentially life-threatening influenza-related illness should be treated with antiviral medications.

Influenza Antiviral Medications:
2004-05 Interim Chemoprophylaxis and Treatment Guidelines
(continued from previous page)

- Any person at high risk for serious complications of influenza and who is within the first 2 days of illness onset should be treated with antiviral medications. (Pregnant women should consult their primary provider regarding use of influenza antiviral medications.)

Rimantadine is not approved for treatment of children aged < 13 years. For treatment, these persons should receive amantadine (children aged 1-12), oseltamivir (children aged 1-12), or zanamivir (children aged 7-12).

Chemoprophylaxis

- All persons who live or work in **institutions** caring for people at high risk of serious complications of influenza infection should be given antiviral medications in the event of an institutional outbreak. This includes nursing homes, hospitals, and other facilities caring for persons with immunosuppressive conditions, such as HIV/AIDS. When vaccine is available, vaccinated staff require chemoprophylaxis only for the 2-week period following vaccination. Vaccinated and unvaccinated residents should receive chemoprophylaxis for the duration of institutional outbreak activity. Rapid tests or other influenza tests should be used to confirm influenza as the cause of outbreaks as soon as possible. However, treatment and chemoprophylaxis should be initiated if influenza is strongly suspected and test results are not yet available. Other outbreak control efforts such as cohorting of infected persons, and the practice of respiratory hygiene and other measures also should be implemented. For further information on detection and control of influenza outbreaks in acute care facilities, see http://www.cdc.gov/ncidod/hip/INFECT/flu_acute.htm
- All persons at high risk of serious influenza complications should be given antiviral medications if they are likely to be exposed to others infected with influenza. For example, when a high-risk person is part of a family or household in which someone else has been diagnosed with influenza, the exposed high-risk person should be given chemoprophylaxis for 7 days.

3) Antiviral medications can be **considered** in other situations when the available supply of such medications is locally adequate.

- **Chemoprophylaxis** of persons in communities where influenza viruses are circulating, which typically lasts for 6-8 weeks:
  - Persons at high risk of serious complications who are not able to get vaccinated.
  - Persons at high risk of serious complications who have been vaccinated but have not had time to mount an immune response to the vaccine. In adults, chemoprophylaxis should occur for a period of 2 weeks after vaccination. In children aged <9 years, chemoprophylaxis should occur for 6 weeks after the first dose, or 2 weeks after the second dose, depending on whether the child is scheduled to receive one or two doses of vaccine.
  - Persons with immunosuppressive conditions who are not expected to mount an adequate antibody response to influenza vaccine.
  - Health-care workers with direct patient care responsibilities who are not able to obtain vaccine.
- **Treatment** of infected adults and children aged >1 year who do not have conditions placing them at high risk for serious complications secondary to influenza infection.

Influenza Antiviral Medications:
2004-05 Interim Chemoprophylaxis and Treatment Guidelines
(continued from previous page)

4) Where the supplies of both influenza vaccine and influenza antiviral medications may not be sufficient to meet demand, CDC does not recommend the use of influenza antiviral medications for chemoprophylaxis of non-high risk persons in the community.

Private Sector Sources of Influenza Antiviral Medications
Pharmaceutical distributors should be contacted directly for availability and procurement of antiviral medications.

Strategic National Stockpile
The United States has a limited supply of influenza antiviral medications stored in the Strategic National Stockpile for emergency situations. Efforts are underway by Health and Human Services to procure additional supplies of antiviral medications. Some of the supply will be held in reserve in the event of an influenza pandemic. However, some of the supply will be made available to States and Territories for use **in outbreak settings,** as might occur in a hospital or long term care facility.

Requesting Influenza Antiviral Medications from the SNS
Influenza antiviral medications in the SNS can be requested **only by State or Territory Health Departments.** Institutions (hospitals or long-term care facilities) experiencing an urgent need for such medications should convey their request to the State or Territory Health Department.

1. The State or Territory Health Department should call (770) 488-7100, the CDC 24/7 emergency number, to make a request for antiviral medications. A logistics plan is being drafted and will be available to all state and territorial health departments in the near future.
2. The State or Territory Health Department should indicate that there is an urgent priority use situation (as defined previously) that can be addressed by use of antiviral medications, and should indicate that all reasonable efforts have been made to procure influenza antiviral medications from private distributors.

For more information, visit www.cdc,qov/flu or call the National Immunization Hotline at (800) 232-2522 (English), (800) 232-0233 (Espanol), or (800) 243-7889 (TTY).

Attachment 3

Attachment 3

INFLUENZA FLU)

Live, Intranasal Influenza Vaccine: What You Need to Know 2004-2005

1. **Why get vaccinated?**

Influenza ("flu") is a serious disease.

It is caused by a virus that spreads from infected persons to the nose or throat of others.

Influenza can cause:
· fever
· sore throat
· chills
· cough
· headache
· muscle aches

Anyone can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes an average of 36,000 deaths each year in the U.S., mostly among the elderly.

Influenza vaccine can prevent influenza.

2. **Live, intranasal influenza vaccine**

Two types of influenza vaccine are now available, an inactivated vaccine and a live vaccine.

Live, intranasal influenza vaccine (trade-name FluMist) was licensed in 2003. FluMist contains live, attenuated (weakened) influenza virus. It is sprayed into the nostrils rather than injected into the muscle.

Inactivated influenza vaccine, sometimes called the "flu shot," has been used for many years, and is given by injection. It contains killed influenza virus.

3. **Who can get live, intranasal influenza vaccine?**

Live, intranasal influenza vaccine is approved for healthy children and adults from 5 through 49 years of age, including household contacts of most people at high risk for influenza complications. However, Flu-Mist should not be used by people with some medical conditions, pregnant women, or others at risk of influenza-related complications (see Section 4).

4. **Who should not get live, intranasal influenza vaccine?**

The following people should not get intranasal influenza vaccine. They should check with their health care provider about getting inactivated influenza vaccine.

- Adults 50 years of age or older or children younger than 5.

- People who have long-term health problems with:
    - heart disease
    - kidney disease
    - lung disease
    - metabolic disease, such as diabetes
    - asthma
    - anemia, and other blood disorders

- People with a weakened immune system due to:
    - HIV/AIDS or another disease that affects the immune system
    - long-term treatment with drugs that weaken the immune system, such as steroids
    - cancer treatment with x-rays or drugs

- Children or adolescents on long-term aspirin treatment (these people could develop Reye syndrome if they get the flu).

- Pregnant women.

- Anyone with a history of Guillain-Barré Syndrome (GBS).

The flu shot (inactivated vaccine) is preferred over live, intranasal influenza vaccine for physicians, nurses, family members, or anyone else coming in close contact with anyone with a severely weakened immune system (that is, requiring care in a protected environment).

The following people should talk with a doctor before getting either flu vaccine:

- Anyone who has ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine.

- If you have a fever or are severely ill at the time the vaccination is scheduled, you should probably wait until you recover before getting influenza vaccine. Talk to your doctor or nurse about whether to reschedule the vaccination.

5. **When should I get influenza vaccine?**

The best time to get flu vaccine is in October or
November. The flu season can peak anywhere from December through March, but most often peaks in February. So getting the vaccine in December, or even later, can be beneficial in most years.

Most people need only one flu vaccination each year to prevent influenza. But children under 9 years of age getting influenza vaccine for the first time should get 2 doses of vaccine. For the live influenza vaccine, these doses should be 6-10 weeks apart. These children should get their first dose in October or earlier. Children in this age group who got one dose the previous year, even if it was the first time they got the vaccine, need only one dose this year.

Live, intranasal flu vaccine may be given at the same time as other vaccines. This includes other live vaccines, such as MMR or chickenpox. But if two live vaccines are not given on the same day, they should be given at least 4 weeks apart.

Influenza viruses change often. Therefore, influenza vaccines are updated every year, and an annual vaccination is needed.

6. **What are the risks from live, intranasal influenza vaccine?**

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm, or death, is extremely small.

Chances of live influenza vaccine viruses spreading from person to person are very small. Even if such spread should occur, it is unlikely to cause illness.

Live, intranasal influenza vaccine can cause mild symptoms in the recipient (see below).

Mild problems:
Some children and adolescents 5-17 years of age have reported mild reactions, including:
• runny nose, nasal congestion or cough
• fever
• headache and muscle aches
• abdominal pain or occasional vomiting or diarrhea

Some adults 18-49 years of age have reported:
• runny nose or nasal congestion
• sore throat
• cough, chills, tiredness/weakness
• headache

These symptoms did not last long and went away on their own. Even when they occur after vaccination, they may not have been caused by the vaccine.

Severe problems:
• Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

• If rare reactions occur with any new product, they may not be identified until many thousands, or millions, of people have used the product. Like all vaccines, live, intranasal influenza vaccine is being monitored for unusual or severe problems.

7. **What if there is a moderate or severe problem?**

What should I look for?
• Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?
• Call a doctor, or get the person to a doctor right away.

• Tell your doctor what happened, the date and time it happened, and when the vaccination was given.

• Ask your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

VAERS does not provide medical advice.

8. **How can I learn more?**

• Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.

- Call your local or state health department.

- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-2522 (English)
  - Call 1-800-232-0233 (Español)
  - Visit CDC's website at www.cdc.gov/flu

Department of Health and Human Services
Centers for Disease Control and Prevention
National Immunization Program

Vaccine Information Statement
Live, Intranasal Influenza Vaccine
5/24/04

Attachment 4

Attachment 4

California Department of Health Services

State of California—Health and Human Services Agency

Department of Health Services

ARNOLD SCHWARZENEGGER
Governor

SANDRA SHEWRY
Director

January 18, 2005 AFL 04-28

TO: General Acute Care Hospitals

SUBJECT: Increased Patient Accommodations Due To Seasonal or Unexpected High Patient Influx.

BACKGROUND: The Department of Health Services, Licensing and Certification program (DHS L&C) is issuing this letter to clarify DHS L&C's authority to address situations of temporary hospital overcrowding due to a disease outbreak or an unexpected event such as a mass causality incident. This memo describes the regulatory mechanisms that DHS L&C utilizes in an attempt to work with hospitals when they are faced with the problem of temporary hospital overcrowding due to a rapid influx of patients. A "state of emergency" declaration by the local health officer or Governor's proclamation is not necessary in order to use the options described in this memo. This memo also describes hospitals' responsibilities for the planning and management of high patient volume and periods of severe overcrowding.

AUTHORITY: California Code of Regulations, Title 22, §70809 (a), (b), & (c)

- **Increased Patient Accommodation** - Hospitals are expected to take proactive steps as outlined in their own policies and emergency plans to anticipate and manage times of high patient influx. However, when the good faith efforts of the hospital and the local emergency medical services authority (LEMSA) have failed to mitigate the problem of high patient influx, DHS L&C district offices may grant hospitals, after review and when appropriate, temporary permission to exceed their licensed bed capacity. CCR Title 22, §70809 (a) states "No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of a justified emergency when temporary permission may be granted by the director or his designee."

  CCR Title 22, §70809 (b) also states "Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as

provided in paragraph (a) above." Under this provision, DHS L&C district offices may grant hospitals temporary permission to house patients in areas which have not previously been approved for patient care if a justified emergency situation exists, and is in the best interest of patient care to do so.

Additionally, CCR Title 22 §70809 (b) states that "Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use".

The DHS L&C district managers (DOM) may act on behalf of the director, in a justified emergency, to give this temporary permission to hospitals to exceed their licensed bed capacity and/or use hospital space in a manner other than that approved by their license. Hospitals may initiate requests for this permission by phone during business hours. The DOM will then inquire as to the steps taken by the hospital to mitigate the over - capacity problem and may require documentation of the hospital's efforts (see attachment A for a suggested worksheet – "DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet"). As long as the DOM is satisfied that the hospital has done what is reasonably possible under the specific circumstances to handle the situation, then permission to exceed licensed bed capacity and/or house patients in alternative areas will be granted. This permission is time limited and the conditions under which the permission is granted must be specified by the district office. Initially, permission will be granted verbally, followed by written verification from L&C. **Hospital should not assume that permission has been granted until they receive verbal approval from an L&C representative.**

If a hospital requires permission to alter their patient accommodations as described above, and it is outside of business hours, hospitals should contact the Office of Emergency Services (OES) Warning Center at (916) 845-8911 and ask that they notify the DHS Duty officer, who will in turn contact L&C.
Because observation beds in emergency services departments are not counted in the licensed bed capacity of the hospital [CCR T 22 70419(b), 70459(b), & 70657(b)], hospitals are expected to meet their obligations under state and federal laws to provide emergency services without regard for any requests they have or have not made to L&C for increase patient accommodations.

Hospital Responsibility: Hospitals are expected to develop, review and update internal policies and procedures that address their response to periods of high patient volume. These policies and procedures should describe the specific steps that they will take to mitigate and manage situations of patient overcrowding (See Attachment A for some suggested steps).

Additionally, hospitals are expected to pre-plan for the possibility that these mitigation efforts may fail, and to identify, for their facility, when the criteria of a "justified emergency" is met for the purposes of patient accommodations. This criterion may be met when the hospital has exercised every available internal response to avoid and respond to an influx of patients, and is still faced with a temporary overcrowding situation. A "justified emergency" may exist in the absence of a hospital or community disaster; however, the mechanisms described in this letter are temporary emergency measures and will not be permitted as long term solutions for chronic problems of hospital overcrowding.

Whenever possible, hospitals should anticipate when they will be unable to avoid a condition of "justified emergency", and contact the local DHS L&C office in advance for permission to exceed their licensed capacity, and/or house patients in areas that were not previously approved for a specific type of care. "Attachment "B" contains some suggestions of temporary, alternative care environments that may be acceptable to DHS L&C, in a justified emergency, to relieve periods of severe hospital overcrowding. Hospitals should be prepared to describe to DHS L&C why these arrangements are the best possible alternative for patients under the circumstances, and how they will provide for necessary equipment and appropriate staffing in these alternate settings. Temporary permission to use these alternative settings is contingent upon the hospital's ability to ensure that patient safety, care needs, and rights to privacy will be protected at all times.

If you have any questions about this memo, or the enclosed attachment, please call Jocelyn Montgomery, Disaster Preparedness Coordinator, at (916) 552-9365.

Sincerely,

Original Signed by Brenda G. Klutz

Brenda G. Klutz
Deputy Director

Attachment

cc: Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814

California Healthcare Association
1215 K Street, Suite 800
Sacramento, CA 95814

Attachment A
AFL 04-28

DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet

District office: _____ Date: _____
Facility Name: _____
Address: _____
Phone _____ Facility Contact _____
Brief description of Problem: _____
_____
_____
Increased Patient Accommodations requested: _____
_____
_____

Facts to Consider For Increased Patient Accommodation Request:

☐ Reschedule non-emergent surgeries and diagnostic procedures.

☐ Transfer patients to other beds or discharge as appropriate.

☐ Set up clinics for non-emergency cases. (If possible)

☐ Request ambulance diversion from LEMSA.

☐ LEMSA area of operation is impacted i.e. Multiple hospitals on diversion due to hospital overcrowding.

☐ Plan in place for staff & equipment if request is for use of alternate space

Permission Granted: ☐ No ☐ Yes From: ____ To: ____
L&C Staff Sign_____
Comments / Conditions:
_____
_____

Instructions – Permission to increase patient accommodations &/or to house patients in areas which have not been approved for patient housing will be granted only in "justified emergencies" per CCR T 22 § 70809 (a).& (c). Permission will be time limited for a period of time to be determined for each request, depending of the facts presented. Initial approvals are given verbally, and then a signed written approval will be faxed to the facility and the L&C disaster preparedness coordinator (916) 440-7369. A copy of the approval should be filed in the facility folder. This worksheet is an optional form, but the L&C district office, when reviewing these requests, should consider the facts identified above, and all other information deemed relevant by the hospital or the Department under the specific circumstances.

Suggested Alternative Housing for Patients during Hospital Overcrowding Due To a "Justified Emergency"

Licensed In-Patient Area	Type Of Patient Housed
Critical Care Unit (CCU)	Medical/Surgical (M/S) at CCU staffing levels
Medical/Surgical Unit	Critical Care at CCU staffing levels
Obstetrical Unit	Medical/Surgical at M/S staffing levels
Outpatient Areas	**Type of Patient Housed**
Short Stay Care Center Procedure Rooms Recovery Rooms Physical Therapy treatment rooms	Critical care &/or Med Surg patients with appropriate equipment and required staffing
Non Patient Areas	**Types of Patients**
Meeting Rooms Conference Rooms Temporary Structures such as Surge Capacity tents or trailers	Outpatients with appropriate equipment and staffing levels Triage and/or treatment for non acute ER/Trauma patients with appropriate equipment and ER staffing levels

Note – The use of these areas for alternative housing requires prior permission from DHS L&C. Temporary permission is contingent on:
1. Presence of a "justified emergency"
2. Evidence that the hospital can adequately meet patient care needs and protect the health, safety and privacy of the individuals housed in these environments and
3. That providing care in these settings is the best possible alternative given the circumstances of the "justified emergency" situation.