January 9, 2017

Hospitals and medical providers in Washington State are encountering a high number of patients seeking medical care due to flu symptoms. Hospitals are seeking guidance from the Washington State Department of Health related to surge capacity, variances, EMS requirements, etc. The following FAQs were developed by the Department of Health to assist Washington State hospitals in making business decisions in order to meet patient needs. Keep in mind that all legal advice depends on the facts and circumstances of a particular situation. As a result, these FAQs are for informational purposes only and are not intended to serve as specific legal advice. Please refer to your specific hospital emergency preparedness plan for guidance.

Medical Surge: The ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive an event and maintain or rapidly recover operations that were compromised.

Q: Can hospitals extend emergency department care beyond 24 hours for influenza surge capacity?

A: We recognize length of stays will vary during surge times. Although facilities may need to utilize appropriate spaces necessary to address surge capacity, facilities are encouraged to find space(s) for triage, exams, and extended observation other than the emergency department.

Q: Can a hospital set up a screening sight away from the actual hospital campus?

A: Yes, a hospital can establish a temporary location in a building off the hospital campus to screen and triage flu patients. The hospital should have a policy and procedure and protocols for the use of temporary locations, which should also be integrated into their hospital emergency preparedness plan. For the purposes of this FAQ, trauma patients should not be sent to these locations, and should be addressed through the communication plan.

Q: During a flu epidemic can a hospital exceed their approved number of inpatient and/or emergency department beds? Will using extra beds, maybe in hallways, possibly be overlooked during an inspection? Or is there a process to request a temporary increase in beds (and if so, what is the process)?

A: There are times when hospitals become very busy and many resort to placing beds in hallways to manage short term needs, particularly during emergencies or surge situations. It is not uncommon for a hospital to add capacity in this manner. However, hospitals must have the capacity to maintain infection control standards. Most hospitals, on a regular basis, do not operate at licensed bed capacity. The department does not routinely conduct a bed count during hospital inspections, except in the case of critical access hospitals. Critical access hospitals, in order to maintain that designation, are not allowed to exceed their 25 bed limit. In consulting with our CMS counterparts, they share the same understanding.

Patients entering Emergency Departments must be given a medical screening and stabilizing treatment examination even if the facility is at capacity, and even if the patient is subsequently transferred. No patient should be simply turned away once they have presented at an Emergency Department. EMTALA obligations remain in effect.

Q: Do hospitals need to follow a formal process for converting areas necessary to handle surge capacity during the current influenza outbreak?

A: Construction Review Services (CRS) is willing to provide technical assistance to facilities upon request. We also recommend contacting CRS with any questions regarding any proposed change of use related to surge capacity needs. There is no formal CRS process for accommodating surge capacity, however, critical areas may require special review. Critical area include surgery and intensive care.

Q: Who has the authority to make the decision to divert patients to another hospital when resources are temporarily unavailable?

A: A hospital should refer to their diversion policy for the emergency department to divert patients to another hospital.

Q: I want to add "surge capacity" at my hospital to deal with the current flu epidemic, do I have to go through Certificate of Need (CoN) first?

A: If your hospital does not have all its licensed beds set-up and staffed, you do not have to go through CoN to increase the number of set-up beds to equal your licensed beds. If you want to add beds beyond your licensed bed capacity, prior CoN review is required.

Q: Can the Secretary waive the CoN review requirements to increase my hospital's bed capacity beyond its current licensed beds to deal with the current flu epidemic?

A: Not without a formal declaration of an emergency by the Governor. If an emergency is declared and the Secretary waves the CoN review requirements, the waiver would be for only a temporary increase in beds. Once the emergency has passed, the hospital's licensed bed capacity must go back to the previous CoN approved pre-emergency level.

Q: Can a hospital apply for an 1135 waiver under this current situation?

A: The purpose of an 1135 waiver is to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid and CHIP beneficiaries. Health care providers that provide such services in good faith can be reimbursed for them and not subjected to sanctions for noncompliance, absent any fraud or abuse.

An 1135 waiver can be granted only if there is a presidential and HHS Secretary emergency declaration. As of January 9, 2016 there is no declaration.

Q: If a hospital has PPS Exempt Psych or Rehab Units, can those beds be converted to Med Surg beds?

A: If the beds are part of an Inpatient Psych or Rehab PPS Exempt Unit, those beds cannot be used for med surgical patients.

Q: If I have a Certificate of Need (CoN) approved dedicated psychiatric unit and/or rehabilitation unit, can I change the use of the beds in those units to deal with the current flu epidemic on a temporary basis without going through CoN review?

A: A CoN review would not be necessary to use the beds temporarily to deal with the current flu epidemic. However, it would be necessary to provide the CoN program notice of the number of beds, type of bed being temporarily converted to general Medical/Surgical care, and the length of time these beds are to be used for general medical/surgical care. The beds would have to revert to their previous use at the end of the epidemic or the time deadline, whichever occurs last. The CoN program will monitor these temporary bed use conversions.

Q: Can EMS transport individuals to an urgent care clinic rather than to a hospital emergency room when they know resources – beds and people – have been exhausted?

A: Washington rules do not allow EMS to transport patients to urgent care clinics. Patients are encouraged to call their primary health care provider, discuss their symptoms and seek medical advice on whether they need to go to the emergency department.

CMS has no authority in the pre-hospital setting unless the ambulance is owned and operated by the hospital.

Q: What pharmacy implications might I consider?

A: Hospital pharmacies should work with wholesalers to ensure there is an adequate supply of Tamiflu available.

In rural areas, medical staff might consider a collaborative drug therapy (CDT) agreement with pharmacists within their community so individuals have greater access to flu vaccine and/or Tamiflu. This agreement could be time limited.

For questions related to pharmacy, please call the Pharmacy Commission at 360-236-4946.

This is the mailbox for questions specific to CMS requirements: ROSFOSO@cms.hhs.gov

For questions related to long term care facilities, contact: Aging and Long-Term Support Administration