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REGULATORY/BUDGETARY INSTITUTIONAL IMPACTS

What do regulatory requirements for physicians and hospitals look like in a COVID-19 world?

HMC Architects

HEALTH-CARE

Faced with an insurmountable burden due to the COVID-19 pandemic, healthcare systems have experienced an unprecedented impact to their bottom-line operating expenses and have stretched abilities to provide care to their patients.

The impacts were so significant that the American Health Association (AHA) reported that hospital systems have collectively lost over $200 billion from March through May and are estimated to lose up to $350 billion through the end of 2020.

During this time period, lost revenue from elective procedures, additional costs for staff training and overtime, and the costs of additional personal protective equipment (PPE) to protect staff have placed our health providers in a vulnerable spot.

HMC Architects has specialized in the planning and design of healthcare spaces for the last 80 years. Through the lens of research, we are exploring the pandemic as an opportunity to learn, reinvent, and most importantly help our clients amid this crisis, and their financial hardship.

As part of this ongoing research effort, we are committed to sharing our findings with the industry on five main areas of Technology, Adaptability and Flexibility, Regulatory/ Budgetary/Institutional Impacts, Space Needs Restructuring, and Impact to Wellness/Mental Health. In this article, we discuss the regulatory, budgetary, and instututional impacts of COVID-19 in the healthcare sector.

SIGNIFICANT CHANGES ARE UNDERWAY

Significant changes to regulations and guidelines for healthcare facilities are underway as the pandemic has exposed the vulnerabilities of healthcare buildings due to the impact of infectious diseases and required emergency response measures.

The forthcoming changes will fall into two broad categories: regulatory requirements from the Centers for Medicare & Medicaid (CMS) and requirements from state or local agencies such as California's Office of Statewide Health Planning and Development (OSHPD), that enforces code requirements and provides guidance on proposed changes.

These organizations have provided waivers related to operations and access, and the temporary use of space requirements during the pandemic. What is unknown at this time is how these "temporary" measures may be adopted as permanent in anticipation of the next viral outbreak or catastrophic event.

Kaiser Permanente Ontario Medical Center, HMC Architects

CMS PLAYS AN OUTSIZED ROLE

The CMS, in coordination with state licensing agencies, has provided temporary regulatory waivers and new rules effective during the COVID-19 crisis.

The guidance, released in March 2020, will equip the American healthcare system with maximum flexibility to respond to the 2020 novel coronavirus (COVID-19) pandemic and to empower hospitals and healthcare systems to rapidly expand treatment capacity and allow them to separate patients infected with COVID-19 from those who are not affected.

The timeline for these changes was applied immediately across the entire U.S. healthcare system for the duration of the emergency declaration.

The goals of the CMS temporary waivers fall into four primary categories:

- The flexibility of buildings to adopt new uses.
- Adjusting or expanding the healthcare workforce.
- Put patients over paperwork.
- Further expand and promote telehealth in Medicare.

THE FLEXIBILITY OF BUILDINGS TO ADAPT TO NEW USES

Surgery centers can:

- Contract with local healthcare systems to provide hospital services.
- Provide other services typically provided by hospitals such as cancer procedures, trauma surgeries, and other essential surgeries.

Non-hospital buildings and spaces can:

- Be used for patient care and quarantine.

Hospitals, laboratories, and other entities can:

- Perform COVID-19 tests on people at home and in other community-based settings.

Healthcare systems, hospitals, and communities can:

- Set up testing sites exclusively for the purpose of identifying COVID-19-positive patients.

Hospital emergency departments can:

- Test and screen patients for COVID-19 at drive-through and off-campus test sites.

Ambulances can transport patients to:

- Community mental health centers
- Federally qualified health centers (FQHCs)
- Physician offices
- Urgent care facilities
- Ambulatory surgery centers

Physician-owned hospitals can:

- Temporarily increase the number of their licensed beds, operating rooms, and procedure rooms to accommodate a surge of patients.

Hospitals can bill for telehealth:

- Emergency departments can use telehealth to triage patients remotely.
- Most patient care visits can be reimbursed at full CMS rates for services.

> The COVID-19 virus has disproportionately impacted the elderly and those with chronic diseases, particularly those in skilled nursing facilities (SNFs). It is estimated that 40 percent of the COVID-19 deaths in the U.S. have occurred with this population in these facilities.

Hospitals and healthcare systems can adjust or increase their workforce capacity:

- Remove barriers for licensed physicians, nurses, and other clinicians to be hired from the local community.
- Allow physician assistants and nurse practitioners to order tests and medications.
- Allow certified registered nurse anesthetists (CRNAs) to fulfill some physician functions for charting and administrative work.

Put patients over paperwork:

- Coverage of respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need.
- Hospitals are not required to have written policies on visitation of patients in COVID-19 isolation.
- Temporary relief from many audit and reporting requirements.

Promote telehealth in Medicare:

- Approval of 80 additional services to be furnished via telehealth.
- Providers can bill for telehealth visits at the same rate as in-person visits for:
  - Emergency department visits
  - Initial nursing facility and discharge visits
  - Home visits
  - Therapy services
  - Patients in inpatient rehabilitation facilities, hospice, and home health
- Providers can give remote patient monitoring services to patients with acute conditions.
- Physicians can supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.

California's Office of Statewide Health Planning and Development (OSHPD) provides waivers for space use.

These waivers are in effect from April 2020 thru April 2021

- Hospitals may reconfigure space as needed to accommodate patient surge but must restore to their original condition.
- Discharge planning documentation and provision of nonmedical services to homeless individuals are temporarily waived.
- Temporary staff shortage relief for hospitals experiencing COVID-19 related surges.
- Hospitals do not need to submit individual program flexibility requests for the requirements specified above, except when seeking a staffing waiver.
- Will permit temporary accommodations such as medical tents to manage.
- Can increase hospital beds for patients over the amount allowed by five percent.
- The ability to implement policies and procedures to accommodate multiple respiratory patients.
- Approved space conversions and tent uses.
- Authorize the use of tents if the facility has obtained written approval from the local fire authority for tent use.
- Authorize surge tents for use as waiting rooms, to conduct triage and medical screening exams, and provide basic first aid and outpatient treatment.

SKILLED NURSING FACILITIES

The COVID-19 virus has disproportionately impacted the elderly and those with chronic diseases, particularly those in skilled nursing facilities (SNFs). It is estimated that 40 percent of the COVID-19 deaths in the U.S. have occurred with this population in these facilities. Given the spread of COVID-19 in these facilities, there is an emerging need for alternate care sites to accommodate COVID-19 positive residents and long-term changes to mitigate infectious diseases.

For SNFs and other low acuity patients, alternate care sites are permitted:

- Allows alternate care sites for low-acuity care to receive adult patients post-discharge from hospitals and, if needed, from emergency departments for ongoing monitoring.
- Admit individuals from SNFs and congregate living facilities. The patients selected are to be at lower risk and semi-ambulatory.
- All patients should be COVID-19 positive or persons under investigation.

> Agencies are collaborating with the private sector to provide added surge capacity during the pandemic.

Temporary allowances for plastic barriers used for separation from COVID-19 positive areas:

- Allow for the temporary use to protect or shield patients from others.

- Staff are instructed to tear down and remove the barriers in case of a fire or emergency exiting.

CALIFORNIA HOSPITAL BUILDING SAFETY BOARD (HBSB) AND OSHPD

The Hospital Building Safety Board (HBSB) is responsible for providing recommendations to OSHPD for potential code changes. In a June 2020 meeting titled: Potential impacts to healthcare facility design, guidance was provided by the board for recommendations about potential code changes:

Planning and Design

- More airborne isolation rooms.
- Some patient rooms should be adjustable to accommodate negative pressure.
- Some operating rooms to be provided with negative pressure anterooms.
- Permanent changes to convert rooms to negative pressure air flow.
- Evaluation of circulation paths in triage spaces and units.

MEP systems

- UV-C treatment at coils and filters.
- Change relative humidity levels from 40 to 60 percent in some areas.
- Enhance filtration with MERV 13 or 14 as a starting point for design.
- In-room HEPA filtration.
- Evaluation of a minimum of six air changes per hour in a hospital.
- Adjustment of some negative pressure rooms to add HEPA / exhaust ICU space.
- Increased locations of low return exhaust grills.
- Dedicated exhaust path for each toilet stall with an increase to 15/air changes per hour (ACH).

Environment

- Touchless operational components.
- Disinfectant mats at entry.

Relaxation of Code Requirements for Temporary Facilities

- Agencies are collaborating with the private sector to provide added surge capacity during the pandemic in structures that had suspended licenses or were not permanently certified for medical use.
- COVID-19 tents have been placed for triage and assessment of infection risk at many medical centers, which is normally done in a permanent building.
- California collaborated with Dignity Health and Kaiser Permanente to lease, staff and temporarily re-open the closed St. Vincent Medical Center in downtown Los Angeles, in the existing hospital building, providing much-needed surge and ICU capacity.
- Los Angeles County placed temporary trailers in the parking lot at Pomona Valley Hospital Medical Center to treat COVID-19 patients.

SUMMARY
The impacts of the COVID-19 pandemic will be felt for many years to come, which will undoubtedly lead to significant regulatory changes in the industry. Code cycle changes and licensing requirements for the healthcare industry generally take a long time to be adopted, but with so many lives lost in the U.S. there will be an added sense of urgency to evaluate and adopt short term waivers and guidelines to protect healthcare workers and patients for the long term.

We believe the impact will be:

Short term
- Relaxation of CMS rules for flexible use of spaces.
- Reimbursement for telehealth services.
- Diversion of patients to other facilities for treatment.
- Use of non-hospital buildings to care for low acuity care and isolation.
- The flexibility of nursing units to treat multiple acuity levels.
- Uses of tents for treatment and triage.
- Alternate facility sites for treatment of low-acuity or SNF patients.
- Improved interagency communications to make fast decisions.
- Temporary relief from audit and reporting requirements.
- Remote patient monitoring for home care.

Long term
- Promotion and reimbursement for telehealth services.
- Hospital reimbursement for home care treatments.
- Adaptable uses of spaces to convert for higher acuities.
- Fewer restrictions on ASCs to treat patients.
- Remote supervision of clinical staff and patients.
- Relaxation of rules for nurse specialist to perform some physician duties.
- Demountable or permanent tent structures to triage patients outside.
- Use of “alternate care facilities” for low acuity patients.
- Additional airborne Isolation rooms.
- Convertible MEP systems for positive and negative air flows.
- New licensing requirements for SNF and congregate living facilities.
- Air change requirements: humidity levels, air changes/hour, exhaust requirements.
- Touchless operational components.
- Changes in requirements for waiting, dining or other spaces which may be risks for infection transmission.

For additional questions, contact:

Christopher Naughton
Healthcare Practice Leader
christopher.naughton@hmcarchitects.com

Haripriya Madireddi
Designer
haripriya.madireddi@hmcarchitects.com