

Date: November 30, 2020

To: WSHA Members

From Taya Briley, Executive Vice President and General Counsel
Darcy Jaffe, Senior Vice President, Quality and Safety
Chelene Whiteaker, Senior Vice President Government Affairs

Re: **Non-Urgent Procedures Proclamation 20-24.2 – Effective December 3, 2020**

The purpose of this memo is to provide information about the just updated Non-Urgent Procedures Proclamation from Governor Inslee <https://www.governor.wa.gov/news-media/inslee-announces-additional-requirements-health-and-dental-facilities>.

We are very pleased with the amount of progress made from the initial draft of this updated proclamation; the final proclamation represents major changes. The initial drafts of the proclamation – and nearly immediate plan for publication – caused WSHA and other health care associations across the state great concern. Working together we were able to elevate those concerns with the Governor’s Office. As a result, the Governor’s staff slowed the process, held negotiating sessions, and accepted many of our suggestions. We greatly appreciate your engagement in our advocacy.

Below is a summary of significant changes in the new proclamation, which is an update to the proclamation issued May 18, 2020^[1]. This is not a comprehensive review of the proclamation. Some sections remain unchanged from the May 18, 2020 version. While much has improved, some areas of the proclamation remain challenging. We have highlighted areas where we suggest hospital and health systems pay particular attention.

We know this proclamation is coming at a terrible time. Trying to immediately implement a lengthy and convoluted document that threatens operations in the midst of a COVID surge is not ideal. Ironically, many hospitals are already canceling or delaying non-urgent procedures, which is the enforcement hook for many of the new requirements. Notwithstanding, we urge you to do all you can to comply, especially with requirements that are straightforward such as meeting with staff/unions twice monthly to discuss PPE supplies.

We will provide updates and clarifications on implementation of the proclamation as they are available. If you have questions please contact Taya Briley at tayab@wsha.org, Darcy Jaffe at darcyj@wsha.org, or Chelene Whiteaker at chelenew@wsha.org.

Non-Urgent Procedure Proclamation Highlights

Expansion/contraction of care plans remains. As in the original proclamation there is a section that requires providers to have an expansion/contraction of care plan depending on the “care phase” determined by the regional health care coalition. We are currently considered to be in the

^[1] <https://www.governor.wa.gov/sites/default/files/proclamations/20-24.1%20-%20COVID-19%20Non-Urgent%20Medical%20Procedures%20Ext%20%28tmp%29.pdf>

“Contingency Care Phase”^[2]. The Regional Healthcare Coalitions, including REDi and the Northwest Health Care Response Network, are carefully working with the state, WSHA, hospitals, and other stakeholders regarding if, and when a change to “Crisis Care Phase”^[3] is warranted, which would impact ability to deliver non-urgent procedures.

Clinicians may prevent possible harm, even in crisis care phase. Even if Crisis Care Phase is reached it is important to remember that among the types of care that may continue to be provided is non-urgent care, the postponement of which for more than 90 days would, *in the judgment of the clinician*, cause harm. Note that the determination of harm is made by the clinician caring for the patient. It will be important that the clinician can clearly show how that determination was made and that consideration is given to consistency within procedure types so patients with similar clinical profiles are receiving similar treatment. Also important is the detailed statement about the meaning of “harm” found in the first “Additionally” paragraph in the proclamation. There is a bulleted list of criteria to consider^[4], along with a statement about diagnostic imaging, procedures and testing.

Procedures fall into (at least) four categories: A number of the proclamation’s operational requirements are within a section where non-compliance means non-urgent services, procedures and surgeries must be reduced or stopped until compliance is achieved. However, in determining what procedures may be performed, hospitals must consider the type of procedure at hand.

- **Urgent procedures.** The proclamation does not limit the performance of procedures considered to be urgent by clinicians.
- **Non-urgent procedures where there is the possibility of harm.** As noted above, there are restrictions on non-urgent health care and dental services, procedures, and surgeries if certain compliance requirements are not met. However, it is critical to consider the full definition of “non-urgent” which means those procedures, “that, *if delayed, are not anticipated to cause*

^[2] In contingency phase, “All appropriate clinical care can be provided so long as there is sufficient access to PPE and, for hospitals, surge capacity is at least 20%.”

^[3] In crisis care phase, “All emergent and urgent care shall be provided; non-urgent care, the postponement of which for more than 90 days would, in the judgment of the clinician, cause harm; the full suite of family planning services and procedures; newborn care; infant and pediatric vaccinations; and other preventive care, such as annual flu vaccinations, can continue.”

^[4] The proclamation states, “The decision to perform any surgery or procedure in health care, dental and dental specialty facilities and offices should be weighed against the following criteria when considering potential harm to a patient’s health and well-being:

- Expected advancement of disease process
- Possibility that delay results in more complex future surgery or treatment
- Increased loss of function
- Continuing or worsening of significant or severe pain
- Deterioration of the patient’s condition or overall health
- Delay would be expected to result in a less-positive ultimate medical or surgical outcome
- Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
- Non-surgical alternatives are not available or appropriate per current standards of care
- Patient’s co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed”

harm to the patient within the next 90 days.” In determining whether a service, procedure or surgery is non-urgent there must be careful consideration of the meaning of harm, as assessed by the clinician. In our conversations with hospitals about the original proclamation, it became clear that many individuals were applying the limit on non-urgent procedures in a too-limited way that did not fully consider the potential for harm if there was delay.

- **Non-urgent procedures where there is not a possibility of harm.** These are the procedures most subject to restriction. Non-urgent health care and dental services, procedures, and surgeries must be restricted if certain compliance requirements are not met.
- **“Not non-urgent” procedures.** The proclamation also creates a category of procedures considered “not non-urgent.” Specifically included in this category is the full suite of family planning services and procedures and other services. While perhaps not rising to the level of an urgent procedure, these services are also not considered to be non-urgent and occupy a sort of middle ground of procedures that may be performed even if the operational criteria cannot be met. WSHA believes that, depending on the judgment of the clinician, other services and procedures, including potentially screening and preventive services, may fall into this category as well.

Telemedicine can continue. The proclamation was revised to state that telemedicine should be used as permitted by law for the type of care being provided, “in order to facilitate access to care while helping to minimize the spread of the virus to other patients and/or health care workers.” We are pleased the telemedicine language is clearer than in some of the drafts, which could have created prior authorization requirements threatening access to care.

Symptom screening is improved. WSHA is very pleased that after strong advocacy there was an update to the original proclamation’s requirements on fever and symptom screening. Instead of requiring screening on site, the guidance has been aligned with the CDC and screening can take place “**prior to** or immediately upon” entering a facility or practice.

Patient wearing of face masks recognizes EMTALA. Among the new operational requirements in the proclamation is a requirement for patients to wear face masks. WSHA was successful in its efforts to have the state allow hospitals to consider Emergency Medical Treatment and Active Labor Act requirements to screen, stabilize and treat any individual who “comes to the emergency department.” Hospitals can still treat emergency patients who refuse to wear a mask.

Social distancing is reasonable. Original language regarding “strict” social distancing within the facility has been updated to include to apply, “to the greatest extent possible” reflecting the practical challenges of health care facility layouts.

Cleaning matches CDC. WSHA was also successful in realigning the proclamation with CDC guidance on cleaning of facilities. Original drafts referenced undefined “deep cleaning.”

Notification of outbreaks is clearer. WSHA is pleased that the original language regarding reporting requirements has been clarified. Notification to the local health jurisdiction must be made within 24

hours of **identification** of an outbreak as defined in DOH guidance^[5]. Hospitals must make a list of confirmed or suspected cases, subject to privacy considerations.

Exclusion of employees with known or suspected high-risk exposure matches CDC. WSHA is pleased that advocacy to base direction regarding exclusion of employees from work on CDC guidance was successful.^[6]

Specific requirements for hospitals and ambulatory surgical facilities are included. Similar to the operational requirements above for all covered facilities and providers, the below requirements for hospitals and ambulatory surgical facilities must be met or non-urgent services, procedures, and surgeries reduced or stopped.

- **Reporting.** Hospital must submit data to WA Health. This is also a part of the WSHA member commitment to each other – that accurate reporting will be an essential function.
- **Staffing plan requirements.** Following last-minute appeals to the Governor’s Office for clarity this section was significantly improved. It is now clear that personnel for all non-urgent services, procedures and surgeries must be assigned in accordance with the facility’s staffing plan. Original drafts contained language that could have been read to mean these requirements were applicable to all services, procedures and surgeries—including COVID care.
- **Mandatory overtime and breaks exceptions waived – but only for non-urgent procedures.** Unfortunately, the proclamation contains waivers of exceptions to mandatory overtime and breaks requirements in existing law that are protective of patients.^[7] Regarding meal and rest periods, the exception for interruptions related to “unforeseeable emergency circumstance” has been eliminated. Regarding mandatory overtime, the existing exceptions to allow for overtime in a situation with a prescheduled call, when employers use reasonable efforts to obtain staffing or for an unforeseeable emergent circumstance have been deleted. These law waivers have the potential to threaten patient care. However, it is important to remember that if a patient emergency arises that requires staff attention, including one that requires a staff member work overtime or miss a break, the service, procedure or surgery is no longer non-urgent and the exemptions may be applied.
- **Notification of workplace exposures.** For hospitals and ambulatory surgical facilities any known or suspected high-risk workplace exposure requires notification of the employee, and with the employee’s authorization, the employee’s union representative within 24 hours of confirmed exposure. WSHA is pleased that the employee privacy protections were added to this section as well as a reporting requirement after exposure is **confirmed**.
- **Testing after workplace exposures.** Following successful advocacy, testing will be conducted according to CDC guidance. Test results must be available within 24 hours of specimen collection, despite WSHA advocacy that the timeframe be lengthened to 48 hours. We are concerned that given the significant increase in testing per the Governor’s request that people test for the holidays, this turnaround time is unrealistic. You may refer staff to other testing sites if they prefer a faster result than you can deliver.

^[5] See Department of Health Covid-19 Outbreak Definition for Healthcare Settings: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/InterimCOVID-HCOutbreak.pdf>.

^[6] <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

^[7] While the Governor may waive state laws in certain circumstances, this proclamation does not appear to follow the legal requirements for such waiver.

- **Surveillance testing of staff when using contingency or crisis PPE protocols.** For hospitals and ambulatory surgical facilities using contingency or crisis PPE protocols, the proclamation requires implementation of randomized surveillance testing of staff in consultation with the local health jurisdiction. WSHA is mindful this will pose an administrative and supply burden on many hospitals since PPE constraints mean most are operating in contingency. WSHA has asked the Department of Health to convene infectious disease physicians and local public health leaders to develop state-wide guidance regarding the surveillance testing requirement.
- **Priority Issue: Facility/employee/union PPE group.** There is a specific requirement to have a group review current PPE, projected PPE burn rates and projected PPE delivery to understand how it impacts operations. This group must meet twice a month, despite WSHA advocacy that it be allowed to meet at an alternative mutually agreed cadence. Please prioritize scheduling these at your facility. This has been a point of emphasis for union advocates, and it is a straightforward element for enforcers to gauge. Organizations that are doing this report improved alignment with unions members and staff that are participating in the work. We have heard from some of you concerns that your unions will not show for the meetings. At a minimum, you should have proof that you have scheduled the meeting and issued an invitation.

Personal protective equipment: All facilities are prohibited from failing to comply with DOH and LNI guidance on PPE, but it not tied to performance of non-urgent procedures. The final revised proclamation is significantly improved from the initial draft. The initial draft made failure to adhere to PPE guidance from the Department of Health and Labor and Industries a trigger to stop or curtail non-urgent procedures. This was problematic because the guidance as issued does not consider the realities of limited PPE supplies. Additionally, the guidance is in the process of being updated through consultation of DOH, LNI, and infectious disease clinicians. Requiring hospitals to follow guidance in the process of being developed seemed unrealistic. Having the new requirement untethered from automatically stopping or curtailing non-urgent procedures but maintaining the expectation that hospitals follow the law in this area is a reasonable approach.