Temporary Permission for Program Flexibility and for Emergencies

When the Medical Health Coordination Center (MHCC) is activated, Providers and District Offices (DOs) will submit requests to CHCQDutyOfficer@cdph.ca.gov

This form is to be used ONLY for program flexibility requests when providers temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Providers are required to submit a program flexibility request to the California Department of Public Health (CDPH), Center for Health Care Quality for approval. This form is a mechanism to expedite the request directly to the Medical Health Coordination Center (MHCC) for approval in emergency situations.

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx

Facility Name: Kaweah Delta Health Care District

Date of Request: July 8, 2020

License Number: 120000580

Facility Phone: 559-624-2836

Facility Fax Number: 559-625-7523

Facility Address: 400 W. Mineral King Ave.

E-Mail Address: [redacted].org

City: Visalia

State: CA

Zip Code: 93291

Contact Person's Name: [redacted] FNP-C, Vice President

Approval Request

Complete one form total per facility

- [x] Staffing
- [ ] Other
- [ ] Tent use (High patient volume)
- [ ] Bed Use
- [ ] Space Conversion (other than tent use)
- [ ] Over bedding

Duration of Request

Start Date: July 8. 2020

End Date: October 5, 2020

Program Flex Request

What regulation are you requesting program flexibility for? Title 22 CCR 70217

Justification for the Request

- [x] A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.
- [ ] An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

Facility	License Number	Request Date
Kaweah Delta Health Care	120000580	7/8/2020

Justification for the Request

☐ Other:

Exhausting Available Alternatives

The provider must exhaust available alternatives before requesting increased patient accommodations. Check all that apply:

- ☑ Rescheduling non-emergent surgeries and diagnostic procedures.
- ☑ Transferring patients to other beds or discharge as appropriate.
- ☐ Setting clinics for non-emergency cases (if possible).
- ☐ Requesting ambulance diversion from LEMSA, if appropriate.
- ☑ Other: Urgent and Emergency surgeries continue, non-essential are delayed and reschedule

Adequate Staff, Equipment and Space

The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- ☑ A plan is in place for staff if the request is for use of alternate space.
- ☑ A plan is in place for equipment if the request is for use of alternative space.
- ☑ The proposed space for care of patients provides sufficient square footage to ensure access for safe care.
- ☐ Other: Over hiring RN's and Student RN's

Additional Information

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

We are currently experiencing an increase in COVID admissions on average 50+ daily inpatient census, increased quarantine of employees with either known dx of COVID or exposure to COVID, projecting 120 employees impacted per month. Units have been setup as respiratory isolation units for adult medical patients, 2-South, 3-West, Medical ICU, and flexed the Pediatric unit for adult inpatients. Staffing plans limit patient care staff from crossing between respiratory infected patients and other medical and surgical patients. Between March 1-June 29 we have experienced 59 RN resignations/terminations with 47 RN hires.

We are currently using agency staffing, 39-RNs under contract to bridge staffing needs. Actively recruiting graduate RNs, 59, to meet current and future staffing needs. These staff are pending licensing and completion of orientation. Current employed staff are transitioning from support patient care roles to RN positions, 21 in total, as new graduates in the next 30-45 days. Many staff are securing interim permits pending exam dates through the BRN.

Nursing leadership and non-clinical licensed staff will be used to staff surge areas if needed. Department nursing leaders are working on their respective units to allow the charge nurses to take assignments. Surgeries are being limited to urgent and emergent cases, those that severely impacting the patients quality of life and or may result in long term impairment and or disability. Urgent surgeries are defined as those that if delayed will result in severe pain, possible loss of function and or prolonged disability and the inability to perform ADLs. Rescheduling of elective cases that will not decrease a patient's quality of life or create harm from a prolonged delay is being implemented. These determinations are being made by the physician in consultation with the patient.

Operating room staff RN's will be floated to appropriate areas to impact and support inpatient care providers. Post Anesthesia RN's will be trained to perform functions in the step down critical care areas when appropriate.

See attached CV19.100, Inpatient Surge Capacity Plans and attached memo dated 7/6/2020

[redacted] Vice President

Signature of person requesting program flexibility Title

[redacted] FNP-C

Printed Name

NOTE: Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DO; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only

Center for Health Care Quality Approval:

☑ Permission Granted from: 7/10/20 to 9/9/20

☐ Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / Conditions:

CHCQ Printed Name: [redacted]

CHCQ Staff Signature: [redacted]

Date: 7/10/20

L&C District Office Staff Signature Title Date

Kaweah Delta Health Care District

Number: CV19.100	Date Created: 04/06/2020 Date Approved:
Approvers: Interdisciplinary Practice Committee; Medical Executive Committee; Patient Care Policy Approval Committee; Pharmacy and Therapeutics; Standardized Procedures Approval Committee	
Inpatient Surge Capacity Plans	

I. High Level Considerations
   a. Cohort isolation patients to reduce personal protective equipment (PPE) use and optimize processes and resources
   b. Establish multiple contingency plans with ready options that can be implemented based on the volume that presents
      i. Overflow areas for non-isolation patients, surge capacity for isolation patients of all acuity types: medical surgical, intermediate intensive care (ICCU), intensive care (ICU)
      ii. Use existing inpatient care spaces first, then consider other existing patient care spaces (ie. endoscopy, ASC) then open space options (physical therapy gym on 4center, old neonatal intensive care unit-Mineral King 2nd floor)
   c. Negative pressure isolation rooms: BP17, 3W01, ICU01, ICU18, PE05, PE06, PE09, 1417, CVICU 1306, MB 1357, 1517, NICU: 1606, 1607, 1617, Mental Health AP24
   d. Temporary conversion to negative airflow: entire unit of ICU and 3W
   e. See VIII. Process to convert an existing patient care unit to a Respiratory Isolation Unit for additional details

II. Triggers to implement surge plans outlined below- when these triggers are met command center will initiate a conversation with incident commander and/or operations chief to discuss
   a. Convert additional inpatient medical-surgical unit to respiratory isolation when existing unit is down to two beds without ability to transfer, ie. rule outs expecting timely test results
   b. Consider additional critical care capacity when all but two ICU beds are full with no plans to downgrade patients.
   c. Broderick Pavilion-
      i. 3W has 6 rule out/ Positive Covid patients, and/or
      ii. ICCU patient holding in the ED without timely admission plan
   d. Pediatrics (Peds)
      i. 3W, BP, 5T full and additional ICCU capacity needed *begin implementing when BP has 9 patients, and/or
      ii. Additional respiratory isolation ICCU capacity needed, and/or

iii. Med-surg overflow needed to open med-surg respiratory isolation unit, and/or
iv. Critical Care bed space needed and 2W, CVICU, 3W, 5T, BP nearing full *if not already using ICCU takes 24-48 hours to convert

e. 6 AHD beds on 4N- when inpatient bed space is consistently impacted
f. Endoscopy, ASC, PACU, old NICU space when inpatient bed space is becoming impacted
g. Rehabilitation Hospital
    i. Inpatient medical surgical overflow needed, and/or
    ii. Discharge location needed for Covid + acute rehabilitation patient, SNF level Covid + or R/O, or Covid+ dialysis patient needed
h. Mental Health Hospital- all other options exhausted

III. <u>Create additional ICCU capacity</u>

a. Broderick Pavilion (BP), 3East 11 beds
    i. Intent to use as respiratory isolation ICCU. Can also be non-isolation if capacity for respiratory isolation needed on 3West.
    ii. BP and Peds share two air handlers, one for perimeter/patient rooms and one for the interior/nurses stations. Both units are required to be all non-isolation (minus negative isolation rooms) or all respiratory isolation patients with appropriate isolation precautions in place.
    iii. Elective surgical cases go to other post-surgical units
    iv. ICCU level of care- patient type added by J.C..Chamberlain
    v. CDPH notification required
    vi. Patient care staff: existing 3W/CVICCU staff, critical care float pool, team model using trained up medical surgical nurses and other medical surgical nurses as necessary
    vii. Equipment:
        1. Drager bedside monitors installed in each patient room, centralized physiological monitoring added with infrastructure for central monitor at the nurses station, information will cross into EHR, CCE's allow device association for additional patient care equipment, ie. dialysis machines, ventilator. Monitor tech will need to be on BP to monitor
        2. Line Cart added
        3. Tethered MAK scanners installed in each patient care room
        4. Additional supply considerations: BiPap, HiFlo, second glucometer
        5. Medical Surgical supplies- mirror supply list from 3W
        6. For respiratory isolation unit- add PPE
    viii. Pharmacy:
        1. Pyxis configured to mirror 3W, additional IV solutions added
    ix. Specimen collection or other aerosol generating procedure- done in BP17 negative isolation room

b. Pediatrics (Peds), 3East 11 rooms, 12 beds
    i. Adult patient overflow, level of care: medical surgical or ICCU
    ii. Pediatric patients moved to Mother Baby (MB) rooms 1358-1366, 7 individual rooms but up to 11 beds using the suites for 3 patients. The Well Baby nursery can hold an additional 4 babies. If MB is saturated post partum patients would be held on Labor and Delivery, 4 beds in the non-stress test (NST) room, 2 beds in the C-section prep room 2E01 and triage as necessary
    iii. ICCU level of care- patient type added by J.C..Chamberlain
    iv. CDPH notification required
    v. Patient care staff: Med-Surg: existing medical surgical unit float staff, float pool. ICCU: existing 3W/CVICCU staff, critical care float pool, team model using trained up medical surgical nurses and other medical surgical nurses as necessary
    vi. Equipment:
        1. Current rolling physiologic monitors would follow pediatric patients to Mother Baby
        2. For ICCU: Drager bedside physiologic monitors to be installed in each patient room, centralized monitoring to be added with infrastructure for monitor at the nurses station, information will cross into EHR, CCE's ordered to associate additional patient care equipment, ie. dialysis machines, ventilator. Monitor tech will needed on the unit to monitor
        3. For ICCU: Line Cart to be shared with BP or second one added as needed
        4. Tethered MAK scanners exist in each room
        5. Additional supply considerations: BiPap, HiFlo, second glucometer
        6. Medical Surgical supplies
            a. Pediatric supplies relocated to Mother Baby
            b. Pediatric supply room stocked with list mirrored from unit with appropriate patient type
        7. For respiratory isolation unit- add PPE
    vii. Pharmacy:
        1. Mother Baby Pyxis configured for pediatrics, drug relocated
        2. Pediatric Pyxis reconfigured to mirror unit with appropriate patient type
    viii. Specimen collection or other aerosol generating procedure- done in negative isolation room- PE05, 06, 07

IV. <u>Create additional Critical Care Capacity</u>
a. 5T, 24 single patient rooms
b. 4T, 24 single patient rooms *if ICCU level care in demand
c. 3W, 19 single patient rooms, 30 double occupancy if both patients positive or negative
d. 3W20, 3 patients

e. Broderick Pavilion, 11 single patient rooms
f. Pediatrics, 11 single patient rooms, 12 beds if both patients positive or negative in shared room
g. Endoscopy, 8 bays shared space
h. PACU, 11 beds with monitors, shared space

V. Convert existing inpatient units to respiratory isolation units
   a. General considerations: MK rooms can be challenged with power supply, should not plug high draw equipment in neighboring rooms; for units without negative airflow rooms specimen collection processes need to be employed- create a negative isolation room with available equipment (maintenance), move patient to a negative isolation room for specimen collection, or use NIOSH approved configuration for HEPA filter
   b. 2South- 29 beds, staff skilled generalists and in cardiac nursing, short length of stay makes it easy to empty the unit
   c. 2North- 34 beds, on the same floor as 2South, service mirrored on 4T may make it easier to relocate specialty
   d. Other inpatient units depending on volume needed and ease of relocating unit patient type, in no particular order:
      i. 4South, 36 beds
      ii. 4North, 31 beds
      iii. 3South, 35 beds
      iv. 3North, 37 beds
      v. 4Tower, 24 beds ICCU, or ICU
      vi. 5Tower, 24 beds ICCU, ICU or Med-Surg
      vii. 6Tower, 23 beds
         1. NICU patients would have to be transferred to Valley Children's Hospital

VI. Convert existing patient care spaces
   a. General considerations
      i. All areas require CDPH notification
      ii. Review patient type and availability of virtual beds to register patients
      iii. Evaluate available patient care equipment, add adult med-surg supplies, inpatient forms box, evaluate MAK scanners
      iv. Evaluate physical space layout and plan for toileting, supply storage
      v. Open spaces require all patients must be of the same isolation status: either non-isolation or all in the same type of isolation for the same organism
   b. 3W20- 4/5 bays for med-surg, 3 patients for ICCU/ICU. No drain option for dialysis. Current outpatient use, CDPH notification required to flex
   c. Endoscopy, 8 bays
      i. Elective or emergent endoscopy occurs in the OR
      ii. Procedure rooms are negative airflow (not isolation) with HEPA filtering, air is shared with adjacent respiratory office

iii. Pharmacy- Pyxis reconfigured to mirror unit with appropriate patient type
iv. 2 possibilities exist to create ante rooms

d. ASC, 18 bays
   i. Patients would have to be prepped in another location if elective surgeries continued
   ii. ASC staff would be relocated to new prep area or remain to care for patients as competencies allow or in team model if required
   iii. Unit shares air with some surrounding locations- resident break room, offices. We can create an anteroom and turn the entire ASC area into a negative isolation ward. Would require 2 days and four large HEPA filters (maintenance to supply if not already in use).
   iv. 2 bathrooms present- multi patient use or bedside options with central disposal location- rinsing location would need to be established
e. PACU, 14 beds
   i. 11 beds have physiological monitors
   ii. Patients would have to be recovered in another location
   iii. PACU staff would be relocated to new recovery location or remain to care for patients as competencies allow or in team model if required
   iv. Patient care supplies would need to be added
   v. Bathroom is located outside the unit, bedside options used with central disposal location- rinsing location would need to be established
f. 2Center old NICU space, possible 8 bays
   i. Space can be used for any level of care
   ii. Virtual beds and nursing unit needs to be created, approximately 48 hours
   iii. Unit is empty so all patient care equipment and medical surgical supplies would need to be added
   iv. Bathroom is located in the hallway outside the unit, bedside options used with central disposal location- rinsing location would need to be established
   v. Shares air with OB Operating Rooms
   vi. One entry point into the unit for bed/gurneys off interior hallway
   vii. Pharmacy- Pyxis or other medication delivery method needed
g. 6 Acute hemodialysis rooms on 4N
   i. Acute hemodialysis would have to be relocated or achieved at patient bedside.

VII. <u>Convert open space options</u>

a. General considerations
   i. All areas require CDPH notification
   ii. Review patient type and availability of virtual beds and nursing station to register patients

iii. Evaluate available patient care equipment, add adult med-surg supplies, inpatient forms box, evaluate MAK scanners, IT equipment
iv. Evaluate physical space layout and plan for toileting, supply storage

b. 4Center, PT Gym
c. Conference Rooms

VIII. Convert existing patient care spaces off the Main Campus

a. Rehabilitation Hospital, total of 61 beds
   i. Patient registration- virtual beds exist, can add more as needed, cost center established for overflow med surg in this location
   ii. CDPH notification required
   iii. Staffing- existing Rehab staff plus other floats, team model if required
   iv. Patient care supplies- added to meet volume and patient type
   v. Medical staff- no provider onsite after hours, need to identify who will be the primary when patient transfers to Rehab
   vi. Pharmacy- reconfigure Pyxis and add medications based on type of patients expected
   vii. Patient identification- in ideal situation identify patient diagnosis by level of acuity to be transferred to Rehab, triage from bed coordinator, case management, transfer center
   viii. Lab services- currently have routine draws one time per day, add ancillary support as needed for patient type
   ix. Respiratory Therapy- currently have evaluation one time per day, add ancillary support as needed for patient type
   x. EVS, Dietary, Therapies, Security- evaluate current capacity and add support as needed for patient type
   xi. Nursing/Physician Cerner considerations- evaluate Powerplan and Powerchart availability to flex by patient type
b. Mental Health/Acute Psych Hospital, total of 60 beds
   i. Unit is divided into two spaces, East unit 21 rooms, 34 beds, and the West unit 10 rooms,18 beds
   ii. Existing patients at Mental Health would need to be relocated or only one unit can be utilized, patients should not be cohorted together
   iii. Patient registration- add new patient type
   iv. CDPH notification required
   v. Patient rooms
      1. Existing box style beds need to be unbolted form the floor and hospital bed brought in
      2. Minimal electrical outlets in rooms, currently covered with plate
      3. No call light system, oxygen or suction in headwall

4. Patient care equipment needed- pulse oximeters, cardiac monitoring, automated blood pressure machine, bedside tables, patient care curtains or privacy screens
5. Medical surgical supplies- added to mirror inpatient unit with desired patient type
6. Shared bathroom in double occupancy room, door will not accommodate a wheelchair
7. Additional par of linen
8. Pharmacy- Pyxis reconfigured to mirror inventory of inpatient unit with desired patient type
9. IT equipment- multiple WOWs with MAK scanning ability, MAK scanners, Bridge printers if using Bridge
10. Ancillary services
    a. Lab- currently draw routines once per day, add ancillary support as needed for patient type
    b. No existing Respiratory or Physical Therapy onsite
    c. EVS, Dietary, Security, case management, patient family services- evaluate current capacity and add support as needed for patient type
11. Medical staff- Psychiatry onsite during daytime hours, need to identify how emergent physician needs are handled

IX. Process to convert an existing patient care unit to a Respiratory Isolation Unit

a. Define the level of care (LOC) and type of patient that will occupy the unit
b. Identify the unit to transition
    i. Evaluate any airflow concerns with Infection Prevention and Maintenance
    ii. Evaluate power supply limitations with Maintenance for any needed equipment
    iii. Evaluate number of current patients on the unit and type of bed needed compared to available space to move them to. Work with the bed coordinator on available bed capacity.
    iv. If the level of care needs to be adjusted contact JC Chamberlain (ISS Application Analyst) to change bed type-changes are fast but need to cross a midnight to take effect. Contact Ben Cripps to notify CDPH via email at Jean.Chiang@cdph.ca.gov
    v. Identify any additional needed equipment- dedicated equipment is best when possible to avoid cleaning in between patients
        1. Monitoring. Telemetry capability, if centralized monitoring needed work with IT/clinical engineering
        2. Medications- consider existing Pyxis inventory and add as needed for patient type. Contact pharmacy as needed.
        3. Respiratory equipment- respiratory supplies, high-flo, cpap, ventilator

4. Patient care equipment- pulse oximeter availability, MAK scanners, glucometers, dialysis capability and plan, line cart, crash cart type/availability,
5. Med surg supplies- adequate par and type for patient population.
6. IT hardware- monitor integration, CCE for device integration, MAK scanners remote versus tethered
7. Isolation equipment- as below

c. Discuss the transition with the unit staff
   i. Provide the why
   ii. Create a forum for professional questions and support for their concerns
d. Identify the patients needing to be transferred into the unit
   i. Based on LOC and type, contact the unit leaders for a list
   ii. Notify the physicians of patients moved with their new location
e. Identify the patients needing to be transferred off the unit to make room for respiratory isolation patients
   i. Move off all existing patients
   ii. Triage the move by
      1. Who is unsafe to stay?
      2. Who will discharge within 12-24 hours (or the necessary timeframe)?
      3. Evaluate if they can/should stay until discharge
   i. Notify the physicians of patients moved with their new location
f. Communicate the plan for transition with the house supervisor, bed coordinator, and other leaders.
   i. Ensure ancillary departments are aware: EVS, Lab, Therapies, Pharmacy, Case Mgmt, Dietary, Respiratory, Patient Family Services, Central Logistics, etc.
   ii. Discuss plan with dietary for meal tray delivery. Suggest having dietary leave the full meal cart on the unit. Then unit staff will pass out to each patient. When meal time is over, unit staff will then remove all trays and put in meal cart. Dietary will pick up.
   iii. EVS: See if they are able to do more regular non-patient room surface cleaning. Discuss frequency of patient room cleans- should be every other day or third day if possible to conserve PPE
g. Supply and ready the unit- (in addition to #2e)
   i. Check rooms for set up for use as an isolation room
      1. Is there dedicated equipment {BP cuff, MAK scanner, monitor} in the room functional and available to the staff? If not work with maintenance or clinical engineering.
   i. Isolation Supplies
      1. Evaluate if individual door caddies appropriate and feasible. Suggest putting a cart/small table in each alcove or hallway if able with supplies instead of individual rom caddies. Or do a caddy per alcove if cart/tables unavailable.

2. Disposable stethoscopes: leave in room for terminal cleaning at discharge. Notify EVS of this plan
3. Adjust unit par levels as appropriate for the increase in supply need
4. If reusing gowns, will need to use non-permanent hooks in the rooms so staff able to reuse gowns.
5. Masks: find a space for masks to be stored in their paper bags or Gladware type containers, both during shift and from shift to shift. Gladware type containers must have holes poked in the sides for ventilation when stacked. Suggest putting employees name on the container with masking tape so it can be cleaned and reused as needed.

i. Copy/provide isolation signage for patient doors
ii. If negative air flow room not on the unit, evaluate the need to create negative pressure rooms (work with maintenance and IP) OR ensure you have HEPA filters available for specimen collection or Aerosol Generating Procedures following the "COVID-19 PPE GRID".

h. Move the patients in and out
   i. Staff up or find other people that can help with the transition
   ii. Please follow proper PPE guidelines when transferring out of the room to the new floor. Staff: please do not wear gowns and gloves outside the patient rooms, clean gloves on the person who is pushing the isolation patients' wheelchair or gurney. Use wheelchairs whenever possible.

i. Continue to console and empower the staff
   i. Suggest leaders/educators be at change of shift huddle for a few shifts (day and night)
   ii. Phone call check in's when not on the unit
   iii. Encourage other leaders and executives to round on the team for support
   iv. Create a running list of answers to their questions
   v. Try to staff up for the first few days to get through the transitions. The increase need for PPE donning with each interaction takes a considerable amount of time.

DEVELOPED BY: Kari Knudsen, Inpatient Medical Branch Director

APPROVAL: Keri Noeske, Incident Commander

Date: 7/6/2020

To: CDPH Licensing and Certification

From: Kaweah Delta Hospital Incident Command Team

Re: Temporary Permission for Program Flexibility and for Emergencies

This is additional information about our efforts to ensure appropriate staffing during the pandemic crisis while also balancing the financial health and well-being to ensure we can operate throughout the pandemic. Kaweah Delta is impacted as the largest health care provider in our area trying to provide safe and quality care to our community and the surrounding communities. The below information outlines efforts being made to ensure nursing staff is available to maintain ratios, plans to reduce surgery schedules to use the resources needed for patient care and a picture of the financial impact the pandemic has had on the operations of the organization. We are working toward licensed staff being available to maintain ratio expectations but the timeline for these steps in onboarding and training is 2-3 months long, necessitating the request for a program flex.

We are hiring, onboarding, and orienting as quickly as possible and to the extent the organization can absorb the influx of new employees safely. We are hopeful that by the October/November timeframe, we will have stable resources; however, that is dependent on future flu or COVID surges, turnover, leaves of absence, and the availability of travelers.

Currently, Kaweah Delta has approximately 60 RN positions open. We also have open CNA positions. Our recruitment department and nursing leadership are working closely together daily to recruit, onboard and orient new staff. We have increased new hire orientation courses to weekly and set up a safe environment for its delivery.

Here is a timeline from March 1, 2020 to June 30, 2020 of changes made:

- 59 RN terms (averaging 15/month including retirement, COVID avoidance, other jobs, and personal reasons)
- 49 hires and 59 pending RN new hires. Of those, 27 are slated to start in July, and 32 are actively awaiting RN licensure. We have another 100 RN applicants in the queue for interviewing.
- In addition, we have 21 of our own internal staff transferring to RN positions as new graduates within the next 30-45 days (awaiting licensure).
- It should be noted that all new grad hires orient for three months or more, depending upon their specialty.
- Travelers are in process with 10 this week and another 29 in the process of obtaining and/or onboarding.
- L.V.N.'s have been added to units to assist with break and meal period coverage.

- We are also onboarding 31 Student Nurse Interns (last year of nursing school) to act as sitters which allows for C.N.A.'s to fulfill their role
- Leaves of absence are significant. Of the 169 employees who have been positive for COVID, 65 have been Registered Nurses. In addition, with school closures and maternity LOA's, we have approximately 60 to 80 RN's on leave at any given time. Of note is that of our 169 employees who have been or who are positive for COVID, about half have been from a work-related exposure (patient/coworker) and another half are community spread.

Also, recognizing the importance of providing acute care within an acute care setting rather than an alternate care site we have identified surge bed locations and developed plans to care for patients in those areas. We will use non-clinical licensed staff within the hospital to care for those patients should the need to use surge beds arise. We have developed nursing refresher courses for these non-clinical staff to prepare for a surge of patients in the coming months. We have made a request to the county resources for support from their volunteer medical response team to help with staffing needs. We have adjusted surgery scheduling to urgent/essential cases for inpatient bed and staff resource use. In a daily census meeting of all inpatient areas, we monitor the patient volumes, census trends, discharges, barriers and patient needs to make changes in how we perform operations to safely provide patient care. Our incident command team stays closely engaged with the county as well as the skilled nursing facilities in the area to facilitate discharges. Our staffing practice when ratio changes are necessary is to give all charge nurses assignments before having bedside nurses go out of ratio. Ratio changes are limited to one additional patient. Intensive care and intermediate intensive care units are staffed to ratio due to acuity and complexity of care. Medical/surgical ratios, when not adhered to are limited to one over ratio. Beyond that, administration is alerted and action steps are taken to try not to exceed more than one patient out of ratio.

Kaweah Delta Health Care District's experienced a ($28.8M) YTD operating loss for July 2019 to May 2020. This Operating loss is ($46.4M) under budget and our excess margin is ($31.2M) under budget. This has put an incredible financial strain on the entire hospital system causing reductions in hours, limiting resources and elimination of positions in non-clinical areas. The financial lifeblood of our hospital is related to our Surgical Services whose annual Net Revenue is approximately $118M a year and a contribution margin of $20M. We recognize the balance between providing resources for safe patient care and performing surgical services. Since the beginning of our COVID crisis, we have delayed and or canceled 387 surgical cases through the end of May. We will continue to closely monitor the scheduled surgery cases performed by our surgery team and use resources from that team to support shortages in other hospital operations areas but we also need to continue providing our community members with access to surgery services for essential needs.