July 1, 2020

Cara M. Christ, M.D., M.S.
Director
Arizona Department of Health Services
150 North 18th Avenue
Phoenix, Arizona 85007

Dear Dr. Christ:

On March 31, the Arizona Hospital and Healthcare Association (AzHHA) submitted a letter to you on behalf of member and non-member hospitals and hospital systems throughout Arizona. In that letter, we requested waivers of various state regulations that impede the ability of hospitals to fully implement their emergency plans and provide life-saving care to Arizonans during a COVID-19 surge.

We appreciate your staff highlighting a list of regulations that ADHS may be willing to waive on a case-by-case basis, but under the current circumstances, we respectfully request that ADHS issue a single, blanket waiver of certain requirements that take time away from hospitals' most important job: caring for patients and saving lives.

As you know, Arizona is experiencing one of the fastest-growing COVID-19 outbreaks in the nation. Arizona's hospitals will continue to use all resources at their disposal to ensure that all Arizonans have access to health care during this emergency – those with COVID-19 and those with other urgent medical needs. But in order to focus energy on providing optimal care to patients in this public health emergency, hospitals need flexibility with compliance to the usual government-mandated requirements that apply during conventional times. The federal government acknowledged this months ago and has issued a long list of blanket waivers of federal laws and regulations to give hospitals and other providers maximum flexibility during the pandemic.

To facilitate an expedient blanket approval of waivers of state regulations that are burdensome to hospitals, AzHHA has worked with a virtual task force of hospitals and health systems across the state to narrow down our requests from the March 31 letter to only those waivers needed immediately. We respectfully request that ADHS issue a blanket waiver of the following regulations, applicable to all hospitals in Arizona throughout the duration of the COVID-19 public health emergency.

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Waivers Identified by ADHS that may be Expeditiously Approved Upon Request	
R9-10-204(B)(1)(e)	Requirement that hospitals document and evaluate each occurrence of exceeding licensed capacity.
R9-10-207(A)(7)(i)	Requirement that hospitals establish and follow requirements for oral, telephone and electronic orders.
R9-10-212(A)(1)	Requirement to post patient rights language, to the extent that tents or similar temporary or repurposed structures are used to house patients during the emergency.
R9-10-212(A)(2)	Requirement that a patient or patient representative receive written patient rights statements upon admission. (Efforts will be made to provide the information, but it will take up valuable time and resources to sterilize electronic signature pads, and it may not be practical to provide documents to very ill patients.)
R9-10-212(B)(2)(h)	Rule prohibiting seclusion of patients except in emergencies or in behavioral health settings with limitations. (We request that quarantine placement of patients who require hospital care not be considered "seclusion." COVID-19 patients necessarily must be kept in quarantine, in settings that might otherwise be interpreted as seclusion, to avoid spread of the infection. Patients must not be permitted to refuse consent to being placed in quarantine rooms or areas in the hospital or in ancillary locations that provide hospital care for so long as they remain in under hospital care. We further request that such orders may be given verbally with documentation at a later time.)
R9-10-212(C)(3)	Patient's right to receive privacy in treatment and care for personal needs.
R9-10-212(C)(4)	Patient's right to have access to a telephone.
R9-10-212(C)(6)	Patient's right to receive a referral to another health care institution if the hospital is not authorized or able to provide physical health services or behavioral health services needed by the patient.
R9-10-215(2)	Requirement to designate an area for providing surgical services as an organized service. (We request waiver of the provisions of this rule to the extent surgical areas are used for nonsurgical patients under hospital surge expansion plans.)
R9-10-217(A)(1)	Requirement that emergency services be provided 24 hours a day in a designated area of the hospital. (Emergency services may need to be provided in the emergency department and elsewhere as hospitals set up temporary and repurposed patient care areas.)
R9-10-217(D)	Requirement that a hospital ensure that a room used for seclusion in a designated area of the hospital used for providing emergency services complies with applicable physical plant health and safety codes and standards for a secure hold room as described in the American Institute of Architects and Facilities Guidelines Institute, Guidelines for Design and Construction of Health Care Facilities, incorporated by reference in R9-10-104.01.
R9-10-221(1)	Intensive care services are provided as an organized service in a designated area under the direction of a medical staff member.

R9-10-223(A)(1)	Requirement that perinatal services be provided in designated areas of the hospital.
R9-10-228(B)(3)	Requirement that a multi-organized service unit and the beds in it all comply with physical plant requirements in R9-1-412. (To the extent that hospitals are building temporary structures or repurposing structures for temporary surge usage, it likely will be impossible to comply with the ADHS physical plant requirements.)
R9-10-229(5)	Requirement that a patient has privacy when communicating with a personnel member providing social services. (In ancillary bed areas in particular, it may not be possible to provide for privacy.)
R9-10-231(8)	Requirement that nutrition assessments be performed according to policies and procedures.
Additional Waivers Requested by Hospital Clinical Leadership to Meet Patient Surge	
R9-10-206 (3)	Requirement that sufficient personnel members be present on the hospital's premises with the qualifications, skills, and knowledge necessary to provide services, meet patient needs, and ensure the health and safety of patients.
R9-10-206 (4)	Requirement to complete orientation of personnel members within the first 30 calendar days after the members begin providing hospital services.
R9-10-217(A)(5)	Requirement that if emergency services cannot be provided at the hospital, measures and procedures are implemented to minimize the risk until the patient is transported or transferred to another hospitals. (It is doubtful that, during a surge period, other hospitals will be available to accept patients. We anticipate that during surge periods, unorthodox methods of transport and transfer may be necessary, including the use of private vehicles. Hospitals will implement risk minimization strategies to the extent feasible while engaging in rigorous practices to assure that sufficient space and resources remain available for the sickest patients.)
R9-10-221(5)	Staffing requirements for intensive care services.
R9-10-206 (2)	Requirement that personnel members' skills and knowledge are verified and documented before the personnel member provides services in the hospital. (During the emergency, we request that when such personnel are needed to provide services immediately, that verbal assurances of skills and knowledge will suffice and the formal verification of skills may be delayed. The hospitals will follow their disaster plan provisions for assuring that personnel members are assigned within the scope of their skills and knowledge.)
R9-10-208 (1)	Requirement that patients be admitted as inpatients only on the order of a medical staff member. (In some cases, physician assistants and nurse practitioners or other advance practice RNs are not considered medical staff members, and RNs generally are not members of the medical staff, but personnel in any of these categories may have a sufficient skill set to admit infected patients during the surge; physicians would be responsible for such patients once in the hospital.)

R9-10-210	Requirements that the administrator of a sending hospital, and the administrator of a receiving hospital, shall ensure that policies and procedures governing transfers are established, documented, and implemented (Hospitals need flexibility in the method used to safely move patients to ancillary facilities, including increased use of private vehicles.)
R9-10-212(C)(1)	Patient right not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis. (We request assurances that if circumstances require the use of tools to prioritize the allocation of scarce equipment, personnel and beds among COVID-19 patients, that ADHS will not consider such prioritization to constitute discrimination.)
R9-10-212(C)(9)	Patient right to receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights. (We request this waiver to the extent that such assistance requires the personal presence of such individuals on hospital/ancillary premises.)
R9-10-214(C)(2)(b)	Requirement that an acuity plan include an assessment of a patient's need for nursing services made by a registered nurse providing nursing services directly to the patient. (During surge periods, staff may become a scarce resource and hospitals may not be able to meet their own acuity staffing expectations.)
R9-10-214(C)(3)	Requirement that all RNs are knowledgeable about and implement the acuity plan. (To the extent that retired, traveling, or volunteer RNs provide services in the hospital, there may not be time during surge periods to assure that they have such knowledge or implement the acuity plan.)
R9-10-217(A)(4)	Requirement that emergency services are provided to all individuals requesting them. (We expect that hospitals will only have the capacity to provide emergency services to patients who require hospital care, and even then, capacity may be tested. Hospitals need the flexibility to send appropriate patients to lower levels of care (e.g., urgent care) to assure that resources are available to patients with emergent conditions.)
R9-10-221(3)	Requirement that admission and discharge criteria for intensive care services be established. (While these criteria have been established in every hospital, we anticipate it will be difficult or impossible to comply with such criteria consistently during surge periods.)
R9-10-222(1)	Requirement that all respiratory care services be performed under the direction of a medical staff member.
R9-10-222(3)	Documentation requirements for respiratory care services provided to a patient.
R9-10-223(A)(2), (4)	Requirements that only patients in need of perinatal services are allowed in the perinatal services area, and that only medical and surgical services approved by the medical staff may be performed on the perinatal unit.
R9-10-223(A)(5)	Requirement that patients receiving gynecological services are not placed with patients receiving perinatal services. (Perinatal and gynecologic patients may need to be placed together, and if the surge worsens, they may need to be placed with other patients.)

R9-10-224(B), (C)	Requirements that pediatric services are provided in a designated area, that pediatric and adult patients may not share a room, and that pediatric and adult medicines must be stored separately. (Every effort will be made to assure that age ranges are matched, but hospitals need flexibility in addressing scarce bed problems as they expand capacity and beds become scarce.)
R9-10-224(E)	Required procedures for using pediatric beds for adults.
R9-10-225(A)(2)	Requirement that inpatient admitted to an organized psychiatric unit have a behavioral health diagnosis. (Some hospital surge expansion plans may include the use of beds in psychiatric units for other purposes.)
R9-10-225(5)(f-j), (7), (9) - (20)	Seclusion requirements. (We request that the seclusion requirements do not apply to COVID-19 patients.)
R9-10-233(7)(c)	Requirement that equipment used to provide services is only used according to the manufacturer's recommendations. (For example, if ventilators become a scarce resource in Arizona hospitals, personnel may wish to use adapted anesthesia ventilation equipment, provide ventilation to two patients using one ventilator, or other methods of ventilation. These emergency lifesaving measures should not be the source of regulatory violations.)
R9-10-209(A)(4) R9-10-209(A)(5)	Requirement that the patient or patient representative receive written information identifying classes or subclasses of appropriate post-hospital institutions.
R9-10-209(B1-3)	Documentation requirements related to discharge.
R9-10-209(C)	Requirement that discharges are accomplished according to the hospital's policies and procedures.
R9-10-209(D)(1)	Requirement that a medical practitioner who provided services to the patient document a discharge order prior to discharge.
R9-10-206 (5)	Requirement that medical and nursing services personnel must be CPR qualified within 30 days after their start date, and they must maintain current CPR qualification. (We request a 120 day extension for cards expiring through end of June and center discretion for those expiring in July and beyond based on circumstances in the community. The waiver would cover current personnel, retired personnel who assist during the surge, and personnel who are providing services during the crisis whose CPR qualification lapses. Hospitals are concerned that giving up personnel while they obtain re-qualification would deprive patients of needed services during the surge period. Moreover, it is unclear whether CPR certification classes are or will continue to be available).
R9-10-212(B)(2)(a)	Requirement that an administrator ensure that a patient is not subject to abuse or neglect. (We request assurances that, in situations in which scarce equipment, beds or personnel must be allocated among COVID-19 patients and hard choices must be made to save patients, that such choices will not provide grounds to allege that a patient has been subject to abuse or neglect.)

R9-10-228(B)(2)	Requirement that a multi-organized service unit be in compliance with the rules that would apply if each service were offered as a single organized service unit. (Specifically, the waivers requested above, if granted, should apply equally to multi-organized service units.)

The following hospitals and health systems participated in the virtual task force and concur with this letter and the above list of waivers that are needed immediately.

Aurora Behavioral Health Care
Banner Health
Dignity Health
Honor Health
Little Colorado Medical Center
Mayo Clinic
Phoenix Children's Hospital
Summit Healthcare
Tucson Medical Center
Valleywise Health
Northern Arizona Healthcare
Yuma Regional Medical Center
Thank you for your consideration, and we look forward to your response.

Sincerely,

Ann-Marie Alameddin
President and Chief Executive Officer
Arizona Hospital and Healthcare Association

cc: Christina Corieri, Senior Policy Advisor to Governor Doug Ducey
Jami Snyder, Director, Arizona Health Care Cost Containment System