

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 <input type="text" value="Adventist Health Delano"/>			Date of Request <input type="text" value="7/1/2020"/>	
License Number <input type="text" value="120000180"/>			Facility Phone <input type="text" value="661-721-5396"/>	Facility Fax Number <input type="text" value="661-375-5804"/>
Facility Address <input type="text" value="1401 Garces Hwy"/>			E-Mail Address <input type="text" value="[REDACTED]"/>	
City <input type="text" value="Delano"/>	State <input type="text" value="CA"/>	Zip Code <input type="text" value="93215"/>	Contact Person's Name <input type="text" value="[REDACTED]"/>	

Approval Request

Complete one form total per facility

- | | |
|---|---------------------------------------|
| <input checked="" type="checkbox"/> Staffing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tent use (High patient volume) | <input type="checkbox"/> Bed Use |
| <input type="checkbox"/> Space Conversion (other than tent use) | <input type="checkbox"/> Over bedding |

Duration of Request

Start Date	<input type="text" value="07/01/2020"/>
End Date	<input type="text" value="09/30/2020"/>

Program Flex Request

What regulation are you requesting program flexibility for?

Justification for the Request

- 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

Adventist Health Delano

License Number

120000180

Request Date

07/01/2020

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:

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:

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.

Nurses are refusing to care for COVID-19 positive patients, resulting in a lack of staff available to cover the ratios needed. We are utilizing all available options, including staffing pools for the hospital as well as reaching out to corporate for assistance. We are also reaching out to registries. As of today, 7/1/2020, we are over ratio by one patient in our COVID-19 unit. We need to exceed the ratios in order to care for all current inpatients.



 Signature of person requesting program flexibility

Quality Improvement Risk Manager

 Title



 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: 7/1/2020 to 9/30/2020
 Permission Denied: Briefly describe why request was denied in comments / conditions below:
 Comments / Conditions:

CHCQ Printed Name:

CHCQ Staff Signature: _____

Date:



 L&C District Office Staff Signature

HFES

 Title

7/1/2020

 Date