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: Centinela Hospital Medical Center

Date of Request: 07/01/2020

License Number: 930000027

Facility Phone: (310)680-673-4660

Facility Fax Number: (310) 677-0535

Facility Address: 555 E. Hardy Street

E-Mail Address: [redacted]ealthcare.com

City: Inglewood

State: CA

Zip Code: 90301

Contact Person's Name: [redacted]

Approval Request

Complete one form total per facility

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

Duration of Request

Start Date: 07/01/2020

End Date: 10/31/2020

Program Flex Request

What regulation are you requesting program flexibility for? 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).

☐ If you are seeking a staffing waiver, has your facility laid off any clinical staff within the previous 60 days? If so, please explain (**Note:** Attach supporting documentation if necessary)

NO

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.

1. The hospital has experienced a COVID-19 related surge of patients
2- The hospital has experienced a shortage of staffing resulting from COVID-19 IMPACTS
3- The COVID-19 Impact is related but no limited to increasing community spread, increasing need to meet demand for regional surge
4- The hospital has experienced staffing absenteeism for multiple reasons including but not limited to school closures
5- Alternative staffing concepts includes but not limited team nursing which may lead to out of ratio staffing and inclusion of non- nursing personnel to assist with non- clinical care
6- Attached evidence
A) bed capacity expansion/ relocation of patients policy

B) Surge management related to Infection Prevention/Control Policy
C) Surge Capacity Assessment form
D) COVID-19 surge flow form
E) Staffing crisis plan and flow chart
F) Full capacity Procedure Policy
G) List of staffing agencies
H) Aggressive hiring -Open house Wednesday/Daily walk-ins, Utilizing in house corporate recruitment , and hiring new grad program every 12 weeks,
I) Utilizing Travelers/contract agencies to assist with open positions
J) COVID -19 Employee Cases list
K) Opening an Out-Patient Clinic for non- emergent cases awaiting CDPH approval
L) COVID-19 Statistics Update Chart

[redacted] CNO / Administrator

Signature of person requesting program flexibility — Title

[redacted]

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:

[X] Permission Granted from: 8/3/2020 to 11/3/2020

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

Comments / Conditions: This is a temporary approval of the PF request for 90 days effective 8/3/2020.

Thank you

CHCQ Printed Name:

CHCQ Staff Signature:

Date:

[redacted] Program Manager, Nursing 8/4/2020

L&C District Office Staff Signature — Title — Date

[redacted]

Interim Chief Executive Officer

Signature of person requesting program flexibility

Title

[redacted]

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: _____ to _____

☐ 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 Title Date