

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="Coastal View Healthcare Center"/>			Date of Request <input type="text" value="July 23, 2020"/>	
License Number <input type="text" value="050000066"/>			Facility Phone <input type="text" value="(805) 642-4101"/>	Facility Fax Number <input type="text" value="(805) 642-0156"/>
Facility Address <input type="text" value="4904 Telegraph Road"/>			E-Mail Address <input type="text" value="REDACTED"/>	
City <input type="text" value="Ventura"/>	State <input type="text" value="CA"/>	Zip Code <input type="text" value="93003"/>	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="July 24, 2020"/>
End Date	<input type="text" value="October 24, 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	License Number	Request Date
Coastal View Healthcare Ce	050000066	July 23, 2020

Justification for the Request

Other:

Local school closure (no child care) and restricting staff with respiratory symptoms (sick stay

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 calling staff on their days OFF and calling registry but no staff to send due to high den

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.

- Facility will continue to comply with unusual occurrence reporting requirements specified in Title 22 of the California Code of Regulations section 72541.
- Facility will continue to report all changes as required under Title 22 CCR section 72211, to CABLTC@cdph.ca.gov, however the 10-day reporting shall not apply. Facility will report all changes as soon as practical within 30 days of the change. When any temporary beds are no longer in use, facility will report the lowering of patient capacity to CDPH.
- Facility will report any substantial staffing or supply shortages that jeopardize resident care or disrupt operations.
- Facility will continue to provide necessary care in accordance with residents' needs and make all reasonable efforts to act in the best interest of residents. In addition, availability of current PPE supplies will be considered so as to not jeopardize current delivery of care to our existing population.
- Facility will not discriminate admits or readmits, nor transfer or discharge residents based on their status as a suspected or confirmed COVID-19 case. Facility will institute appropriate

- Admissions of COVID -19 patients from the hospital will be screened according to the Public Health Officer ' s, CMS and CDC guidelines as well as in accordance with county and state protocols. COVID-19 admissions must test negative prior to the admission and once on the 14th day of admission. Must not have a fever x 72 hours without use of antipyretic prior to being considered admission to Coastal View Healthcare Center.
- Customer services in the facility will continue by non- licensed personnel who had undergone infection control precaution.
- Facility will continue to seek out staffing replacements in cases of call offs or nursing leave by having a temporary contract with a staffing registry, offer overtime to those staff willing to work, and coordinate workload with the nursing members of the convent.
- Facility will continue to project daily nursing schedule and assignments according to daily census.
- Non Direct care staff will be tapped and assigned in dietary hydration tasks, daily resident activity needs, answering call lights while waiting for help.
- Facility asking that CDPH waive the requirement of 3.5/2.4 for the duration of this event or until we can maintain minimal staffing. Facility will maintain 3.20.
- IDT and the facility medical director will communicate on staffing issues.

[Redacted Signature]

Director of Operations

Signature of person requesting program flexibility

Title

[Redacted Name]

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: July 23, 2020 to October 23, 2020

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

Comments / Conditions:

The Department may revoke the program flexibility if the licensee does not comply with the conditions set forth in the approval or if the Department determines the proposed alternative does not adequately meet the intent of the regulations.

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted Signature]

District Manager

Title

7/23/20

Date

L&C District Office Staff Signature