

### 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](mailto: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			Date of Request	
Desert Regional Medical Center			7/13/20	
License Number			Facility Phone	Facility Fax Number
250000139			760-323-6511	760-323-6725
Facility Address			E-Mail Address	
1150 Indian Canyon Drive			[REDACTED]	
City	State	Zip Code	Contact Person's Name	
Palm Springs	CA	92262	[REDACTED] MSN RN	

**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	7/13/2020
End Date	10/13/2020

**Program Flex Request**

What regulation are you requesting program flexibility for? Title 22 Section 72329.2(a)

**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).

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)

**Justification for the Request**

Other:

We are currently experiencing a surge of COVID positive patients. As of today, 7/13/20, we have 10 COVID positive residents.

**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**

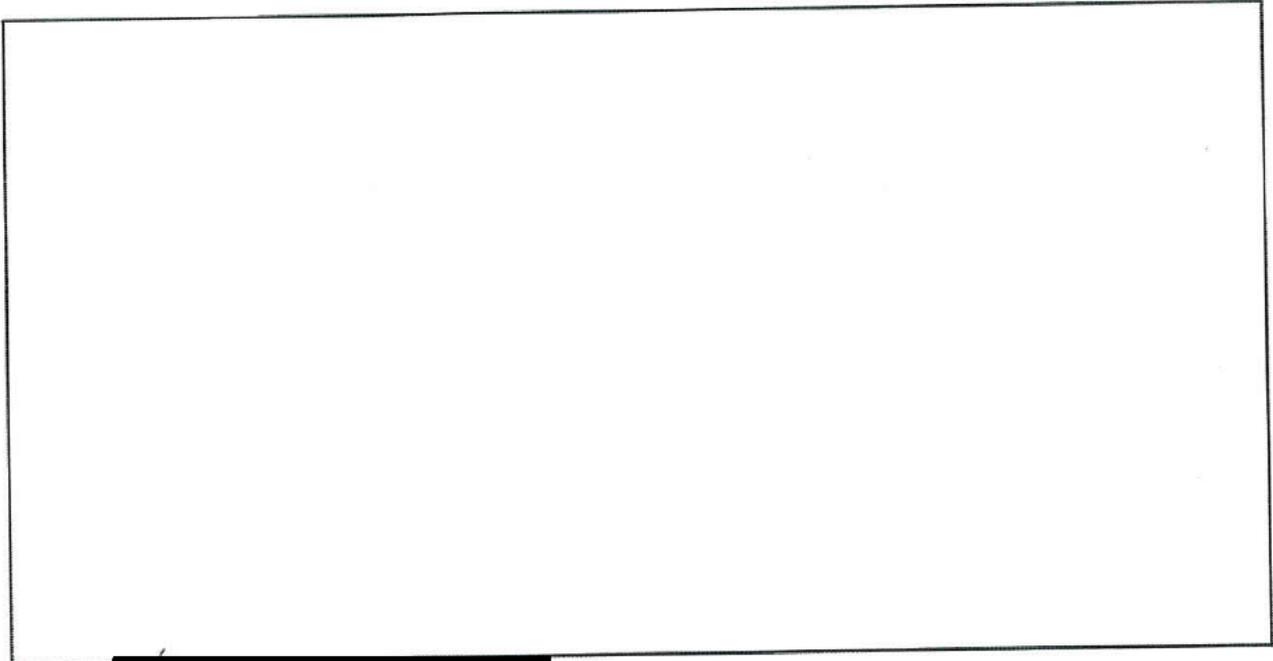
The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- 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.

Due to the COVID pandemic and surge of patients combined with patient care staff currently on leave of absence, 3 nurses out with COVID, 2 nurses recently resigned, we will exceed our normal staffing grid. We are requesting to have one RN and C.N.A, with extra C.N.A. support, care for our COVID positive residents in order to avoid "mixing" staff caring for COVID positive and non-COVID positive residents. A separate break room has been designated for staff caring for COVID positive residents. We have adequate PPE supplies as well. The rest of our Skilled Nursing Facility staffing will be maintained utilizing our normal staffing grid.



[Redacted Signature]

Signature of person requesting program flexibility

Regulatory Manager

Title

[Redacted Printed 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 13, 2020 to October 13, 2020

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

Comments / Conditions: Approval for Title 22 CCR Section 72329.2 (a) with the conditions the facility will maintain 3.2 staffing DHPPD overall.

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted Signature]

RN

L&C District Office Grant Signature

HFEN

Title

July 13, 2020

Date