

## 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

Huntington Drive Health and Rehabilitation C

Date of Request

7/2/2020

License Number

90000057

Facility Phone

626-445-2421

Facility Fax Number

626-821-5916

Facility Address

400 W. Huntington Dr

E-Mail Address

@huntingtondrivehcc.ca

City

Arcadia

State

CA

Zip Code

91007

Contact Person's Name

Administrator

### 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<br>(other than tent use) | <input type="checkbox"/> Over bedding |

### Duration of Request

Start Date 7/1/2020

End Date 10/30/2020

### Program Flex Request

What regulation are you requesting program flexibility for? Title 22 Section 72329.1 and 72329.2

### 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

Huntington Drive Health and

License Number

950000057

Request Date

7/2/2020

**Justification for the Request**

Other:

The restriction of staff with symptoms of COVID 19 and the resurgence of COVID 19 in our co

**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 closure of local services, restrictions of staff that may exhibit COVID related symptoms from returning to work, and the resurgence of COVID-19 in the community that makes it more difficult for us to determine staffing stability we are unable to remedy the situation through staff recall and other staffing solutions. We are asking that CDPH waive the requirement to meet 3.5/2.4 staffing ratio for the duration of this event or until we can maintain stable minimal staffing.

- IDT and the facility medical director will communicate daily on staffing issues.
- Communicate as necessary with CDPH district office regarding staffing levels and follow guidance given by CDPH.
- DON and other assigned RN will assess residents every shift for any change of condition and implement their change of condition policy as needed.
- Social Service Director will communicate with residents frequently and bring any grievances or concerns to the IDT to address.

- Call in any available non direct care staff and assign them duties to assist in resident safety, dietary, hydration and activity needs.
- Continue to exhaust all measure to meet 3.5 and 2.4 staffing requirements.

\_\_\_\_\_  
 Signature of person requesting program flexibility

\_\_\_\_\_  
 Administrator

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:  to

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

Comments / Conditions: This program flex is approved for 90 days effective 8/18/20 to 11/18/20 for regulation Section 72329.2 (all staffing ratios). It is approved with the condition of a minimum 3.2 DHPPD overall staffing.

CHCQ Printed Name:

CHCQ Staff Signature: \_\_\_\_\_

Date:

\_\_\_\_\_  
 L&C District Office Staff Signature

Title

Date