

## 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	
<input type="text" value="Kaiser Foundation Hospital - Zion"/>			<input type="text" value="7-15-20"/>	
License Number		Facility Phone	Facility Fax Number	
<input type="text" value="080000062"/>		<input type="text" value="619-528-5000"/>	<input type="text" value="619-528-5190"/>	
Facility Address			E-Mail Address	
<input type="text" value="4647 Zion Ave."/>			<input type="text" value="██████████@kp.org"/>	
City	State	Zip Code		
<input type="text" value="San Diego"/>	<input type="text" value="CA"/>	<input type="text" value="92120"/>		
Contact Person's Name			<input type="text" value="██████████"/>	

### 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	<input type="text" value="7-15-20"/>
End Date	<input type="text" value="10-15-20"/>

### 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

Kaiser Foundation Hospital

License Number

080000062

Request Date

7-15-20

**Justification for the Request**

Other:

CA Governor's proclamation of emergency dated 3-4-20 COVID-19 Pandemic (patient surge)

**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.

KFH- Zion is requesting a program flex for staffing of the Intensive Care (ICU), Definitive Observation Unit(DOU),and Medical/Surgical/Telemetry (MST), due to the inability to meet the nurse staffing ratios for a prolonged or sustained basis due to COVID-19 volume. Program flex to include the patients that will be staffed according to acuity and bed status regardless of location.

The hospital has taken the following actions to obtain additional ICU, DOU, Telemetry & Med/ Surg staff:

\*\* The hospital has requested a total of 69 travelers for ICU, DOU & Telemetry starting the end of July through mid September.(see attachment - Request for RN Travelers)

\* Agreement reached with union for extra shift incentives for hours worked in excess of the employee's current schedules(This is in addition to applicable overtime and differential provisions.)

\$150 for each additional 8 hour shift  
 \$200 for each additional 10 hour shift  
 \$250 for each additional 12 hour shift

\*The hospital is proposing a "Team Nursing Model" for ICU, DOU, Telemetry & Med/Surg units (see attachments: SD Nursing Roles & Responsibilities and Huddle Message\_Team Nursing)

[Redacted Signature]

Director AR&L

Signature of person requesting program flexibility

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: 8/1/2020 to 11/30/2020

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

Comments / Conditions:

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted Signature]

Health Facilities Evaluator Manager I

July 29, 2020

L&C District Office Staff Signature

Title

Date