

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

Kaiser Foundation Hospital - Downey

Date of Request

July 10, 2020

License Number

93000078

Facility Phone

562-657-4000

Facility Fax Number

562-657-4007

Facility Address

9333 Imperial Highway

E-Mail Address

[Redacted]

City

Downey

State

CA

Zip Code

90424

Contact Person's Name

[Redacted]

Approval Request

Complete one form total per facility

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

Duration of Request

Start Date 07/11/2020

End Date 10/11/2020

Program Flex Request

What regulation are you requesting program flexibility for? 70217 (a)(1)(9)(10)(11)

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)

None

Justification for the Request

Other:

Patient Surge: Governor's proclamation of emergency dated 03-04-20 COVID19 pandemic.

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.

The facility is requesting a program flex for Intensive Care (ICU), Definitive Observation Unit (DOU) and Med/Surg/Tele. Staffing due to the meet the nurse staffing ratios on a prolonged or sustained basis due to COVID-19 volume, current numbers are above normal staffing (surge). Attachment #1 reflects current census. Waivers to include the patients will be staffed according to acuity and bed status regardless of location.

The hospital has made the following efforts to obtain additional staff.

* An agreement with the union has been reached for per diem and part time staff to schedule additional hours in the Intensive Care Unit (ICU), Definitive Observation Unit (DOU) and Med, Surg, Tele Units (MST).

* The facility has taken the following actions to obtain additional staffing for ICU, DOU and MST: see attachment 2. 19A deficit still exists in the number of ICU RNs needed due to a

Agreement has been reached with the union for Extra Shift Incentives for hours worked in excess of their current schedule. This is in addition to applicable overtime and shift differential provisions. The facility is proposing a "Team Nursing Model for ICU, DOU and MST.

Chief Nursing Executive

Signature of person requesting program flexibility

Title

[Redacted Signature]

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: 7/23/2020 to 10/23/2020

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

Comments / Conditions:

Approved for 90 days based on the recommendation of RN PF/Waiver Unit

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted Signature]

Program Manager, Nursing

7/23/2020

L&C District Office Staff Signature

Title

Date