

### 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 <input type="text" value="Kindred Hospital Baldwin Park"/>			Date of Request <input type="text" value="08/07/2020"/>	
License Number <input type="text" value="930000390"/>			Facility Phone <input type="text" value="626-388-2705"/>	Facility Fax Number <input type="text" value="626-388-2788"/>
Facility Address <input type="text" value="14148 Francisquito Avenue"/>			E-Mail Address <input type="text" value="██████████@kindred.com"/>	
City <input type="text" value="Baldwin Park"/>	State <input type="text" value="Ca"/>	Zip Code <input type="text" value="91706"/>	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 (other than tent use) | <input type="checkbox"/> Over bedding |

**Duration of Request**

Start Date	<input type="text" value="08/07/2020"/>
End Date	<input type="text" value="10/01/2020"/>

**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).

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)

No we have not laid off any staff.

**Justification for the Request**

Other:

High demand for patient beds and availability of licensed staff to meet the challenge.

**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 amount of referrals that we are receiving from Acute Care Hospitals and the Community to care for COVID19 patients, we want to be a good partner and support in any way that we can. We are utilizing registry nurses and travel nurses to assist with staffing as they are available. In addition, we are offering incentives for staff to pick up extra shifts but still are faced with staffing challenges.

*Handwritten notes in the box:*  
 Please see attached letter  
 8/10/2020

Signature of person requesting program flexibility \_\_\_\_\_ Title \_\_\_\_\_  
*Handwritten:* 08/07/2020

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: 8/10/2020 to 11/10/2020

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

Comments / Conditions: Based on the recommendations by the RN Waiver-Program Flex unit, this was approved for 90 days effective 8/10/2020.

CHCQ Printed Name: \_\_\_\_\_

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

Date: \_\_\_\_\_

L&C District Office Staff Signature \_\_\_\_\_ Title Program Manager, Nursing Date 8/10/202