

### 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

Kindred Hospital Riverside

Date of Request

8/25/2020

License Number

250000234

Facility Phone

951-436-3535

Facility Fax Number

951-436-3478

Facility Address

2224 Medical Center Drive

E-Mail Address

[Redacted]@kindred.com

City

Perris

State

CA

Zip Code

92571

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   
 End Date

#### 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

**Justification for the Request**

- Other:

Current impact of COVID-19 has significantly increased staff absenteeism. This is seen by an increase in call-offs due to illness and/or fear of caring for COVID patients. The other issue is an increase in the number of staff on a LOA due to a positive COVID-19 illness.

**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 hospital has experienced an increase in census and COVID-19 positive patients. With this, there has been a significant increase in staff absenteeism due to illness, fear of caring for COVID-19 positive patients, and LOA's for being COVID positive themselves. Currently we have 8 COVID positive patients, which is over 20% of our patients with our census at 38. For staff, we currently have 28 employees COVID positive and 3 PUIs. With being a 40 bed Long Term Acute Care facility, that amount of employees has a significant impact to our ability to staff the nursing units.

In regards to our specific staffing mitigation strategies, we follow our Provision on Care, Staffing Plan, and policy on the Influx of People with Infectious Diseases (please see supporting documentation). We continue to try all avenues to obtain needed staff through calling our own staff, Kindred Central Staffing, staff from other Kindreds, and staffing agencies. With all of these resources, staffing remains an issue and a challenge.

On a daily basis we continue to update and send in status reports to CDPH, Riverside County EOC, and HHS. These reports include patient census, COVID positive and PUI patients and staff, and staffing challenges.

Proposed nurse ratios when we are unable to get staff would be:

ICU: 3:1

Med/Surg: 6:1

### Chief Clinical Officer

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: August 27, 2020 to November 27, 2020

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

Comments / Conditions: The CHCQ Duty Officer has received your program flex request and has forwarded the request to the Riverside D.O. for review/approval. Your program flex request for Title 22 (a)(1) staffing, along with the provided supportive documentation has been reviewed and approved effective date August 27, 2020, through COB November 27,2020.

CHCQ Printed Name: [Redacted]

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

Date: [Redacted]

[Redacted Signature]

HFES

8/27/20

L&C District Office Staff Signature

Title

Date