

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 | | | Date of Request | |
| <input type="text" value="LAC/Olive View-UCLA Medical Center"/> | | | <input type="text" value="7/22/2020"/> | |
| License Number | | | Facility Phone | Facility Fax Number |
| <input type="text" value="060000133"/> | | | <input type="text" value="747-210-3300"/> | <input type="text" value="747-210-3011"/> |
| Facility Address | | | E-Mail Address | |
| <input type="text" value="14445 Olive View Drive"/> | | | <input type="text" value=""/> | |
| City | State | Zip Code | Contact Person's Name | |
| <input type="text" value="Sylmar"/> | <input type="text" value="CA"/> | <input type="text" value="91342"/> | <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="07/04/2020"/> |
| End Date | <input type="text" value="03/01/2020"/> |

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)

Justification for the Request

Other:

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 currently operating under its surge operational plan due to the COVID-19 pandemic. As such, we request temporary flexibility to initiate Team Nursing protocols for inpatient services (see attached request submitted 7/22/2020). Due to the COVID pandemic, our facility is experiencing an increase of staff shortages and an influx of acutely ill patients who require a higher level of care. The flexibility to adjust our staffing patterns to Team Nursing will ensure appropriate and safe levels of patient care across the facility at all times. Please note, we have not experienced layoffs in the last 90 days and we have requested staffing support from our local public health department, but they are unable to fulfill that request due to staffing needs related to the pandemic.


 Signature of person requesting program flexibility

Director of Regulatory Affairs
 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:

CHCQ Printed Name:

CHCQ Staff Signature: _____

Date:


 L&C District Office Staff Signature

Title

Date