

### Temporary Permission for Program Flexibility and for Emergencies

When the MHCC is activated, Providers and DO's 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 (CHCQ) 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 LAC+USC Medical Center			Date of Request July 17, 2020	
License Number 060000130			Facility Phone 323-409-2800	Facility Fax Number 323-441-8030
Facility Address 1200 N. State Street, IPT Room C2K100				
E-mail Address [REDACTED]@lacounty.gov				
City Los Angeles	State CA	Zip Code 90033	Contact Person Name [REDACTED]	

#### 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:	July 17, 2020
End Date:	October 17, 2020

#### Program Flex Request

What regulation are you requesting program flexibility for? CCR Title 22, §70217 Nursing Service Staff (a)

#### 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).

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**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 alternate space.
- The proposed space for care of patients provides sufficient square footage to ensure access for safe care.

Other: 

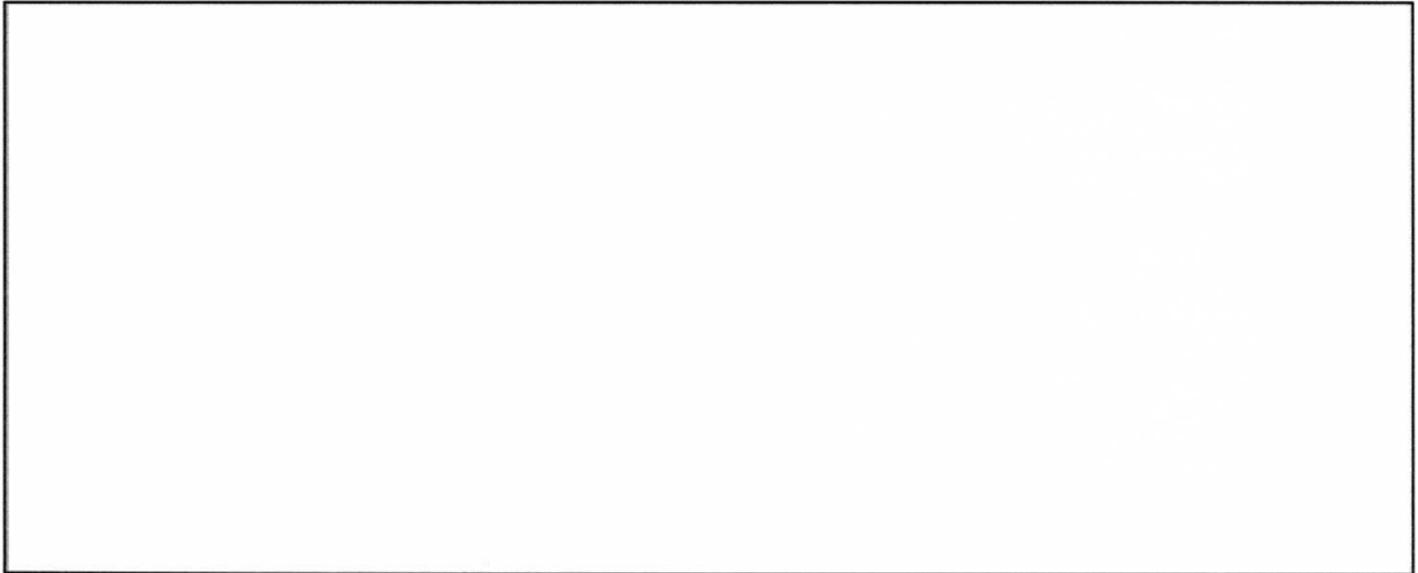
See attached information

**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.

Request for Program Flex for nurse-to-patient ratio.

See attached for additional information



[Redacted Signature]

Digitally signed by Victoria E. Walsh, RN  
Date: 2020.07.17 11:49:38 -0700

Director, Regulatory Affairs

Signature of person requesting program flexibility

Title

[Redacted 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: 7/1/20 to 8/30/20

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

Comments / conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CHCQ Printed Name:

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

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

[Redacted Signature]

District Manager

7/22/20

L&C District Office Staff Signature

Title

Date