

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

Pacific Coast Post Acute

Date of Request

7/8/20

License Number

070000130

Facility Phone

8314248072

Facility Fax Number

8314246329

Facility Address

720 E. Romie Lane

E-Mail Address

[REDACTED]@com

City

Salinas

State

CA

Zip Code

93901

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 7/1/20

End Date 9/28/20

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
 L & C DIVISION
 SAN JOSE
 AUG 12 2020

Program Flex Request

What regulation are you requesting program flexibility for? Title 22 - section 72329.1 and 72329.2

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 lay offs in the past 60 days.

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.

Due to the closures of our local school districts and the restriction of symptomatic staff from the facility, we have a shortage of qualified direct care staff and we can not remedy the situation through staff recall and other staffing solutions. This situation has worsened with the recent surge in Monterey County and Covid19 outbreak in our facility. We are asking that CDPH waive the requirement to meet 3.5/2.4 for the duration of this event or until September 28, 2020 (90 days from July 1, 2020) or until we can maintain minimum staffing.

-IDT, including the facility Medical Director, will communicate pertinent updates regarding staffing levels

-We will communicate with CDPH district office regarding staffing levels and follow guidance given by CDPH

-The DON and other assigned RN Supervisors will assess residents every shift for any

-Social Service Director will communicate with residents frequently and bring any grievances or concerns to the IDT to address

-Call in any available non-direct care staff and assign them duties to assist in resident safety, dietary, hydration, and activity needs.

-Continue to exhaust all measures to meet 3.5 and 2.4 staffing requirements

-Notify residents and responsible parties of staffing plan and changes as needed.


 Signature of person requesting program flexibility

Administrator

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

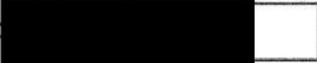
Center for Health Care Quality Approval:

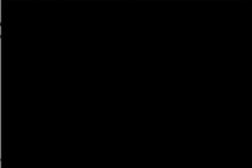
Permission Granted from: 7/1/2020 to 9/28/2020

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

HFEH2
 Title

8/12/2020
 Date