

### 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  
Victorian Post Acute

Date of Request  
7/16/2020

License Number  
220000077

Facility Phone  
415 922-5085

Facility Fax Number  
415 922-5335

Facility Address  
2121 Pine St

E-Mail Address  
[Redacted]

City State Zip Code  
San Francisco CA 94115

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 7/1/2020  
End Date 10/1/2020

#### Program Flex Request

What regulation are you requesting program flexibility for? Minimum Staffing requirement 3.5, 2.4  
72329.1 & 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)

Facility has not laid off any clinical staff within the previous 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: We have partnered with registry companies.

**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 spread of the Novel Corona Virus (COVID-19) we ask for a program flex waiver for the minimum staffing requirements of 3.5 and 2.4 for nursing and CNAs respectively. While we are staffing accordingly at this time and have made partnerships with registry and sister facilities, we ask for this waiver in the event that a sufficient number of our workforce are too sick to work or in the event of mass absenteeism due to the fear factor of working in a COVID+ facility.

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Signature of person requesting program flexibility

Administrator  
Title

[Redacted] 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: 7/28/20 to 10/27/20

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

Comments / Conditions:

*Please ensure to implement your Mitigation Plan.*

CHCQ Printed Name: [Redacted]

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

Date: [Redacted]

[Redacted] L&C District Office Staff Signature

HFEM II  
Title

7/28/20  
Date