

### 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 West Hills Hospital			Date of Request 8/6/2020	
License Number 930000189			Facility Phone 818-676-4000	Facility Fax Number 818-704-3880
Facility Address 7300 Medical Center Drive			E-mail Address [REDACTED]@e.com	
City West Hills	State CA	Zip Code 91307	Contact Person Name [REDACTED]	

#### Approval Request

Complete one form total per facility

#### Duration of Request

- Staffing
- Tent use (High patient volume)
- Space conversion (other than tent use)
- Other
- Bed use
- Over bedding

Start Date: 8-6-2020  
End Date: 10-2020 or end of pandemic outbreak

#### Program Flex Request

What regulation are you requesting program flexibility for? Licensing

#### 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).

<b>Facility Name</b>	<b>License Number</b>	<b>Request Date</b>
West Hills Hospital and Medical Center	930000189	8-06-2020

**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: Local and national registry utilization

**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:

**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 COVID-19 Pandemic has caused undo stress to our facility, West Hills Hospital. The increase in active and PUI COVID-19 cases as well as staff exposure, requiring furlough and staff needing to call off due to community acquired COVID- 19 is taxing our available staffing resources. This problem has been exacerbated by the closure of schools and day cares in Los Angeles County and local Skilled Nursing Facilities denying admissions due to COVID-19 staff issues. We are working to create alternate care locations to provide additional Intensive Care capacity to meet the rapidly increasing demand for care and to meet the health care needs of our community. The increasing volume is in turn creating demand for critical care staffing. West Hills Hospital is requesting program flexibility be granted to increase RN to patient ratios for the following levels of care: increase ICU RN to patient ratio to 1:3, increase Telemetry Rn to patient ratio to 1:5, increase Med/Surg Rn to patient ratio to 1:6, and ED RN to patient ratio to 1:6. These ratio variations will only be used when we experience a rapid influx of patients and/or lack of staffing to make meeting Title 22 standards impossible. A review of acuity will be factored into each decision to provide care outside of Title 22 standards and patients will continue to be assigned based on acuity to minimize care impact. To accommodate an increased need for critical care beds, West Hills Hospital is requesting to relocate up to 8 Burn ICU beds to the Burn Med/Surg unit. This would then allow expansion of our regular ICU into the BICU to care for COVID-19 patients.

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\_\_\_\_\_  
Signature of person requesting program flexibility

CNO  
\_\_\_\_\_  
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: 10/7/2020 to 1/7/2021

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

Comments / conditions: Based on conditions indicated on the e-mail from CDPH RN Alex and

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CHCQ Printed Name: \_\_\_\_\_

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

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

\_\_\_\_\_  
L&C District Office Staff Signature

Prog. Manager Anne 10/7/2020  
\_\_\_\_\_  
Title Date