

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

Windsor Post-Acute Healthcare Center of Md

Date of Request

08/11/2020

License Number

100000038

Facility Phone

209-577-1055

Facility Fax Number

209-550-3619

Facility Address

2030 Evergreen Ave

E-Mail Address

[Redacted]

City

Modesto

State

CA

Zip Code

95350

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 07/10/2020

End Date 10/08/2020

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

Justification for the Request

Other:

We are experiencing challenges meeting the 3.5/2.4 requirements as a result of having positive COVID-19 cases in our facility among both residents and staff.

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.

We are experiencing challenges meeting the 3.5/2.4 requirements as a result of having positive COVID-19 cases in our facility among both residents and staff. Since our baseline testing on June 3, 2020, where we found our first positive COVID-19 cases, we have had a total of 30 staff take a personal leave of absence or resign, including leadership roles of the Director of Nursing, Assistant Director of Nursing, Director of Staff Development, as well as the Social Services Director. At this time, those positions have been replaced. Registry companies are being utilized, but this has proven to be difficult and a slower on-boarding process, as many registry staff candidates have left California to work in other states. Recruiting has been a challenge as all nursing homes are looking for staff and most healthcare school programs are not graduating students at this time.

To incentivize staff to continue working in the facility, and recruit new staff, the facility is offering "Hero Pay" of an additional \$2/hour for the non-COVID units and an additional \$5/hour for the "Red Zone" (COVID-19 positive unit). Also, a \$100 bonus is offered every pay period for perfect attendance, on top of the already bonus applied for perfect attendance each month. We have utilized 12-hour shifts in the Red Zone to reduce the amount of staff needed in rotation there, but it has been a divisive challenge to implement in the entire facility, as much of our staff is limited with their abilities to extend beyond 8-hour shifts given their personal childcare needs. Many staff have also left in seeking the unemployment benefits that have been offered through the government.

Administrator

Signature of person requesting program flexibility

Title

[Redacted Signature]

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:

See conditions as listed in approval email.

CHCQ Printed Name:

CHCQ Staff Signature: _____

Date:

[Redacted Signature] *RN AFEM*

L&C District Office Staff Signature

Title

Date