

### 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 [CHCCDutyOfficer@cdph.ca.gov](mailto:CHCCDutyOfficer@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/CHCC/LCP/Pages/DistrictOffices.aspx>

|  |                    |                          |  |  |
|--|--------------------|--------------------------|--|--|
| Facility Name<br><b>Woodland Memorial Hospital</b> |                    |                          | Date of Request<br><b>July 10, 2020</b>    |  |
| License Number<br><b>03000115</b>                  |                    |                          | Facility Phone<br><b>530.669.5318</b>      | Facility Fax Number<br><b>530.668.9833</b> |
| Facility Address<br><b>1325 Cottonwood Street</b>  |                    |                          | E-Mail Address<br><b>[REDACTED]</b>        |  |
| City<br><b>Woodland</b>                            | State<br><b>CA</b> | Zip Code<br><b>95695</b> | Contact Person's Name<br><b>[REDACTED]</b> |  |

**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 **July 7, 2020**  
End Date **October 9, 2020**

**Program Flex Request**

What regulation are you requesting program flexibility for? **Staffing Ratio Waiver**

**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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- 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)

Yes, when surgical procedures were suspended during the anticipated surge of COVID-19, staff were furloughed. Our hospital returned to normal operations in May 2020, however now that we are experiencing a significant surge in COVID-19 patients we are limited with staffing.

**Justification for the Request**

- Other:

Our facility is currently in phase 3 of our surge plan with our ICU and Med-Surg COVID-19 unit near capacity. 367 new COVID-19 cases in Yolo County in the last 14 days.

**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 requesting program flex in response to COVID-19 and the need to adjust staffing ratios based on increased volumes, decreased workforce and the inability to obtain additional resource support to manage patient care. With an increase in both sick calls and leave options being utilized to care for family members related to school closures, caring for elderly relatives, or being part of the affected group recommended for isolation, alternative staffing solutions may be necessary. Temporary staffing options will be attempted; however, there is concern about national shortages and the need for secure staff support many months in advance. There is an inability for us to obtain adequate additional commitments. We are currently experience a patient surge, currently we are in phase 3 of our surge plan, and expect these conditions to continue to worsen based on projections from other countries.

We continue to follow guidance set forth by the state and federal governments. Below is a summary of our plan.

1. One alternate solution would be to obtain support from other facilities within our geographic region. The challenge here is that with a national emergency – we are all impacted similarly, we would like to offer cross training to our surgical services nurse to be able to provide care to our intensive care patients or complementary level skill.
2. With a potential need for adjusting ratios, the following would be considered. If unable to meet the AB394 State Mandated Ratios, we would propose the ratios based on the acuity of the patient with lower nurse to patient ratios with higher acuity and higher nurse to patient ratios with lower acuity. We would use the following as recommendations and make adjustments from there based on patient acuity.
  - o Adjust Intensive Care Unit to 1:3
  - o Adjust Med-Surg to 1:7
  - o Adjust Tele-medicine to 1:6
  - o Adjust the Emergency Department to 1:6
3. Hospital Incident Command Center will continue to meet to manage and mitigate the situation.

[Redacted Signature]

Director of Quality and Patient Safety

Signature of person requesting program flexibility

Title

[Redacted Printed 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: July 7, 2020 to October 5, 2020

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

Comments / Conditions 1. Approval is for 70217(a)(1), 70495(e), 70217(a)(8), 70217(a)(10), & 70217(a)(11)  
 2. The facility shall staff at required ratio; whenever possible. 3. The facility shall document all efforts to meet the required ratio; if not met. 4. The facility shall comply with all conditions as noted in AFL 20-26.3.

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: 7/23/2020

[Redacted Signature]

HFSM II

Title

7/23/2020

Date

L&C District Office Staff Signature