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: Adventist Health Delano

Date of Request: 11/19/20

License Number: 120000180

Facility Phone: [redacted]

Facility Fax Number: [redacted]

Facility Address: 1401 Garces Hwy

E-Mail Address: [redacted]

City: Delano

State: CA

Zip Code: 93312

Contact Person's Name: [redacted]

Approval Request

Complete one form total per facility

- [x] Staffing
- [ ] Other
- [ ] Tent use (High patient volume)
- [ ] Bed Use
- [ ] Space Conversion (other than tent use)
- [ ] Over bedding

Duration of Request

Start Date: 11/19/20

End Date: 02/19/21

Program Flex Request

What regulation are you requesting program flexibility for? Please see attachment 70217 and 70495 (c) (see comments)

Justification for the Request

- [x] 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 a surge of patients with the rate of admission continuing to rise, and we are anticipating a greater surge with the start of the flu season. See attached for further information.

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.

The facility is experiencing a surge of COVID positive patients resulting in difficulty obtaining sufficient staff to care for patients within the approved ratios. We have been able to transfer or discharge patients up to this point to maintain ratios, but expect that as cases rise, this will become more difficult.
We are requesting this flex with the following understanding:
o The facility shall staff at required ratio whenever possible.
o The facility shall document and maintain records of all efforts to meet the required ratio if not met.
o The facility shall comply with all conditions as noted in AFL 20-26.3.
Please see attachment for further information.

[redacted] Quality and Risk Analyst

Signature of person requesting program flexibility 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: 11/30/2020 to 2/19/2020

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

Comments / Conditions: For 70495 (c) as stated in the supporting documentation: Disaster Plan, Step 4 there will be a modified delivery of core team utilizing team nursing. Hospital will partner an experienced RN with a non-specialty RN.

CHCQ Printed Name:

CHCQ Staff Signature: _____

Date:

[redacted] Health Facilities Evaluator Supv 11/30/2020

L&C District Office Staff Signature Title Date