

### 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 Modoc Medical Center			Date of Request 12/9/2020	
License Number 230000026		Facility Phone 530 -708 8 81		Facility Fax Number 530-233-6609
Facility Address 1111 N. Nagle Street			[Redacted] .org	
City Alturas	State CA	Zip Code 96101	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

End Date

**Program Flex Request**

What regulation are you requesting program flexibility for?

**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).

Facility

Modoc Medical Center

License Number

230000026

Request Date

12/9/2020

**Justification for the Request**

Other:

[Empty text box for justification]

**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

[Empty text box for other alternatives]

**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:

[Empty text box for other accommodations]

**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 currently experiencing an outbreak at our SNF of COVID-19. We will test all our residents again tomorrow and anticipate that others will also be positive for COVID-19 at that time. Our current COVID-19 hallway at the SNF is at capacity with 11 residents that are currently cohorted on that hallway and positive for COVID-19. We have two more that have just yielded positive results and need to come to the hospital. We anticipate that more will also test positive tomorrow when we test all residents again.

We are implementing our surge plan as a precautionary measure at this time. In order to accommodate caring for all these patients and meeting the current care needs of regular inpatients in the hospital we are asking for permission to utilize two offices and two other rooms (PT treatment room and the family room) at the end of our med/surge hallway as patient rooms for COVID-19 patients. Linens, supplies, isolation carts, toileting accommodations, nurse call solutions, staffing, and other critical care needs are arranged for

in these areas. We would also like the option to utilize our PACU for hospital inpatients if additional beds are needed for patients that need to be hospitalized, are not positive for COVID-19, and cannot be transferred out to other facilities due to surges at those facilities as well.

In conjunction with this request we are also asking that we be allowed to staff our Med/Surge floor and the COVID-19 floor at a nurse to patient ratio of 1:6 at this time. This will allow us to manage our med/surge floor that is Non-COVID (6 beds), our COVID Hallway (6 beds), and the PACU (4 beds) with 1 RN per unit.

 CEO  
Signature of person requesting program flexibility 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:  to


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

Comments / Conditions:

CHCQ Printed Name: 

CHCQ Staff Signature: 

Date:

    
L&C District Office Staff Signature Title Date