EL CENTRO REGIONAL MEDICAL CENTER
**BOARD OF TRUSTEES** – REGULAR MEETING

**MONDAY, DECEMBER 18, 2023**
**5:30 PM**

**MOB CONFERENCE ROOM 1&2**
**1271 ROSS AVENUE, EL CENTRO, CA**

**PRESIDENT:** Tomas Oliva
**MEMBERS**: Sylvia Marroquin; Martha Cardenas-Singh; Edgard Garcia; Sonia Carter; Patty Maysent-CEO, UCSD Health; Christian Tomaszewski-M.D.-CMO, UCSD; Pablo Velez-CEO ECRMC

***CLERK**: Belen Gonzalez*

***ATTORNEY**: Elizabeth Martyn, City Attorney*

*This is a public meeting. If you are attending in person, and there is an item on the agenda on which you wish to be heard, please come forward to the microphone. Address yourself to the president. You may be asked to complete a speaker slip; while persons wishing to address the Board are not required to identify themselves (Gov't. Code § 54953.3), this information assists the Board by ensuring that all persons wishing to address the Board are recognized and it assists the Board Executive Secretary in preparing the Board meeting minutes. The president reserves the right to place a time limit on each person asking to be heard. If you wish to address the board concerning any other matter within the board's jurisdiction, you may do so during the public comment portion of the agenda.*

BOARD MEMBERS, STAFF AND THE PUBLIC MAY ATTEND VIA ZOOM.
To participate and make a public comment in person, via Zoom or telephone, please raise your hand, speak up and introduce yourself.

**Join Zoom Meeting:** https://ecrmc.zoom.us/j/85644020718?pwd=eGa4SPjWjf7ghrx3eZs3W41y49FzSh.1
**Optional dial-in number**: (669) 444-9171
**Meeting ID**: 856 4402 0718 **Passcode:** 801201

Public comments via zoom are subject to the same time limits as those in person.

## OPEN SESSION AGENDA

**ROLL CALL:**

**PLEDGE OF ALLEGIANCE:**

**PUBLIC COMMENTS:** Any member of the public wishing to address the Board concerning matters within its jurisdiction may do so at this time. Three minutes is allowed per speaker with a cumulative total of 15 minutes per group, which time may be extended by the President. Additional information regarding the format for public comments may be provided at the meeting.

**BOARD MEMBER COMMENTS:**

**CONSENT AGENDA:** *(Item 1-4)*
All items appearing here will be acted upon for approval by one motion, without discussion. Should any Board member or other person request that any item be considered separately, that item will be taken up at a time as determined by the President.

1. Review and Approval of Board of Trustees Minutes of Regular Meeting of November 27, 2023.

2. Review and Approval of New Policy: Emergency Operations Plan Policy 21534_0

3. Review and Approval of New Policy: Continuity of Operations Plan Policy 21549_1

4. Review and Approval of Updated Triennial Policy: Value Analysis Program

**FINANCE and OPERATIONAL UPDATE**

5. Presentation of Financial Statements for Month and Year-to-Date as of November 2023

6. Presentation of Current Weekly Cash Budget—**Informational**

7. Presentation of DP-SNF Affiliation with El Centro Post-Acute Care—**Informational**

**CHIEF EXECUTIVE OFFICER UPDATE**

8. Verbal Report from the CEO to the Board of Trustees—**Informational**

9. Manager Update—Patty Maysent—**Informational**

**RECESS TO CLOSED SESSION**:

A. **HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES.** The Hospital Board will recess to closed session pursuant to Government Code Section 37624.3 for a hearing and/or deliberations concerning reports of the ___ hospital medical audit committee, or _X_ quality assurance committees, or _X_ staff privileges.

B. **TRADE SECRETS.** The Hospital Board will recess to closed session pursuant to Govt. Code Section 37606(b) for the purpose of discussion and/or deliberation of reports involving hospital trade secret(s) as defined in subdivision (d) of Section 3426.1 of the Civil Code and which is necessary, and would, if prematurely disclosed create a substantial probability of depriving the hospital of a substantial economic benefit:

| Discussion of: | Number of Items: |
|---|---|
| _X_ hospital service; | 1 |
| _X_ program; | 1 |
| _X_ hospital facility | 1 |

C. **CONFERENCE WITH LEGAL COUNSEL—**The Hospital Board will recess to closed session pursuant to Government Code Section 54956.9(d)(2) and 54956.9(d)(4).

**RECONVENE TO OPEN SESSION – BOARD PRESIDENT**

**ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY – GENERAL COUNSEL**

10. Approval of Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff *(Approved in Closed Session)*

**ADJOURNMENT:** Adjourn. (Time: ) Subject to additions, deletions, or changes.

**El Centro Regional Medical Center**
**BOARD OF TRUSTEES – REGULAR MINUTES**
***OPEN SESSION MINUTES***
MOB CONFERENCE ROOMS 1 & 2
1271 Ross Avenue, El Centro, CA 92243
Zoom Meeting link: https://ecrmc.zoom.us/j/81801854045?pwd=RE9g0CHrZzpermLX89oJcjOuWi8QTM.1

**Monday, November 27, 2023**

| TOPIC | DISCUSSION/CONCLUSION | RECOMMENDATION/ACTION |
|---|---|---|
| **ROLL CALL** | **PRESENT**: Oliva; Marroquin; Cardenas-Singh; Garcia; Carter; Maysent; Tomaszewski; Chief Executive Officer Pablo Velez and Executive Board Secretary Belen Gonzalez<br>**ABSENT**: -<br>**ALSO PRESENT:** Sunny Richley, M.D., Chief of Staff; City of El Centro Manager Cedric Ceseña<br>**VIA Zoom:** Elizabeth Martyn, City of El Centro Attorney | |
| **CALL TO ORDER** | | The Board of Trustees convened in open session at 5:32 p.m. Board President Oliva called the meeting to order. |
| **OPENING CEREMONY** | The Pledge of Allegiance was recited in unison. | None |
| **NOTICE OF MEETING** | Notice of meeting was posted and mailed consistent with legal requirements. | None |
| **PUBLIC COMMENTS** | None | None |

| TOPIC | DISCUSSION/CONCLUSION | RECOMMENDATION/ACTION |
| --- | --- | --- |
| **BOARD MEMBER COMMENTS** | | None |
| **CONSENT AGENDA:** *(Item 1-3)*<br>**Item 1. Review and Approval of Board of Trustees Minutes of Regular Meeting of October 30, 2023.**<br><br>**Item 2. Monthly Human Resources Statistical Update for October 2023—Informational** *(Board Finance).*<br><br>**Item 3. Review and Approval of ECRMC Board of Trustees Meeting Schedule 2024.** | All items appearing here were acted upon for approval by one motion (or as to information reports, acknowledged receipt by the Board and directed to be appropriately filed) without discussion. | MOTION: by Cardenas-Singh, seconded by Marroquin and carried to approve the Consent Agenda.<br><br>All present in favor; none opposed. |
| **OLD BUSINESS:**<br>**Item 4. Review and Approval of Amendment No.1 to Letter of Intent (LOI) between El Centro Regional Medical Center (ECRMC), the City of El Centro, and the University of California San Diego Health (UCSD) for Interim Management and Operations of the Hospital to extend for an additional six month period commencing November 27, 2023.** | ***Trustee Oliva***- presented the Amendment No. 1 to Letter of Intent (LOI) between ECRMC, the City of El Centro, and UCSD for Interim Management and Operations of the Hospital to extend for an additional six-month period commencing November 27, 2023. | MOTION: by Marroquin, seconded by Carter and carried to approve the Amendment No.1 to Letter of Intent (LOI) between El Centro Regional Medical Center (ECRMC), the City of El Centro, and the University of California San Diego Health (UCSD) for Interim Management and Operations of the Hospital to extend for an additional six month period commencing November 27, 2023<br><br>All present in favor; none opposed; Maysent abstained; Dr. Tomaszewski abstained. |

| TOPIC | DISCUSSION/CONCLUSION | RECOMMENDATION/ACTION |
|---|---|---|
| **FINANCE and OPERATIONAL UPDATE**<br>**Item 5. ECRMC Retirement Income Plan—Informational** *(Presentation by Steve J. Persons) (Board Finance)* | David Momberg provided a summary of the Defined Benefit Pension Plan Fund Valuation. This item was presented by Steve J. Persons at the ECRMC Board Finance Committee. | Informational |
| **Item 6. Presentation of Financial Statements for Month and Year-to-Date as of October 2023** *(Board Finance)* | David Momberg provided an overview and summary of the Financial Statements for Month and Year-to-Date as of October 2023. | MOTION: by Marroquin, seconded by Garcia and carried to approve the Financial Statements for Month and Year-to-Date as of October 2023.<br><br>All present in favor; none opposed. |
| **Item 7. Presentation of Current Weekly Cash Budget—Informational** | David Momberg presented the current weekly cash budget handout and answered questions. | Informational |
| **Item 8. Update of the FYE 2023 Audit Work—Informational** | David Momberg updated the Board of Trustees on the FYE 2023 Audit Work. | Informational |
| **CHIEF EXECUTIVE OFFICER UPDATE**<br>**Item 9. Verbal Report from the CEO to the Board of Trustees—Informational** | Item to be discussed in Closed Session | Informational |
| **Item 10. Manager Update—Patty Maysent—Informational** | Item to be discussed in Closed Session | Informational |
| **RECESS TO CLOSED SESSION** | | MOTION: by Cardenas-Singh, seconded by Garcia and carried to recess to Closed Session at 6:09 p.m. for HEARING/ |

| TOPIC | DISCUSSION/CONCLUSION | RECOMMENDATION/ACTION |
|---|---|---|
| | | DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES, TRADE SECRETS, and CONFERENCE WITH LEGAL COUNSEL.<br><br>All present in favor to recess to Closed Session. None opposed. |
| **RECONVENE TO OPEN SESSION** | | The Board of Trustees reconvened to Open Session at 7:15 p.m. |
| **ANNOUNCEMENT OF CLOSED SESSION ACTIONS** | | [**A. HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES—GOVERNMENT CODE SECTION 37624.3**]<br><br>MOTION: by Cardenas-Singh, seconded by Garcia and carried to approve the Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff.<br><br>All present in favor; none opposed |

| TOPIC | DISCUSSION/CONCLUSION | RECOMMENDATION/ACTION |
|---|---|---|
| | | **[C. CONFERENCE WITH LEGAL COUNSEL—Anticipated Litigation, Significant exposure to litigation pursuant to Government Code Section 54956.9(d)(2)—1 claim**<br><br>MOTION: by Marroquin, seconded by Maysent and carried to approve the response from ECRMC to claim; to be mailed out via certified USPS mail. |
| **ADJOURNMENT** | | There being no further business, meeting was adjourned at approximately 7:17 p.m. |

________________________________________
BELEN GONZALEZ, BOARD EXECUTIVE SECRETARY

APPROVED BY

________________________________________
TOMAS OLIVA, PRESIDENT

**TO:** ECRMC BOARD MEMBERS

**FROM:** Kimberly Probus, Chief Nursing Officer

**DATE:** December 18, 2023

**COMMITTEE:** Board of Trustees

**SUBJECT:** Move to approve new Policy 21534_0 Emergency Operations Plan

**BUDGET IMPACT**: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: ______________

**BACKGROUND:** Updates and replaces previous policy "Code Triage" to better align the hospital with current Disaster Preparedness practices

**RECOMMENDATION:** (1) Approve (2) Do not approve

**DISCUSSION:** New policy has been developed with input from Emergency Preparedness Committee, Management forum, and Chief Executive Team.

**ATTACHMENT(S):**

- Emergency Operations Plan: Policy 21534_0

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Ortiz ______________

## El Centro Regional Medical Center

# Emergency Operations Plan

**Policy 21534_0**
**November 27, 2023**

**TABLE OF CONTENTS**

**TABLE OF REVISIONS** .......... **1**

**1 EMERGENCY OPERATIONS PLAN (EOP)** .......... **4**

1.1 OVERVIEW .......... 4
1.2 ACTIVATION OF THE EOP .......... 5
1.2.1 Authority to Activate .......... 5
1.2.2 EOP Activation Levels .......... 5
- Level 1 EOP Activation (Alert/Notification) .......... 6
- Level 2 EOP Activation (Minor Impact) .......... 6
- Level 3 EOP Activation (Moderate Impact) .......... 6
- Level 4 EOP Activation (Major Impact) .......... 6

1.2.3 Hospital Command Center Activation .......... 6
1.2.4 Incident Recognition & Notification .......... 6
1.3 CONCEPT OF OPERATIONS/INCIDENT MANAGEMENT .......... 8
1.3.1 Assumption of Command .......... 8
1.3.2 Organization-Wide Incident Command Structure .......... 8
1.3.3 Assignment of Incident Command Functions .......... 8
1.3.4 Assessment of Event and Available Facility Resources .......... 9
1.3.5 Identification and Prioritization of Incident Objectives .......... 10
1.3.6 Reference Planning Support & Incident-Specific Plans .......... 10
1.3.7 Activation of Initial HICS Positions .......... 10
1.3.8 Expansion of the Hospital Incident Management Team (HIMT) .......... 10
1.3.9 Order of Succession/HICS/HIMT Succession Plan .......... 11
1.4 IDENTIFICATION OF HICS PERSONNEL .......... 11
1.5 INTEGRATION WITH UNIFIED COMMAND .......... 11
1.5.1 Common Operating Picture .......... 12
1.5.2 Delegation of Authority .......... 12
1.6 STAFF AUGMENTATION .......... 13
1.7 STAFFING EXPANSION CONSIDERATIONS .......... 13
1.8 DISASTER PRIVILEGING .......... 14
1.8.1 Licensed Independent Practitioners .......... 14
1.8.2 Medical Volunteer Credentialing and Identification .......... 15
1.8.3 Non-Independent Licensed Practitioners .......... 15
1.8.4 Labor Pool Roles and Responsibilities .......... 16
1.8.5 Release from Duty .......... 16
1.8.6 Spontaneous Volunteers .......... 17
1.9 TRANSFER OF COMMAND .......... 17
1.10 DEVELOPMENT OF AN INCIDENT ACTION PLAN .......... 17
1.11 ESCALATION OF RESPONSE .......... 17
1.12 PLANNED DEGRADATION OF SERVICES .......... 18
1.13 PUBLIC INFORMATION .......... 18
1.13.1 Media Relations .......... 18
1.13.2 Media Access .......... 18
1.14 TERMINATION OF EMERGENCY RESPONSE .......... 19
1.15 PRE-DESIGNATED INCIDENT LOCATIONS AND FACILITIES .......... 19
1.15.1 Incident Facilities Matrix .......... 19
1.16 DEPARTMENT-LEVEL PREPAREDNESS .......... 20

1.16.1 Department-Level Activation ........ 20
1.16.2 Department-Specific Contingency Procedures ........ 21
1.17 Departmental Status Reporting (STATREP) ........ 21
1.18 Healthcare Emergency Codes ........ 21
1.19 Recovery & Resumption of Normal Activities ........ 21
**2 HOSPITAL COMMAND CENTER ........ 22**
2.1. HCC Mission ........ 22
2.2. HCC Staffing ........ 22
2.3. Virtual vs. Physical HCC Activation ........ 22
2.4. HCC Operations ........ 23
2.5. HCC Evacuation/Relocation ........ 23
**3 ADVANCE PREPARATIONS ........ 24**
3.1. General Preparedness Measures ........ 24
3.2. Communications ........ 24
3.3. Resources and Assets ........ 25
3.4. Security and Safety ........ 26
3.5. Staff Management ........ 26
3.6. Utility Management ........ 27
3.7. Patient Population ... ........ 27
3.8. Patient Management ........ 27
**4 RECOVERY AND RESUMPTION OF NORMAL ACTIVITIES ........ 29**
4.1. Overview ........ 29
4.2. Facility Repair and Inspection ........ 29
4.3. Accreditation and Licensure ........ 30
4.4. Resumption of Clinical Services ........ 31
4.5. Resumption of Pre-Incident Staff Scheduling ........ 31
4.6. Resource Inventory and Accountability ........ 31
**5 MEDICAL SURGE AND LOSS OF COMMUNITY SUPPORT ........ 32**
5.1. Surge Support ........ 32
5.1.1 Bed Capacity/Expansion (Internal) ........ 32
5.1.2 Alternate Care Site Operations (External)/Expansion of Facilities ........ 33
5.2. Loss of Community Logistical Support ........ 35
5.2.1 Corrective Actions ........ 35
5.2.2 Procedural Interventions ........ 35
**TABLE 1-1. ECRMC ACTIVATION MATRIX ........ 38**
**TABLE 1-2. ECRMC INCIDENT FACILITIES MATRIX ........ 42**
**APPENDIX A – PLANNING SUPPORT ANNEXES ........ 51**
**APPENDIX B – INCIDENT SUPPORT ANNEXES ........ 53**
**APPENDIX C – DEPARTMENTAL EOPS ........ 55**
**APPENDIX D – RESOURCE ANNEXES ........ 56**

# 1 EMERGENCY OPERATIONS PLAN (EOP)

## 1.1 OVERVIEW

The Emergency Operations Plan (EOP) details how the facilities and personnel of El Centro Regional Medical center respond to and recover from emergencies. The plan and supporting documents (annexes and forms) including the Continuity of Operations Plan, were developed with input from the hospital's non-clinical and clinical leaders as well as members of the Emergency Preparedness Committee. The hospital's senior leaders provide oversight and support for emergency management activities, including reviewing this plan and supporting documents. The EOP and its associated attachments and annexes applies to all ECRMC hospitals, facilities, associates, hospital administration, and all staff and all departments. Per The Joint Commission (TJC) standards, the policy and supporting documents are reviewed at least every two years (biennial review), or more often as events dictate.

In this document and the attached appendices, various response plans and guidance documents detail how the hospital mitigates, prepares for, responds to, and recovers from hazards and event-specific incidents identified in the ECRMC Hazard Vulnerability Analysis (HVA). ECRMC's EOP utilizes an all-hazards approach for responding to any emergency or incident that impacts or has the potential to affect hospital operations, life safety, or patient care.

Plan activation begins with incident or situation recognition. This involves deciding at what point reported or anticipated events transition from a routine to a non-routine emergency situation. By activating the EOP, an individual (the Incident Commander) is delegated to focus on fulfilling the functions of being the Incident Commander and begin assessing the situation to determine further needs and actions (*see Figure 1.1: Incident Cycle)*.

In making the activation assessment, the Administrator On-Call and Executive Leadership will be guided by two clear policy directions. First, early but unnecessary plan activation is better than a needed but delayed activation (i.e., if an incident appears to present an actual or potential impact on the organization, activate the plan). Second, the best training tool for familiarizing staff and leadership with emergency procedures is through experiencing actual plan activation, even if at a low level. Therefore, the organization benefits from low-level emergency plan activation as a training experience for more significant events. **However, never activate the plan nor establish incident command until CEO approval is obtained.**

Advance preparation steps (see below) and incident annexes may be activated to provide event-specific guidance for hospital leadership and responders. While the Incident Commander is making this determination, staff continues to act and respond in their current capacity. When the EOP is activated, the Hospital Incident Command System (HICS) is always utilized. A demobilization and recovery plan will be developed to provide an orderly return to normal operations. After-action analysis and reporting will be conducted to identify lessons learned and opportunities for improvement. The Hospital Incident Management Team (HIMT), along with the response and recovery teams will develop a Corrective Action Plan and track progress.

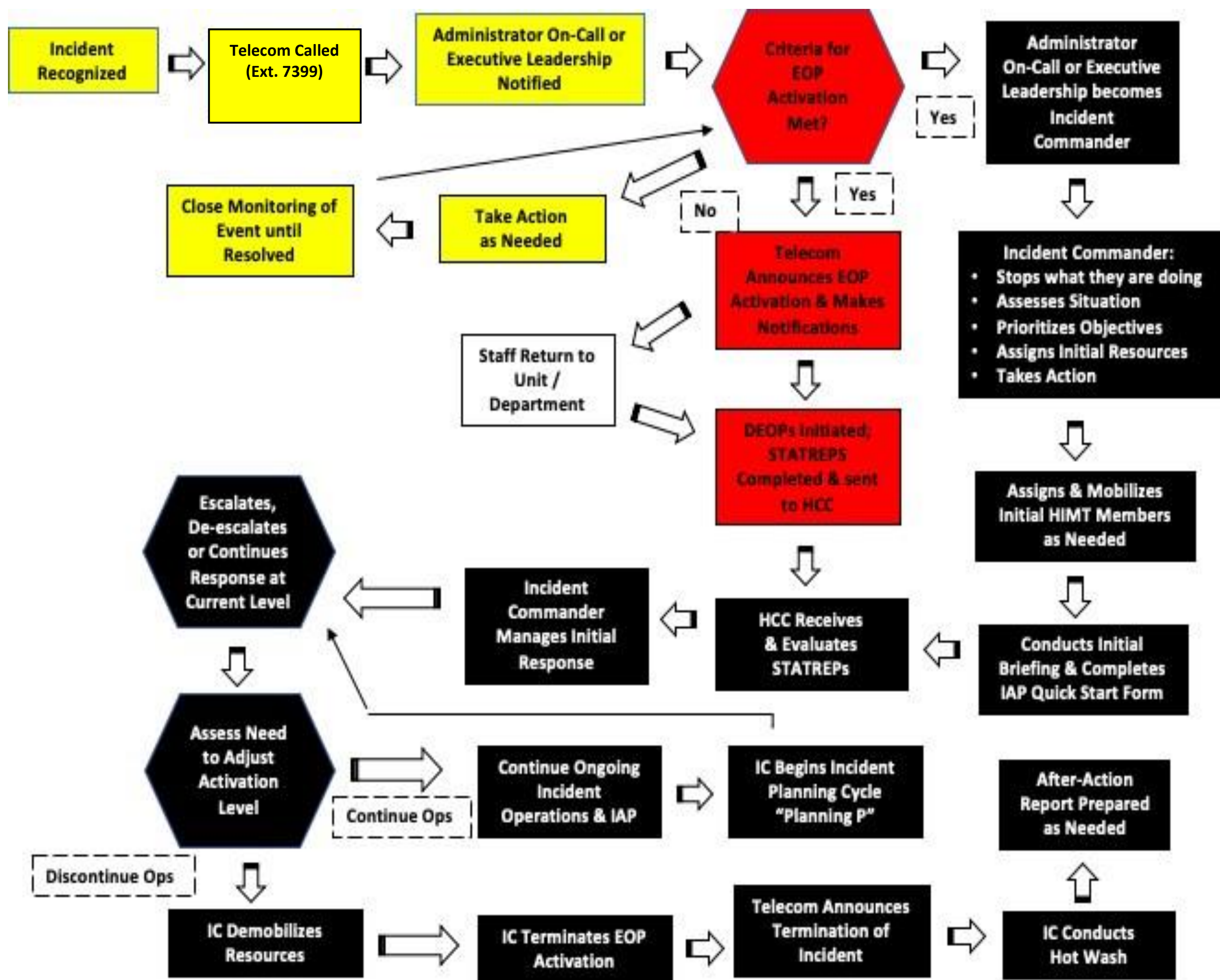



**Figure 1-1: Incident Cycle**

## 1.2 ACTIVATION OF THE EOP

### 1.2.1 Authority to Activate

The EOP may be activated **only upon approval by the CEO or designee**.

Prior to plan activation, Chief Executive Officer or designee approval is required. Sequence for securing activation is as follows: CEO, Assistant to the CEO, CHRO, CFO, CNO. Upon plan activation, the operator will follow internal protocols and implement notifications as directed by the Incident Commander, or designee (*see Appendix A-2 Activation Authority Plan*).

### 1.2.2 EOP Activation Levels

The hospital's EOP will become active at one of the following four activation levels. **Note that an activation can occur at any level and does not require a stepwise sequence of activation.** For example, the plan can begin at Level 3 for a situation having a moderate to potentially severe impact on the facility, and all activities and notifications consistent with Levels 1 and 2 activations will be active concurrently. Refer to Table 1-1, ECRMC Activation Matrix, for parameters that describe conditions that may lead to activation at the various levels.

- **Level 1 EOP Activation (Alert/Notification)**

Level 1 Activation (Alert/Notification) is appropriate when advance notice is received about an incident that has the potential to produce casualties or disrupt normal business operations. The hospital is not currently impacted by the incident (e.g., a severe thunderstorm watch, a notification about a bus accident with no known casualties at that time, an upcoming presidential visit, a visit by the Pope).

- **Level 2 EOP Activation (Minor Impact)**

Level 2 Activation is for an incident having minor impact on hospital operations. This type of activation typically occurs when an incident impacts one or two departments or a small part of operations, its scope is limited and of short duration.

- **Level 3 EOP Activation (Moderate Impact)**

Level 3 Activation is appropriate for an incident with a moderate impact on operations. This type of activation typically occurs when an incident impacts about half of hospital operations and/or requires substantial support.

- **Level 4 EOP Activation (Major Impact)**

Level 4 Activation is for an incident with likely significant impact on operations, including the potential for long duration. This type of activation is considered significant, meaning that nearly all normal activities in the hospital are disrupted and the focus of most leadership and staff is on the incident.

### 1.2.3 Hospital Command Center Activation

The IC will activate the Hospital Command Center (HCC) based on the level of EOP activation. The HCC is located in the CEO Conference Room (North Lobby area). At a minimum, a virtual HCC can be used for Level 2 EOP activations. The virtual HCC will be operational via communication link (Verkada Safe application), ideally within five minutes of EOP activation. For every Level 3 or 4 activation, an actual (physical) HCC shall be established (so long as there are no potential health and safety implications) and operational within 15 minutes of EOP activation (see Section 2.0).

### 1.2.4 Incident Recognition & Notification

- The person receiving the first notification that an emergency (or potential emergency) incident has taken place will quickly obtain as much information as possible on the situation. **This individual immediately contacts the hospital operator (Ext. 7399 or 911) informing them of the situation. Information to obtain includes at least:**
    - What area of the hospital/campus is involved/declaring an emergency (i.e., location, department, etc.)?
    - What type of emergency (Internal/External)?
    - Approximately how many people are involved or injured?
    - Where should emergency resources respond within the hospital or campus?
- **The operator initiates notification of the Administrator-on-Call or Executive Leadership** (*see Appendix D, Resource Annex, Forms*). Direct voice contact must accomplish this notification. The operator making voice contact shall record the name and time each leadership person acknowledges the message. The Chief Executive Officer, or designee, will ascertain current information about the incident, assess the situation, and then decide if there is a need to assume command and activate the Emergency Operations Plan (EOP).

- If the Operator receives notification from an unknown source, he/she will attempt to validate the information with the House Supervisor, Security, and/or Emergency Management before making further notifications beyond the Administrator-on-Call or Executive Leadership.

#### 1.2.4.1 Staff Notification

Organization leaders will be notified upon activation of the ECRMC EOP through various means as described in Appendix A - Emergency Communications Plan. **Upon notification/EOP Activation, on-duty staff will:**

- Return immediately to their assigned area to obtain a situational update and assignment from their manager/supervisor and review their Department/Emergency Operations Plan (DEOP).
- Assess the status of their patients, for those working in clinical areas, and complete a Patient Assessment Form (*see Appendix D – Resource Annex).*
- Determine the status of their work area and report any emergent resource needs to their manager/supervisor.
- Assist manager/supervisor in completing **Status Report** form **(STATREP)** online to be provided to the Hospital Command Center (HCC).

**Upon notification/EOP Activation, off-duty staff will:**

- Implement their Personal/Family Disaster Plan.
- Await notification or direct communication before responding to the hospital or other affected site(s).
- Monitor the hospital's website and other media for situational updates.

#### 1.2.4.2 State/County/Local/Vendor/Media Notification

Appropriate state/local entities, vendors, media, etc. will be notified upon activation of the ECRMC EOP as deemed necessary by the nature of the incident and as directed by the IC (*see Table 1-1, ECRMC Activation Matrix and EOP, Appendix A, Emergency Communications Plan*). These include but are not limited to:

- El Centro City Office of Emergency Services (911, El Centro Fire Department)
- Imperial County Emergency Medical Services – (MHOAC Director)
- Law Enforcement
- Fire
- Emergency Medical Services
- California Department of Public Health (CDPH)
- Other area hospitals & medical clinics
- UCSD Medical Center
- Imperial County Office of Emergency Services (IC-OES)

- Hospital Association of San Diego & Imperial Counties (HASDIC)
- California Hospital Association
- Regional Healthcare Coalition
- Local media

#### 1.2.4.3 Notification Documentation

The hospital's Communication Log will be used to document notifications during an EOP activation (*see Appendix D, Resource Annex, Hospital Forms, Communication Log*).

## 1.3 CONCEPT OF OPERATIONS/INCIDENT MANAGEMENT

### 1.3.1 Assumption of Command

Once EOP activation is approved by the CEO or designee, the Administrator-on-Call or Executive Leadership will assume command as the ECRMC Incident Commander (IC) for that incident. The IC is the designee of the Chief Executive Officer and is accountable for all hospital resources and operations necessary to manage the event. The IC is responsible for policy decisions during emergency operations.

Upon assuming command, the IC immediately activates the Hospital Command Center (HCC), either virtually or by proceeding to the actual HCC location and using the hospital's mass notification system, TigerText HICS groups, or the overhead paging system. The IC should generally remain at the HCC throughout the emergency, maintaining a visible command posture. If leaving the HCC, the IC will identify an HCC Manager who will be in direct contact at all times with the IC, preferably by a clear radio channel, until the IC's return.

### 1.3.2 Organization-Wide Incident Command Structure

Leadership designees at each ECRMC facility are trained and assigned to assume the role of Incident Commander for any emergency, which may or is impacting their facility's operations or poses a risk to life safety. Initially, the Incident Commander will be an individual who is physically present onsite (the Administrator-on-Call or other designee). This designated facility leader will assess the situation to determine the need for:

- EOP activation
- Establishment of Incident Objectives
- Appointment of a Hospital Incident Management Team (HIMT)
- Upward delegation of authority

In the event of an emergency affecting more than one ECRMC facility, a single Incident Commander will be appointed to manage the incident. This individual will establish an 'Area Command' to oversee the response and recovery phases of the incident while a designated leader at each impacted location will assume the role of Branch Director to execute incident objectives (*see HICS/ICS Planning Annex*). Additional command staff positions (e.g., Operations, Plans, Logistics, and Finance) will be appointed as needed and will report to the designated EOC. The Incident Commander will communicate directly with each facility's command center and community partners (*see Communications Planning Annex*).

### 1.3.3 Assignment of Incident Command Functions

Consistent with the Hospital Incident Command System (HICS) principles, the only position that must be activated is that of the Incident Commander. **Should the IC determine that he or she can manage all necessary functions for the incident without additional assistance; no other positions need to be activated.** Additional

Hospital Incident Management Team (HIMT) positions are activated and assigned after the IC has assessed the situation, established initial response objectives, and developed a plan to manage it.

For many of the positions in the HICS organization, the HICS/HIMT Succession Plan (*see Resource Annex*) identifies Primary, Secondary and Tertiary (Business/Non-Business Hours) HIMT members. The Secondary and Tertiary coverage identifies those positions that cannot be filled with on-duty staff during non-business hours, signifying that an on-call person would likely be needed for those specific roles to be activated. The organization can effectively staff through a Level 2 incident during non-business hours with existing staff on duty but may need staff augmentation for any Level 3 incident.

In every department, the senior person present takes charge and makes all necessary decisions until relieved by a superior or otherwise directed by the HCC. Department heads are responsible for succession and continuity planning for leadership within their departments.

Once notification of the incident has occurred, the Emergency Operations Plan (EOP) is activated, and command is in place, further plan implementation and response actions will be dictated by the IC based on the situation. The sequence for this implementation is noted below. Note that these steps need not be sequential; several processes may occur simultaneously.

### 1.3.4 Assessment of Event and Available Facility Resources

The Incident Commander will assess (“size-up”) the situation and the facility resources in three categories: **specifics regarding the incident**; the **impact that the episode is having** (or is expected to have) on the organization; and the **resources available** to manage the event, logistics, and operations. The initial response to the incident is based on the preliminary assessment as it relates to communications, safety and security, resources and assets, staffing and assignments, utilities, and the environment of care. This response also considers issues related to patient care and clinical support personnel, equipment, supplies, structural components, and utilities impacted or available at the time of activation.

#### 1.3.4.1 Criteria for Size-Up

***Size-up*** refers to a mental process of appraising and evaluating all of the influencing factors relating to an emergency incident before committing personnel and resources to a course of action. This usually includes an estimation of hazards, life safety, extent, or impact of the problem, and an initial strategy for response.

The following key elements will be considered when sizing up a hospital incident:

- Type of incident
- Internal or external
- Threat to environment and/or security assessment
- Size of incident or area affected
- Number of patients affected by the situation
- Anticipated duration of event impact
- Projected impact on normal facility operations
- Hospital patient occupancy and bed availability
- Status of patient care and ancillary services

- Current and projected staffing levels (clinical, support, and supervisory/managerial)
- State of hospital physical plant, utilities, and environment of care
- Need for shelter-in-place, evacuation, or patient relocation
- Need for additional resources

### 1.3.5 Identification and Prioritization of Incident Objectives

Based on the assessment of the situation and the status of facility resources, the IC will decide upon the initial response to the incident. For example, in the event of a wildfire, based on the effects of the ensuing flames and smoke on the physical plant and operation of utilities, the IC may decide to shut down operations in some areas, augment operations in other areas, evacuate the facility, or accept patients from other facilities.

Incident objectives should always follow the NIMS-standard sequence of events: **life safety issues and objectives are always considered and addressed first**, followed by incident stabilization and management issues, then considerations of preserving property and conserving resources. The key is to ensure that objectives are selected and assigned to the proper priority.

The second consideration for assigning objectives is that they should always be ***SMART*** objectives:

- **S**pecific - Clearly state the task.
- **M**easurable - A point of completion (and progress along the way) can be definitively assessed.
- **A**ttainable -Resources being assigned can accomplish the mission.
- **R**elevant - Show a relationship to the situation at hand.
- **T**imely - Establish a clear target for completion or prioritization.

### 1.3.6 Reference Planning Support & Incident-Specific Plans

Appendix A contains incident specific plans that support prevention, mitigation, preparedness, response, and recovery actions. Appendix B includes guidance on particular events such as severe weather, utility failure, and security incidents. Appendix C addresses specific steps required of each department during the initial sixty minutes of EOP activation. Resource Annexes in Appendix D provide guidance on HICS/HIMT assignments, community resources, vendor lists, utility system contacts, staff directories, etc.

### 1.3.7 Activation of Initial HICS Positions

The Incident Commander will build the HICS organization to implement the incident objectives effectively. The HICS structure is scalable and not all positions need to be activated to achieve the incident objectives. In some cases, one individual may be assigned to more than one position.

### 1.3.8 Expansion of the Hospital Incident Management Team (HIMT)

A primary function of the Incident Commander is to ensure that expansion or escalation of the HIMT is sufficient to meet the incident objectives, while simultaneously minimizing the event's impact on non-involved areas of the hospital. **As much as possible during EOP activation, routine operations should be maintained.**

The Hospital Incident Management Team (HIMT) chart depicts the various command functions and how authority and responsibility are distributed. Each event is different, so incident leaders must assess the situation and organize resources and activities within HICS based on current reality. Having certain leadership elements pre-determined or pre-planned expedites the decision-making process and standardizes the approach in a crisis. The HIMT chart does not intend to suggest that every position will be activated for every incident or event. Instead, in keeping with the principle of efficiency, HICS positions are assigned (by the IC) to personnel during actual incidents only as indicated by an assessment of the scope and magnitude of the particular situation.

The Hospital Incident Management Team Chart (*see Resource Annex*) for ECRMC represents the primary or first tier of leadership as developed in the ECRMC HICS/HIMT Succession Plan (*see Resource Annex*).

### 1.3.9 Order of Succession/HICS/HIMT Succession Plan

The hospital has pre-identified internal hospital positions that could be potential candidates for various HICS positions. In doing so, this HICS/HIMT Succession Plan identifies what other ECRMC positions might be candidates for filling a particular HICS role should the first choice not be available (*see Resource Annex*). All personnel who hold a place on the Succession Planning Matrix must be familiar with both the Incident Command System, the HICS position assigned, and corresponding Job Action Sheet (JAS).

**NOTE:** The HICS/HIMT Succession Plan is a tool to guide the Incident Commander. Based on the availability of personnel and the incident, the IC may or may not be able to adhere entirely to the succession matrix. The IC has full authority to appoint other employees as necessary. The HICS/HIMT Succession Plan is used to create the ECRMC HICS Hospital Incident Management Team Chart (*see Resource Annex—Hospital Incident Management Team Chart*).

## 1.4 Identification of HICS Personnel

All personnel assigned to an HIMT role should wear identification, when possible, that correctly communicates their role. ECRMC uses special vests for this purpose that identifies the HICS position title on the front and back (and is visible in both normal and low-light conditions). The vests are color-coded to the HICS Hospital Incident Management Team chart:

- White with Black Trim - Command Staff
- Red - Operations
- Blue - Planning
- Yellow - Logistics
- Green - Finance/Administration

The vests and other tools such as tablets, pens, markers, Job Action Sheets (JAS), forms, and other office supplies are readily available from the Hospital Command Center (HCC) closets. These supplies are regularly checked to ensure that these items are present and in proper supply. Radios, which are accessible in HCC, will be available upon activation of the EOP/Incident Command. At a minimum, vests are worn for any activation of the actual Hospital Command Center.

## 1.5 Integration with Unified Command

Hospital leadership is aware that response to any disaster or untoward moderate or significant impact event they will not be responding alone. Depending on the nature and extent of the incident, it is likely that a wide variety of agencies will be engaged to some degree in the response effort; therefore, the hospital will strive to

integrate into the community response, including the overall incident command structure. This integration begins before an incident occurs, through the hospital's regular participation in community preparedness meetings, trainings, and exercises (e.g., Imperial County Disaster Coalition).

Depending on the situation, the incident may be managed overall by a single agency. However, there will be circumstances where instead of the single agency command model, a unified command approach is used. The unified command is employed when more than one agency has jurisdiction over the incident. This approach involves senior leadership from identified agencies, who are co-located and make decisions together, as they analyze available information and establish a standard set of objectives and strategies for a single Incident Action Plan (IAP). This command model does not change any feature of HICS. It does allow for all agencies with responsibility for the incident, including the hospital, to participate in the decision-making process.

### 1.5.1 Common Operating Picture

The National Incident Management System (NIMS) defines the common operating picture in the following manner: "*A common operating picture is established and maintained by the gathering, collating, synthesizing, and disseminating of incident information to all appropriate parties involved in an incident. Achieving a common operating picture allows on-scene and off-scene personnel to have the same information about the incident, including the availability and location of resources, personnel, and the status of requests for assistance. Additionally, a common operating picture offers an overview of an incident, thereby providing incident information, which enables the Incident Commander (IC), Unified Command (UC), and supporting agencies and organizations to make effective, consistent, and timely decisions. To maintain situational awareness, communications and incident information must be updated continually*."

The IC is responsible for directing the establishment of a common operating picture to aid in situational awareness, interoperability, consistent decision-making, and facilitating communications among responding organizations or departments. The IC is responsible for ensuring that the following communication activities occur as necessary to support the incident response and maintain a common operating picture:

- Incident notifications
- Status reporting
- Situational briefings

The goal of creating a common operating picture is to ensure that all participants in the response have consistent, accurate, and reliable information about the incident. An outcome of this process is often a unified, collaborative, coordinated response structure both internally and with outside response organizations. For small to moderate-impact events, the IC will likely be able to quickly establish this common operating picture, whereas, for larger incidents involving more community and possibly state and federal resources, it is more likely to fall under the jurisdiction of the local EOC.

### 1.5.2 Delegation of Authority

Delegation is the downward transfer of authority from a supervisor to a subordinate in a management organization. When such authority is delegated, the subordinate is empowered to carry out the work on the supervisor's behalf, while the supervisor remains accountable for the outcome. As with any management system, HICS leaders may delegate their authority to carry out certain functions by establishing a lower level in the Hospital Incident Management Team. During EOP activation, delegation of authority will occur based upon

the needs of the incident (i.e., the quantity and complexity of the objectives to be met), the facility resources, and the available personnel. This may be an ongoing and dynamic process.

The Incident Commander is ultimately responsible for all incident functions, although the IC delegates authority for activities and tasks to Section Chiefs and Unit Leaders to carry out. Both clinical and operational services will be managed administratively in the same manner.

### 1.6 STAFF AUGMENTATION

It is ECRMC's policy to consider any employee, staff/faculty member, resident or student on the premises during an Emergency Operations Plan (EOP) activation to be on duty. Any of these individuals may be called upon to aid in tasks other than prescribed by their job or clinical assignment, work in departments or carry out functions other than those customarily assigned, or work hours in excess of (or different from) their usual schedule. All staff should confer with their manager or supervisor before leaving the premises while the EOP is activated.

In addition to carrying out their regularly assigned duties, new incident management–related objectives or tasks are often assigned during an emergency. These assignments are made using the HICS model, based on the Incident Action Plan (IAP) developed for a given operational period. Such duties are given to the best-qualified individuals who are available to carry them out. The ECRMC HICS/HIMT Succession Plan provides the primary guidance for assigning staff to essential HICS functions. Each appointed staff member is given a Job Action Sheet (*see Resource Annex—Job Action Sheets*) explaining the mission and prioritized work activities to be carried out.

### 1.7 STAFFING EXPANSION CONSIDERATIONS

In the event of an emergency or declared disaster (local, state, or federal), at the determination of the Incident Commander (IC), all or some staff members may be required to work longer than a standard 8-hour shift to maximize staffing. These shifts may be scheduled as needed to meet hospital emergency response objectives. Options for expansion of both clinical and non-clinical staff include the following:

- Temporarily increase nurse-to-patient ratios on floors
- Hold current team on overtime after shift
- Change from 8-hour shifts to 10-hour, 12-hour, or other shifts
- Reassign clinical and non-clinical staff to areas of need
- Call back off-duty staff from other shifts
- Contract additional agency nurses
- Contract outside help from staffing agencies
- Cancel staff days off
- Cancel holiday and vacation leaves
- Coordinate through the Imperial County Medical-Health Operational Area Center (MHOAC)/Department of Public Health and California Hospital Association for staffing support from outside the hospital (considering credentialing needs)—including other hospitals, home-based care staff, Medical Reserve Corps, and staff from an unaffected area of the county/region/state/country.

## 1.8 DISASTER PRIVILEGING

### 1.8.1 Licensed Independent Practitioners

ECRMC may activate its EOP for an incident where it is unable to meet immediate patient needs due to a shortage of physician staffing. During EOP activation, the Chief Executive Officer, Chief Medical Officer, or designee (Administrator-on-Call or Executive Leadership), may grant "Disaster Privileges" to licensed independent practitioners who volunteer to assist the facility. Granting such rights will be on a case-by-case basis at the discretion of the CEO or Medical Staff Executive. The privileges should be effective immediately and continue through the completion of the patient care needs or until the orderly transfer of patient care to an appropriately credentialed member of the medical staff can be accomplished, but in all cases the granting of privileges will follow existing Medical Staff policies and by-laws.

Following approval for emergency credentialing privileges, the practitioner will be provided and be required to keep with them, their professional credential identification, hospital-issued identification, and written verification of privileges that identifies their role in the emergency response and identifies by naming the person to whom they report.

The practitioner will take direction from the Department Chair, or designee, in their clinical specialty regarding patient care services. The practitioner's notations in the medical record must reflect that the physician is working under "Disaster Privileges". For quality review purposes, a list of all patient encounters should be kept, if practical. The Department Chair, or designee, will monitor the practitioner's performance, concurrently and retrospectively as conditions permit, through a combination of direct observation, mentoring, and medical record review.

Practitioners who request Disaster Privileges must be currently licensed medical practitioners who maintain equivalent privileges at another facility. Privileges requested should be consistent with those currently in place in the appropriate department and specialty at the practitioner's "home" hospital.

Identification requirements for those practitioners requesting Disaster Privileges must be met before the practitioner is considered eligible to function as a volunteer licensed independent practitioner. Minimum identification credentials include a valid photo-identification issued by a state, federal, or government regulatory agency (e.g., driver's license, passport) and at least one of the following:

- A current hospital/healthcare photo-identification card identifying professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a federal or state Disaster Medical Assistance Team (DMAT) or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organizations or groups
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during an emergency

As soon as the immediate emergency situation is under control, primary source verification of the credentials

and privileges of individuals who receive Disaster Privileges will be undertaken in accordance with ECRMC Disaster Privileges Policy. This will be accomplished not more than 72 hours from the time the volunteer practitioner presents to the hospital, unless documented extraordinary circumstances intervene. This verification should include:

- Current state licensure verification
- DEA and state narcotics registration verification
- National Practitioner Data Bank (NPDB) discovery
- Health and Human Services/Office of Inspector General (HHS/OIG) List of Parties Excluded from Federal Programs
- Current active hospital affiliation

If extraordinary circumstances intervene preventing primary source verification, the Logistics Section Chief will document the following:

- Reason(s) verification could not be performed within 72 hours of the practitioner's arrival
- Proof of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

### 1.8.2 Medical Volunteer Credentialing and Identification

The Logistics Section Chief will ensure that, as conditions warrant, appropriate identity, and credentialing verification processes are followed. The Medical Staff Services Department will be consulted as necessary in the credentialing process. Hospital identification indicating "Volunteer Licensed Practitioner" and the individual's name and title will be provided and displayed conspicuously at all times while the practitioner is engaged in providing care and services. Current hospital policy shall be followed wherever in conflict with this Plan.

### 1.8.3 Non-Independent Licensed Practitioners

During EOP activation, the need for assigning disaster responsibilities to volunteer non-independent licensed practitioners may arise. A volunteer non-independent licensed practitioner is defined as a person other than a licensed independent practitioner who is qualified to practice a health care profession. This individual is required by law and regulation to have a license, certification, or registration; and is engaged in the provision of care and services (e.g., a registered nurse or respiratory therapist). ECRMC may modify the usual process for determining qualifications and competencies of volunteer non-independent licensed practitioners, if necessary, to meet immediate patient needs during an emergency. Assigning disaster responsibilities to volunteer practitioners will be made on a case-by-case basis, taking into consideration the needs of the organization and the patient(s).

Staffing resources are monitored and tracked by Human Resources, including the entire ECRMC pool of clinical and non-clinical staff. Under HICS, staffing would be managed and organized by the Labor Pool Unit within the Logistics section at each facility in conjunction with the Patient Tracking Manager in the Planning Section. The Labor Pool Unit Lead provides daily reports to the Finance Section Chief who will track hours associated to the incident. Additionally, the Labor Pool Unit Lead provides a staffing report to the Logistics Section Chief at the beginning of each operational period.

Identification requirements for those volunteer non-independent licensed practitioners assigned disaster

responsibilities must be met before the practitioner is considered eligible to provide care and services. Minimum identification credentials include a valid photo-identification issued by a state, federal, or government regulatory agency (e.g., driver's license, passport) and at least one of the following:

- A current, valid hospital photo-identification card identifying professional designation
- A current, valid license, certification, or registration as required by their professional discipline
- Primary source verification of license, certification, or registration (if required by law and regulation to practice)
- Identification indicating that the individual is a member of a federal or state DMAT, the Medical Reserve Corp, Disaster Healthcare Volunteer (DHV), Related Disaster Service Workers (DSW), or other recognized state or federal response organizations or groups
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a hospital staff member with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during an emergency

The Director of Human Resources, or their designee, will maintain a list of all volunteer practitioners and the responsibilities they have been assigned. Oversight of the professional performance of volunteer practitioners, including direct observation, mentoring, and clinical record review will be performed by the Director of Quality Management. Based on this oversight, the Director of Quality Management will recommend to the Logistics Section Chief whether assigned disaster responsibilities should continue.

As soon as the immediate emergency situation is under control (but not more than 72 hours from the time the volunteer non-independent licensed practitioner presents to the hospital, unless documented extraordinary circumstances intervene), primary source verification of the licensure, certification, or registration of individuals who were assigned disaster responsibilities will be undertaken. Primary source verification is not required if the individual has not provided care, treatment, or services under their assigned disaster responsibilities.

If extraordinary circumstances intervene, the hospital shall document the following:

- Reason(s) verification could not be performed within 72 hours of the practitioner's arrival
- Proof of the volunteer non-independent licensed practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

### 1.8.4 Labor Pool Roles and Responsibilities

When inpatient staffing needs exceed the volume of available staff, the Hospital Incident Commander (IC) will activate the Inpatient Labor Pool. The Patient Flow/Capacity Management team or designee will manage staffing needs for inpatient care areas and ancillary departments by deploying labor pool personal who possess the skills needed by each unit.

When additional assistance is required at the outpatient sites, a similar Labor Pool activation will take place. The staffing team will work with managers at the sites to understand what level and amount of staffing is needed at each of the sites.

The labor leads will work together to ensure appropriate staffing is assigned, no duplication of assignments occurs, and to the best of their ability maintain operations at all units and sites.

### 1.8.5 Release from Duty

Before a disaster healthcare volunteer can be demobilized, he/she must be released from duty. Therefore, the HCC must affirm that the disaster healthcare volunteer is dismissed from the assigned duties. Out-processing will be managed via the Labor Pool.

### 1.8.6 Spontaneous Volunteers

ECRMC recognizes that disasters often activate willing community members who offer services directly to the health system. ECRMC volunteers will be processed internally as needed through the internal system. Volunteers seeking to donate blood will be referred to the most readily available Blood Bank. Spontaneous community volunteers may be referred to the County of Imperial volunteer recruiting agencies. Additional information about California Disaster Healthcare Volunteers can be found at www.healthcarevolunteers.ca.gov.

## 1.9 Transfer of Command

As conditions evolve or higher-level leadership arrives at the Hospital Command Center, the command may transfer between leaders. The decision to do so is generally at the discretion of the higher-ranking leader. However, at activation Level 3 or higher, the most senior leadership is expected to assume command functions, or closely monitor and mentor subordinate command staff.

The transfer of command occurs following a face-to-face briefing (when no health risks are present) or a virtual briefing, during which the Incident Commander informs the person relieving him/her of conditions at the hospital, impacts, problems, progress, the strategy for managing the incident, and any other pertinent information. The oncoming IC should consider retaining the off-going commander for a period of time in the HCC to maintain continuity in leadership and knowledge transfer.

As an incident de-escalates, consideration may be given to having lower-level leadership assume command roles, both for relief purposes and for ongoing leadership development.

## 1.10 Development of an Incident Action Plan

With the HICS organization in place, an Incident Action Plan (IAP) will be developed, as early as practical, to enable Incident Command Staff to receive and disseminate information. It will also be used to perform an ongoing assessment of the incident, and monitor, coordinate, and document plan response. Depending on the scope, complexity, and anticipated duration of the incident, the plan may be disseminated verbally or may be written down and communicated more formally using the HICS Incident Action Plan form (*see Resource Annex*). When an incident extends beyond a single operational period (e.g., a single work shift), a written incident action plan will be created and maintained by the Plans Section.

## 1.11 Escalation of Response

An incident may be managed initially, according to the above process, but it may also require expansion due to a need for additional resources, personnel, or because of incident scope, complexity, and/or or duration. In this case, other procedures, such as staff augmentation and disaster privileging or transfer of supplies from other facilities, may need to be implemented.

Escalation of plan activation is at the discretion of the Incident Commander, based on the impact that an event actually or potentially has on the organization. The rationale for escalating plan activation is that at the higher level of activation, additional sets of non-essential functions may be set aside in each department, making staff

and other resources available for higher-priority assignments, as needed. Each department manager will identify staff that can be made available for loan to the Labor Pool.

Escalation options include, but are not limited to, the following:

- Increasing the internal level of activation (i.e., reducing non-essential activities and functions, and shifting staff and other resources as needed to address the priority needs).
- Increasing staffing by mandating staff overtime, partially, or fully implementing departments' off-duty mobilization plan, placing staff on 12-hour emergency shifts, acquiring staff and/or logistical support from other facilities, and cancellation of leave and days off.
- Supplementing resources from outside the community through mutual aid, Emergency Management Assistance Compact (EMAC), or government support.

## 1.12 Planned Cessation of Services

If demand exceeds capability, capacity, and external support and solutions (including patient transfer or evacuation) are not available, a plan for degradation of services will be developed and initiated by the Incident Commander. Such degradation of services may include (but are not limited to):

- Conserving, consolidating, or rationing scarce resources
- Reducing or curtailing services, capacity, and capabilities
- Closing the hospital to new patients
- Altering standards of care
- Staged or partial evacuation
- Full facility evacuation and relocation

Specific strategies are in the Planning Support Annex—Medical Surge and Loss of Community Resources and Hospital Evacuation.

## 1.13 Public Information

### 1.13.1 Media Relations

ECRMC remains committed to the principles of a public right to know, balanced against the rights of patients, staff, and guests (visitors) to privacy, and our obligation to preserve and protect those rights. When an incident involving EOP activation generates media interest, the Incident Commander will assign a Public Information Officer (PIO). The mission of the PIO, a Command Staff member, is to serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media. The PIO gathers the information necessary to provide to stakeholder groups, develop appropriate messaging (including content, format, and medium), and, with the approval of the IC, release the information.

### 1.13.2 Media Access

When members of the press present themselves (or are expected) at the hospital in connection with EOP Activation, the Public Information Officer may establish a Media Staging and Briefing Area at an appropriate area not affected by the incident. The ECRMC Marketing Department is familiar with appropriate locations for this activity. The PIO will be in charge of this area and will release information to the media as directed by the Incident Commander.

The following general policies apply to any situations involving the media during EOP activation:

- Members of the press will not be allowed inside the hospital without prior approval from the IC.
- In the event that a member of the press is granted access to any part of the facility, they will be accompanied and escorted at all times by the PIO or designee.
- Still or video photography is only permitted with signed written authorization from the hospital Marketing Department.
- Written consents and a HIPAA briefing will be required prior to any photographs or video taken of people (including patients, family members, staff, and visitors) inside patient care areas on the hospital campus.

### 1.14 Termination of Emergency Response

The individual who is the Incident Commander has the authority to initiate and terminate the hospital's response and recovery phases of the emergency. During this transition (phase between the end of the crisis and the change to predominately restoration and recovery operations) the Incident Commander will take steps to ensure that the emergency has been contained and that no new or ongoing threats are anticipated. A status report (STATREP) will be requested from each department and reviewed by personnel in the Hospital Command Center to ensure the incident has genuinely transitioned to the restoration and recovery phase. Status of the response (including termination) will be communicated to staff and outside entities as directed by the PIO.

The Incident Commander will meet with his/her Command and General Staff for a debriefing and post- incident analysis and complete an After-Action Report. Feedback will also be sought from department managers, medical and nursing staff, and non-clinical personnel. Initial emphasis will focus on:

- What happened?
- Why did it happen?
- What went well? What didn’t? What can be improved upon?
- Was HICS established immediately and appropriately? Were roles and assignments clearly defined?
- Was the hospital’s response organized according to the existing Emergency Operations Plan?
- Was information, including response objectives, communicated appropriately?
- Were operations conducted in a timely and coordinated fashion?
- Do revisions need to be made to the plan, response procedures, documentation, and tracking forms, etc.?
- Were resources (human and materiel) adequate to conduct the response effectively?
- Are improvements needed to equipment or facility?
- Were mutual aid agreements (MOU/MOA/etc.) available and executed appropriately?
- How will plans and procedures be upgraded or enhanced to reflect successful and unsuccessful aspects of the emergency response?
- Did this event highlight the need for additional training?

## 1.15 Pre-designated Incident Locations and Facilities

### 1.15.1 Incident Facilities Matrix

The hospital has pre-established specific locations on the ECRMC Campus where pre-determined incident management activities will occur. Table 1-2 depicts those locations, known as incident facilities, which may be activated for use during Emergency Operations Plan (EOP) activation. Should a particular facility or area be unsuitable for any reason, the responsible Unit Leader or Section Chief shall ensure that a suitable alternate site is selected, and its location provided to the Hospital Command Center (HCC) and all concerned parties.

## 1.16 Department-Level Preparedness

Each area (unit or department) of the hospital shall have a plan to implement during an emergency incident (whenever the hospitals' EOP is executed, regardless of the activation level). This plan, called a Department Emergency Operations Plan (DEOP), will be prepared by the department head, and updated at least annually. The department head will make copies readily available for reference and review by departmental staff. At a minimum, each DEOP should include the following (*see Appendix C, Departmental Annex*):

- Departmental mission during Emergency Operations Plan (EOP) activation.
- Department functions and responsibilities during the first 60 minutes of any EOP activation.
- Process for reporting status to the Hospital Command Center (HCC).
- Notification process for departmental staff, including staff augmentation process.
- Process for terminating and reactivating non-essential functions.

Department heads will ensure that all personnel within their departments are current on emergency procedures, documentation forms, and equipment, and familiar with their roles as well as the hospital's plan for managing emergencies.

### 1.16.1 Department-Level Activation

In preparation for EOP activation, department heads will utilize their Department/Emergency Operations Plan (DEOP) to:

- Ensure that all staff return to their floor/unit/department to obtain an incident briefing, assess their patients and clinical area (using the Patient Assessment Form – Appendix D, Resource Annexes), and carry out activities as directed by the next-level leader.
- Inform off-duty staff on the incident as needed.
- Determine staffing needs.
- Report area status and resource needs to the Hospital Command Center via a STATREP Form online, if requested by HCC

In every department, the senior person present will take charge and make all necessary decisions until relieved by a superior.

- Within 15 minutes of EOP activation, the department manager, or in their absence the best available alternate, will contact the Incident Commander/HCC and advise the Plans Section Chief or designee of the department's status. Initial Status Reports (STATREP) should be completed online and periodically

throughout the incident. Problems encountered should be communicated immediately to the next level in the Hospital Incident Command System (HICS) organization.

- Each department manager is responsible for informing their key personnel as conditions warrant. Department heads will keep an up-to-date call list incorporating phone, text, and cell numbers within their immediate access at all times, and copies on file with Administration for this purpose.

### 1.16.2 Department-Specific Contingency Procedures

Certain departments maintain extensive contingency procedures for department-specific activity. For example, the Facilities Department maintains detailed procedures for failure and restoration of various utilities, and the Food and Nutrition Services maintains the minimum required inventory of foodstuffs and water to support nutritional needs when cooking is not possible. These department-level procedures should be considered attachments to a given department's DEOP and shall be maintained by the department for immediate reference, as needed. The department head shall ensure that such DEOP attachments are current and reviewed annually.

## 1.17 Departmental Status Reporting (STATREP)

A critical component in the development of an effective emergency response is timely, accurate information. Within 15 minutes of EOP activation, each on-duty department head, or in their absence, the best available alternate, will contact the HCC and advise the Plans Section Chief or designee (or Incident Commander if no Plans Chief has been designated) of the status of their areas. Each department shall immediately complete a Status Report (STATREP) online, within 15 minutes of the initial incident occurring (and periodically—at least once per shift—thereafter). The STATREP provides concise information directly to the HCC on:

- **S**taffing
- **T**racking (patient count)
- **A**vailable beds
- **T**echnology status
- **R**esources available/needed
- **E**vent impact on department
- **P**roblems or progress toward resolution

The STATREP is the basis for the decision-making and prioritization that follows. Status reports should be communicated to the HCC periodically through the incident. Problems encountered shall be communicated immediately to the next level in the HICS organization or to the HCC.

The STATREP data is aggregated from all reporting units/departments and the data is available for all HCC staff, who in turn will brief the department submitting the report on the nature and scope of the incident and provide any other available information. In this way, the STATREP process serves as an information exchange ensuring that the most accurate, timely information is passed along.

## 1.18 Healthcare Emergency Codes

ECRMC utilizes a standard set of emergency codes for announcing critical events while minimizing the alarm to non-staff present in the hospital. If a situation corresponds to one of these Healthcare Emergency Codes, the IC will direct the appropriate code announcement immediately preceding the Code HICS announcement (*see*

*Resource Annex—List of Hospital Emergency Codes currently approved for use*).

### 1.19 Recovery & Resumption of Normal Activities

Once an incident stabilizes or allows time for planning, the Incident Commander and Hospital Incident Management Team (HIMT) will begin planning for the recovery and resumption of normal hospital activities (*see Appendix A.19 Business Continuity/Continuity of Operations Plan and Appendix A.20 Disaster Recovery Plan*).

## 2 HOSPITAL COMMAND CENTER

### 2.1. HCC Mission

The Hospital Command Center (HCC) is the command-communications-control (C3) point from where the Incident Commander (IC), Command Staff, and General Staff Section Chiefs will direct the organization's response to an incident. The HCC will be located in CEO Conference Room in the North Administration area. At a minimum, a virtual HCC shall be established for every EOP activation. The virtual HCC shall be operational via communication or internet link within five minutes of EOP activation. For every Level 3 & 4 EOP Activation, an actual (physical) HCC shall be established and operational within 15 minutes of EOP activation.

### 2.2. HCC Staffing

The HCC is staffed (as HICS positions are activated) by the IC, Section Chiefs (i.e., Operations, Planning, Logistics, and Finance Chiefs), Command Staff (i.e., Safety, Liaison, and Public Information Officers and Medical/Technical Specialists), the Resource and Situation Unit Leaders, and administrative support staff (as necessary) to answer the phone and radio, operate HCC equipment, compile information, and maintain event records. Other HICS positions will be deployed as directed to appropriate work locations to carry out response and/or recovery activities. Appropriate security will be provided to the HCC to ensure that only authorized individuals are permitted entry.

### 2.3. Virtual vs. Physical HCC Activation

A virtual HCC is a structured communications arrangement between Hospital Incident Management Team (HIMT) members who are not physically co-located. In a virtual HCC arrangement, the IC and any activated Command Staff and Section Chiefs establish and maintain communication via a designated communications network (e.g., telephone, radio, and videoconferencing) rather than mobilizing in a physical HCC location. A virtual HCC may be effective under the following conditions:

- A Level 1 or 2 event in which a potential event or actual event with minimal impact is being monitored but no immediate leadership actions (beyond planning or resource mobilization) are required.
- Meeting physically may have an impact to the health and safety of the team.
- An effective communications network can be established and reliably maintained.
- A schedule of contacts is established and maintained.
- Leadership visibility or physical centrality is not beneficial or significant to incident management.
- Command and control can be effectively maintained.

When a virtual HCC is established, the IC or Communications Unit Leader carries out all notifications and communication activities remotely. At the discretion of the IC, a virtual HCC will be transitioned to an actual HCC when any of the above conditions cannot be met or maintained.

At the discretion of the Incident Commander, either a virtual or a physical HCC will be utilized for minor event (Level 2) EOP activations. A physical HCC will be established for all moderate or major impact events (Level 3 or 4), when the conditions permitting a virtual HCC cannot be met or maintained, or at the discretion of the IC for any EOP activation level. The actual HCC provides the distinct advantages of shortening lines of communication, avoiding reliance on technology for command-and-control actions, improving access to information, and hastening the decision-making process. When activated, an actual HCC should be operational within 15 minutes of the activation decision.

The IC will direct the organizational transition from a virtual HCC to a physical HCC. The virtual HCC environment will be maintained while the actual HCC participants are assembling. In the event that conditions require the loss of virtual contact between HCC participants during the assembly process (e.g., leaders must travel off-site and may be unavailable for contact), alternates shall be identified to maintain command and control until such contact can be reliably re-established. At no time shall the loss of communication be permitted to disrupt the command-and-control process of the organization.

### 2.4. HCC Operations

The IC should generally remain at the HCC throughout the emergency, maintaining a visible command posture. If leaving the HCC, the IC will identify an HCC Manager, who will be in direct contact with the IC at all times until the IC's return. At the direction of the IC, the HCC initiates the following functions as soon as possible:

- Assign appropriate staff to HICS functions, provide briefing and direction, and issue HICS vests and clipboards.
- Activate the HCC telephone lines and assign incoming numbers to activated HICS Section Chiefs and HCC staff as necessary.
- Develop and implement a reporting schedule (at various time intervals dependent upon what complexity and scope of the emergency). Staff are required to report updated patient/resource status to the HCC.
- Log in and track status reports from all departments reporting.
- Communicate with Patient Flow/Patient Access regarding bed availability and current census.
- Call in additional help as necessary using the HICS organizational structure to provide specific assignments and ensure control, coordination, and integration of effort.
- Initiate the Situation tracking function, maintaining as complete a log of events and decisions as possible. Log sheets are maintained in the HCC Emergency Equipment Cabinet.
- Establish a process to collate forms, reports, and logs described in this plan to facilitate decision-making, documentation, and business continuity.
- Secure the HCC and restrict entry only to authorized personnel whose presence is required. An HCC sign-in log should be maintained documenting those people present in the HCC.

### 2.5. HCC Evacuation/Relocation

If the primary HCC is inaccessible or becomes unusable during the incident, an alternate HCC location may be activated. Evacuation or relocation of the alternate HCC will occur only at the direction of the IC or if there is immediate life or safety threat. Location of an alternate HCC may be the ASB conference room, or MOB conference room.

## 3. ADVANCE PREPARATIONS

Although many incidents occur with little or no warning, there are others where advance notice is provided to the hospital hours, days, or longer ahead of an occurrence. Examples may include weather events (e.g., storm watches and warnings), public safety threats (e.g., changes in the Homeland Security Advisory System), and planned events (e.g., a planned shutdown of the hospital electrical system for testing or service). For such situations, there are actions that may need to be implemented by the hospital in advance of the event to prepare the organization to respond when and if the threat materializes or an adverse impact occurs. The actions below are grouped based on core critical areas of healthcare emergency management (as required by The Joint Commission [TJC]) and are enhanced by planning documents found in Annexes A-C. Depending on the circumstances, these guidelines may be implemented hours to days before impact is anticipated. Variation from prescribed activities may occur at the discretion of the Incident Commander, and activities may be adjusted to meet specific situations.

### 3.1. GENERAL PREPAREDNESS MEASURES

As an event approaches, general readiness measures may include but are not limited to:

- Activating the Emergency Operations Plan (EOP) and placing potential Hospital Command Center (HCC) staff on alert status.
- Establishing a Planning Section to prepare specific contingency plans for the impending situation.
- Activating a watch desk to monitor evolving conditions.
- Activating external support agreements (e.g., security augmentation, staff transportation, staff lodging, and dependent/pet care) or placing in alert status.
- Maintaining monitoring of local and/or relevant news media and weather forecasting for updates and status changes.
- Reviewing emergency plans and procedures with staff and other stakeholders.

### 3.2. EMERGENCY COMMUNICATIONS

- Communicate information with staff regarding the impending event, hospital and community activities being undertaken, and staff and staff family personal preparedness measures.
- Test radio, paging, amateur radio (HAM/RACES/ARES), mass notification, satellite phone, and internet links and alternate communications plans and equipment. Ensure all batteries are fully charged.
- Reposition rooftop/exposed transmission antennas to prevent potential damage.
- Update regional critical resource inventories and online data management systems.

- Establish contact with local broadcast news media to review procedures for public announcements and staff alert broadcasts.
- Establish contact with the SDEMS-MHOAC and the Imperial County-EOC if activated. Provide liaisons to Emergency Operations Centers (EOCs), as needed.
- Maintain effective communications with all involved parties: staff, patients, patient families, vendors, UCSD Campus EOC, assisting and cooperating agencies, and the community.

**Note:** Additional information may be found in Appendix A.2. The Communications Plan

### 3.3. Resources and Assets

ECRMC has established inventory listings of the following types of supplies considered to be critical to an emergency response:

- Medical supplies
- Non-medical supplies
- Surgical supplies
- Personal protective equipment (PPE)
- Pharmaceuticals
- Water, potable and non-potable
- Food
- Linen
- Fuel
- Medical gas

The Emergency Preparedness Department, and/or designee, ensures each critical department maintains required inventory lists: Materials Management, Pharmacy, Maintenance, EVS, Dietary, and other departments maintain inventory lists for the appropriate resources. Lists are reviewed and updated at least annually.

Per AB 2537, hospital maintains a stockpile of personal protective equipment (PPE) equal to three months of normal consumption of the following supplies:

- N95 filtering facepiece respirators
- Powered air-purifying respirators with high efficiency particulate air filters
- Elastomeric air-purifying respirators and appropriate particulate filters or cartridges
- Surgical masks
- Isolation gowns
- Eye protection
- Shoe coverings

All supplies will be monitored as consumed. As the point of depletion is approached, the Incident Commander will consider options to prolong operation with the potential for evacuation of the facilities. On a routine basis, the hospital will:

- Review inventory of critical supplies to support loss of community supply chain lasting more than 96 hours.
- Inventory and replenish (as necessary) resource stockpiles, including food, potable water, linen, pharmaceuticals, medical supplies, spare batteries, generator fuel, and damage control materials.
- Update resource and asset inventories.
- Place advance or accelerated orders to reinforce stockpiles as needed/anticipated.
- Activate or mobilize emergency stores and/or vendor-managed inventories.
- Review and update vendor emergency contact information.
- Review status of emergency purchase orders and standing order deliveries.
- Service and fuel hospital vehicles and generators.
- Stock food and bedding or make preliminary arrangements for staff lodging and hygiene.
- Secure or consolidate supplies of scarce resources (e.g., antibiotics, fuel).
- Consider fiscal needs, including availability of cash reserves to support post-event purchases and staff.
- Maintain sufficient cash on hand for emergency advances.
- Review need to locate critical assets to safer/more secure areas.

### 3.4. SAFETY AND SECURITY

In planning for an emergency, the hospital will plan to:

- Remove/secure outdoor items that could become airborne.
- Secure materials (e.g., pharmaceuticals, narcotics, radioisotopes) requiring special handling or security measures.
- Deploy enhanced security measures, ranging from 100 percent identification checks to facility or campus lockdown.
- Evaluate parking areas for restriction or traffic flow adjustment.
- Establish staging areas for incoming resources.
- Conduct an event-specific threat and vulnerability assessment of the facility.
- Review policies for community influx for shelter or resources.
- Review procedures for security reinforcement (including external vendor and law enforcement contacts), and restriction of facility egress/access, and control traffic flow.
- Review use-of-force policy.

### 3.5. Staff Management

- Prepare staff scheduling enhancements to cover the period, including shift alterations, extended shifts, and additional contracted coverage.
- Place off-duty/on-call staff in alert status.
- Review human resource policies covering staff absenteeism during emergencies.
- Implement denial of leave requests, cancellation of pre-scheduled leaves and days off, and medical clearance for use of sick leave.
- Ensure continuity of executive leadership coverage in the staffing plan.
- Update lists of employees who live or will stay within close proximity of the hospital. Ensure that complete address information, including apartment numbers, and contact information, including cell phone, e-mail, and text-messaging addresses are updated.
- Facilitate and encourage establishment of employee self-help transportation pools. Limit routine use of hospital vehicles in order to provide staff transportation during extreme circumstances.
- Create sleeping arrangements or reserve hotel accommodations for key staff.
- Assist staff in preparing their homes and families for the potential event impact (e.g., stocking food, fueling vehicles, reviewing dependent care, family communications plan, and pet care arrangements).
- Identify potential need for staff dependent care (including pets) and activate plans as needed.
- Direct incoming personnel to bring extra clothing and food in preparation for an extended stay, as well as personal items such as toiletries, and prescription medications.
- Review hospital emergency procedures with staff, including shelter-in-place and evacuation plans and policies for absenteeism.
- Brief the Critical Incident Stress Management (CISM) team, if needed.

### 3.6. Utility Management

- Review and practice event-specific utility management, shutdown, restoration, and recovery procedures.
- Activate protective air filtration systems or ventilation zoning controls.
- Activate systems requiring advance priming before operations (e.g., generators, utility backup, and electronics).
- Consider engineered pre-event shutdown or controlled degradation of utilities and/or critical systems (e.g., medical gases, vacuum).
- Review the business continuity plan and consider the need for activation of a hot backup data site. Store fresh backup files off-site, out of the impact area.
- Establish contact with service and support vendors and public utilities.

- Review and update emergency service contact information.

### 3.7. Patient Population

The hospital serves the surrounding communities and during an emergency, will, to the best of its ability, serve the at-risk community. At-risk patients served by ECRMC include but are not limited to geriatric, chronic conditions, behavioral health, dialysis, and other populations.

In the event that vulnerable persons not normally cared for by ECRMC are admitted to the hospital during disasters, all efforts will be made to provide the best level of care with available resources.

Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence.

#### 3.7.1. Patient Management

- Prepare modifications of clinical scheduling, including cancellation of elective procedures, census reduction, and discontinuation of outpatient activities. Pre-assign available staff to meet projected facility staffing needs.
- Notify patients regarding the potential cancellation/suspension/delay in planned services (e.g., lab, admission, treatment, procedure).
- Prepare home-care clients for extended periods without staff visitation. Identify those clients who will be leaving the area, who will be assisted by an alternate caretaker, or who may require assistance with shelter-in-place and/or evacuation plans. Prioritize service needs for scheduling purposes when visits can be resumed.
- Prepare to activate surge-capacity spaces for intake of evacuated special needs populations, overflow, evacuees from other impacted medical facilities, or patients generated by the event.
- Prepare for potential degradation of services in response to evolving emergency conditions, including changes in patient/office cleaning intervals, changing of bed linens, rationing of supplies, etc.

The hospital Emergency Management Director consults with relevant community partners, online databases, and regional coalitions whenever the hospital's needs or vulnerabilities change:

- To review probability, impact, level of preparedness, and vulnerability scores
- Communicate the hospital's needs and vulnerabilities to the appropriate community emergency response agencies
- Identify the community capabilities needed to meet its needs during an event.

This communication and identification of vulnerabilities occurs, at a minimum, at the time of the hospital's every two-year review of its EOP and/or whenever its needs or vulnerabilities change. Community partners include:

- Public safety (fire, law enforcement, EMS)
- Neighboring hospitals/healthcare organizations
- Local/county/state public health departments

- Public works/utilities
- Local/state emergency management
- Vendors/suppliers
- Local/County/State public health departments, County Medical Examiner, and Environmental Services Department
- Local/State Emergency Management: California Department of Emergency Planning, California
- Department of Health Services, FEMA, Red Cross, California State Emergency Response & Recovery Plan (SERRP) California Office of Emergency Services
- Community Organizations
- Vendors and suppliers
- The Emergency Management Director maintains documentation of all external review and coordination efforts.

## 4. RECOVERY AND RESUMPTION OF NORMAL ACTIVITIES

### 4.1. OVERVIEW

Recovery activities are those actions taken following an event with the intent of returning the organization to its pre-event or new normal state. Recovery actions may range from the concluding steps taken by each member of the Hospital Incident Management Team (described on their Job Action Sheets) to compiling documentation, conducting a critique, preparing an after action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the Emergency Operations Plan (EOP), and training or retraining personnel, as necessary.

As the incident evolves, the Plans Section Chief will begin to develop a strategy for demobilization of the response and associated resources. Depending on the scope of the incident, the demobilization process ranges from simple to complex. The Demobilization Unit may be established to develop the assessment and plan for the demobilization and recovery. Demobilization and recovery plans should be carefully addressed as part of the Incident Action Plan (IAP) for the event.

The Incident Commander (IC), in consultation with senior executive and clinical leadership, will make the determination of when to transition from the response phase to the recovery phase and when to terminate the recovery phase. The Hospital Command Center (HCC) will remain active and staffed through the recovery process, or until the IC deems it appropriate to secure.

All Incident Management Team members will complete the recovery tasks itemized on their respective Job Action Sheets and forward all incident-related documentation to the HCC for compilation. The HCC will assign staff as necessary to consolidate and process the paperwork and record keeping.

### 4.2. FACILITY REPAIR AND INSPECTION

As the hospital enters the recovery phase, there are several facility issues to consider. The first, general housekeeping and cleanup, is likely to be indicated following almost any response. The combination of

response-related activity, coupled with the possible suspension of non-essential routine housekeeping services to free up staffing for other assignments, suggests that early attention is needed in this area. Terminal cleaning may be indicated and will be directed by the Infection Prevention Team. The Operations Section (Infrastructure Branch) will take the lead in inspecting the facility and in planning, prioritizing, and organizing the cleanup personnel and assignments to accomplish the work expeditiously.

The second issue - damage assessment and mitigation - is indicated if the facility was involved in the problem (e.g., fire, flood, shooting) or has been unable to maintain an environment of care. In such cases, the Infrastructure Branch and the Safety Officer will be activated. One or more damage assessment teams will be sent out to mitigate immediate threats, assess general safety and habitability, and survey and document damage. The Infrastructure Branch Director shall develop a plan of action for facility restoration and begin to carry out the plan as approved by the IC.

Longer-term recovery is the third issue. Depending on the extent of the damage, repairs and restoration may take days to months to carry out. To expedite the necessary activities, the hospital may use outside vendors or contractors to perform some or all of the work. The Operations Section, supported by the Infrastructure Branch, will initiate the planning process, transitioning the information into the IAP process whenever possible. ECRMC will reconstruct the facility following applicable federal, state, and local laws, regulations, and guidelines

#### ACCREDITATION AND LICENSURE.

The Joint Commission provides specific re-accreditation requirements for organizations that have been closed or out of service as the result of a disaster and/or the organization's decision to cease operations (*see Table 4-1*). The Joint Commission will also work with responsible state and federal agencies to assist ECRMC in re-establishing operations as well as its qualification for accreditation. This will be accomplished through the California State Department of Public Health Services architecture review and licensing department review.

**Table 4-1. The Joint Commission Post-Disaster Accreditation Status.**

| Time After Disaster | TJC Accreditation Status |
|---|---|
| ***≤ 30 days*** | Original JC accreditation status remains in effect.<br>**NOTES: (1)** When the hospital resumes operation, the time frame for complying with any outstanding TJC requirements (e.g., PPR, ESC) also resumes.<br>**(2)** Usually, no need to survey affected organization to reassess its level of standards compliance.<br>**(3)** If a survey is conducted, the accreditation decision is based on survey findings. |
| ***31-90 days*** | An extension survey is conducted to determine accreditation status.<br>**NOTE:** The circumstances surrounding the closure will determine the survey's length and scope. |

| ***91 days -<br>6 months*** | An environment of care onsite survey is required.<br>**NOTES: (1)** Survey takes place 1-2 weeks after services are resumed.<br>**(2)** It is assumed that clearance has been received from the fire marshal and other local/ state authorities before services are resumed.<br><br>A second onsite survey is conducted approximately 4 months after services are resumed to evaluate sustained compliance with standards and requirements.<br>**NOTES: (1)** The track record for demonstrating standards compliance will be 4 months.<br>**(2)** Affected organizations will continue to be listed as Accredited up to 6 months after a disaster, unless survey findings dictate otherwise. |
|---|---|
| ***> 6 months*** | Accreditation is discontinued.<br>**NOTES: (1)** If the organization resumes operations, re-application for accreditation is required.<br>**(2)** The re-accreditation process will involve at least 2 surveys. The first survey is conducted at the organization's request and will assess the organization's ability to provide safe patient care. The second survey is conducted approximately 4 months later to assess sustained compliance with requirements.<br>**(3)** The track record requirement for demonstrating standards compliance is 4 months. |

### 4.3. RESUMPTION OF CLINICAL SERVICES

Once an environment of care is restored, the restoration of on-campus clinical service can begin. The Operations Section (Medical Care Branch Director) will investigate and report on the status of clinical services—specifically, what can be resumed (and in what timeframe), and what must continue to remain out of commission pending further activity or developments. This assessment and determination of resuming deferred clinical services will be done in coordination with Executive Leadership under the auspices of the hospital Board of Trustees and in concert with the clinical program leaders. If significant, the resumption and restoration process will be prioritized and incorporated into the IAP for each operational period until completed.

If the event impacts patient care areas, clinical services and critical ancillary support departments receive priority for restoration. The HCC, in collaboration with executive leadership, will determine which departments will be prioritized for restoration based on the current event and its impacts.

### 4.4. REPATRIATION OF PATIENTS AND STAFF

Repatriation is the process of returning patients and staff from relocation outside their normal service areas to their original hospital placement. Key elements of any repatriation planning include establishing communications between the facility and the returning individuals, and leadership consideration of the evacuees' difficulties when returning to the facility.

The Logistics Section should consider assignment of the patient experience team— individuals who are exceptionally compassionate and can be deployed to assist returning individuals (patients and staff) with the myriad challenges that face them.

### 4.5. RESUMPTION OF PRE-INCIDENT STAFF SCHEDULING

As circumstances allow, personnel should be released from emergency duties to resume normal duties, attend to personal or family needs, be sent home, or to attend critical incident stress debriefing sessions, memorial services, or religious services. A staffing schedule should be quickly established, with early efforts targeted at releasing mutual aid personnel from other facilities, as well as volunteer licensed and non-independent licensed practitioners. Alternately, if the mutual aid and volunteer staffing will be used to provide relief for hospital staff, then one-for-one relief scheduling should be arranged, and a relief schedule posted. Other staff members may be released based on personal necessity. Personnel from other departments who were temporarily reassigned should be returned to their own departments for assignment. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.

### 4.6. RESOURCE INVENTORY AND ACCOUNTABILITY

Department managers will initiate an inventory of all critical supplies and equipment, and should request repair, replacement, or replenishment as needed from the Logistics Section and/or from appropriate departments. On-duty personnel should do this immediately after the EOP is implemented and should not be postponed until the next shift or ordering day. Department managers shall ensure that their areas are returned to a state of full operational readiness as quickly as possible.

# 5. MEDICAL SURGE AND LOSS OF COMMUNITY LOGISTICAL SUPPORT

## 5.1. Surge Support

### 5.1.1 Bed Capacity/Expansion (Internal)

When the Incident Commander determines that normal bed vacancies cannot accommodate the admission requirements of casualties or those requiring medical or surgical inpatient services, the following steps will be taken.

- The Incident Commander will:
  - Activate the EOP/HICS at corresponding level.
  - Identify capacity level needed and duration.
  - Determine which surge spaces will be activated and in what order.
  - Initiate transfer activities as needed to clear the Emergency Department (ED) of all pending admissions and holds and maximize available ED and pre-admission holding space as rapidly as possible.
  - Refrain from initiating in-patient (disaster) discharge activities until valid confirmation of need is received from competent authority.
  - Ensure notifications are made.
- The Plans and Operations Section Chiefs will:
  - Review STATREP data that is received from every clinical area of the hospital to assess current capacity and require STATREP updates every two hours, as needed.
  - Initiate actions to maximize ED and holding capacity.
  - Begin canvassing the hospital, as needed, to identify available rooms or space, patients ready for discharge, and prioritization of patients for discharge.
  - Initiate measures to staff surge spaces as directed.
- The Logistics Section Chief will initiate measures to open, acclimatize, clean, equip, and supply surge spaces as directed.
- The Finance/Administration Section Chief will initiate cost tracking for all associated expenses and prepare projections of daily impact based on anticipated surge level.
- As many patients as possible, normally scheduled for discharge the following day, will be discharged immediately; available hospitalists and house staff physicians will prepare to discharge these patients upon notification and Case Management will begin contacting family/Power of Attorney.
- Those patients admitted for elective surgery will be discharged and re-admitted at a later date.
- Additional beds can be made available by doubling bed capacity (where feasible) in existing patient rooms or using classrooms and waiting rooms as patient rooms or holding areas.
- Patients selected for evacuation, either discharged to home or to another facility, will be sent to their respective discharge loading area. Nursing will supply staff to oversee these areas with the

help of other physicians. Patients who are discharged to home will be directed to leave immediately and directed to the discharge area.

- Assess need to establish alternate care sites (see below).

### 5.1.2 Alternate Care Site Operations (External)/Expansion of Facilities

There are several circumstances under which establishment of an Alternate Care Site may become necessary. These include the need to evacuate all or part of the hospital due to an internal or external event threatening the facility or its occupants; an external incident producing a patient load that exceeds the facility's in-patient capacity for care; and an event where special circumstances, such as a communicable disease threat, require separation of some patients from the general hospital population. It also includes an event where the facility is tasked with establishing a screening facility or Point of Distribution for medication or vaccination during a community-wide crisis. Under these circumstances, the IC may elect to activate one or more of the following preplanned alternate sites for care, treatment, and services to meet the needs of its patients during emergencies:

#### Campus Alternate Care Sites

- North Lobby
- MOB classrooms
- Main Lobby
- Meeting Rooms
- Tents in Parking Lots

#### Facility-Controlled Alternative Care Sites

IC may activate alternative care sites. Arrangements to support these sites will be managed through the Section Chiefs**.**

- The HCC will be in contact with the ICEMS-MHOAC and ascertain information about other community alternative care sites potentially meeting the needs of ECRMC patients.

When the ECRMC experiences an actual emergency, the needed response procedures related to care, treatment, and services for its patients are activated under HICS. Objectives for the management of the actual emergency are defined by the Incident Commander and direct patient care is managed under the Operations Section with support from both Command (Safety, Liaison, PIO) and General (Logistics, Planning, Operations, Finance) Staffs, under HICS.

- **Alternative Care Site Implementation Procedures**

When an alternate care site is activated, the following general procedures will be implemented:

- The EOP will be activated at a minimum of Level 3. Notification will be made to the ECRMC Department of Emergency Preparedness, local government oversight agencies, the Imperial County Healthcare Disaster Coalition, ICEMS-MHOAC, and other Mutual Aid Agreement partners.
- A suitable command structure will be established and staffed for each alternate care site. The site commander will be known as the Alternate Site Branch Chief and will report at the general staff level to the Incident Commander. The level of Command Staff provided will be determined by the

nature, scope, and anticipated duration of the alternate site activation.

- Clinical and support staff for the alternate site will be determined by the Alternate Site Branch Chief and sourced as available from the hospital labor and medical staff pools, and other resources.
- The Logistics Section Chief will address logistical needs, including transportation and communications between the facility and the alternate site. At a minimum, telephone, fax, and two-way radio communications links should be established. Transportation will be required for movement of patients, staff, and equipment. In the event of anticipated operation in excess of 24 hours, efforts should be made to establish computer data links as well. The Logistics Section will also support medical and pharmaceutical supply needs. The following general process shall be followed:
  - When preparing to activate the alternate site, the Command and General Staff collaborate on the resources, assets, and capabilities needed to activate the site, based on site-specific logistics and the particular site mission or tasking.
  - Once the Resource and Asset Needs List are developed, the Logistics Section (Service and Support Branches) are responsible for assembling the resources, assets and capabilities needed, arranging for transportation, delivering them to the alternate site, and rendering them operational as conditions dictate.
- The Public Information Officer will ensure that appropriate notifications are made to patients and their families when they are relocated to or from an alternate care site. The Plans Section will be responsible for planning and documentation needs, including management of patient tracking and records. HICS standard forms will be used for tracking and incident documentation.

As the need for an alternate care facility decreases, the Site Branch Chief, in consultation with the Incident Commander, General Staff, and Medical Care Director, will develop a written action plan for de- escalation of alternate care site operations; return of patients, staff, records, and resources to the hospital; and discontinuation of alternate care site operations.

### 5.2. Loss of Local Logistical Capability

There may be incidents or times when the local area is unable to support the hospital in the six critical areas: communications, resources and assets, safety & security, staff responsibilities, utilities management, and patient clinical and support activities. Significant degradation or loss of local area support for any of the six critical areas may result in the suspension or reduction of specific services, temporary or partial facility closure, or facility-wide evacuation.

#### 5.2.1 Corrective Actions

ECRMC evaluates its capabilities and response procedures to self-sustain should the organization become unable to be supported by the local area. In the event ECRMC is unable to be self-sufficient for an initial or subsequent 96-hour period, ECRMC will consider pursuing one or more of the following options.

- **Conservation of resources** - Command staff will make every effort to extend the use of the resources (e.g., service reduction, modify or limit admissions, and partial or full evacuation if no other safe alternative is available). Should an evacuation be required to lessen the patient load and the requirement of resources, it will be executed as a planned evacuation (see Appendix A – Evacuation Support Annex).

- **Curtailment of Services** - the Command staff along with organization leadership will assess what services may relocated to another facility or discontinued for a period of time.
- **Acquire Essential Resources** - ECRMC will seek resources from Imperial County and regional medical facilities, support agencies and vendors within the region.
- **Seek State Support** - ECRMC will accept support from the State of California military assets when available and other State and Federal system support as needed/available. Requests for these assets will flow through the established process where ECRMC requests resources from Imperial County (ICOES-MHOAC). The County will send requests to the next level, which may ultimately extend to requests for regional, State and Federal resources.

### 5.2.2 Procedural Intervention

Specific actions that the hospital takes to reduce the need for community logistical support to remain operational include:

- **Service Scheduling.** Scheduling elective procedures that align with existing staff and resources as well as referring patients to satellite facilities depending upon the needs and circumstances of the patient and the impact of the emergency/disaster event.
- **Redundant Communications.** Redundant communication systems will be utilized to mitigate the impact on the facility and sustain operations, to the best of its ability, for at least 96 hours. Multiple forms of communication have been identified within the facility such as dedicated lines, LAN network, cell phone, Internet, HAM radios, and handheld radios that are supported by repeater system. The staff from the Hospital Command Center (HCC) determines the mode of communication during the event (see Planning Support Annex, Communications Plan).
- **Inventory Management.** (*Appendix D.13 Critical Resource Inventory*) ECRMC maintains inventory of food, water, medical, non-medical, and pharmaceutical supplies on site to provide immediate availability of critical resources at the onset of an emergency. During the emergency event, if supplies are becoming depleted, the first source of additional resources and supplies may be vendors, other nearby facilities and community healthcare partnerships followed by other regional facilities. The Logistics Section Chief will facilitate and track requests for these resources. In addition, Supply Chain Management/Warehouse maintains emergency contact information for all vendors, including emergency supply vendors, should additional purchases become necessary (see Resource Support Annex).
- **Resource Management.** Resources and assets are inventoried and maintained by the responsible department. These departments include but are not exclusive to Materials Management, Dietary, Respiratory Therapy, Laboratory, Pharmacy, and Maintenance. Each of these departments maintains independent inventories of their supplies, and estimates approximate usage timelines. These departments assist as advisors to the HCC making decisions to reduce or eliminate usage of certain supplies. When supplies and assets to support certain service lines are exhausted, the service lines are prioritized based on acuity and life-sustaining variables and are evacuated/terminated accordingly at the direction of the HCC (see Resource Support Annex).
- **Safety and Security.** The safety and security of patients, staff and visitors is the prime responsibility for ECRMC during an emergency. As additional safety and security assets are needed, the hospital will utilize both internal resources (i.e., staff from other departments) as well as external public safety, security, and military personnel. An ongoing needs assessment will be

made and reported to the HCC (see Planning Support Annex, Safety & Security).

- **Staff Responsibilities.** Staff responsibilities and emergent actions are addressed in each Department Emergency Operations Plan (DEOP) as well as through communication from the HCC through area managers. During an event, certain departments and activities may be considered non- essential. Departments and individuals that are regarded as non-essential will be designated to the Labor Pool for reassignment to essential/business sustaining service lines at the request of the HCC. Department emergency call lists will be used to contact additional staff off campus. Volunteers will be credentialed and assigned tasks at the direction of the Labor Pool. Individual situations will be considered and resolved for personnel to help sustain staffing for additional periods of time. The staffing plan is designed to exceed 96 hours. However, resources required for different magnitudes of an event will significantly impact the staffing plan. If additional resources are unavailable through ECRMC, contract services, or through Memorandum of Understandings (MOUs), the facility would be evacuated to an alternate care site.

- **Utility Management.** Utilities are managed by the Facilities Department. The department has policies and procedures to respond to utility failures. An inventory of critical supplies onsite, such as water and fuel, is maintained. When water scarcity, contamination, or power becomes an issue, the Planning Support Annex—Utility Management Plan is immediately implemented. The Facilities Department provides direction to the HCC on the remaining resources during the event to estimate when utility resources may end. A time estimate for evacuation to an available Alternate Care Site should be considered when resource availability is presented to the HCC (see Planning Support Annex, Utility Management).
- **Clinical and Support Activities.** Patient clinical and support activities will be available based on the supply, staff, and utility contingency plans. Clinical and support activities may be altered to treat an influx of patients in the Emergency Department. The ED Department Emergency Operations Plan (DEOP) includes predetermined locations for patients triaged as well as locations for treating and caring for existing and event specific patients. The facility may develop plans to expand capacity, and to extend clinical and support activities for the duration of the event. The Incident Commander ultimately decides if the facility can continue or eliminate certain patient activities. Some of the decisions that the IC may consider would be to immediately discharge as many patients as possible normally scheduled for discharge the following day, or to discharge patients admitted for elective surgery. The Senior Medical and Administrative Staff, Operations Chief, as well as Medical Technical Specialists would serve as advisors when necessary. When patient clinical and support services cannot be provided, patients are evacuated to the nearest available facility (see Planning Support Annex, Patient Care and Clinical Support Plan).

**Table 1-1. ECRMC Activation Matrix**

| ACTIVATION LEVEL | DEFINITION/ PARAMETERS | AUTHORITY TO ACTIVATE | ANTICIPATED HICS ACTIVATION | NOTIFICATIONS |
|---|---|---|---|---|
| **1**<br><br>ALERT | Information received indicating a situation or event that may have an actual or potential unusual impact on facility operations. ***Examples:***<br>• National Weather Service issuance of a severe thunderstorm **watch or warning**<br>• EMS notification of a multiple casualty incidents (MCI)<br>• Peak Census Alert<br>• IS Outage Alert | Chief Executive Officer<br><br>Or<br><br>Designee | • None for Level 1 (informational only) | • PBX<br>• Administration<br>• Department Directors and Managers<br>• Emergency Preparedness Director |

<table>
<tr><th>ACTIVATION LEVEL</th><th colspan="2">DEFINITION/ PARAMETERS</th><th>AUTHORITY TO ACTIVATE</th><th>ANTICIPATED HICS ACTIVATION</th><th>NOTIFICATIONS</th></tr>
<tr><td rowspan="8">2<br><br>MINOR IMPACT</td><td colspan="2">An actual situation or event that is having a minor or unusual impact on facility operations.</td><td rowspan="8">Chief Executive Officer<br><br>Or<br><br>Designee</td><td rowspan="8">• Incident Commander<br>• Operations Section Chief<br>• Command Staff as needed<br>  ○ Liaison Officer<br>  ○ Safety Officer<br>  ○ Public Information Officer<br>• Branches / Sections Divisions / Groups / Units / Individual Resources as needed</td><td rowspan="8">• PBX<br>• Administration<br>• Department Directors and Managers<br>• Emergency Department Charge<br>• Emergency Preparedness Director<br>• Security Manager<br>• Facilities Supervisor<br>• Environmental Services Manager<br>• PBX Supervisor<br>• Safety Officer<br>• Other Departments / Units / Managers as warranted<br>• External notifications, as warranted</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT AND CLINICAL FACTORS</td></tr>
<tr><td colspan="2">• ED overcrowded<br>  ○ ED wait time exceeds 4 hours<br>  ○ Increase in ED patient census (>50% above normal for 4 hours)<br>  ○ Admitted patients awaiting inpatient bed exceeds 20 hours<br>• Patients from a single event – 10 actual patients, or 3 patients anticipating immediate OR/ICU admission</td></tr>
<tr><td colspan="2">LOGISTICAL FACTORS</td></tr>
<tr><td>Facilities</td><td>Physical plant or utility disruption that is limited, contained, and/or has a minor impact on operations (e.g., a partial system failure; failure of a non-mission-critical system)</td></tr>
<tr><td>Staff</td><td>15 percent of staff not available for duty</td></tr>
<tr><td>Supplies/ Materiel</td><td>Actual or projected supply shortage of non-critical items, or 96 hours supply remaining of critical items</td></tr>
<tr><td>Internal occupancy</td><td>Need for horizontal evacuation of patients/visitors/staff from one floor or wing of a building</td></tr>
</table>

<table>
<tr><th>ACTIVATION LEVEL</th><th colspan="2">DEFINITION/ PARAMETERS</th><th>AUTHORITY TO ACTIVATE</th><th>ANTICIPATED HICS ACTIVATION</th><th>NOTIFICATIONS</th></tr>
<tr><td rowspan="9">3<br><br>MODERATE IMPACT</td><td colspan="2">An actual situation or event that is having a moderate or unusual impact on facility operations.</td><td rowspan="9">Chief Executive Officer<br><br>Or<br><br>Designee</td><td rowspan="9">• Incident Commander<br>• Operations Section Chief<br>• Logistics Section Chief<br>• Command Staff<br>• Liaison Officer<br>• Safety Officer<br>• Public Information Officer<br>• Planning Section Chief as needed<br>• Finance Section Chief as needed<br>• Branches / Divisions / Groups / Units / Individual Resources as needed<br>• Medical / Technical Specialists as needed</td><td rowspan="9">• Telecom<br>• Administration<br>• Department Directors and Managers<br>• Construction Supervisor<br>• Emergency Department<br>• Security<br>• Emergency Preparedness<br>• Facilities Supervisor<br>• Environmental Services<br>• PBX Supervisor /Manager<br>• All Departments<br>• External notifications, as warranted</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT AND CLINICAL FACTORS</td></tr>
<tr><td colspan="2">• Hospital census impacts<br>• ED severely overcrowded<br>  ○ ED wait time exceeds 8 hours<br>  ○ Admitted patients awaiting inpatient bed exceeds 36 hours</td></tr>
<tr><td colspan="2">LOGISTICAL FACTORS</td></tr>
<tr><td>Facilities</td><td>Physical plant or utility disruption affecting a major or mission-critical area or system, or affecting general operations</td></tr>
<tr><td>Staff</td><td>25 percent of staff not available for duty</td></tr>
<tr><td>Supplies/ Materiel</td><td>Actual or projected supply shortage of critical items, or 48 hours supply remaining of critical items</td></tr>
<tr><td>Internal occupancy</td><td>Need for vertical evacuation of patients/visitors/staff from one floor of a building</td></tr>
<tr><td>Event duration</td><td>Level 2 event lasting greater than 8 hours</td></tr>
</table>

<table>
<tr><th>ACTIVATION LEVEL</th><th colspan="2">DEFINITION/ PARAMETERS</th><th>AUTHORITY TO ACTIVATE</th><th>ANTICIPATED HICS ACTIVATION</th><th>NOTIFICATIONS</th></tr>
<tr><td rowspan="10">4<br><br>MAJOR IMPACT</td><td colspan="2">An actual situation or event that is having a major and unusual impact on facility operations.</td><td rowspan="10">Chief Executive Officer<br><br>Or<br><br>Designee</td><td rowspan="10">• Incident Commander<br>• Operations Section Chief<br>• Logistics Section Chief<br>• Planning Section Chief<br>• Finance/ Administration Section Chief<br>• Command Staff<br>• Liaison Officer<br>• Safety Officer<br>• Public Information Officer<br>• Medical / Technical Specialists as needed<br>• Branches / Divisions / Groups / Units / Individual Resources as needed</td><td rowspan="10">• PBX<br>• Administration<br>• Department Directors and Managers<br>• Emergency Department<br>• Security Depart ment<br>• Facilities Supervisor<br>• Environmental Services<br>• Construction Supervisor<br>• PBX Supervisor<br>• All Departments<br>• External notifications, as warranted</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT AND CLINICAL FACTORS</td></tr>
<tr><td colspan="2">• Hospital census impacts<br>• ED severely overcrowded<br>  ○ ED wait time exceeds 12 hours<br>  ○ Admitted patients awaiting inpatient bed exceeds 48 hours</td></tr>
<tr><td colspan="2">LOGISTICAL FACTORS</td></tr>
<tr><td>Facilities</td><td>Physical plant or utility disruption affecting multiple areas or systems</td></tr>
<tr><td>Staff</td><td>40 percent of staff not available for duty</td></tr>
<tr><td>Supplies/ Materiel</td><td>Critical shortage of essential items</td></tr>
<tr><td>Internal occupancy</td><td>Complete evacuation of a patient care building</td></tr>
<tr><td>Event duration</td><td>Greater than 24 hours</td></tr>
</table>

**Table 1-2. ECRMC Incident Facilities Matrix.**

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Hospital Command Center (HCC)** | Command and control point for overall incident management.<br><br>Location of Incident Commander, Command Staff, and General Staff. | Incident Commander | Primary- CEO Conference Room<br><br>Secondary- ASB Conference Room<br><br>Tertiary- MOB Conference Room | |
| **Media Staging Area** | Holding area for media awaiting briefing | Public Information Officer | MOB Conference Room | |
| **Media Briefing Area** | Briefing area for media | Public Information Officer | MOB Conference Room<br>or<br>Outside E.D. | |
| **Security Command Post** | Command and control point for<br><br>onsite direction of security and law-enforcement related activities | Security Branch Director | Security Office Near Medical Records | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Hazardous Materials Unit Leader Location** | Command and control point for onsite direction of hazardous materials mitigation/ decontamination activities | Hazardous Materials Branch Director | Construction Parking Lot | |
| **Mass Dispensing Clinic or Point of Dispensing (POD)** | A designated area to distribute medications, vaccinations, provide risk communication and public education during a public health emergency | Medical/Technical Specialist – Clinic Administration<br><br>POD Branch Director | MOB Parking Lot w/tent<br><br>(Or other areas as designated) | |
| **Staging Area** | Location established where resources (in available status) can be placed while awaiting a tactical assignment | Staging Manager | MOB Parking Lot<br>Or<br>MOB Classroom | |
| **Vehicle Holding Area** | Staging Area where vehicles are held in available status awaiting assignment | Vehicle Staging Team Leader | Church Parking<br>Or<br>Bucklin Park | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Equipment Holding Area** | Staging Area where equipment and supplies are held in available status awaiting assignment | Equipment/Supply Staging Team Leader | MOB Dirt Parking Lot | |
| **Medication/ Pharmaceutical Holding Area** | Staging Area where medications and pharmaceuticals are held in available status awaiting assignment | Medication Staging Team Leader | Pharmacy | |
| **Emergency Department Operations Area** | Operations control point for the Emergency Department | Casualty Care Unit Leader | ED Break Room | |
| **Patient Receiving Area (Triage Area)** | Location for reception and sorting of incoming casualties | Casualty Care Unit Leader | South Parking Lot | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Decontamination Area** | Location for decontaminating patients contaminated with hazardous materials (including nuclear, chemical, or biological agents) | Hazardous Materials Branch Director | South Parking Lot (Decon Tent to be Erected ASAP) | |
| **Immediate (Red) Treatment Area** | Treatment location for acute incoming patients | Casualty Care Unit Leader | E.D.- in the hospital | |
| **Delayed (Yellow) Treatment Area** | Overflow treatment location for patients with urgent, but not life-threatening, injuries/illnesses | Casualty Care Unit Leader | Southwest Parking Lot (Arctic Tent to be Erected ASAP) | |
| **Minor (Green) Treatment Area** | Overflow treatment location for patients with minor injuries/illnesses | Casualty Care Unit Leader | ER Patio | |
| **Expectant (Black) Treatment Area** | Holding area for mortally injured receiving palliative or pastoral care | Casualty Care Unit Leader | Morgue | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Morgue Area** | Collection, storage, and identification point for deceased patients | Casualty Care Unit Leader | Morgue | |
| **Alternate/ Overflow to ED** | Serve as an alternate location for the ED in the event that there is facility damage to current ED. To serve as overflow for delayed and minor patients when necessary. | Casualty Care Unit Leader | Surgery | |
| **Plans Section Center** | Operations control point for Planning Section (may be located in or adjacent to HCC) | Plans Section Chief | Hospital Command Center (HCC) | |
| **Family Support Center** | Briefing area for visitors and families regarding status and location of patients | Family Reunification Unit Leader | MOB Lobby | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Labor Pool & Credentialing Area** | Mobilization points and credentialing area for medical and non-medical personnel and volunteers | Labor Pool & Credentialing Unit Leader | OB Waiting Room & Patio<br><br>Or Virtual | |
| **Medical Staff Pool Area** | Mobilization points and credentialing area for physicians and other medical staff | Labor Pool & Credentialing Unit Leader | OB Patio<br><br>Or Virtual | |
| **Logistics Section Center** | Operations control point for Logistics Section (may be located in or adjacent to HCC) | Logistics Section Chief | HCC | |
| **Ambulance Loading Area** | Loading point for patients being discharged out of the hospital | Transportation Unit Leader | ER Ambulance Loading Dock | |
| **Ambulance Off-Loading Area** | Off-loading point for patients arriving at the hospital by ambulance | Transportation Unit Leader | ER Ambulance Loading Dock | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Finance Section Center** | Operations control point for Finance Section | Finance/ Administration Section Chief | HCC or Finance Office | |
| **Operations Section Center** | Operations control point for Operations Section | Operations Section Chief | HCC | |
| **Discharge Area** | Mobilization and control area for patients being discharged | Medical Care Branch Director | Hospital Front Lobby | |
| **Critical Care Area(s)** | Operations control point for specified critical care area(s) | Inpatient Unit Leader | HCC | |
| **Radiology Services Area** | Operations control point for radiology services | Clinical Support Unit Leader | Radiology Office | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Laboratory Services Area** | Operations control point for laboratory services | Clinical Support Unit Leader | Laboratory Manager's Office | |
| **Pharmacy Services Area** | Operations control point for pharmacy services | Clinical Support Unit Leader | Pharmacy Office | |
| **Cardiopulmonary Services Area** | Operations control point for cardiopulmonary services | Clinical Support Unit Leader | Cardio Office | |
| **Staff Information Center** | Emergency information update/rumor control center for staff | Public Information Officer | HCC | |
| **Staff Rest and Nutrition Area** | Calm, relaxing environment for staff support and nutrition | Food Services Unit Leader | Cafeteria Area | |

| INCIDENT FACILITY | MISSION | RESPONSIBLE OFFICER | MAIN CAMPUS | |
|---|---|---|---|---|
| **Debriefing Area** | Location for critical incident stress debriefings for staff | Employee Health and Well-being Unit Leader | Chapel | |
| **Dependent Care Area** | Location for sheltering and feeding staff and volunteer dependents | Employee Family Care Unit Leader | MOB Conference Room | |

## APPENDIX A – PLANNING SUPPORT ANNEXES

| Annex # | Title |
|---|---|
| 1 | All Hazards<br>• All Hazards *(HICS Procedures)* |
| 2 | Communication Plan |
| 3 | • ECRMC- Hospital Shelter-in-Place & Evacuation Support Annex *Evacuation – Complete or Partial (Incident Planning Guide & Standard Operating Procedures)*<br>• Evacuation, Shelter-in-Place & Hospital Abandonment (Incident Response Guide) |
| 4 | Emergency Nutritional Plan |
| 5 | Exercise & Training |
| 6 | External Support Agreements<br>• *MOA/MOU – (Emergency HVAC)*<br>• *MOA/MOU – (Potable/Bottled Water)*<br>• *MOA/MOU – (Service Contracts e.g., Snow Removal, Emergency Repairs)*<br>• *MOA/MOU – (Food Services)*<br>• *MOA/MOU – (Utility Services)*<br>• *MOA/MOU – (Decontamination)* |
| 7 | Fire Suppression<br>• *Fire Prevention Plan*<br>• *Fire Response Plan*<br>• *Fire Prevention & Fire Response Plan - Surgery* |
| 8 | Hazardous Materials & Decontamination Support Plan |
| 10 | Mass Fatality Plan |
| 11 | Medical Surge and/or Loss of Community Logistical Support<br>• *Hospital Overload (Incident Planning Guide & Standard Operating Procedures)*<br>• Mass Casualty Incident (Incident Response Guide)<br>• *Pandemic Plan* |
| 12 | Patient Care & Support Plan<br>• *Palliative Care During a Disaster (Incident Planning Guide & Standard Operating Procedures)* |
| 13 | Resource & Asset Management Plan |
| 14 | Safety & Security Plan |
| 15 | Shelter-in-Place Plan<br>• Shelter-in-Place *(Incident Planning Guide & Standard Operating Procedures)* |

| Annex # | Title |
|---|---|
| 16 | Staff & Family Support Plan<br>• Family Reunification Plan |
| 17 | Utility Support Plan<br>• Utility Failure (Incident Response Guide) |
| 18 | Emergency Management Plan |
| | |
| | |
| | |

## APPENDIX B – INCIDENT RESPONSE GUIDES

| Annex # | Title |
|---|---|
| 1 | • Active Shooter - Killer |
| 2 | • Chemical Incident |
| 3 | • Earthquake |
| 4 | • Evacuation, Abandon, Shelter in Place |
| 5 | • Explosive Incident |
| 6 | • Hostage |
| 7 | • Infectious disease |
| 8 | • IT Failure |
| 9 | • Mass Casualty |
| 10 | • Missing Person |
| 11 | • Radiologic Incident |
| 12 | • Severe Weather |
| 13 | • Staffing Shortage |
| 14 | • Supply Chain Disruption |
| 15 | • Utility Failure |
| 16 | • Water Rationing / Sewer Disruption |

## APPENDIX C – DEPARTMENTAL EMERGENCY OPERATIONS PLANS

This appendix is a place holder to reference  departmental specific plans to prevent, prepare for, respond to, recover from, mitigate and various incidents that may affect staff safety and specific operations. These departmental plans are developed in accordance with this overarching organizational plan and department specific Business Continuity plans.

## APPENDIX D – INCIDENT RESOURCE SUPPLEMENTS

| Supplement # | Title |
|---|---|
| 1 | ECRMC Forms<br>• *After Action Report (AAR)*<br>• *Code HICS Form*<br>• *Communication Log*<br>• *Critical Resource Inventory*<br>• *Incident Alert Form*<br>• *Patient Assessment Form*<br>• *Status Report (STATREP)*<br>○ Critical Care STATREP<br>○ Emergency Department STATREP<br>○ *Floor/Unit STATREP* |
| 2 | ECRMC Facility Maps |
| 3 | City/County/State/Federal Emergency Contact Information<br>• *California Division of Emergency Management*<br>• *State and Federal Contact Information* |
| 4 | Definition of Terms |
| 5 | Emergency Codes |
| 6 | Glossary of Acronyms & Terms |
| 7 | Hazard Vulnerability Analysis (HVA) |
| 8 | HICS Forms |
| 9 | HICS Job Action Sheets |
| 10 | Hospital Emergency Contact Information<br>• *ECRMC Incident Command Contact Information*<br>• *Hospital Internal Phone Directory* |
| 11 | Hospital Incident Management Team (HIMT) Chart |
| 12 | *Critical Resource Inventory*<br>*Vendor/Supplier Emergency Contact Information* |
| 13 | Source Documents |
| 14 | Utilities Contact Information |
| 15 | Emergency Management Committee Charter |

## Annex A: Order of Succession

Continuity of Leadership during an emergency situation is critical to ensure the continuity of the healthcare essential functions. ECRMC maintains an order of succession for key positions in the event leadership is unavailable or unable to perform authorized duties. Successors have the full, unlimited authority to operate in the position they are assuming to the fullest extent possible until such person is relieved by the next highest-ranking individual or as identified in the delegations of authority. Orders of succession will take affect if the named key position cannot be reached and/or cannot function, and will terminate if and when the incumbent is available and able to perform their authorized duties. The following Orders of Succession are pre-established guidelines. Decisions will be made based on real-world event circumstances and in consultation with HICS leadership.

| Key Position | Successor 1 | Successor 2 | Successor 3 |
|---|---|---|---|
| Chief Executive Officer | Chief Nursing Officer | Chief Medical Officer | CHRO |
| Chief Medical Officer | Associate Chief Medical Officer | Chief of Staff | |
| Chief Nursing Officer | House Supervisor | ED Director | Med/Surg Director |
| Chief Financial Officer | Hospital Comptroller | Purchasing Supervisor | |
| Associate Administrator of IT Services | IS Supervisor of Applications Services | Senior Network Architect | Systems Administrator II/Help Desk Lead |

## Annex B: Delegations of Authority

Delegations of Authority allows certain duties of one individual/position to be assigned/delegated to multiple individuals if the selected Successor is not available or if the expertise to make the authority is present with another individual.

ECRMC has established Delegations of Authority to provide successors the authority to act on behalf of ECRMC for specific purposes and to carry out specific duties.
Delegations of Authority will take effect when normal channels of authority are disrupted due to a significant emergency or disaster and will terminate when these channels are reestablished.

Delegation of authorities for making policy determinations and for taking necessary actions at all levels of an organization ensures a rapid and effective response to any emergency requiring the activation of a continuity plan. The following established delegations of authority are pre- established guidelines. Decisions will be made based on real-world event circumstances and in consultation with HICS leadership.

| Authority | Triggering Conditions | Position Holding Authority | Delegated Authority |
|---|---|---|---|
| Activate Emergency Operations Plan and any Incident Response Guides | When conditions exist that make activation possibly necessary | 1. CEO | 1. Assistant to CEO<br>2. CNO<br>3. CFO<br>4. CHRO |
| Close and Evacuate the facility | When conditions make coming to or remaining in the facility unsafe | 2. CEO<br>3. Incident Commander | 5. Alternate Chief Officer<br>6. Safety Officer<br>7. Facilities Manger |
| Represent the facility when engaging with government officials | When the pre-identified senior leadership is not available | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Public Information Officer<br>3. Emergency Prep. Director |
| Selective provision of utilities | When utility resources are limited | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Facilities Manger |
| Selective provision/reallocation on of resources | When resources to support patient care are limited | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Order of Succession for CEO |
| Temporary curtailment of services | When resources are limited and census cannot be maintained | 1. CEO<br>2. Incident Commander<br>3. Chief Nursing Officer | 1. Order of Succession for CEO<br>2. Order of Succession for CNO |
| Emergency Procurement and Contracts | When critical resources to sustain census must be procured through purchasing | 1. CEO<br>2. CFO | 1. Order of Succession for CFO<br>2. Incident Commander<br>3. Order of Succession for IC |

**TO:** HOSPITAL BOARD MEMBERS

**FROM:** Kimberly Probus, Chief Nursing Officer

**DATE:** December 18, 2023

**COMMITTEE:** Board of Trustees

**SUBJECT:** Move to approve ECRMC's Continuity of Operations Plan policy.

**BUDGET IMPACT**: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No
B. If yes, what is the impact amount: _______________

**BACKGROUND:** New policy, necessary for Total Joint Commission (TJC) compliance.

**RECOMMENDATION:** (1) Approve (2) Do not approve

**DISCUSSION:** After approval, incorporate into the Hospital Incident Command System (HICS) training.

**ATTACHMENT(S):**
- Continuity of Operations Plan: Policy 21549_1

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Velez ________________

## El Centro Regional Medical Center

# Continuity of Operations Plan

**Policy 21549_1**
**December 08, 2023**

## TABLE OF REVISIONS

Revisions to this plan shall be submitted to the Emergency Preparedness Director as required changes are identified. Proposed amendments shall be reviewed and approved by the Emergency Management Committee. The revised plan will be posted to the hospital's intranet. Department managers are responsible for reviewing and updating related departmental emergency operations documents within their areas of responsibility. Department managers and supervisory personnel will ensure that all staff members are trained on the contents of the Emergency Operations Plan (EOP).

| Version | Date | Section/ Page(s) | Change | Approved By |
|---|---|---|---|---|
| 1.0 | 12/10/2023 | All | Initial Publication | Emergency Preparedness Committee<br>Environment of Care Committee<br>CSEC<br>CET |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# Contents

**TABLE OF REVISIONS** .......... 2
Applicability .......... 4
Approval .......... 4
Purpose .......... 4
Overview .......... 4
Background .......... 6
Mission-Essential Services .......... 6
Procedure .......... 7
Definitions .......... 22
Annexes .......... 22
Related Policies .......... 22
Contacts .......... 23
Approvals .......... 23
Revision History .......... 23
Annex A: Redundancy of Communications .......... 24
Annex B: UC San Diego Health Property Loss Claim Form .......... 27
Annex C: Orders of Succession .......... 28
Annex D: Delegations of Authority .......... 29

**Applicability**

ECRMC policy 21549_1, though hereinafter referred to as the Continuity of Operations Plan ('COOP'), is an institutional policy applicable to all parts of the ECRMC operations, which includes ECRMC Board of Trustees. This policy is iterative and continues to be updated as policies, plans and practices are updated.

ECRMC includes the main hospital campus and all ancillary services locations, rural outpatient clinics, and all remote operations and facilities.

**Approval**

The approval process for this plan includes the Emergency Preparedness Committee (EP-MDT), Chief Executive Officer, and Board of Trustees.

**Purpose**

This COOP delineates the organizational structure to implement in the event that a disaster or emergency situation has occurred requiring potential or actual augmentation of day-to-day operations/business functions. It is the intent of ECRMC to maintain operations at levels as near to normal as possible. If interruption of services occurs, essential services will be maintained with available personnel insofar as it is possible. Essential services are those services necessary to maintain any activity, service, or function which will directly affect the immediate delivery of patient care, and which will ensure the safety of patients, staff, guests, and others who play a role onsite (e.g. volunteers, contractors).

**Overview**

ECRMC has developed this Continuity of Operations Plan, which provides procedures to be implemented by leadership in the event that an emergency situation has disrupted services. These procedures are intended to facilitate orderly and effective handling of the disruption resulting from emergency situations by providing an operational framework and guide for personnel involved in the ECRMC Response.

ECRMC provides for the continuation and reestablishment of operations following emergencies that have impacted the facilities to the level of requiring CODE TRIAGE or other significant activations. Activations are usually focused and quickly recoverable. However, large-scale events are possible. Specific areas of concern are identified in the ECRMC Hazard Vulnerability Analysis. Mitigation actions are pursued when feasible, thus reducing the likelihood of the risk or impact of its occurrence.

A. During and following an emergency, it is the intent of ECRMC to maintain and return operations to normal levels as soon as possible. If interruptions of services occur, essential services will be maintained with available personnel as best as possible. ECRMC essential services include functions that directly affect the immediate delivery of patient care and will ensure patient safety.

B. This document does not address specific units' operational issues due to service and work interruption secondary from an emergency. Each department head and supervisor is responsible to consider the implications of an emergency that interrupts services. Departments are educated and encouraged to develop specific written contingency plans to assist with the performance of essential services while full recovery is pursued. The aim is to provide service that is sustainable. The plans account for changes that affect hospitalized patients accounting for resources and personnel availability. Initial tasks may need to be performed without the aid of automated or electronic tools.

C. Departments have the Hazard Vulnerability Analysis Tool (HVA) available to support the identification of critical risks and aid them in preplanning. ECRMC has provided the "probability and risk categories" for personnel, systems, supplies/equipment and structure loss for the institution. The "preparedness" rating can best be determined by each department for their individual areas of functions. The focus of this tool is to support the departments in the prioritization of the decision making process regarding the loss of critical systems that support services.

D. This COOP is intended to be used as a recovery plan with specific activities outlined. Those recovery actions listed in this plan are for reference and may be implemented as deemed appropriate. ECRMC is under the umbrella of the City of El Centro and as such may have available some additional resources of the city. Mutual aid will be coordinated via Hospital Command Center and by other methods.

E. The implementation of the strategy for recovery is linked to concrete action steps. These plans develop priorities, secure resources, set a timeline, and identify specific actions needed to ensure the recovery of the institution.

F. This plan along with Department-specific plans provide reference to potential relocation of or expansion of clinical service lines.

G. Ancillary or support services may be able to utilize off-site locations such as the clinics and office buildings owned or leased by ECRMC. Information Systems may assist with connectivity, conference lines and other communication alternatives while maintaining support to the primary acute care site.

**Background**

This plan is designed as an all-hazard response plan. ECRMC has developed a comprehensive Hazard Vulnerability Assessment (HVA) to help determine the most likely hazards, though impacts may vary. Along with the HVA, the hospital has also developed mitigation strategies for various identified vulnerabilities, both of these resources may be found in policy 21534_0, Emergency Operations Plan. This ECRMC COOP serves as the framework for recovery back to a normal state. Some of these activities are described here.

A. Key elements addressing recovery information are gathered under the Plans, and Finance, functional areas in the HICS structure. Documentation during the response phase will support financial recovery. The recovery phase will also include damage assessment during and after the event.

B. The fundamental principles underlying the operation of this plan are:
    1. Centralized control
    2. Restoration of internal and external lines of communication
    3. Determination of essential services
    4. Determination of staffing requirements to maintain essential services
    5. Deployment of staff to essential service areas as dictated by the demands of the emergency
    6. Coordination of the discharge and/or transfer of patients to establish a census level consistent with ECRMC's ability to provide quality medical care
    7. Reduction or elimination of nonessential services as long as required
    8. An expectation that each department head and supervisor will have considered the implications of a disaster impacting their specific area and will have developed a specific written plan to enable performance of essential services for at least the immediate period and to plan for the recovery of services.

**Mission-Essential Services**

Mission-essential services and functions are important and urgent. Essential functions are the activities that cannot be deferred during an emergency. These activities must be performed continuously or resumed quickly following a disruption.

A. The recovery timeframe of all services, departments and functions are assessed and prioritized to assist in planning and recovery implementation. They serve as key continuity planning factors necessary to determine appropriate staffing, communications, essential records, facilities, training, and other requirements.

B. Each ECRMC department shall maintain a specific plan that identifies the department's essential functions, staffing, vital records, key applications, equipment, and supplies. Implementation of a department's continuity plan will be based on the needs and considerations of the actual incident and resources available. Departments will use their disaster plans and departmental contingency plan as appropriate.

**Procedure**

The ECRMC Continuity of Operations Plan serves as the organization-wide overarching plan. The COOP serves to augment the specific departmental policies and procedures developed to serve the identified department, unit, or service area. Those plans describe in more detail the resources and assets necessary to continue operations when facilities or infrastructure have become temporarily unavailable, damaged, or destroyed, or if there is reduction of staff due to a planned or non-planned incident.

The COOP and department specific COOPs are to be referenced in tandem prior to, during, and after an actual or potentially impactful incident. Coordination, communication, and collaboration will be implemented through the activated Hospital Command Center (HCC).

This plan provides high-level organizational guidance including departmental references for alternate facilities and locations as well as alternate staffing methods.

ECRMC monitors its business practices on an on-going basis. This includes such factors as patient census, case mix, discharge data, acuity of patients, and the identification of profitable services, among many other factors. This close and on-going monitoring will assist business functions in determining the priority of recovery response and participation in the broad decisions needed to recover services.

ECRMC maintains specific days' cash on hand and a budgeted contingency fund for emergency repair as part of business practice.

During the business continuity and recovery period, employees will receive informational releases from the HCC in collaboration with the CEO, and/or Chief Nursing Officer (CNO) reporting the general status of the ECRMC Business Continuity and Recovery Plan. Termination of this plan will be announced by means of a statement issued by the HCC, CEO or designee. It is expected that employees will resume normal job responsibilities as soon as safe and feasible to do so.

I. **Response Considerations**

A. The Incident Commander (IC) and Section Chiefs should determine to the fullest extent possible, impacts to the organization and operations. This includes actual details, causes, nature of the disruption, and the impact/disruption to activities, departments and services. Based on this information, the IC in consultation with the Chief Executive Officer (CEO) or designee will make the decision to proceed with the COOP and the recovery process. In addition to the departments, the HCC may access the departmental COOP's via the intranet. The Recovery Time Objective (RTO) is the duration of time within which a business process must be restored in order to avoid unacceptable consequences associated with a disruptive event. Priority assistance should be considered for the departments identifying a lower RTO (i.e. 0-4 hours) so service interruptions can be minimized.

B. Type of Response:

1. There are a number of variables that define the parameters of the plan's activation:
   i. The number and skill level of employees impacted by the disaster.
   ii. The impact on key ECRMC units and their functions.
   iii. The extent of damage to buildings, infrastructure, and/or critical business operations such as communications or Information Systems.
   iv. The availability of medical supplies and equipment to safely provide and sustain patient care.

C. The Incident Commander (IC) will delegate recovery aspects during the period of time in which the Hospital Incident Command System (HICS) is in effect. Recovery actions may be initiated during the response phase under HICS.

1. It is possible that recovery actions will continue past deactivation of HICS. Continuation of, and reestablishment of, operations during and following an emergency require transition planning. The IC will communicate status with the CEO and the Executive Team of ECRMC to ensure that aspects of business recovery are smoothly transitioned at the point that HICS becomes deactivated. At this transition, the CEO and the Executive Team, or their designee, will assume responsibility for recovery and business plans. The recovery team will promulgate a disaster recovery plan.
2. Recovery activities at ECRMC include the restoration of normal operations and essential services following the impact of a disaster. It includes the plans to support staff, minimize loss of revenue, address the recovery of systems, and the return of the facility to normal service.

3. Recovery planning and actions begin during response activities and include documentation of the event and actions performed in response to the activation of the Emergency Operations Plan and the Hospital Incident Command System (HICS).
4. Recovery activities are pre-planned and in anticipation of an all hazard need that may occur in the community.

D. Orders of Succession:

1. Continuity of leadership during an emergency is critical to ensure continuity of essential functions. ECRMC has established and maintains Orders of Succession (see: Annex D) in the event leadership is incapable of performing authorized duties. The designation as a successor enables that individual to serve in the same position as the principle in the event of that principal's death, incapacity, or unavailability.
2. All persons (by position) listed will have full, unlimited authority to operate in the position they are assuming to the fullest extent possible until such person is relieved of duty or as identified in the Delegation of Authority.

E. Delegations of Authority:

1. Delegation of Authority (see: Annex D) allows certain duties of one individual/position to be divided up and assigned or delegated to another, or to multiple, individuals if the designated Successor is not available or based on the expertise of other personnel within the organization.
2. ECRMC has established Delegations of Authority to provide successors the legal authority to act on behalf of ECRMC for specific purposes and to carry out specific duties. Delegations of Authority will take effect when normal channels of direction are disrupted and will terminate when these channels are reestablished.

## II. Activation of the Business Continuity Plan

A. The Incident Commander under HICS in consultation with the CEO, the Executive Team and Department of Emergency Management will make the decision to activate the Continuity of Operations Plan. At this point, the CEO, the Executive Team and other key organizational members will develop a Recovery Plan with the goal of ensuring departmental leaders have established plans and have resources available to implement those plans.

B. All ECRMC department leaders will be notified of the action via mass notification system or other means if this system is not functional. Departments will be notified to continue utilizing their Departmental Disaster Plan, activate their contingency plans or return to normal function as determined under HICS or by the CEO and Executive Team.

## III. Maintaining Operations

ECRMC will make every effort to maintain normal operations prior to, during, and after an incident. This section provides guidelines on maintaining operations should there be an effect on or need to conserve resources or curtail services.

Essential elements are defined by services and logistics primarily responsible for maintaining the mission and functions of the organization. These include at least the factors involved in safety, security and well-being of the community, patients, volunteers, staff and others. Examples include documentation (electronic or otherwise), personal protective equipment and the staff to provide those services.

In creating this plan, other considerations include the mission of the organization, recovery time objective, critical infrastructure, and essential resources to providing care to the community and patients.

### Essential Utilities

A. The hospital's alternative sources for essential utilities to support business operations includes generator power for electricity capable of operating all essential electric equipment. Alternative sources of safe water, safe medical gas and vacuum; and waste disposal in the event of sewer system failure are planned (see ECRMC Facilities plans).

B. If appropriate, the CEO or designee will work with Human Resources, Business Office, Information Services, Materials Management, Facilities, Construction, Environmental Services, and other special service and impacted areas such as the Departments of Pharmacy, Cardio-Respiratory Care, ICU, etc., to determine the availability and provision of subcontracted services, including supplies, personnel and equipment.

### Communications

A. The Information Systems team maintains a high level of readiness, is strategically effective, has extensive defenses against cyber-attacks and maintains a disaster recovery plan that is defensive and proactive.

B. The hospital has provided for alternative communication methods in the event of telephonic failure until internal and external communication are fully restored to pre-incident operations. This includes the availability of two-way radio communication of both 400 and 800 MHz radios. Radios are available in the Emergency Department, North Administration Office, and Security Department. Alternate communication methods include TigerConnect (Mass Notification System), amateur radio (HAM), satellite phone, access to departmental direct connect, and cell phone options. In the case of all telephonic or cell service loss, e-mail, fax, and/or written messages will be hand-carried and megaphones are available (Annex A: ECRMC Emergency Communications Plan to Support Redundancy of Communications).

C. Community Notification and Business Continuity:

1. Within the HICS structure, working in conjunction with the IC, the Public Information Officer (PIO) will coordinate internal and external communications, ensuring that timely, accurate and consistent information is dispersed to constituents, including the media, ECRMC and City Administration, hospital staff, donors and friends, and other interest groups.
    a. Working with the ECRMC Administration and with the Board of Trustees as appropriate, the PIO will develop local messages and updates.
2. The PIO will manage the media, working with media on site, and responding to media requests for information and interviews by providing written information and statements, by holding regular briefings, or by arranging for spokespersons to speak with reporters.
    a. ECRMC spokespersons will address contingency planning, preparations, and the status of hospital and clinic operations, in addition to answering general questions about emergency situations and the resultant recovery period.
    b. ECRMC spokespersons will not state opinions about recovery or business contingency that deal with bargaining issues, personnel on strike, or about any work action. Local communications will focus on maintenance of operations and provision of patient care and business during a work action.

## Risk

A. Risk is responsible for credentialing verification and assuring current licensure and appropriate documents of providers. Identification of physicians and their orientation, will be managed by Medical Staff Services personnel. Credential files may be maintained in hard copy back-up files, especially during a period of infrastructure and damage assessment.

## Human Resources

A. Personnel records are maintained in hard copy back up files and portions such as retirement, payroll, benefits, etc. are also maintained with system-wide computer storage files, securing record recovery.
B. If needed, the HCC will make arrangements through the ECRMC Human Resources department to employ temporary help.
C. The HCC, working through Human Resources, will reallocate internal resources by diverting personnel from services not essential to patient care to services that are essential to patient care.

D. Human Resources will keep HCC apprised of current changes/information regarding activity from any current/anticipated Labor Issues:
    i. Expedite the sign-in process.
    ii. Follow the departmental EOP/disaster plan.
    iii. Ensure that HR personnel are maintaining open communication with staff members.

## Payroll

A. Establish off-site area for distribution of paychecks if needed; the site will be deemed safe to occupy and properly secured by Security Department.
B. Coordinate efforts with the Timekeeping Unit to expedite the process required to get paychecks out to employees in a timely manner. Timekeeping may be able to perform their functions remotely via WFH. This will be discussed with leadership to determine appropriateness and availability.

## Department Heads and/or Supervisors

A. It shall be the responsibility of every department head to complete status reports (StatRep) as often as they are requested; these should be submitted in a timely manner through the HICS system as instructed.
B. StatReps may include various information requested. Individual units should also retain copies of these report forms.
C. Staffing Status, Availability, and Skills Summary, a listing of "personnel available for other assignments" may be requested by the HCC as part of a StatRep.
D. Required Material, Supplies and Services List should be included on the StatRep.
E. Departments should follow their Departmental Emergency Operation Plans.

## Department of Nursing

A. ECRMC Human Resources and the Nursing Department have developed a plan and assessed implementation of staff augmentation strategies during past incidents. This will initially be managed by HICS.

## Staffing Administration

A. Poll entire Per Diem staff to determine who would be willing to work additional hours.
B. Report number/name of both part-time and full-time nursing staff that are willing to work extra hours or overtime.

C. Pre-schedule registry personnel following Nursing Staffing procedure.
D. Make up a separate written draft of all patient care areas indicating census, available career nursing staff, and additional staff needed for each shift.
E. Procure additional nursing staff via HICS-directed procedures.

## Security

A. The ECRMC Security Department will ensure general security for ECRMC patients, personnel, and facilities in the event of a disaster or emergency situation to include the recovery period. This plan includes at least:
   1. Alternate parking locations/plans.
   2. When indicated, provisions for additional or alternate security officers.
   3. Provide safe access to the workplace for employees.
   4. Assist as possible with identification of unsafe structures, infrastructure failures, damage to communication and information service infrastructure, sabotage of equipment and/or plant facilities.
   5. Control vehicle traffic coming into the hospital area; Security Manager and Leads will maintain safety of all officers.
   6. Secure all access points except those designated to remain open.
   7. Maintain an orderly environment within the patient care areas.
   8. Maintain liaison with civil and military authorities involved in incident.
   9. Assist with arrangement of alternative transportation and vehicle staging.
   10. Issue special identification badges as needed.
   11. Monitor activity in parking lots and other designated parking areas.

## Elective Admissions (Including Elective Surgeries)

A. Elective admissions/inpatient surgeries that involve impacted services will not be prioritized. The potential use spaces will be identified as alternate care locations and will be requested to reschedule these services.
B. Elective admissions/inpatient surgeries will not be scheduled for a predetermined period of time, or until the surgery can safely commence with the available or recovered resources.
   1. Transfers from other hospitals and emergency rooms, including ECRMC capitated patients, will not be turned away.
   2. Contracted custodial patients will be redirected to another appropriately identified institution for any needed admissions unless care can safely be delivered with the available resources, including possible telehealth visits.

## Critical Services: Emergency Department and Trauma Care

For the purpose of this plan, ‘Critical Services’ are defined as the Emergency Department (ED), and Surgery Services.

A. Assessments will be made at regular, designated intervals to understand appropriate

staffing levels and existing patient load to determine whether the ED and/or Surgery Service should declare Ambulance Bypass status. If Bypass is declared, ReddiNet shall be updated immediately with every change of status, and be updated at least every two hours.

B. The ED will remain operational as long as it is safe to do so.
C. The Emergency Department will continue to take walk-in patients even if on bypass.
D. ECRMC does not perform transplants. Organ donation collection should continue as long as possible, following ECRMC Organ Donation policy.
E. In the event ECRMC is deemed unsafe, alternate care sites will be establish either on hospital grounds or by working with the MHOAC to establish additional safe off-site locations.

## Inpatient Care

A. Services supporting inpatient care will be provided on a schedule as defined by the HCC until the nurse personnel status is assessed. Ongoing care will be reassessed at regular intervals during the impacted period for the expansion of services.
B. The House Supervisor will initiate and maintain contact with Inpatient Nursing units, Outpatient Nursing administration and the Emergency Department. Nursing leadership will review current operational impact and prioritize services. This may include deploying services to alternate care sites such as traditional and non- traditional areas. When HICS is activated, this responsibility may be assigned under HICS.
    1. Traditional and non-traditional alternate care sites may include the deployment of surge tents external to the hospital such as to the parking lots.
    2. The House supervisors will maintain oversight of discharges, transfers and redirection.
    3. All service line leaders will be requested to identify the number of available beds, patients eligible for early discharge or decreased acuity under the HICS structure.
C. Every effort will be made to expedite the discharge or transfer of inpatients during the immediate emergency situation under HICS, if the situation warrants these actions. Subsequent redirection of services will follow the direction of the COOP recovery plan, once HICS has been deactivated.

   It may be necessary to redirect inpatients or emergency inpatient admissions to other facilities depending on ECRMC staffing levels in the various service areas.

D. House supervisors will initiate and maintain contact with nearby hospitals to determine bed availability.

E. If the personnel shortage or physical/infrastructure impact cannot easily be resolved, the HCC shall take the following actions:

1. Medical services may be distributed across ECRMC facilities to include the Ambulatory Care sites and may include a pivot to telehealth appointments for some cases.

   a. Reduce Services - It may be necessary to either discharge or transfer inpatients and/or cancel elective admissions in order to maintain bed occupancy consistent with the hospital's ability to provide care. It may be necessary to transfer service to other sites such as ambulatory care services.

   b. It may be necessary to use non-clinical space to manage clinical operations or repurpose clinical space to provide for immediate needs of patients during the crisis. Relocation of patients and support operations into dedicated or defined space will be accomplished as quickly as possible.

   c. In consultation with Nursing Service, the HCC shall determine the number of beds available for inpatient care. Bed availability will depend not only upon nursing staff levels, but also upon the availability of Laboratory services and support services such as Environmental Services, Food and Nutrition Services, and Facilities services.

   d. The Capacity Management & Patient Flow functions, in consultation with Nursing Service and Medical Department Heads will submit to the HCC at the latter's request, a listing of patients who can be immediately discharged or transferred to other institutions.

   e. If the patients must be transferred, and the HCC is no longer activated, the CNO or their designate will survey other hospitals on at least a twice-daily basis to determine bed availability at other institutions. The Admitting/Transfer unit can assume this activity.

   f. The reduction of ambulatory services or the reassignment of services to other ECRMC sites for both the hospital-based clinics and the outpatient clinics will be coordinated with the Physician Medical Director.

## Care Coordination/Case Management:

A. Case Management will perform rounds to ascertain number of possible discharges. They will also assist patient caregivers in discharge planning and in determining which health care activities require further assistance. For patients being discharged home, Case Management will assist patient caregivers in obtaining necessary home care resources.

B. Case Management will initiate and maintain an activity log to record discharges and transfers to other acute care facilities and to record home care discharge arrangement activities, and communicate with family members of patients.

## Labor and Delivery

A. Labor and Delivery requests will be directed to Pioneer's Hospital.
B. Emergency Obstetrics cases will be seen in the Emergency Department and triaged for either immediate care, or transfer to other facilities.

## Behavioral Health Services

A. The hospital will direct Behavioral Health Services requests to County Mental Health resources.

## Research Patients/Programs

A. Principal investigators will reschedule admissions when feasible until necessary resources are available. For studies that must continue and there is a lack of available nursing staff, medical supplies or material resources, the investigator must be available to provide oversight and administration of the study product.
B. Patients will be consolidated with other inpatients if the need arises to maximize available nursing care.

## Outpatient Sites Surgery and other Interventional Procedures

'Outpatient sites' refers to various ECRMC clinics (e.g. Calexico and El Centro Rural Clinics), mobile clinic sites and interventional procedures. The Outpatient Clinics shall maintain regular business hours or return business function to regular hours as soon as is possible. Clinic hours may be extended, offered after routine hours or services transferred to alternative sites during the business recovery period.

A. Only emergency outpatient surgeries/procedures will be performed with the approval of Incident Commander during the period in which HICS is activated.

B. When the transition to the recovery period occurs and oversight is transferred to COOP authorities, authorization for outpatient surgeries and other interventional procedures will occur with the approval of COOP authorities. It is anticipated that outpatient surgeries and other interventional procedures will be performed during the period of emergency and business recovery, if the procedure can be performed safely and with available personnel and supply resources. If an outpatient surgery/procedure COULD result in an admission and ECRMC cannot provide necessary resources, the case may be rescheduled.

C. In the event an admission is required from the Outpatient Clinics during an emergency situation that admission will be accepted or arrangements may need to be made at another facility. If this is the case, the admission arrangements are to be coordinated by the Outpatient Clinic medical staff. (Redirecting patients through an ECRMC service line.) The Emergency Department is not to be used as an alternative. In the event of a

prolonged service interruption, the availability of nursing personnel will dictate the ability to admit patients to the hospital.

D. During activations, the clinic manager/designee will assess the availability of equipment and supplies and report the status to the Hospital Command Center (HCC) as requested. During this process the following steps will be taken:
   1. Inventory and document status of equipment and supplies
   2. Check condition of storage or onsite stockpiles to determine potential operational sustainability
   3. Create a resupply list
   4. Request assistance from HCC, if needed.

## Laboratory Services

A. Laboratory Services may be transferred to alternative locations as possible either within Laboratory Services or externally to other facilities within ECRMC or approved reference laboratories, ideally within Imperial County. Laboratory Administration will notify the HCC as services are transferred, curtailed or restored.
B. Out of county Laboratory services may be utilized if necessary.
C. The HCC will be notified if Transfusion Services in either hospital is affected. The Surgery Department and ED may need to go on bypass if transfusion services are not available. Remote provision of blood and blood products to the ED or Surgery will result in unacceptable delays.
D. Phlebotomy services to the Outpatient Clinics will be maintained as possible.

## Pharmacy Services

A. In the event of a major disaster, the Department of Pharmacy will make every effort to maintain the highest level of service possible until operations return to normal. In any event, the Pharmacy Director, and/or Pharmacist-in-Charge (PIC), will begin the establishment of the continuity needs.
B. Inpatient hospital pharmacy programs exist for the main campus hospital. In order to ensure continuity of critical pharmacy services, the department may operate using contingency procedures. There is also the potential to use pharmacists and technicians from other hospitals based on current memoranda of understanding. This potential exists based on availability. The department will activate any necessary drug delivery service and move critical controlled substances as necessary. Due to the interruption, expanded pharmacy services may be contracted (via Human Resources) to ensure safe and optimal care. The department will extend hours where possible and move to an alternative location if a specific site is affected. For example:
   1. Order verification can be done from an alternate location.
   2. Outpatient pharmacies can extend hours for patients.

C. Policies and procedures pertinent to the Pharmacy Department's contingency plan are available online (i.e. PolicyTech). The department also has printed information for its staff to follow in times of emergencies. Processes have been developed with wholesalers if the need for additional medications arises. The department also has a process in place for borrowing medications from local area facilities. The department maintains an emergency cache of medications that can be mobilized if needed.

D. Other critical issues include equipment and technology. There are downtime procedures for equipment such as automated dispensing cabinets and high-density storage. Automated dispensing systems can be placed on override while the high-density storage can be placed on manual manipulation. There is also a facility-wide plan for any EHS downtime procedure.

## All Departments

A. Staff should report to work when it is safe to do so and as scheduled by their department. All healthcare employees are considered essential workers in emergency situations; staff must remain at work and be available for reassignment until released by their supervisor.

B. If an employee's usual access route is blocked, an alternative means of arriving should be sought. If necessary, the Security Department will implement a plan to pick up and transport ECRMC employees depending on situation at hand.

C. Staff may be assigned to other than their usual work site to assist in business recovery operations. The department head at the discretion of the CEO may make reassignment to other healthcare areas. Efforts will be made to match employee skill levels to reassignments. Departments will provide orientation and chain of command contacts to the reassigned employee to support their work in the new environment. Employees are asked to be flexible in the transfer of assignment or change of duties to support business and department recovery.

## Academic & Research Activities at ECRMC

A. Physicians may be requested by the IC and the HCC to cancel or curtail academic activities during the emergency to allow physicians and staff to focus on direct patient care.

B. Depending on available nursing personnel during the emergency period, physicians will be requested to remain available and accessible to provide assistance in patient care. Patient's well-being must supersede routine protocol.

C. Physicians will not be expected to assume routine bedside nursing responsibilities for prolonged periods of time.

IV. **Restoring Operational Capabilities – Damage Assessment**

A. ECRMC has mechanisms in place to restore operational capabilities for the

facility to pre-emergency levels. The Damage Assessment Team includes support from Facilities, Safety, Construction, Risk Management, and Administration. This group will begin assessing the damage to the facility, environmental concerns, and determine whether the facility can safely continue to provide medical care.

B. As soon as a department determines that any property loss will exceed $6,800.00, a Property Loss Claim Form (see: Annex B) shall be submitted to Risk Management with copies of pictures, receipts, and purchase orders. Risk Management will process the claims with the hospital's third-party administrator.

   1. Pictures will be taken, and reports will be made on all damaged facilities, property, supplies and equipment for insurance purposes and to support recovery.
   2. Documentation by photographs or video will be available for submission with documentation of events and pertinent records.
   3. Architects and building inspectors will be consulted to determine the safety of buildings for occupancy.
   4. Clearance of debris and unsafe buildings will occur.
   5. Hazard areas will be marked with restricted access.
   6. Inventory of equipment will be performed and supplies to restore function will be procured.

## V. Staff Activities and Support

A. ECRMC may provide for staff support in the event of an emergency and in the recovery period. This support may include respite, personal care items, and family support needs as well as emotional support and crisis counseling opportunities. This is anticipated to occur during response and recovery phases of the incident.

B. Services, crisis counseling, and stress reduction will be available under routine hospital programs to include Employee Assistance Program (EAP), and assistance via Human Resources and Benefits programs with appropriate referral to employee benefits and insurance supports. These services may be available during the event but are also part of the continuity of operations plan post-event.

## VI. FEMA Reimbursement

At the request of the Governor, the President may declare a major disaster or emergency if an incident is beyond the combined response capabilities of the area, region, state, tribal, and jurisdictional governments. Among other factors, this declaration allows federal assistance to be mobilized and directed in support of

jurisdictional response efforts. In addition, in the absence of a specific request, the President may provide accelerated federal support where necessary to save lives, prevent human suffering, or mitigate severe damage, and notify the State of that activity. The hospital will apply for any eligible reimbursement funds under the conditions of any disaster or emergency condition experienced.

A. FEMA's Public Assistance Program and Policy Guide identifies disaster and emergency events eligible for federal reimbursement funding, requirements to apply, and Emergency Protective Measures (Category B) eligible for federal funding.
    1. Policy available at: Public Assistance Program and Policy Guide Version 4 (fema.gov)
B. "Payment for Care at Hospital Alternative Care Sites" Fact Sheet for hospitals that find it necessary to establish alternate care sites to expand the ability of the facility to care for patients is available at CMS Hospital Alternate Care Site (cms.gov)

VII. **Returning To Normalcy:**

a. As the business process is restored to a reliable process under the Continuity of Operations Plan, the organization will:
    1. Provide an executable plan to transition from reconstitution operations to normal operations once the threat or disruption has passed.
    2. Coordinate options for reconstitution, including movement of services from the originating operating facility to a new operating site if necessary.
b. Implementation:
    1. Review infrastructure required allowing the business process to return to its original state.
    2. Address permanent changes that should be made to the business process given the extent of the disaster.
    3. Establish actions to ensure outputs of the business process operated under this plan reconcile with what would normally have been expected.
    4. Determine policy exceptions required and how they should be handled.
    5. Inform all personnel that the threat of or actual emergency no longer exists, and provide instructions for resumption of normal operations.

6. Supervise an orderly return to a normal operating facility or movement to other temporary or permanent operating facility.
7. Verify that all systems, communications, and other required capabilities are available and operational and that the facilities are fully capable of accomplishing all essential functions/operations at the new or the restored facility.
8. Communicate relocation of major services or point of contacts to key community authorities including the County and City Emergency Operations Centers and Imperial County Emergency Medical Services and MHOAC.
9. Conduct an after-action review of operations and effectiveness of plans and procedures, identify areas of correction, and develop a remedial action plan as soon as possible after reconstitution.

**Definitions**

I. *Hospital Incident Command System (HICS)*: Nationally recognized and implemented organizational structure incorporating Incident Command System principles activated during emergencies. The HICS structure is also used for anticipated planned (non-emergency) events.

II. *Work Stoppage:* Withholding of services, interruption of work or other concerted activities that interfere directly or indirectly with the ECRMC operations and its services.

III. *Essential Services:* Services necessary to maintain any activity, service, or function which will directly affect the immediate delivery of patient care and which will ensure patient safety.

IV. *Departmental Work Stoppage Contingency Plan*: A department specific plan that outlines progressive actions to take place in the event of a work stoppage. The departmental plan is specific to the department's employees, patient needs and unit activity.

**Annexes**

Annex A: ECRMC Redundancy of Communications
Annex B: ECRMC Property Loss Claim Form
Annex C: Orders of Succession
Annex D: Delegation of Authority

**Related Policies**

ECRMC 21534_0, “Emergency Operations Plan (EOP)”

**Contacts**

Emergency Preparedness Director

**Approvals**

Emergency Preparedness Multi-Disciplinary Team (EM-MDT)

Chief Executive Officer (CEO)
ECRMC Board of Trustees (BOT)

**Revision History**

Original: 12/15/2023

## Annex A: Redundancy of Communications

ECRMC has multiple modalities for redundant communications. This Annex provides an overview of the various systems available, for more details please see 21534_1 (Emergency Operations Plan) Annex A. Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, public telephones, two-way radios, an 800- megahertz portable radio and cellular phones. The specific modalities used for communicating will depend upon the affect and duration of the emergency (including impact on communication mediums). More than one type of communication modality may be necessary to assure that effective communication occurs.
Some redundant communications include the following:

| **Alarm Systems** | **Alternative Transmissions** |
|---|---|
| • Fire and evacuation alert alarm system.<br>Security Alarms (i.e., intrusion, infant monitor, etc.) | • Messages hand carried by vehicle transport, on bicycle or by runners<br>• Messages transmitted by Public Authority (Police, Fire, Public Health, County EMS directly or via County EOC) |
| **TigerText Notification System**<br>• Mass notification system used to send out ECRMC messages to enrolled users | **Cell Phone**<br>• Personal cell phones<br>• Hospital-issued cell phones, tablets, and laptops |
| **Conferencing Tools**<br>• Conferencing capabilities available with display in CEO Conference Room North Admin Suite<br>• Portable white boards with paper flipchart capability in HCC's.<br>• Videoconferencing via Zoom has been set up in the following locations.<br>− CEO Conference Room MOB<br>− Board Conference Room MOB<br>− Admin Conference Room ASB<br>− MOB Classrooms 1 & 2<br>− Construction Management office<br>• Video conferencing is also available in<br>− Marketing House<br>− IS Meeting Room<br>• Portable video conferencing equipment is also available from IS and Marketing. | **Email**<br>• Direct e-mail to individuals or groups<br>• "All users" e-mail with transmission without delay and directly from HCC by authorized trained staff.<br>• "All users" e-mail with transmission without delay<br>• "All users" e-mail with transmission by Information Services (IS), requires review by IS and may be delayed depending on availability. Urgent communications can be accommodated.<br><br>**Bullhorns**<br>• Bullhorns for voice/siren alarms and batteries located in North Administration suite. |
| **Face to Face meetings & Print**<br>• Making the Rounds<br>• Hospital Newsletters via Marketing<br>• Hard copy communications with staff via Print & Copy Center for distribution and/or posting on bulletins boards on units and in common areas<br>• Whiteboards for posting | **Facebook & Media Relationships**<br>• Partnership with media (TV and radio) via Marketing Department |

## Annex A: Redundancy of Communications

ECRMC has direct telephone lines that may be dialed from outside telephones (cell or landline). These lines bypass the PBX system. These phone numbers are considered confidential and should not be distributed outside the HICS roster. The Red Phone instruments are stored in each department. Department managers and leads shall acquaint themselves with the locations of the Red Telephone for their department, and the location of the phone jack to be used in case of emergency.

| STATION | ZONE | NUMBER | LOCATION OF PHONE JACK |
|---|---|---|---|
| 1 | Old ICU (NW) | (760) 352-0580 | Counter behind nurse's station |
| 2 | Emergency | (760) 352-0610 | South back counter V-128-2 |
| 3 | Obstetrics | (760) 352-0634 | Counter under nurse's station |
| 4 | North Wing | (760) 352-0651 | Front counter |
| 5 | South Wing (temp OB) | (760) 352-0839 | East counter under cabinet |
| 6 | Surgery | (760) 339 4836 | Under counter (V-13) |
| 7 | Imaging Tech Area | (760) 339-4837 | East wall phone on shelf |
| 8 | ER Registration | (760) 339-4838 | Wall phone in place |
| 9 | Incident Command | (760) 339-4839 | CEO conference room east wall |
| 10 | Pediatrics | (760) 339-4840 | East wall nurse's station |
| 11 | East Wing | (760) 336-0374 | Under counter (V-70-1) |
| 12 | West Wing | (760) 336-0373 | Under counter (V-11-2) |
| 13 | ICU 2nd Floor | (760) 336-0371 | West ICU under counter (V-107-1) |
| 14 | Central Station | (760) 336-0370 | Under front couter (V-8-2) |
| 15 | PBX Operator | (760) 336-0369 | Under counter (V-89-2) |
| 16 | Laboratory | (760) 352-1444 | West center counter in tech area |
| | **OFF CAMPUS** | | |
| 1 | IV Mall | (760) 339-9927 | |
| 2 | Human Resources | (760) 337-7990 | |
| 3 | Accounting | (760) 312-5916 | |
| 4 | Information Services | (760) 339-4983 | |
| 5 | HIM Warehouse | (760) 355-3811 | |
| 6 | El Centro Clinic | (760) 370-8600 | |
| 7 | Calexico Clinic | (760) 768-4196 | |

<table>
<tr><td>

**Hospital Incident Command Software**

- Web-based program: Adobe Connect disaster management system for managing emergencies, communication, and tracking documentation in activations online.

</td><td>

**Hospital Telephone System**

- Avaya Telephone System<br>POTS incoming lines to both rural clinics and the hospital
- Auxiliary Telephone System with direct phone numbers to HCC.

</td></tr>
<tr><td>

**National Communication System**

- Government Emergency Telecommunications Service (GETS). Distribution sites: Telecommunications (1); selected leaders 3)

</td><td>

**Information System**

- Computers and usual hospital systems for storage and transmission of records, results, and communications.
- Hospital laptops
- Dedicated computers on mobile stands (WOW's)
- Hospital printers and scanners
- Additional access points and antennae for wireless to serve areas outside of the hospital such as surge tent potential locations
- Encoded USB drives dedicated for emergency use.

</td></tr>
<tr><td>

**Imperial County EOC**

- EOC located in Heber

</td><td>

**Public Address System**

- Internal system that can be used to transmit live broadcasts
  - Overhead paging uses this system

</td></tr>
<tr><td>

**Internal Radios**

- Emergency Department, Radiology, Transporters all have simplex line-of-sight FRS walkie-talkies
- IT has web-based walkie-talkies

**If Information Systems are down, Telecommunications has in place:**

- Hard copy of the "on-call" schedule, so "on-call" information is always available.

</td><td>

**Radio System**

- 800-Megahertz radio at Emergency Department with direct access to area hospitals
- Imperial County Regional Communication System, (RCS) 800-MHz Mutual Aid radios (5), located in Admin CEO Office, Security, Emergency Preparedness, Emergency Department, and Base Station Coordinator office
- 400 MHz Motorola (46 radios) walkie-talkie radios used by Main Campus & Outpatient Clinics EVS, Maintenance, Administration, and Security

</td></tr>
<tr><td>

**Twitter**

- Social media platform that can be used to push information to the public

</td><td>

**Information Poster on Website**

</td></tr>
<tr><td>

**Signage**

- Copy & Print Center
- Portable temporary and permanent sign board access
- Marketing Department – Large format printer

</td><td>

**Facebook**

- Social media platform that can be used to push information to the public

</td></tr>
</table>

## Annex B: ECRMC Property Loss Claim Form

| | |
|---|---|
| **DATE OF NOTIFICATION TO RISK MANAGEMENT** | |
| **LOCATION** | |
| **DEPARTMENT** | |
| **DATE OF INCIDENT** | |
| **TIME OF INCIDENT** | |
| **CAUSE OF INCIDENT STATEMENT** | |
| **CONTACT PERSON**<br>**NAME, PHONE # & EMAIL ADDRESS** | |
| **ESTIMATED INCIDENT AMOUNT**<br>**$** | |
| **FM WORK ORDER #** | |
| **REIMBURSEMENT INDEX/FUND/ORG** | |
| **PROJECT MANAGER**<br>**(Name, Office # and Cell Phone #)** | |

RETURN COMPLETED FORM TO

**Claim # ______________________________**

## Annex C: Order of Succession

Continuity of Leadership during an emergency situation is critical to ensure the continuity of the healthcare essential functions. ECRMC maintains an order of succession for key positions in the event leadership is unavailable or unable to perform authorized duties. Successors have the full, unlimited authority to operate in the position they are assuming to the fullest extent possible until such person is relieved by the next highest-ranking individual or as identified in the delegations of authority. Orders of succession will take affect if the named key position cannot be reached and/or cannot function, and will terminate if and when the incumbent is available and able to perform their authorized duties. The following Orders of Succession are pre-established guidelines. Decisions will be made based on real-world event circumstances and in consultation with HICS leadership.

| Key Position | Successor 1 | Successor 2 | Successor 3 |
|---|---|---|---|
| Chief Executive Officer | Chief Medical Officer | Chief Nursing Officer | Chief HR Officer |
| Chief Medical Officer | Chief Medical Officer | Chief of Staff | |
| Chief Nursing Officer | House Supervisor | ED Director | Med/Surg Director |
| Chief Financial Officer | Hospital Controller | Purchasing Supervisor | |
| Associate Administrator of IT Services | IS Supervisor of Applications Services | Senior Network Architect | Systems Administrator II/Help Desk Lead |

## Annex D: Delegations of Authority

Delegations of Authority allows certain duties of one individual/position to be assigned/delegated to multiple individuals if the selected Successor is not available or if the expertise to make the authority is present with another individual.

ECRMC has established Delegations of Authority to provide successors the authority to act on behalf of ECRMC for specific purposes and to carry out specific duties.
Delegations of Authority will take effect when normal channels of authority are disrupted due to a significant emergency or disaster and will terminate when these channels are reestablished.

Delegation of authorities for making policy determinations and for taking necessary actions at all levels of an organization ensures a rapid and effective response to any emergency requiring the activation of a continuity plan. The following established delegations of authority are pre-established guidelines. Decisions will be made based on real-world event circumstances and in consultation with HICS leadership.

| Authority | Triggering Conditions | Position Holding Authority | Delegated Authority |
|---|---|---|---|
| Close and Evacuate the facility | When conditions make coming to or remaining in the facility unsafe | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Safety Officer<br>3. Facilities Manager |
| Represent the facility when engaging with government officials | When the pre-identified senior leadership is not available | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Public Information Officer<br>3. Emergency Prep Director |
| Selective provision of utilities | When utility resources are limited | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Facilities Manager |
| Selective provision/reallocation on of resources | When resources to support patient care are limited | 1. CEO<br>2. Incident Commander | 1. Alternate Chief Officer<br>2. Order of Succession for CEO |
| Temporary curtailment of services | When resources are limited and census cannot be maintained | 1. CEO<br>2. Incident Commander<br>3. Chief Nursing Officer | 1. Order of Succession for CEO<br>2. Order of Succession for CNO |
| Emergency Procurement and Contracts | When critical resources to sustain census can be procured through purchasing | 1. CEO<br>2. CFO | 1. Order of Succession for CFO<br>2. Incident Commander<br>3. Order of Succession for IC |

**TO:** HOSPITAL BOARD MEMBERS

**FROM:** David Momberg, Chief Financial Officer

**DATE:** December 18, 2023

**MEETING:** Board of Trustees

**SUBJECT:** Move to approve the review of ECRMC's Value Analysis Program Policy.

**BUDGET IMPACT**: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _______________

**BACKGROUND:** As ECRMC faces financial challenges, there is a need to revamp current Value Analysis Program ensuring that all product, services and equipment will be vetted by the Value Analysis Committee to ensure the greatest value without compromising quality patient care and experience.

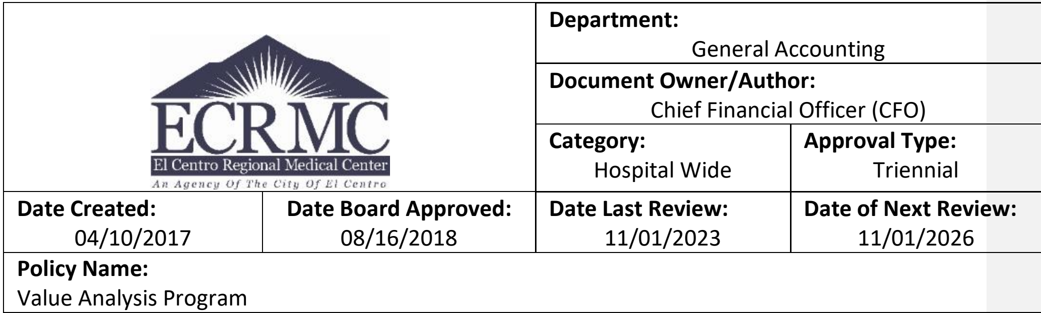
**RECOMMENDATION:** (1) Approve (2) Do not approve

**ATTACHMENT(S):**

- Current Value Analysis Program
- Updated Value Analysis Program

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo V[illegible]



| | | Department: General Accounting | |
|---|---|---|---|
| | | Document Owner/Author: Chief Financial Officer (CFO) | |
| | | Category: Hospital Wide | Approval Type: Triennial |
| Date Created: 04/10/2017 | Date Board Approved: 08/16/2018 | Date Last Review: 11/01/2023 | Date of Next Review: 11/01/2026 |
| Policy Name: Value Analysis Program | | | |

1

2 ## Purpose

3 To evaluate, trial, select, and implement products and services that provide the greatest value
4 for El Centro Regional Medical Center (ECRMC) and its patients.

5

6 ## Scope

7 The scope of the Value Analysis Program (VAP) is to bring together all available resources that aid in
8 identifying those products or services that contribute to positive patient outcomes and experiences
9 while meeting the medical/surgical needs of ECRMC providers and ensuring the financial impact is
10 reasonable.

11

12 ## Policy Statement

13 El Centro Regional Medical Center (ECRMC) strives to maintain proper balance between providing
14 cost-effective patient care and using new, emerging medical technologies in healthcare. The
15 ECRMC Value-Based Analysis Committee (VAC) has been at the forefront of this commitment and
16 has established a culture of continuous medical innovation in a fiscally responsible manner.

17

18 ## Responsibilities

| Person/Title | Responsibilities |
|---|---|
| The Chief Executive Team (CET) | Scope & Roles<br>1. Provides a high level of oversight of processes and outcomes<br>2. Provides final request approval<br>3. Performs barrier resolution to problematic recommendations<br>4. Supports all improvement activities<br>5. Maintains decision impact reporting on a regular basis<br>6. Maintains the integrity of all Value Analysis processes<br>7. Review requests for compatibility with hospital Strategic Plan |

Deleted: .

Deleted: Under the guidance of the ECRMC Value Analysis Steering Committee (VASC),

Deleted: t

Deleted: Value Analysis Steering Committee

Deleted: VASC

| | |
|---|---|
| | 8. Coaches and supports members of the VAC<br>9. Prioritize requests submitted |
| | |
| Value Analysis Committee (VAC) | 1. Review requests for compatibility with hospital Strategic Plan<br>2. Engage and align with physicians<br>3. Understand physician practice patterns<br>4. Ensure all requests are criteria based<br>5. Research cutting edge technologies using internal and external resources<br>6. Validate Return on Investment (ROI) documents<br>7. Recommend a timeline for capital acquisition<br>8. Carry recommendations forward to CET |
| Chairperson (VAC) | 1. Develop meeting agenda and schedule meetings coordinating with the Purchasing Manager/Department<br>2. Conduct meetings<br>3. Report activities and recommendations to CET<br>4. Ensure team follows protocols for project using VAC tools.<br>5. Chairperson appointed by Chief Executive Team. |
| Chairperson (VAC)<br>Scope and Roles. | 1. Focus on clinical and physician preference items<br>2. Ensure activities fit hospital Information Systems plan and seek approval if appropriate<br>3. Understand practice patterns and purchases by vendor and physician<br>4. Research and validate information provided<br>5. Conduct product evaluation as needed<br>6. Provide CET recommendation for approval or denial<br>7. Defer problematic requests to CET<br>8. Identify standardization opportunities<br>9. Provide follow-up audits to CET |

## Procedure/Plan

**The CET**

CET Evaluation Criteria

1. Requests are reviewed by the CET and categorized as follows:
    a. Mission critical
    b. Revenue enhancing
    c. New medical technology

**Deleted:** <#>Appoints all VATs including those for special purchases, product reviews, and projects, periodic reviews of items under used or dormant.¶
<#>

**Deleted:** Chairperson (VASC)

**Deleted:** <#>Develop meeting agenda with the Purchasing Manager¶
<#>Conduct the Steering Committee meetings¶
<#>Report activities and decisions to Chief Executive Team¶
<#>Chairperson appointed by Chief Executive Team¶
<#>

**Deleted:** VASC

**Deleted:** Steering Committee.

**Deleted:**

**Deleted:** Value Analysis Steering

**Deleted:** Committee

**Deleted:** Steering Committee

**Deleted:** Steering Committee

**Deleted:** VASC

**Deleted:** Membership¶
The VASC includes all members of the CET. Ad hoc members may be invited as needed.¶
¶
Meetings¶
Meetings will be held monthly. Ad hoc meetings may be called by chairperson. ¶
Decisions supported by a majority of the members in attendance will be final. A quorum of at least 60% is required.¶
Each member has one vote.¶
¶
VASC

**Deleted:** VASC

d. Patient/Staff safety
e. Equipment failure
f. Risk management considerations
g. Replacement

2. Research/due diligence is conducted jointly by the specific VAC requestor, Purchasing Manager and any other individuals deemed necessary to provide required information for decision making.
3. The CET reviews the organizations approved Capital Equipment items.

## The VAC

### Membership

1. The permanent members of the VAC are from following departments (unless otherwise stated):
   a. Chief Nursing Officer (CNO)
   b. Purchasing Department
   c. Materials Management Department
   d. Director of Quality and Risk Management
   e. Director of Patient Accounting
   f. CFO
   g. Controller
   h. And others members designated/appointed by the CFO and/or CEO

2. Any hospital staff or medical staff member can submit request form to the VAC for product or service consideration.

### Meetings

1. Meetings will be held monthly.
2. Decisions supported by a majority of the members in attendance will be final. A quorum of at least 60% is required.
3. Each member has one vote.

### Values

1. Patient and staff safety is a primary concern at all times.
2. VAC will strive to anticipate needs, respond timely, and meet or exceed expectations
3. VAC will collaborate to problem solve and pursue opportunities creatively
4. VAC will make evidence-based decisions supported by best practices
5. VAC will utilize all available internal and external resources for decision-making

### Guiding Rules

1. All members of Chief Executive Team are responsible for advocating and supporting Value Analysis throughout the organization.

**Deleted:** VASC r

**Deleted:** e

**Deleted:** and can require a VAC project for VAC.¶

**Deleted:** ¶
Education¶
Surgical Services¶
Maternal Child¶
Inpatient Services (Med / Surg, and ICU)¶
Infection Control¶
Administration¶

**Deleted:** <#>Finance¶

**Deleted:** Safety (ad hoc)

**Deleted:** <#>Facility Services (ad hoc)¶
<#>Medical Staff (ad hoc, and as appointed by CMO or COS)¶
<#>Ad hoc members are determined by need and scope of project and is limited to the time needed to complete the project.¶

**Deleted:** per complexity of product or equipment

**Deleted:** <#> project. Ad hoc meetings called by chairperson.¶

130 2. Value Analysis is a fundamental way of doing business. Managers are expected to embed
131 value analysis principles into the core functions of their departments.
132 3. All product, equipment, medical technology, and service decisions will be made using
133 value analysis processes. No department is exempt.
134

135 Evaluation Criteria

136 Group Purchasing Program
137 1. The hospital is a participating member of GPO Purchasing Programs. Prime vendor
138 relationships and existing GPO contracts will be the preferred resources for product
139 utilization unless serious quality or patient safety issues are documented.
140 2. GPO contracted items are given first consideration in the review of new products and
141 equipment to remain compliant with and to maximize the benefits of GPO.
142 Existing Products/Equipment
143 1. Commodity products will continue to be used for the duration of our GPO contract and
144 are considered to be in the "hospital formulary" of products. These items are
145 conventional products procured for use via GPO, or independent Hospital contracts.
146 2. Value analysis review is required if there is a radical product change, contract expiration,
147 the product is discontinued with no acceptable substitution, or if there is a significant
148 clinical or patient safety concern related to the product. A *Request for Review/Evaluation*
149 *of Equipment/Supply Form* *and a ROI for New Supplies/Items (Return of Investment)* *See*
150 **Attachments A and C** must be submitted to Purchasing for evaluation. (Forms can also
151 be downloaded from the Intranet)
152 3. Infection control items such as cleaning agents, disinfectants, hand cleansers, and hand
153 gels must comply with CDC regulations and be approved by the Infection Prevention
154 Nurse and Director/Manager of EVS prior to inclusion in the hospital formulary of
155 products.
156 4. Equipment currently in use and under contract will remain in use through the life cycle or
157 until deemed necessary for replacement.
158 Standardization
159 1. The Purchasing Department will identify product lines for standardization to reduce
160 duplication of services and inventory levels.
161 2. The Value Analysis Committee will review utilization patterns, solicit input from all users,
162 including physicians, and, using the *Guiding Principles for Product Review* (See
163 Attachment "B"), rule on standardization opportunities.
164

165 Evaluation of New Products / Equipment and Technology

166 Physician Requests
167 1. All requests for new products, equipment or medical technology are directed to the
168 member of the area/department where the product will be used. The member will work
169 with the physician to complete the necessary information required on the *Request For*
170 *Review/Evaluation of Equipment/Supply* *and a ROI for New Supplies/Items (Return of*

Deleted: VASC members must complete the
Deleted: See
Deleted: and
Deleted: submit
Deleted: Steering

176 *Investment* a ROI ***See Attachments A and C***. All required information on the request form
177 must be completed in full to ensure expeditious ruling.

Deleted: Request may also be submitted on-line via the hospital Intranet.

178 Non-Physician Requests

179 1. The department or individual identifying the need for a new product, equipment or
180 medical technology will complete all required information on the *Request for*
181 *Review/Evaluation of Equipment/Supply* and send to Purchasing department for analysis.
182 2. Purchasing staff will validate the information provided using *Guiding Principles for*
183 *Product Review* ***See Attachment B*** and suggest a recommendation for approval, denial,
184 or deferral
185 3. Requests for liquid, gas, or foam-based products shall be reviewed by the Safety Officer
186 or his/her designee prior to consideration by the VAC.
187 4. The VAC will determine if a pilot study is necessary and identify the study area, time
188 required for proper evaluation, establish criteria for the qualitative evaluation, and assign
189 one member of the Team the responsibility of monitoring the progress of the
190 evaluation.
191 5. Emergency procurement of non-approved products and/or equipment will be allowed on
192 a limited basis and approval granted only by the CET or its designee.

Deleted: VASC

193

194 Budgeting Process

195 1. Capital & operating budget items will be submitted using established budgeting protocols.
196 2. Items and/or projects submitted may be eligible for VAC evaluation as determined by the
197 CET prior to purchase or implementation.

Deleted: VASC

198

199 General

200 1. Once an item or product line has been reviewed, the VAC will not reconsider the product
201 for a period of three years unless there has been a substantial circumstance change.
202 2. Purchasing is responsible for communicating to the organization including medical staff,
203 projects currently being evaluated, those approved for use and any decisions made by the
204 VAC and CET.

Deleted: VASC.

205

206 **Definitions**

| Term | Definition |
|---|---|
| Value Analysis | Healthcare value analysis contributes to optimal patient outcomes through an evidenced-based systematic approach to review healthcare products, equipment, technology and services. Using recognized best practices, and in collaboration with organizational resources, value analysis evaluates appropriate utilization, clinical efficacy, and safety issues for the greatest financial value. |

207

213 ## Associated Policies/Plans/Protocols/Procedures/Forms

| **Title** | **Number** | **Location** *(Hyperlink)* |
|---|---|---|
| Value Analysis Program | 1426 | Product Evaluation v.4 |
| | | |

214

215 ## References

216 360° Supply Saving Analysis Report for ECRMC, Strategic Value Analysis in Healthcare; May 9, 2007
217 Clinical Quality and Values Analysis, NOVATION, Inc., 2007

**TO:** HOSPITAL BOARD MEMBERS

**FROM:** David Momberg, Chief Financial Officer

**DATE:** December 18, 2023

**MEETING:** Board of Trustees

**SUBJECT:** November 2023 Month and Year-to-Date Financial Statements

**BUDGET IMPACT**: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _______________

**BACKGROUND:** The month of November resulted in net operating loss of $477K, a Negative margin of 2.1% and positive EBIDA of $1.38. FYTD EBIDA is positive at $2.1M and positive margin increase from 1.6% to 2.1%.

**DISCUSSION:** For a more detailed description of financial performance, please see the attached Financial Report.

**RECOMMENDATION:** (1) Approve (2) Do not approve

**ATTACHMENT(S):**

- Financial Packet for November 2023

Approved for agenda, Chief Executive Officer

Date and Signature: ______________ 12/14/23

# November 2023 Financial Report

**December 18, 2023**

**To: Finance Committee**

**From: David Momberg, Chief Financial Officer**

The following package contains:

- Comparative volumes vs. Prior Month/Year
- Balance Sheet vs. Prior Month comparison
- Operating Statement vs. Prior Month comparison
- Monthly Cash Flow (Fiscal Year to Date)

**Balance Sheet:**

a) Cash balance increased ($21.7M) due to Distressed Hospital Loan Program received ($28M) partially offset by higher vendor payments, 5 payment runs ($1.1M usually 4; every Thursday) and capital project payments ($1.3M).
b) Net patient receivables increased ($1.5M) mainly due to higher admissions (282 vs. 229 last month, 23% increase) coupled with higher Oncology, volumes (2,263 vs. 2,086 last month, 8% increase).
c) Other receivables increased ($63k) due to 340b pharmacy revenues.
d) Due from third-party payers increased ($1.2M), no supplemental payments received.
e) Prepaid expenses increased ($158k) due to Cardinal Health prepaid orders.
f) Restricted building capital fund increased ($13k) due to UBS generated interest.
g) Due to third-party payers increased ($28M) due to Distressed Hospital Loan Program received.

h) Days in A/R decreased to 41.43 from 42.82 days. The goal is 50 days.
i) Accounts payable days increased, 88.81 vs. 86.10 days from previous month.
j) Current Ratio increased to 0.83 vs. 0.81 previous month.

**Income Statement – Current Month Actual vs. Prior Month:**

a) Our Inpatient Revenue is 12% higher than prior month due to higher admissions (282 vs. 229 prior).
b) Outpatient Revenue is 5.2% lower than last month due to lower outpatient visits (7,199 vs. 7,878 last month) partially offset by higher oncology visits and infusions (2,263 vs. 2,086 prior).
c) Contractuals for the month are 18.8% of gross revenues (18.0% last month).
d) Charity and Bad debt decreased $23k directly related to lower gross revenues.
e) Other third-party programs are 22.5% higher due to higher supplemental programs received than budget (HQAF $357K).
f) Salary expense is lower 3.7% directly related to month's days (30 in Nov. vs. 31 in Oct).
g) Registry expense is higher 14.8% related to higher patient days (1,290 vs. 1,209 last month).
h) Employee benefits expense is lower 6% related to lower employee insurance expense.
i) Non-Medical Prof Fee expense is 47% higher mainly related to union negotiations legal expenses (Sheppard Mullin).
j) Supplies medical are 8.7% lower mainly due to lower Intuitive Xi Robot supply expenses (inventory supplies purchase made in October).
k) Food expense is 12.7% higher related to higher patient days.
l) Rent expense is higher $30k related to Shared Imaging lease true-up.
m) Utilities expense is 16% higher due to higher water expenses.
n) Insurance expense is 73% higher due to timing on Marsh Malpractice and Workers comp. installments.
o) November 2023 shows a Net loss of $269k (*$1.38M positive EBIDA*), showing steady improvement over the last couple of months.

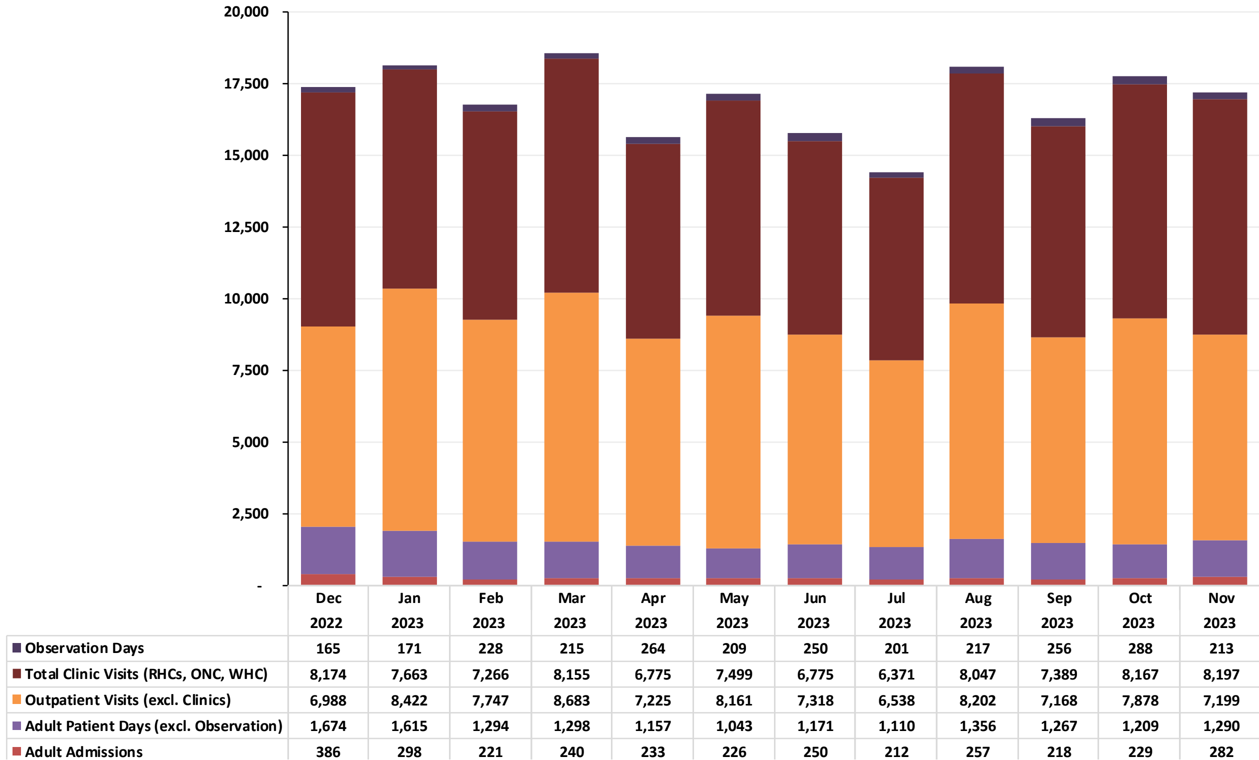
**Definitions:**

- **EBIDA** - Earnings Before Interest, Depreciation, and Amortization.
- **Contribution Margin** – Total Revenue minus Expenses (excluding functional areas of IT, Finance, HR, and management assessments/restructuring costs).
- **EBIDA Margin** – EBIDA/Total Revenue.
- **Operating Expenses Per Day** – Total Expenses less Depreciation divided by Days.
- **Operating Revenue Per Day** – Operating Income/Days.
- **Days Cash on Hand** – Cash/Operating Expenses per Day.
- **Days Revenue in A/R** – Accounts Receivable/Operating Revenue per Day.
- **Current Ratio** – Current Assets/Current Liabilities.
- **Equity Financing Ratio** – Total Capital/Total Debt.

# El Centro Regional Medical Center
## Comparative Volumes as of November 30, 2023

| | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 | YTD Actual | YTD Budget | YTD Variance |
|---|---|---|---|---|---|---|---|
| Adult Admissions (excl. Observation) | 257 | 218 | 229 | 282 | 1,198 | 1,551 | (353) |
| Patient Days (excl. Observation) | 1,356 | 1,267 | 1,209 | 1,290 | 6,232 | 8,046 | (1,814) |
| Average Length of Stay (excl. Observation) | 5.3 | 5.8 | 5.3 | 4.6 | 5.2 | 5.2 | 0.0 |
| Average Daily Census (excl. Observation) | 43.7 | 42.2 | 39.0 | 43.0 | 40.7 | 40.7 | - |
| Average Daily Census (ADC) Observation | 7.0 | 8.5 | 9.3 | 7.1 | 7.7 | 6.9 | 0.8 |
| Total ADC (including Observation) | 50.7 | 50.8 | 48.3 | 50.1 | 48.4 | 47.7 | 0.8 |
| Observation Days (excluding Obstetrics) | 217 | 256 | 288 | 213 | 1,175 | 1,059 | 116 |
| Outpatient Visits (excluding Clinics) | 8,202 | 7,168 | 7,878 | 7,199 | 36,985 | 41,357 | (4,372) |
| Emergency Room Visits | 2,873 | 2,673 | 2,858 | 2,898 | 13,972 | 16,608 | (2,636) |
| El Centro Rural Health Clinic Visits | 3,974 | 3,657 | 4,061 | 4,007 | 18,538 | 21,610 | (3,072) |
| Calexico Rural Health Clinic Visits | 3,035 | 2,946 | 3,224 | 3,221 | 15,201 | 15,539 | (338) |
| Rural Health Clinic Visits - Total | 7,009 | 6,603 | 7,285 | 7,228 | 33,739 | 37,148 | (3,409) |
| Wound Healing Center Visits | 175 | 178 | 222 | 210 | 948 | 885 | 63 |
| Oncology Center Visits | 863 | 608 | 660 | 759 | 3,484 | 3,353 | 131 |
| Oncology Center Infusion Procedures | 1,461 | 1,309 | 1,426 | 1,504 | 6,765 | 6,690 | 75 |
| Surgeries without C-Sections | 601 | 474 | 540 | 465 | 2,489 | 2,667 | (178) |
| DaVinci Cases | 62 | 47 | 56 | 59 | 283 | 184 | 99 |

## Rolling-12 Volume Trend




| | Dec 2022 | Jan 2023 | Feb 2023 | Mar 2023 | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Observation Days | 165 | 171 | 228 | 215 | 264 | 209 | 250 | 201 | 217 | 256 | 288 | 213 |
| Total Clinic Visits (RHCs, ONC, WHC) | 8,174 | 7,663 | 7,266 | 8,155 | 6,775 | 7,499 | 6,775 | 6,371 | 8,047 | 7,389 | 8,167 | 8,197 |
| Outpatient Visits (excl. Clinics) | 6,988 | 8,422 | 7,747 | 8,683 | 7,225 | 8,161 | 7,318 | 6,538 | 8,202 | 7,168 | 7,878 | 7,199 |
| Adult Patient Days (excl. Observation) | 1,674 | 1,615 | 1,294 | 1,298 | 1,157 | 1,043 | 1,171 | 1,110 | 1,356 | 1,267 | 1,209 | 1,290 |
| Adult Admissions | 386 | 298 | 221 | 240 | 233 | 226 | 250 | 212 | 257 | 218 | 229 | 282 |

## ECRMC BALANCE SHEET COMPARED TO PRIOR MONTH

| | November 30, 2023 | October 31, 2023 | Variance ($) | Variance (%) |
|---|---|---|---|---|
| **Assets** | | | | |
| Current Assets: | | | | |
| Cash and Cash Equivalents | $ 23,386,252 | $ 1,635,094 | $ 21,751,158 | 1330% |
| Net Patient Accounts Receivable | 15,654,026 | 14,145,859 | 1,508,166 | 11% |
| Other Receivables | 202,164 | 138,511 | 63,653 | 46% |
| Due from Third-Party Payors | 17,809,106 | 16,587,733 | 1,221,373 | 7% |
| Inventories | 2,792,946 | 2,796,567 | (3,621) | 0% |
| Prepaid Expenses & Other | 3,061,924 | 2,903,434 | 158,490 | 5% |
| Total Current Assets | 62,906,417 | 38,207,197 | 24,699,220 | 65% |
| Assets Limited as to Use | | | | |
| Restricted Building Capital Fund | 23,733 | 10,997 | 12,736 | 116% |
| Funds Held by Trustee for Debt Service | 11,685,198 | 11,023,003 | 662,195 | 6% |
| Restricted Programs | 11,497 | 11,497 | - | 0% |
| Total Assets Limited as to Use | 11,720,428 | 11,045,497 | 674,930 | 6% |
| Property, Plant, and Equipment: Net | 145,202,576 | 141,671,788 | 3,530,788 | 2% |
| Other Assets | 262,595 | 262,595 | - | 0% |
| **Total Assets** | 220,092,015 | 191,187,077 | 28,904,938 | 15% |
| **Deferred Outflows of Resources** | | | | |
| Deferred Outflows of Resources - Pension | 2,219,400 | 2,605,667 | (386,267) | -15% |
| Total Deferred Outflows of Resources | 2,219,400 | 2,605,667 | (386,267) | -15% |
| **Total Assets and Deferred Outflows of Resources** | $ 222,311,415 | $ 193,792,744 | $ 28,518,671 | 15% |
| **Liabilities** | | | | |
| Current Liabilities: | | | | |
| Current Portion of Bonds | 1,310,000 | 1,305,000 | 5,000 | 0% |
| Current Portion of Capital Lease Obligations | 1,331,408 | 1,348,764 | (17,356) | -1% |
| Accounts Payable and Accrued Expenses | 27,453,629 | 26,394,701 | 1,058,928 | 4% |
| Accrued Compensation and Benefits | 7,959,847 | 7,739,955 | 219,892 | 3% |
| Due to Third-Party Payors | 38,097,181 | 10,097,231 | 27,999,950 | 277% |
| Total Current Liabilities | 76,152,065 | 46,885,651 | 29,266,414 | 62% |
| Long-Term Bond Payable, Less Current Portion | 112,152,610 | 112,243,878 | (91,267) | 0% |
| Capital Lease Obligations, Less Current Portion | 3,679,190 | 4,053,036 | (373,846) | -9% |
| Net Pension Liability | 39,119,000 | 39,119,000 | - | 0% |
| **Total Liabilities** | 231,102,865 | 202,301,564 | 28,801,301 | 14% |
| **Deferred Inflows of Resources** | 7,448,200 | 7,448,200 | - | 0% |
| Deferred Inflows of Resources - Pension | 7,448,200 | 7,448,200 | - | 0% |
| **Total Deferred Inflows of Resources** | | | | |
| **Net Position** | | | | |
| Restricted Fund Balance | 17,238 | 17,238 | - | 0% |
| Fund Balance | (16,256,889) | (15,974,259) | (282,630) | 2% |
| **Total Net Position** | (16,239,650) | (15,957,020) | (282,630) | 2% |
| **Total Liabilities, Deferred Inflows of Resources and Net Position** | $ 222,311,415 | $ 193,792,744 | $ 28,518,671 | 15% |
| Days Cash on Hand | 53.84 | 3.59 | | |
| Days Revenue in A/R | 41.43 | 42.82 | | |
| Days in A/P | 88.81 | 86.10 | | |
| Current Ratio | 0.83 | 0.81 | | |
| Debt Service Coverage Ratio | (0.91) | (1.39) | | |

# STATEMENTS OF OPERATIONS COMPARISON TO BUDGET

| | MTD August 31, 2023 | MTD September 30, 2023 | MTD October 31, 2023 | MTD November 30, 2023 | YTD November 30, 2022 | YTD November 30, 2023 | YTD FLEX November 30, 2023 |
|---|---|---|---|---|---|---|---|
| Adult Admissions | 257 | 218 | 229 | 282 | 1,767 | 1,198 | 1,198 |
| Adult Patient Days (excl. Observation) | 1,356 | 1,267 | 1,209 | 1,290 | 8,392 | 6,232 | 6,232 |
| Outpatient Visits (excl. Clinics) | 8,202 | 7,168 | 7,878 | 7,199 | 40,313 | 36,985 | 36,985 |
| Total Clinic Visits (RHCs, ONC, WHC) | 8,047 | 7,389 | 8,167 | 8,197 | 42,623 | 38,171 | 38,171 |
| Observation Days | 217 | 256 | 288 | 213 | 1,027 | 1,175 | 1,175 |
| **OPERATING REVENUE** | | | | | | | |
| I/P Revenue | $ 15,924,237 | $ 13,975,989 | $ 14,356,601 | $ 16,086,283 | $ 89,286,677 | $ 71,854,834 | $ 70,448,109 |
| O/P Revenue - Laboratory | 6,807,670 | 6,489,172 | 6,662,846 | 6,516,066 | 34,922,597 | 32,733,090 | 33,364,644 |
| O/P Revenue - CT Scanner | 6,484,885 | 6,670,978 | 6,284,614 | 6,053,020 | 32,324,068 | 32,025,061 | 30,492,373 |
| O/P Revenue - Emergency Room | 6,012,887 | 5,730,037 | 6,015,509 | 6,132,301 | 31,126,706 | 29,860,848 | 28,937,438 |
| O/P Revenue - Oncology | 6,504,363 | 5,447,711 | 5,742,087 | 6,490,018 | 24,638,685 | 28,804,872 | 29,196,678 |
| O/P Revenue - Others | 20,475,549 | 17,796,902 | 20,606,460 | 17,770,753 | 96,929,321 | 94,304,501 | 90,221,840 |
| Gross Patient Revenues | 62,209,592 | 56,110,789 | 59,668,118 | 59,048,441 | 309,228,053 | 289,583,205 | 282,661,081 |
| Other Operating Revenue | 429,856 | 358,280 | 316,468 | 257,669 | 1,965,297 | 1,674,004 | 2,327,025 |
| Total Operating Revenue | 62,639,448 | 56,469,068 | 59,984,585 | 59,306,110 | 311,193,350 | 291,257,209 | 284,988,105 |
| Contractuals | | | | | | | |
| IP Contractuals | 12,190,328 | 11,667,150 | 11,939,998 | 10,752,946 | 69,835,695 | 56,837,612 | 61,531,738 |
| OP Contractuals | 38,339,874 | 34,739,706 | 37,008,939 | 37,190,467 | 175,937,735 | 180,211,141 | 169,642,682 |
| Charity | 332,175 | 312,890 | 320,558 | 281,285 | 3,884,593 | 1,458,747 | 6,878,676 |
| Provision for Bad Debts | 386,413 | 363,822 | 425,000 | 443,470 | 1,998,193 | 2,146,560 | 1,554,728 |
| Other Third Party Programs | (1,632,422) | (1,591,268) | (1,591,268) | (1,949,241) | (5,842,814) | (8,548,761) | (7,956,338) |
| M/Cal Disproportionate Share | (1,242,523) | (226,793) | (226,793) | (226,793) | (967,055) | (2,149,694) | (1,133,964) |
| Total Deductions | 48,373,846 | 45,265,508 | 47,876,434 | 46,492,135 | 244,846,346 | 229,955,605 | 230,517,523 |
| Total Net Revenues | 14,265,602 | 11,203,560 | 12,108,151 | 12,813,975 | 66,347,004 | 61,301,604 | 54,470,583 |
| **EXPENSES** | | | | | | | |
| Salaries & Wages | 5,080,613 | 4,787,273 | 4,955,883 | 4,771,365 | 27,520,858 | 24,585,735 | 22,807,031 |
| Registry | 121,909 | 83,764 | 87,098 | 99,986 | 5,695,030 | 496,053 | 453,680 |
| Employee Benefits | 1,463,945 | 1,235,362 | 1,277,736 | 1,165,193 | 6,954,951 | 6,107,918 | 6,048,489 |
| Employee Benefits - Pension GASB 68 | 386,267 | 386,267 | 376,430 | 386,267 | 1,027,510 | 1,921,498 | 1,598,000 |
| Professional Fees - Medical | 1,367,538 | 1,401,289 | 1,492,069 | 1,436,498 | 7,677,475 | 6,834,920 | 7,727,826 |
| Professional Fees - Non-Med | 259,518 | 217,592 | 239,220 | 352,065 | 1,117,068 | 1,363,929 | 1,189,053 |
| Supplies - Medical | 2,506,768 | 2,374,400 | 2,389,927 | 2,182,866 | 11,788,228 | 11,555,013 | 10,642,131 |
| Supplies - Non-Medical | 140,632 | 90,468 | 160,376 | 164,907 | 1,122,881 | 697,912 | 1,054,944 |
| Food | 87,092 | 81,304 | 74,460 | 83,904 | 432,862 | 396,808 | 387,764 |
| Repairs and Maintenance | 658,240 | 531,844 | 608,083 | 645,726 | 3,742,255 | 3,043,284 | 3,567,682 |
| Other Fees | 643,628 | 665,824 | 637,405 | 676,853 | 3,538,972 | 2,961,840 | 3,325,008 |
| Lease and Rental | 42,400 | 1,545 | 8,707 | 38,115 | 381,820 | 127,132 | 233,286 |
| Utilities | 245,402 | 233,277 | 183,103 | 212,258 | 991,617 | 1,071,351 | 985,973 |
| Depreciation and Amortization | 685,421 | 659,358 | 679,455 | 656,343 | 3,441,570 | 3,367,926 | 3,522,861 |
| Insurance | 335,987 | 97,331 | 173,067 | 300,249 | 1,025,049 | 1,190,701 | 1,010,211 |
| Other Expenses | 111,619 | 115,526 | 123,164 | 118,663 | 814,409 | 578,520 | 741,445 |
| Total Operating Expenses | 14,136,980 | 12,962,425 | 13,466,181 | 13,291,256 | 77,272,556 | 66,300,541 | 65,295,383 |
| Operating Income | 128,622 | (1,758,865) | (1,358,030) | (477,281) | (10,925,553) | (4,998,936) | (10,824,800) |
| Operating Margin % | 0.9% | -15.7% | -11.2% | -3.7% | -16.5% | -8.2% | -19.9% |
| Non-Operating Revenue and Expenses | | | | | | | |
| Investment Income | 12,325 | 9,814 | 16,138 | 100,590 | 25,494 | 295,408 | 94,124 |
| Grants and Contributions Revenue | 17,699 | 2,930 | 18,565 | 12,500 | 308,746 | 197,922 | 281,998 |
| Non Operating Revenue/(Expense) | 525,899 | 8,283 | 8,283 | 704,754 | 149,866 | 1,372,927 | 830,845 |
| Interest Expense | (601,527) | (604,069) | (601,808) | (610,132) | (3,052,002) | (3,018,968) | (3,021,966) |
| Total Non-Operating Rev. and Expenses | (45,604) | (583,041) | (558,822) | 207,711 | (2,567,896) | (1,152,710) | (1,814,998) |
| (Deficit)/Excess Rev. Over Exp. | $ 83,018 | $ (2,341,907) | $ (1,916,852) | $ (269,570) | $ (13,493,449) | $ (6,151,647) | $ (12,639,798) |
| (Deficit)/Excess Rev. Over Exp. % | 0.6% | -20.9% | -15.8% | -2.1% | -20.3% | -10.0% | -23.2% |
| EBIDA | 1,756,233 | (692,213) | (259,160) | 1,383,171 | (5,972,367) | 2,156,745 | (4,496,971) |
| EBIDA % | 12.3% | -6.2% | -2.1% | 10.8% | -9.0% | 3.5% | -8.3% |

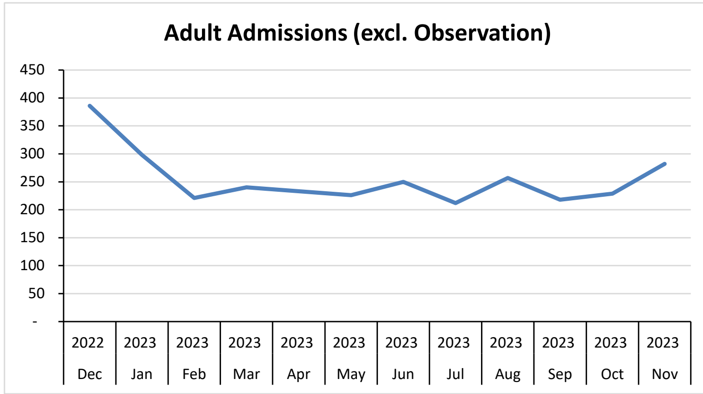
# El Centro Regional Medical Center

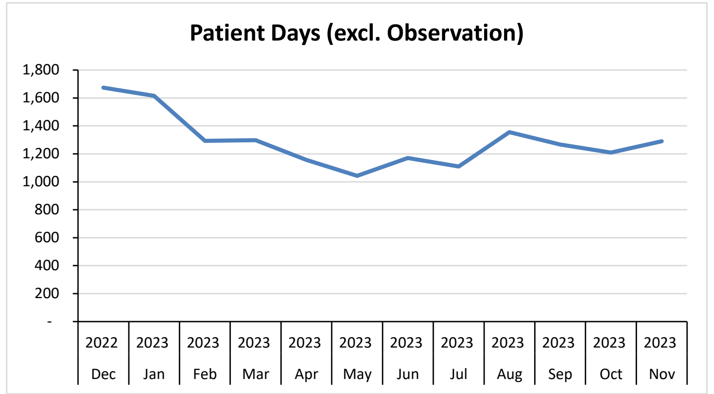
*Unaudited*

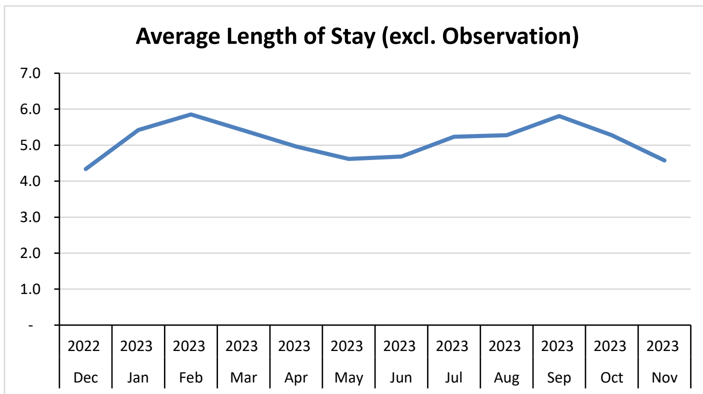
## Monthly Cash Flow

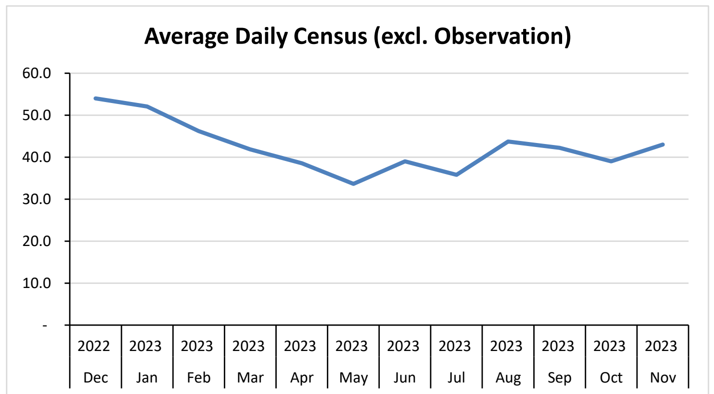
| | July 2023 | August 2023 | September 2023 | October 2023 | November 2023 | Year-to-Date 2024 |
|---|---|---|---|---|---|---|
| *Cash Flow From Operating Activities* | | | | | | |
| Net Income/(Loss) | $ (1,693,276) | $ 83,018 | $ (2,341,907) | $ (1,916,852) | $ (282,630) | **$ (6,151,647)** |
| *Adjustments to reconcile net income to net cash:* | | | | | | |
| Add: Depreciation | 687,349 | 685,421 | 659,358 | 679,455 | 656,343 | **$ 3,367,926** |
| Capital Lease Interest | 10,925 | 10,082 | 9,561 | 8,804 | 12,188 | **$ 51,560** |
| Bond Interest | 588,073 | 588,073 | 588,073 | 588,073 | 588,073 | **$ 2,940,366** |
| Accounts Receivable | 525,767 | (874,155) | 425,746 | (840,534) | (1,508,166) | **$ (2,271,343)** |
| Other Receivables | 53,835 | (135,607) | 3,196 | 90,258 | (63,653) | **$ (51,971)** |
| Inventory | (90,320) | 62,497 | 3,184 | (17,349) | 3,621 | **$ (38,367)** |
| Prepaid Expenses/Other Assets | (135,337) | 341,100 | 241,311 | (101,557) | (158,490) | **$ 187,026** |
| Accounts Payable and Accrued Expenses | 378,705 | 96,138 | 2,040,657 | 1,838,873 | 261,768 | **$ 4,616,142** |
| Accrued Compensation and Benefits | 339,108 | (1,581,815) | 281,567 | 612,150 | 342,711 | **$ (6,279)** |
| Third-Party Liabilities | (1,818,060) | (1,842,679) | (1,781,141) | (1,174,454) | 26,778,577 | **$ 20,162,242** |
| Net Pension Obligation | 386,267 | 386,267 | 386,267 | 376,430 | 386,267 | **$ 1,921,498** |
| *Net Cash From Operating Activities* | $ (766,964) | $ (2,181,659) | $ 515,872 | $ 143,296 | $ 27,016,608 | **$ 24,727,153** |
| *Cash Flow From Investing Activities* | | | | | | |
| Fixed Assets - Gross | $ (21,365) | $ (100,025) | $ (625,596) | $ (292,897) | $ (4,187,130) | **$ (5,227,013)** |
| Intangible Assets - Gross | $ - | $ - | $ - | $ - | $ - | **$ -** |
| Restricted Assets | 4,509,875 | (300,196) | (1,330,489) | 468,290 | (674,930) | **$ 2,672,549** |
| *Net Cash From Investing Activities* | $ 4,488,509 | $ (400,221) | $ (1,956,085) | $ 175,393 | $ (4,862,061) | **$ (2,554,465)** |
| *Cash Flow From Financing Activities* | | | | | | |
| Bond Payable | $ (4,661,219) | $ - | $ - | $ - | $ - | **$ (4,661,219)** |
| Capital Leases | (320,043) | (303,673) | (272,050) | 30,075 | (403,389) | **$ (1,269,080)** |
| Notes Payable | - | - | - | - | - | **$ -** |
| *Net Cash From Financing Activites* | $ (4,981,262) | $ (303,673) | $ (272,050) | $ 30,075 | $ (403,389) | **$ (5,930,299)** |
| *Total Change In FY 2024 Cash* | $ (1,259,717) | $ (2,885,553) | $ (1,712,263) | $ 348,765 | $ 21,751,158 | **$ 16,242,390** |
| *Cash & Cash Equivalents, Beginning Balance* | 7,143,861 | 5,884,145 | 2,998,592 | 1,286,329 | 1,635,094 | **7,143,861** |
| *Cash & Cash Equivalents, Ending Balance* | **$ 5,884,145** | **$ 2,998,592** | **$ 1,286,329** | **$ 1,635,094** | **$ 23,386,252** | **23,386,251** |

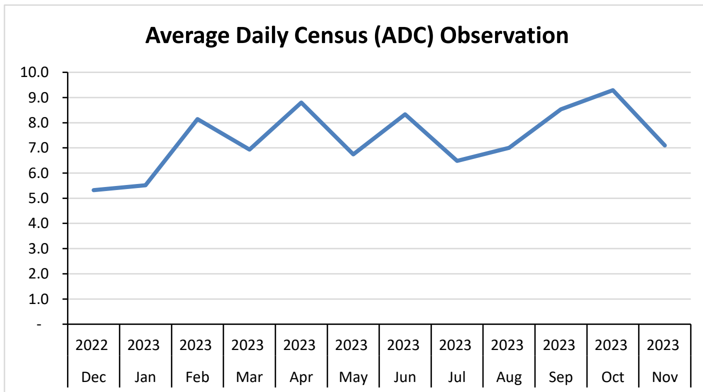
# El Centro Regional Medical Center
# Rolling-12 Volume trend

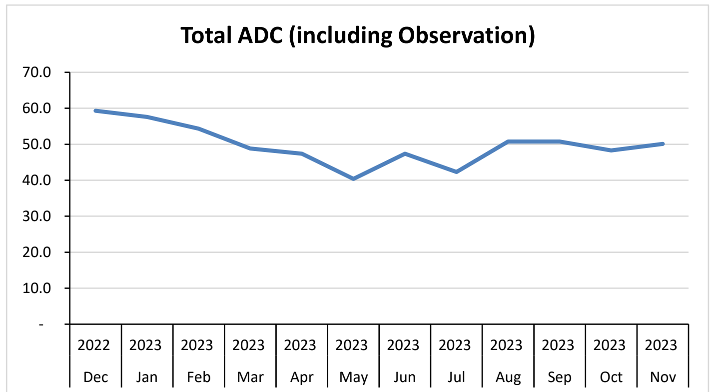


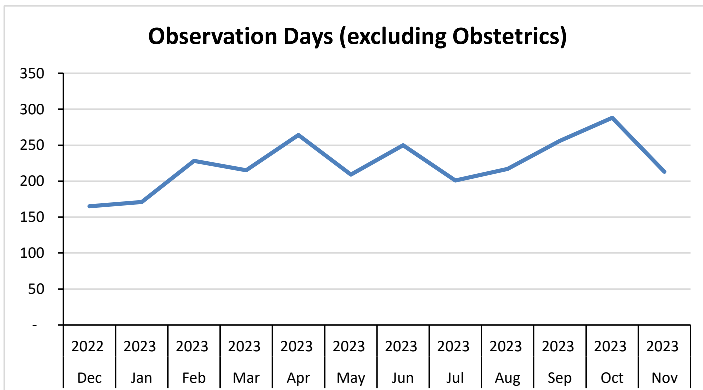



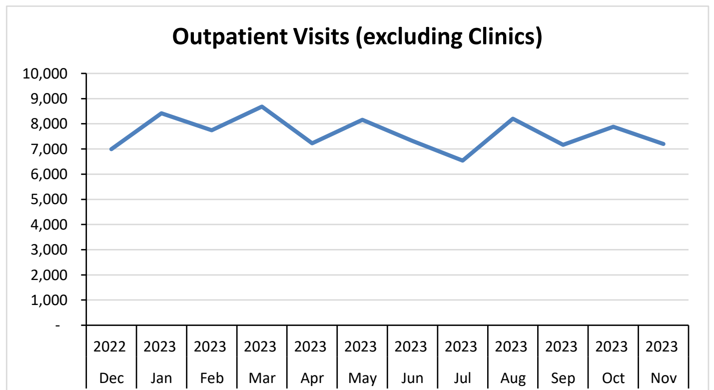



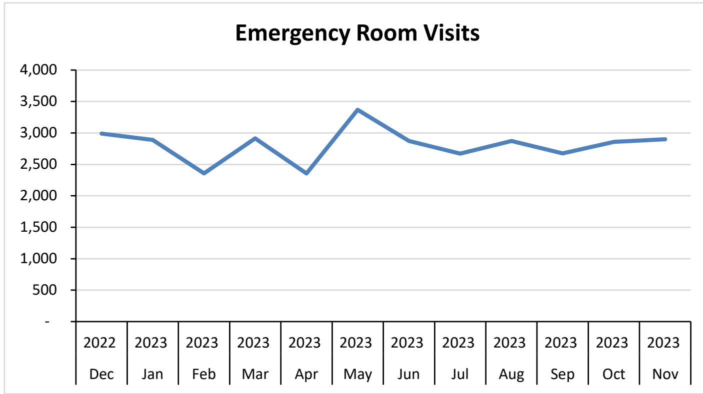



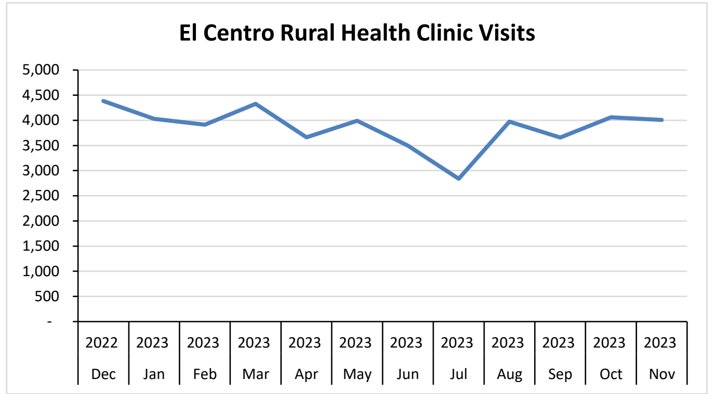



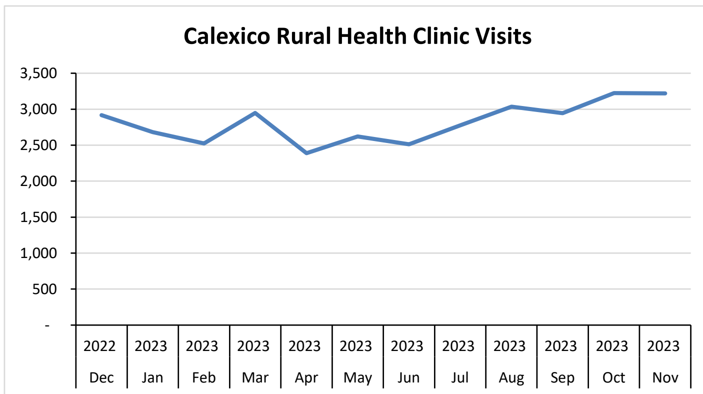



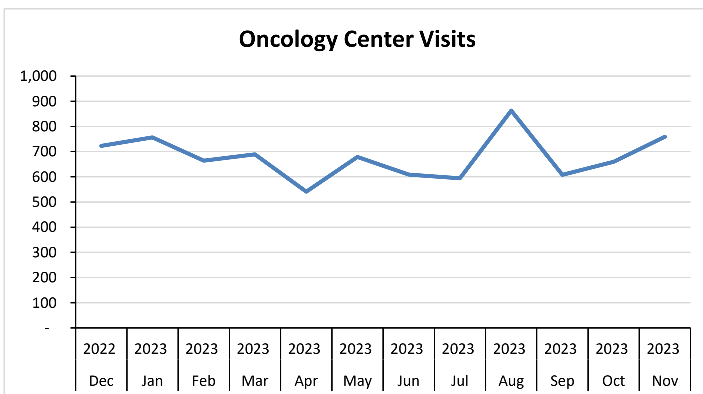



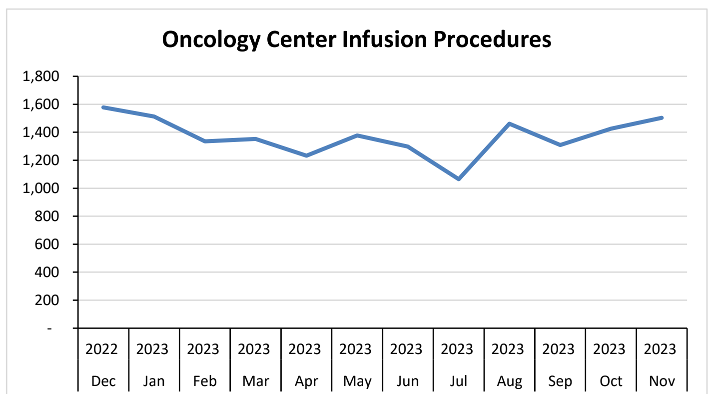
# El Centro Regional Medical Center
# Rolling-12 Volume trend

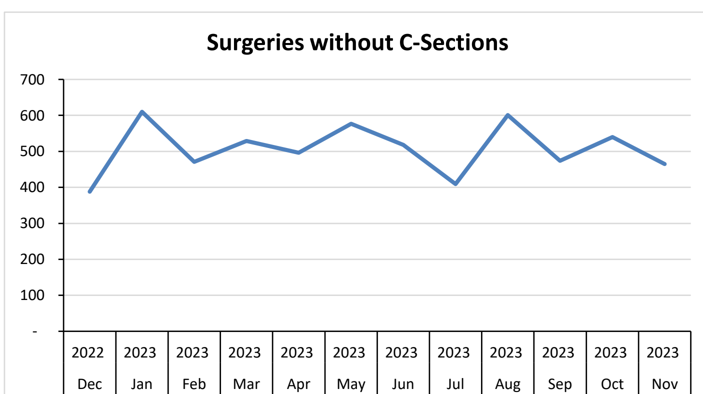


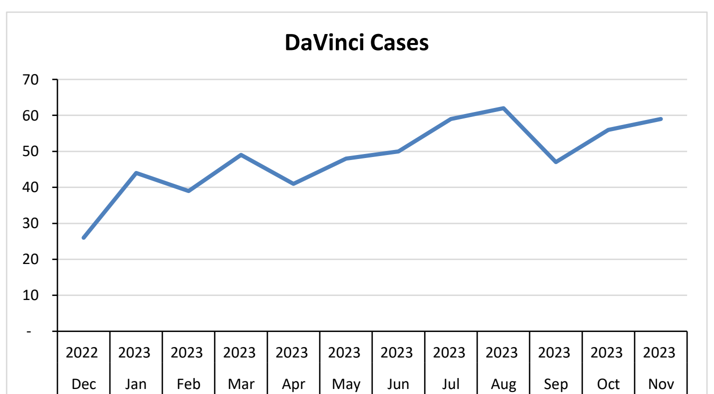





**TO:** HOSPITAL BOARD MEMBERS

**FROM:** David Momberg, Chief Executive Officer

**DATE:** December 18, 2023

**MEETING:** Board of Trustees

**SUBJECT:** 2024 Fiscal Year Cash Flow Projection

**BUDGET IMPACT**: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _______________

**BACKGROUND:**

Due to economic considerations the Hospital has been dealing with (Medi-Cal's Supplemental payment delays, Inflation, COVID-19 State regulations, new EHR implementation, Building constructions, Operational mishaps, etc.), the Medical Center Administration has the necessity to anticipate more than ever before the cash inflows and outflows for coming months to appropriately plan ahead the operation and the decision making of the Management and the Board.

The Cash Flow forecast attached to this motion sheet has the main intention of tracking our monthly cash position to implement immediate actions that will help us reduce our cash deficits foreseen in the near future.

**DISCUSSION:** N/A

**RECOMMENDATION:** Informational

**ATTACHMENT(S):**

- Cash Flow Forecast –CY2024

Approved for agenda, Chief Executive Officer

Date and Signature: ______________________

**El Centro Regional Medical Center**

| Actual/Projection | Projection | Projection | Projection | Projection | Projection | Projection | Projection | Projection |
|---|---|---|---|---|---|---|---|---|
| Month | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 | Apr 2024 | May 2024 | Jun 2024 |
| **Beginning Wells Fargo cash balance** | **3,822** | **24,428** | **29,830** | **26,267** | **18,136** | **9,403** | **23,729** | **21,460** |
| **Cash receipts** | | | | | | | | |
| Patient receipts | 10,524 | 11,701 | 9,360 | 9,360 | 11,701 | 9,360 | 9,360 | 11,701 |
| Cerner Implementation - AR Slowdown | - | - | - | - | - | - | - | - |
| Pharmacy receipts | 60 | 72 | 57 | 57 | 72 | 57 | 57 | 72 |
| Collector deposits | 99 | 140 | 112 | 112 | 140 | 112 | 112 | 140 |
| Rent collection | 2 | 5 | 4 | 4 | 5 | 4 | 4 | 5 |
| Cafeteria receipts | 2 | 6 | 5 | 5 | 6 | 5 | 5 | 6 |
| Other receipts | 33 | 51 | 41 | 41 | 51 | 41 | 41 | 51 |
| **Total operating receipts** | **10,722** | **11,975** | **9,580** | **9,580** | **11,975** | **9,580** | **9,580** | **11,975** |
| | | | | | | | | |
| **Total operating disbursements** | **(11,000)** | **(9,643)** | **(11,525)** | **(11,525)** | **(15,347)** | **(11,525)** | **(11,525)** | **(13,464)** |
| **Cash flow from operations** | **(278)** | **2,332** | **(1,945)** | **(1,945)** | **(3,373)** | **(1,945)** | **(1,945)** | **(1,489)** |
| | | | | | | | | |
| Supplemental receipts | - | 4,635 | - | (2,100) | (4,106) | 17,484 | 890 | (104) |
| Capital expenditures | (2,788) | (781) | (564) | (3,033) | (200) | (160) | (160) | (200) |
| Bond payments | (1,323) | (662) | (662) | (662) | (662) | (662) | (662) | - |
| Other loan payments | 25,030 | (23) | (393) | (393) | (393) | (393) | (393) | (785) |
| Transfers (to)/from bond funds | - | - | - | - | - | - | - | - |
| Transfers (to)/from UBS | - | - | - | - | - | - | - | - |
| Restructuring Cost | (40) | (100) | - | - | - | - | - | - |
| **Net non-operating cash flows** | **20,883** | **3,070** | **(1,618)** | **(6,187)** | **(5,360)** | **16,270** | **(324)** | **(1,089)** |
| **Net cash flow excl. sweep transfers** | **20,605** | **5,402** | **(3,563)** | **(8,132)** | **(8,732)** | **14,326** | **(2,269)** | **(2,578)** |
| | | | | | | | | |
| **Beginning unrestricted cash** | **3,824** | **24,430** | **29,832** | **26,269** | **18,137** | **9,405** | **23,730** | **21,462** |
| Total net cash flow | 20,605 | 5,402 | (3,563) | (8,132) | (8,732) | 14,326 | (2,269) | (2,578) |
| **Ending unrestricted cash** | **24,430** | **29,832** | **26,269** | **18,137** | **9,405** | **23,730** | **21,462** | **18,884** |

**TO:** HOSPITAL BOARD MEMBERS

**FROM:** David Momberg, Chief Financial Officer

**DATE:** December 18, 2023

**MEETING:** Board of Trustees

**SUBJECT:** DP-SNF Affiliation with El-Centro Post Acute Care

**BUDGET IMPACT**: _X_Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _______________

**BACKGROUND:**

Imperial Valley has a significant lack of SNFs which impacts the hospitals ability to discharge patients who require further care.

Bayshire group is the facility manager of El Centro Post Acute Care (ECPA). ECPA is located across the street next to our Finance and HR suites, housed in Dr Zadehs building.

ECRMC is discussing an affiliation with ECPA to assume their SNF beds under our hospital license which would grant ECPA DP-SNF status which allows both organizations to access higher reimbursement rates and to increase supplemental funding.

**DISCUSSION:** N/A

**RECOMMENDATION:** Informational

**ATTACHMENT(S):**

- Cash Flow Forecast –CY2024

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo V[illegible] ____________

# Bayshire Senior Communities

# Mission Statement

- To create exceptional communities for senior living -- places in which employees, residents, and families feel important, safe, and loved.

BAYSHIRE YORBA LINDA
SENIOR LIVING

LA FUENTE
POST ACUTE

Vista Gardens
Memory Care Community

Heritage Hills
A Senior Memory Care Community

SHADOWRIDGE
Senior Living

Oak Hill
Residential Care

BAYSHIRE RANCHO MIRAGE
SENIOR LIVING

BAYSHIRE CARLSBAD
SENIOR LIVING

Vista del Lago
A SENIOR MEMORY CARE COMMUNITY

EL CENTRO
POST-ACUTE

BAYSHIRE
TORREY PINES
SKILLED NURSING

CLOISTERS
OF THE VALLEY
Senior Living

Bayshire is LOCAL, with 13 communities in SoCal, Bayshire Support Headquarters are in Escondido

- Bayshire acquired El Centro Post-Acute in May of 2021
- Prior to acquisition, ECPA was losing money, struggling with staffing, and in dire need of plant improvements
- Since the acquisition, ECPA has enjoyed modest profitability, stable and happy staff, and several plant improvements, including but not limited to:
  - New exterior and interior paint
  - New wood-grain laminate flooring
  - Nursing station aesthetic and functional improvements
  - Several new HVAC upgrades

# Acute Medi-Cal Dilemma

Poor SNF Reimbursement and Negative SNF Margins

SNF Partners Unable to Consistently Admit

Increased Acute Length of Stay

Reduced (or Negative) Acute Margins

Reduced Community Access

# DP NF Solution

DP NF Medi-Cal Reimbursement 2.5x that of Traditional SNF

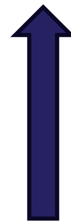
Positive Operating Margins Enable NF to Rapidly Admit Medi-Cal

Decreased Medi-Cal Acute Length of Stay

Reduction in Acute Medi-Cal Losses

Improved Community Access

Affiliated with
UC San Diego Health
CARE NETWORK™



License Affiliation
classified as a
Distinct-Part Nursing Facility
(DP NF)

# Regulations

Additional detail can be found on Proposal Introduction and Summary dated 09.26.23 and Memorandum of Understanding dated 11.17.23

The Department of Health & Human Services (DHHS) Health Care Financing Administration (HCFA) Publication 15-1 2337.1 defines the following:

The term “distinct part” refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However the distinct part need not be confined to a single location within the institution or institutional complex’s physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards which are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units that are physically separate from those units housing other patients of the institution or institutional complex. Where an institution or institutional complex owns and operates a SNF and/or a NF distinct part, that SNF and/or NF distinct part is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number.

# In Summary

- El Centro Post-Acute (ECPA) uniquely qualifies to be Distinct-Part, due to its close proximity to ECRMC.
- Bayshire is the current operator of ECPA, and will continue to be the operator. ECPA license will go away, ECRMC license will include SNF beds.
- ECPA employees will remain Bayshire employees, with exception of a few predesignated shared-services employees.
- Any costs – including labor, supplies, utilities, capex, etc. will remain Bayshire's costs.
- ECRMC will be indemnified as an additional insured on EPCA's GL insurance.
- As a Distinct-Part, CMS requires a portion of ECPA profits be shared with ECRMC (referred to as Gain-Share).
- ECRMC will see far greater through-put of Medi-Cal patients from the acute hospital to SNF.
- As ECRMC includes SNF beds in cost reporting, ECRMC will see substantial increases in IGT revenue through DHDP

ECPA Benefit

Significant increase in daily revenue rates for Medi-Cal patients

ECRMC Benefit

Significant increase in through-put of Medi-cal patients from Acute to SNF

Case Management estimates a daily average of 3-10 Medi-Cal (or Managed Medi-Cal) SNF appropriate patients that cannot discharge due to the lack of an accepting SNF (Acute Medi-Cal Dilemma illustrated previously).

ECRMC is no longer collecting revenue for these patients, and each day they continue to stay it costs ECRMC roughly **$2,751.**

Discharging these patients to DP NF could save ECRMC roughly **$412,650 monthly**. (5 patients x 30 Days x [Daily Cost])

Gain-Share for ECRMC from ECPA

Largely dependent on collaborative cost reporting by ECPA (managed by Waypoint and ECRMC with SC&A's support). ECPA estimates a share of $500,000-$1,000,000 to ECRMC annually

IGT increase

As ECMRC includes DP NF beds in cost reporting for DHDP, the health system's supplemental revenue partner estimates $100 per DP NF patient per day (net revenue). Here is a likely scenario: 100 Managed Medi-Cal ADC (average daily census) at DP NF x $100 PPD x 30 days = **$3,600,000 annually**

# DHDP / IGTs

**Results of Analysis Below**

Adding the DP-NF would impact three programs identified below. HQAF is going away in CY25 thus you won't realize that $3.7m in that program but the program dollars will likely be added to DHDP, thus you should see a similar return (maybe reduced by 30%).

**Timing**

If you added the days in CY2024 then the first payment would be from DHDP in CY26. HQAF will be eliminated by then so those dollars will flow to you in CY26, likely via DHDP.

**Best Estimate Cash Flow**

Assuming adding DP-NF days on 7/1/24

| Hospital Fiscal Year | Amount | From programs | Notes |
|---|---|---|---|
| FY24/25 | $ - | | |
| FY25/26 | $ - | | |
| FY26/27 | $ 6,595,450 | QIP partial, DHDP, HQAF | QIP will be half year, HQAF will be added to DHDP at 70% level |
| FY27/28 | $ 6,994,622 | QIP, DHDP, HQAF | HQAF will be added to DHDP at 70% level |

***Use the box below to input needed data into the orange cells to see the impact on various Medi-Cal Supplemental Programs***

| Inputs | | |
|---|---|---|
| Medi-Cal MCO SNF days | 35,482 | Utilized the projection numbers |
| Medi-Cal FFS SNF days | 1,425 | Utilized the projection numbers |
| Medi-Cal MCO Revenue | 17,741,000 | Estimated a cost of $500/day |

**Net Gain of Supplemental Funding**

**$ 8,129,513**

# ECRMC Financial Benefit Estimate

- Annual Patient Throughput Savings: $4.95M
- Annual Gainshare: $500K to $1M
- Annual DHDP: $3.6M – $6.9M

Total Annual Impact: $8.7M - $12.9M

# Acute Change of Bed Process Summary

- Determine Space to be Converted

  Target bed count, and comprising which units.

- Determine OSHPD Requirements for Conversion

  May not require any updates, but CDPH will require a case to be opened for the

# Acute Change of Bed Process Summary (cont)

- ## Submit to CDPH and CMS for approval

  Submitted to CDPH via a "modified CHOW" application. CMS requires a narrative "written request".

- ## DHCS Initial Rate Setting

  Waypoint and hospital finance team to submit initial "Pro-Forma of Projected Cost" to DHCS to determine initial rate. Rate will retro back to CHOW date.

- ## Staff Integration

  NF employees are employees of the operating partner.

- ## Oversight and Quality Control

  Major administrative decisions and personnel policies for the NF are submitted by Waypoint to the Acute leadership team for review and approval. Waypoint oversees financial and clinical compliance, and QA systems and presents to Acute leadership regularly and as needed.

# Contact

Chad Coleman
Director of Operations
Bayshire Senior Communities
(858) 888-5969
chad@bayshire.com

Tim Cooley
CEO
Waypoint Management Consulting
(805) 732-3470
tcooley@waypointmc.net