Schwabe

September 23, 2025

Gary Bruce
Admitted in Oregon and Washington
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VIA ELECTRONIC MAIL

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RE: Public-Facing Version of Critical Access Hospital Application

Dear Sarah and Anna:

Attached please find a redacted, public-facing version of the revised application for critical access hospital ("CAH") status submitted by Adventist Health Columbia Gorge on August 28, 2025. Please note that I have opted simply to reference, rather than send in redacted versions, of the transfer agreements forming Attachments A1-A21. Full, unredacted copies of these agreements were previously uploaded to HCMO's secure document portal, where they are available for your inspection.

Please let me know if you have any questions or need anything else from us. In the meantime, we will continue to work on our response to the requests set forth in your letter of September 16, 2025.

Sincerely,

Gary Bruce

Gary Bruce

cc: Kyle King, Adventist Health System/West (kingk2@ah.org)
Wendy Apland, Adventist Health System/West (aplandwh@ah.org)
Micah Smith, Adventist Health System/West (smithm1@ah.org)
Karine Gialella, Oregon Department of Justice (karine.gialella@doj.oregon.gov)
HCMO Staff (hcmo.info@odhsoha.oregon.gov)

OREGON APPLICATION FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL

1. Applicant identifying information

Hospital Name: Mid-Columbia Medical Center d/b/a Adventist Health Columbia Gorge

Legal Name of Organization owning/operating facility: [redacted]

Mailing Address: [redacted]

City: [redacted] Zip: [redacted]

County: [redacted]

Telephone Number: [redacted] Fax: _____

2. Name and title of hospital administrator

Name: Jayme Thompson

Title: Administrator

Email: [redacted] Phone: [redacted]

3. Name and organization of who is conducting the financial feasibility assessment for your hospital

Name: Erik Prosser, Senior Manager and Katie Raebel, Partner

Organization: Wipfli

Email: eprosser@wipfli.com, kraebel@wipfli.com Phone: (509)232-2709, (509)232-2044

4. Premises located at (if different than mailing address)

1700 E. 19th Street, The Dalles, OR 97058

5. Medicare Provider Number: [redacted]

6. **What level (if any) Trauma Center Designation does this facility currently have?**
Trauma level IV

7. **Does this facility intend to maintain its current level of Trauma Center Designation?** √ Yes ☐ No If no, explain:
_____

8. **Number of Acute Care Beds Designated?** The organization will maintain no more than 25 beds prior to survey date in order to meet CAH requirements.

9. **Does your hospital have distinct part (IPPS-excluded) psychiatric beds and/or rehabilitation beds?** __No__ **If yes, how many rehabilitation beds?** _0__ **How many psychiatric beds?** __0___

10. **Swing-beds designated?** √ Yes: Number: 25 ☐ No Not all 25 beds are currently designated swing-beds, but our intent is to designate all 25 beds as swing-beds.

11. **Are you a member of a Rural Health Network (see also #12 below)?**
√ Yes ☐ No

12. **Do you have a signed written agreement for (check applicable boxes; you will also attach agreements in your application as Attachment A)?**

√ Emergency and non-emergency patient referral and transfer;
√ Patient transportation;
√ Development and use of communications systems; and
√ Credentialing and quality assurance with at least one hospital that is a member of the Rural Health Network.

Referral Hospital Name: See Attachments A1 – A21.

Referral Hospital Address: _____

City: _____ ZIP: _____

13. **CAH statutory requirements. A hospital electing CAH status must meet the following federal statutory requirements. Please check all that apply.**

√ Is located more than a 35-mile drive (or, in the case of mountainous terrain or, in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area (If hospital sought mountainous terrain from the state or was designated as a necessary provider before January 1, 2006, add documentation to application as Attachment F).

√ Has determined that conversion to a CAH will be fiscally appropriate, as indicated by a financial feasibility analysis (add to the application as Attachment C).

☐ Has notified the public of the intent to convert to a CAH, and the community substantially agrees with the plan (add notice and community meeting minutes to the application as Attachment B). Agrees to provide up to 25 inpatient beds that can be used interchangeably for acute or swing-level care (if designated for swing beds). **Per email from Sarah Andersen on 3/14/25 date, this is not applicable due to our ALOS being less than 96 hours.**

√ Agrees to maintain staffing levels of at least one physician associate or nurse practitioner as long as there is physician oversight.

√ Agrees to limit the annual average length of inpatient stays to no more than 96 hours.

√ Agrees to remain open at all times when there is at least one acute care patient in the facility.

√ Agrees to make available 24-hour emergency care services, seven days a week, regardless of inpatient census.

√ Has established procedure under which a practitioner (MD, DO, NP or PA) is on call and immediately available by telephone or radio contact, and available on-site within 30 minutes, on a 24-hours a day basis.

By signing the below, I attest that this application is truthful and complete.

Kerry Heinrich

Board Chair, Kerry Heinrich

Kerry L. Heinrich

Board Chair (signature)

Kyle King

President, Kyle King

Kyle King

President (signature)

Jayant Eldurkar, MD

Chief Medical Officer, Jayant Eldurkar M.D.

Jayant Eldurkar

Chief Medical Officer (signature)

August 28, 2025

Date Submitted

For Official Use Only

Date Received: _____

ORH: _____

OHA: _____

Attachments A1-A21

Transfer Agreements

(Full copies of these agreements have been uploaded to HCMO's secure portal.)

Attachment B

Community Notices and Meeting Minutes

AHCG has not yet announced to the public its desire to convert to a critical access hospital ("CAH"). Instead, the hospital has decided to hold off on issuing such announcements until it has received approval for the proposed conversion, or indications that such approval may be forthcoming, from relevant government agencies. In the meantime, the hospital has consulted with its community board about the proposal to convert to CAH status. The board, which is comprised of community members, business owners, physicians, and local public officials, is fully supportive of the change.

It is important to point out that AHCG was informed in an e-mail dated March 14, 2025, from Sarah Andersen, the Director of Field Services for the Oregon Office of Rural Health, that it is not required to notify the public of its proposed change to CAH status because its current average length of stay is less than 96 hours.

In connection with this response, AHCG is attaching a summary of its most-recent community health needs assessment.

MID-COLUMBIA MEDICAL CENTER

2022 Community Health Needs Assessment Executive Summary

Mid-Columbia Medical Center was (MCMC) founded by local residents for local residents. We are proud of our community heritage and as so we are committed to improving the health of our diverse community in the Columbia Gorge region. Our mission is to provide exceptional health services and experiences through person-centered care by executing our values of compassion, integrity, wellness, teamwork, and quality. Additionally, MCMC is a nonprofit, community health care system serving the Columbia River Gorge that offers a 49-bed hospital, 24/7 emergency care, immediate, care center, cancer care, breast center, cardiovascular services, surgery childbirth, physical therapy, internal medicine, behavioral health, and more.

The Community Health Needs Assessment (CHNA) is an opportunity for Mid-Columbia Medical Center to engage the community every three years with the goal of better understanding community strengths and needs. At MCMC, this process informs our partnerships, programs, and investments. Improving the health of our communities is foundational to our Mission and a commitment deeply rooted in our heritage and purpose. Along with other community hospitals, clinics, and partners, MCMC participated in the Gorge CHNA Collaborative to work toward the common goal of creating a regional health assessment.

OVERVIEW OF THE CHNA PARTNERSHIP

Mid-Columbia Medical Center is a not-for-profit organization dedicated to provide exceptional health services and experiences through person-centered care. Striving to offer the values of compassion, integrity, wellness, teamwork, and quality which are part of our Planetree Philosophy. MCMC operates both primary and specialty clinics along with a 49-bed hospital and immediate care center to serve the Columbia Gorge community.

Seven community health organizations worked together to complete a comprehensive assessment of our communities' most pressing needs. Each organization contributed meaningfully by attending planning meetings, translating documents, assisting with outreach, analyzing survey data, and much more. The seven community health organizations included: Klickitat Valley Health, Mid-Columbia Community Action Council, Mid-Columbia Medical Center, Once Community Health, Providence Hood River Memorial Hospital, Skamania County Public Health, and Skyline Health.

Before beginning this year's CHNA this process, these Principles of Collaboration were agreed to:

- Producing accurate and actionable products, as Partners agree on the needs within our region and communities and as we align our abilities to address those needs together.
- Avoid community partner burnout with respect to qualitative data collection through a coordinated approach to listening sessions and key stakeholder interviews.
- Maximize collective resources available for improving health in the region.
- The collaborative approach requires commitments of cash or in-kind resources from all Partners, using it to satisfy a regulatory requirement.

Our Principles of Collaboration outline our shared beliefs:

- A collaborative approach to the Community Health Needs Survey (CHNA) and subsequent Community Health Improvement Plans (CHIP) is better for our region, yielding more accurate and more actionable products, as community providers agree on the needs within our region and communities, and as we align our abilities to address those needs together.

- A collaborative approach to the CHNA and CHIP will maximize collective resources available for improving health in the region.
- The rest of this document illustrates our collaborative effort and our shared recognition of the greatest needs in the Columbia Gorge Region.

The 2022 CHNA was approved by the Gorge CHNA Collaborative on November 11th, 2022 and made publicly available by December 31st, 2022.

GATHERING COMMUNITY HEALTH DATA AND COMMUNITY INPUT

Using quantitative and qualitative data through a mixed-methods approach, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), County Health Rankings & Roadmaps, ESRi Updated Demographics, Oregon Health Authority, Oregon Student Wellness Survey, the COVID-19 Vaccine Tracker, and the U.S. Census. These sources provided insight into public health data regarding health behaviors, morbidity and mortality, rates of vaccination, illness, and death, and hospital-level data. To better understand the unique perspectives, opinions, experiences, and knowledge of community members, we conducted eight listening sessions with 66 community members who are from diverse communities, have low-incomes, and/or are medically underserved. All community input was collected between April and June of 2022. We also conducted 11 stakeholder interviews with 16 representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. In addition, the Gorge CHNA Collaborative conducted an online and paper community health survey in English and Spanish that engaged 1,279 residents. Some key findings include the following:

- The primary strength identified by stakeholders was the collaboration and relationships between local organizations. Examples of this include the Bridges to Health Pathways program, the local Coordinated Care Organization, the Natives Along the Big River collaborative, COVID-19 response services, community-wide trauma-informed practices, and more.
- Stakeholders and listening session participants shared there is a desperate need for affordable housing as the cost of housing continues to increase. Housing stability is connected to health and economic security; the cost of housing is a burden for many families trying to meet their basic needs.
- Only 30% of community health survey respondents stated that they received all the mental health services they needed in the past year.
- 65% of community health survey respondents felt socially isolated or lonely at least some of the time over the last year, with 6% feeling isolated or lonely “all of the time.”

While care was taken to select and gather data that would tell the story of the region's service area, it is important to recognize the limitations and gaps in information that naturally occur. A full accounting of data limitations can be found starting on page [25] of the full CHNA report. For more information related to the CHNA methods and process please see page [15] of the full CHNA report.

IDENTIFYING COLLABORATIVE HEALTH PRIORITIES

Through a collaborative process of data collection, analyzing community input, and cross referencing qualitative and quantitative data, the Gorge CHNA Collaborative identified the following key themes: homelessness and housing instability, behavioral health challenges and access to care, access to health care services, economic and food insecurity, and chronic conditions.

For a rank order list and a description of significant health needs, see page [39]. For a list of potential resources available to address the identified needs, see the end of each Key Theme description in the collaborative CHNA report.

Mid-Columbia Medical Center 2022 PRIORITY NEEDS

The Gorge Collaborative identified various prioritized needs. Considering MCMC's scope of practice, capabilities, community partnerships, and strategic initiatives we are committed to addressing the following priority areas:

Homelessness and Housing Instability: Housing costs have increased and community members are experiencing "housing-burden" trying to keep up with the rising costs.

Access to Health Care Services: Social Determinants of Health such as transportation have impacted people in accessing care, as well as a shortage of providers that offer culturally and linguistically centered care.

Chronic Conditions: Gorge Residents are experiencing unmanaged chronic conditions as a result of having to focus on how they will cover their other basic needs and the limited access there is to primary care providers and specialists.

Mid-Columbia Medical Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs considering resources and community strengths and capacity. The 2023-2025 CHIP will be approved and made publicly available no later than 5/31/2023.

MEASURING OUR SUCCESS: RESULTS FROM THE 2019 CHNA AND 2020-2022 CHIP

This report evaluates the impact of the 2020-2022 CHIP. Mid-Columbia Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. This summary includes just a few highlights of our efforts across the Columbia Gorge region. In addition, written comments were solicited on the 2019 CHNA and 2020-2022 CHIP reports, which were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with our community-based organization partners.

Below is a summary of the outcomes for each priority:

Table 2: Outcomes from 2020-2022 CHIP

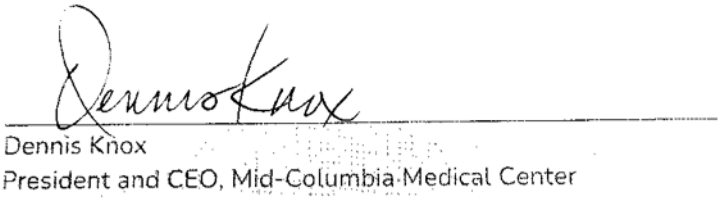
Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Access to Equitable Healthcare Services	Increase signage and program materials in Spanish	Culturally and linguistically appropriate communication materials are made available (flyers, patient letters).	Since 2020, as a best practice all public-facing signage is printed in Spanish and English. 8 Zone Tools were translated into Spanish. Patient letters are translated into Spanish on an on-going basis.
	Access to same-day appointments	Increased same-day appointment capacity at MCMC Immediate Care	MCMC's Immediate Care center opened in April 2020. Current

		center. Baseline data was 375 appointments a month. Intended goal was 550 appointments a month.	appointment capacity is 660 a month.
	Increase accessibility for timely care to clinic based Behavioral Health Services.	Increase capacity for internal mental health referral wait times. Baseline date was 10 days. Intended goal was 2 days.	Due to the COVID-19 pandemic this measure was not met as the pandemic exacerbated mental health conditions. However, MCMC did implement telemedicine appointments for patients who were not comfortable having an in-person appointment due to COVID-19. MCMC hired 1-2 new FTE to offer behavioral health services at our primary care clinics.
	Increase PCP assignment	Increase Medicaid assigned individuals from a baseline of 3,400 to a target of 4,500 by 2022.	MCMC increased Medicaid assigned individuals up to 4,820.
	Food box distribution	Increase access to healthy food options for vulnerable populations such as low-income, un-insured, and migrant and seasonal farmworkers (MSFW).	Between June and July 2021, Community Health Worker's (CHW's) distributed 50 food boxes each week during outreach events.

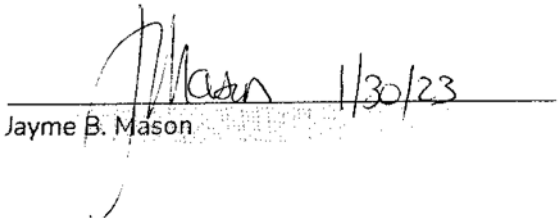
			In June and July of 2022, CHWs distributed a total of 505 food boxes to MSFW. In 2022, 15 patients that screened positive for food insecurity were identified and enrolled in the Gorge Grown Food Network's VeggieRx program.
Social Determinants of Health	Persistent Pain Education Program	Our Persistent Pain Education program is a series of presentations that educate people in a comprehensive, pain-management approach. Each 90-minute talk is led by a different healthcare professional including a physical therapist, clinical psychologist, clinical pharmacist, sleep specialist, dietitian and therapeutic yoga instructor.	There are 7 recorded classes available on the MCMC website. Between 2020 and 2021, 43 individuals benefited from this program.
Patient Empowering Education	PREVENT Program	PREVENT is a free wellness program facilitated by a trained lifestyle coach. Participants learn how to	Between 2020 and 2021, 22 individuals attended and benefited from the PREVENT program.

		make the lifestyle changes necessary to lose weight, prevent disease and increase overall health.	
	Mommy & Baby Wellness Program	This program discusses important topics including, postpartum depression, fitness and yoga for moms, returning to sports activity, strengthening your pelvic floor, infant bonding and massage, scar management, birth control, baby sign language, bladder health and regaining your sex life after baby.	In 2021, eight individuals benefited from this program.

2022 CHNA Governance Approval



Dennis Knox
President and CEO, Mid-Columbia Medical Center



Jayme B. Mason

CHNA/CHIP Contact:

CONTACT: Jasmin Huila

ROLE: Community Outreach Coordinator

EMAIL: jasminh@mcmc.net

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email jasminh@mcmc.net.

Attachment C

Financial Feasibility Analysis

WIPFLI

201 W. North River Drive
Suite 400
Spokane, WA 99201

509.489.4524
fax 509.489.4682
wipfli.com

March 13, 2025

Adventist Health Columbia Gorge
1700 East 19th Street
The Dalles, OR 97058

Management of Adventist Health Columbia Gorge:

Adventist Health Columbia Gorge ("the Hospital") is a Sole Community Hospital located in The Dalles, Oregon (Hospital). The Hospital is considering pursuing the Critical Access Hospital (CAH) designation. Under this designation, the Hospital would benefit from cost-based reimbursement for both inpatient and outpatient services for Medicare beneficiaries. Note, no changes to the Hospital's rural health clinic payment methodologies would change due to CAH certification.

Wipfli has performed a CAH analysis to determine the potential gain from CAH certification. This analysis was based on the last two filed Medicare cost reports for the years ending 2022 and 2023. Please note that these cost reports have not yet been finalized by the Medicare Administrative Contractor. In addition, no changes in operations of the Hospital, including changes in costs, square footage, or patient days were assumed as part of the analysis. Any changes to the above could affect the estimates, attached and described.

Below is summary of the attached analysis:

Inpatient Estimated Reimbursement Effect
For inpatient services, the Hospital currently receives the higher of the Federal Specific Rate or the Hospital Specific Rate. The Hospital also received a low volume payment for 2022 and 2023. For the 2025 federal fiscal year, the low volume payment was not extended (possible legislation could extend the payment with a retroactive adjustment). Therefore, we compared current reimbursement with and without the low volume payment to the calculation of Medicare's share of inpatient costs as a CAH.

- [redacted]
- [redacted]

- [redacted]

Outpatient Estimated Reimbursement Effect

For outpatient services, the Hospital currently receives APC payments with an add-on payment as a Sole Community Hospital. [redacted]

Estimated Coinsurance Increase

As a PPS hospital, Medicare beneficiary coinsurance is based on 20% of the allowed Medicare amount. As a CAH, patient coinsurance is calculated as 20% of the Hospital's customary charge. [redacted]

Other Potential CAH Benefit

As a CAH, the Hospital has the option of billing under the Method II billing election for outpatient services (not including the rural health clinics). [redacted]

Total Estimated CAH Benefit

[redacted]

Should you have any questions regarding the above information and the attached detail, please feel free to contact me at eprosser@wipfli.com or 509.232.2709.

Sincerely,

Wipfli, LLP

Erik Prosser

MID-COLUMBIA MEDICAL CENTER
Projected Impact of Conversion to CAH Status
Based on the As-Filed FYE 2023 & 2022 Medicare Cost Report

		2022 Low Vol	2022 without low volume		2023 Low Vol	2023 without low volume
Part A:						
Cost:	D-1 line 49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	[redacted]	[redacted]		[redacted]	[redacted]
	Times 101%					
	Net of 2% sequestration					
PPS reimbursement:	E Part A line 59.00 Total (sum of amounts on lines 49 through 58)	[redacted]	[redacted]		[redacted]	[redacted]
	E Part A line 70.93 HVBP payment adjustment amount					
	E Part A line 70.94 Hospital readmissions reduction adjustment					
	E Part A 70.96 Low volume adjustment for federal fiscal year					
	E Part A line 70.97 Low volume adjustment for federal fiscal year					
	E Part A line 70.99 HAC adjustment amount					
	Total					
	Net of 2% sequestration					
Cost over(under) PPS		[redacted]	[redacted]		[redacted]	[redacted]
Part B:						
Cost:	E Part B line 2.00 Medical and other services reimbursed under OPPS (see instructions)	[redacted]	[redacted]		[redacted]	[redacted]
	Times 101%					
	Net of 2% sequestration					
PPS reimbursement:	E Part B line 24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)	[redacted]	[redacted]		[redacted]	[redacted]
	Net of 2% sequestration					
Cost over(under) PPS		[redacted]	[redacted]		[redacted]	[redacted]
Estimated ER On-Call Reimbursement (50% Provider time @ 25% MCR Utilization)		[redacted]	[redacted]		[redacted]	[redacted]
Estimated Method II Physicain Addon Payment - Not Estimated		[redacted]	[redacted]		[redacted]	[redacted]
Total cost over(under) PPS		[redacted]	[redacted]		[redacted]	[redacted]

FOOTNOTES

1) Calculations above exclude cost reimbursement for lab fee schedule services and other CAH enhancements.

2*) *Under CAH status, the basis for O/P Part B Coinsurance (payable by patients) would change from 20% of the approved OPPS amount to 20% of allowable charges. The projected impact of this change is shown below.

	Actual O/P Part B Coinsurance assessed under OPPS (per the PS&R)	[redacted]	[redacted]		[redacted]	[redacted]
	Medicare O/P Part B Charges (W/S D, Pt. V, line 200.00, column 2.00)	[redacted]	[redacted]		[redacted]	[redacted]
	Imputed Coinsurance @ 20% of Charges					
Additional Projected Coinsurance Assessed to Patients under CAH Status		[redacted]	[redacted]		[redacted]	[redacted]
	Projected Increase in Total Reimbursement under CAH (from above)					
Percentage of Increased Reimbursement under CAH to be Collected from Patients		[redacted]	[redacted]		[redacted]	[redacted]

3) Low Volume Adjustment payment - subject to annual renewel [redacted]

Attachment D

Description of How Emergency Services Will Be Provided

AHCG does not anticipate that its proposed change to CAH status will materially change the way it provides emergency services. The hospital will continue to provide emergency services on a 24-hour per day basis, with a physician and other qualified and trained medical professionals onsite at all times. The hospital will also ensure that it has readily available at all times such equipment, supplies, medication, blood and blood products as are needed to treat emergency cases in an efficient and effective manner.

To provide additional detail about its plans for meeting the emergency care needs of the community, ACHG is attaching its emergency staffing plan, emergency management program/emergency operations plan, and the relevant portion of its scope of services policy.

Emergency Department Staffing Plan Adventist Health Columbia Gorge

Date of Review: December 2024		**Additional Details**
Patient Population	☑Adult/Geriatric ☑ Pediatric ☑ Neonate ☑ Cardiac Telemetry ☑ Critical Care ☑ Emergency ☑ Medical Surgical ☐ NICU ☐ Step-down ☑Women's & Newborn	The MCMC Emergency Department is a level 3 trauma receiving center. [redacted] **ORS 441.154, 333-510-0110 (2c)**
Patient Factors Based on Typical Unit Population Type	**Average census:** [redacted] **Average transfers out of unit:** [redacted] Staffing model based on [redacted] RN 12-hour nurses and [redacted] CNA 12 hour shift gives [redacted] nursing care hours per patient visit. Patient acuity average ESI level 3, E&M level 3 Patient distribution by Acuity: **Acuity** **Patient / acuity level** ESI 1-life/limb [redacted] ESI 2-emergent ESI 3-urgent ESI 4-less urgent ESI 5-non—urgent **Grand Total** [redacted] ED average length of stay: [redacted] o Admits: [redacted] o Discharges: [redacted]	The Emergency Severity Index is used to triage patients into 5 levels with 1 being the most critical and 5 being least acute. Evaluation and Management codes are levels 1-5 plus critical care. **ORS 441.154, 333-510-0110 (2b)**

Average Daily Census	2021 [redacted] / 2022 [redacted] / 2023 [redacted]	
Unit Hours per Patient Day	ENA guidelines recommend use of ED staffing tool. HPPV calculation makes it difficult to adjust for the daily variations that occur with volume, acuity, and length of stay. ENA's tool uses patient visits and length of stay as a proxy for patient acuity to determine the number of FTE's required per year in an ED.	
Required Competencies/ Credentials for Unit	Emergency Department registered nurses are required to be BLS, PALS, ACLS, TNCC, and Moderate Sedation certified. CNA II: BLS required.	NRP recommended. [redacted]
Unit Matrix (minimum staffing)	**Emergency Department Regular Staffing Matrix.** **On any given shift at least one nurse on duty will have all unit required certifications.** Normal staffing for the Emergency Department: 0700 – 1900 [redacted] 0900 – 2200 1100 – 2400 1900 – 0700 1300 – 0100 Minimum staffing in the department is [redacted] RN and [redacted] CNA II. Staff utilize ESI acuity/intensity tool for staffing. Examples of average ESI patient to nurse ratios are as follows:	**Accommodation for low census:** The 0700, 0900 and 1900 RNs will not be called off prior to the start of their shift and shall be considered essential staff. Once the 0900 RN comes on shift, the team will huddle, assess the acuity of RN to patient ratio in the department and decide, based on accumulated on call hours and patient acuity, whether to put the 11 RN on call or send the 0700 RN home on call at 1300. Approximately 2 hours prior to the end of each shift, the Resource RN and Nursing Supervisor will determine if the nurse-to-patient ratio and acuity is low enough to justify sending an RN or CNA home on HCD. The 1900-0700 RN staff will never drop below two on duty. **Accommodations for Surge:** If at any time, patient volumes exceed or have the immediate potential to exceed the capabilities of the

- Nurse A has an ESI level 3 patient and 1 ESI level 2
- Nurse B has 4 ESI level 4 patients
- Nurse C has 1 ESI level 1 patient

Based off ESI acuity level, RNs should maintain an acuity of [redacted](non-trauma); [redacted]rauma (until stabilized). If acuity is greater consider surge planning.

The RNs may be supported by CNAs based on patient care needs and most often assigned tasks (vitals, transport, specimens etc.) When a CNA is placed in an assignment, the following applies. [redacted] patients at a time during a day or evening shift, short stay is closed at night.

Emergency Department Provisional Staffing Matrix for PROLONGED Low Census*

When the monthly average census drops to a level that does not justify scheduling both mid-shift RNs (10-2200 and 12-0000), for an extended period of time, the ED staffing plan shall flux to the following:

Monday through Friday:

0700 – 1900	[redacted]
1100 – 2300	
1900 – 0700	
1300 – 0100	

Saturday and Sunday (due to limited hospital-wide resources):

0700 – 1900	[redacted]
1000 – 2200	
1200 – 0000	

nursing staff, the Resource RN should consider the following criteria in order to obtain more staff:

- Patient volume grossly exceeds the ability for the Resource RN to triage
- More than [redacted] patients waiting for triage for more than an hour
- Patient volume grossly exceeds the ability of the team to provide safe patient care (multiple 1:1 situations)
- Mass casualty

If it is identified that there is a need for more staff the Nursing Supervisor and Department Director are contacted for additional staffing resources. The Resource RN may go into Triage and manage the waiting room. The Code team may be activated house-wide, External triage/mass casualty may be initiated.

Provision of rest/meal breaks:

Meal and rest breaks will be tracked utilizing the unit's daily assignment sheet. Missed lunches will be documented in the organization's Electronic Timecard system for tracking purposes **441.155(2)(h) and Oregon Administration Rule 333-510-0110(2)(h).** Staff will provide coverage for one another on a rotating basis ensuring that minimum staffing is not violated. If there is concern for violating minimum staffing on the unit, Nursing Leadership and the Nursing Supervisor may be another resource that is available to assist staff getting rest and meal breaks to ensure the unit is always meeting minimum staffing guidelines.
It is every staff member's responsibility to practice safely, should any staff member believe another staff member is too tired, sick, or incapacitated in anyway, the charge nurse, nursing Supervisor &/or nursing

	1900 – 0700 [redacted] 1300 – 0100 There will also be VOLUNTARY on-call shifts for ED staff to elect, in addition to their regularly scheduled hours, Monday-Friday. The RNs may be supported by CNAs based on patient care needs and most often assigned tasks (vitals, transport, specimens etc.) When a CNA is placed in an assignment, the following applies: [redacted] patients at a time during a day or evening shift, short stay is closed at night. 0900 – 1500 [redacted] 1500 – 2100 -OR- 0900 – 2100 **Staffing plan shall revert back to **Regular Staffing Matrix** when it is determined by the department director that the monthly average census justifies scheduling all six RNs. Staff shall be informed of such change by the 10th of the month prior to the month in question when the preliminary schedule is released.*	administration will be notified, and replacement staff will be arranged. **Overtime:** [redacted] **ORS 441.154, 333-510-0110 (2a,b,c,d,e,f,g,h,I,j)**
Environmental Factors	**Unit Size – 8 Patient rooms** **Room occupancy**☑ Single ☐ Multiple The Emergency department has one Triage room and eight private rooms. Two rooms are designated for high acuity patients such as trauma. All rooms can be utilized for most patients. Additional space near the nursing station can be utilized for surge if the patient situation warrants them immediately coming out of the waiting room	

	for care. There is also a bereavement room for crisis counseling and support for families or patients.	
Evaluation Metrics	Safe staffing compliance levels are measured by decreased rates of: o Door to doctor times o Door to triage times o Left without being seen o Patient throughput o Standard of nursing hour per patient visit between [redacted] (measured monthly)	Measurement methods include: o EPIC and BOBJ reports o Administrative review o End of shift overtime o Staff satisfaction survey
Evidence-based Staffing Standards or Guidelines	Ray, C. Jagim, M, Agnew, J, Ingalls McKay, J, Sheehy, S & ENA staffing Best Practices Work Group, (2003) ENA guidelines for determining emergency department nurse staffing. Journal of Emergency Nursing, DOI 10.1067 Emergency Nurses Association (2017) Staffing and Productivity in the Emergency Department, Position Statement. American Academy of Emergency Medicine Emergency Nurse to patient ED staffing ratios.	**ORS 441, 333-510-0110 (2d)**

Adventist Health
Columbia Gorge

☐ Systemwide Standard Policy
☒ Systemwide Model Policy

Model Policy No. 11989
Approval Pathway: Clinical
Department: Emergency Management

MODEL POLICY: EMERGENCY MANAGEMENT PROGRAM/EMERGENCY OPERATIONS PLAN

Adventist Health Columbia Gorge adopts the following systemwide Adventist Health Model Policy.

POLICY SUMMARY/INTENT:

The Adventist Health Emergency Management Program (EMP) utilizes an all-hazards approach to provide guidelines for addressing risks to our normal hospital and healthcare operations in a comprehensive manner. These guidelines are consistent with Adventist Health's vision of transforming the health of our community by improving health, enhancing interactions, and making care more accessible. The EMP encompasses mitigation, preparedness, response, and recovery activities to address identified hazards and maintain a process of continuous improvement.

The Emergency Operations Plan (EOP) is designed to respond to single and multiple emergencies for an extended length of time without reliance on community support. Therefore, the organization has planned for managing the six critical areas of emergency response, so that it can assess needs and prepare associates to respond to potential events regardless of cause. Detailed plans expanding upon the six critical areas of managing an emergency and/or disaster incidents are contained within EOP Annexes, and administrative policies and hazard specific plans are included within EOP Appendices.

The six critical areas include communications, resources and assets, staff management, safety and security, patient management, and utilities.

A. Summary:

The Emergency Operations Plan (EOP):

1. Is in compliance with applicable codes and regulations and designed to provide structure and processes for responding to events that pose or potentially could pose an immediate danger to the health and safety of associates, patients, and visitors.
2. Provides response guidance for situations most likely to disrupt operations to include the physical environment and supports the return to normal operations at market service locations as soon as possible.
3. Is an all hazards plan designed to be used as a general response plan to threats identified in the Hazard Vulnerability Analysis (HVA). The is completed to assess the impact of likely emergencies and used to guide the development of the EOP. The HVA is reviewed at least every two (2) years to determine if the likely emergencies and/or disaster incidents have changed.
4. Addresses the availability of resources and continuation of patient care and ongoing healthcare services to the community during an emergency and/or disaster incident.
5. Accounts for when the hospital cannot be supported by the local community and addresses communication, resources, utility and infrastructure management, safety/security, staffing, and patient care needs during emergency and/or disaster incident for a minimum of 96 hours in addition to addressing overarching continuity of operations.
6. Is developed with participation by Hospital/Healthcare leaders, including medical staff.
7. Defines the process for initiation and implementation of the plan, and includes responses that can be adapted based on the emergency to include actions such as; expanding services, conserving resources, completing full or partial evacuations, etc. The description includes the command structure for the plan, the conditions requiring activation of the plan, and the individual(s) responsible for implementation of the plan.
8. Includes a current description and organization chart illustrating how the Incident Command Team staff will be organized and will work interactively with the system and community Emergency Operations Centers (EOC's).
9. Identifies alternative sites for care, treatment, and services that meet the needs of the patients during emergencies.
10. Response procedures related to care, treatment, and services for patients.
11. A description of the methods of identification for caregivers, other facility personnel, and community responders. Community responders may include but are not limited to law enforcement, fire service personnel, media, volunteer organizations, and contractors.
12. Processes that address support of associates and their family members.
13. Processes for identifying critical supplies, monitoring consumption, and a process for re-supplying.
14. Backup systems for internal and external communications systems.
15. Current contact lists of associates, governmental organizations (local, state, federal), and commercial organizations.
16. Adventist Health Columbia Gorge (AHCG) updates the EOP and associated plans/policies to achieve preparedness and response to and recovery from emergencies and/or disaster incident. When plans and procedures are revised, they are exercised and reviewed to measure functional capability and effectiveness. This process is also in compliance with the NIMS Objective 7.

DEFINITIONS:

1. **All Hazards:** Homeland Security Presidential Directive defines “all hazards” as preparedness for domestic terrorist attacks, major disasters, and other emergencies.
2. **Emergency:** A dangerous event that can normally be managed by the hospital or outpatient center. An emergency can be: internal or external; natural or human caused disasters, events or catastrophes that significantly disrupts care and treatment; results in sudden or increased demands for the facility.
3. **External Disaster:** An External Disaster involves an incident beyond the immediate boundaries of the market or its service locations. Such an incident can result in a sudden arrival of a large number of casualties, including contaminated or contagious victims, which involve the Emergency Department. External Emergencies may include but not be limited to earthquakes, utility outages, and refinery fires/explosions that may not impact the market directly but could require a status alert.
4. **Hospital Incident Command System (HICS):** an incident management system based on principles of the Incident Command System (ICS), which assists hospitals and healthcare organizations in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events.
5. **Hazard Vulnerability Analysis (HVA):** a process for identifying the hospital’s highest vulnerabilities to natural and human caused hazards and the direct and indirect effect these hazards may have on the hospital and community. An HVA provides the hospital with a basis for determining the most likely potential demands on emergency services and other resources that could occur during a crisis so that effective preventive measures can be taken, and a coordinated disaster response plan can be developed.
6. **Internal Disaster:** An Internal Disaster involves an incident within any of the service locations of a market that disrupts normal operations. Incidents may include but are not limited to bomb threats, utility failures, hostage situations, and infant/pediatric abductions.
7. **Market:** A market refers to a hospital and all its associated clinics and networks.
8. **Mass Casualty Incident:** A Mass Causality Incident involves a large influx of victims from an internal or external event requiring treatment, such as those that may result from a fire, explosion, train wreck, or bio-terrorism event. The victims may arrive at the Emergency Department or other alternative location as designated local authorities via ambulance or other emergency service vehicle or walk in. Any series of events that can create an overload in the Emergency Department may require the use of emergency procedures as described in the Disaster Surge Plan. The mass casualty incident may be combined with other response plans used to protect the facility.
9. **MIR3:** Is an intelligent notification platform selected and utilized by Adventist Health to send, receive, respond to and track emergency and operational mass communications.
10. **National Incident Management System (NIMS):** Is an incident management system that guides all levels of government, nongovernmental organizations and the private sector to work together to prevent, protect against, mitigate, respond to and recover from incidents. The five components of this guideline are: Preparedness, Communications and Information Management, Resource Management, Command and Management, and Ongoing Management and Maintenance.

ACRONYMS:

1. **AAR:** After Action Report
2. **CAP:** Corrective Action Plan
3. **CMS:** Centers for Medicare and Medicaid Services
4. **DHV:** Disaster Healthcare Volunteers (California)
5. **DMAT:** Disaster Medical Assistant Team
6. **DRC:** Disaster Resource Center
7. **EMA:** Emergency Management Agency (Hawaii)
8. **EMP:** Emergency Management Plan
9. **EMS:** Emergency Management System
10. **EOC:** Environment of Care
11. **EOP:** Emergency Operations Plan
12. **EVS:** Environmental Services
13. **FRC:** Family Reunification Center
14. **HCC:** Hospital Command Center
15. **HIPAA:** Health Insurance Portability and Accountability Act
16. **HVA:** Hazard Vulnerability Analysis
17. **JIC:** Joint Information Center
18. **MAC:** Medical Alert Center
19. **MO:** Medical Officer
20. **MRC:** Medical Reserve Corps
21. **NEO:** New Employee Orientation
22. **NIMS:** National Incident Management System
23. **NRF:** National Response Framework

24. **ODEM**: Oregon Department of Emergency Management
25. **OE:** Operations Executive
26. **OEM:** Office of Emergency Management
27. **OHA:** Oregon Health Authority
28. **PBX:** Private Branch Exchange/Operator
29. **PCE:** Patient Care Executive
30. **PIO:** Public Information Officer
31. **PPE:** Personal Protective Equipment
32. **SEMS:** Standardized Emergency Management System
33. **SO:** Safety Officer

AFFECTED DEPARTMENTS/SERVICES:

A. Systemwide: All departments and services, both clinical and non-clincal.

POLICY: COMPLIANCE – KEY ELEMENTS

A. Scope:

1. Comprehensive Emergency Management Program

    a. The comprehensive EMP all hazards approach utilizes a framework which includes leadership structure and program accountability, HVA analysis to guide program development, mitigation and preparedness activities in addition to the development of the EOP and associated policies and procedures. The EMP framework encompasses a comprehensive education, training, exercise, and testing program as well as a program evaluation to support continuous improvement toward continuity and disaster recovery objectives. Community Boards, Medical Staff, and Executive Leaders have established and support the EMP developed by the Integrated Emergency Management Committee (IEMC) and adopted by each Adventist Health market.

2. Integrated Emergency Management Program

    a. As a part of the Adventist Health system EMP, AHCG actively participates in the development of the unified and integrated EMP which is developed and maintained in a manner that considers AHCGs unique circumstances, patient population and services offered. AHCG is capable of actively using the unified and integrated emergency management program and maintains compliance with the program. AHCG conducts, maintains, and documents an all-hazards community-based risk assessment and all-hazards facility-based risk assessment to address the unique hazards present within their respective market area. The EMP establishes unified and integrated plans, policies, and procedures to include a coordinated communication plan as well as a training and testing program. The market specific EOP addresses market-specific plans and policies supporting the EMP and compliance with emergency preparedness regulatory requirements is the responsibility of each separately licensed and certified market.

3. System Integrated Emergency Management Program

    a. System Integrated Emergency Management Council (SIEMC)

        i. Program oversight is governed by the SIEMC, which consists of Adventist Health System/West leadership representation. The SIEMC provides overarching direction to the Adventist Health System/West emergency management program. The core strategic functions of the SEIMC are as follows:

            I. Governs Adventist Health System/West Integrated Emergency Management Program oversight

            II. Recommends activities and provides strategic direction to the IEMC

            III. Reviews and approves training, exercise, and incident evaluation

            IV. Prioritizes Program incident response based on the vulnerability to identified risks

            V. Prioritizes Program incident recovery based on after-action reporting and operational impact

            VI. Facilitates engagement with Adventist Health System/West teams as required

            VII. Oversees an integrated communication plan

            VIII. Participates in the annual review of the System Integrated Emergency Management Program

    b. Integrated Emergency Management Committee (IEMC)

        i. The IEMC is a sub-committee of the SIEMC. Committee members demonstrate participation in the IEMC by adopting system-wide policies and procedures that guide the emergency management program across the system. The IEMC exists as an entity for emergency management collaboration as directed by the SIEMC and consists of emergency management representation from each Adventist Health System/West market and ad hoc members who provide subject matter expertise. The IEMC supports the organization and assists in program development at the market and system level, engaging in design, implementation, and evaluation of existing and new emergency management and business continuity processes. The core strategic functions of the IEMC are as follows:

            I. Supports emergency management TJC and CMS regulatory requirements for each market in collaboration with the system in emergency management program development

II. Provides assessments and reports to the SIEMC

III. Ensures market-specific needs and unique circumstances are included in the Program

IV. Completes and evaluates the HVA for each market and integrates into system planning processes to include developing, maintaining, and revising policies and procedures

V. Engages in all-hazards mitigation, preparedness, response, and recovery strategies

VI. Recommends planning, training, and testing strategies engaging markets and the system

VII. Assists with managing an integrated communication plan

VIII. Participates in the annual review of the System Integrated Emergency Management Program

4. Transplant Program

a. Adventist Health does not offer transplant services.

B. Leadership Oversight

1. Senior Leadership

a. AHCG senior leadership, to include Community Boards, Medical Staff and Executive Leaders, provide oversight and support for the emergency management program and activities. Oversight and support includes the allocation of resources, program documentation, emergency operations plan, policies, training, education, after-action reports (AAR) and improvement plans that support the emergency management program and activities.

2. Emergency Manager

a. AHCG senior leaders identify and designate a qualified Emergency Manager to lead the emergency management program. Qualifications are based upon education, training, and experience in emergency management. The desired background for an Emergency Manager includes formal and informal training, education, and/or experience in emergency management, incident command, and hospital/healthcare operations and familiarity with local, regional, and state healthcare-systems. The training required for the Emergency Manager are ICS100, 200, 700 and 800 courses (NIMS Objective 5).

b. A designated Emergency Manager addresses the increasing complexity and importance of emergency management for hospitals and healthcare systems. This person provides overall support to AHCG's preparedness efforts, including the development and maintenance of the EOP, policies, and procedures. The Emergency Manager is responsible for the implementation of the four phases of emergency management (mitigation, preparedness, response and recovery) and implementation of emergency management activities across the six critical areas of communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities. Responsibilities also include the coordination of emergency management exercises, after action reports and improvement plan development and management. The Emergency Manager is the designated individual whose sole responsibility during emergency management exercises is to monitor performance and document opportunities for improvement. The person will be knowledgeable in the goals and expectations of the exercise. In response to an actual emergency, it is understood it may not be possible to have an individual whose sole responsibility is to monitor the performance. Their responsibilities also include collaboration across clinical and operations areas and community response partners to implement organization wide emergency management. The Emergency Manager is an integral part of the IMT during response to emergencies and/or disaster incidents from the onset of the event through recovery and is commonly assigned Liaison Officer and or Planning Chief role(s). The Emergency Manager typically represents AHCG at various emergency management related meetings at the local, regional, and state levels.

3. Emergency Management Committee

a. AHCGs Emergency Management Committee is a sub-committee of the multidisciplinary Environment of Care (EOC) Committee. The Emergency Management Committee is a multidisciplinary committee that oversees the emergency management program. Members include, but are not limited to, the Emergency Manager, Medical Staff, Administration, Nursing, Facilities & Engineering, Risk Management, Accreditation and Auxiliary Services (e.g., Dietary, EVS, Supply, Pharmacy, Infection Prevention, IT, Security, Human Performance and Finance).

b. Members of the Emergency Management Committee are required to complete the following training: ICS 100, 200, 700 and a Hospital Incident Command System (HICS) course in accordance with the NIMS Objective 5.

c. The Emergency Management Committee will include community partners such as law enforcement, fire, emergency medical services, emergency management and public health on an as needed basis. The Emergency Management Committee provides input and assists in the coordination of AHCGs emergency management program preparation, development, implementation evaluation and maintenance. The activities include, but are not limited to, development of the HVA, EOP, policies/ procedures, Continuity of Operations Plan, training and education, as well as planning and coordinating incident response exercises, AAR's, and improvement plans.

d. The Emergency Management Committee meets regularly, with the frequency defined by the committee. The Emergency Manager, as the Chairperson, will set each meeting's agenda, with consideration given to the established continuous improvement plan, and facilitate the council/committee work to achieve the established objectives and goals defined by the committee. Minutes of each meeting will be published and disseminated to other council/committees as necessary. The Emergency Manager must regularly inform the hospital's President, Operations Executive (OE), Patient Care Executive (PCE), and Medical Officer (MO) of committee activities, obstacles encountered, assistance needed and obtain leadership direction.

C. Hazard Vulnerability Analysis

1. Facility Based HVA

a. AHCG completes an individual facility-based hazard vulnerability analysis (HVA) using an all-hazards approach to assess the probability of a hazard to occur and the degree of impact to AHCG and the community that could affect demand for the AHCG's services or its ability to provide those services. The HVA evaluates the frequency of hazard, the necessity of AHCG to respond, the degree of impact across human, business and property elements as well as the existing capabilities of AHCG to mitigate, prepare, respond to and recover from all-hazards to establish a prioritized list of hazards. The HVA process is a collaborative effort relying on the participation of senior leadership, medical staff, and department and program leaders. The HVA is reviewed at least every two years, or as changes are required, to determine if the current prioritization of the hazards is accurate based on the emergency management activities taken and any changes to identified hazards.

b. The HVA process incorporates an all-hazards community-based risk assessment into the HVA assessment process. Community and government partners are engaged to ensure that the HVA process considers a community-wide view of risks, threats, and hazards. Additional sources used to

develop the HVA include but are not limited to, the City/County Hazard Mitigation Plan, the HVA from the previous year, security and other hazard risk assessments from the previous year, and historical data. AHCG will prioritize potential emergencies/disasters identified from the HVA.

c. A separate HVA is conducted at facilities that significantly differ from the main site, such geographical location, hazard and/or patient population and services offered, rendering the facility unique, thus benefiting from an individual facility-based HVA.

d. The completed HVA will be submitted to and reviewed by the Emergency Management Committee, EOC Committee and forwarded for executive leadership and physician review within AHCGs reporting process. Additionally, AHCG has established a relationship with Community Partners such as the Healthcare Coalition, City and or County Emergency Medical Services Agencies, Department of Public Health, Fire Department, and local Police Department. The Emergency Manager is the facility's representative to the local Emergency Management Agencies, and may share the EOP and HVA with community partners to establish, priorities based on potential emergencies, the capabilities to support one another, identify potential areas of collaboration to mitigate threats, inform partners of potential facility needs that may arise due to an emergency and/or disaster incident, and identify the capabilities of the community in meeting the needs of the hospital/organization.

2. All-Hazards HVA

a. The HVA uses an all hazards approach to include natural hazards (e.g., flooding and wildfires), human-caused hazards (e.g., bomb threats and cyber/information technology crimes), technological hazards (e.g., utility and information technology outages), hazardous materials (e.g., radiological, nuclear and chemical) and emerging infectious diseases (e.g., Ebola, Zika Virus, and SARS-CoV-2).

3. Prioritized Hazards

a. As a result of the most recent HVA, AHCG has identified the following hazards for planning purposes:

b. (1)Workplace Violence,(2) Inclement Weather,(3) Air Quality Issues (4) Patient elopement, (5) MCI- Trauma (6) Trauma, (7) IT outage

c. The current HVA is located as an attachment within Annex 7 – Continuity of Operations Plan (COOP). The planning activities worksheet with specific mitigation, preparedness, response, and recovery procedures for each prioritized hazard are also located within Annex 7 as an attachment.

4. Mitigation and Preparedness Activities

a. The HVA will be used to establish emergency management program priorities, strategies, and tactics to be used to mitigate the severity and impact of the hazards on services provided, especially services and functions identified as essential. In addition, plans, policies, and procedures will be reviewed and updated as needed based on the threats identified in the HVA.

b. **Mitigation** strategies and activities are utilized to reduce the impact of a hazard (e.g., the installation of a flood barrier in an identified flood zone)

c. **Preparedness** activities are a continuous cycle of planning, organizing, training, equipping, exercising, evaluating and taking corrective action in an effort to ensure effective coordination during incident response.

d. **Response** strategies are measures the market undertakes to respond to disruptive events.

e. **Recovery** strategies are activities the market undertakes to return the facility to normal business operations. The recovery phase may be initiated during the Incident Action Planning (IAP) session or when the Incident Commander has determined that the existing emergency situation is stable enough to begin recovery activities. Short-term actions assess damage and return essential and lifesaving support operations to minimum operating standards. Long-term focus should be on returning to normal or an improved state of normal operations.

D. EOP Development

The EOP is developed using an all-hazards approach addressing prioritized hazards identified by the HVA process.

1. Supporting Policies and Procedures

a. AHCG has a comprehensive, all-hazards written EOP with supporting policies and procedures (if needed). That provides guidance to staff, volunteers, physician and other licensed practitioners, their roles and actions taken during emergency and/or disaster incidents. The EOP and its associated policies and procedures may include, but are not limited to, activating the EOP; mobilizing the Hospital Incident Command System; utilizing its communications plan; maintaining, expanding, and curtailing or closing operations; protecting critical systems and infrastructure; conserving and/or supplementing resources; activating surge plans (e.g., flu or pandemic plans); identifying alternate treatment area(s) or location(s); plans for sheltering in place or evacuating (partial or complete), relocating services; safety and security plans, and securing information and records.

2. Population(s) Served

a. AHCG serves (a) patient population(s) that include Wasco County: Approximately population: 27000 with 19.7% being 65 and older, and 5.5% of the population being under the age of 5. Sherman County: approximately 1800 people with 31.2% over the age of 65 and 6.7% under the age of 5. Gilliam County: Approximately 1900 people with 27.5% being 65 and older and 5.1% under the age of 5. and may include at-risk populations. The at-risk populations served by AHCG include, but are not limited to, elderly, dialysis patients, disenfranchised, limited English speaking populations and persons with physical or mental disabilities that may have additional needs to be addressed during an emergency and/or disaster incident, such as medical care, communication, transportation, supervision and maintaining independence. At-risk individuals are people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the terms "access and functional needs" are defined as follows:

i. **Access-based needs:** All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on.

ii. **Function-based needs:** Function-based needs refer to restrictions or limitations an individual may have that require assistance before, during, and/or after a disaster or public health emergency.

b. The 2013 Pandemic and All-Hazards Preparedness Reauthorization Act defines at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance. Examples of these populations **may include but are not limited to** individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing homelessness, individuals who have chronic medical disorders, and individuals who have pharmacological dependency. (Refer to Annex 3- Patient Care and Clinical Support)

3. Shelter & Evacuation

a. Hazards may arise that result in a need to shelter-in-place or evacuate to protect the safety of patients, visitors and personnel. AHCG has written procedures that address when and how it will shelter-in-place or evacuate (partial or complete). Shelter-in-place plans may vary by department, facility and situation. Safe evacuation (partial or complete) will consider the care, treatment and service needs of evacuees, staff responsibilities, communication (e.g., patient and staff tracking) and logistic needs (e.g., transportation). (Refer to Evacuation Policy listed in Annex 7- COOP)

4. Essential Needs Provisions

a. Emergency Operations Plan includes written procedures that address support of associates and provisions for their essential needs during emergencies, which include but not limited to shelter-in place and evacuation. (Refer to Annex 5- Resources and Assets)

i. Identification of Essential Needs

I. The intent of AHCG is to provide essential needs during an emergency. Essential needs include but are not limited to the following:

A. Food and other nutritional supplies

B. Medications and related supplies

C. Medical/surgical supplies

D. Medical oxygen and supplies

E. Potable or bottled water

5. Incident Command Structure

a. The Emergency Operations Plan follows the National Incident Management System (NIMS), the Standardized Emergency Management System (SEMS), and state resources that are respective of the markets locale; California Emergency Medical Services Authority Manual on the Hospital Incident Command System (HICS), Oregon Office of Emergency Management (OEM) Guideline on NIMS Implementation for Healthcare Organizations, and Hawaii Emergency Management Agency (EMA) guidelines. These considerations promote consistency with and integration into the local community's command structure, conforming to the National Response Framework (NRF). (NIMS Objective 1, 3, 4, 8)

b. The EOP includes a current description and organization chart illustrating how the Hospital Incident Management Team (HIMT) is organized and how the team engages interactively with the system and with community Emergency Operations Center's.

c. National Incident Management System (NIMS)

i. Adventist Health has adopted and is compliant with the National Incident Management System (NIMS) and the associated healthcare objectives.

ii. Hospital Incident Command System (HICS) and National Incident Management System (NIMS) training requirements for select associates include: ICS 100, 200, 700 courses.

iii. Plans, policies, and procedures have been reviewed, updated, and evaluated to ensure NIMS principles and language compliance. Training records and resource and assets inventories are maintained per NIMS standards. (NIMS Objective 3, 5, 7, 10).

d. Hospital Incident Command System (HICS)

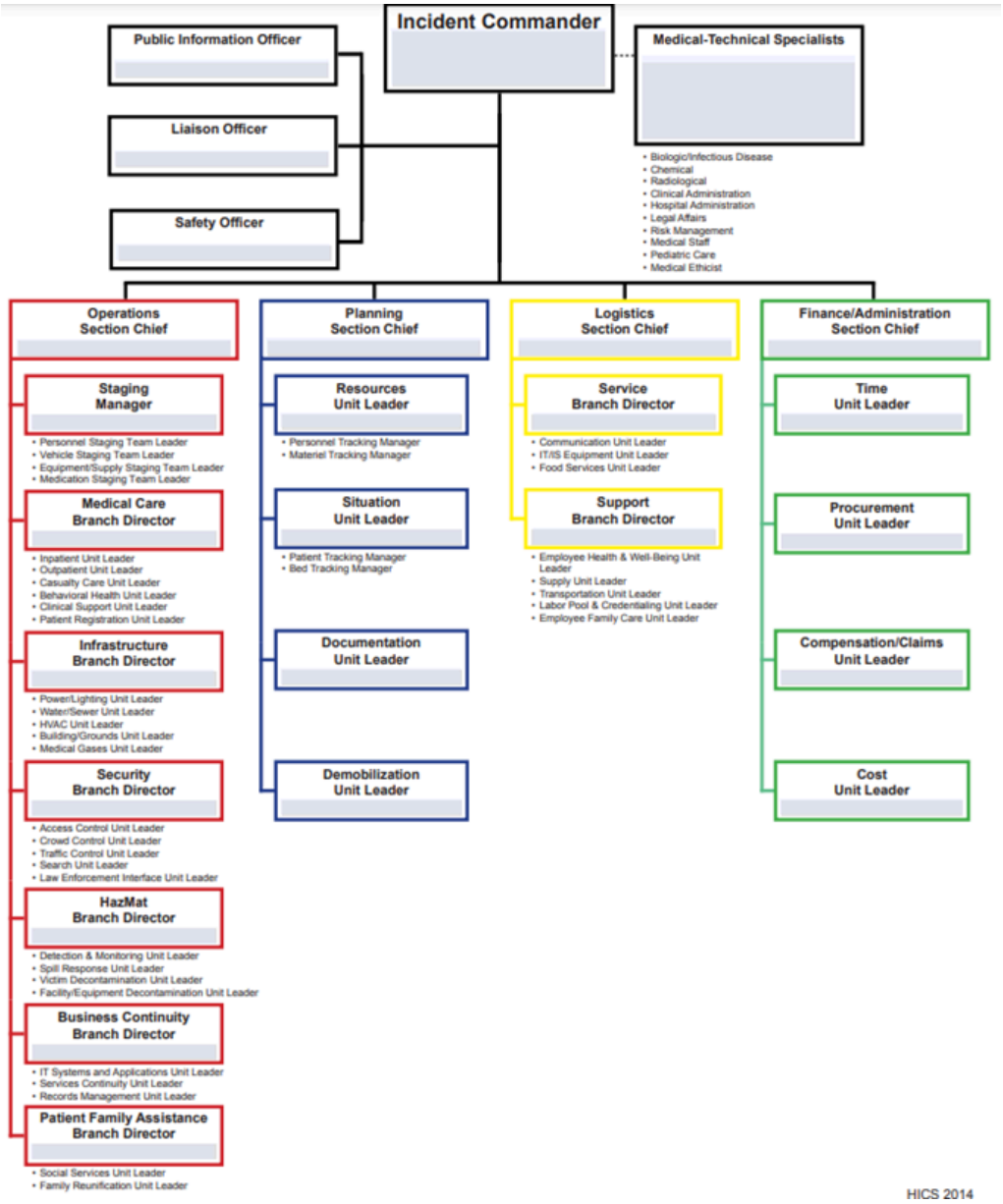
i. Adventist Health hospitals, clinics, outpatient services, and corporate offices, have adopted the Hospital Incident Command System (HICS) as a response model to guide organizational responsibility, in the event of an emergency and/or disaster incident, as part of the organization's EOP. HICS is an incident management system based on the Incident Command System (ICS). It assists hospitals/healthcare systems in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events. HICS has been structured to be consistent with ICS and NIMS principles and will provide flexibility/adaptability for the hospital setting. The HICS model meets Adventist Health's responsibilities for requirements of The Joint Commission (TJC), Center for Medicare Medicaid Services (CMS), and Homeland Security Presidential Directive #5 (HSPD-5). (Refer to Policy: Hospital Incident Command System appended to this document).

ii. HICS is an emergency management incident management system comprised of key positions reflected on an organizational chart. HICS is designed to be flexible and scalable to meet the incident needs and objectives. Only those positions, or functions, which are needed, should be activated. The only position that is required during any activation is the Incident Commander, It allows for the addition of needed positions, as well as, the deactivating of unnecessary positions at any time. HICS may be fully activated for a large, extended emergency, or only partially activated for smaller or more localized incidents. During a disaster or emergency all personnel will use plain English and HICS terminology when communicating with each other and the HICS command system. (NIMS Objective 9)

iii. HICS allows for the efficient transfer of command by recognizing that personnel initially assuming a command position may be relieved by someone with more experience as additional personnel arrive and share the incident command workload, or at shift change. The transfer of command begins with a transition meeting in which, the outgoing commander briefs the replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital.

iv. Each HICS position has a specific list of job responsibilities and actions listed in Job Action Sheets (JAS). HICS also provides forms that support response documentation including, resource tracking, safety information, cost collection and other critical activities within the HCC.

v. An organizational chart depicting the command structure of this organization's HICS model is noted below:



e. Hospital Incident Management Team (HIMT)

i. The Hospital Incident Management Team (HIMT) is a group of leaders trained in emergency management, depicted in the HICS organizational chart and represents the command functions. The HICS organization chart represents how authority and responsibility are distributed within the HIMT.

ii. The Incident Commander (IC) shall appoint individuals to the other leadership positions within the HICS command structure based on availability and expertise. These individuals shall remain in these positions until such time that they are relieved / replaced by the IC. Positions are assigned only as indicated by an assessment of the scope and magnitude of the particular situation and the availability of trained personnel to assume a role.

iii. The senior-most administrative leader on-call, the House Supervisor or individual with most expertise and most qualified to respond to the emergency at the time, who has completed the required NIMS training, at the time of the emergency shall assume the role of Incident Commander until such time as the responsibility is assumed or assigned to another qualified individual.

iv. The HCC will be established by the Incident Commander. The following is an example of the order of succession the role of Incident Commander typically follows:

I. House Supervisor

II. Administrator on Call (AOC)

III. Patient Care Executive (PCE)

IV. Operations Executive (OE)

V. Hospital President

Command Staff		
HICS Role	**General Responsibilities**	**Potential Candidates**
Incident Commander	Responsible for managing the entire incident, and is specifically responsible for ensuring incident safety, providing information to internal and external stakeholders and establishing and maintaining liaison with other organizations participating in the incident. Ensure the System Command Center is notified of the event and that status updates are provided for each operation period	– Hospital Administrator – Administrator On Call – Nursing Supervisor – Operations Executive – Medical Officer – Patient Care Executive – Executive Officer – Emergency Manager
Public Information Officer	Acts as the communicator to internal people and to external stakeholders such as the news media.	– Hospital Public Information Officer (PIO) – Marketing Director – Patient Relations – Hospital Administrator – Administrator On Call – Safety Director – Facilities Director/Manager
Liaison Officer	Individual who makes contact with community responders to convey information about the market status, critical issues and resource needs and requests. They also gather information from the community responders.	– Executive Officer – Emergency Manager – Risk Management – Information Officer – Community Relations
Safety Officer	Monitors incident operations and advises the Incident Commander on all matters relating to operational safety	– Safety Director – Security Director – Facilities Director/Manager – Emergency Manager – Radiation Safety Officer – Employee Health – Infection Preventionist – Risk Management – Industrial Hygienist
Medical/Technical Officer	Technical experts that can be activated to provide anyone in the Command with specific information about the response or the hazard the market is facing.	– Industrial Hygienist – Infectious Disease Specialist – Infection Preventionist – Epidemiology – Medical Officer/Medical Staff – Pediatrics Leadership – Radiation Safety Officer – Nuclear Medicine – Health Physicist – Structural Engineer – Outpatient Services Administrator – Trauma Leadership – Primary Care Director – Behavioral Health Director – Legal Counsel – Risk Manager – Poison Control Director – Information Technology/ Information Services (IT/IS) Director

General Staff		
HICS Role	**General Responsibilities**	**Potential Candidates**
Operations Section Chief	Directs and coordinates all incident tactical operations	– Operations Executive – Medical Officer – Patient Care Executive – Nursing Supervisor – Emergency Manager
Planning Section Chief	Collects, evaluates and disseminate incident information to the Hospital Command Center (HCC) team including the Incident Action Plan (IAP) and archives all documentation.	– Strategic Planning – VP of Administration – Human Resources Director – Nursing Director – Patient Care Executive – Nursing Supervisor – VP of Facilities – Emergency Manager
Logistics Section Chief	Supports the other sections by providing resources, whether that be personnel, supplies, equipment, pharmaceuticals, etc. from internal or external sources.	– Procurement Officer – Support Services Director – Supply Director – Operations Executive – Facilities Director – Warehouse Director
Finance / Administration Chief	Accounts for and analyzes costs, activating or developing contracts or vendor agreements to procure needed resources for the incident response.	– Finance Officer – VP of Business Services – VP of Administration – Controller/Comptroller – Information Officer

f. Adventist Health System Command

i. The purpose of System Emergency Resource Center (SERC) activation is to outline appropriate measures and actions regarding management of all hazard incidents that impact one or more markets in the Adventist Health System. The SERC functions as the System Command Center and supports the overarching system strategy and System Command Center priorities. The focus is on strategic assistance, direction, and resolving competition for scarce and/or critical response resources; to ensure the continued operations of the healthcare system and individual markets under emergency conditions. The System Command Center staffing follows the HICS model which is flexible and scalable to meet the needs of the incident with the available resources.

ii. When a significant incident occurs, Emergency Management leadership and Adventist Health executive leadership are notified. Adventist Health executive leadership is responsible for determining the level of System response required based on the nature and emergency or disaster type. Markets should be notified of SERC activation as quickly as possible. During activations of the SERC, the on-scene incident command, market level tactical operations, and local response/coordination remain the responsibility of the market HIMT functioning within the Hospital Incident Command System (HICS) structure.

iii. A System Incident Commander will be designated and given appropriate Delegation Authority. This designation helps to eliminate confusion and provides the System Incident Commander with authority to oversee the management of incidents.

iv. The SERC team should consist of the best-qualified associates with respect to their functional roles. The functions of the SERC require associates that have experience in, and are qualified to oversee, complex incident situations. The concepts of System Command should be part of planning, training, and exercises. The System Command Center should be kept as small as functional. The size of the System Command Center and position assignments will be determined by requirements of the incident(s) and follows standard HICS principles like flexibility and scalability.

g. Community Partnerships & Collaboration

i. AHCG has established a collaborative relationship with community partners which include, but are not limited to, the Healthcare Coalition, Mid-Columbia Fire and Rescue, Wasco, Sherman and Gilliam County Emergency Medical Services Agency, Department of Public Health, Fire Department, Law Enforcement Agencies and other local, tribal, regional, state and federal preparedness officials. The collaborative partnership is intended to develop a supportive relationship, promote information sharing, mutual aid and provide an integrated response during an emergency or disaster incident. The community partnership extends to training and exercise collaboration as appropriate to maintain the unified command capabilities as appropriate.

h. Activation Authority

i. The senior-most administrative leader on-call, the House Supervisor or individual with most expertise and most qualified to respond to the emergency at the time, who has completed the required NIMS training, at the time of the emergency shall assume the role of Incident Commander and has the authority to activate the EOP, establish the HCC and activate the HIMT.

I. Activation Levels

Type 5 Emergency	Market event no disaster threat. Conditions or actions that caused the incident do not persist. Notification by EMS and/or other sources of a minor incident with casualties. Small incident only involving a few departments. Examples: local weather event, short term electrical/IT outage, and incidents with risk to BRAND or finances. – Facility decision to activate IC – General Staff positions may not be filled – Formal activation of the HCC discretionary – Market notification of incident required – SERC activation not required – Local and internal resources not required – MHOAC activation not required

Type 4 Emergency	Multi-area incident or single market incident with possible resource needs. Incident may extend multiple hours to days. Examples: wildfire, local flooding, earthquake, MCI, HazMat, or protest with impact to operations, and incidents with risk to BRAND or finances. – IC may be activated and the decision to fill General Staff positions at the decision of the IC – Formal activation of the HCC discretionary – Market notification of incident required – Consider SERC activation – Local and internal resources may be required – MHOAC activation as needed
Type 3 Disaster	Multi-area incident with impact across many areas/markets. Patients may cause surge to Emergency Departments and/or the affected area. Local resources may be insufficient. Incident may extend multiple days to weeks. Examples: wildfire requiring patient movement, explosion, active shooter, significant supply shortages, cyber-attack, and incidents with risks to BRAND or finances. – Activation of HCC IC and General Staff Positions – Planning and IAP required – Multiple operational periods – Market notification of incident required – Consider SERC activation – Local and internal resource requests, financial, legal, and PIO support may be required – MHOAC activation as needed – May require community healthcare partner notification/collaboration
Type 2 Disaster	Multi-area incident with widespread system impact. Large numbers of patients are received, and/or significant issues have occurred with need for extensive support. Local resources insufficient. Multiple jurisdictions involved. Incident may be prolonged. Examples: pandemic, wildfire requiring evacuation, tsunami/large scale flooding, prolonged utilities infrastructure disruption, and incidents with risks to BRAND or finances. – Activation of HCC IC and General Staff Positions – Planning and IAP required – Multiple operational periods – Possible Unified Command or engagement with Area Command activities – Mutual Aid across the system – Market notification of incident required – SERC activation – Local and internal resource requests, financial, legal, and PIO support may be required – MHOAC and county resources as needed – May require community healthcare partner notification/collaboration

Type 1 Disaster	Multi-area complex incident with widespread system impact. Internal and external Market and System resources insufficient. Surge of patients that may overwhelm operation capabilities, and/or significant issues have occurred that need extensive support but mutual aid is not readily available. Cascading incident effects highly probable lasting weeks to months. Disruption in operations. Engagement with State and Federal assets. Multiple jurisdictions involved. Examples: Cat 3,4,5 hurricane or catastrophic earthquake. – Prolonged activation of HCC IC and General Staff Positions – Prolonged operational periods – Unified Command or engagement with Area Command activities requiring EOC activation, Multi Agency Coordination (MAC) with local, State, and Federal agencies – Market notification of incident impact required – SERC activation – Local and internal resource requests, financial, legal, and PIO support required – Activation of MHOAC and county resources – Community healthcare partner notification/collaboration – Requires system wide coordination and supplemental resources from external healthcare partners and or government agencies

i. Activation Procedures

I. To facilitate the orderly initiation of the response to a disaster or emergency, the following steps of the EOP will be initiated upon determining that an emergency situation presents a risk to the facility, its occupants or a potential for an influx of patients.

A. The Administrator on-call shall evaluate the need for EOP activation and Code Triage paging. If House Supervisor is unable to contact the Administrator on Call the House Supervisor or designee has the authority to call the Code Triage and activate the EOP.

B. The following will be reviewed by House Supervisor and Administrator on-call for activation of the EOP (If possible):

1. Evaluate the source of information for reliability (i.e., community partners such as Emergency Management Services and local fire/police may be more reliable than news stations or patients arriving).

2. Evaluate issues such as location of incident (internal, external), the distance from AHCG , the scope of the incident (e.g., infrastructure status, impacted services) and weather conditions.

3. Discuss the operations pertaining to the conversion of AHCG to disaster status and the local requirements and protocols to establish disaster status with community partners.

4. Evaluate the information concerning this emergency and determine if initiation of the EOP is warranted.

5. Plan for care of an influx of casualty and non-casualty patients.

C. Once it has been determined to activate the EOP, the House Supervisor or designee, acting as the Incident Commander, will follow AHCGs Communications Process, such as notifying the Communications Department. After identifying him/herself, the Incident Commander will request the paging operator to provide communication regarding the disaster, either a Code Triage-Internal (Internal Disaster) or Code Triage-External (External Disaster). Examples for communication include but are not limited to the following:

1. announce via overhead page

2. mass communication notification (example MIR3)

3. emergency radio

4. runners

5. computer based alerts

D. The HIMT is notified as needed (may include but not limited to the following):

1. Operations Executive

2. Medical Officer

3. Patient Care Executive

4. Facilities Director

5. Emergency Manager

6. County, EMS, Medical Alert Center (MAC)

7. Hospital President/Administrator

E. The Incident Commander or designee considers notifying the SERC based on the type of incident. Escalation to System Command should use the following guidelines. (Refer to System Emergency Response Escalation Policy appended to this document for additional details):

1. **Advisory-** No system response is needed but the potential for a response exists. The EOP has not been activated.

2. **Alert-** A response is likely or imminent and should prompt an elevated level of response preparedness.

3. **Activation-** A response is required. Activation of the EOP and Hospital Command Center (HCC) has occurred. A disaster situation exists.

4. **All Clear-** The disaster situation is contained.

F. Update External Stakeholders as appropriate.

ii. Hospital Command Center (HCC) Activation

I. The HCC is the central location to provide command, coordination and decision-making in support of the incident response. The HCC shall be established immediately at Type 3 disaster and may be established at the discretion of the Hospital Incident Commander for a Type 4 or 5 emergency. If the usual locations are unavailable an alternate location will be identified by the Hospital Incident Commander, and the location will be announced. The location of the HCC are as follows:

A. Board Room

B. Conference Room 1

II. The Hospital Incident Management Team reports to the HCC and assumes the role designated by the Incident Commander.

III. Once the type of the emergency is determined, the Incident Action Plan (IAP) is created and the appropriate Emergency Response Plan is initiated.

iii. Alternative Hospital Command Center (HCC) Sites

I. The EOP identifies primary and alternate HCC locations. The primary and secondary HCC location maintains appropriate supplies, resources, communications and information technology capabilities to maintain incident awareness and promote continuity of operations.

A. Medical Office Building- MOB A

B. IT Building Conference Room

II. The HCC alternate site includes activation of a virtual command center.

iv. Departmental Response To Activation

I. The following actions are employed by departmental leadership when a Code Triage is activated.

A. Each Director, Manager, or Supervisor for both clinical and non-clinical departments, will assess the status of their associates to maintain normal operation and the status of their existing operations.

B. Each Director, Manager, or Supervisor will identify available resources, such as beds, personnel, and equipment, which could be allocated to the emergency response if needed.

C. The Director, Manager, or Supervisor will complete the Department Status Report form within 15 minutes of Code Triage Activation and have it delivered the HCC or other location as directed by Incident Commander. Delivery may be made using the most appropriate means (e.g., email, runner)

D. The Director, Manager, or Supervisor may be requested to report to the HCC to receive assignment for a Hospital Incident Command System (HICS) position, not limited to normal business hours.

E. The Director, Manager, or Supervisor will provide updates to the HCC as requested or needed.

F. When additional personnel are requested by the HCC the Director, Manager, and/or Supervisor will send additional personnel that are not otherwise engaged in essential care or operations to the Labor Pool for disaster reassignment.

G. The Director, Manager, or Supervisor will prepare their department for the possibility of an influx of patients as appropriate.

H. The Director, Manager, or Supervisor will report any problems or concerns to the appropriate Section Chief.

I. No department should reduce its hours of operation without prior approval from the Incident Commander.

J. When requested by the Incident Commander to recall personnel, the Staffing Office is typically responsible but this may be delegated to the Labor Pool.

II. Refer to Annex 7 COOP for additional departmental response/recovery strategies.

v. Associates Response Activation

I. The following actions are employed by associates when a Code Triage is activated:

A. All associates will initiate the market EOP and follow department specific plans/processes upon hearing and announcement of Code Triage.

B. All associates on duty will continue with usual duties unless instructed to report to their Supervisor for operational changes or reassignment. Associates will sign in on HICS-252 Section Personnel Timesheet form if instructed.

C. Associates away from their department, who cannot report physically to the department, will communicate with their department and provide their current location and status of activity.

D. Patient care activities being conducted away from the department (e.g., radiology, surgery, etc.) will continue until the activity is complete. The patient and associate will return to their department if possible, or if unable, will go to an ancillary location as directed by their supervisor.

E. Associates will check all patients and verify the critical equipment is plugged into the red plugs. Associates will inform the patient of the situation and provide comfort and reassurance when possible.

F. All associates requesting to go home or go off duty must first obtain approval from their Director, Manager, or Supervisor. The Director, Manager, or Supervisor may not grant permission without clearance from the Incident Commander or designee.

G. Associates must not leave their workstations until relief has arrived or until dismissed by the appropriate authority.

H. Associates may be assigned to other duties during a disaster or emergency.

vi. Emergency Codes

I. The following Emergency Codes are used to notify associates, patients, and visitors of emergencies. The Alert Codes and “All Clear” signals are usually announced via over-head page or with alternative communication methods when need:

California & Oregon	
EVENT	**CODE NAME**
Medical Emergency (Adult)	Code Blue
Medical Emergency (Child)	Code White
Fire	Code Red
Missing/Abducted (Infant)	Code Pink
Missing/Abducted (Child)	Code Purple
Missing/Abducted (Adult)	Code Green
Hazardous Materials Spill/Release	Code Orange
Bomb Threat	Code Yellow
Combative Person	Code Gray
Person with a Weapon	Code Silver
Active Shooter	Active Shooter
Internal Disaster	Code Triage Internal
External Disaster	Code Triage External
Massive Blood Transfusion	Code Crimson

Hawaii	
EVENT	**CODE NAME**
Medical Emergency (Adult)	Code Blue
Medical Emergency (Child)	Code Blue Pediatric
Fire	Code Red
Missing/Abducted (Infant)	Code Pink
Code Pink Pediatric____ Insert Age	Code Pink Pediatric
Massive Blood Transfusion	Code Crimson
Bomb Threat	Code Green
Hazardous Materials Spill/Release	Code Orange
Medical Emergency Cath Lab	Code STEMI
Combative Person	Code Gray
Neonatal Emergency	Code OB
Active Shooter	Active Shooter
Activate Hospital Disaster Plan	Code Triage
Hospital Disaster Plan Standby	Code Triage Standby
Trauma Full/Modified	Code Trauma
Stroke Hemorrhagic or Emboli	Code Stroke
Hostage Situation	Code Brown
Urgent Medical Event	Rapid Response Team

i.

ii. 1135 Waivers

I. Disasters and emergency events can create many challenges to the abilities of hospitals to sustain normal operations and provide a high level care as required by both state and federal entities. The intent of this policy is to provide guidelines for hospital command center staff on how to communicate the need for waivers or flexibility from normal operations, when a disaster or emergency is declared by the President and the Health and Human Services Agency Secretary. The Secretary may elect to authorize waivers/modifications of one or more of the requirements described in Section 1135(b). (Refer to Policy: 1135 Waiver Public Health Emergency appended to this document)

II. When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his/her regular authorities. Under the 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of these 1135 waivers or modifications include:

A. Conditions of participation or other certification requirements

B. Program participation and similar requirements

C. Pre-approval requirements

D. Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)

E. Emergency Medical Treatment and Labor Act (EMTALA) sanctions for direction or relocation or of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient’s source of payment or ability to pay.

F. Stark self-referral sanctions

G. Performance deadlines and timetables may be adjusted (but not waived).

H. Limitations on payment for health care items and services furnished Medicare Advantage enrollees by non-network providers

III. Adventist Health System providers located in an area where a disaster or emergency has been declared by the President and HHS Secretary should:

A. Consider using an 1135 waiver if they are unable to operate under normal conditions.

B. Activate the EOP for the emergency/disaster that has been declared and activate the Hospital/Healthcare Command Center.

C. Once waivers are submitted, Center for Medicaid/Medicare Services (CMS) may institute tracking of specific waivers.

IV. Requesting an 1135 Waiver

A. If Adventist Health sites are impacted by a disaster to a degree that compliance to CMS requirements is not possible, at the request of the Healthcare Incident Command System (HICS) Incident Commander, the Accreditation and Licensing Director or designee will submit a request to operate under an 1135 waiver authority to the CMS Regional Office and appropriate State Survey Agency via email (preferred method) if applicable.

1. HICS Incident Commander

a. Document the request in your HICS 214 activity log. Ensure that during any transfer of command staff, it is followed up and the outcome is documented in the HICS 214 activity log.

b. Contact via email, the site Accreditation and Licensing Director or Designee and copy the corporate Accreditation and Licensing Director to request an 1135 waiver.

c. Contact the System Emergency Resource Center (SERC) by phone at 916-406-2395 and communicate that an 1135 waiver has been requested.

2. Accreditation and Licensing Director or Designee

a. 1135 waiver submission:

i. While utilizing the CMS Quick Reference Guide to Submit an 1135 Waiver/Flexibility Request (Attachment) the System Director Accreditation, Regulatory and Licensing or Designee will navigate to the **CMS 1135 Waiver/Flexibility Request and Inquiry Form** at https://cmsqualitysupport.servicenowservices.com/cms_1135 to complete the submission process.

I. Web Portal Submission Process:

A. To Begin: Select “I want to submit a waiver/flexibility request”

B. Step 1: Select the Public Health Emergency (PHE) for which you are making your request.

C. Step 2: Provide your contact information and your organization information. This is to be completed in full.

D. Step 3: Describe, in full detail, your waiver/flexibility request

E. Step 4: Submit the form.

II. Notification of 1135 Waiver Submission to local State Agencies

A. State Survey Agencies: Contacts for each state can be found in the hyperlinks below:

B. The type of relief the facility is seeking or the regulatory requirement(s)/reference(s) the facility is seeking waived, Examples include:

1. Requests by hospitals to provide screening/triage of patients at a location off-site from the hospital’s campus.

2. Hospital's housing patients in units not otherwise appropriate under the Medicare Conditions of Participation or for a duration that exceeds regulatory requirements.

3. Hospital's or nursing homes requesting increases in their certified bed capacity.

C. Draft email to appropriate State Survey Agency that contains:

1. Facility Name

2. Full Mailing Address (including county)

3. CMC Certification Number (CCN)

4. Facility Contact Name and Information

5. Explanation of why the waiver is needed.

a. Example: Facility is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g., flooding, tornado, fires, or flu outbreak). Facility needs a waiver to exceed its bed limit by "X" number of beds for "Y" days/weeks (be specific).

6. The scope of the issue and the impact it has on the entity

a. *NOTE:* It is critical that the request be succinct and specific as to the issue and the impact that it is having on the site. Include an example to illustrate clearly.

7. The type of relief the facility is seeking or the regulatory requirement(s)/reference(s) the facility is seeking waived, Examples include:

a. Hospitals or nursing homes requesting increases in their certified bed capacity

b. Hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation or for a duration that exceeds regulatory requirements;

c. Requests by hospitals to provide screening/triage of patients at a location off-site from the hospital's campus

D. At the start of a survey (i.e. GACH, CMS, TJC) advise the surveyor(s) of waivers used or in use.

E. State Contacts:

1. **California -** California requires a cc to a CDPH District Office at the time the Regional CMS is emailed https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx

2. **Oregon -** https://www.oregon.gov/oha/PH/HLO/PAGES/index.aspx

3. **Hawaii -** http://health.hawaii.gov/ohca/

b. Assure processes are in place to keep careful records of CMS beneficiaries to whom services are provided and assure proper payment may be made. Track beneficiaries using HICS form 254 Disaster Patient Tracking or Adventist internal patient tracking tool on EHR.

c. There is currently no statutory authority that would permit Medicare to pay for evacuation costs. However, depending on particular circumstances, an ambulance transport to the nearest appropriate facility equipped to treat the beneficiary may be covered by Medicare Part B if transport of the beneficiary by ambulance was medically necessary and all other Medicare coverage requirements were met (i.e., the vehicle must meet certain requirements, the crew must be certified as required, the transport must be from an eligible origin to an eligible destination, certain billing and reporting requirements must be met, and Medicare Part A payment is not made directly or indirectly for the services).

d. The "DR" condition code should be used by institutional providers (but not by non-institutional providers such as physicians and other suppliers) in all billing situations related to a declared emergency/disaster.

e. Return to compliance as soon as possible and by the end of the approved operational period or end of the emergency period.

f. Ensure communication/notification are maintained with the System Emergency Management Director during the emergency period and return to normal operations.

g. Keep all processes labeled clearly as an independent section within your emergency management survey binders.

iii. Disaster Recovery

I. Assessments & Return to Operations

A. Refer to Annex 7 COOP for additional recovery strategies.

a. Returning to full operations will be multifaceted and progressive. Transition to recovery is the time period where the response phase ends, and the recovery phase begins. This period can be extensive depending on the incident and extent of loss. Recovery is considered whenever the HCC is activated. Recovery addresses how functions, services, and operations are restored. IMT assignments should be reassessed and modified according to the recovery process objectives. Recovery from a major incident will typically begin while response activities are still being conducted.

b. Recovery operations will require AHCG to conduct an organization wide damage assessment to include an assessment of status of critical systems and essential services. Incident planning will have to take into account that patient care activities will be ongoing, but the ramped-up methods to accommodate a surge will be dismantled as patient care activities allow. Improvised patient care areas will be returned to their prior state. Extra equipment, supplies, and medications will return to the pre-incident "just-in-time inventory levels," as soon as the opportunity permits.

c. The supplemental staffing levels required during the response, may continue to be maintained longer for certain patient care and support service areas than for others. However, eventually even these areas will return to their normal or "new normal" operational levels.

d. Recovery efforts must also address personnel issues such as PPE usage with exposure to hazardous chemicals or substances. Associates should complete a medical surveillance form and receive a health assessment which covers signs/symptoms and responsive actions to subsequent health effects of exposure or contamination.

e. Associates who became ill or injured while on duty will have financial, psychological, and medical-care issues that can be coordinated by the Compensation/Claims Unit. The possibility of a line-of-duty death occurring should be addressed through the combined efforts of the Logistics Section, Finance/Administration Section, Operations Section, the Safety Officer, and the Public Information Officer.

f. All matters pertaining to associate and family support will be coordinated to include an assessment of the need for a stress debriefing for staff and volunteers. One key aspect to improve staff and volunteers emotional recovery and maintaining their ongoing commitment is formal and informal recognition.

g. The degree to which the physical plant will have to be restored will vary by incident. At a minimum, all patient-care areas and equipment will have to be thoroughly cleaned. The Facilities Unit Leader will primarily be responsible for coordination of this activity, along with the Medical Care and Infrastructure Branches. The actual clean-up work may be done using normal environmental services personnel or, to reduce recovery time, general hospital staff when they are available or contractors when needed.

h. For hazardous material or biological-related incidents, clean-up efforts may require special cleaning agents and procedures to be used; some situations may even require special contractors to do the work. Hazardous waste, including the collected runoff from decontamination operations, should be disposed of properly by licensed, bonded, and insured contractors. Supervision of the clean-up of contaminated areas should be coordinated by the HazMat Branch and the Infrastructure Branch with logistical support coming from the Support Branch.

i. From the outset of the response, the Finance/Administration Section has the responsibility to track the various costs associated with the hospital's response. The primary costs to be closely tracked include personnel, patient care, resources, equipment repair and replacement, and facility operations. A disaster cost center may be established for the purpose of identifying hours worked by personnel during a disaster. The Finance Department will establish this cost center and work with department leadership to capture the disaster related salary costs. Detailed documentation including the number of hours worked, dates, type and location of disaster related work conducted by employees will be needed to seek reimbursement from local, State and Federal agencies and/or insurance companies.

j. Video Taping/Photos will be used to document damage sustained in a disaster and/or disaster related response by AHCG . Video of the facility prior to any disasters should be taken routinely to show pre-disaster facility status.

k. Whenever possible, price negotiations for services needed post disaster will be negotiated pre-disaster to reduce the expense of recovery. Items that can be borrowed will be borrowed, items that can be rented will be rented and only as a last resort will items needed during a disaster be purchased. This too, will reduce the disaster expenditures and help facilitate a more rapid recovery after an event.

l. AHCG will ensure that during a disaster, all items, equipment and services used for disaster victims or disaster related repairs will be captured. Invoices must include what the item/service was used for, including date, time and location. Copies of this documentation must be maintained in the Finance Department for later review by legal and auditing agencies. Reimbursement depends upon how well the organization documents goods and services.

II. Deactivation the Emergency Operation Plan

A. As the initial impact of the disaster has subsided and all critical threats have been neutralized, the IC, with the support of hospital response staff, will begin to initiate a demobilization process. The process of demobilizing and returning the facility to normal operation must be carefully planned and organized, ensuring that all facets of the operation are able to support this phase of the operation and adequate personnel and resources are in place to manage the process.

B. The IC will make the determination of when the demobilization process will be initiated. The following factors may be considered when making the determination to demobilize:

a. The number of incoming patients is declining to a manageable level using normal staffing patterns and resources

b. Hospital infrastructure and utilities have been restored to normal operation

c. Other responders are beginning their demobilization

d. Other critical community infrastructure returns to normal operations

C. As the threats and risks posed by an incident diminish, consideration should be given to de-escalation of the HCC and reducing assigned IMT positions and activities. Incident demobilization should consider the priority of the incident and how activities will be transferred effectively to resume normal operations, project teams, and/or other supporting business departments. When the scope and timeliness of the response need decreases, the HCC will be deactivated.

D. As the incident stabilizes, a demobilization plan is developed to deactivate IMT positions and resources. A demobilization plan outlining the roles and responsibilities of the individuals tasked with recovery strategies will be developed and included in the action planning process as the tactical objectives are met, and normal operations resume. Demobilization processes include:

a. The IC shall request that Code Triage Internal/External "All Clear" be announced through appropriate means. External partners and the SERC will be notified when deactivation activities have been declared.

b. Hospital staff assigned a response role will be released as their operational functions conclude.

c. Any equipment or resources that were used during the operation will be returned to the appropriate department in working order.

d. Damaged equipment shall be tagged appropriately and taken out of service.

e. Equipment that was borrowed from a community resource or partner will be serviced and returned in proper working order to the original owner.

f. All HCC and HICS documentation related to decisions, action, and resource acquisitions during the response will be collected and organized and submitted to the Planning Section Chief or designee.

g. Any outstanding invoices will be submitted for payment, staff cost will be tracked and calculated in the event reimbursement is available.

h. Facilitate debriefing and document AAR.

i. Other processes as required.

III. EP 2: Family Reunification

A. AHCG will coordinate with community partners to establish/support a Family Reunification Center (FRC), a temporary centralized location set up for families and friends seeking vetted/legitimate information about loved ones.

B. AHCG will establish a FRC that works in conjunction with the community FRC. The purpose of the FRC is to coordinate with community partners to locate and assist with the identification of adults and unaccompanied children. In addition, coordinate vetted information sharing to family and friends of disaster victims at the facility so as not to impede essential service delivery. Refer to AHCG specific FRC processes.

iv. Education & Training

I. The hospital has a written education and training program in emergency management that is based on the hospital's prioritized risks identified as part of its HVA, the EOP, the communication plan, and policies/procedures. Training includes but is not limited to the following:

A. Training prior to during and after an incident

B. Training during drills/exercises

C. Engagement in community training events

D. Training in response to Hospital Preparedness Program (HPP) grant requirements

E. Other training opportunities as identified

Note: If the hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs.

II. Initial Education

A. Initial education and training in emergency management is provided to all new and existing staff, individuals providing services under arrangement, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following:

1. Activation and deactivation of the emergency operations plan

2. Communications plan

3. Emergency response policies and procedures

4. Evacuation, shelter-in place, lockdown, and surge procedures

5. Where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment)

III. Ongoing Education

A. Department leaders should identify the trainings necessary to prepare themselves and their team for the recommended capabilities and objectives tested in the outline exercises. Department leaders should identify trainings that cover any gaps revealed as part of the After Action Report/Improvement Plan process, and update their training schedule to reflect the accomplishments and progress of their respective department(s). Ongoing education and training is provided to all staff, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:

1. At least every two years

2. When roles or responsibilities change

3. When there are significant revisions to the emergency operations plan, policies, and/or procedures

4. When procedural changes are made during an emergency or disaster incident requiring just-in time education and training

B. Competence Assessment

1. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

IV. Incident Command Training

A. The Incident Management Team (IMT) staff participate in education and training specific to their duties and responsibilities in the incident command structure. Identified organizational leadership are responsible for completing ICS 100, 200, 700 within 90 days of hire. Ongoing education and training is provided to all IMT staff that is consistent with their roles and responsibilities in an emergency:

1. At least every two years

2. When roles or responsibilities change

3. When there are significant revisions to the emergency operations plan, policies, and/or procedures

4. When procedural changes are made during an emergency or disaster incident requiring just-in time education and training

B. Training Records

1. Training and education records are maintained by the Education Department. Just in time training and documentation of drills/exercises are maintained by the Emergency Manager.

v. Testing & Exercise

I. The planned exercises attempt to stress the limits of its emergency response procedures in order to assess how the preparedness level if a real event or disaster were to occur based on past experiences. AHCG considers the prioritized hazards identified within the HVA when developing drills/exercises. Annual exercise & testing of the emergency operations plan is based on the following:

A. Likely emergencies or disaster scenarios

B. Emergency operations plan and policies and procedures

C. After-action reports (AAR) and improvement plans

D. The six critical areas (communications, resources and assets, staffing, patient care activities, utilities, safety and security)

II. Exercise Frequency & Scope

A. Two exercises per year will be conducted to test the emergency operations plan. The exercise & testing program will be conducted in a progressive manner, moving from a discussion-based to an operations-based exercise. One of the annual exercises must consist of an operations-based exercise as follows:

1. Full-scale, community-based exercise; or

2. Functional, facility-based exercise when a community-based exercise is not possible

B. The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:

1. Full-scale, community-based exercise; or

2. Functional, facility-based exercise; or

3. Mock disaster drill; or

4. Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

III. Exercise Frequency & Scope-Outpatient Services

A. AHCG would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident and documents the incident response and evaluation activities, Discussion based exercise are excluded from this exemption.

B. Each accredited freestanding outpatient care building that provides patient care, treatment, or services will conduct at least one operations-based or discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with AHCG emergency exercises.

vi. Evaluation

I. Evaluation & Improvement Planning

A. An after action report (AAR) is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events, to include but not limited to emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. The Emergency Management Committee reviews and evaluates all exercises and actual emergencies and disaster incidents and assists in the development of the AAR. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. Upon completion of all exercise and incidents and after action review and report will be compiled to promote and support continuous improvement activities. The Committee will coordinate the continuous improvement process by developing recommendations and providing oversight of activity completion.

II. Senior Leadership Evaluation Review

A. The AAR, opportunities for improvement and recommendations from the Emergency Management Committee are provided to senior leadership for review.

III. Improvement Planning

A. AHCG reviews and updates the Emergency Management Program; Hazard Vulnerability Analysis; Emergency Operations Plan and associated policies and procedures, Communications Plan; Continuity of Operations Plan; Education and Training Plan; and testing program based on the AAR and/or opportunities for improvement identified every two years, or more frequently if necessary.

B. When plans and procedures are revised, they are exercised and reviewed to measure functional capability and effectiveness. This process is also in compliance with the NIMS components. (NIMS Objective 7)

vii. EOP Appendices and Annexes

I. EOP Administrative Appendices

A. California Civil Code 56.10

B. System Escalation Policy

C. Hazard Vulnerability Analysis (HVA)- Hospital

D. 1135 Waiver - Public Health Emergency

E. Hospital Incident Command System

F. Hospital Incident Command System- Finance

II. EOP Annexes

A. Annex 1- Communications (EM12.02.01)

B. Annex 2- Staffing Plan (EM 12.02.03)

C. Annex 3- Patient & Clinical Support Activities (EM.12.02.05)

D. Annex 4- Safety & Security (EM.12.02.07)

E. Annex 5- Resources & Assets (EM.12.02.09)

F. Annex 6- Managing Critical Utilities (EM.12.02.11)

G. Annex 7- COOP (EM.13.01.01)

H. Annex 8- Hazard, Threat & Incident Response Plans

I. Annex 9 - HICS Documents

ATTACHMENTS: (REFERENCED BY THIS DOCUMENT)	**Annex 1: Communication Plan** **Annex 2: Staffing Plan** **Annex 3: Patient Clinical & Support Activities Plan** **Annex 4: Safety and Security Plan** **Annex 5: Resources and Assets Plan** **Annex 6: Managing Critical Utilities** **Annex 7: Continuity of Operations Plan (COOP)** **HVA-AHCG Hospital** **Hospital Incident Command System-Finance** **HICS Documents** **https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx** **https://www.oregon.gov/oha/PH/HLO/PAGES/index.aspx** **https://cmsqualitysupport.servicenowservices.com/cms_1135** **1135 Waiver - Public Health Emergency** **http://health.hawaii.gov/ohca/** **Hospital Incident Command System** **California Civil Code 56.10** **1135 Waiver - Public Health Emergency** **Hospital Incident Command System-Finance** **System Emergency Response Escalation** **Hospital Incident Command Forms**
OTHER DOCUMENTS: (WHICH REFERENCE THIS DOCUMENT)	
FEDERAL REGULATIONS:	
ACCREDITATION:	
CALIFORNIA:	**Not applicable**
HAWAII:	**Not applicable**
OREGON:	**Not applicable**
WASHINGTON:	**Not applicable**

REFERENCES:

California, State of. “Hospital Incident Command System – Current Guidebook and Appendices.” EMSA, 2014, emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system/.

“Emergency Management .” Joint Commission Resources Portal, Joint Commission, 2020, e-dition.jcrinc.com/MainContent.aspx.

“Hawaii Emergency Management Agency.” Department of Defense, 2020, dod.hawaii.gov/hiema/.

“National Incident Management System.” National Incident Management System | FEMA.gov, United States Government, 2020, www.fema.gov/emergency-managers/nims.

“National Incident Management System (NIMS).” Oregon Office of Emergency Management : National Incident Management System (NIMS) : Plans and Assessments : State of Oregon, www.oregon.gov/oem/emresources/Plans_Assessments/Pages/NIMS.aspx.

“National Response Framework.” National Response Framework | FEMA.gov, United States Government, 2020, www.fema.gov/emergency-managers/national-preparedness/frameworks/response.

“Standardized Emergency Management System.” Planning & Preparedness Standardized Emergency Management System, 2020, www.caloes.ca.gov/cal-oes-divisions/planning-preparedness/standardized-emergency-management-system.

"State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance, 21 Feb. 2020, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_z_emergprep.pdf. "

ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**Director, Emergency Management**
ENTITY POLICY OWNER:	**Manager, Emergency Management**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(06/11/2024) Clinical Best Practice Committee (CBPC), (07/25/2024) Clinical Cabinet (CC)**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	
ENTITY:	**(09/23/2024) Emergency Management Committee, (10/16/2024) Medical Staff Executive Committee (MEC), (10/24/2024) Community Board Clinical Committee (CBCC)**
ENTITY INDIVIDUAL:	**(10/31/2024 06:54AM PST) Stefanie E Boen, Manager, Emergency Management**
REVIEW DATE:	**02/22/2024**
REVISION DATE:	**03/17/2021, 07/01/2022, 07/25/2024**
NEXT REVIEW DATE:	**10/31/2027**
APPROVAL PATHWAY:	**Clinical**

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Organization Wide
SUBJECT/TITLE: ***Scope of Services for Mid-Columbia Medical Center***	
DEPARTMENT: Administration	OWNER: Executive Leadership Team

PURPOSE OF THE PLAN

The purpose of the Organizational Plan for Patient Care is to provide: 1) a framework by which the Executive Leadership Team, Directors/Managers, Medical Staff Leadership, hospital and department committees, teams and task forces, and staff as appropriate will plan, implement, direct, coordinate, evaluate and improve the health care services provided so that 2) they are responsive to the patient population served, our Mission, and identified patient care and community needs. The Plan is based on the assumption that the Hospital is a network of integrated and collaborative processes, and is supported by the strategic plan, the annual budget plan, community needs assessment, departmental plans and referenced policies. The plan serves as a basis to:

- Identify existing and new patient care services.
- Direct and integrate patient care services throughout the organization.
- Implement and coordinate services among departments.
- Demonstrate improvement in the services provided.
- Direct and support a comparable level of patient care throughout the hospital.

DESCRIPTION AND DEMOGRAPHICS

A. Mid-Columbia Medical Center (MCMC) is a 49-bed, not-for-profit, acute care facility that provides care to Wasco County and surrounding areas in the states of Oregon and Washington. MCMC has a tradition of and commitment to excellence based on the Planetree philosophy. MCMC strives to be a careful steward of the resources entrusted to it and is committed to addressing the needs and interests of the public, which it serves. The hospital's strong belief in the intrinsic dignity of each person commits it to be a just employer, to provide healthcare for the whole person, body, mind and spirit, and to collaborate with physicians and other healthcare providers to increase access to healthcare.

B. The Board of Trustees for MCMC has delegated operational decisions regarding patient care to the hospital CEO. The Board of Trustees retains responsibility for monitoring the performance of the CEO to ensure quality care is consistently provided to all patients. MCMC leaders participate with the Board and officers of the organization in developing policy decisions that affect patient care services.

C. MCMC is very active in the communities we serve. Leaders, physicians and staff are encouraged to participate in community programs and activities. Examples of facility involvement in the community, established in response to our community needs assessment are through a variety of community outreach and educational programs such as patient navigation and SOMOS (Serving Oregon and its Migrants by Offering Solutions).

D. MCMC is a full-service acute care facility, providing acute inpatient care, surgical care, labor and delivery, emergency services, and a variety of outpatient services.

LEADERSHIP RESPONSIBILITIES AND ORGANIZATION

Structure/Delegation

The activities of MCMC are governed by the Board of Trustees. The responsibility and accountability for these activities is delegated by the Board of Trustees to the CEO, who in turn delegates responsibility and accountability to Executive Leadership Team and/or designated Directors or Managers. The Executive Leadership Team works closely with the Medical Staff Leadership to provide direction, integration and coordination of the governance, management, clinical and support processes for MCMC.

Board of Trustee Meetings and Communication

- The Board of Trustees and Subcommittees meet at least every other month and per schedule, and are attended by the CEO and Executive Leadership for Mid-Columbia Medical Center or designee(s). Minutes are recorded and distributed to the CEO to disseminate and keep on file in the Administrative offices.
- Reports: The Quality Committee of the Board reviews the facility's Performance Improvement Plan and quarterly reports. Financial reports are reported to the Finance Committee of the Board. Strategic Planning activities are reported to the Board at large. Other business or operational information is presented directly to the Board.

DECISION-MAKING PROCESS AND PLANNING FOR SERVICES

A. All decision-making processes are based on our Mission, Vision, Core Values and Strategic Plan. The Executive Management Team solicits input from the department/service Directors and Managers and Medical Staff Leadership during the budgetary cycle and at various times during the year as changes in practice and technology occur. Department managers and physicians participate in the decision- making structures and processes through their administrative designee on the Executive Management Team.

B. Annually, the Plan for the Provision of Patient Care is reviewed and revised, as appropriate, by the Executive Management Team and leadership, taking into account: 1) our Mission, Vision, Core Values and Strategic Plan, as well as 2) quality standards of care and service, regulatory and accreditation standards, patient feedback and community needs. The Team uses data from sources including: ongoing patient satisfaction surveys, performance improvement findings, Medical Staff leadership recommendations, physician input and provider practices, employee input, market analysis, community needs assessment, staff recruitment/retention and new technologies to plan and redesign patient care services and the systems which support them.
In addition, relevant community leaders and other community provider organizations are involved in the process. This may occur via Board feedback, surveys, joint meetings, task forces and/or open forums.

COMMUNICATION PROCESS

A. The Executive Management Team, department Directors/Managers and Medical Staff Leadership use a variety of mechanisms to communicate with each other and to the staff including publications, department meetings, electronic mail, walking rounds and general meetings.

B. Broad-based ongoing communication tools include:
Weekly Update to all employees, medical staff, and Leadership Team from CEO
Unit update.

C. Routine multi-disciplinary meetings include:

- Executive Management Team meetings.
- Full Management Team meetings, Division meetings, and Operations Council meetings
- Hospital and Medical Staff Leadership meetings
- Nursing/Quality Performance Improvement meetings (various)
- Medical Staff committee meetings (various)
- Hospital committee meetings (various)

D. Open forum communication sessions are held periodically and as needed by the Executive Management Team. These forums promote interactive discussion between leaders and staff on a variety of subjects. Medical Staff Leaders and department Directors/Managers hold regular staff meetings within their departments. Ad hoc meetings, communication sessions and conferences occur throughout the year as needed.

DEFINITION OF CLINICAL AND SUPPORT SERVICES

A. Clinical Services: are provided through an organized and systematic process designed to ensure the delivery of safe, effective, and timely care and treatment. Providing and delivering patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, clinical services are planned, coordinated, provided, delegated and supervised by professional healthcare providers.

1. Patient Care is the provision of direct professional services to the patient and his or her family including: provision for patient rights, assessment, planning for care, intervention or treatment, reassessment of effectiveness, patient and family education and planning for care across the continuum.
2. Delivery of patient care is led by the physicians and/or advanced practice nurses in concert with a multi-disciplinary healthcare team, functioning collaboratively to achieve and improve patient and operational outcomes.
3. A Registered Nurse will assess each patient's need for nursing care in all settings in which nursing care is to be provided In accordance with the Oregon Nursing Practice Act. Nursing is defined as the provision of direct and indirect patient care measures that help people cope with the difficulties of daily living which are associated with their actual or potential health or illness problems or as it relates to their capacity for self-care. Additionally, nurses execute and administer diagnostic and therapeutic regimens prescribed by medical practitioners and supervise, delegate and evaluate patient care activities.

B. Support Services: are those services provided by those who may not have direct contact with patients, but who are integral to the support of care provided by clinical care staff. Support services departments and staff work collaboratively with patient care units and departments to assure that the overall physical plant and basic service needs of our patients, staff, physicians and guests are met.

INPATIENT ACUTE CARE

[redacted]

[redacted]

ICU

[redacted]

TELE

[redacted]

Critical Care

[redacted]

		[redacted]

OB

[redacted]

EMERGENCY SERVICES

The Emergency Department is open and operational with onsite physician coverage 24 hours a day 7 days a week. Normal nurse staffing for the Emergency Department is as follows: (2) RNs 0700-1900, (1) RN 0900-2200, (1) RN 1100-2300, (2) RNs 1900-0700.

The patient population served by the Emergency Department consists of the newborn, pediatric, adolescent, adult and geriatric patient requiring or seeking emergent care for acute conditions.

The Emergency department offers a variety of medical services to unscheduled patients who need urgent medical attention, surgical procedures and/or acute care. The scope of services offered includes but are not limited to consultations, whereby a patient is carefully diagnosed by the on-call physician to ascertain the condition the patient presents with. Full and modified trauma response which may include General surgery, Anesthesia, lab, pharmacy, and other critical departments. The patient diagnosis may entail simple to complex procedures such as suture placement depending on location. It may also include laboratory tests for blood, stool, or urine. In some, cases the diagnosis may involve complex procedures using MRIs and CT-scans to observe the internal body structure of the patient. Diagnosis is then followed by treatment approaches based on the outcomes of the initial tests. The Emergency Department also maintain constant communication with the emergency medical service (EMS) providers, to offer medical advice concerning the patient being transported, in case they are in critical conditions. This open-line communication also comes in handy in case the emergency department has reached its capacity because they can advise the EMS to take patients to other centers, rather than wasting time coming and being turned away.

SURGERY

[redacted]

LABORATORY

[redacted]

[redacted]

CARDIOPULOMONARY SERVICES

[redacted]

[redacted]

DIAGNOSTIC IMAGING

[redacted]

AMBULATORY CLINICS

[redacted]
www.mcmc.net
[redacted]

CELILO

[redacted]

[redacted]

DIETITIAN AND DIETARY SERVICES

[redacted]

REHAB SERVICES

[redacted]

VISITING HEALTH SERVICES

[redacted]

References:

Approval Process: Executive Leadership and Board of Directors.

Review/Revision Date	Title	Description of Change
1/25/23	COO, CNO	Revised Edits of Policy

Attachment E

Completed CMS Form 1514

According to CMS announcement S&C-04-31, the use of CMS Form 1514 was discontinued in 2004. In its place, CMS issued two documents: (1) the "Authorization for Accreditation Organization to Release the Most Recent Accreditation Survey for a Hospital or a CAH," and (2) a "Hospital/CAH Medicare Database Worksheet." Rather than attaching a signed copy of this former form, the Parties have simply attached copies of the accreditation letters that AHCG received from the Joint Commission after the hospital's most-recent survey.

The Joint Commission

May 18, 2023

Dennis M Knox, FACHE
President And Chief Executive Officer
Mid-Columbia Medical Center
1700 East 19th Street
The Dalles, OR 97058

Re: # 9720
CCN: # 380001
Deemed Program: Hospital
Accreditation Expiration Date: February 18, 2026

Dear Mr. Knox:

This letter confirms that your February 14, 2023 - February 17, 2023 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on May 12, 2023. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of February 18, 2023.

The Joint Commission is also recommending your organization for continued Medicare certification effective February 18, 2023. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Mid-Columbia Medical Center
1700 East 19th Street, The Dalles, OR, 97058

Mid-Columbia Medical Center
d/b/a Celilo Cancer Center
1700 East 19th Street, The Dalles, OR, 97058

Mid-Columbia Medical Center
d/b/a MCMC XRAY
551 Lone Pine Blvd., Suite 302, The Dalles, OR, 97058

Mid- Columbia Medical Center
d/b/a MCMC Anticoagulation Clinic
1700 East 19th Street, The Dalles, OR, 97058

The Joint Commission

Mid Columbia Medical Center
d/b/a MCMC Center for Sleep Medicine
551 Lone Pine Blvd Suite Suite 300, The Dalles, OR, 97058

Mid-Columbia Medical Center
d/b/a MCMC Pathology
1810 E. 19th St, The Dalles, OR, 97058

Mid-Columbia Medical Center Cardiac Rehabilitation
d/b/a MCMC Cardiac and Pulmonary Excercise
551 Lone Pine BLVD suite 101, The Dalles, OR, 97058

Mid-Columbia Medical Center
d/b/a MCMC Outpatient Therapy
551 Lone Pine BLVD. Suite 103, The Dalles, OR, 97058

Mid-Columbia Medical Center
d/b/a MCMC ECHO/Ultrasound
551 Lone Pine Blvd Suite 290-291, The Dalles, OR, 97058

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

cc: CMS/Baltimore Office/Survey & Certification Group/Division of Acute Care Services
CMS/SOG Location 10 /Survey and Certification Staff

The Joint Commission

May 18, 2023

Dennis M Knox, FACHE
President And CEO
Mid-Columbia Medical Center
1700 East 19th Street
The Dalles, OR 97058

Re: # 9720
CCN: # 387041
Deemed Program: Home Health Agency
Accreditation Expiration Date: February 17, 2026

Dear Mr. Knox:

This letter confirms that your February 14, 2023 - February 16, 2023 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for home health agencies through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on May 12, 2023. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of February 17, 2023.

The Joint Commission is also recommending your organization for continued Medicare certification effective February 17, 2023. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location:

Visiting Health Services
1730 East 12th Street, The Dalles, OR, 97058

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Deborah A Ryan

Deborah A. Ryan, MS, RN

The Joint Commission

Executive Vice President
Division of Accreditation and Certification Operations

cc: CMS/Baltimore Office/Survey & Certification Group/Division of Acute Care Services
CMS/SOG Location 10 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Attachment F

Mountainous Terrain Designation

Oregon
Tina Kotek, Governor

Department of Transportation
Engineering & Technical Services Branch
Roadway Section
4040 Fairview Industrial Drive SE, MS1
Salem, OR 97302-1142
Telephone: 503-986-3568
Fax: 503-986-3749

January 27, 2025

Steven Slusser
System Director
Adventist Health
ONE Adventist Health Way
Roseville, CA 95661

Re: Confirmation of "mountainous terrain" characteristics

Dear Steven,

This letter confirms that at least 15 miles of the numbered state or federal highway travel routes in Oregon from Adventist Health Columbia Gorge located in The Dalles, Oregon ("The Dalles Hospital") to the closest hospital, Providence Hood River Memorial Hospital in Hood River, Oregon ("Hood River Hospital"), has characteristics considered "mountainous terrain."

Critical Access Hospital Mountainous Terrain Definition
Pursuant to 42 C.F.R. § 485.610(c), in order to qualify for Critical Access Hospital ("CAH") status, among other things, a provider must show it is either: (1) more than 35 miles from any other hospital or CAH; **or** (2) in areas of mountainous terrain or, where only secondary roads are available, more than 15 miles from any other hospital or CAH (emphasis added).

To meet the mountainous terrain standard identified in (2) above, a hospital must demonstrate: (a) over 15 miles of the roads on the travel route(s) from the CAH to any hospital or another CAH is located in a mountain range; **and** (b) the drive to any other hospital or CAH includes travel through "mountainous terrain." (emphasis added). With respect to the requirement under (b), the CAH must obtain a letter from the State Transportation agency confirming that at least 15 miles of the route have either of the following characteristics:

- Extensive sections of roads with steep grades (i.e., greater than 5 percent), continuous abrupt and frequent changes in elevation or direction, or any combination of horizontal and vertical alignment that causes heavy vehicles to operate at crawl speeds for significant distances or at frequent intervals. (Horizontal alignment refers to the "straightness" of the roadway, vertical alignment refers to the roadway's "flatness," and crawl speed is the speed at

which a truck has no power to accelerate on long, steep grades. Thus, roads in mountainous terrain are commonly described as winding and steep); or

- Be considered mountainous terrain based on significantly more complicated than usual construction techniques that were originally required to achieve compatibility between the road alignment and surrounding rugged terrain. For example, because the changes in elevation and direction are abrupt in mountainous terrain, roadbeds may require frequent benching, side hill excavations, and embankment fills.

Route Between the Dalles Hospital and Hood River Hospital
In Oregon, two travel routes were reviewed 1) I-84 and 2) US-30 and I-84. Attached as Exhibits A and B are maps of the travel routes between The Dalles Hospital and Hood River Hospital in Oregon.

Exhibit A: I-84 Travel Route

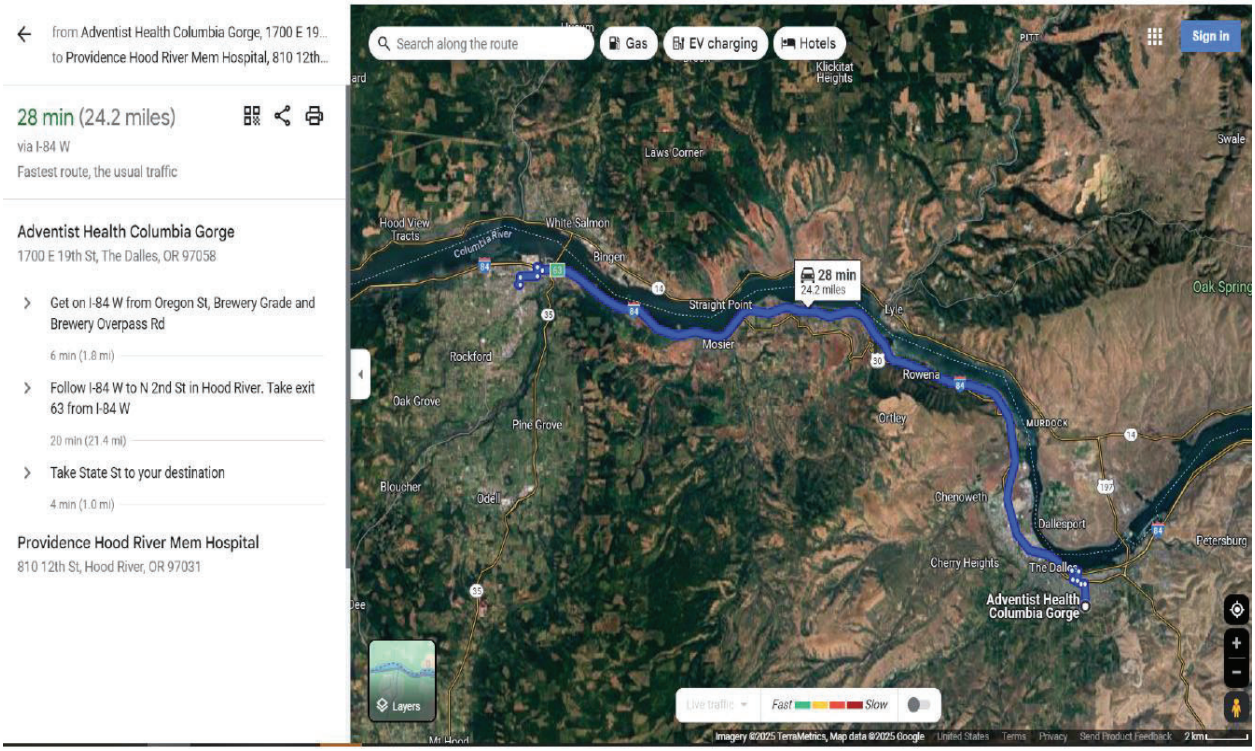
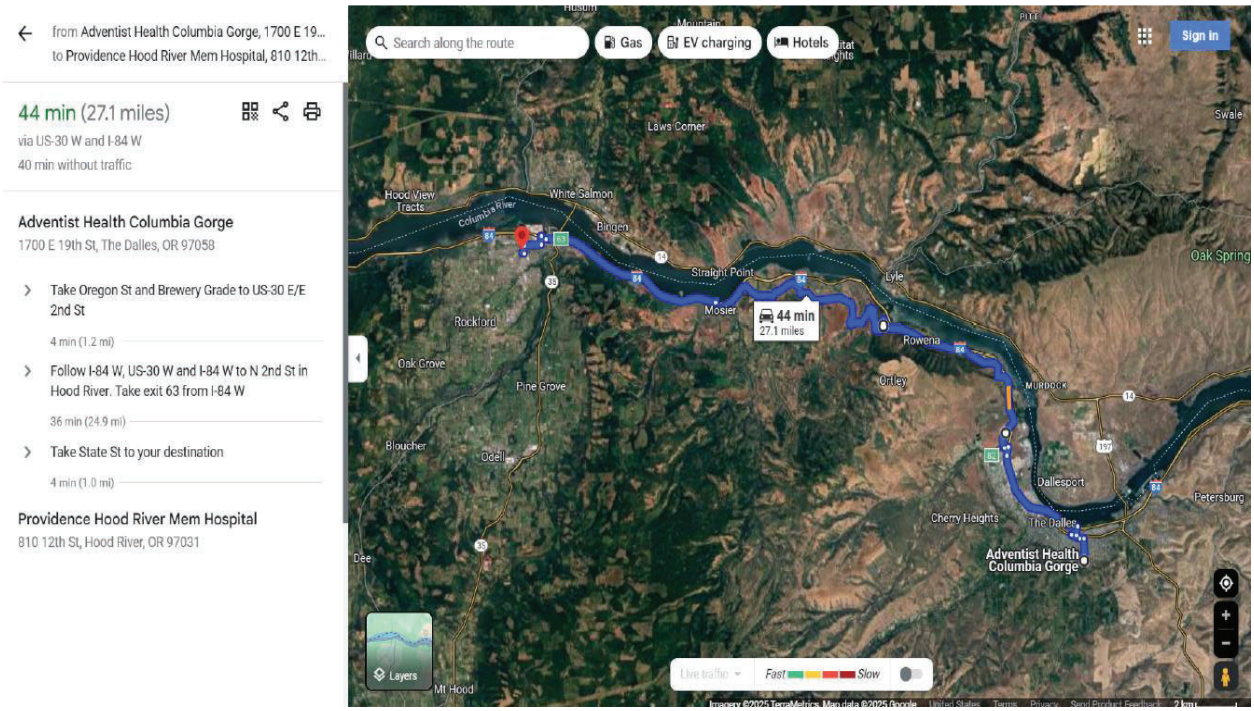


Exhibit B: US-30 to I-84 Travel Route



Below is a summary of the portions of each route that are in “mountainous terrain”. For both routes they required significantly more complicated than usual construction techniques that were originally required to achieve compatibility between the road alignment and surrounding rugged terrain in the Cascade Mountain Range and the rugged Columbia River Gorge.

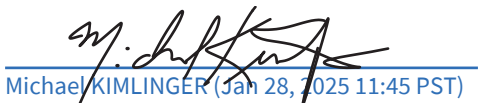
I-84 Mountainous Distances					
MP*	to	MP*	Notes	Mountainous Criteria Met:	Mountainous Miles
81.53		81.25	Rock Cut Observed Starting near MP 81.53 (WB direction) Retaining Wall	Yes	0.28
81.25		79.5	Alternating Cuts and Fills Fills up to approx. 50' over drainage near MP 81.2 (04V-367) Cuts up to 30' at CL near MP 80.6 (04-367) Rock Cuts observed MP 80.4-79.5	Yes	1.75
79.5		78.7	Flat section of highway Embankment generally 15-20' up to 40'+ Embankment Quant. ~380,000 Cu. Yd. (04V-367 and 06V-201)	Yes	0.8
78.7		77.2	Rock Cut Observed Starting near MP 78.7 Rock cut continues to occur throughout. Section near Rowena Interchange includes a chain-up area for WB traffic near MP 77.	Yes	1.5
77.2		76.5	Flatter area with no rock cut observed near Rowena Interchange		
76.5		75.3	Fill ~ 40' at centerline and cuts 15'-20'	Yes	1.2
75.3		74.4	RR relocation along segments of the alignment constructed. Rowena Plaeau above highway with steep cliffs in this segment. Rowena plateau ~600' elev. And I-84 is at ~100' elev. According to Google Earth measurements. Cliff near MP 75.2 gains approx. 500' vertical feet with face of cliff within ~30' from southern edge of pavement. From northern edge of pavement RR track are ~30' with the edge of pavement. Columbia River just to the north of the RR tracks. (4V-325)	Yes	0.9
74.4		71.8	Alternating cuts and fills along project. Rock cuts in basalt common. Spot locations where +60' of cut at centerline were shown in as-builts. (4V-282)	Yes	2.6
71.8		71.3	Generally flat - Crossing Farm Land		
71.3		63.95	Work in this segment includes Construction in the Columbia River with Hydraulic Embankment, Rock Toe Embankment, and a 3' Rock Blanket for slope protection. Work also required Solid Rock Excavation and RR relocation. Hydraulic Emb. generally appears to be 20-30' at centerline, (some locations less) up to +90' depths on centerline of rock toe. Crossing of Hood River just prior to the 2nd Street Exit ramp. (4V-199 & 4V-282)	Yes	7.35
			Total		**16.38**
* MP Based on ODOT DVL 2024/TransGIS					

US-30 and I-84 Mountainous Distances					
MP*	to	MP*	Notes	Mountainous Criteria Met:	Mountainous Miles
71.71		70.94	Sharper curves with side hill excavation/fills	Yes	0.77
70.94		70.31	Generally flatter with less cuts and fills		
70.35		67.57	Sharper curves with side hill excavation/fills	Yes	2.78
67.57		66.52	Within Rowena, generally flatter. Side hill excation/fills present, not included in mountianous miles but may warrant additional review.		
66.52		62.73	Sharper curves with side hill excavation/fills	Yes	3.79
62.73		61.46	Generally flatter with less cuts and fills. Side hill excation/fills present, not included in mountianous miles but may warrant additional review.		
61.46		59.65	Sharper curves with side hill excavation/fills	Yes	1.81
59.65		58.94	Farmland Limited cuts and fills. Some sharper curves present, not included in mountianous miles but may warrant additional review.		
58.94		57.8	57.8 approach to single lane bridge over Mosier Creek, Sharper curves with side hill excavation/fills	Yes	1.14
57.8		57.57	Within Mosier		
			(MP 70.00 (I-84 connection) = MP 57.57 (US-30)		
70		69.86	Within Mosier		
69.86		69.79	RR overcrossing with cuts and fills to connect up with I-84	Yes	0.07
			MP 69.79 = MP 69.61		
69.61		69.84	Connection to loop ramp (note: MP's run reverse on this connnecting segement)	Yes	0.23
			MP 69.84 (I-84 connection) = MP 69.79 (I-84)		
69.79		63.95	Work in this segment includes Construction in the Columbia River with Hydraulic Embankment, Rock Toe Embankment, and a 3' Rock Blanket for slope protection. Work also required Solid Rock Excavation and RR relocation. Hydraulic Emb. generally appears to be 20-30' at centerline, (some locations less) up to +90' depths on centerline of rock toe. Crossing of Hood River just prior to the 2nd Street Exit ramp. (4V-199 & 4V-282)	Yes	5.84
			Total		**16.43**
* MP Based on ODOT DVL 2023/TransGIS					

Conclusion

As detailed above, the Oregon Department of Transportation confirms at least 15 miles of the travel routes in Oregon between The Dalles Hospital and Hood River Hospital has characteristics considered “mountainous terrain.”

Sincerely,



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