

Operational Policy Agenda 3-18-26

Title	Area	Revised?	Summary of Changes
Health Center's Registration & Waiting Area Checklist	Ambulatory Care	New	Checklist associated with an Ambulatory Care policy.
Health Center's Administrative Area Compliance Checklist	Ambulatory Care	New	Checklist associated with an Ambulatory Care policy.
Health Center's Clinical Area Compliance Checklist	Ambulatory Care	New	Checklist associated with an Ambulatory Care policy.
Health Center's Employee Only Compliance Checklist	Ambulatory Care	New	Checklist associated with an Ambulatory Care policy.
Health Center's Finding's and Plan of Correction Compliance Checklist	Ambulatory Care	New	Checklist associated with an Ambulatory Care policy.
Policy for Utility Emergency Repair Service Contacts	Facilities Management	Revised	Updated the contact information for the City of Martinez Water and the name changes for security and fire extinguisher inspection company in October of 2025
CCRMC's Continuity of Operations Plan (COOP)	Hospital & Health Centers	Revised	<ul style="list-style-type: none"> • Updated leadership titles and activation authorities. • Refreshed essential functions and staffing contingencies. • Updated alternate care sites and logistical coordination language. • Clarified communication pathways and IT/EHR downtime procedures. • Updated recovery/reconstitution steps and improvement planning references.
CCRMC's Emergency Disaster Recovery Plan	Hospital & Health Centers	Unchanged	No Comment Provided
CCRMC's Emergency Management Communications Plan	Hospital & Health Centers	Unchanged	No Comment Provided
CCRMC's Emergency Management Education and Training Plan	Hospital & Health Centers	Unchanged	No Comment Provided
CCRMC's Emergency Management Exercise Testing Plan	Hospital & Health Centers	Unchanged	No Comment Provided

Title	Area	Revised?	Summary of Changes
CCRMC's Emergency Operations Plan (EOP)	Hospital & Health Centers	Revised	<ul style="list-style-type: none"> • Updated HICS roles, responsibilities, and organizational structure. • Revised hazard annex references to align with current HVA priorities. • Clarified evacuation, shelter in place, and surge procedures. • Updated internal/external communication workflows. • Refreshed resource management and exercise/after action linkages.
CCRMC's Hazard Vulnerability Assessment	Hospital & Health Centers	Unchanged	No Comment Provided
Hospital Policy for Follow-Up Actions After a Patient Assaults Someone	Hospital & Health Centers	Revised	Added all changes to create a hospital wide policy instead of psychiatric area specific.
Policy for Accepting Patient Transfers from Outside Facilities and Referrals from Contra Costa Health Centers	Hospital & Health Centers	Revised	Removed a patient transferred over cannot have cardiac monitoring, added in a couple more things around stability (must have midline or central line for pressors and be on stable amount, must be stable on BiPAP with a blood gas prior to transfer)

Title	Area	Revised?	Summary of Changes
Policy for Code Silver: Person with a Weapon	Hospital & Health Centers	Revised	<ol style="list-style-type: none"> 1. Grammar and sentence structure revised in the opening policy statement paragraphs. 2. Youth Stabilization Unit added as a Martinez campus facility in the policy statement and guidelines. 3. "If needed" added to Guideline A.1.d. 4. E and F merged to just E in Guideline A.5.d.ii 5. Guideline A.5.d.ii(G) changed to (F) and "Use cover" replaced "Provide" 6. Guideline A.5.d.ii(H) changed to (G) and "Do not" replaced "Not" 7. iv. and v. merged to just iv. in Guideline A.5.f. 8. "With lethal force or through hostage negotiation techniques" and "such as the Sheriff's Office SWAT Team..." removed from Guideline A.5.g.vi. 9. E and F merged to just E in Guideline B.3.d.ii 10. Guideline B.3.d.ii(G) changed to (F) and "Use cover" replaced "Provide" 11. Guideline B.3.d.ii(H) changed to (G) and "Do not" replaced "Not" 12. "such as the Sheriff's Office SWAT Team..." removed from Guideline B.3.g.vi
Policy for Patient Grievance/Complaint Process	Hospital & Health Centers	Revised	No content change. Removed old links to iSite. Attached current grievance form.

REGISTRATION/WAITING AREAS

KEY= USE #1 FOR YES, NO AND/OR N/A

#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
1	Emergency evacuation routes are posted				
	ELECTRICAL				
2	Waiting areas and other areas where children may frequently be present contain childproof electrical sockets				
3	Walkways are free of clutter/equipment				
4	There are no extension cords in use				
5	All areas have flashlights in working order				
	ENVIRONMENTAL/OTHER				
6	"Welcome to Health Center" brochure (English/Spanish)				
7	Visit rate schedule is posted in registration and rates are current				
8	Medicare/Medi-Cal participation notices posted (English/Spanish)				
9	"Advance Directives" brochure (Multiple languages)				
10	"Information about the Interpreter services" brochure				
11	Wallet cards and Speak Up Flyers				
12	Patient Comment cards (English/Spanish)				
13	CCRMC & CCHS brochures				
14	"Language Assistance Services" information sheet is posted				
15	"Five Steps for Patients to Safer Health Care" flyers (English/Spanish) are posted in waiting areas				
16	ADA (Americans Disabilities Act) notice (English/Spanish) are posted in waiting areas				
17	Prostate & Breast Cancer notices (English/Spanish) are posted				
18	No hand written signs are taped to walls, signage is professional and clear				
19	Floors/Carpets are clean and in good repair				
20	Waiting area furniture is properly placed and torn/broken items removed				
21	Multi-colored "Emergency Action Plan" flipchart is visibly available in all work areas				
22	All staff wearing ID badges				
23	Registration areas have a designated area for proper disposal/pick up of discarded stickers				
24	Computer monitor either have privacy screens or are positioned in a way that patient specific information is not visible to the public				
25	Patient education material display is present in waiting areas				
26	All areas of clinic are clean, organized and clutter free				
27	Bulletin boards are neat and orderly and any posted policies are current				
28	Website address to MSDS icon is on all PCs				
	INFECTION CONTROL				
29	There are no shared children's play toys present in the health center				
30	Drinking fountains are operational				
31	Bathrooms are clean and in good repair				

	TOTAL	0	0	0	
	PERCENTAGE	#DIV/0!			

REVISED 2/2021

CONTRA COSTA REGIONAL MEDICAL CENTER HOSPITAL AND HEALTH CENTERS		AC NURSING POLICY NO:3037-F ADDENDUM F			
<u>ADMINISTRATION RECORD KEEPING CHECKLIST</u>		KEY= USE #1 FOR YES, NO AND/OR N/A			
#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
1	Documentation of quarterly fire drills is complete				
2	Documentation of safety inspections every six months is complete				
3	Last fire inspection was within last 12 months and certificate is readily available				
	ENVIRONMENTAL/OTHER				
4	Ensure CCRMC license is posted and current (if applicable)				
5	Ensure Clinical and Public Health Laboratory registration and CLIA License is posted and current				
6	Ensure Hazardous Materials Permit to Operate is posted and current (if applicable)				
7	Ensure Environmental Permit to Operate is posted and current (if applicable)				
8	Ensure individual Lab licenses (copy okay) are posted for Laboratory draw stations and units (if applicable)				
9	A copy of Hospital & Health Center Policy & Procedure Manuals are present				
10	A copy of Ambulatory Care Policy & Procedure Manual is present				
11	A copy of CCHP Provider Manual is present				
12	A copy of Infection Control Manual is present				
13	MSDS binder is present and current				
14	Point of Care Procedure Manual is present				
15	After hours messages on main phone line to health center is working and accurate				
16	All health centers have staff complete asbestos notification form and it is available and organized in Personnel records (if applicable)				
17	Personnel Files (including those for contract and temporary employees are complete with):				
	*Current Licensure, if applicable				
	*Job Description				
	*Orientation documentation				
	*Competency assessment				
	Ongoing training and education, including				
	*SICR				

	*Harassment Prevention/Discrimination				
	*HIPPA				
	*Workplace Violence				
	*Professional Development Transcript				
18	Sterile Processing Department procedure is available online				
19	Signature sheets in manual current (updated every 3 years)				
TOTAL		0	0	0	
PERCENTAGES		#DIV/0!			

CLINICAL AREAS

#	Items to Inspect/Review	Compliant	
		Yes	No
1	All telephones in clinic suites contain current California Poison Control stickers with phone number (To order, call 1800-582-3387)		
2	Bulletin boards in nursing suites are neat and orderly and any posted policies are current		
3	Multi-colored "Emergency Action Plan" flip chart visibly available in all work areas		
4	Website address to MSDS On-line is visibly available to all staff at all PCs		
5	Code yellow report forms are available at all workstations		
6	All staff are wearing ID badges that have 18-point type		
7	Patient identifiable information is properly disposed in recycle paper containers labeled "SHRED" and not in regular recycle bag		
8	Computer monitors either have privacy screens or are positioned in a way that patient specific information is not visible to the public		
9	Original licenses of Laboratory staff and Diagnostic Imaging staff are posted and are current		
10	Emergency evacuation routes are posted		
11	The view of all exit signs is not obstructed		
12	If emergency exit signs are lighted, lights are working		
13	All door stops are removed		
14	All areas have flashlights in working order		
15	Fire extinguishers have clear unobstructed access		
16	Fire extinguisher inspection monthly sign off is current and the extinguisher safety seal is intact		
17	There are no extension cords in use		
18	Nothing is stored under sink cabinets		
19	Back door entrances not intended for public use are locked from the outside to ensure security of staff-only areas; however, emergency exiting is allowed		
20	All areas of clinic are clean, organized and clutter free		
21	No hand written signs are taped to walls; signage is professional and clear		
22	Bathrooms are clean		
23	Floors are clean and in good repair		
24	Dirty linen hampers are closed/covered		
25	Biological/medical waste is disposed in appropriate biohazard container		
26	Biomedical waste posters are displayed in appropriate areas		
27	Storage areas do not have boxes on the floor or piled within 18" of a sprinkler head		
28	Interior hallways have at least 44" clearance and items in the hallway are only on one side		

#	Items to Inspect/Review	Compliant	
		Yes	No
29	Walkways are free of clutter/equipment		
30	Freestanding shelves and cabinets are secured to wall		
31	Shelving has a “lip” to prevent spillage during an earthquake (for applicable storage materials)		
32	Hospital & Health Center Policy & Procedure Manuals are present		
33	Ambulatory Care Policy & Procedure Manual is present		
34	CCHP Provider Manual is present		
35	Infection Control Manual is present		
36	MSDS binder is present and current		
37	In dental areas, exposure plan is available		
38	Locked biohazard storage areas contain only biohazard material		
39	Point of Care Procedure Manual is present		
40	Refrigerator temperature logs are completed daily and temperature is maintained at 35 ⁰ to 46 ⁰ Celsius		
41	Freezer temperature logs are completed daily and temperature is maintained between 0 ⁰ – 5 ⁰ Celsius		
42	Crash carts/emergency medication storage:		
	• Checklist is present and inspection is documented daily on log		
	• O ₂ /suction and internal inspection of cart monthly is documented		
	• E –tanks are turned on and amount recorded every month.		
43	All staff can assemble laryngoscope correctly and easily		
44	There are no outdated drugs, culture tubes, blood tubes, guiac kit, KY jelly, KOH, NS, sterile equipment, etc. (Remember <u>every</u> drawer and cabinet may be inspected)		
45	All opened multi-dose injectables are dated and signed when opened; Expiration date is current and not more than 90 days since open date		
46	Internal and external drugs and lab reagents are separated		
47	• Medication refrigerators contain only medications or lab reagents (stored in seal container)		
	• No food or specimens are present		
	• Medication refrigerator is locked or in a secure area		
48	Clean and dirty items are not stored in the same room		
49	Autoclave sterility tests are done and documented (Dental and Central Supply) and procedure is present. Documentation includes:		
	• Date, time and operation of each run		
	• Dates and results of sterilizer calibration		
	• Results of routine spore testing at least monthly		
50	Protective clothing and equipment (e.g. gloves, goggles, masks, etc.) are readily available and staff is aware of location		
51	Surgical instruments are not stored in examination rooms		
52	All syringes and medications are secured when nurse is not present		

EMPLOYEE ONLY AREAS		KEY= USE #1 FOR YES, NO AND/OR N/A			
#	ITEMS TO INSPECT/REVIEW	COMPLIANT			
		YES	NO	N/A	ACTION
	ELECTRICAL				
1	If emergency exit signs are lighted, lights are working				
2	There are no extension cords in use				
	EXITS/MECHANICAL AREAS/FIRE PROTECTION				
3	Interior hallways have at least 44" clearance and items in the hallway are only on one side				
4	All door stops are removed				
5	Nothing is stored under sink cabinets				
6	Walkways are free of clutter/equipment				
7	Storage areas do not have boxes on the floor or piled within 18" of a sprinkler head				
8	Fire extinguisher inspection is current and the extinguisher safety seal is intact				
9	Fire extinguisher have clear unobstructed access				
10	The view of all exit signs are not obstructed				
11	Back door entrances not intended for public use are locked from the outside to ensure security of staff-only areas; however, emergency exiting is allowed				
	ENVIRONMENT/OTHER				
12	Employee posting included in the Annual Labor Law posters:				
	<u>Safety</u>				
	* Workers' Compensation Notice to Employees (AK-230)				
	*CAL OSHA Safety and Health on the Job				
	*Emergency poster				
	*Emergency action plan				
	<u>Personnel</u>				
	*Drug Free Workplace				
	*Harassment prevention				
	*Unemployment insurance/disability notification				
	<u>Affirmative Action</u>				
	*EEOC Discrimination (DFEH-162)				
	*American Disability Act				
13	Emergency evacuation routes are posted				
14	Multi-colored "Emergency Action Plan" flip chart visibly available in all work areas				

15	Freestanding shelves and cabinets are secured to walls				
16	Floors/Carpets are clean and in good repair.				
17	All areas of clinic are clean, organized, and clutter free				
18	No hand written signs are taped to walls, signage is professional and clear				
19	Shelving has a "lip" to prevent spillage during an earthquake (for applicable storage materials)				
	INFECTION CONTROL				
20	Supplies of toilet paper and paper towels are not stored in "dirty" housekeeping closet				
21	Drinking fountains are operational and in good repair.				
22	Bathroom are clean and in good repair				
	TOTAL	0	0	0	
	PERCENTAGE	#DIV/0!			

REVISED 2/2021

BI-ANNUAL SAFETY INSPECTION - EOC - CORRECTION PLAN

Department Manager is usually considered the person responsible for follow up

Include Door Numbers, work order numbers or specific location as appropriate

PROBLEM AREA	DISCREPANCY / EXPLANATION FOR QUESTIONS ANSWERED "NO"	CORRECTIVE ACTION	TARGET DATE	DATE COMPLETED	PERSON RESPONSIBLE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
PROBLEM AREA	DISCREPANCY / EXPLANATION FOR QUESTIONS ANSWERED "NO"	CORRECTIVE ACTION	TARGET DATE	DATE COMPLETED	PERSON RESPONSIBLE
16					
17					
18					
19					

20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						



Origination 01/2019
 Last Approved N/A
 Effective Upon Approval
 Last Revised 01/2026
 Next Review 3 years after approval

Owner Swandi Singh:
 Facilities Manager
 Area Facilities Management

Policy for Utility Emergency Repair Service Contacts

POLICY STATEMENT:

It is the policy of CCRMC and Health Centers to have trained personnel on duty 24 hours per day. These personnel, although very qualified, may not have the expertise to handle all problems for all occasions. The contacts listed below will be utilized for emergency back up and response.

Utility System or Emergency	Contact	Contact Number	
Fire Department	CCC Fire	911 for emergency otherwise 925-941-3300	
CCC Sheriff Deputy	Lt Adalberto Garibay	911 for emergency otherwise 925-383-2367	
Gas Company	PGE	1800-743-5000	
Water Company	City of Martinez Water Dept.	925-372-3575	
<u>Water Company</u>	<u>City of Martinez Water Dept.</u>	<u>Corporate Yard: M-F 0700 - 1530 925-372-3580 After Hours Police Dispatch 925-372-3440 Dirty Water - TX Plant 925-372-3588</u>	
Electricity	PGE	1800-743-5000	
Plumbing	Matrix	925-914-1563 925-459-9200	

A/C & Refrigeration	Matrix	925-914-1563 925-459-9200	
HVAC	Matrix	925-914-1563 925-459-9200	
Fire Alarm Monitoring	Denalect	925-932-2211	
Fire Detection & Notification System	SureFire	510-490-7873	
Fire Extinguisher Service	Battalion One	510-653-8075	Silicon Valley Fire 408-841-9700
Boilers and Associated Equipment	CalDiesel	1866-468-7697	
Bulk Oxygen Delivery System	LindeGas (Praxair)	925-427-3900	
Telephone	ATT	800-288-2020	
Telecommunications	DOIT	925-370-5470	
Medical/Surgical Vacuum or Compressed Air Systems	CYA Carsten Lunde	510-520-6605	
Communication System	ESS	925-370-5470	
Nurse Call System	Comtel	408-543-5600	
Other			

REFERENCES:

TJC EC 02.05.05

APPROVALS:

CCRMC Chiefs: 10/24/2024

Joint Conference Committee: 11/14/2024

Approval Signatures

Step Description	Approver	Date
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Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	02/2026
	Swandi Singh: Facilities Manager	02/2026

Standards

No standards are associated with this document



Origination 01/2026
 Last Approved N/A
 Effective Upon Approval
 Last Revised 01/2026
 Next Review 3 years after approval

Owner Rick Ortiz: Chief of Plant Operations CPO
 Area Hospital & Health Centers

CCRMC's Continuity of Operations Plan (COOP)

Scope

This Continuity of Operations Plan ("COOP") applies to Contra Costa Regional Medical Center and Health Centers, herein referred to as "CCRMC & HCs" and includes the following Locations:

Contra Costa Regional Medical Center 2500 Alhambra Avenue Martinez, CA 94553	Antioch Health Center 2335 Country Hills Drive Antioch, CA 94509	Brentwood Health Center 171 Sand Creek Road Brentwood, CA 94513 Bay Point Health Center 215 Pacifica Avenue Bay Point, CA 94565		
Brentwood Health Center 171 Sand Creek Road Brentwood, CA 94513	Concord Health Center 3052 Willow Pass Road Concord, CA 94519	Martinez Health Center 2500 Alhambra Avenue Martinez, CA 94553	Miller Wellness Center 25 Allen Street Martinez, CA 94553	Concord Health Center, Building 2 3024 Willow Pass Road Concord, CA 94519
Martinez Health Center 2500 Alhambra Avenue Martinez, CA 94553	Miller Wellness Center 25 Allen Street Martinez, CA	North Richmond Health Center 1501 Fred Jackson Way Richmond, CA 94801		

	94553		
North Richmond Health Center 1501 Fred Jackson Way Richmond, CA 94801	Pittsburg Health Center 2311 Loveridge Road Pittsburg, CA 94565	West County Health Center 13601 San Pablo Ave. Avenue San Pablo CA 94806	

Mission Critical Services

Contra Costa Regional Medical Center and Health Centers consider the following services to be "mission critical." During an emergency event or disaster these services will be provided for continuity of operations:

<ul style="list-style-type: none"> • Emergency Department • Psychiatry Services • Medical/ Surgical • Critical Care • Labor & Delivery • Surgical Services • Imaging • Pharmacy • Laboratory 	<ul style="list-style-type: none"> • Food Services • Sterile Processing • Security • Environmental Services • Communications Operators • Health Information Management • Biomedical Engineering • Supply Chain
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Succession and Delegation of Authority

During an emergency, key leaders may not be available to carry out their duties for a variety of reasons. Regardless of the reason, a succession plan has been developed that list who may replace key leaders during an emergency when they are not available. Additionally, for each key position, a delegation of authority plan describes the decisions and policies that can be implemented by authorized successors. The criteria for activation of the succession and delegation of authority plan for any particular leader are:

- the key leader is currently unavailable to carry out their duties, and
- the Incident Commander (IC) determines, in the interest of continuity of operations, the role needs to be filled.

The Incident Commander shall authorize activation of the succession and delegation of authority plan for each applicable key leader listed below.

Chief Executive Officer (CEO)

Upon authorization of the IC, the following individuals, in descending line of succession and availability, may be designated to act on behalf of the Chief Executive Officer (CEO) in the event of absence or vacancy.

1. Chief Nursing Officer
2. Chief Medical Officer

Once authorized, authority is delegated to carry out the following decisions and policies:

- Manage the overall daily operations and resources of the hospital and clinics
- Review and execute contracts related to the emergency event.

Chief Medical Officer (CMO)

Upon authorization of the IC, the following individuals, in descending line of succession and availability, may be designated to act on behalf of the Chief Medical Officer (CMO) in the event of absence or vacancy.

1. Hospital Medical Director
2. Specialty Care Medical Director
3. Medical Staff President

Once authorized, authority is delegated to carry out the following decisions and policies:

- Oversee and coordinate all activities related to the hospital and ambulatory medical staff.
- Develop, implement, and evaluate patient safety measures related to the emergency event.

Chief Nursing Officer (CNO)

Upon authorization of the IC, the following individuals, in descending line of succession and availability, may be designated to act on behalf of the Chief Nursing Officer (CNO) in the event of absence or vacancy.

1. Director of Nursing, Inpatient Services
2. Director of Nursing, Ambulatory Services
3. Director of Nursing, Infection Prevention and Control

Once authorized, authority is delegated to carry out the following decisions and policies:

- Oversee and coordinate the hospital and clinic nursing and ancillary departments and daily operations.
- Serve as the primary spokesperson for nurses and ancillary staff
- Act as the primary liaison between nurses and physicians.

Chief Operations Officer (COO)

Upon authorization of the IC, the following individuals, in descending line of succession and availability, may be designated to act on behalf of the Chief Operations Officer (COO) in the event of absence or vacancy.

~~1. Materials Management Manager~~

1. Chief of Plant Operations

Once authorized, authority is delegated to carry out the following decisions and policies:

- Oversee and coordinate the hospital and health center's supply chain departments.

Chief of Plant Operations (CPO)

1. Facilities Manager

Once authorized, authority is delegated to carry out the following decisions and policies:

- Oversee and coordinate the hospital and health center's facilities departments and daily operations
- Oversee and coordinate the hospital and health center's supply chain departments.

Incident Commander (IC)

When the incumbent incident commander is no longer able to fulfill incident command duties, they shall hand off incident command responsibilities to another associate of their choosing.

In the event the incident commander has not appointed a successor when they are no longer available, the Order of Succession below shall apply.

The order for succession for the incident commander is:

- a. The Chief Executive Officer, then
- b. The Hospital Medical Director
- c. The Chief Nursing Officer
- d. The Chief Medical Officer
- e. The Chief Operations Officer
- f. The Director of Nursing
- g. The House Supervisor
- h. The most senior manager available if all others in the succession list are unavailable.

Guiding Principles

1. Protect all individuals onsite	<ul style="list-style-type: none">• Identify incident health and safety hazard(s)• Establish site control (hot zone, warm zone, cold zone,
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	<p>and security)</p> <ul style="list-style-type: none"> • Consider evacuations, as needed • Develop an Incident Action Plan (IAP) • Develop site safety and health plan for response hospital employees using HICS form 215A • Ensure safety briefings are conducted • Protect the safety of patients, hospital employees, visitors, vendors, and Response Personnel
1. Maintain mission critical service	<ul style="list-style-type: none"> • Identify services interruption and potential operational interruption issues • Assist with internal/external investigations • Activate operations continuity plan
1. Manage coordinated response effort	<ul style="list-style-type: none"> • Complete or confirm notifications and provide updates as required • Develop a communication plan • Establish a unified command structure • Initiate emergency response Incident Action Plans (IAP) • Ensure mobilization and tracking of response resources & hospital employees • Complete documentation • Evaluate planned response objectives vs. actual response (debrief) • Coordinate response activities with the county, as applicable
1. Minimize economic impacts	<ul style="list-style-type: none"> • Maintain situational awareness of CCRMC & HCs and local economic impacts throughout response • Consider additional financial impacts to hospital employees and the community • Document expense activities
1. Keep the public informed of response activities	<ul style="list-style-type: none"> • Press and media inquiries should be directed to the Public Information Officer.

Managing Patient Clinical and Support Activities

Upon activation of the Emergency Operations Plan and throughout the duration of the disaster, the hospital Incident Commander (IC) will implement processes necessary to safely and adequately manage patient care and clinical support including patient surge, scheduling, treatment, transfer/evacuation, and management of decedents. The IC can access the county Medical Health Operational Area Coordinator (MHOAC) to assist with transfers and transportation resources. In addition, the county MHOAC can assist with supplies.

If the disaster results in a surge of patients to the Emergency Room, Contra Costa Regional Medical Center will activate its surge plan, which includes procedures for setting up additional triage and treatment areas. The surge plan includes utilizing emergency tents and other areas available in the hospital and campus (i.e., cafeteria, hallways, lobby waiting rooms, etc.) to accommodate a sudden influx of patients.

Based on the number of patients, acuity, and hospital capacity, the IC may request additional support from the MHOAC, including transfer assistance and alternative care sites. The Incident Commander will notify the Contra Costa County Emergency Services Administrator of the day.

The Incident Management Team will consider curtailing current operations in the Miller Wellness Center and/or the Martinez Health Center (e.g., cancelling scheduled appointments) based on a case-specific evaluation if additional space and staff are needed.

The Miller Wellness Center and/or Martinez Health Center will be considered as a site for the medical screening and stabilization for ESI category 4, and 5 patients. It may also be used for "vertical" ESI 3 patients (ESI 3 patients who do not require a gurney for the purpose of medical screening).

Depending on the nature, scope, and duration of the emergency, non-urgent tests, procedures, diagnostic studies, and care appointments may need to be delayed or canceled. When possible, patients should be notified of any delay or cancellation and when routine service is expected to resume. A record should be maintained of any cancellations so that patients can be contacted at the conclusion of the emergency for rescheduling of tests and/or procedures.

Clinical Records

Patient information includes the current location of admitted or registered individuals, as well as the status and destination of those who have been discharged or transferred. The destination of transferred patients will also be recorded. In the event that the electronic medical record is not available, "downtime" paper forms will be used to capture all required information.

Vital information (e.g., patient identifying information, status, disposition) and scanned copies of the paper portions of the record will be entered into the electronic record once it comes back online. The timing of this "updating" of the electronic medical record will vary depending on the status of hospital and medical records operations.

Information may be shared with other providers, family, and other represented as governed by the organization's HIPAA/Security of Information policy.

Pharmaceuticals

The Hospital maintains memoranda of understanding with pharmaceutical suppliers to replenish pharmaceutical supplies and equipment. The Hospital also has access to local, state and federal stockpiles of pharmaceuticals, which is moderated by the Contra Costa County Emergency Services Department. Once notified of any supply chain disruption, the hospital will begin stockpiling resources to supplement any on allocation or shortages until resolved.

Patient Transportation

The Logistics Section is responsible for implementing existing provisions for the transport of patients to other locations or institutions, including the tracking of patient-specific transport information to facilitate patient tracking. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer.

Managing Safety and Security

The nature of the disaster may require the Incident Commander (IC) to alter existing policies and procedures to protect the patients, hospital staff personnel, providers, and visitors, and may necessitate additional safety and security measures. Upon activation of the EOP, a damage assessment and safety analysis will be conducted to identify actions required and what additional resources are needed. Depending upon the threat, the IC may obtain additional resources from local law enforcement, local public health department, and contracted security services. The IC, or Operations Section Chief, will coordinate with building owners at leased property to ensure site access if applicable.

Safety Officer

The safety officer or their designee, under the direction of the Incident Commander, shall be responsible for identifying and investigating environmental hazards that may arise during the emergency event. They are responsible for taking steps to ensure that such safety risks are mitigated and, to the extent possible, abated.

Campus Security

Contra Costa Regional Medical Center has a team of co-located county sheriff deputies, sergeants, and a Lieutenant who serves as the campus Chief of Security. This collaboration ensures quick response and activation of additional security resources when needed. Additionally, CCRMC may request support from external entities, such as:

- Local Law Enforcement / CHP: Law Enforcement may be needed to assist with security management. This could include bomb threats, active shooters, infant abductions, civil unrest, and terrorist activities. Law enforcement agencies include local police departments, county sheriff departments and/or California Highway Patrol (CHP).
- Federal Bureau of Investigation (FBI): The FBI is the lead investigative agency during a

terrorism or WMD event. www.fbi.gov

- California Department of Public Health (CDPH): CDPH is the lead agency in responding to a Biological and Radiological terrorism event. CDPH will coordinate all hospital issues and be ready to provide epidemiological and environmental health support as requested to Local Health Departments. <http://www.cdph.ca.gov>
- Local Fire Departments / CalFire: Local Fire Departments / CalFire can assist with evacuation of patients under the direction of the Hospital Incident Commander. They can extinguish fires, disperse noxious fumes and smoke, support patient decontamination and help to secure building safety.

During an incident, campus security is responsible for securing the campus to ensure emergency personnel have adequate space to provide care and maintain patient and staff safety. They may also consider the following:

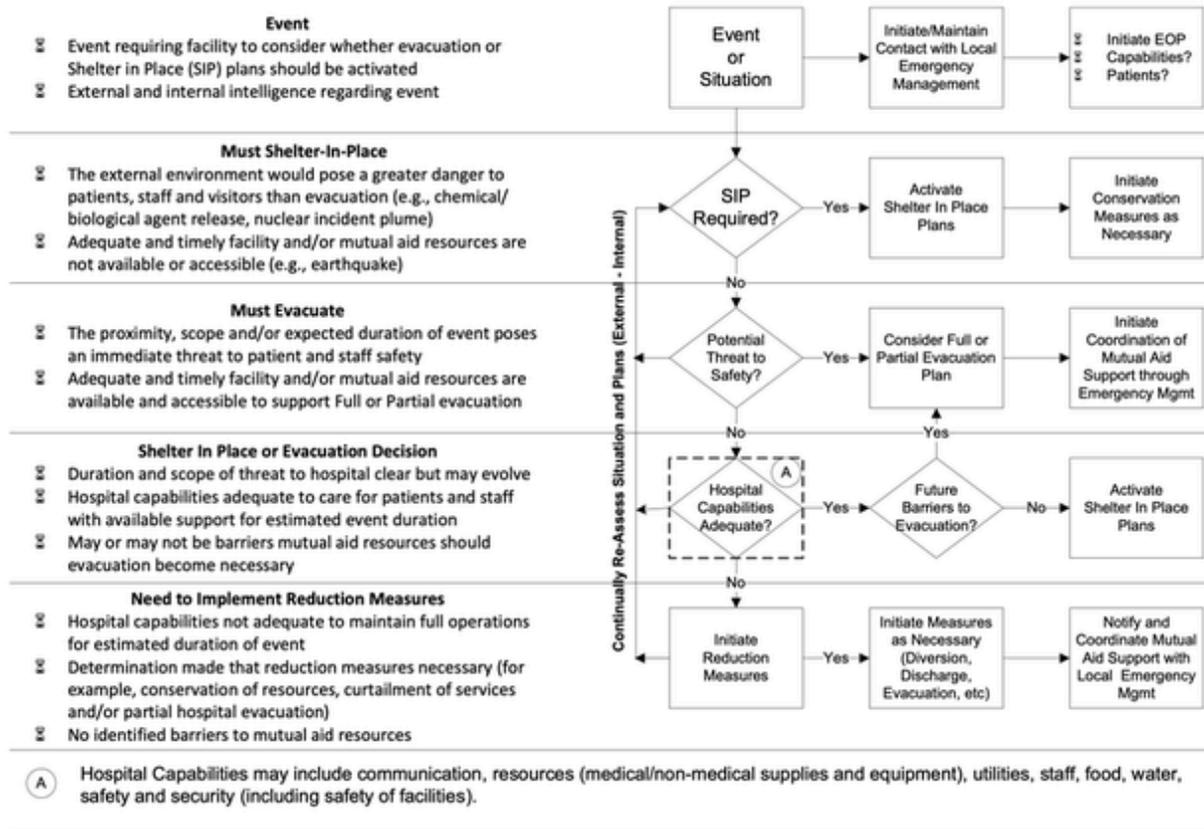
- Close off the parking lot to non-ambulance vehicular traffic.
- Expand security parameter to include Miller Wellness Center
- Restrict access to Miller Wellness Center
- Close other hospital entrances

Whenever multiple law enforcement agencies are involved, the hospital may participate in Unified Command (UC) to ensure the needs and goals of the hospital, agencies and other organizations are represented.

Evacuation and Shelter-In-Place

Given the complex nature of hospital evacuation, the preferred protective action is to shelter-in-place. If a shelter-in-place order is ordered by the Incident Commander (IC), the Incident Management Team (IMT) will establish areas that are safe and adequate for hospital staff personnel, patients, and visitors to remain. Considerations should be given to isolating the heating and cooling systems, expected term of sheltering (food, water, restrooms, etc.), security of premises, and medical needs of hospital staff personnel. When shelter-in-place is not viable, evacuation of part or all the hospital building may be ordered by the IC or fire department. The evacuation process will be methodically coordinated by the IMT. All Hospital Staff Personnel are trained in evacuation and emergency response procedures.

The following decision tree (developed by the California Hospital Association) may be used to guide this decision. The plan should include provisions for tracking and communication when sheltering in place.



Information Accompanying an Evacuated Patient

Preferably, a printed Patient Summary will accompany each evacuated patient. If it's not possible to print the summary, at a minimum the following information will accompany each evacuated patient as they are transported to an alternate care site:

- The patient's name, age, and date of birth
- The patient's reason for admission and medical diagnosis
- Known allergies and blood type
- List of current medications
- Any advanced directives
- Names and contact information for next of kin and emergency contacts

Alternative Care Sites

If additional space is needed for caring for patients, the Incident Commander (IC) will contact the Emergency Operations Center (EOC) to request support for Alternative Care Sites. These may include designated areas on campus, other hospitals, or other designated sites by the county Emergency Operations Center (EOC). Depending on the scope of need, the command center personnel will coordinate transfers to Alternative Care Sites and track all patient discharges to help with repatriation and reunification when the event is concluded.

Mortuary Services

Provisions for overflow mortuary services will be coordinated with the Contra Costa County Emergency Operations Center. Unidentified deceased individuals shall be referred to the County Coroner's office as prescribed in hospital policy.

Acquiring Additional Hospital Staff Personnel Members

Emergency Staffing

Department managers are responsible for keeping the department staff emergency contact lists current and accurate.

Practitioners

Physicians and other Licensed Practitioners eligible for Medical Staff Privileges shall be processed through the Medical Staff Office according to existing policies and procedures, which allow for volunteer privileges and emergency processing of new privileges.

Associates

Non-privileged associates shall be processed according to current Human Resources policies, which provide for the processing of volunteers during an emergency when necessary.

Disaster Service Workers

Government Code 3101 specifically identifies all public employees as disaster service workers, which includes all public employees and all volunteers in any disaster council or emergency organization accredited by the Office of Emergency Services. The term "public employee" includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed. After securing their family and home, employee will:

- Call the Emergency Hotline (1-866-946-9911) for reporting information and instructions.
- Report to their normal worksite during normal shift.
- If unable to get to worksite during normal shift, then they will report to another CCHS site.
- If unable to report to a CCHS site, then should report to a governmental health services site in the county where located with their employee badge and inform their supervisor.

Tracking On-duty Hospital Staff Personnel and Patients

Hospital Staff Personnel on-duty at the time of the incident shall report to their immediate supervisor. Before leaving the site, all Hospital Personnel shall receive authorization from their supervisor. Supervisors are responsible for tracking Hospital Staff Personnel under their direction. Tracking of

Hospital Staff Personnel serving in an IMT role will be completed on the Section Personnel Timesheet, HICS Form 252. All IMT Hospital Staff Personnel shall check in and out on this form.

Managing Hospital Staff Personnel and Support Activities

Housing for Staff

If call in procedures for off-duty staff is activated, the Incident Command Center will identify areas or location where staff members can relax and sleep when not working.

Transportation of Staff

The Contra Costa County Department of Public Works, Fleet Services, will provide vehicles for transportation as needed during a County-wide emergency.

Mental Health Support/Stress Debriefing

The Employee Assistance Program will be available upon request to address staff needs during and following the emergency event.

Childcare for Staff Family Members

When necessary to support staffing levels, the Incident Command Center will coordinate with the Contra Costa County Emergency Operations Center.

Managing Resources and Assets

An up-to-date inventory of resources and assets shall be maintained. The inventory should be reviewed at least once each calendar year and as needed during the disaster.

Resource and asset use shall be monitored closely during a declared emergency, and current or projected shortfalls shall be communicated promptly to the Logistics Section of the Incident Command Center. All tracking details will be used for recovery efforts after the emergency is ended.

Resources and assets may be shared with or from other institutions upon approval by the Incident Commander in accordance with the Contra Costa County Mutual Aid Agreement.

The Logistics Section of the Incident Command Center will contact relevant suppliers immediately upon the identification that The Hospital's resources or assets, including pharmaceutical supplies, may be exhausted within 96 hours. The IC will escalate these issues to the county Emergency Operations Center as well to activate a regional mutual aid request if needed.

96-Hour Sustainability

Except as noted, the hospital maintains sufficient assets and resources to sustain operations for at least

96 hours without replenishment.

Management of Systems and Utilities

CCRMC has established a comprehensive utilities management program to provide a safe, controlled, and comfortable environment for patient care and all occupants of the building. Each utility system and its components have been evaluated to assure proper capacity, operational reliability, failure reductions, and risk minimization. Utilities examined and considered to be essential or critical to provide care, treatment and services include:

<ul style="list-style-type: none">• Data Exchange Systems• Communication Systems• Normal Power Systems• Emergency Power Systems• Heating Ventilation and Air Conditioning (HVAC)	<ul style="list-style-type: none">• Fire/Life Safety Systems• Domestic Water System (Potable & Industrial)• Sewer/Sanitary System• Medical Gas / Vacuum Systems• Natural Gas
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If system failure of these infrastructures go down, below are the plans:

Communications Systems:

1. Staff would use the Motorola XPR3500 Security Radios
2. The Emergency Red Phones throughout the hospital would be activated. The Red Phone activation switch is located in the Hospital first floor Telecom Room.
3. BCA computers and printers would be accessible.

Normal Power Systems:

(Reference- *Electrical Power Disruption Policy* Stat ID #16563629)

- When electrical power has been interrupted, the emergency power generator system will engage automatically to restore power to all areas of the hospital, normal power, life safety power, and critical power buses. This should take place within 10 seconds. The emergency power outlets are identified by their red color.
- MCS will notify hospital leadership
- MCS will send out staff notifications as directed by leadership.
- MCS will consult with the duty engineer
- Engineer on duty will verify generator operation and power supply to Emergency Transfer Switches.
- Engineer on duty will notify CPO, FM or FMM
- Engineer on duty will notify PGE of the outage at 800-743-5000.
- Engineer on duty will check in with Medical Center Supervisor for updates.

- Security staff will check elevators for entrapments.
- Security staff will check perimeter doors are secure.
- Nursing personnel should check to see that equipment that must continue to operate is connected to an emergency outlet.
- Nursing personnel should assess critical patient care activities, such as ventilators, anesthesia equipment, and defibrillators.
- Staff will move computers to Red outlets as needed.
- Staff will manually restart computers not backed up by UPS.
- Staff will verify Omnicell and Omnicell refrigerator operation. Reset if necessary.
- Pharmacy staff will move medication from areas where there is no emergency power to areas that are served by emergency power.
- Continue patient care operations and report any changes or concerns to the MCS. Identify patients for potential relocation and/or evacuation, if determined by the MCS.
- Engineering department will notify the MCS when normal power has been restored.

Recovery:

- Once the ALL CLEAR has been notified, the following should occur:
- Evaluate building systems for normal operations.
- Evaluate patient for status and relocated normal power outlet usage to normal.
- Inspect generators for operations.
- Verify air handlers and HVAC has been restored to normal.
- Refill fuel day tanks, if necessary.
- All equipment and/or supplies used during the failure should be accounted for restocked or reordered depending on their status.

Emergency Power Systems:

(Reference- Electrical Power Disruption PolicyStat ID #16563629, Utility System Failure and Emergency Response PolicyStat ID #16563637, Emergency Operations Plan)

- The hospital is equipped with two backup generators. When electrical power has been interrupted, the main emergency power generator system will engage automatically to restore power to all areas of the hospital, normal power, life safety power, and critical power buses. This should take place within 10 seconds. The emergency power outlets are identified by their red color.
- If the main generator fails, the secondary generator will engage.
- MCS will notify leadership of power failure.
- Leadership will determine if Incident Command Center should be activated.
- Fire Department should be notified.
- If there is a partial loss of power with no emergency power available, using emergency flashlights staff should begin manually ventilating patients, regulate IV's, and begin evacuating

patients to areas with power.

- If the entire facility has lost power which is not returning, under the direction of the Incident Commander, a full hospital evacuation will be initiated, and patient transfer process will begin.

Heating Ventilation and Air Conditioning (HVAC):

(Reference – Hospital and HC PolicyStat ID #16563720 Utility Disruption HVAC Failure; TJC EOC 02.05.01 EP10, 11, 12, 13)

- Engineering department will notify the HVAC vendor's 24-hour Emergency phone number for loss heating or cooling, if unable to repair or determine cause of failure.
- Engineering department will notify the MCS of heating or cooling failure and time frame for repair.
- Nursing personnel should check to see that patients are comfortable with loss of heat and determine needs. Isolation Patients will be transferred to another negative flow area or use portable isolation units.
- Material Management will distribute blankets and supplies as needed.
- Engineering department will notify the MCS when HVAC has been restored.

Recovery:

- Once the ALL CLEAR has been notified, the following should occur:
- Verify air handlers and HVAC has been restored to normal operations.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Fire/Life Safety Systems:

(Reference - Interim Life Safety Measures PolicyStat ID #16563728; Utility System Failure & Emergency Response FM PolicyStat ID #16563637; TJC Elements of Performance for LS.01.02.01)

- Engineering will assess the issue and notify the Medical Center Supervisor or Incident Commander of the system failure.
- Communications will make an overhead announcement that the Code Red System is out of service, and staff are to dial 222 in the event of a fire.
- The Interim Life Safety measures (ILSM) will be implemented.
- When the fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building, then Fire Watch will be initiated using FM PolicyStat ID #16563728, Att. 440E.
- In the event of a fire during the system failure, staff will begin evacuation procedures if deemed necessary.
- Communications will make an overhead announcement to notify all departments of fire and location.

Domestic Water System (Potable & Industrial):

(Reference PolicyStat ID #16563590 Utility Disruption Sewer & Water Failure; CCRMC Water Rationing Plan 11/24/2024; Hot Water Shutdown)

A. System Failure:

1. When staff discovers a failure, Engineering or the Switchboard Operator should be contacted.
2. Engineering will assess the extent of the failure and notify the Medical Center Supervisor or Incident Commander of the failure. Engineering will notify the affected department and will also contact the local water department for immediate assistance if loss is from an outside source.
3. Nursing personnel would observe restrictions to limit the use of water in caring for patients; limit flushing commodes, with physicians' approval substitute juices for forced fluids, limit changes of bed linen, etc.
4. Materials Management would provide disinfectant wet wipes, alcohol-based hand gels, dry shampoo and cleaners for cleaning patients and any additional materials, if needed.
5. Environmental Services will provide bags so the bathroom facilities can be utilized by bagging the toilets for usage. Used bags will be disposed of in biohazard bags by staff and Environmental Services round for biohazard bag removal.
6. EVS staff will post "Out of Order" signs on public and employee restroom doors that have been closed. Portable toilets will be used by employees and visitors. Signage will be placed in the hallways as to the location of the portable toilets.
7. Drinking water will be made available through the use of bottled water obtained by contacting the EVS and Materials Management Department. Backup meal plans will be determined during event.
8. Surgery and Endoscopy/GI areas will determine caseloads and will suspend all disinfecting and sterile processing procedures. Account for packs and decontaminate with potable water or place contaminated instruments into biohazard bags until water returns.
9. Dialysis will be shut down and patients rescheduled or transferred when reserved water is low. If the water is lost during procedure, follow the protocol to hand pump the machines and return the patients' blood.
10. Engineering will determine if audible house fire alarm needs to be disabled to prevent a false flow switch alarm, due to loss of water.

B. Response for flooding:

1. Determine and isolate water lines or cause of flooding. Conduct risk assessment to determine hazards and response.
2. Remove all individuals and equipment within the area of flooding. If hazards exist, any exposures to staff, patient or visitors will be medically evaluated.
3. Staff will be assembled to begin clean-up of the area affected. Equipment, such as

fans, floor/carpet extractors, wet vacuums, mops, towels, will be potentially used. PPE will be utilized while cleanup occurs.

4. Call vendor/contractor for response to flooding.
5. Engineering will determine if audible house fire alarm needs to be disabled to prevent a false flow switch alarm, if sprinkler head has been disabled. Perform ILSM Assessment and Measures.
6. Begin drying the walls and floors. After 24 hours, determine wicking of walls with moisture meter. If determined, that walls or floors need to be removed and replaced, a construction project will be opened for the area.

Recovery:

1. Replenish any stores of water, oil dry, or other stock used during the emergency. Clean equipment used during event.
2. Once water has been restored, the following must be done:
 - Check the domestic water lines for shocks that have been blown.
 - Check function of all RO and filtration systems. Change filters and cartridges in systems.
 - Flush toilets, sinks, water fountains, coffee makers, ice machines, and Y-strainers and test systems for proper working order.
 - Manual reset on hot water heaters.
 - Continue construction or renovation of areas damaged from excessive water or loss of water.
 - Bottled water will be continued for minimum of 24 hours. Before restriction is lifted, Risk Management and Infection Control will conduct testing of water quality. Upon approval and after testing indicates safe to drink, will announce a lift of water restrictions.

Sewer/Sanitary System:

(Reference Utility Disruption Sewer and Water Failure Hosp and HC PolicyStat ID #16563590)

- When staff discovers a failure, Engineering or the Switchboard Operator should be contacted.
- Engineering will assess the extent of the failure and notify the MCS or Incident Commander of the failure. Engineering will notify the affected department and will also contact the local water department for immediate assistance if loss is from an outside source.
- Nursing personnel would observe restrictions to limit the use of water in caring for patients; limit flushing commodes, with physicians' approval substitute juices for forced fluids, limit changes of bed linen, etc.
- Materials Management would provide disinfectant wet wipes, alcohol-based hand gels, dry shampoo and cleaners for cleaning patients and any additional materials, if needed.
- Environmental Services will provide bags so the bathroom facilities can be utilized by bagging the toilets for usage. Used bags will be disposed of in biohazard bags by staff and Environmental Services round for biohazard bag removal.
- EVS staff will post "Out of Order" signs on public and employee restroom doors that have been

closed. Portable toilets will be used by employees and visitors. Signage will be placed in the hallways as to the location of the portable toilets.

- Drinking water will be made available through the use of bottled water obtained by contacting the EVS and Materials Management Departments. Backup meal plans will be determined during event.
- Surgery and Endoscopy/GI areas will determine caseloads and will suspend all disinfecting and sterile processing procedures. Account for packs and decontaminate with potable water or place contaminated instruments into biohazard bags until water returns.
- Dialysis will be shut down and patients rescheduled or transferred when reserved water is low. If the water is lost during procedure, follow the protocol to hand pump the machines and return the patients' blood.
- Engineering will determine if audible house fire alarm needs to be disabled to prevent a false flow switch alarm, due to loss of water.

Recovery:

1. Replenish any stores of water, oil dry, or other stock used during the emergency. Clean equipment used during event.
2. Once water has been restored, the following must be done:
 - Check the status of the domestic water lines for shocks that have been blown.
 - Check function of all RO and filtration systems. Change filters and cartridges in systems.
 - Flush toilets, sinks, water fountains, coffee makers, ice machines, and Y-strainers and test systems for proper working order.
 - Manual reset on hot water heaters.
 - Continue construction or renovation of areas damaged from excessive water or loss of water.
 - Bottled water will be continued for minimum of 24 hours. Before restriction is lifted, Risk Management and Infection Control will conduct testing of water quality. Upon approval and after testing indicates safe to drink, will announce a lift of water restrictions.

Medical Gas / Vacuum Systems:

(Reference-Utility Disruption Medical Gas Failure PolicyStat ID #16563696, Utility Failure & Emergency Response PolicyStat ID #16563637, Labeling for Emergency Shutdown PolicyStat ID #16563685)

- When medical gas has failed, the tanks or oxygen monitoring system will send an alarm to Engineering main control panel and the Medical Gas vendor.
- If both the oxygen supply and the reserve have been disabled and the problem is not remedied immediately, notify Praxair and Engineering Department to deliver portable cylinders to the critical care areas immediately. Connect H cylinders to the gas line in the unit, if available.
- Engineering will notify medical gas supplier for loss of medical gas.
- Engineering will notify Incident Commander of medical gas failure and time frame for repair. If a leak is suspected, the main oxygen shut off valves and all zone valves will be shut down.
- Nursing personnel will check to see which patients are prioritized for oxygen needs. Patients

who have unstable oxygenation should have the highest priority and should be attended to first. Stable patients receiving mechanical ventilator support should be the next priority since their equipment is electrically powered.

- Engineers will work to determine location of leak and will isolate the zone with the leak until repairs can be made.
- Engineering will notify the Incident Commander when medical gas has been restored.

Response to Vacuum Failure:

- When the vacuum system has failed, the alarms will sound in main control panel.
- Engineering will notify Incident Commander of vacuum failure and time frame for repair. They will notify the various departments of the failure.
- Nursing personnel will check to see which patients are prioritized for vacuum needs. Portable vacuum will be distributed to those most critical.
- Engineering will notify the Incident Commander when vacuum has been restored.

Recovery:

- Once the ALL CLEAR has been notified, the following should occur:
- When gas or vacuum system is restored, maintenance will test system and monitor to assure all systems are working properly.
- Verify all zone valves are set to normal operation and assist as needed.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Natural Gas:

(Reference Utility Disruption Natural Gas Failure Hosp & HC PolicyStat ID #16563723; TJC EOC 02.05.01 EP10, 11, 12, 13)

- When natural gas has been interrupted, the boilers will send an alarm to main control panel
- Engineers will notify the local gas service 24-hour Emergency phone number for loss of natural gas.
- Engineering will notify Incident Commander of natural gas failure and that heating may be interrupted while moving boilers to fuel oil.
- Materials Management to distribute blankets, fluid, wipe warmers, and other supplies as needed.
- The Incident Commander with the Engineering staff will discuss options to maintain warmth and discontinue use of hot water until system is fully operational.
- The Clinical Engineering department will monitor supported equipment that needed heated water for sterilization methods.
- Nursing personnel should check to see that patients are comfortable with loss of heat and determine needs.
- Engineering will notify the Incident Commander when normal gas distribution has been restored.

Recovery:

- Once the ALL CLEAR has been notified, the following should occur:
- Inspect boilers for operation.
- Verify air handlers and HVAC has been restored to normal operations.
- Check all equipment in kitchen area to verify that all pilots are relit as needed.
- Make sure all boilers are switched back to natural gas and running.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	02/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT	01/2026
	Rick Ortiz: Chief of Plant Operations CPO	01/2026

Standards

No standards are associated with this document



Origination	01/2026
Last Approved	N/A
Effective	Upon Approval
Last Revised	01/2026
Next Review	3 years after approval

Owner	Rick Ortiz: Chief of Plant Operations CPO
Area	Hospital & Health Centers

CCRMC's Emergency Disaster Recovery Plan

Purpose

To ensure a coordinated and effective response to restore essential services following an emergency or disaster at Contra Costa Regional Medical Center.

Scope

Covers all department and units within the hospital, addressing various types of emergencies including natural disaster, technological incidents, and human-caused events.

Objectives

Restore essential utilities, information systems, and patient care services. Ensure the safety of patients, staff, visitors. Minimize disruption to hospital operations. Facilitate quick recovery and restoration of normal operations.

Recovery

- **Continuity of Operations Plan (COOP):** The COOP will be implemented to ensure the continuation of essential services until full operations are restored.
- **Damage Assessment:** A thorough damage assessment will be conducted to prioritize recovery efforts and allocate resources effectively.
- **Restoration of Services:** Strategies will be put in place to restore critical systems and services in the most expeditious manner possible, ensuring minimal disruption to patient care. The Incident Commander would be responsible for overseeing the overall emergency response and

recovery efforts.

Critical Resources Essential for Recovery

Utilities:

Utilities examined and considered to be essential or critical to provide care, treatment and services include:

<ul style="list-style-type: none">• Data Exchange Systems• Communication Systems• Normal Power Systems• Emergency Power Systems• Heating Ventilation and Air Conditioning (HVAC)	<ul style="list-style-type: none">• Fire/Life Safety Systems• Domestic Water System (Potable & Industrial)• Sewer/Sanitary System• Medical Gas / Vacuum Systems• Natural Gas
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If system failure of these infrastructures go down, below are the plans for Recovery:

Once the ALL CLEAR has been notified, the following should occur:

Communications Systems:

- The telephone system would be reactivated, and an overhead announcement would be made that the telephone system is now restored.
- The Red Phones would be deactivated at the switch located in the Hospital first floor Telecom Room.
- The use of the hospital computers and printers would be restored by the Information Technology Department and staff would be notified they no longer are required to use only the BCA computers and printers.

Normal Power Systems:

- Once the ALL CLEAR has been notified, the following should occur:
- Evaluate building systems for normal operations.
- Evaluate patient for status and relocated normal power outlet usage to normal.
- Inspect generators for operations.
- Verify air handlers and HVAC has been restored to normal.
- Refill fuel day tanks, if necessary.
- All equipment and/or supplies used during the failure should be accounted for restocked or reordered depending on their status.

Emergency Power Systems:

- Once the ALL CLEAR has been notified, the following should occur:
- They system will be switch over to normal power.

Heating Ventilation and Air Conditioning (HVAC):

- Once the ALL CLEAR has been notified, the following should occur:
- Verify air handlers and HVAC has been restored to normal operations.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Fire/Life Safety Systems:

- Engineering will assess the issue and notify the Medical Center Supervisor or Incident Commander of the system restoration.
- Communications will make an overhead announcement to notify all departments that the Code Red System is now back in services.

Domestic Water System (Potable & Industrial):

- Once water has been restored, the following must be done:
- Check the status of the domestic water lines.
- Check function of all RO and filtration systems. Change filters and cartridges in systems.
- Flush toilets, sinks, water fountains, coffee makers, ice machines, and Y-strainers and test systems for proper working order.
- Manual reset on hot water heaters.
- Continue construction or renovation of areas damaged from excessive water or loss of water.

Sewer/Sanitary System:

- Once water has been restored, the following must be done:
- Check the status of the domestic water lines.
- Check function of all RO and filtration systems. Change filters and cartridges in systems.
- Flush toilets, sinks, water fountains, coffee makers, ice machines, and Y-strainers and test systems for proper working order.
- Manual reset on hot water heaters.
- Continue construction or renovation of areas damaged from excessive water or loss of water.

Medical Gas / Vacuum Systems:

- Once the ALL CLEAR has been notified, the following should occur:
- When gas or vacuum system is restored, maintenance will test system and monitor to assure

all systems are working properly.

- Verify all zone valves are set to normal operation and assist as needed.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Natural Gas:

- Once the ALL CLEAR has been notified, the following should occur:
- Inspect boilers for operation.
- Verify air handlers and HVAC has been restored to normal operations.
- Check all equipment in kitchen area to verify that all pilots are relit as needed.
- Make sure all boilers are switched back to natural gas and running.
- All equipment and/or supplies used during failure should be accounted for restocked or reordered depending on their status.

Communications System

- Adequate call system enabling patients to summon staff for assistance.
- Functional system in place for internal communication with all operational areas of the hospital, including radio system.
- Emergency call system functional to summon assistance to a specific area (e.g., code blue, fire or security emergency).
- Functional fire alarm system for receiving manual (pull station) or automatic (e.g., smoke/heat detectors, waterflow, etc.) inputs and issuing appropriate automatic outputs (visual and audible annunciators, elevator recall, HVAC shutdown, signal to hospital communications).
- Notification to emergency department and other appropriate departments if scope of services of hospital has been reduced.
- Notification to staff of any alternate means of communications that may be used.
- Notification to staff of what is operational, what is not operational, and what alternate means of communications are in place.

Information Technology/Medical Records

- Ensure that all usual internal and external systems, backup systems, clinical systems, medical information systems, and patient registration systems are functional, or there is an alternate method for capturing the information.
- System in place to maintain a medical record for each patient served.
- Storage space to ensure security and maintain integrity of medical records (i.e., protection from fire, environmental hazards, unauthorized access).
- System in place to ensure medical records are readily accessible and promptly retrievable when needed.

Dietary

- Ensure adequate facilities, personnel, and supplies are onsite, or arrangements made to meet the nutritional needs of patients and staff as necessary.
- Ensure all necessary equipment, including refrigeration, for storage of foods and dietary supplies are available.
- Ensure adequate storage is available for all prepared food to ensure appropriate temperature and sanitation.
Pharmacy
- Ensure adequate facilities, equipment, supplies, and appropriate staff to meet the pharmaceutical needs of patients.
- Ensure adequate equipment and facilities, including refrigeration for storage of drugs and biologicals.

Security

- Hospital Security should be in place to ensure the safety of patients, visitors, and staff, including access control, securing sensitive areas, and protection of staff and property from crowds.

Personnel

- **Staffing:** Ensure adequate types and numbers of personnel onsite for services.
- **Retention Plan:** Ensure adequate retention plan to maintain personnel, (i.e. transportation, meals and lodging).

Family Reunification

- **Activate Reunification Plan:** Upon notification of a disaster, the hospital's emergency management team will immediately activate the Reunification Plan.
- **Establish Reunification Center:** Set up a dedicated reunification center within the hospital premises, ensuring it is easily accessible and well-marked.
- **Deploy Trained Staff:** Assign trained personnel to manage the reunification center, including Hospital Security, social workers, and mental health professionals.
- **Patient Tracking System:** Utilize Contra Costa Regional Medical Center's patient tracking system to provide real-time updates on patient status, location, and care details.
- **Clear Signage and Communication:** Ensure that there are clear signs and communication strategies to guide families to the reunification center.
- **Provide Emotional and Psychological Support:** Offer emotional and psychological support services to families, including counseling and mental health resources.
- **Regular Updates:** Keep families informed with regular updates on the status and location of their loved ones, as well as any changes to the reunification process.
- **Review and Debrief:** After the reunification process is complete, conduct a review and debrief

with all involved staff to identify areas for improvement and update the Reunification Plan as needed.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT [TT]	01/2026
	Rick Ortiz: Chief of Plant Operations CPO	01/2026

Standards

No standards are associated with this document

Status

Pending

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Last Revised	01/2026
Next Review	3 years after approval

Owner	Rick Ortiz: Chief of Plant Operations CPO
Area	Hospital & Health Centers

CCRMC's Emergency Management Communications Plan

Purpose

To ensure effective, timely and reliable communication during an emergency, disaster, or other significant incident impacting Contra Costa Regional Medical Center (CCRMC) and Health Centers.

HOW CCRMC IS NOTIFIED OF AN EMERGENCY

Contra Costa Regional Medical Center may be notified of an actual or potential emergency through multiple internal and external sources. These include, but are not limited to:

- A. Contra Costa County Emergency Services
- B. Local fire and law enforcement agencies
- C. Emergency Medical Services (EMS) and ambulance providers
- D. Contra Costa Health Services Administration
- E. Local, state, or federal emergency operations center (EOC)
- F. Hospital staff, patients, or visitors reporting incidents on campus
- G. Automated monitoring systems (fire alarm, security, infrastructure monitoring)
- H. ReddiNet alerts and other healthcare coalition notifications

Notification may occur via telephone, radio, ReddiNet, email, text message, alarm systems, or in-person notification. Upon receipt of emergency notification, the administrator on call, Security, Facilities, or the Hospital Incident Commander will evaluate the situation and determine if activation of the Hospital Incident Command System or other emergency protocol is required.

If warranted, the Hospital Command Center will be activated, and internal staff notification will be initiated through IRIS, SANDS, overhead paging, radios, runners, and other available systems.

COMMUNICATIONS PLAN

- A. Department/service managers and chiefs are to ensure that telephone utilization is limited to official calls necessary in the care and treatment of patients and the development of the disaster plan. Non-essential telephone calls are not permitted in the event of a disaster.
- B. The Hospital pager and public address system will be utilized when feasible and operable.
- C. The Hospital Incident Commander will be responsible for coordination of radio communications with emergency planning agencies.
- D. Departments/services are to be prepared to furnish messenger service; consider non-essential staff as runners.
- E. Emergency radios throughout the hospital campus can be used for communication in the hospital.
- F. Ham Radios are available for use by a licensed user.
- G. If telephones in the hospital are out of service, runners can be provided, Red Emergency Telephones can be activated, emergency XPR3500 Motorola radios in departments can be used.
- H. If telephones are out of service, off duty personnel may receive information on the following radio and/or T.V. station:

RADIO	T.V.
KCBS am 740	Ch. 5

INITIAL INTERNAL NOTIFICATION PROCESS

Once CCRMC is made aware of an emergency, initial internal notifications will be made as quickly as possible. This may include:

- A. Activation of the overhead paging system with clear response instructions.
- B. Notification of executive leadership, department directors, and critical service areas.
- C. Implementation of IRIS and/or SANDS to notify staff and support services.
- D. Contact with Security, Facilities, and Engineering for immediate response.
- E. Activation of Hospital Incident Command (if appropriate).

These systems work together to ensure rapid and widespread awareness of the incident and to support a coordinated response across all departments and health centers.

REDUNDANT EMERGENCY COMMUNICATIONS

The following redundant emergency communication systems are available should normal telephone

and/or internet systems become inoperable:

A. Telephones

1. RED PHONES - Backup telephone system that will activate when main telephone phones go down. Activation button panel in the hospital first floor Telecom Room. *(contact Engineers, DOIT, or Safety Coordinator to activate)
2. HOSPITAL COMMAND CENTER PHONES - The following telephones become active when the Hospital Command Center is activated:
Hospital Command Center: (925) 646-9901- (phones)
(925) 646-9902 - (fax)

B. IRIS – Incident Response Information System

A web-based communication system for all Contra Costa Health Services Department and Divisions which provides immediate emergency information via email, text, cell phone, etc.

IRIS is typically activated by Contra Costa Health Services Leadership or the Hospital Incident Commander when an incident has the potential to impact operations, patient safety, staffing, or facility infrastructure. IRIS messages may include incident details, protective actions, reporting instructions, and situational updates throughout the event.

C. SANDS – Staff Alert Notification System

Automated messaging system that will transmit emergency information directly to staff personal and business communication devices listed in the Employee Communication Data Base.

SANDS is used to rapidly notify CCRMC and Health Center employees of emergencies requiring staffing support, modified operations, or protective actions. Messages may include call-back instructions, reporting locations, shift modifications, or shelter-in-place/evacuation guidance.

D. Emergency Radios

1. EBRCS/APX 4000 radios that link CCRMC & Health Centers and to other emergency facilities in Contra Costa County – see display screen on radios:
 - a. Hospital Administration, Facilities, and Health Centers - Channel 1 HSD RMC1
 - b. CCRMC Emergency Dept. – Connects Emergency Department with Emergency Medical Services and other hospitals.
2. CCRMC Hospital & Health Centers internal radio system:
Motorola XPR3500, EX 500 models
 - a. CHANNEL 1 - Connect all immediate campus locations to Security. Located in all buildings on CCRMC Martinez campus as well as all Health Centers in geographically dispersed locations (Antioch, Brentwood, Bay Point, Concord, Pittsburg, North Richmond, West County -San Pablo). The radios are programmed to communicate directly with campus Security in the event of an emergency.
 - b. CHANNEL 2 - Facilities Maintenance and EVS staff radio system for day-

to-day operations.

- c. CHANNEL 6 – Restricted Command and Critical Operations Channel. These radios are marked with RED TAPE on the antennas and are programmed with Channel 6 to ensure controlled, secure communications during emergency operations. Communication on this channel is limited to the following:
 - i. Hospital Administration
 - ii. Security
 - iii. Facilities/Engineering
 - iv. Emergency Department Leadership
 - v. Hospital Command Center Team

- E. ReddiNet – In the event of an emergency, our hospital is typically notified through the ReddiNet System, a dedicated emergency communications network that facilitates information exchange among hospitals, EMS agencies, paramedics, dispatch centers, law enforcement, and other health care system professionals over a reliable and secure network. ReddiNet alerts provide real-time notifications about incidents such as mass casualty events, disasters, and public health emergencies.

ReddiNet is often the first external notification of region-wide incidents, mass casualty events, diversion status changes, or large-scale disasters impacting hospitals and EMS operations.

EMPLOYEE RESPONSIBILITIES

When a disaster is declared, employees should do the following:

- A. If at work, remain until properly relieved or sent home by someone in authority.
- B. If at home, take care of immediate situation. If telephone call is not forthcoming from supervisor or call-back staff assignment, tune in to KCBS Radio 740 AM.
- C. Call Employee Emergency Hotline (866) 946-9911.
- D. If not directed to report immediately, report to primary work location at next regularly scheduled shift.
- E. If unable to report to primary work site, go to nearest Health Services Department location and report to the manager in charge.
- F. If outside Contra Costa County, report to the closest office of that County and report to the manager in charge.

Approval Signatures

Step Description

Approver

Date

Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT [TT]	01/2026
	Rick Ortiz: Chief of Plant Operations CPO	01/2026

Standards

No standards are associated with this document



Origination	01/2026
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Effective	Upon Approval
Last Revised	01/2026
Next Review	3 years after approval

Owner	Rick Ortiz: Chief of Plant Operations CPO
Area	Hospital & Health Centers

CCRMC's Emergency Management Education and Training Plan

Purpose

To ensure hospital staff are fully prepared to respond to emergencies effectively and maintain clear and consistent communication during such events.

Objectives

1. Ensure all staff understand and can implement the hospital's Emergency Operations Plan (EOP)
2. Provide role-specific training to enhance response capabilities during emergencies.
3. Test and improve emergency preparedness through drills and exercises.
4. Promote effective communication and coordination internally and externally.
5. Foster a culture of safety, continuous learning, and compliance with regulatory standards.

Education Plan

Orientation and Onboarding

New Hire Training: Includes emergency preparedness as part of the onboarding process, which is conducted monthly during new employee orientation, focusing on:

- The hospital's Emergency Operations Plan (EOP)
- Emergency Codes (e.g., Code Red, Code Blue) and their responses.

- Evacuation procedures, routes, and protocols.
- Shelter In Place
- Emergency Communications; Radios, Red Phones, Reddinet

Leadership and Staff Training

Offer specialized education for leadership and staff on:

- The Hospital Incident Command System (HICS) Training 100, 200 and 700, 800- A standardized approach to incident management, designed to improve emergency management planning, response, and recovery.
- First Responder Operational (FRO) Decontamination Training.

Training On Recognition and Declaration of an Emergency

The recognition or discovery of an emergency may occur in several ways, including but not limited to:

- Obvious event such as an earthquake, severe storm, infectious disease outbreak or power outage
- Notification from external sources (e.g., Nixle) of an impending issue such as storms, flooding, power outage
- Notification from internal sources such as ReddiNet the county's emergency services tool for communicating hospital status, bed capacity, evacuation, and Mass Casualty Incidents

Any of the following individuals may declare an emergency and mobilize the hospital's incident command center:

- The Administrator On-Call
- Any member of the hospital executive team – Listed in our Emergency Operations Plan.

All staff are trained on recognizing internal and external disasters and emergencies in our Emergency Operations Plan, during their initial hospital orientation and in required annual trainings.

Emergency is defined as "a natural or manmade event that significantly disrupts the environment of care." An example would be loss of power due to a storm.

Disaster is defined as "a destructive event that disrupts day to day operations within an organization that cannot be managed by the resources available within the organization." An example would be a major earthquake or wildfire.

Internal disasters occur within our organization and can endanger the safety of patients, visitors, or staff. An example could be a hazardous chemical spill. They usually do not disrupt day-to-day functions and do not last very long.

External disasters occur outside our organization and endanger the safety or wellbeing of patients, visitors, and staff and may severely affect our community. Examples include earthquakes, acts of

terrorism, and hurricanes.

We use specific emergency codes to communicate situations that may affect the safety of patients, visitors and staff. Effective communication is essential, and staff are trained on the different emergency codes and know their role in responding to each situation.

In order to ensure the highest level of preparedness for emergency situations and to test our emergency operations plan and response procedures, our hospital conducts regular disaster drills, which encompass a variety of scenarios including fire drills, disaster response drills, and Code Pink (infant abduction) drills. These drills are listed below and take place as follows:

- **Fire Drills – (Business Occupancy Building):** Required Annually
- **Fire Drills – (Hospital Occupancy Building):** Required once per shift, per quarter
- **Disaster Exercise - (both Community-Wide & Hospital Wide):** Two Drills Annually
- **Code Pink – (Infant Abduction):** Required Annually
- **After-Action Reviews –** Required Post-Drill/Emergency

These drills are designed to simulate real-life emergencies, which include but are not limited to hazard vulnerability analysis, incident command system implementation, evacuation procedures, and communication protocols. The drills must evaluate our ability to respond to emergencies using an all-hazards approach, ensuring preparedness for a multitude of potential disasters. Staff participation is mandatory to evaluate and enhance our readiness. Following each drill, a debriefing session is held to review actions taken, identify areas for improvement, and implement corrective measures as needed. Adherence to these drills not only complies with regulatory standards but also significantly contributes to the safety and well-being of our patients, visitors, and staff.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT [TT]	01/2026
	Rick Ortiz: Chief of Plant Operations CPO	01/2026

Standards

No standards are associated with this document



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Next Review	3 years after approval

Owner	Rick Ortiz: Chief of Plant Operations CPO
Area	Hospital & Health Centers

CCRMC's Emergency Management Exercise Testing Plan

Purpose

The purpose of this plan is to establish a structured approach for testing and evaluating emergency response procedures at Contra Costa Regional Medical Center. These exercises ensure that staff are prepared for disaster, cybersecurity threats, and operational disruptions, improving overall resilience and response efficiency.

Objectives

1. Validate the effectiveness of emergency response protocols
2. Ensure staff readiness for various disaster scenarios
3. Identify gaps and areas for improvement in emergency management.
4. Strengthen coordination between departments and external agencies.
5. Incorporating lessons learned into future ongoing plans.

Types of Exercises & Drills

- **Tabletop Exercises (Discussion-Based)**
 - Scenario-based discussions involving leadership and key response teams.
 - Focus on decision-making, communication, and policy review.
 - Example: Cybersecurity breach response planning.
- **Functional Exercises (Target Action Testing)**

- Simulated response drills for specific functions (e.g., IT downtime, patient evacuations)
- Hands-on practice with emergency equipment and response tools.
- Example: Activating backup power and manual patient record systems.
- **Full-Scale Drills (Live Emergency Simulations)**
- Multi-department and real-time response to a simulated disaster.
- Coordination with external agencies (fire department, EMS, law enforcement.
- Example: Hazardous chemical exposure or active shooter scenario with full hospital involvement.

Exercise Planning & Execution

- **Develop Exercise Scenarios** – Tailored to hospital-specific risk and vulnerabilities
- **Define Participant Roles** – Assign key responsibilities and observers
- **Establish Evaluation Criteria** – Metrics for measuring response effectiveness. Each department should have their own criteria for their area.

Post-Exercise Review & Improvement

- Conduct debriefings with participants
- Identify successes and areas needing improvement
- Update emergency management documents based on findings
- Implement corrective actions and retraining if necessary

Compliance & Reporting

- Ensure exercises align with regulatory standards
- Maintain documentation of all drills and test results
- Report findings to leadership for policy and training updates

Exercise & Testing Schedule

MONTH	ACTIVITY
January	<ul style="list-style-type: none"> • Dept. Specific Dis. Plans – Update • Review EM Documents • Planning for Community Wide Drill • Nutrition Serv. 1st Quarter Fire & Evacuation Drill
February	<ul style="list-style-type: none"> • Begin Planning OR Fire Drills • Review Ancillary Dept. Plans- Drill Planning

	<ul style="list-style-type: none"> • 1st Quarter Hospital Fire Drills
March	<ul style="list-style-type: none"> • Disaster Supply Inventory Check • HICS 100/200 & 700/800 Trainings • Dept. Specific Disaster Plans – DUE • 5th Floor Operating Room Fire Drill
April	<ul style="list-style-type: none"> • Annual Staff FRO Decon Training • 2nd Quarter Nutrition Serv. Fire & Evacuation Drill • Annual Rehab Therapy Dept. Fire & Evacuation Drill
May	<ul style="list-style-type: none"> • 2nd Floor Operating Room Fire Drill • 2nd Quarter Hospital Fire Drills
June	<ul style="list-style-type: none"> • Community Wide Disaster Exercise
July	<ul style="list-style-type: none"> • Meet to begin Planning for Fall Disaster Exercise • 3rd Quarter Nutrition Serv. Fire & Evacuation Drill
August	<ul style="list-style-type: none"> • Meet to begin planning for Code Pink Drill • 3rd Quarter Hospital Fire Drills
September	
October	<ul style="list-style-type: none"> • Hospital Code Pink Drill • 4th Quarter Nutrition Serv. Fire & Evacuation Drill
November	<ul style="list-style-type: none"> • Fall Hospital Disaster Exercise • 4th Quarter Hospital Fire Drills
December	<ul style="list-style-type: none"> • Annual Lab Departments Fire & Evacuation Drill

Approval Signatures

Step Description	Approver	Date
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Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
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Standards

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Owner Rick Ortiz: Chief of Plant Operations CPO
 Area Hospital & Health Centers

CCRMC's Emergency Operations Plan (EOP)

Scope

This Emergency Operations Plan ("EOP") applies to Contra Costa Regional Medical Center and Health Centers, herein referred to as "CCRMC & HCs" and includes the following Locations:

Contra Costa Regional Medical Center 2500 Alhambra Avenue Martinez, CA 94553	Antioch Health Center 2335 Country Hills Drive Antioch, CA 94509	Brentwood Health Center 171 Sand Creek Road Brentwood, CA 94513 Bay Point Health Center 215 Pacifica Avenue Bay Point, CA 94565		
Brentwood Health Center 171 Sand Creek Road Brentwood, CA 94513	Concord Health Center 3052 Willow Pass Road Concord, CA 94519	Martinez Health Center 2500 Alhambra Avenue Martinez, CA 94553	Miller Wellness Center 25 Allen Street Martinez, CA 94553	Concord Health Center, Building 2 3024 Willow Pass Road Concord, CA 94519
Martinez Health Center 2500 Alhambra Avenue Martinez, CA 94553	Miller Wellness Center 25 Allen Street Martinez, CA 94553	North Richmond Health Center 1501 Fred Jackson Way Richmond, CA 94801		
North Richmond	Pittsburg	West County Health		

Health Center 1501 Fred Jackson Way Richmond, CA 94801	Health Center 2311 Loveridge Road Pittsburg, CA 94565	Center 13601 San Pablo Ave. Avenue San Pablo, CA 94806		
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Populations Served

CCRMC and HCs aims to provide health care for all people in Contra Costa County with special attention to those who are most vulnerable to health problems. Contra Costa Health serves patients with Contra Costa Health Plan, Medi-Cal and Medicaid and the uninsured. Contra Costa Regional Medical Center (CCRMC) is the county's 166-bed full-service hospital. It is the central hub of Contra Costa Health's nine [outpatient health centers](#). CCRMC and HCs serve patients in the following services:

• Emergency Services	• Surgical Services:
• Psychiatric Emergency Services	<i>Urology, ENT, Ortho, GYN</i>
• Inpatient Medical (Tele and Med Surg)	• Cancer Services
• Labor and Delivery	• Primary Care (outpatient)
• Inpatient Psychiatry Services	• Pediatric Care (outpatient)
• Laboratory	• Specialty Care (outpatient)
• Radiology:	• Physical Therapy and Rehabilitation
<i>CT, Imaging, MRI, Ultrasound, Nuclear Medicine</i>	

At Risk Populations

- Labor and Delivery
- Intensive Care
- Surgical Services
- Psychiatric Services

All Hazards Planning

Contra Costa Regional Medical Center utilizes the Kaiser Permanente Hazard Vulnerability Assessment (HVA) tool to assess threats that are likely to occur and to document actual incidents to prepare for emergencies in the future. The HVA is updated throughout the year with real events. Please see HVA for more information on anticipated and actual hazards. Below are summaries of our planned efforts to

mitigate and respond to our highest risk hazards.

- **FIRE, EXTERNAL:**

In the event of an external fire outside the hospital threatening the safety of patient, staff, and visitors necessitating either a partial or full evacuation, the Command Center will be activated, and the Incident Commander will take charge from the Incident Command Center. The Incident Commander will initiate and implement the hospital's evacuation plans, ensuring coordinated and orderly evacuation procedures are followed to maintain safety and minimize disruption to patient care. In a partial evacuation, only certain sections of the hospital will be evacuated, first evacuating horizontally to an adjacent designated smoke compartment, unless instructed by the fire department personnel to evacuate to a different floor. In a full evacuation, all patients, staff, and visitors will be moved to predetermined safe locations. Facilities Maintenance Engineers are responsible for securing medical gas (oxygen, nitrous oxide and medical air) systems at the direction of Fire Department personnel and will secure medical gas systems only after notifying Unit Charge Nurse, Nursing Manager or Medical Center Supervisor. *Reference Policy Stat ID 16733567 Code Red (Fire) and Fire Drills.*

- **IT SYSTEM OUTAGE:**

In the event of an IT system outage, the hospital and health centers follow a predefined protocol referenced in Policy Stat ID 16712096, CCH Clinical Information Systems Downtime to ensure patient care continues with minimal disruption. First, the Incident will immediately be reported to the Help Desk by the staff member in charge of the site/unit noticing a system interruption. If IT is unaware of the incident, the IT Incident Response Team will assess the scope of the outage and implement recovery procedures. Critical systems, such as electronic medical records and communication tools, will be prioritized for restoration. Backup systems, including paper records and alternative communications methods, will be utilized until normal operations are resumed.

- **FIRE, INTERNAL:**

In the event of an internal fire, an immediate alarm will be pulled to alert staff, patients, and visitors. The hospital will activate the fire emergency protocol, which includes calling the fire department, using fire extinguishers if safe, and beginning evacuation procedures. Patients in critical areas will be prioritized for evacuation, and staff will assist in moving them to predetermined safe zones. The Command Center will be activated, and the Incident Commander will coordinate efforts from the Incident Command Center, ensuring safety measures are maintained. The primary goal is to ensure the safety and wellbeing of everyone within the facility while effectively managing the fire situation. *(Ref. Policy Stat ID 16733567, Code Red Activation)*

- **EARTHQUAKE:**

In the event of an earthquake causing damage and injuries within the hospital, the hospital will follow emergency protocol to ensure patient and staff safety. The procedure begins with staff taking cover to ensure immediate safety. Once the shaking stops, staff should report any damage or injuries to the Medical Center Supervisor or the Hospital Command Center. The Incident Commander makes the decision to activate the Command Center to coordinate the response. Medical teams assess and triage injuries. Staff are instructed to use backup communication systems, for example emergency radios and Emergency Red phones if the phone systems should go down. The Incident Commander communicates with Facilities staff and emergency services to assess structural damage to decide if a partial or full evacuation is necessary. Evacuation plans are activated if required, directing patients and staff to

predetermined safe locations. The primary goal is to ensure the safety and care of all individuals within the hospital while managing the aftermath of the earthquake.

- **WORKPLACE VIOLENCE:**

In the event of a workplace violence, employee will move to a secure location if possible and alert security immediately and seek medical assistance for any injuries. Employee should inform managers and supervisors. All CCRMC and Health Center workplace violence incidents should be reported using the Safety Event Reporting System (SERS). Managers are responsible for ensuring that all incidents are reported in a timely manner as outlined by HSD policy and governing procedures. Every workplace violence incident will be investigated. The HSD Workplace Violence Incident Reporting Procedures Employee Instruction Packet is located in iSite.

Response

Introduction

This section aims to identify response procedures based on disasters or emergencies that may occur at the hospital and in the community where the hospital will be impacted. This document is designed to enable hospital staff members to make informed decisions during the initial response to an incident. They are not intended to replace emergency response knowledge, training, or sound judgment and do not cover all possible scenarios. The safety of all staff members must be prioritized over property protection during any planned or actual incident. Specific hazard response procedures (e.g., Fire Response, Bomb Threat) are included as attachments to this plan.

The required response level depends on the incident's severity, size, potential environmental, social, and economic impact, and the expected public interest. Staff members will be familiar with the tiered response model and emergency classifications. Any staff member who first observes an emergency must immediately report the details to their on-site supervisor.

For planning purposes, potential emergencies will be classified by emergency levels. These classification levels are essential for determining an appropriate tiered response. Higher levels of escalation require more resources, increased notification requirements, and potentially more complex responses. Refer to the **Hospital Incident Command System Activation Level**, which defines emergency response levels and corresponding activities to support emergency operations.

The Hospital Incident Command System (HICS) is the structure used within Contra Costa Regional Medical Center for responding to and recovering from emergencies, consistent with the community's incident command system. The Hospital Incident Command System (HICS) command structure outlines the roles and responsibilities of medical staff members during emergencies, including position authorities and reporting relationships.

Immediate actions will be taken at the onset or discovery of an incident to mitigate effects and ensure an effective response. Hospital staff personnel must never place themselves in harm's way or be directed to do so by others during response activities.

Recognition and Declaration of an Emergency

The recognition or discovery of an emergency may occur in several ways, including but not limited to:

- Obvious event such as an earthquake, severe storm, infectious disease outbreak or power outage
- Notification from external sources (e.g., Nixle) of an impending issue such as storms, flooding, power outage
- Notification from internal sources such as ReddiNet the county's emergency services tool for communicating hospital status, bed capacity, evacuation, and Mass Casualty Incidents

Any of the following individuals may declare an emergency and mobilize the hospital's incident command center:

- The Administrator On-Call
- Any member of the hospital executive team

All staff are trained on recognizing internal and external disasters and emergencies in our Emergency Operations Plan, during their initial hospital orientation and in required annual trainings.

Emergency is defined as "a natural or manmade event that significantly disrupts the environment of care." An example would be loss of power due to a storm.

Disaster is defined as "a destructive event that disrupts day to day operations within an organization that cannot be managed by the resources available within the organization." An example would be a major earthquake or wildfire.

Internal disasters occur within our organization and can endanger the safety of patients, visitors, or staff. An example could be a hazardous chemical spill. They usually do not disrupt day-to-day functions and do not last very long.

External disasters occur outside our organization and endanger the safety or wellbeing of patients, visitors, and staff and may severely affect our community. Examples include earthquakes, acts of terrorism, and hurricanes.

We use specific emergency codes to communicate situations that may affect the safety of patients, visitors and staff. Effective communication is essential, and staff are trained on the different emergency codes and know their role in responding to each situation.

CCRMC and HC's designated emergency codes are:

CCRMC & Health Centers Standardized

Emergency Codes & Phone Numbers

CODE	HOSPITAL – speed dial	CLINIC – outside line	DEFINITION
Code Red	222	9-911	Fire
Code Blue	111	9-911	Adult Medical Emergency

			*Code Blue and 911 called in Infusion Clinic
Code White	111	9-911	Neonatal/Pediatric Medical Emergency
Code Pink	333	9-911	Infant Abduction
Code Purple	111	9-911	Child Abduction
Code Yellow	111	9-911	Bomb Threat
Code Grey	333	9-911	Combative Patient
Assist Call	333	9-911	Standby or show of support
Code Orange	222	9-911	Hazardous Material Spill/Release
Code Silver	111	9-911	Person with Weapon/Hostage
Code Black	111	9-911	Bioterrorism
OB Response	111		Emergency Cesarean Section
Malignant Hyperthermia	111		Malignant Hyperthermia Code Blue
Code Green	Email or overhead page		ccLink Downtime
RRT	111		Rapid Response Team
BRT (pager system)	555 – 444 them enter the return phone # to call		Behavioral Response Team
Disaster	866-946-9911	925-866-9911	Employee Emergency Information Hotline
Disaster	925-646-9901	925-646-9901	Building 1 Command Center - A
Disaster	925-646-9901	925-646-9901	Hospital 4 th Floor Command Center – B

Drills

In order to ensure the highest level of preparedness for emergency situations and to test our emergency operations plan and response procedures, our hospital conducts regular disaster drills, which encompass a variety of scenarios including fire drills, disaster response drills, and Code Pink (infant abduction) drills. These drills are listed below and take place as follows:

- **Fire Drills – (Business Occupancy Building):** Required Annually
- **Fire Drills – (Hospital Occupancy Building):** Required once per shift, per quarter
- **Disaster Exercise - (both Community-Wide & Hospital Wide):** Two Drills Annually
- **Code Pink – (Infant Abduction):** Required Annually

These drills are designed to simulate real-life emergencies, which include but are not limited to hazard

vulnerability analysis, incident command system implementation, evacuation procedures, and communication protocols. The drills must evaluate our ability to respond to emergencies using an all-hazards approach, ensuring preparedness for a multitude of potential disasters. Staff participation is mandatory to evaluate and enhance our readiness. Following each drill, a debriefing session is held to review actions taken, identify areas for improvement, and implement corrective measures as needed. Adherence to these drills not only complies with regulatory standards but also significantly contributes to the safety and well-being of our patients, visitors, and staff.

On-Site Notifications

Any person who observes or becomes aware of an emergency shall immediately report the incident to their direct supervisor and to the operator at that specific location. Information should be documented and retained by the Safety Officer/Emergency Preparedness Coordinator or designee to ensure appropriate incident evaluations are completed. If the event occurs outside of a hospital building and immediate response is required by public safety dial 9-911 from any hospital phone.

1. Immediate notification to supervisor and MCS
2. Overhead page
3. MCS calls AOD
4. AOD texts chiefs
5. All staff emails and texts

Hospital Operator:

Upon notification, the Hospital Operator will:

- Record information from the hospital staff personnel or external agencies into Logbook.
- Overhead page would be made.
- Alert the appropriate leaders or responders based upon the situation (MCS, Security, Engineering, etc.)

Safety Officer/Emergency Preparedness Coordinator or Designee:

Upon notification, the Safety Officer/Emergency Preparedness Coordinator or Designee will:

- Document information from the hospital staff personnel or external agencies.
- Maintain contact with hospital leaders and department managers and any other persons in order to remain current with the situation as it evolves.

CCRMC CEO / Medical Center Supervisor / Administrator on Duty (AOD):

Upon notification, the CCRMC CEO / Medical Center Supervisor / Administrator on Duty (AOD) will:

- Determine if activation of Hospital Incident Command System (HICS) is needed, and if so
- Activate the Hospital Command Center (HCC)
- Determine the level of response necessary
- Notify their supervisor and members of the executive team, and others identified as deemed appropriate

Incident Commander:

The Incident Commander will confirm that additional notifications are completed (as needed), such as those to:

- Contra Costa Emergency Medical Services Agency (EMS) (ReddiNet)
- Contra Costa County Emergency Operations Center
- Contra Costa Medical Health Operational Area Coordinator (MOHAC)
- California Department of Public Health (CDPH)
- Stakeholders
- Local authorities
- Response vendors/Supplies
- Patient/Family Members

Off-Site Notifications

Hospital Staff Personnel and physicians (providers) not on duty at the time of the emergency are notified (if necessary) through the activation of the County's mass notification system, SANDS (Staff Automated Device System.)

- Safety Officer or Incident Commander will initiate the activation system and share summary of event and instructions for staff to report in for duty.
- May activate county Disaster Service Workers if needed.
- Hospital Staff Personnel responding will be instructed where to check-in.
- Providers will be notified, as warranted by the situation, including impacts on patient care operations.

Activate Command Center

Upon receiving notification that an emergency exists the CEO or designee, will determine if an activation of the Hospital Incident Command Center (HICC) is warranted and will assign the Incident Commander. To determine the level of response necessary they will follow the steps listed in the below table.

The Incident Commander will confirm that additional notifications are completed (as needed), such as those to:

- Contra Costa Emergency Medical Services Agency (EMS) (ReddiNet)
- Contra Costa County Emergency Operations Center

- Contra Costa Medical Health Operational Area Coordinator (MOHAC)
- California Department of Public Health (CDPH)
- Patient/Family Members
- Stakeholders
- Local authorities
- Response vendors/Supplies

Incident Command System Activation Levels

Level	Activation	Response
1. Low activation	Alert/ standby	Used to notify executive leadership team and operational leaders that an event is occurring or has occurred, response may be needed
1. Partial activation	Analysis/ Rapid Response/ System Guidance/ virtual command center/ small incident management team	Utilize ICS structure (command center positions as needed) to analyze and provide coordinated/standardized guidance
1. Full activation	Hospital Command Center & Incident Management Team	Mobilize Incident Management Team members as needed to respond to incident requirements/ needs

Through the response we can move from one level to another!

Level 3	Level 2	Level 1
		
Alert and monitoring may only have incident commander position filled	Most common can be virtual only a few positions are activated	Organization chart is filled fully- all hands on deck usually in person/ large conference room other external partners are involved

Command Center Personnel

CCRMC utilizes the Hospital Incident Command System (HICS) to manage incident related operations.

Hospital Incident Command System (HICS) is a methodology designed for healthcare facilities to manage both emergency and non-emergency events. Hospital Incident Management Team (IMT) charts depict the hospital command functions that have been identified and represent how authority and responsibility are distributed within the IMT. The Incident Commander (IC) is responsible for all aspects of an emergency response; including quickly developing incident objectives, managing all incident operations, application of resources as well as responsibility for all persons involved. The IC sets priorities and defines the organization of the incident response teams and the overall incident action plan. Incident Response Guides (IRG's) can serve as guidelines for the IC and Incident Management Team regarding what Hospital Incident Command System (HICS) positions may be most helpful in the response. Job Action Sheets (JAS) for specific Hospital Incident Command System (HICS) positions define each role and responsibilities for the duration of the emergency and act as a guide for individuals filling Hospital Incident Command System (HICS) positions.

As defined in the Job Action Sheets, staff roles and responsibilities are outlined in the following key areas:

- Communications
- Resources and Assets
- Safety and Security
- Utilities
- Clinical Activities

In addition, staff roles and responsibilities may be further delineated in a variety of documents such as specific policies and procedures, instructions on the use of forms and checklists, flow charts, etc. All employees have at a minimum, the following responsibilities relative to the above-mentioned areas:

- To communicate situational needs, observations, operational status, and issues in a clear, concise, and timely manner to the appropriate individual(s) or entity(s).
- To conserve resources and assets and utilize said resources and assets appropriately.
- To be aware of, and maintain, the safety and security of themselves and the environment in which care, treatment, and service is rendered.
- To appropriately utilize and conserve utilities, and to report disruption or failure of utilities to the appropriate individual(s) or entity(s) in a timely manner.
- To assure that clinical activities are carried out in accordance with accepted standards of care, and in a safe and efficacious manner.

The Incident Commander shall appoint individuals to the leadership positions within the Incident Management Team (IMT) structure based on availability, expertise, and as the situation dictates. These individuals will remain in the assigned positions until such time that they are relieved or replaced by the Incident Commander. All positions within the Hospital IMT structure ultimately report to (either directly or through intermediaries) to the Incident Commander. The IC will consider the following when making IMT and HCC assignments:

- Determine the level of response necessary for the situation.
- Is the area affected isolated to a small portion of the hospital or the entire hospital?

- Are the resources on hand adequate to manage the response?
- Are outside agencies and/or off-site resources required to respond?
- What other considerations will determine the success of the response?

Mobilize Incident Management Team (IMT)

- CEO, House Supervisors, AOD, or designee, will utilize all means necessary including but not limited to verbal, text, call or utilizing the SANDS Mass Notification System to notify and mobilize members of the Hospital Incident Management Team (IMT).
- Specific positions will be determined by the nature of incident and Incident Response Guides (IRGs), if applicable.
- The IMT will report to the Hospital Command Center.
- The Incident Commander, or designee, shall discuss the situation and the immediate/long term needs with the CEO.

Hospital Command Center (HCC) locations and Set Up

CCRMC has designated a Primary and Alternate Hospital Command Center, and an external virtual Command Center.

Command Center A	Command Center B	Virtual
MHC 1 st Fl. Conference Room	CCRMC 4A Conference Room	Virtual
925-646-9901	925-646-9901	Microsoft Teams

1. The first responding personnel will begin setting up the Hospital Command Center. The Command Center supplies are contained in the designated disaster cabinets.
2. Members of the Hospital Incident Management Team will prepare for the Immediate Operational Period.
3. The Liaison Officer, at the direction of the Incident Commander, will notify external agencies of the opening of the Command Center.

Communications

Primary and alternate means of notifications/communications may include but not limited to:

<ul style="list-style-type: none"> • ReddiNet • Landline & satellite telephones • HAM radio • Hand-held radios • Overhead PA System 	<ul style="list-style-type: none"> • Cellular communications • SANDS Mass Notification System • Intranet and websites • Fax Machines
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ReddiNet

A secure, web-based emergency medical communications system that is used to report hospital, patient, and emergency event status. ReddiNet is used by hospitals, EMS, first responders, and other health care providers to communicate. A dedicated ReddiNet terminal is in the Emergency Department. The HCC may access through the internet.

SANDS Mass Notification System

The Staff Alert and Notification Device System (SANDS) is a communication tool that can be used during an emergency or disaster to contact staff via the contact information provided. The message entered into SANDS goes out as a text or robo-call. After a message is sent you can view who the message was sent to and if they responded that they received it.

Communication with Local Emergency Operations Center

Contra Costa Regional Medical Center, upon request will provide information about the hospital's occupancy, needs, and its ability to provide assistance to relevant authorities such as the County EMS Agency or Emergency Operations Center verbally, via the designated County's electronic Status Report form or other delivery method.

MHOAC email	Medhealthcoalition@cchealth.org
EMS Duty Officer Email	Ems.event@cchealth.org

First Responders

Normal processes for communicating with fire, paramedics, or police will continue unless the Incident Commander (in collaboration with the Liaison Officer) direct an alternate method of communication.

Family, Visitors, Clergy

The Incident Command Center (Operations Sections) will establish and communicate an area that family, visitors and clergy will be located. A staff member will be assigned to respond to concerns and answer questions.

Situation Status Reports distributed by the Public Information Officer should be communicated to waiting individuals (e.g., posted in the waiting location).

Press and Media

Press and media inquiries should be directed to the Public Information Officer at 925-608-5463.

Managing Safety and Security

The nature of the disaster may require the Incident Commander (IC) to alter existing policies and

procedures to protect the patients, hospital staff personnel, providers, and visitors, and may necessitate additional safety and security measures. Upon activation of the EOP, a damage assessment and safety analysis will be conducted to identify actions required and what additional resources are needed. Depending upon the threat, the IC may obtain additional resources from local law enforcement, local public health department, and contracted security services. The IC, or Operations Section Chief, will coordinate with building owners at leased property to ensure site access if applicable.

Safety Officer

The safety officer or their designee, under the direction of the incident command center, shall be responsible for identifying and investigating environmental hazards that may arise during the emergency event. They are responsible for taking steps to ensure that such safety risks are mitigated and, to the extent possible, abated.

Campus Security

Contra Costa Regional Medical Center has a team of collocated county sheriff deputies, sergeants, and a Lieutenant who serves as the campus Chief of Security. This collaboration ensures quick response and activation of additional security resources when needed. Additionally, CCRMC may request support from external entities by contacting the CCRMC Hospital Security Lieutenant at (925)-370-5331. If it is after hours, call (925)-584-7040. This could include:

- Local Law Enforcement / CHP: Law Enforcement may be needed to assist with security management. This could include bomb threats, active shooters, infant abductions, civil unrest, and terrorist activities. Law enforcement agencies include local police departments, county sheriff departments and/or California Highway Patrol (CHP).
- Federal Bureau of Investigation (FBI): The FBI is the lead investigative agency during a terrorism or WMD event. www.fbi.gov
- California Department of Public Health (CDPH): CDPH is the lead agency in responding to a Biological and Radiological terrorism event. CDPH will coordinate all hospital issues and be ready to provide epidemiological and environmental health support as requested to Local Health Departments. <http://www.cdph.ca.gov>
- Local Fire Departments / CalFire: Local Fire Departments / CalFire can assist with evacuation of patients under the direction of the Hospital Incident Commander. They can extinguish fires, disperse noxious fumes and smoke, support patient decontamination and help to secure building safety.

During an incident, campus security is responsible for securing the campus to ensure emergency personnel have adequate space to provide care and maintain patient and staff safety. They may also consider the following:

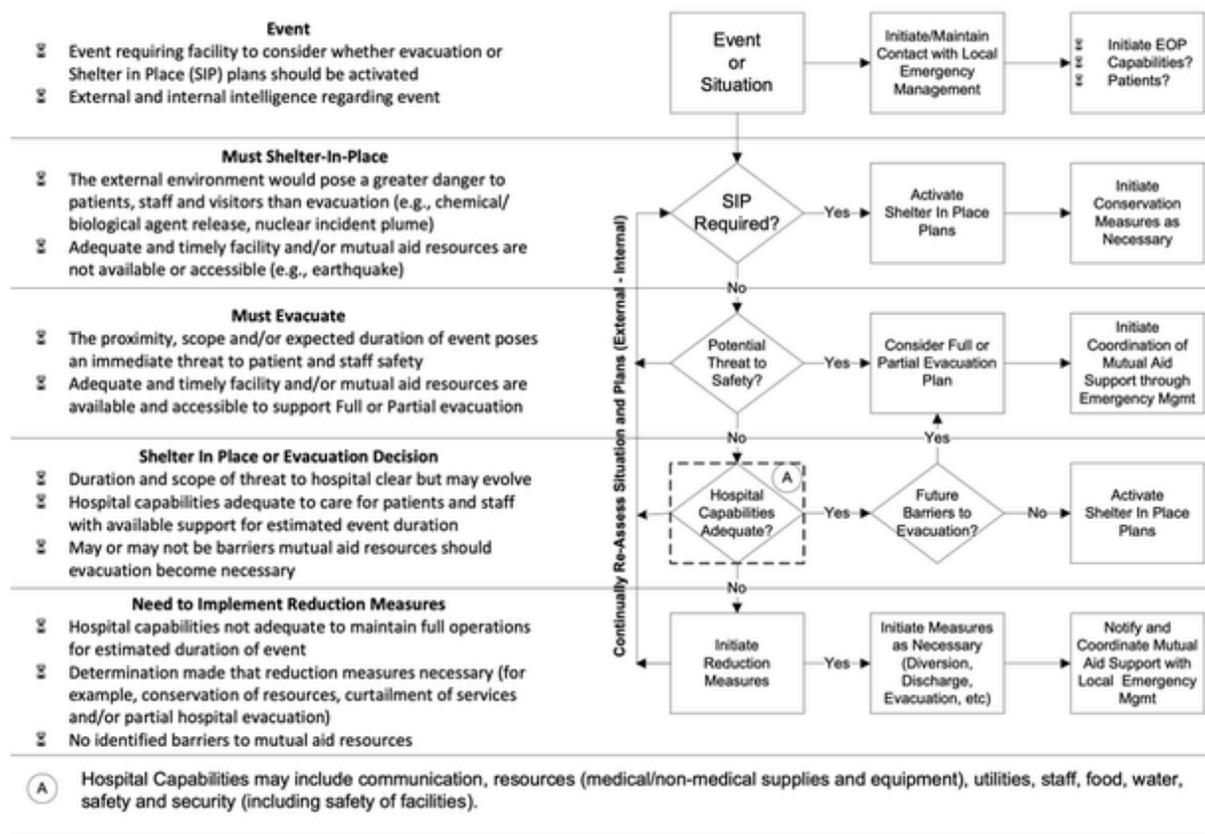
- Close off the parking lot to non-ambulance vehicular traffic.
- Expand security parameter to include Miller Wellness Center
- Restrict access to Miller Wellness Center
- Close other hospital entrances

Whenever multiple law enforcement agencies are involved, the hospital may participate in Unified Command (UC) to ensure the needs and goals of the hospital, agencies and other organizations are represented.

Evacuation and Shelter-In-Place

Given the complex nature of hospital evacuation, the preferred protective action is to shelter-in-place. If a shelter-in-place order is ordered by the Incident Commander, the Incident Management Team (IMT) will establish areas that are safe and adequate for Hospital Staff Personnel, patients, and visitors to remain. Considerations should be given to isolating the heating and cooling systems, expected term of sheltering (food, water, restrooms, etc.), security of premises, and medical needs of Hospital Staff Personnel. When shelter-in-place is not viable, evacuation of part or all the hospital building may be ordered by the IC or fire department. The evacuation process will be methodically coordinated by the IMT. All Hospital Staff Personnel are trained in evacuation and emergency response procedures.

The following decision tree (developed by the California Hospital Association) may be used to guide this decision. The plan should include provisions for tracking and communication when sheltering in place.



Information Accompanying an Evacuated Patient

Preferably, a printed Patient Summary will accompany each evacuated patient. If it's not possible to print the summary, at a minimum the following information will accompany each evacuated patient as they are transported to an alternate care site:

- The patient's name, age, and date of birth
- The patient's reason for admission and medical diagnosis
- Known allergies and blood type
- List of current medications
- Any advanced directives
- Names and contact information for next of kin and emergency contacts

Alternative Care Sites

If additional space is needed for caring for patients, the IC will contact the EOC to request support for Alternative Care Sites. These may include designated areas on campus, other hospitals, or other designated sites by the county Emergency Operations Center. Depending on the scope of need, the command center personnel will coordinate transfers to Alternative Care Sites and track all patient discharges to help with repatriation and reunification when the event is concluded.

Mortuary Services

Provisions for overflow mortuary services will be coordinated with the Contra Costa County Emergency Operations Center. Unidentified deceased individuals shall be referred to the County Coroner's office as prescribed in hospital policy.

Acquiring Additional Hospital Staff Personnel Members

Disaster Service Workers

Government Code 3101 specifically identifies all public employees as disaster service workers, which includes all public employees and all volunteers in any disaster council or emergency organization accredited by the Office of Emergency Services. The term "public employee" includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed. After securing their family and home, employee will:

- call the Emergency Hotline (1-866-946-9911) for reporting information and instructions.
- Report to their normal worksite during normal shift.
- If unable to get to worksite during normal shift, then they will report to another CCHS site.
- If unable to report to a CCHS site, then should report to a governmental health services site in the county where located with their employee badge and inform their supervisor.

Emergency Staffing

Department managers shall make arrangements for the maintenance of emergency contact lists.

Practitioners

Physicians and other Licensed Practitioners eligible for Medical Staff Privileges shall be processed through the Medical Staff Office according to existing policies and procedures, which allow for volunteer privileges and emergency processing of new privileges.

Associates

Non-privileged associates shall be processed according to current Human Resources policies, which provide for the processing of volunteers during an emergency when necessary.

Tracking On-duty Hospital Staff Personnel and Patients

Hospital Staff Personnel on-duty at the time of the incident shall report to their immediate supervisor. Before leaving the site, all Hospital Personnel shall receive authorization from their supervisor. Supervisors are responsible for tracking Hospital Staff Personnel under their direction.

Tracking of Hospital Staff Personnel serving in an IMT role will be completed on the Section Personnel Timesheet, Hospital Incident Command System (HICS) Form 252. All IMT Hospital Staff Personnel shall check in and out on this form.

Managing Hospital Staff Personnel and Support Activities

Housing for Staff

If call in procedures for off-duty staff is activated, the Incident Command Center will identify areas or location where staff members can relax and sleep when not working. The IC will work with the division or county Emergency Operations Center to identify additional options as needed.

Transportation of Staff

The Contra Costa County Department of Public Works, Fleet Services, will provide vehicles for transportation as needed during a County-wide emergency.

Mental Health Support/Stress Debriefing

The Employee Assistance Program will be available upon request to address staff needs during and following the emergency event. Behavioral Health staff debrief team will also be made available to support teams and staff as needed.

Childcare for Staff Family Members

When necessary to support staffing levels, the Incident Command Center will coordinate with the Contra Costa County Emergency Operations Center.

Securing information and records

Contra Costa Regional Medical Center utilizes servers and cloud-based data exchange systems. There are rigorous security screening and monitoring protocols in place to maintain the integrity of our electronic medical record and business files. If there is an unplanned outage or breach, our service desk staff identify, and work to solve the issue. The Information Technology Department coordinates with hospital leadership during these events to ensure patient information is secure and will be updated after any downtime.

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT	01/2026
	Rick Ortiz: Chief of Plant Operations CPO	01/2026

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19687643**



Origination 01/2026
Last Approved N/A
Effective Upon Approval
Last Revised 01/2026
Next Review 3 years after approval

Owner Rick Ortiz: Chief of Plant Operations CPO
Area Hospital & Health Centers

CCRMC's Hazard Vulnerability Assessment

Please see attached file.

Attachments

[CCRMC's Hazard Vulnerability Assessment 2025.xlsm](#)

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	01/2026
Chief Operations Officer	Shannon Abella: Chief Operations Officer-Exemp	01/2026
Emergency Management Committee	Patrice Ringo: EMERG MED EXEMPT [TT]	01/2026

Standards

No standards are associated with this document



Origination	08/1997
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Effective	Upon Approval
Last Revised	12/2025
Next Review	3 years after approval

Owner	Ngozi Emenalom: Nursing Program Manager
Area	Hospital & Health Centers

Hospital Policy for Follow-Up Actions After a Patient Assaults Someone

POLICY STATEMENT:

This policy outlines follow-up actions after a patient assaults another patient, staff member, provider, or visitor ~~on a psychiatric unit~~. In addition to efforts that are made to prevent assaults ~~—including assessing risk and implementing~~, action steps are also taken after an assault ~~precautions—action steps are also taken after an assault~~ by a patient as part of the Hospital's work to prevent workplace violence. These events are reported and reviewed, and it may be escalated for further review involving Department or Hospital leaders. The guidelines in this policy underline the Hospital's commitment to a culture of safety.

GUIDELINES:

For the purposes of this policy, an assault is a purposeful act of choking, hitting, kicking, biting, pushing, scratching, punching, pulling hair, or any other unwanted forceful physical contact by a patient against another person (another patient, visitor, staff member or provider) that has the potential for or causes bodily injury.

After a patient assaults another patient, staff member, provider, or visitor ~~on a psychiatric unit or in transit to or from a psychiatric unit~~, ~~the following steps will be followed~~ follow these guidelines:

- A. The staff member completes a report in the Safety Events Reporting System (SERS). ~~And the~~ The Nurse Program Manager (NPM)/ Medical Center Supervisor (MCS) completes follow-up actions as appropriate.
- B. The Charge Nurse/~~Team Leader~~ Relief Charge Nurse informs the Nurse Program Manager

- (NPM)/Medical Center Supervisor (MCS), and the assaultive patient's ~~treating psychiatrist~~attending physician of the assaultive ~~incident~~event.
- C. If there is an injury to the victim, first aid is offered by the nurse. If there is a patient injury that requires treatment, medical evaluation and/or treatment is carried out according to protocols by unit, or, if the victim is a staff member or provider or visitor, the person is offered the option to go to the Emergency Department for evaluation.
 - D. The Charge Nurse/~~Team Leader~~Relief Charge Nurse calls Hospital Security to request that an Officer come to the unit for investigation. If the victim wishes to press charges, the steps~~guidelines~~ in the following policy are followed: Hospital Policy ~~372~~: Pressing Charges against Patients Who Assault Others in the Hospital.
 - E. The Charge Nurse/~~Team Leader~~Relief Charge Nurse ensures that a ~~brief~~ treatment team debrief is completed. ~~The huddle and debrief is completed about the reason(s) for the assault.~~ ~~The huddle~~ will identify any missed opportunities and ongoing safety measures as well as any changes to patient management, ~~treatment plan~~/care plans, orders, or procedures.
 - F. The Charge Nurse/~~Team Leader~~Relief Charge Nurse uses the Department Specific Immediate Actions Checklist to guide the ~~huddle and to ensure that all key immediate safety steps are taken~~debrief. ~~That~~The checklist is then passed along to the NPM/MCS to complete investigation and follow-~~up~~ups as needed.
 - G. The NPM/MCS ensures that staff members who are assaulted are given required information and risk management forms.
 - H. The NPM/MCS escalates the event for additional review if the assault victim is seriously injured/ requires treatment and/or if the assault is concerning regarding an actual or potential pattern of assaults. Escalation will include communication to the Department Chief(s), other appropriate members of the Department Leadership Team if indicated, Department of Safety and Performance Improvement, and Hospital leaders.
 - I. ~~The~~An escalation may result in a Department Review or a review ~~of safety events is~~ led by the Department of Safety and Performance Improvement. A Threat Assessment Response Team (TART) review or Certification (CERT) review will include investigation and an assessment as to what additional steps may be needed (e.g. Root Cause Analysis (RCA), Corrective Actions, Peer Review referral, or outside reporting).

RELATED LINKS:

[Attachment A: Immediate Actions Checklist for Psychiatric Units](#)
Contra Costa Health Services Workplace Violence Prevention Plan
[Pressing Charges Against Patients Who Assault Others](#)
[Pressing Charges Against Patients Who Assault Others](#)

REFERENCES:

The Joint Commission (TJC) 2023 Standards: EC.02.01.01, LD.03.01.01, PC.01.02.09, RI.01.01.01, RI.01.06.03.

APPROVALS:

Psychiatry Department: 06/2021, 1/24, [10/25](#)

Clinical Practice Committee: 09/2021, 3/24

Patient Care, Policy & Evaluation Committee: 10/2021, 3/24

Medical Executive Committee: 11/2021, 4/24

Joint Conference Committee: 12/2021, 4/24

Attachments

- [ED Immediate Actions Checklist After every Assault](#)
- [IP Non-Psych Units Immediate Actions Checklist After Every Assault](#)
- [Psych Units Immediate Actions Checklist After Every Assault](#)

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	01/2026
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	12/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	11/2025
	Mariamay Torres: Nursing Program Manager	10/2025

Standards

No standards are associated with this document



Origination	05/1991
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2025
Next Review	3 years after approval

Owner	Geena Jester: Medical Director
Area	Hospital & Health Centers

Policy for Accepting Patient Transfers from Outside Facilities and Referrals from Contra Costa Health Centers

POLICY STATEMENT:

To outline the conditions under which transfers will be accepted at Contra Costa Regional Medical Center (CCRMC) from outside facilities and the conditions under which referrals will be accepted from health centers within our system.

GUIDELINES:

- A. The CCRMC Emergency Department, Psychiatric Emergency Services (PES), and inpatient units will only accept patients to be transferred from outside facilities if the patients:
 - 1. Are medically and/or psychiatrically appropriate.
 - 2. Require further medical or psychiatric care that we are capable of providing.
 - 3. Are stable for transfer. In selected cases, we will accept unstable patients if CCRMC represents a higher level of care than what is available at the sending facility.
- B. Appropriate request from the transferring physician and acceptance by the receiving CCRMC physician shall **precede** all transfers from outside facilities.
- C. All unstable patient transfers from outside facilities will be reported to the transferring hospital's administrator and to CMS, through the State Department of Health Services, as required by law.
- D. Procedures:

The general prerequisites outlined in Section A below shall be met before any patient transfer from an outside facility is accepted. In addition, specific procedures regarding medical/

surgical (Section E) and psychiatric transfers (Section I) must be followed as appropriate.

1. General prerequisites

- a. The patient requires further medical or psychiatric care. Patients not requiring further treatment (including patients simply intoxicated or who have problems only with placement) will not be accepted.
- b. Contra Costa Regional Medical Center is capable of providing care the patient needs. Examples of services not provided at CCRMC include high-risk obstetrics, intensive neonatal care, dialysis, treatment of extensive or complicated burns, continuous EEG and cardiac surgery. If there is any question about our ability to provide the necessary level of care, the Medical Officer of the Day (MOD) shall be consulted.
- c. CCRMC has bed availability, equipment, and support staff necessary to care for the patient.
- d. CCRMC is the closest and most appropriate hospital capable of providing care to a patient with an emergency medical condition (i.e., a life- or limb-threatening condition which requires immediate treatment).
The patient (or other responsible person if the patient is a minor or incompetent) understands the reasons for transfer and consents.
Documentation of appropriate advisement and consent shall accompany the patient. An exception would be the transfer of a patient on a 5150 72-hour legal hold. In this instance, the patient still must be informed of the reason for transfer.
- e. The patient has been adequately evaluated by the transferring facility. The patient shall have received appropriate evaluation to determine that the patient is stable for transfer and requires further care that CCRMC is capable of providing.
- f. The patient is medically stable for transport:
 - i. Per federal COBRA and OBRA laws, and EMTALA, a patient with an "emergency medical condition" shall not be transferred except in limited circumstances (see below). The "emergency medical condition" is defined as:
 - ii. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or unborn child.
 - iii. A patient with an "emergency medical condition" may not be

transferred prior to medical stabilization unless:

- A. The patient or responsible person for the patient refuses to consent to treatment at the hospital. This person must be informed of risks and benefits of treatment prior to transfer. The hospital must take all reasonable steps to obtain a signed written refusal of treatment.
 - B. The patient may request transfer to another emergency department. The patient or responsible person should be informed of the hospital's obligation and of the risks of transfer. The individual's request must be in writing and indicate the reasons for the request and that he/she is aware of the risks and benefits of the transfer.
- g. California Medi-Cal defines medically stable as "able to reasonably sustain a transport in an Emergency Medical Technician I (EMT I) staffed ambulance with no expected increase in morbidity or mortality."
- i. Guidelines for Stability
 - A. Per COBRA and EMTALA, stabilized means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility. Stabilization of a woman in labor with an emergency medical condition, as defined above, means that the woman has delivered the child and the placenta.
 - B. The patient shall have stable vital signs. Patients who are apneic or unable to protect their airway (even if intubated), or who have severe alterations in blood pressure, pulse, or temperature shall not be accepted (if care is available at the sending facility).
 - C. The patient shall have a stable level of consciousness. If the patient's level of consciousness is reduced, it must be stable at that level. Patients with varying or declining levels of consciousness shall not be accepted.
 - D. ~~The patient shall not require cardiac monitoring or intensive monitoring of vital signs.~~
 - E. The patient shall have no potential for rapid changes in condition that may require intervention that can be better provided in the transferring hospital than in an ambulance. For example, patients with pneumothorax and without chest tube, who are actively bleeding, who are in advanced labor or have fetal distress, or

overdose patients who have not received adequate initial treatment shall not be accepted.

- F. ~~If the patient has an IV, he/she shall be accepted in transfer only if maintenance of the IV is not critical and only if the rate could vary substantially without ill effect. The IV shall contain neither medication, blood, blood products, nor colloid volume expanders. No syringes or piggybacks shall be attached to the IV.~~
- G. If the patient is on a pressor, they should have a midline, PICC, or central line placed prior to transfer and should not have escalating pressor requirements.
- H. If a patient is requiring BiPAP, there should be a blood gas obtained after at least an hour on BiPAP and prior to sending to ensure stability.
- I. Patients who are unstable may be accepted for transfer when we represent a higher level of care than what is available at the sending facility.

2. Responsibility:

- a. CCRMC physicians shall make a reasonable effort to avoid accepting patients who are unstable for transfer. However, ultimate responsibility for the decision to transfer (as well as responsibility for pre-transfer evaluation and stabilization, responsibility for deciding on the mode of transport and the need for accompanying equipment and personnel, and responsibility for deciding on the mode of personnel, and responsibility for any complication attributed to transfer) shall rest solely with the physician who initiates the transfer.

3. Documentation:

- a. Complete and legible document supporting the evaluation prior to transfer should accompany the patient. The following items must be included as a minimum:
 - A. History of present illness, including presenting complaint.
 - B. Any information pertaining to patient's wishes. For advance directives pertinent physical exam, including vital signs, taken on presentation to and departure from the transferring hospital.
 - C. Record of all treatments given and patient's response to treatment.

4. Notification:

- a. Appropriate request by the transferring physician (or appropriate designee in cases in which a physician is not available) and acceptance by a CCRMC physician shall precede all transfers.

E. Medical/Surgical Transfers:

1. Medical/Surgical Outpatient Transfers from Other Emergency Departments:

a. General procedure:

- i. The Emergency Department should be contacted by phone (370-5975) to request an ED-to-ED patient transfer. The Emergency Department charge nurse or designee shall contact the Medical Center Supervisor (MCS) (925-407-7341) to determine bed availability.
- ii. The Charge Nurse or designee shall gather the following information on all patients using the Emergency Department Incoming Transfer Form (MR-114-6):
Name, age, date of birth, sex, address, name of referring physician and facility, reason for transfer, mode of transport planned, and tentative diagnosis.
- iii. The physician shall:
 - A. Complete the lower portion of the Emergency Department Incoming Transfer Form;
 - B. Confirm that all appropriate records will accompany the patient;
 - C. Inform appropriate nursing staff (charge nurse or MCS) that the transfer has been accepted.

F. Medical/Surgical Direct Admissions from Contra Costa Health Centers

Direct admissions from Contra Costa Health Centers (CCHCs) should be referred to the Medical Officer of the Day (MOD). Any patients with unstable vitals or for any reason requiring urgent evaluation should be sent to the Emergency Department. Appropriate medical records shall accompany the patient.

1. General Procedures:

- a. The referring physician shall notify the Medical Officer of the Day (MOD).
- b. The accepting physician shall:
 - i. Check bed availability by contacting the Medical Center Supervisor (MCS).
 - ii. Inform the MCS of the transfer and obtain the admitting unit.
- c. Medical Center Supervisor (MCS) shall:
 - i. Ensure that insurance screening is completed.
 - ii. Assign patient to unit/bed.
 - iii. Inform accepting physician of unit/bed assignment.
 - iv. Inform admissions of Patient MRN, name, admitting physician, and bed assignment.
 - v. Inform Charge Nurse of the receiving unit.
 - vi. Call clinic nurse where patient is being directly admitted from to:

(1) provide information on admitting unit and confirm that clinic nurse will call unit nurse with clinical information about the patient; and (2) confirm estimated time of arrival.

vii. Inform Emergency Department (x5975) so that the patient can be appropriately directed upon arrival.

G. Referrals From Doctor's Offices, Urgent Care Centers, or Skilled Nursing Facilities (SNFs) requiring evaluation for potential admission to an Inpatient Medical Unit.

- a. The referring physician shall discuss the case with the Emergency Department physician. Appropriate medical records shall accompany the patient as well as contact information for the SNF or Board and Care/Group Home.
- b. Advice concerning residency, our ability to care for a specific problem involved (including bed and staff availability) may be discussed. If the patient appears to be potentially unstable, the referring physician shall be instructed to send the patient via ambulance to the nearest appropriate hospital.
- c. In the case of Skilled Nursing Facility referrals, these facilities should hold the patient's bed to allow for the possibility that the patient may not need admission. Medical Social Services and/or Administration shall be notified if there is refusal upon the part of the SNF to accept the patient back.

H. Medical/Surgical Inpatient Transfers from Other Inpatient Acute Care Hospitals

1. Sending Hospital and Medical Center Supervisor

- a. A representative of the transferring hospital shall contact the Medical Center Supervisor (MCS) at 925-407-7341 or pager 346-4243. Whenever possible, this should occur before the transferring physician contacts the accepting physician at CCRMC. The MCS shall:
 - b. Request that all records be sent. The transferring facility is responsible for ensuring that all appropriate records are sent. If the imaging or other records such as those that are usually sent on a disk are not included and must be sent separately, the transferring facility will be responsible for courier delivery of the records.
 - c. Complete insurance screening/establish payor source
 - d. Inform the Medical Officer of the Day (MOD) that financial clearance has been confirmed and facilitate contact between that physician and the transferring physician.

2. Physician Acceptance

- a. The transferring physician shall contact the MOD to request transfer. Upon accepting the transfer, the accepting physician shall:
 - i. ~~Confirm that all appropriate records (including imaging, discharge summary, and items mentioned above in Section III.A.9 Documentation), will accompany the patient.~~
 - ii. The MOD writes an incoming transfer acceptance note and informs the MCS (925-407-7341) that the transfer has been

medically approved.

3. Medical Center Supervisor (MCS)

- a. Upon being informed by the accepting physician that the transfer has been approved, the MCS will:
 - i. Assign patient to unit/bed.
 - ii. Inform accepting physician of unit/bed assignment.
 - iii. Inform Charge Nurse of the receiving unit.
 - iv. Call sending hospital's unit to (1) confirm that the transfer has been approved; (2) provide the phone number for sending nurse to call the CCRMC unit nurse with clinical information about the patient; and (3) confirm estimated time of arrival.
 - v. Inform Admissions office.
 - vi. Inform the Emergency Department (x5175) in the event the patient inadvertently arrives at the E.D., the patient can be appropriately directed upon arrival.
 - vii. Confirm that all appropriate records (including imaging, discharge summary), will accompany the patient.

4. Destination

The patient shall be taken directly to the assigned unit/bed.

I. Psychiatric Transfers:

1. Transfer of Patients from Other Emergency Departments

- a. If an outside hospital's Emergency Department wishes to transfer a medically stable patient who needs psychiatric crisis stabilization, these are the steps that are followed. If the patient is accepted for transfer, the transfer destination is the Psychiatric Emergency Services (PES). In the PES, the attending psychiatrist completes the required medical screening examination for emergency medical conditions as part of the intake psychiatric evaluation of the patient (see Psychiatric Nursing Policies 804 and 806).
- b. The outside facility may contact the PES directly, and if the PES is not over crowded (Saturation Level is not RED), a clerk will invite the facility to fax a referral packet with cover checklist to 925-335-7418. If PES is over-crowded (Saturation Level is RED), the clerk will redirect the calls to the Medical Center Supervisor (MCS) at 925-407-7341. The cover checklist serves as guidance for the required records and information (Attachment B: PES Medical Clearance Checklist).
- c. A PES psychiatrist will review the patient packet and make a decision to accept or not accept the patient as an appropriate transfer to the PES for psychiatric crisis stabilization. As part of that process, the psychiatrist may speak with the sending physician, or request additional information (or the psychiatrist may ask the clerk to request the information). The PES

psychiatrist or a member of the PES team will call the sending facility to finalize acceptance for transfer.

- d. Requests from outside facilities for transfer to PES may be delayed if PES is in RED Saturation. The MCS will coordinate requests for transfer to the PES when the PES is in RED Saturation Level, including any communication to outside facilities about delays or suggested time to call back to request a transfer or to check on the status of a packet being reviewed by a psychiatrist in the PES.

2. Inpatient Psychiatry Direct Admissions: Transfer of Patients from Inpatient Medical Care Who Meet Acuity for Inpatient Psychiatric Care

- a. Patients who are hospitalized in a medical / surgical unit at CCRMC or outside hospital who meet acuity and insurance requirements for Inpatient Psychiatric care at CCRMC and who no longer require complex inpatient medical care may be approved for direct admission to one of the Inpatient Psychiatry units. Requests require coordination by the MCS and acceptance by an attending Psychiatrist on the Inpatient Service.
- b. Appropriate Insurance Coverage and Inquiry of Bed Availability go to the MCS, who completes insurance screening and verification of legal status.
- c. Unit and Bed Decision: The MCS identifies an available bed on one of the IP Psych Units and shares the packet with the appropriate Inpatient attending psychiatrist for review (or shares the patient MRN/Unit with the psychiatrist to review in ccLink).
- d. Review of Records: The attending psychiatrist reviews the packet or the chart in ccLink. Admission requirements include meeting acuity for IP Psych, not requiring complex medical care, and having a recent negative COVID test result (refer to Psychiatric Nursing Policy 701: Inpatient Psychiatry Admission Criteria).
- e. Consultation by Department of Hospital Medicine (DHM) physician: The attending psychiatrist makes a determination if a second review of medical issues is needed, and if so, requests that review be done by the consulting Department of Hospital Medicine (DHM) physician on the Inpatient Psychiatry Service (or the MOD on weekends or after Hours). The attending psychiatrist can also consult with the medical internist as needed on particular questions regarding the requested admission.
- f. Patient Acceptance: The attending psychiatrist makes the decision to accept or not accept the patient as appropriate for transfer/direct admission to the Inpatient Psychiatry Unit. The psychiatrist informs the MCS of the decision and provides any additional information to facilitate transfer timing as appropriate. In cases where additional guidance or discussion is needed to make a decision, the attending psychiatrist may escalate/discuss the case with the Inpatient Psychiatry Chief or Psychiatry Chief.
- g. The MCS assigns the unit/bed, notifies the Charge Nurse of the acceptance and bed assignment, updates the bed planning activity in

ccLink, and gives an estimated time of the transfer.

- h. The MCS notifies the requesting physician / facility or CCRMC Unit of the admission decision, and, if the patient will be admitted, gives any updated information about the timing of the transfer.

3. Transfer to PES from Skilled Nursing Facilities

- a. If a patient at a Skilled Nursing Facility (SNF) requires psychiatric crisis stabilization, the representative shall contact the MCS or the PES directly and follow the guidelines for requested transfer to the PES. If the patient is age 70 or older, weighs 400 pounds or greater, is bed-bound/not ambulatory, requires C-PAP for sleep apnea, is COVID-19 positive, has symptoms of COVID-19, or has signs or symptoms of an acute medical issue, the patient will be sent to the Emergency Department (ED) directly for evaluation. (See Psychiatric Nursing Policy Attachment 119-A: Psychiatric Emergency Triage Form).

J. Transportation

1. All transportation arrangements shall be made by the transferring hospital. CCRMC is not responsible for paying for or securing transportation required by incoming patients. If the patient is on the Contra Costa Health Plan, the outside hospital/ facility should contact the Health Plan with any questions about transportation.

K. Inappropriate Transfer

1. In the case of an inappropriate transfer to the Emergency Department or the Psychiatric Emergency Services (PES), the MCS, Charge Nurse or Nurse Program Manager for the Unit shall ensure that the Chief(s) and Administrative leaders are notified, and that proper documentation is completed. Emergency Department documents inappropriate transfers on the Incoming Patient Transfer form (MR 144-6) and, if available, on the county-wide Patient Transfer form (EMS 7). All questionable transfers shall be reviewed by the NPM(s) and Chief(s) and reported to Administration. Reporting shall occur according to the county transfer guidelines, state, and federal standards.
2. In the case of inappropriate in-patient transfers, the appropriate department Chief shall be notified in writing on Incoming Transfer Form-Inpatients (MR-480). Those transfers shall be reviewed and reported to Administration with reporting as above.
3. Hospital personnel shall maintain a courteous and professional demeanor when dealing with potential or completed transfers that are considered inappropriate. Potentially inappropriate transfers may be avoided by taking the following steps:
 - a. Ensure review of legal status and insurance coverage prior to acceptance, transfer or admission.
 - b. Discuss further steps to evaluate and stabilize the patient prior to transfer;
 - c. Discuss indications for specialty consultation. A request to discuss the case with the appropriate department head at the transferring hospital is reasonable.
 - d. In case of Emergency Department transfers, discussion with Hospital MOD

may be appropriate.

- e. Escalate any objection to the transfer if it is felt the transfer is inappropriate, citing policy. Escalate the issue to the NPM(s) and/or Chief(s) and/or Hospital Leaders as appropriate. Bring up the issue in the Hospital's morning Safety Huddle if there is an urgent safety issue.

RELATED LINKS:

[MR 114-6 Incoming Transfer Consultation Emergency Department](#)

REFERENCES:

- A. Emergency Medical Treatment and Labor Act of 1994 (EMTALA)
- B. Consolidated Omnibus Reconciliation Act of 1985 (COBRA), amended by Omnibus Reconciliation Act (OBRA) in 1989
- C. Health and Safety Code, Sections 1217-1317.9a.
- D. The Joint Commission (TJC) Standards – Chapters PC - Provision of Care, Treatment and Services and RI - Rights and Responsibilities of the Individual
- E. Title XXII, California Administration Code
- F. Code of Regulations, Title 42, Part 489, Sec. 489.20-24 and Sec. 413.65
- G. Contra Costa Health Center Policy 3055: Health Center Referrals to CCRMC Emergency Department

APPROVALS:

Joint Conference Committee: 3/2025

Attachments

[📎 Referrals to Contra Costa Regional Medical Center Emergency Department](#)

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	01/2026

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	12/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	11/2025
	Geena Jester: Medical Director	10/2025

Standards

No standards are associated with this document

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Last Revised 12/2025
Next Review 3 years after approval

Owner Adalberto Garibay: Deputy Sheriff-40 Hour
Area Hospital & Health Centers

Policy for Code Silver: Person with a Weapon

POLICY STATEMENT:

This policy ensures ~~proving a safe,~~ and effective ~~procedure~~procedures for all ~~person~~employees working ~~on the at~~ CCRMC ~~and or any~~ Health ~~Centers~~Center campus to ~~respond~~follow when responding to a situation ~~where a person~~in which an individual is observed ~~to be~~ displaying a weapon in a threatening manner. (Note: A threatening manner ~~is~~refers to any situation perceived by ~~the~~an employee to be imminently violent or makes them feel uncomfortable.)

Any employee who ~~sees~~observes anyone in or near ~~CCRMC or any~~ ~~GCRMC~~-and Health Center ~~facilities~~facility displaying a weapon in a threatening manner, must initiate a CODE SILVER to warn personnel and summon the facility's Security Unit, Contra Costa Sheriff's Office and/or ~~the~~ local ~~Police Department~~police department.

Facilities located in Martinez will follow Plan "A" procedures (see page 2 of 6)

- A. Contra Costa Regional Medical Center and outlying facilities on campus
- B. Martinez Health Center
- C. George & Cynthia Miller Wellness Center
- D. Youth Stabilization Unit

All other facilities will follow Plan "B" procedures (see page 4 of 6)

- A. All CCRMC Health Centers (except Martinez locations)

GUIDELINES:

A. Plan "A"

Code Silver procedure: Martinez locations

Contra Costa Regional Medical Center, George & Cynthia Miller

Wellness Center, Youth Stabilization Unit, Martinez Health Center

1. Any employee who sees anyone in or near CCRMC ~~Hospital~~ and all outlying buildings, George & Cynthia Wellness Center, Youth Stabilization Unit, and/or Martinez Health Center, displaying a weapon (a gun, knife, stun gun, club, etc.) in a threatening manner must take the following steps:
 - a. Contact the on-site Security/Communications personnel via two-way radio or dial 3-3-3 and give your name, location, and the location and description of the person or persons with the weapon(s), and describe the weapon itself.
 - b. Move to a safe location if possible and warn others of the situation.
 - c. Contact the following:
Martinez Health Center and Miller Wellness Center employees will contact the Clinical Coordinator, who will notify the Medical Center Supervisor.
 - d. ~~The~~ If needed, the Hospital Security Unit will contact Sheriff's Office Dispatch and request patrol back up and ensure that the Martinez Police Department is advised of the situation.
 - e. Communications (hospital operator) will overhead page "Code Silver Exterior or Interior and exact location. Secure All Work Areas."
2. Staff need to know that an event can be exterior to one area but interior in another, and must respond accordingly. Examples may be Code Silver in the ED of CCRMC is exterior to all other buildings on campus, but it is an interior event for the hospital. Code Silver in Administration is an external response for CCRMC and Health Centers, but an internal response to Administration.
3. Securing all Work Areas includes the following:
 - a. All staff should return to their work area (unless it is the site of the Code Silver); in that case go inside another secure work area.
 - b. Staff should secure/lock all doors and entrances to the building and units when possible. (refer to Lock-Down Procedure #370).
 - c. Determine if staff members and patients need to be moved to a more secure location.
 - d. Immediately escort patients/visitors into a secure work area explaining "there is a potential danger and we are getting behind locked/closed doors until everything is clear."
 - e. Do not open any door to check on what is going on!
 - f. Do not involve Code Gray members in Code Silver situations.
 - g. Ask patients to return to their beds to make sure everyone is accounted for

and close bedroom doors when possible.

4. Code silver: Exterior (Person with weapon is outside of a building)
 - a. All patients, visitors and staff are to remain within whatever building they are in.
 - b. Close and lock doors when possible.
 - c. Keep everyone away from windows.
 - d. Close shades.
 - e. Await further orders from the Hospital Security Unit, Sheriff's Department or Martinez Police.

5. Code Silver: Interior (Person with weapon is within a building)
 - a. Attempt to remove all patients and staff from the area of danger, if possible.
 - b. Hide behind file cabinets, etc. as needed to maintain safety.
 - c. Stay quiet- silence cell phones. Keep Security radio with you with volume turned down so as not to alert the shooter to your location.
 - d. Consider RUN, HIDE, FIGHT:
 - i. RUN when an active shooter is in your vicinity:
 - A. If there is an escape path, attempt to evacuate.
 - B. Evacuate whether others agree to or not.
 - C. Leave your belongings behind.
 - D. Help others escape if possible.
 - E. Prevent others from entering the area.
 - F. Call 911 when you are safe.
 - ii. HIDE: if evacuation is not possible, find a place to hide.
 - A. Lock and/or blockade the door.
 - B. Silence your cell phone.
 - C. Hide behind large objects
 - D. Remain very quiet.
 - E. ~~Your hiding place should~~
 - F. ~~Be~~Your hiding place should be out of the shooter's view
 - G. ~~Provide~~Use cover protection if shots are fired in your direction
 - H. ~~Net~~Do not trap or restrict your options for movement
 - iii. FIGHT as a last resort, and only if your life is in danger;

- A. Attempt to incapacitate the shooter
 - B. Act with physical aggression
 - C. Improvise weapons
 - D. Commit to your actions
- e. Await further orders from the Hospital Security Unit or local law enforcement officers handling the incident.
- i. Upon arrival of the Hospital Security Unit and local law enforcement: Do not leave your patients or your unit unless instructed to do so by law enforcement.
 - ii. Use the telephones ONLY for emergencies – keep the lines clear!
 - iii. The Hospital Security Unit's initial responsibility will be to deal with the person(s) with a weapon.
 - iv. Sheriff's Office personnel and local law enforcement who respond to assist with the incident, will provide logistical and manpower support.
 - v. The Hospital Security Unit Chief or his/her designee will determine "All Clear" status and will inform the MCS/AOD.
 - vi. The Hospital Security Unit will contact Communications to announce "All Clear" status.
- f. Communications will announce "CODE SILVER ALL CLEAR" status via overhead page and on Security Radio Channel 1.
Upon hearing "CODE SILVER ALL CLEAR":
- i. When it is safe to do so, get medical help as required for patients and/or injured employees.
 - ii. Return to your normal work duties unless otherwise directed.
 - iii. Offer support to anxious patients and staff members.
 - iv. Information about the event may ONLY be released via the Health Services [Department Public Information Officer \(PIO\). Information released must be approved by the CCRMC CEO or designee.](#)
 - v. ~~Department Public Information Officer (PIO). Information released must be approved by the CCRMC CEO or designee.~~
- g. In the event of an Active Shooter, or Hostage Situation, respond Immediately:
- i. Move patients, visitors and staff away from immediate danger if possible and alert others.
 - ii. The Hospital Security Unit will direct Hospital Communications to announce the active shooter event providing the location of the shooter and the number of suspects involved so that staff

can appropriately react to the event.

- iii. Lockdown all units and buildings as quickly as possible (see Lockdown Procedure #370). Notify MCS of the incident to initiate the Emergency Notification Process as soon as it is safe to do so.
- iv. RUN, HIDE, FIGHT as outlined earlier in this policy.
- v. Await further directions from Security personnel.
- vi. The Hospital Security Unit personnel and local law enforcement officers will address the shooter or hostage taker ~~with lethal force or through negotiation techniques~~. The Hospital Security Unit will request additional support from the Sheriff's Office and/or local law enforcement ~~such as the Sheriff's Office SWAT Team and Hostage Negotiations Team~~.

B. Plan "B"

Code Silver procedure: CCHS health centers & mobile health units

Antioch Health Center, Brentwood Health Center, Bay Point Family Health Center, Pittsburg Health Center, Concord Health Center(s), North Richmond Health Center, West County Health Center

1. Procedure:

- a. Any employee who sees anyone in or near a CCHS Health Center campus or Mobile Health Unit displaying a weapon (a gun, knife, stun gun, club, etc.) in a threatening manner must take the following steps:
 - i. Contact the on-site or roving Security personnel via two way radio and give your name, location, and the location and description of the person or persons with the weapon(s), and describe the weapon itself.
 - ii. Move to a safe location if possible and warn others of the situation.
 - iii. Contact the Clinical Coordinator and provide them with the same information as above. Staff should also contact 911 to report the incident. Staff should use overhead paging or telephone tree to announce "Code Silver: Interior or Exterior and the location."
 - iv. When safe to do so the Clinical Coordinator or designee will contact the respective Clinical Service Manager (CSM).
- b. Staff at local site will overhead page or use the telephone tree "Code Silver Exterior or Interior and exact location. Secure All Work Areas." (waiting on CSM approval of statement)
- c. Staff needs to know that an event can be exterior to one area but interior in another, and must respond accordingly.
- d. Securing all Work Areas includes the following:
 - i. All staff should return to their work area (unless it is the site of

the Code Silver); in that case, go inside another secure work area.

- ii. Staff should secure/lock all doors and entrances to the building and units when possible. (Refer to Lock-Down Procedure #370).
- iii. Determine if staff members and patients need to be moved to a more secure location.
- iv. Immediately escort patients/visitors into a secure work area explaining "there is a potential danger and we are getting behind locked/closed doors until everything is clear."
- v. DO NOT open any door to check on what is going on!

2. Code Silver: Exterior (Person with weapon is outside of a building)

- a. All patients, visitors and staff are to remain within whatever building they are in.
- b. Close and lock doors when possible.
- c. Keep everyone away from windows.
- d. Close shades.
- e. Await further orders from the Security Unit or local law enforcement.

3. Code Silver: Interior (Person with weapon is within a building)

- a. Attempt to remove all patients and staff from the area of danger, if possible.
- b. Hide behind file cabinets, etc. as needed to maintain safety.
- c. Stay quiet- silence cell phones. Keep Security radio with you with the volume turned down so as not to alert the shooter to your location.
- d. Consider RUN, HIDE, FIGHT:
 - i. RUN when an active shooter is in your vicinity:
 - A. If there is an escape path, attempt to evacuate.
 - B. Evacuate whether others agree to or not.
 - C. Leave your belongings behind.
 - D. Help others escape if possible.
 - E. Prevent others from entering the area.
 - F. Call 911 when you are safe.
 - ii. HIDE if evacuation is not possible, find a place to hide.
 - A. Lock and/or blockade the door.
 - B. Silence your cell phone.
 - C. Hide behind large objects
 - D. Remain very quiet.

- E. ~~Your hiding place should~~
 - F. ~~Be~~Your hiding place should be out of the shooter's view.
 - G. ~~Provide~~Use cover protection if shots are fired in your direction.
 - H. ~~Not~~Do not trap or restrict your options for movement.
- iii. FIGHT as a last resort, and only if your life is in danger;
 - A. Attempt to incapacitate the shooter.
 - B. Act with physical aggression.
 - C. Improvise weapons.
 - D. Commit to your actions.
 - iv. Await further orders from the Hospital Security Unit or local law enforcement officers handling the incident.
- e. Upon arrival of the Hospital Security Unit and local law enforcement:
 - i. Do not leave your patients or your unit unless instructed to do so by law enforcement.
 - ii. Use the telephones ONLY for emergencies – keep the lines clear!
 - iii. The Hospital Security Unit's or Local Law Enforcements initial responsibility will be to deal with the person(s) with a weapon.
 - iv. Sheriff's Office personnel and local law enforcement who respond to assist with the incident will provide logistical and manpower support.
 - v. The Hospital Security Unit or Local Law Enforcement will determine "All Clear" status and will inform the Clinical Coordinator.
 - vi. There will overhead or telephone tree announce "All Clear" status.
 - f. Health Center staff will announce "Code Silver All Clear" status via overhead page, telephone tree and on Security Radio Channel 1. Upon hearing "Code Silver All Clear:"
 - i. When it is safe to do so, get medical help as required for patients and/or injured employees.
 - ii. Return to your normal work duties unless otherwise directed.
 - iii. Offer support to anxious patients and staff members.
 - iv. Information about the event may ONLY be released via the Health Services Department Public Information Officer (PIO). Information released must be approved by the CCRMC CEO or designee.

- g. In the event of an Active Shooter, or Hostage Situation, respond Immediately:
 - i. Move patients, visitors and staff away from immediate danger if possible and alert others.
 - ii. The Clinical Coordinator or designee will announce the active shooter event, providing the location of the shooter and the number of suspects involved so that staff can appropriately react to the event.
 - iii. Lockdown all units and buildings as quickly as possible (see Lockdown Procedure #370). Notify CSM of the incident to initiate the Emergency Notification Process as soon as it is safe to do so.
 - iv. RUN, HIDE, FIGHT as outlined earlier in this policy.
 - v. Await further directions from Security personnel or local law enforcement.
 - vi. The Hospital Security Unit personnel and local law enforcement officers will address the shooter or hostage taker. The Hospital Security Unit will request additional support from the Sheriff's Office and/or local law enforcement ~~such as the Sheriff's Office SWAT Team and Hostage Negotiations Team.~~

RELATED LINKS:

CCRMC Lockdown Procedure #370

APPROVALS:

Clinical Practice Committee: 9/2018, 8/2022, 12/23

Patient Care and Policy Evaluation Committee: 9/2022

Medical Executive Committee: 9/2022

Joint Conference Committee: 09/2022

REFERENCES:

- A. The Joint Commission 2017 EOC Standards, EC.01.01.01, and EC.02.01.01, "The Hospital Manages Safety and Security Risks"
- B. California Code of Regulations, Title 8, Section 3342, Violence Prevention in Healthcare."

Approval Signatures

Step Description	Approver	Date
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Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	12/2025
	Adalberto Garibay: Deputy Sheriff-40 Hour	12/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19490640**



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Owner Leah Carlon:
Health Care Risk
Manager
Area Hospital & Health
Centers
References TJC 2025

Policy for Patient Grievance/Complaint Process

POLICY STATEMENT:

To establish a process that is easily accessible, and provides for the prompt resolution of a patient, patient's representative or significant other complaint or grievance.

GUIDELINES:

All Contra Costa Regional Medical Center and Health Center employees or contracted agent will support and facilitate each patient's right to invoke the grievance system.

Patients and families shall be notified of their right to present complaints or grievances at the time of admission.

Patients and families have the right to communicate any complaints or grievances that arise in the provision of their care, without the threat of discrimination or reprisal.

Every grievance received is managed in a manner that safeguards the confidentiality of the patient, the family, and the nature of the grievance itself.

All complaints or grievances involving situations or practices that place the patient in immediate danger or involve abuse or neglect shall be resolved in a timely manner.

Contra Costa County Board of Supervisors has delegated oversight of the patient grievance/complaint process to the Grievance Committee.

A. Definitions:

A **COMPLAINT** is any verbal complaint from a patient, or the patient's representative, related to

patient care provided by Contra Costa Regional Medical and Health Centers, which can be easily resolved to the patient's or representative's satisfaction at the time of complaint with staff present.

STAFF PRESENT includes any hospital or health center staff present at the time of the complaint or who can quickly be at the patient's location to resolve the patient's complaint.

A **GRIEVANCE** is a written (letter, e-mail, or fax, etc.) or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient or the patient's representative, regarding the patient's care, abuse or neglect, or issues related to the organization's compliance with the CMS Hospital Conditions of Participation, or a Medicare patient's billing complaint related to rights and limitation provided by 42 CFR Section 489. Post-hospital verbal communications regarding patient care are to be considered grievances. Whenever the patient or the patient's representative requests their complaint be handled as a formal complaint or grievance or when the patient requests a written response, then the complaint is a grievance.

Information obtained with patient satisfaction surveys does not usually meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.

A **PATIENT** is any individual receiving service at Contra Costa Regional Medical Center and Contra Costa Health Centers. All patient rights apply to any person who may have legal responsibility to make decisions regarding medical care for the patient, including the right to file a grievance.

The **GRIEVANCE COMMITTEE** is a subcommittee of the Patient Safety and Performance Improvement Committee (PS&PIC). The committee will be responsible for assuring the efficient and effective operation of this policy. At the discretion of the Patient Relations Services Coordinator, unresolved grievances may be submitted to the Grievance Committee for guidance in resolution. Membership of this committee includes, at a minimum, the Health Care Risk Manager, Chair of PS&PIC, Director of S&PI, Patient Relations Services Coordinator. The committee shall meet on an as needed basis.

- B. Any employee or contracted agent receiving a complaint from a patient and/or family/ significant other will take prompt action within their scope of authority and/or responsibility to resolve the communicated dissatisfaction or concern.

If the issue cannot be resolved at the time of the complaint, it shall be referred to the appropriate GRIEVANCE COORDINATOR as follows:

1. Ambulatory Care Patients: Non-clinical complaints to Clinic Coordinator or designee and clinical complaints to Clinic Service Managers or designee.
Contra Costa Regional Medical Center: Patient Relations Services Coordinator or designee.
- C. Grievances Involving Hospital/health Center Patients
 1. If neither the Grievance Coordinator nor the designee is available, the patient or representative will be asked to complete a "Patient Complaint/Grievance Form"

(A-546).

The completed form will be immediately sent to the Patient Relations Services Coordinator in the Patient Relations Department.

2. The Patient Relations Services Coordinator, along with Patient Services Managers, Medical Staff Department Chairs, Clinic Coordinators, Executive Directors, and the Health Care Risk Manager, will investigate and provide a resolution to the patient's grievance(s).
 - a. Operational issues are investigated by the Clinic Coordinator or the department manager.
 - b. Quality of Care issues are investigated by the Medical Staff Department Chair and reviewed with the treating provider.
 - c. Responses are to be returned to the Patient Relations Services Coordinator within 7 days of request.
 - d. CCHP will manage their own Potentially Quality Incident (PQI) program; however CCRMC can forward information that fits a PQI that deals directly with the operations of the health plan.
3. Grievances will be responded to within 30 days of the grievance. If the investigation is not or will not be completed within 7 days, the patient or patient's representative will be informed by the Patient Relations Services Coordinator, or designee, in writing that their complaint has been received, is being investigated, and that a written response will be sent to the patient (or representative) within 30 days.
4. Written responses will include the name of the person investigating, a hospital contact person, steps taken to investigate the grievance, the results or final disposition, date of completion, and the right to appeal the resolution with:
 - a. California Department of Public Health, Licensing and Certification Program, East Bay District Office, 850 Marina Bay Parkway, Building P, 1st Floor, Richmond, CA 94804-6403 (phone 510-620-3900, TTY# 866-247-9100, fax 510-620-3924 and 510-620-5820), regardless of whether they have used the hospital or health center's complaint process.
 - b. Livanta, LLC, BFCC-QIO Program, Area 5, 9090 Junction Drive, Suite 10, Annapolic Junction, MD 20701 (phone 877-588-1123, TTY# 855-887-6668, fax 855-694-2929).
 - c. If a complaint is in writing and related to the professional competence or conduct of a physician or podiatrist, the complainant will be informed that the only authority that can take disciplinary action against the provider's license is the State Medical Board of California or the California Board of Podiatric Medicine, and the address and phone numbers can be provided.
5. If the patient requests a response via e-mail, one may be provided containing the elements described above.
6. When there is any issue of hospital, health center, or provider liability, the Patient Relations Services Coordinator or Health Care Risk Manager must review the response.

7. When the grievant is not identifiable, or when the responsible staff member cannot resolve a problem, after reasonable and appropriate actions are followed the complaint can be considered closed.
Documentation of all efforts to resolve the issue must be maintained, including the reasons why the issue could not be resolved and the individual(s) responsible for that decision.
8. The grievance records, including the actual complaint, correspondence, and resolution, will be maintained in a confidential manner and retained for at least six years. These records will be open to inspection by the State Department of Public Health and the Centers for Medicare and Medicaid Services.

D. CCHP Member Grievances

1. CCHP Members can call Health Plan Members Services at 1-877-661-6230 to file a written grievance with a Member Service Representative.
2. Should a CCHP Member grievance be filed with the Clinic Coordinator or Patient Relations Services Coordinator a copy of the grievance will be immediately forwarded to CCHP Member Services to process the grievance.
3. When a grievance is filed through CCHP Member Services, the Member Services Representative will document the complaint.
4. Grievance copy will be mailed to the patient for his/her signature. CCHP Member Services will include a copy of the Patients' Rights (80.ntm).
5. When the patient returns the complaint to CCHP, the Member Services Representative will immediately fax or email the grievance to CCRMC Patient Relations Services Coordinator.
6. If the investigation is not or will not be completed within 7 days, the patient or patient's representative will be informed by CCHP Member Services in writing that their complaint has been received, is being investigated, and that a written response will be sent to the patient or patient's representative within 30 days.
7. CCHP Member Services will immediately send CCRMC Patient Relations Services Coordinator a grievance investigate request for the appropriate staff to investigate and response to a grievance. The completed investigation responses will be immediately forwarded to CCHP Member Service who will officially provide a final written response to the patient, or patient's representative within 30-days. CCHP Member Services will officially respond to the patient in writing.

E. Mental Health Grievances

Patients/consumers of the Contra Costa Mental Health Division may file complaints or grievances, verbally or in writing, with the Office of Quality Improvement, 1340 Arnold Drive, #200, Martinez, CA 94553, (925) 957-5160 or 1-888-678-7277.

F. Patient Billing Grievances

Billing grievances that do not involve quality of care issues will be referred to Patient Accounting, in writing and addressed to the Credit and Collections Supervisor, 595 Center Avenue #300, Martinez, California, 94553.

1. Bills concerning room charges, double charges, or deductibles (including share-of-

cost) will remain within Patient Accounting.

2. The Credit and Collections Supervisor will notify the Patient Relations Services Coordinator of grievances regarding the quality or level of care.
 - a. The Department Chair will review the care to determine if a reduction is warranted.
 - b. The Credit and Collections Supervisor will inform the patient if the bill is reduced and send a copy of the final letter to the Patient Relations Services Coordinator.
 - c. When a reduction is not warranted, the Patient Relations Services Coordinator will inform the patient the criteria justifying the charges and send a copy of the letter to the Credit and Collections Supervisor.

G. Medi-Cal Grievances

If the patient has Medi-Cal coverage and files a grievance regarding the care they received in relation to their Medi-Cal coverage or the denial of Medi-Cal coverage, refer to the EHSD Appeals office, 400 Ellinwood Way, Pleasant Hill, CA 94523 phone (800-952-5253).

H. Premature Hospital Discharge issue: Refer to the Utilization Review Director

RELATED LINKS:

~~[Patient Complaint/Grievance Form \(A-546\)](#)~~

~~[Patient Complaint/Grievance Form \(A-546\)](#)~~

~~[CCHP Member Rights and Responsibilities](#)~~ [CCHP Member Rights and Responsibilities](#)

REFERENCES:

42 CFR 482.13 Condition of Participation *Interpretive Guidelines*, Tag A-0118 to A-0123.

Title 22, California Code of Regulations, Section 70707(c) 64 Fed. Reg. 36070, 36073

TJC 2021 Standard RI.01.07.01, "The patient and his or her family have the right to have a complaint(s) reviewed by the hospital."

Contra Costa Health Plan Grievance/Complaint Procedures - MS 8.001, MS 8.017, MS 8.031, MS 8.032, MS 8.020, MS 8.026.

Ambulatory Care ~~["Patient Complaints" Policy 1019](#)~~ ["Patient Complaints" Policy 1019](#)

Mental Health Administration- ~~[Policy #804, "Mental Health Consumer Grievance Procedure"](#)~~ [Policy #804, "Mental Health Consumer Grievance Procedure"](#)

APPROVALS:

Patient Care Policy & Evaluation Committee: 9/2021, 8/2022

Medical Executive Committee: 10/2021, 8/2022

Joint Conference Committee: 3/2023

Reviewed: 4/91; 4/95; 2/00; 10/00; 6/04; 12/05; 1/10; 8/13; 12/16; 7/17, 8/2021, 7/2022

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Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: CCRMC Chief Executive Officer	12/2025
	Leah Carlon: Health Care Risk Manager	12/2025

Standards

No standards are associated with this document