IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD OF DIRECTORS

Katherine Burnworth, President | Laura Goodsell, Vice-President | James Garcia, Treasurer | Arturo Proctor, Secretary | Enola Berker, Director | Rodolfo Valdez, Director

AGENDA
SPECIAL MEETING OF THE BOARD OF DIRECTORS
TUESDAY, September 30, 2025, 6:00 P.M.

El Centro Regional Medical Center | MOB Conference Room 1&2
1271 Ross Avenue, El Centro, CA. 92243

Join Microsoft Teams
Meeting ID: 265 617 430 675 0
Passcode: vm2jN6uV

1. **Call to Order**

2. **Roll Call**

3. **Pledge of Allegiance**

4. **Approval of Request for Remote Appearance by Board Member(s)**, *if Applicable*

5. **Consider Approval of Agenda**
   In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety, or both. Items on the agenda may be taken out of sequential order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**
   At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themself, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on

items not appearing on the agenda at anyone one meeting to one hour.

7. Items for Discussion and/or Board Action:

a. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/ procedures/forms, or other related recommendations.

b. Discussion and Action Regarding Future El Centro Facility Naming/Branding

c. Interview Interested Applicants for Vacant Director Position

d. Discussion and Possible Action to Appoint Director to Vacant Board Position

8. Items for Future Agenda

This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

9. Adjournment

a. The next regular meeting of the Board will be held on October 9, 2025, at 6:00 p.m.

POSTING STATEMENT

A copy of the agenda was posted September 26, 2025, at 601 Heber Avenue, Calexico, California 92231 at 8:00 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board, including such records and written distributed less than 24 hours prior to this meeting are available for public inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)970- 6046. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodation to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

DATE: September 16, 2025

TO: Imperial Valley Healthcare District Board of Directors

FROM: Ramaiah Indudhara, M.D; Chief of Staff, Pioneers Memorial Hospital

SUBJ: PMH Medical Staff Recommendations for Approval

ITEMS FOR CONSIDERATION: Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms or other related recommendations.

SUMMARY AND BACKGROUND: The Medical Executive Committee, upon the recommendations of the Credentials Committee and the respective clinical services and/or chiefs and based on the completed credential files, policies and procedures, recommends that medical staff membership and/or clinical privileges be granted as outlined below:

1. Recommendation for **Initial Appointment** to the **Provisional Staff effective October 1, 2025** for the following:
   - Chachere II, Danny, MD — Neurology (Telemedicine)
   - Dodd, Cameron, MD — Orthopedic Surgery
   - Patel, Prashant, MD — Interventional Cardiology
   - Porter, Evan, MD — Orthopedic Surgery
   - Stillson, John, MD — Family Medicine (limited EGD privileges)
   - Cohenca, Ilan, CRNA — Nurse Anesthetist

2. Recommend **Reappointment** effective **October 1, 2025** for the following:
   - El Ramah, Mohsen, MD — Internal Medicine
   - Englea-Larra, Jaime, DO — Anesthesiology, Pain Medicine
   - Friedline, John, MD — Internal Medicine
   - Moukarzel, Elias, MD — OB/GYN
   - Van Pratt Levin, Benjamin, MD — Family Medicine
   - Alcantara, Teresa, CRNA — Nurse Anesthetist
   - Blais, Marylou, CRNA — Nurse Anesthetist
   - Whitehead, Thomas, NP — Nurse Practitioner

3. Recommend **Release from Proctoring and/or Advancement** effective **October 1, 2025:**
   - Malik, Mobin, MD — Interventional Cardiology (General Cardiology)

4. Recommend acceptance of the following **Resignations from Staff** effective **August 31, 2025** (unless otherwise noted)**:**
   - Morrell, Mignonne, MD — Teleradiology
   - Rodriguez, Norma, MD — Pathology
   - Orduno, Ramon, CRNA — Nurse Anesthetist (Did not return reappointment)

5. Recommend **Additional Temporary Privileges** as follows effective October 1, 2025:
   - Idrees Suliman, MD — Addition of Temporary Privileges with the temporary Fluoroscopy permit by the state (ERCP Procedures, Diagnostic and Therapeutic Ultrasonography, Interventional Gastroenterology, Moderate Sedation, Fluoroscopy)

6. Recommend acceptance of the following policies/forms:
   - Care and Management of Central Venous Catheters and Prevention of CVC-Associated Blood Stream Infections (CLN-02377)
   - *Care of an Emergency Patient Contaminated with Hazardous Materials – CODE ORANGE (EOC-00095)*
   - *Firearms and Weapons (EOC-00056)*
   - Ketamine Protocol for Ventilated Patients (ICU-00414) Pre Printed Order
   - *Redisclosure of Protected Health Information (PHI) (DPS-00320)*
   - Use of Blood Warmer during Blood Transfusion (CLN-0scop0095)
   - Massive Blood Transfusion and Massive Transfusion Protocol (TRM-069)

Note: not all of these policies require Board approval. Only those requiring this approval will be forwarded to the Governing Body..

7. Mr. Bjornberg stated that, with the signing of the MOU, there are more things that we can work on with ECRMC. For Master Planning, we are meeting with the group we hired and it looks like there are some of our areas that will not need as much work as we originally thought. We will continue to work with those affected and the group to finalize plans for the areas that are not seismically compliant right now. Four options were discussed as we move forward with construction planning.

8. It was reported that we had a loss of $20k in the month of July. We are at 83.5 days Cash on Hand. There were discussions regarding the observation: increased revenue from the Clinics was observed (10%) compared to loss (-6.25%) in hospital revenues

9. Respiratory Mask Fit Testing compliance is currently 77% for the Medical/Allied Health Staff. This is an OSHA requirement and needs to be done annually. Reminders have been sent to those who have not complied with the requirement. There are discussions about the current CDPH and OSHA annual requirements for continued need for Respiratory Mask Fit testing for all providers. ECRMC does not have this policy. Administration was asked about the future status in view of the hospitals merger.

10. Transfer Report for January – August, 2025 indicates 908 total transfers from the ER, 150 in July and 118 in August. The top three reasons for transfer remain Gastro, Neurosurgery and Pediatrics. Reported was also a total of 100 transfers from the inpatient side from January through August, 2025.

11. Clinical Service and Committee Reports:
    - Medicine – Dr. Krutzik reports no meeting. There was a credentialing question that will be reviewed.
    - Emergency Medicine – Dr. Nelson stated that they had a meeting and invite specialists to attend and would like to review some of the tough cases for education.
    - Surgery/Anesthesia/Pathology – Dr. Larra reported that there will be a new class of SRNA's this fall, they help fill coverage gaps for us from the Navy. Dr. Rodriguez stated that they are doing ok..
    - OB/GYN – No meeting was held, no updates.
    - Pediatrics – No meeting was held. There has been changes to the on-call schedule in Pediatrics.and a Pediatric Hospitalist program or assistance from Radys Childrens was proposed..
    - Medical Imaging – Dr. Rapp stated that they did not have a meeting and there was no additional report.
    - Ambulatory Services – Ms. Zamora reported that they are starting to see an increase in volumes in the clinics. Both Pediatrics and OB will need locums coverage for the next several months to fill the gaps.
    - Credentials & Bylaws – Approved information above. In addition, the process has started to review the Medical Staff Bylaws with ECRMC and an ad-hoc committee of members of the Medical Staff.
    - MSQC –approved policies as listed above.
    - Utilization Management – Reported was that the PMH Average Length of Stay, January to August, was 2.94. Case Mix Index is 1.34 Medicare One Day Stays count is 11 and the percentage is 11.7. Total Observations 32, converted 15 with a conversion rate of 44%. Hospital readmissions are 4.26.

RECOMMENDATION: That Imperial Valley Healthcare District Board of Directors approves each of the recommendations of the Medical Executive Committee for medical staff membership and clinical privileges as outlined above, policies and procedures as noted and authorize the chief executive officer to sign any documents to implement the same.

Respectfully submitted,
Ramaiah Indudhara, MD, MBA, FACS
Chief of Staff, Pioneers Health Center.
RI/cb

POLICIES FOR APPROVAL AT BOARD

	Policy	Policy No.	Page #	Revisions (see policy for full description)
1.	Care of an Emergency Patient Contaminated with Hazardous Materials – CODE ORANGE	EOC-00095	• 1-11	• Changed PMHD to PMH on sections 3.1, 3.3, 3.4, 3.6. 5.3, 5.5, 5.6, 5.6.1, 5.8, 5.9.1.6, 5.15.1, 5.15.2, 5.15.3, 5.1.6.1, 5.1.6.2. • Updated Reference 6.2 from 2004 to the latest OSHA Reference 2020. • Updated Reference 6.3 from 2008 to the latest 2016 Version. • Changed PMHD to PMH on attachment A • Revised with no further changes.
2.	Firearms and Weapons	EOC-00056	• 12-14	• Revised header. • Changed Pioneers Memorial HealthCare District to IVHD. • Changed definition section 4.1 from PMHD to PMH • Changed PMHD to PMH in all sections. • Revised with no further changes.
3.	Redisclosure of Protected Health Information (PHI)	DPS-00320	• 15-17	• Revision of minor spelling and grammatical errors • Added references • Updated header to reflect IVHD • Replaced PMHD with PMH • Revised reference list – removed link to HHS page that no longer exists

Imperial Valley Healthcare District

Title: **Care of an Emergency Patient Contaminated with Hazardous Materials – CODE ORANGE**	Policy No. EOC-00095
	Page 1 of 10
Current Author: Jorge Mendoza	Effective: 8/1/1995
Latest Review/Revision Date: 4/2025	Manual: EOC / Hazardous & Waste Mgmt

Collaborating Departments: ED, Facilities, EVS		Keywords: Hazmat, Hazardous Materials, Decontamination, Contaminated		
Approval Route: List all required approval				
MARCC 9/9/2023	PSQC	Other: Safety Committee 10/2023		
Clinical Service _____		MSQC 11/2023	MEC 11/2023	BOD 12/2023

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 PMH (Pioneers Memorial Hospital) may be confronted with patients that have been contaminated by residual biological spores, chemical and/or radioactive effects from natural or man-made incidents. This policy will establish guidelines for facilitating safe and efficient decontamination of patients.

1.2 The primary concern for a hazardous materials response is for the safety and security of patients, staff and the facility.

2.0 Scope: Hospital wide

3.0 Policy:

3.1 The PMH Emergency Operations Plan (EOC-00213) will be activated for all hazmat/decontamination events.

3.2 At a minimum, an Incident Commander and Safety Officer will be assigned for all hazmat/decontamination events.

3.3 The PMH decontamination team will consist of trained personnel, may be clinical or non-clinical, from various departments at PMH.

3.4 All PMH Employees who will serve as part of the PMH decontamination team will receive training that meets the requirements set forth in 29 CFR 1910.120(q)(6)(ii) "Hazardous Materials First Responder Operations (FRO)" requirements.

3.5 Employees will receive annual refresher training that meets the requirements set forth in the above regulation.

3.6 The PMH EMS/Emergency Preparedness Manager will be responsible for procuring and maintaining decontamination equipment and personal protective equipment.

3.7 Upon notification of a hazmat incident, the assigned Incident Commander will complete the hazardous materials incident checklist.

4.0 Definitions:

4.1 Decontamination – Procedures taken to rid of contamination

4.2 Decontamination Team – A team of individuals properly trained to decontaminate victims of hazardous materials incidents.

4.3 Hospital Incident Command System (HICS) – A system designed to establish command and control for hospitals in response to an emergency/disaster situation.

4.4 FEMA – Federal Emergency Management Agency

4.5 Hazardous Material (HazMat) – A material considered to be a danger to life or the environment if released without precautions (i.e., chemical agent, biological agent, radioactive material, etc.)

5.0 Procedure:

5.1 Initial notification of possible patients from a hazmat incident in the community can come from various sources including, but not limited to:
- 5.1.1 Fire Department/EMS
- 5.1.2 Law Enforcement
- 5.1.3 Media Sources
- 5.1.4 Patients

5.2 Upon receiving initial notification of an incident potentially requiring patient decontamination, the following information should be obtained as rapidly as possible:
- 5.2.1 Type and nature of the incident (motor vehicle accident, explosion, etc.)
- 5.2.2 Contact information of the notifying agency (name, phone number, etc.)
- 5.2.3 Approximate number and ages of victims
- 5.2.4 Victim signs and symptoms
- 5.2.5 Nature/degree of victim injuries
- 5.2.6 Type of chemical or other agent involved
- 5.2.7 Extent of victim decontamination occurring in the field
- 5.2.8 Approximate time of EMS arrival
- 5.2.9 Expected number of self-presenting patients
- 5.2.10 PPE should be immediately gathered from the Hazmat Trailer and brought to the Emergency Department break room or other empty ED room to establish a PPE donning area.

5.3 In order to effectively protect PMH in response to a hazmat event, the following internal notifications must be made immediately:
- 5.3.1 Emergency Department Charge Nurse
- 5.3.2 House Supervisor
- 5.3.3 Security
- 5.3.4 Safety Officer
- 5.3.5 Administration
- 5.3.6 EMS/Emergency Preparedness Manager
- 5.3.7 Brawley Police/Fire Dispatch Center via 9-1-1 or the 800MHz radio system
  - 5.3.7.1 Coordinate with Brawley Fire Department if decontamination assistance is necessary. Brawley Fire Department may be available to assist or may contact the Imperial County Hazardous Emergency Assistance Team (HEAT Team) for a larger operation.

5.4 The Hospital Operator will be contacted to page a “Code Orange” overhead.

5.5 The PMH Emergency Operations Plan will be activated for all incidents that require patient decontamination.
- 5.5.1 A full complement of HICS staff is not necessary; however an Incident Commander and Safety Officer must be assigned.

5.6 In the event an unannounced patient(s) presents to PMH from a suspected hazmat incident, the employee who first encounters the patient shall immediately direct the patient(s) to the decontamination showers outside the Emergency Department and notify the Emergency Department Charge Nurse, who will ensure the notifications listed in 5.3 are made.

5.6.1 The first member of the PMH Decontamination team to arrive, will don the highest level of PPE available (Level C), described in this policy, unlock the decontamination showers and begin to interview the patient.

5.6.2 Attempt to identify and characterize the product with which the patient was contaminated:

5.6.2.1 What is the name or chemical ID number for the product?

5.6.2.2 What is the chemical used for?

5.6.2.3 What is the chemical's classification (oxidized, flammable, corrosive, etc.)?

5.6.2.4 Is the chemical water soluble?

5.6.2.5 Number of possible patients who may present from the incident

5.6.2.6 If the chemical is unknown or cannot be identified, what were the circumstances surrounding the use of the agent (i.e. spraying plants, cleaning, machinery, etc.)?

5.7 The following resources may be used to determine the contaminant; level of PPE required and suggested treatment plans:

5.7.1 Current Emergency Response Guidebook (must know name or chemical ID number) – located in ED reference book section as well as triage desks

5.7.2 MSDS sheets (must know name of chemical)

5.7.3 WISER app/WebWiser (wiser.nlm.nih.gov)

5.7.4 Regional Poison Control Center (800) 222-1222

5.8 Immediately upon notification of a hazmat incident, PMH will initiate a controlled access plan and all foot traffic into the facility will be directed through the Emergency Department. Decontamination team members in appropriate PPE will prevent contaminated individuals from entering the facility until they have been properly decontaminated.

5.9 PPE selection for decontamination team members is critical at the onset of a hazmat event. The guidelines below describe the PPE available, process for selection of PPE, donning and doffing procedures:

5.9.1 Level C PPE is available for decontamination team members and includes:

5.9.1.1 Powered-Air Purifying Respirator (PAPR) with organic vapor cartridge and Butyl Rubber Hood

5.9.1.1.1 PAPRs and butyl rubber hoods are located in the PAPR/Backboard closet in the ED, near the ambulance entrance

5.9.1.2 Chemically protective suit

5.9.1.3 Two layers of gloves including (from inner layer to outer layer):

5.9.1.3.1 Nitrile Gloves

5.9.1.3.2 Chemically Protective Gloves
5.9.1.4 Chemically protective rubber boots or shoe covers
5.9.1.5 Suit openings sealed with chemically protective tape.
5.9.1.6 Level C PPE is stored in the PMH Hazmat Trailer, located outside the Emergency Department Ambulance Entrance
5.9.1.6.1 The key to the Hazmat Trailer should be obtained from one of the following:
5.9.1.6.1.1 House Supervisor
5.9.1.6.1.2 Emergency Department Manager
5.9.1.6.1.3 Emergency Preparedness Manager
5.9.1.6.1.4 Emergency Department Key Locker

5.10 Upon notification of a possible decontamination event, PPE should be obtained from the Hazmat Trailer and brought to the Emergency Department break room or other empty ED room to establish a PPE donning area

5.10.1 An assistant is required to don PPE, the donning sequence is as follows:
5.10.1.1 Assemble and test the PAPR using the manufacturer's recommendations
5.10.1.2 Remove watches, jewelry, name badges and personal clothing and put on scrubs
5.10.1.3 Inspect all PPE for damage prior to donning, if any damage is present discard and obtain a replacement
5.10.1.4 Put on the inner nitrile gloves
5.10.1.5 Put on the chemical protective suit to waist.
5.10.1.6 Put on boots/shoe covers
5.10.1.7 Put on the chemically protective outer gloves
5.10.1.8 Put on PAPR hood and position the inner shroud
5.10.1.9 Pull chemical protective suit up and over the inner shroud
5.10.1.10 Pull suit sleeves over gloves, zip-up and ensure the Velcro closure covers the zipper
5.10.1.11 Pull outer PAPR hood shroud over the suit
5.10.1.12 Secure PAPR belt to waist
5.10.1.13 Pull suit cuff over top of boot/shoe cover
5.10.1.14 Use chemically protective tape to seal all openings; sleeve cuffs and zipper
5.10.1.15 Place a piece of tape on the front and back of the hood exterior and label with the employee's name with a permanent marker

5.11 Employee safety is crucial to ensure safe decontamination operations. The assigned Safety Officer will closely monitor and document the length of time each employee is in Level C PPE.

5.11.1 The Incident Commander and Safety Officer will coordinate to ensure employees are rotated efficiently to ensure their safety.

5.11.2 The Incident Commander or Safety Officer will need to designate a location to be used as a rehabilitation area for staff during decontamination operations.

5.11.3 The Incident Commander will coordinate with the dietary department to provide hydration and nutritional items for staff in the rehabilitation area.

5.11.4 While in the rehabilitation area, employees should be monitored for signs of heat stress.

5.11.4.1 Hot, unusually dry, red or spotted skin

5.11.4.2 Elevated body temperature

5.11.4.3 Altered level of consciousness, confusion or delirium

5.11.4.4 Weakness or fatigue

5.11.4.5 Vomiting

5.11.4.6 Body cramps

5.11.5 Any employee who shows signs and symptoms of a heat related illness should be immediately removed and will no longer participate in the operations. They will be taken immediately to the Emergency Department for appropriate treatment.

5.11.6 Prior to leaving the rehabilitation area and returning to operations in PPE the following conditions must be met:

5.11.6.1 Diastolic Blood Pressure ≤ 95

5.11.6.2 Heart Rate ≤ 110

5.11.6.3 Respirations ≤ 20

5.11.6.4 Oral Temperature ≤ 99.5

5.11.7 If an employee's vital signs persistently remain above these limits, they should be taken to the Emergency Department for evaluation.

5.12 Prior to leaving the Hospital Decontamination Zone to enter the Rehabilitation Area the following procedure must be followed, while still in PPE, using soap and running water:

5.12.1 An assistant in PPE should decontaminate employees, in a separate area from victims (Technical Decontamination Area), using a soft bristled brush with gentle scrubbing in a unilateral direction from top down.

5.12.2 Remove tape from exterior of suit.

5.12.3 Thoroughly wash exterior gloves

5.12.4 Thoroughly wash PAPR Hood

5.12.5 Thoroughly wash torso front and back

5.12.6 Thoroughly wash PAPR Hose and PAPR unit including belt

5.12.7 The employee should reach down and remove PAPR from waist, while leaving the hood on, and hold it away from body. The PAPR unit may be placed on a chair, gurney or hung from an IV pole if available.

5.12.8 Thoroughly wash each leg and boots.

5.12.9 Thoroughly wash the bottom of each boot

5.12.10 Step out of the technical decontamination area into the PPE doffing area.

5.12.11 Remove PAPR Hood – place in waste

5.12.12 Remove chemical boots – place in waste

5.12.13 Unzip chemical suit

5.12.14 Remove exterior gloves – place in waste

5.12.15 Remove the chemical suit from the torso – roll the suit away from you inside out touching the inside of the suit.

5.12.16 Remove each leg from the chemical suit – place in waste
5.12.17 Step over clean line and remove nitrile gloves – place in waste

5.13 In the event a decontamination team member has an emergency during decontamination operations, they should immediately follow the above procedure and be moved to the post decontamination zone for treatment or new PPE.

5.14 Patient Decontamination:

5.14.1 Ambulatory Patient Decontamination:

5.14.1.1 Ambulatory patients should be directed by a decontamination team member to self-decontamination in the decontamination showers.
5.14.1.2 Children should be kept with their parents, if possible; if no parent or older sibling is available then a decontamination team member should provide needed assistance to a child
5.14.1.3 Separate decontamination showers should be designated for male and female victims to maintain privacy if necessary.
5.14.1.4 Victims should be given a personal decontamination kit prior to entering decontamination showers.

5.14.2 The following decontamination instructions should be provided:

5.14.2.1 Remove all valuables and seal in the small plastic bag.
5.14.2.2 Remove all clothing and seal in the larger plastic bag.
5.14.2.3 Seal both the valuables bag and clothing bag in a third plastic bag that has been labeled with unique patient identifiers.
5.14.2.4 Place the final sealed bag in the barrel at the exit of the decontamination showers for future disposition.
5.14.2.5 Gently brush off dry contaminants being careful to avoid contact with eyes, nose and mouth.
5.14.2.6 Using the soap provided wash from head-to-toe paying special attention to the hair and all body crevices.
5.14.2.7 Wash time cycle should be five (5) minutes per person.
5.14.2.8 Use a gentle, unilateral scrubbing motion from top down.
5.14.2.9 Upon completion of decontamination, the patient should step out of the wash area towel dry and put on supplied gown or given a sheet/blanket to cover.
5.14.2.10 Place wash cloths and towels in the designated barrel

5.14.3 The patient should then be directed to the Emergency Treatment Area, if established, and re-triaged for treatment in the Emergency Department.

5.14.4 Non-Ambulatory Patient Decontamination:

5.14.4.1 Patients who are unable to perform self-decontamination should be taken to the non-ambulatory decontamination area; this includes but is not limited to patients who are non-ambulatory due to:

5.14.4.1.1 Injury/illness caused by the incident
5.14.4.1.2 Patients who have an underlying medical condition that prevents them from performing self-decontamination (i.e. paralysis, dementia, bed/wheelchair bound, etc.)

5.14.4.1.3 Age-affected; consider elderly and infant patients who cannot perform decontamination.

5.14.4.2 Non-ambulatory patient decontamination should be performed simultaneously with patient stabilization. Basic Life Support (ABC's) will be maintained until the patient is decontaminated, to a degree that ensures staff safety and that invasive procedures will not increase the patient's risk of systemic absorption.

5.14.4.3 The two black cots located in the hazmat trailer should be used for non-ambulatory decontamination and the patient placed on a plastic/fiberglass backboard. **Infants should be decontaminated in infant baths or similar baskets*.

5.14.4.3.1 Emergency Department gurneys, with the mattresses removed, should be used to transport patients after the decontamination process.

5.14.4.4 The following procedures should be used for non-ambulatory decontamination:

5.14.4.4.1 Follow the procedures for removal and bagging of personal valuables.

5.14.4.4.2 Patient clothing should be removed using blunt tipped trauma shears and bagged using the above procedures.

5.14.4.4.3 Wash the patient from head-to-toe using a gentle, unilateral scrubbing motion from top down paying special attention to the patient's hair and body crevices.

5.14.4.4.4 Remove any dressings applied prior to decontamination and use copious amounts of water to irrigate wounds.

5.14.4.4.5 A clean dressing should be applied if necessary to control bleeding.

5.14.4.4.6 The patient should then be transferred to a clean Emergency Department gurney, without the mattress, and moved to the designated area to be transferred to the post-decontamination zone.

5.14.5 Special Considerations:

5.14.5.1 Glasses and contact lenses:

5.14.5.1.1 Patients with glasses should keep them if they cannot see without them. They must be washed and rinsed thoroughly during the decontamination process before being worn. Otherwise, the glasses should be placed in the valuables bag.

5.14.5.1.2 Contact lenses should be removed, after thoroughly washing hands, and discarded or placed in the valuables bag.

5.14.5.2 Patients who use walking assist devices may retain them, but the device must be washed and rinsed thoroughly during the decontamination process.

5.14.5.3 Intravenous lines and Saline locks should be removed prior to

decontamination. After the area is cleaned, a dressing should be applied until the patient reaches the treatment area.

5.14.5.4 Hearing aids should be removed and placed in the valuables bag.

5.14.5.5 Dentures:

5.14.5.5.1 Unless the oral cavity is contaminated dentures should remain in place and no special decontamination is necessary.

5.14.5.5.2 If the oral cavity is contaminated, then the dentures should be removed, placed in a clear plastic bag for later decontamination based on poison control or dentist recommendations.

5.14.5.6 Law Enforcement Officers with Weapons:

5.14.5.6.1 In most cases law enforcement personnel who have been injured on the scene will have had their gun(s) removed before arrival and given to a fellow officer.

5.14.5.6.2 If an officer arrives and still has a weapon, it should be left in the holster and the gun belt removed by a decontamination team member and sealed in two clear plastic bags labeled with the officer's name. It should be transferred to the treatment area and given to a fellow officer for safe keeping.

5.14.5.6.3 Decontamination team members should be aware that oftentimes an officer may have a second weapon that can usually be found in a holster near the ankle, their pocket, in a ballistic vest or near an armpit. If found the weapon should be handled following the above guidelines.

5.14.5.6.4 An officer's duty-belt may also contain items that can be dangerous if allowed in the wrong hands. Thus, the duty-belt should be collected and sealed as described above and handed to a fellow officer or hospital security for safekeeping.

5.14.5.6.5 Decontamination of an officer's weapon or duty belt will be the responsibility of their respective agency.

5.14.6 Personnel Decontamination:

5.14.6.1 Prior to leaving the decontamination area, decontamination team members must undergo decontamination using the guidelines outlined in this policy (5.12.1 – 5.12.17)

5.14.6.2 Once the above steps have been completed, each decontamination team member must remove all clothing, shower and dress in replacement scrubs or personal clothes.

5.14.6.3 After redressing, each decontamination team member must present to the Emergency Department for appropriate medical screening and monitoring for chemical exposure as determined by the Emergency Department Physician.

5.15 Decontamination Water Containment and Run-Off:

5.15.1 During an emergency, PMH will take all necessary steps to protect staff, the public and save lives. Once imminent threats to human health and life are

addressed PMH will take all reasonable steps to contain contamination and avoid or mitigate environmental consequences.

5.15.2 For all incidents, PMH decontamination team members will use the fixed decontamination showers as the primary means for patient, staff and equipment decontamination

5.15.3 In the event the number of victims that present to PMH exceeds the capacity of the fixed decontamination shower facilities the following steps will be taken after imminent life threats have been mitigated:

5.15.3.1 The storm drain adjacent to the decontamination showers will be sealed with two layers of plastic sheeting and secured.

5.15.3.2 Reasonable efforts to collect water run-off from mass decontamination efforts should be taken (i.e., diking, waste-water bladders, etc.)

5.15.3.3 In the event that waste-water run-off cannot be collected prior to entering the storm drain, the Imperial County Office of Environmental Health will be notified immediately.

5.15.4 After decontamination operations have been completed, the PMHD hazardous waste contractor will be contacted to assist in cleaning, testing and disposal of waste-water and equipment.

5.16 After Action Reporting/Improvement Plan:

5.16.1 Immediately following the event, the PMH EMS/Emergency Preparedness Manager or designee will conduct Hot-washes with all staff and coordinating agencies involved to identify the effectiveness and deficiencies of the response.

5.16.2 Within forty-five (45) days after the termination of operations, the Emergency Preparedness Coordinator will submit a Draft After Action Report and Improvement Plan to the PMH Safety Committee for approval.

5.16.3 The After Action Report/Improvement Plan will be submitted to the Imperial County Medical Health Operational Area Coordinator and other appropriate agencies upon request.

6.0 References:

6.1 CFR 1910.120 HAZWOPER

6.2 OSHA, Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances, 2020

6.3 FEMA Center for Domestic Preparedness, Hospital Emergency Response Training for Mass Casualty Incidents, 2016

7.0 Attachment List

7.1 Attachment A – Hazardous Materials Incident Checklist

8.0 Summary of Revisions:

8.1 Changed PMHD to PMH on sections 3.1, 3.3, 3.4, 3.6.

8.2 Changed PMHD to PMH on sections 5.3, 5.5, 5.6, 5.6.1, 5.8.

8.3 Changed PMHD to PMH on Section 5.9.1.6.

8.4 Changed PMHD to PMH on Section 5.15.1, 5.15.2, 5.15.3.
8.5 Changed PMHD to PMH on Section 5.1.6.1, 5.1.6.2.
8.6 Updated Reference 6.2 from 2004 to the latest OSHA Reference 2020.
8.7 Updated Reference 6.3 from 2008 to the latest 2016 Version.
8.8 Changed PMHD to PMH on attachment A
8.9 Revised with no further changes.

Hazardous Material Incident Checklist

Name of Person Receiving Call:_____

Title:_____

Date:_____Time:_____Phone:_____

*Reporting Agency:_____*Unit #/Name:_____

*Contact Information (phone/radio):_____

Location of Incident:_____

Threat to Hospital (Circle): Yes No Comment:_____

_____

Nature of Incident (i.e. traffic accident, explosion, leak, etc.):_____

_____

Name of Chemical:_____

Approximate # of Patients:_____Children (Circle): Yes No Elderly: Yes No

Victim Signs/Symptoms:_____

_____

On Scene Decontamination: Yes No Description:_____

_____

EMS Transport: Yes No ETA of First Arriving Unit:_____

Estimated # of Patients Who May Self Present:_____

This form is to be completed, with as much information as possible, by the employee who receives initial notification from field personnel. The ED Charge Nurse will immediately notify the on-duty House Supervisor and proceed as directed by PMH Policy EOC-00095. Additional information regarding the incident and pre-hospital treatment provided may be recorded on the back of this form.

Attachment A – EOC-00095

Imperial Valley Healthcare District

Title: **Firearms and Weapons**	Policy No. EOC-00056
	Page 1 of 3
Current Author: Jorge Mendoza	Effective: 12/30/2016
Latest Review/Revision Date: 06/2025 R1	Manual: EOC / Safety Management

Collaborating Departments: Admin, Compliance, Legal, HR, Safety, Ambulatory Services		Keywords: Firearms, weapons, guns		
Approval Route: List all required approval				
MARCC 3/7/2023	PSQC	Other: Safety Committee: 4/2023		
Clinical Service _____		MSQC 5/2023	MEC 5/2023	BOD 5/2023

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 Pioneers Memorial hospital is committed to maintaining a safe and secure environment for its patients and employees. This policy is a proactive step towards reducing the risk of injury or death associated with intentional or accidental use of weapons.

2.0 Scope: District wide

Pioneers memorial

3.0 Policy:

3.1 All members of the PMH community, as well as visitors, (except Sworn Peace Officers as described in Section 5.1, below) are prohibited from possessing weapons, of any kind, in, or on, any PMH premises regardless of whether a federal or state license to possess the same has been issued to the possessor.

4.0 Definitions:

4.1 PMH – Pioneers Memorial Hospital

4.2 Firearms – Any device that shoots a bullet, pellet, flare, tranquilizer, spear dart, or other projectile.

4.3 Weapons – any device or simulated device, including firearms and simulated firearms that is designed to, or traditionally used, to inflict harm (i.e. knives, metal pipes, bats, etc.).

5.0 Procedure:

5.1 All patients, employees, visitors, board members, medical staff members, clinical practitioners, independent contractors, volunteers, vendors, and any other persons entering into or located on, any the PMH premises, which includes, without limitation, Pioneers Memorial Hospital, outpatient clinics or any other premises on which PMH is conducting any form of business activities are strictly prohibited from possessing Fire Arms or Weapons.

5.2 This policy shall not prohibit the following persons from carrying a firearm/other deadly weapon on PMH premises:

5.2.1 Sworn Peace Officers to the extent they are legally permitted to possess weapons in the jurisdiction in which the PMH premises are located and "On Duty", as well as, "off Duty", and "Retired" Sworn Peace Officers with the exception that the weapon is concealed.

5.2.2 Forensic Agencies performing legal functions and "On Duty"

5.2.3 Security/designated alternative guards employed by or contracted with local, state or federal agencies have permission to carry a firearm while on duty.

5.3 Should an employee find a firearm or observe one in the possession of an individual in the hospital, the employee should call security to escort the individual out of the facility.

5.4 Signs will be posted at all entrances of Pioneers Memorial Hospital, including entrances for employees and clinical practitioners, announcing PMH policy prohibiting weapons on PMH property.

5.4.1 English and Spanish signage shall state:

5.4.1.1 *"Pioneers Memorial Hospital prohibits any person from carrying a firearm or other deadly weapon onto these premises."*

5.5 **Patients** – Any permit holding patient carrying a firearm/other deadly weapon is required by law to inform the Emergency Department/Admitting personnel that they are carrying a concealed weapon. If the permit-holder is transported for treatment, Emergency Department personnel are authorized to turn custody of the weapon over to any law enforcement officer with the authority to arrest.

5.5.1 If a patient is discovered to be in possession of a firearm or other deadly weapon, the person discovering the firearm or deadly weapon should immediately contact Security and security will take charge of calling local law enforcement immediately.

5.5.2 Security will not retrieve any firearm or deadly weapons. Security will only notify law enforcement (BPD) about individuals with firearm or deathly weapons on premises.

5.6 **Visitors/Vendors** – No visitor or vendor will be allowed to possess a firearm or other deadly weapon on campus. All individuals are to notify Security if a visitor or vendor is believed to have a firearm or other deadly weapon. Security staff will respond and inform the visitor or vendor of Pioneers Memorial Hospital policy and ask the visitor or vendor to remove the firearm/weapon from the Pioneers Memorial Hospital premises immediately or return it to his or her vehicle. If the visitor/vendor refuses, Brawley Police Department will be notified.

5.7 **Employees/Volunteers/Medical Staff Personnel/Student** – No volunteer, employee, student, medical staff member, clinical practitioner, independent contractor or lessee shall be allowed to possess a firearm or other deadly weapon while on Pioneers Memorial Hospital Property. Individuals are to notify Security immediately if any employee, medical staff member, clinical practitioner, independent contractor, or lessee is believed to be carrying a firearm or other deadly weapon. Security staff will respond and inform the individual of the Pioneers Memorial Hospital policy and ask the individual to remove the firearm/weapon from hospital premises immediately or return it to his or her vehicle. If person refuses, Brawley Police Department will be notified.

5.8 **Safety** – Employees should be aware that the enforcement of this policy deals with confronting individuals carrying loaded firearms or other deadly weapons. Under no circumstances should any employee take any unnecessary risk or compromise his/her safety in enforcing this policy. Local law enforcement should be contacted immediately, if deemed necessary.

5.9 **Off-Site Areas** – Upon discovery of any unauthorized firearm or other deadly weapon,

employees at off-campus facilities should contact the security officer or an appropriate member of management at the off-site facility. If the individual refuses to comply, management will contact local law enforcement immediately by call 911.

6.0 References:

6.1 California Family Code, Code of Civil Procedure, Penal Code, Welfare & Institutions Code, Federal Statute

6.2 California Health and Safety Code Section 1257.7

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Revised header.

8.2 Changed Pioneers Memorial HealthCare District to IVHD.

8.3 Changed definition section 4.1 from PMHD to PMH

8.4 Changed PMHD to PMH in all sections.

8.5 Revised with no further changes.

Imperial Valley Healthcare District

Title: **Redisclosure of Protected Health Information**	Policy No. DPS-00320
	Page 1 of 3
Current Author: Lorena Santana	Effective: 04/2003
Latest Review/Revision Date: August 2025	Manual: Department Specific/Med Rec

Collaborating Departments:		Keywords:	
Approval Route: List all required approval			
MARCC x	PSQC	Other:	
Clinical Service _____		MSQC x	MEC x	BOD x

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The policy will govern the redisclosure of information obtained by Pioneers Memorial Hospital (PMH) from other healthcare providers, PMH not being the originator of the information.

2.0 Scope: District wide

3.0 Policy:

3.1 A patient's medical record will often contain reports, transcribed notes and other documents that were created by another provider and sent to the current attending or referring provider. Even though the treating provider might not have created all the information in the patient's medical record, these requests are acceptable because HIPAA requires that all valid authorizations contain a statement that says, "information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule". This rule pertains to electronic as well as paper-based records.

3.2 Providers should remember that all information contained in the record should be treated the same - with a few exceptions. Information created by another provider relating to mental health/ drug and alcohol abuse is not subject to redisclosure because of The Confidentiality of Alcohol and Drug Abuse Patient Records rules. Some states also have laws that address redisclosure of information that may be more stringent than HIPAA. If this is the case, then state law or regulation will prevail. Information that may be determined detrimental to the safety, health or well-being of the patient may be submitted to the patient in summary form.

3.3 Otherwise, valid authorizations relating to the incorporated information should follow the same procedures as an authorization for information created by the current provider. This means that the Minimum Necessary standards still apply. Likewise, providers should remember that exceptions to requests for the record still apply if the individual makes a request to view his or her record. Lastly, patients who view their record and request an amendment to any incorporated information should be directed to the facility where the information originated. PMH cannot amend, change or request change for records that were not originally created by them.

3.4 PMH is ***not required*** to allow patients or their legal guardian's access to designated record sets if an LIP determines that access to such information would not be in the best interest of the patient or another individual. The originator of the information may be

given the opportunity to give a summary form to the patient in lieu of the original document.

4.0 Definitions: PMH - Pioneers Memorial Hospital

5.0 Procedure:

5.1 Disclosures of an Individual's Information on a Routine or Recurring Basis

5.1.1 For Routine and Recurring Disclosures, PMH will:

5.1.1.1 Determine who is requesting the information and the purpose for the request. If the request is **not** compatible with the purpose for which it was collected, refer to and apply the "Non-Routine Use" policies.

5.1.1.2 Confirm that the applicable PMH policies permit the requested use and/or disclosure.

5.1.1.3 Identify the type and amount of information that is necessary to respond to the request; and

5.1.1.4 If the disclosure is one that must be included in the PMH accounting of disclosures, include required documentation in an accounting log.

5.2 Disclosures of an Individual's Information on a Non-Routine Basis

5.2.1 For Non-Routine Disclosures, PMH will:

5.2.1.1 Determine who is requesting the information and the purpose for the request. If the request is compatible with the purpose for which it was collected, apply the "Routine and Recurring Use" policies from the above previous section.

5.2.1.2 Determine which information of the individual is within the scope of the request, and what PMH policies apply to the requested use.

5.2.2 If the information requested can be disclosed under the applicable policies, limit the amount of information to the minimum amount necessary to respond to the request;

5.3 Designated Record Sets

5.3.1 The medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or used, in whole or in part, by or for the health plan or health care provider to make decisions about individuals.

5.3.2 For purposes of this definition, the term *record* means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by PMH to make healthcare decisions regarding that patient.

5.4 Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

5.4.1 Is created or received by PMH and

5.4.2 Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

5.4.3 That identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

6.0 References:

6.1 45 C.F.R. §§ 164.502(b), 164.514(d).
6.2 45 C.F.R. § 164.514(d)(3).
6.3 45 C.F.R. § 164.504(e)(2)(i).

7.0 Attachment List: Not applicable

8.0 Summary of revisions:

8.1 Revision of minor spelling and grammatical errors
8.2 Added references
8.3 Updated header to reflect IVHD
8.4 Replaced PMHD with PMH
8.5 Revised reference list – removed link to HHS page that no longer exists

IMPERIAL VALLEY HEALTHCARE DISTRICT

207 West Legion Road, Brawley, CA 92227 voice 760.351.3250 ~ fax 760.351.4489

IMPERIAL VALLEY HEALTHCARE DISTRICT
BOARD OF DIRECTORS

NOTICE OF VACANCY
AND
CALL FOR APPLICATIONS

The Imperial Valley Healthcare District ("**IVHD**") Board of Directors hereby provides notice that a vacancy has been declared on the IVHD Board of Directors.

The Board will fill the vacancy by appointment. The individual appointed will serve as an IVHD Board Director until the person who is elected to fill the vacancy at the next general District election (November 2026) has been qualified.

The Board is seeking applications to fill the vacant Board Director position. Each applicant must be a registered voter and a resident of the District. Applicants should submit a resume and a statement of interest to arochoa@swlaw.com **by no later than 5:00 p.m. PST on September 26, 2025.**

Applicants should be available to attend an in-person interview with the IVHD Board at a Special Board meeting on September 30, 2025 at 6:00 p.m. at El Centro Regional Medical Center, Medical Office Building Conference Room 1&2, located at 1271 Ross Avenue El Centro, CA 92243. A virtual TEAMS option may also be offered for candidates that have special circumstances, such as an illness or unavoidable conflict, subject to the Board's approval.

For information about the IVHD, see https://imperialvalleyhealth.com/.

IVHD BOARD - INTERVIEW SCHEDULE 9/30

TIME	CANDIDATE	NOTES
6:15 PM - 6:30 PM	Dr. Carlos Ramirez	
6:30 PM – 6:45 PM	Dr. Mervat Minerva Kelada	
6:45 PM – 7:00 PM	Matthew Cowie	
7:00PM – 7:15 PM	Ramon Castro	
7:15 PM – 7:30 PM	Natalie Erickson	
7:30 PM – 7:45 PM	Felipe Irigoyen	
7:45 PM – 8:00 PM	Guillermo Hermosillo	
8:00 PM – 8:15 PM	David Dhillon	Via Microsoft TEAMS