"EASTERN SIERRA HOSPITAL MUTUAL AID NETWORK"

("EASTERN SIERRA H-MAN")

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) is made and entered into as of this 1st day of October in the year 2013, by and between Mammoth Hospital (MH), Northern Inyo Hospital (NIH), and Southern Inyo Hospital (SIH).

Each of these hospitals is a party to this MOU and collectively they constitute the "Eastern Sierra Hospital Mutual Aid Network" (Eastern Sierra H-MAN) for the purposes of this MOU.

This Eastern Sierra H-MAN MOU is a voluntary agreement among said hospitals for the purpose of providing medical mutual aid at the time of a declared emergency.

This MOU is not and shall not be construed as a legally binding contract, but rather signifies the belief and commitment of the undersigned hospitals that in the event of an emergency, regardless of cause, which exceeds the effective response capability of a hospital(s), the medical needs of the community will be best met if the undersigned hospitals make their "best effort" to collaborate, to coordinate their response efforts, and to provide mutual aid through the procedures set forth herein, in order to optimize the utilization of available resources.

Nothing in this MOU is intended to create any relationship among the hospitals other than that of independent entities agreeing with each other solely for the purposes set forth in this MOU.

This document addresses the relationships between and among hospitals and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for hospitals to coordinate their actions with other primary members of the Mono County and Inyo County Healthcare Coalitions (MCHCC and ICHCC), to include the Inyo and Mono County Medical and Health Operational Area Coordinator (MHOAC) Programs, the appropriate jurisdictional emergency management personnel and structure, and the Inland Counties Emergency Medical Agency (ICEMA), during planning and response.

An emergency declaration or proclamation (e.g., federal, state, or local declaration/proclamation of an emergency or health emergency by the government officials with authority to so declare or proclaim – President, Governor, Board of Supervisors, County Sheriff, local Health Officer) activates the terms of this MOU. The MOU does not govern the exchange of resources among the parties in non-emergency situations, but may be used to guide resource allocations during training exercises as agreed to by the parties.

Each hospital shall have full and absolute discretion to determine the extent, if any, to which it wishes to provide resources to assist another hospital under this MOU. Accordingly, no hospital shall be required to provide medical supplies, equipment, services, personnel, or bed capacity to another hospital, either during an emergency, or at any other time, regardless of available capacity or other conditions at the affected or assisting hospital. For purposes of this MOU, the emergency may be an external or internal event for one or more hospitals, and is

subject to the affected hospital's emergency operations plan being implemented. The terms of this MOU are to be integrated into and coordinated with each hospital's emergency operations plan.

The term of this MOU shall be effective from Oct 1, 2013, for one year. A hospital may at any time terminate its participation in this MOU by providing sixty (60) days written notice to the Chief Executive Officer (CEO) at each of the other participating hospitals. The term of this MOU shall automatically be renewed annually for one year periods (with no limitations on the number of renewals possible) upon the terms and conditions then in effect, unless a party gives the other parties written notice of its intention not to renew, which notice shall be given no less than thirty (30) days prior to the expiration date of the then current term.

All amendments and modifications to this MOU must be formally agreed to in writing by the parties and signed by all the parties.

Disaster management personnel from MH, NIH, SIH, Mono and Inyo MHOAC Programs, and ICEMA shall conduct development of operational procedures, forms, and other tools to operationalize this MOU, which will be included as "Appendices" to the main document. Updates to these procedures, forms, and tools do not require revision of this MOU.

Now, therefore, in order to provide for continuation of care of patients of hospitals within the Eastern Sierra, the parties hereby mutually agree to make a reasonable effort to abide by the following:

Section 1: Organizational Structure and Communications

Section 2: Patient Movement, Distribution, and Evacuation

Section 3: Equipment and Supplies

Section 4: Personnel

Section 5: Financial and Legal

Appendix A: Definitions

Section 1: Organizational Structure and Communications

Parties shall integrate Hospital Incident Command System (HICS) and National Incident Management System (NIMS) principles into their emergency operations plans including NIMS Implementation Activities for Hospital and Healthcare Systems established by the NIMS Integration Center. <http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf>

This shall include:

- Parties shall have established a command hierarchy which facilitates communications between hospitals, government officials, and their communities.
- Parties shall comply to the maximum extent possible with NIMS requirements for healthcare facilities concerning baseline credentialing, certification, training, and education. Party administrators and healthcare workers likely to assume a supervisory or leadership position during a government declared state of emergency shall complete prescribed NIMS compliance courses.
- Parties agree to participate in training and exercises related to all-hazards, including hospital evacuation. This includes exercise planning, execution, hotwash and debriefing, After-Action Reports (AAR), and Improvement Plans (IP).
- Parties agree to actively participate in all debriefings and after action reports and improvement planning following any declared emergency and activation of this MOU.
- Each party agrees to identify a designated representative to meet and communicate with other parties prior to a government-declared state of emergency and to ensure compliance with NIMS requirements. The names and contact information for the designated representatives and alternate(s) will be shared and included in an appendix. These individuals will be responsible for determining the distribution of information within their own internal organization.
- Prior to an event, hospitals will designate persons, positions, and redundant interoperable contact information, to be used by external agencies (e.g., MHOAC, ICEMA, other hospitals) when attempting to establish a communications channel into the facility (e.g., Nurse Supervisor, Registered Nurse on Duty, Administrator on call, etc.) during an emergency. A designated representative must be available to act at all times. This information will be shared only with other parties to this MOU, and updated at least annually and sooner as necessary.
- A communications plan must be designed and established by each party to enable efficient communication during declared emergencies when prevailing modes of communication may be unavailable or compromised. The plan must specify a process for utilizing alternate communication modes (e.g., satellite phone, radio, etc.). Implementation and maintenance of such plans should be regularly tested in periodic exercises with the other parties and partners.

Activation of any elements of this MOU will occur through procedures as outlined in applicable communications plans, such as the Inyo County Intelligence/Information Sharing and Dissemination Plan, the Mono County Health Department Operations Plan (DOP), each county's Emergency Operations Plan, each hospital's emergency operations plan, and the California Public Health and Medical Emergency Operations Plan (EOM).

Hospitals will notify the MHOAC for all unusual occurrences or emergencies (internal or external), as they become aware. Hospitals will provide the MHOAC with the requested information in the Mono or Inyo County Operational Area (OA) Med/Health Situation Report (Sit Rep), which includes HAvBED information (e.g., bed availability, and hospital capacity/status).

During a response, hospitals will coordinate efforts to respond primarily via their liaison officers, public information officers (PIO's), and Hospital Incident Commanders, once they have activated their emergency operations plan and opened a Hospital Command Center (HCC). Redundant interoperable communications systems will be utilized for sharing intelligence and information between HCC's, the MHOAC, and ICEMA.

Hospitals agree to participate in a Joint Information Center (JIC), coordinated by the local emergency management agency (OES, CAO, or designee), during a disaster that will allow their appointed PIO and community relations personnel to communicate with each other and release accurate, consistent, and timely community and media educational/advisory messages to the public and the media. Each hospital should designate a PIO who will be the hospital liaison with the JIC.

The Hospital Incident Commander of the evacuating hospital should already be in contact with the MHOAC when a hospital evacuation decision is made, or as soon as feasible in a level 1 evacuation (see Section 2 for definition of "level 1"). Once a decision to evacuate has been made, the MHOAC should be in contact with the jurisdictional authorities to declare a local emergency.

The MHOAC will:

- perform statutory functions out of the Medical/Health Branch of the Operations Section of the operational area EOC
- notify all other healthcare coalition partners and stakeholders (to include local emergency management (OES, CAO, or designee), ICEMA, Region 6, the California Department of Public Health (CDPH), the California Emergency Medical Services Authority (EMSA), and the California Emergency Management Agency (CalEMA)), of the activation of this MOU, and provide situation reporting both horizontally and vertically to all parties, partners, and stakeholders.
- function as the channel (single source shopping) for all requests for resources (medical, non-medical, equipment, supplies, personnel, subject matter expertise, etc.) from the parties, once normal supply channels have been or are expected to be exhausted or overwhelmed
- enlist the jurisdictional local health department in the assessment of any public health impacts
- be responsible for maintenance and update of all appendices

Parties shall provide mutual assistance as set forth in this MOU to the maximum extent possible. Decisions about providing mutual assistance pursuant to this MOU shall be made by:

- objectively assessing whether and which resources can be feasibly shared and the degree to which patients can be safely transferred or received;

- clearly conveying capacity for mutual assistance to other parties; and
- striving to ensure transparency, honesty, and fairness in all phases of mutual assistance.

After an emergency declaration is made, the affected hospital's designated representative may initially request personnel or resources from the assisting hospital's designated representative verbally, and be followed with written verification within 24 hours if feasible. All requests for resources must be directed to the designated representative who is authorized to agree to provide requested resources. This request must be confirmed in writing within 24 hours, or as soon as possible, and must employ NIMS data-types where possible. Parties shall confirm receipt of verbal or written requests for mutual assistance and provide responses within 24 hours when possible.

The affected hospital shall set forth in the written request to the assisting hospital the following:

- the type and number of requested personnel and resources;
- an estimate of how quickly personnel and resources are needed;
- the location where the personnel should report or the resources should be delivered; and
- an estimate of how long the personnel or resources will be needed.

Parties shall participate in a medical and health Multi-Agency Coordination System (MACS) with the public and private sectors and nongovernmental organizations as requested and appropriate and necessary. The MACS will be facilitated by the Medical/Health Operational Area Coordinator (MHOAC). Hospitals, when requested by the MHOAC, will designate an individual(s) to be part of a Multi-Agency Coordination (MAC) Group, which would serve as an advisory group to the MHOAC when critical decisions need to be made, such as the allocation and prioritization of scarce resources when multiple requests have been made.

Section 2: Patient Movement/Distribution/Evacuation

Definitions:

- Level 1 – Immediate evacuation requires the immediate, prompt departure of patients from a hospital due to life-threatening conditions. Such an evacuation may require the affected hospital to move patients to an external holding area in the parking lot or other outside or sheltered locations before being moved to an assisting hospital. Critical care patients should be moved directly to the assisting hospital. It may not be practical to pull medical records to go with the patients, and medical records may have to follow as soon as possible at a later time.

- Level 2 – An urgent evacuation allows for a quick, but orderly hospital departure. Such an evacuation allows time for patient dispersion from the affected hospital directly to assisting hospitals. It may result from non- life threatening environmental conditions which allows for orderly gathering of transportation and staffing resources before patient are moved out of the affected hospital. Patients may be moved to one or more internal staging areas (e.g., ambulatory versus wheelchair versus gurney) allowing for the staging of appropriate transportation resources in order to expedite patient movement and egress. There should be time to ensure that the patient's records are sent with the patient.

The critical consideration that Level 1 versus Level 2 evacuations affects is the decision regarding which patients to evacuate first. Patients with critical care needs require more time and resources to evacuate. Their place in the evacuation process may change depending on whether the evacuation is urgent or immediate. In an immediate evacuation, the priority will be to get as many patients out as possible, so the first priority might be the easiest to evacuate – ambulatory patients, those with the least equipment and who need the least amount of assistance from staff. In this scenario, patients with special needs would be the last to be evacuated. In an urgent evacuation when there is time to move patients, the critical care patient would be the first to move as there is time to accommodate equipment and patient care considerations.

The parties, through a designated liaison representative, will use the OA Sit Rep to report to the MHOAC the hospital's bed capacity, its capabilities, and its ability to receive patients. The MHOAC will update this information with each hospital at the beginning of each operational period and more frequently as indicated during an evolving event.

If an emergency affects one or more of the hospitals resulting in partial or complete facility evacuation, upon request of the affected hospital(s), the other hospital(s) agree to confer with the MHOAC and the affected hospital(s) to determine the extent to which the hospital(s) are willing to participate in the distribution of patients from the affected hospital(s) to assisting hospitals.

Transfer of patients shall be considered in terms of "resourced beds." The designated representatives of the parties shall monitor the availability and make transfer requests in terms of specific types of resourced beds Classifications of resourced beds, depending on the capacities of the parties, will be identified according to categories in the Healthcare Facility to Op Area Sit Rep.

Parties will use the patient evacuation tracking form provided by the MHOAC.

Parties shall comply with all preexisting government public health surveillance and reporting requirements to the maximum extent possible.

A Field Treatment Site (FTS) (a/k/a casualty collection site), or an Alternate Care Site (ACS) may be required in the event an emergency overwhelms area hospitals' capacity and capabilities. The MHOAC will coordinate administration, staffing, and site operations for Mono and Inyo County. The parties may be asked to contribute volunteer staff to a FTS or an ACS on an urgent basis, subject to availability.

Emergency Departments (EDs) at assisting hospitals will NOT be used as receiving sites for patient transfers. The ED will need to continue to focus on the emergency healthcare needs of the community.

Parties will identify external holding areas close to their location to provide temporary shelter if an immediate evacuation is required (Level 1), and internal staging areas for patients for an urgent evacuation (Level 2).

Non-ambulance transport methods for non-critical patients may be used if needed. It is assumed that the primary modes of non-ambulance transportation will come from vendors that have been pre-identified and listed as resource assets within the jurisdictional Emergency Operations Plan (EOP).

Unless there is a federal declaration, there is no deviation from EMTALA compliance.

Transfer and tracking of patients will be in accordance with HIPAA regulations. The parties recognize the importance of maintaining the privacy of patient identifiable health data to the maximum extent possible consistent with national or regional health information privacy protections without compromising the provision of critical healthcare services during a government-declared state of emergency. Although these protections may be modified or waived during a government-declared state of emergency, parties shall agree on a procedure for securely sharing identifiable health data concerning transferred patients.

Affected hospital:

- The affected hospital's administration or other authority having jurisdiction (e.g., fire department, OSHPD) declares the hospital unsafe and unstable, requiring a full or partial evacuation. Hospital's decision to evacuate should be determined based on pre-developed evacuation criteria.
- The affected hospital carries out measures to decrease patient census (as time allows) including: review all elective surgical procedures, early discharges and discharges of patients to home, or transfer to a skilled nursing facility (SNF).
- Prior to the transfer of patients, the affected facility must have utilized its internal surge plan, capacity, and capability in an attempt to keep patients within its facility in order to minimize disruption of patient care and business continuity.
- The affected hospital must determine that prior to being screened, the patient cannot receive adequate healthcare services at its facility because of circumstances arising from the emergency and that the potential harm to the patient from the transfer does not outweigh the potential harm from staying at the affected hospital due to the state of healthcare services at the affected hospital.
- The affected hospital must seek patient consent to the transfer unless such consent is impossible due to the exigencies of the emergency or the inability of the patient or a surrogate to consent due to legal incapacity, incompetence, or unavailability of the healthcare surrogate.
- The affected hospital must make all reasonable efforts to either directly notify the patient, the patient's healthcare surrogate, or next of kin of the transfer including the time of transfer and the location of the assisting hospital, or share patient lists to enable these persons to locate transferred patients.

- The affected hospital must designate a single person as the Hospital Planning Technical Specialist. This individual will work with the medical and nursing staff and coordinate with the MHOAC to determine the most appropriate destination, staff, equipment, and method of transport. The MHOAC must rely on the medical triage completed by the hospital and utilize hospital personnel to coordinate appropriate treatment, personnel, equipment, and methods of transport.
- The request for transfer of patients by an affected hospital can initially be made verbally to the MHOAC and/or potential assisting hospital(s). The initial verbal request, however, must be followed up with a written communication as soon as possible, which may be facilitated by the MHOAC. The affected hospital, to the extent possible, will identify to the MHOAC and the assisting hospital:
    - The number of patients needing to be transferred
    - The general nature of their illness/injury/condition
    - Any type of specialized services required
    - Patient medications, and/or specialized equipment needed
- The affected hospital will ensure that appropriate transportation to the assisting hospital is provided to ensure patient safety to the maximum extent possible given the exigencies of the emergency. The affected hospital is responsible for arranging transportation of patients from the assisting hospital back to the affected facility when feasible. The affected hospital will pay the transportation cost and seek reimbursement by billing third party payers or the patient.
- The affected hospital will help the assisting hospital in obtaining proper consents for care.
- The affected hospital will send with each patient at the time of transfer (or as soon thereafter as possible) all of the patient's personal effects, and any information relevant thereto. In the event that personal effects cannot be sent with an alert and competent patient, the affected hospital may elect to secure such personal effects until the emergency is over. The affected hospital will remain responsible for such items until receipt thereof is acknowledged by the assisting hospital.
- The affected hospital, to the extent possible in an emergency situation and in accordance with governing state and federal law, is responsible for providing the assisting hospital with:
    - The patient's medical records
    - Insurance information
    - Any other patient information necessary for the care of the patient
    - Patient's medications
    - Any specialized equipment necessary for the care of the patient
- The affected hospital is responsible for tracking the destination of all patients transferred out (patient evacuation tracking sheet) if time allows and during an urgent evacuation is responsible for notification of each patient's physician and family of pending relocation, if time allows.
- If time does not allow for pulling medical records, at a minimum, the affected hospital will ensure that the medication administration record accompanies the patient.
- The affected hospital, whenever possible, sends appropriate physician and/or nursing personnel to accompany patients to the assisting hospital.
- The affected hospital designates appropriate administration, nursing supervisory staff, and pharmacy staff to coordinate care with the assisting hospital.
- The medical/nursing staff/patient ratio during transport will be determined as reasonably safe for care by the affected hospital's designated medical staff and the transportation supervisor/coordinator.
- The affected hospital maintains responsibility for patients until accepted by an assisting hospital.

- Traditional triage tags will not be used. The affected hospital will track patients using the name and hospital number from the patients existing armband and write this information on the Patient Tracking Form. Triage tags will only be used if individuals do not have such an identifying armband.
- The affected hospital assumes responsibility for all costs of transportation of patients to external staging areas or assisting hospitals
- The affected hospital ensures that the vacated premises are secure (e.g., medications, radioactive devices, etc.) and that no one is left behind after the evacuation.
- The affected hospital ensures that appropriate notifications are carried out (e.g., OSHPD, Licensing and Certification, fire department, law enforcement, MHOAC), in coordination and with the assistance of the MHOAC.
- The affected hospital agrees to readmit patients when services are restored at the affected hospital.

Assisting hospitals will:

- carry out measures to decrease patient census including: review all elective surgical procedures, early discharge and discharge of appropriate patient to home, or transfer to a skilled nursing facility (SNF).
- determine ability to accommodate influx of patients, and communicate this status and any changes to the MHOAC.
- make preparation for receiving patients, including calling in additional staff and implementing their emergency credentialing policy.
- obtain additional equipment and supplies needed to provide care.
- maintain communication with the affected hospital (if feasible) and the MHOAC.
- continue patient tracking within its hospital when patients are received. Send the Patient Tracking Form (e.g., Fax) to the MHOAC, and back to the affected hospital if feasible, in order to allow the affected facility to send more medical records (if feasible) and to complete their internal patient tracking process.
- notify families/responsible party and attending physician upon receipt of patients.
- designate the admitting service, the admitting physician for each patient, and, if requested, will provide at least temporary courtesy privileges to the patient's original attending physician per the assisting hospital's policy and procedure. (Emergency privileges for physicians and other healthcare providers will be granted in accordance with any applicable standards of JCAHO, the Licensing and Certification Division (L and C) of the California Department of Public Health (CDPH), and the California Department of Health Care Services (DHCS).
- be responsible for the safety of staff from the affected hospital working within its building, and for the safekeeping and continued operability of medical equipment that is sent from the affected hospital.
- Assume responsibility of evacuated patients when received.
- Notify L and C about their change in status or if they have exceeded licensed bed capacities.
- return all patients and equipment to the hospital of origin unless other arrangements have been made (e.g., the affected hospital is not able to be reoccupied for a long duration of time), upon notification that the affected hospital is able to be reoccupied.
- discharge patients in accordance with its standard procedures.

Section 3: Equipment and Supplies

In the event that needed items (supplies, equipment, pharmaceuticals) are available at one of the undersigned hospitals and lacking at another, the undersigned hospital with available supplies will share supplies to help ensure that patients in the Eastern Sierra area receive necessary treatment during a disaster.

Parties shall use an inventory system to track resources that may be available during a government-declared state of emergency, including any resources stored off premises. The inventory list shall be accessible to the designated representative during a government-declared state of emergency.

To enhance emergency preparedness, parties shall follow the national typing protocol as prescribed by NIMS to describe available resources using category, kind, components, metrics, and type data, when available.

Parties shall acquire equipment that will perform in accordance with minimum standards as prescribed by NIMS so that equipment is interoperable with similar equipment used by other parties in the HMAN and other hospitals.

Requests initially can be made verbally but must be followed up with a written request as soon as practical.

During a disaster, the affected hospital will accept and honor the assisting hospital's standard requisition forms. Documentation should detail the items involved in the transaction, condition of the material prior to the loan or transfer (if applicable), and the party responsible for the material.

The affected hospital will have supervisory control /direction over the borrowed medical supplies, pharmaceuticals, or equipment, once they are delivered to the affected hospital.

Any physical resources may be shared between parties including pharmaceuticals, medical equipment, non-medical equipment, and basic supplies. Parties shall continuously monitor the availability of physical resources for potential transfer during a government-declared state of emergency, and share this information with the MHOAC.

The sharing of equipment and/or supplies will occur in cooperation between the Incident Commanders at the involved hospitals, with the MHOAC functioning in a coordinating role.

In the event of scarcity of resources (e.g., resource need greater than the sum of all available resources, the MHOAC may convene a MAC Group to prioritize the allocation of scarce resources.

The assisting hospital may recall its personnel and resources from an affected hospital through a formal request for recall. Recall requests may be made by the assisting hospital at any time in its discretion. Affected hospitals shall honor the assisting hospital's request for recall at the earliest opportunity possible without significantly and irreversibly harming existing patients, and must immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

Section 4: Personnel

In the event of a disaster when patient care staff can be made available at one of the undersigned hospitals and are needed at another, the hospital with available staff will share staff to ensure that available hospital beds in the Eastern Sierra are adequately staffed during a disaster.

The sharing of personnel will occur in cooperation between the Incident Commanders at the involved hospitals, with the MHOAC in a coordinating role.

The following personnel may be transferred between parties subject to limitations set forth below:

- Employees: Assisting hospitals may allow or encourage the voluntary transfer of employees to an affected hospital under the terms of this MOU. No employee may be ordered to transfer to an affected hospital if the employee is not willing to be transferred.
- Contractors: Parties may allow the transfer of contractors to an affected hospital. All transferred contractors provide their services to the affected hospital voluntarily. Whenever possible, contractors with a prior or existing relationship with the affected hospital should be transferred first.
- In-State VHPs. Volunteer registration systems across the nation, including California's DHV program, Medical Reserve Corps programs, and hospital-specific registries facilitate rapid deployment of vetted VHPs to meet surge capacity needs in hospitals. Whenever the use and deployment of VHPs through such registries can be accomplished without compromising the provision of healthcare services to patients, parties shall do so before requesting employees or contractors from other parties.
- Inter-state VHPs. Under the Emergency Management Assistance Compact (EMAC), VHPs who hold out-of-state licenses may be deployed during an emergency.

The request for the "transfer" of personnel can initially be made verbally followed by written documentation of the request as soon as practical. Requests will be made in a standardized format. A request and documented response will occur prior to the arrival of personnel at the affected hospital. A hospital is not obligated under this MOU to provide the requested personnel if the hospital does not have the available personnel, or if the personnel are unwilling to provide the services under this MOU. The affected hospital will identify to the assisting hospital the following:

- The type and number of requested personnel
- An estimate of how quickly the request is needed
- The location of where they are to report (including contact person and information)
- an estimate of the duration of time that requested personnel would be needed

The "transferred" personnel will be required to present their identification badge from their employer hospital at the affected hospital's check-in site as designated by the affected hospital's Command Center. The affected hospital will be responsible for the following:

- Providing a contact person at the check-in site to receive the "transferred" personnel
- Providing adequate identification (e.g., "visiting personnel" badge, to the "transferred" personnel
- Provide food, housing, and/or transportation for "transferred" personnel asked to work for extended periods or for multiple shifts. Including the costs for these services
- Within 90 days following receipt of invoice, reimburse the assisting hospital for the actual salaries and benefits of such personnel

- Provide and coordinate any necessary demobilization procedures and post event stress debriefing

The affected hospital will have supervisory direction over the assisting hospital's staff once they are received by the affected hospital. The affected hospital shall clarify the relevant procedures concerning authorization, scope of practice, and supervision for transferred personnel that arrive at the affected hospital pursuant to the terms of this MOU. The requesting hospital shall clarify the prescribing powers of transferred personnel to ensure consistency with California prescription laws.

All facilities will have in place emergency credentialing plans that will permit credentialing of personnel who may wish to volunteer their professional services during an emergency.

The affected hospital will be responsible for providing a mechanism for granting emergency privileges for physicians, and other licensed healthcare providers to provide services at the affected hospital. Joint Commission Standard 1.25 requires the volunteer practitioners must at a minimum present a valid government ID and at least one of the following:

- Current hospital picture ID
- A current license or certification
- Primary source verification
- Identification from a DMAT, MRC, or DHV
- Identification by a current organization member who possesses personal knowledge regarding the practitioner's qualifications

Liability, malpractice, and disability claims, attorneys' fees and other incurred costs are the responsibility of the affected hospital. An extension of liability coverage will be provided by the affected hospital, to the extent permitted by federal law, insofar as the loaned personnel are operating within their scope of practice.

The assisting hospital shall ensure that the records of all transferred healthcare workers comply with requirements applicable to the assisting hospital, including licensure and accreditation requirements for healthcare professionals. To the maximum extent possible, the assisting hospital shall provide the affected hospital with copies of deployed healthcare professionals' credentialing documents to facilitate the granting of emergency staff privileges.

Resident physicians, students, or healthcare workers who are not fully-trained shall only be transferred with the agreement of the affected hospital, which shall closely supervise their activities.

Nothing contained herein is intended to permit practitioners who have not been granted privileges to practice within a particular hospital the right to practice therein without first having obtained clinical privileges from the hospital in accordance with its customary procedures. Each hospital, however, agrees to work cooperatively to ensure the patient care is not unduly interrupted, and will work to coordinate care between their respective medical staffs, or to grant temporary privileges to practitioners pursuant to its standard procedures.

The assisting hospital may recall its personnel and resources from an affected hospital through a formal request for recall. Recall requests may be made by the assisting hospital at any time in its discretion. Affected hospitals shall honor the assisting hospital's request for recall at the earliest opportunity possible without significantly and irreversibly harming existing patients, and must immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

Section 5: Financial and Legal

The affected hospital will assume legal responsibility for the professional services of the personnel, supplies, pharmaceuticals, and/or equipment from the assisting hospital during the time the personnel, equipment, pharmaceuticals, and/or supplies are at the affected hospital. The affected hospital will reimburse the assisting hospital, to the extent permitted by federal law, for all of the affected hospital's costs determined by the assisting hospital's regular rate. Costs include all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the assisting hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. The assisting hospital shall also be reimbursed for services rendered, including salaries of the transferred personnel at their normal pay rate as if those personnel were being paid by the assisting hospital. Reimbursement shall be for actual costs, but shall not include ancillary expenses, such as administrative costs or loss of revenues. Reimbursement will be made within 90 days following receipt of the invoice.

Hospitals accepting patients assume the legal and financial responsibility for transferred patients upon arrival into their facility. Upon admission, the assisting hospital is responsible for liability claims originating from the time the patient is admitted to the assisting hospital. Reimbursement for care should be negotiated with each hospital's insurer under the conditions for admissions without pre-certification requirements in the events of emergencies.

Parties shall maintain and demonstrate their existing professional liability, property, workers' compensation, or other insurance coverage and affirm their intention to retain such coverage at all times as a party to this MOU.

All reasonable and eligible costs associated with the activation and implementation of provisions of this MOU in a declared emergency will be submitted for consideration and reimbursement through established State and Federal disaster assistance/reimbursement.

The affected hospital shall hold harmless the assisting hospital for acts of negligence or omissions on the part of the assisting hospital in their good faith response for assistance during an emergency. The assisting hospital, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the affected hospital.

An emergency declaration changes the legal environment in diverse and numerous ways that may impact the operation of this MOU. An emergency declaration may:

- Suspend laws and regulations applicable to hospitals, including those that regulate the provision of healthcare services by healthcare workers;
- Require hospital compliance with local, state, regional, and national emergency management agency directives and regional response efforts;
- Initiate temporary licensure reciprocity through which healthcare professionals licensed in one jurisdiction are allowed to practice in another jurisdiction, often pursuant to various requirements such as advance volunteer registration or affiliation with an entity that deploys VHPs;
- Provide enhanced liability protections to healthcare workers or VHPs for services that they render in responding to the emergency;
- Extend workers compensation benefits to VHPs who would not otherwise qualify as covered employees;

- Change the applicable standards of care;
- Provide enhanced government emergency and disaster relief funding for ongoing response activities and reimbursement for rendered emergency and disaster services; and
- Provide increased and expedited access to public entitlement programs, including through the waiver of enrollment requirements for Medicaid and Medicare.

Parties shall actively follow directives from federal, state, and local emergency management agencies and accommodate these agencies in their efforts to oversee or direct the use of property or allocate health resources across impacted areas during an emergency.

EMTALA can impact the provision of healthcare services at hospitals, including medical triage, by requiring hospitals to screen and stabilize individuals requesting emergency treatment and prohibiting inappropriate transfer of patients. Under certain circumstances during declared emergencies, federal officials can suspend some of the requirements under EMTALA. If an EMTALA waiver is issued which covers one or more parties to this MOU, such parties shall immediately assess capacity to accept transferred patients and provide additional screening and stabilization services. As well, other parties shall be informed as soon as possible of:

- the inception of the party's disaster protocol and the duration of the waiver's coverage;
- any plans to suspend or modify patient screening and stabilization procedures; and
- intended or expected needs regarding the transfer of existing patients, pursuant to the section on patient movement/distribution/evacuation.

During an emergency, potential liability can be a major concern for hospitals and healthcare workers. While exposure to liability cannot be fully eradicated, it can be significantly minimized through the clear expression of the expectations of the parties. The parties recognize the following principles concerning liability:

- Changing standards of care. Emergency declarations may lead to alterations or changes in the standard of care that healthcare workers are obligated to adhere to in the treatment of patients. These changing standards of care may impact potential claims of liability to the extent that they provide varying expectations of the duties healthcare workers or hospitals owe to patients in the provision of personnel or resources.
- Use of VHPs. Parties may minimize their potential exposure to liability and workers' compensation costs relating to personnel by utilizing registered VHPs. VHPs may be legally protected from liability claims and entitled to governmental coverage for workers' compensation benefits and costs during declared emergencies (subject to specific laws). Use of VHPs may also decrease the need for the transfer of employees and contractors whose acts may not be similarly protected from liability or entitled to workers' compensation coverage via government.
- Employees. An affected hospital may normally be responsible for all liability claims, disability claims, litigation costs, and other foreseeable costs incurred by transferred employees involving third parties except in instances arising from gross, willful, or wanton misconduct of the transferred employee. Transferred employees shall not be principally liable to an affected hospital, including through indemnity actions, for their actions taken in good faith.
- Contractors. The affected hospital also shall be responsible for all liability claims, malpractice claims, disability claims, attorneys' fees and other foreseeable costs incurred by transferred contractors except in instances arising from gross, willful, or wanton misconduct of the transferred contractor. A contractor who agrees to be transferred shall not be contractually liable

for failing to fully discharge the terms of employment at the assisting hospital provided that the assisting hospital agrees in writing to the transfer.

- Assisting hospitals: Vicarious liability. An assisting hospital shall not be held vicariously liable for the actions of transferred employees, contractors, or VHPs, except in instances of gross, willful, or wanton misconduct of the assisting hospital personnel in assuring the credentials of transferees.
- Failure to respond or inadequacies. Parties are not bound to a specific course of action for which the failure to act constitutes an actionable claim for breach of contract or equitable relief, except with respect to the credentialing of transferred personnel. Execution of this MOU shall not result in any liability or responsibility for failure to respond to any request for assistance, inefficiency in answering such a request, or for the inadequacy of equipment or skills of the responding personnel.
- Workers' compensation coverage. Transferred employees and contractors shall be considered "employees" of the affected hospital for the purposes of workers compensation coverage in the event that an injury or death of the employee or contractor occurs in the scope of the work at the affected hospital.

This MOU is in no way meant to affect any of the participating hospitals' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

The participating entities shall maintain the confidentiality of patient and other records as required by law.

In the event of any conflict between any provisions of this MOU and any applicable law, rule, or regulation, this MOU shall be modified only to the extent necessary to eliminate the conflict and the rest of the MOU shall remain unchanged and in full force and effect.

The laws of the State of California shall govern this MOU.

The provisions of this MOU shall be applied consistent with these and other changing legal norms to the maximum extent possible during emergencies.

This MOU is not intended to provide the basis for post-emergency litigation. However, to the extent that litigation could result from the acts of the parties in carrying out the MOU (e.g., claims related to actual costs of reimbursement), parties agree to submit any actionable claim to mediation and dispute resolution (or an analogous mechanism) prior to the inception of litigation.

In the event that a portion of this MOU is impossible to fulfill, the parties agree to attempt to comply with the remainder of the MOU to the maximum extent possible. If any party withdraws from the MOU, the remaining parties shall continue to recognize and honor the MOU.

The invalidity of any provision of this MOU shall not affect the validity of the remainder hereof.

This MOU constitutes the entire understanding between the parties respecting the subject matter contained herein and supercedes any and all prior oral or written agreements regarding such subject matter.

This MOU represents the entirety of the agreement of the parties with respect to the subject matter hereof and may not be amended except by written instrument signed by all of the affected parties.

The parties hereto agree that they will not discriminate against any patient affected by this MOU on the basis of race, age, creed, color, sex, national origin, inability to pay or handicap.

While response to a disaster (e.g., facility evacuation) represents a potential deviation from care, hospital personnel are held to the same standard of care as in any other activity of patient care. It is recognized that response to disasters may entail unavoidable interruptions of some aspect of patient care (e.g., giving medication on schedule) that are beyond the control of the hospital staff. The expectation is that hospital personnel will use such reasonably prudent practices as any professional person in their place might be expected to use.

In witness whereof, we have set our hands and seals that date below written.

Signed Tom Halter	9-17-16 Dated
CEO Title	N-Inyo Hospital
Signed	9-20-2013 Dated
CEO/CFO Title	Southern Inyo Hospital Hospital
Signed	9.23.13 Dated
Interim CEO Title	Mammoth Hospital Hospital

Appendix A - Definitions

As used in this MOU, these terms shall be defined as follows:

"Affected hospital" means a hospital that has been impacted by an emergency. This would include an evacuating hospital, where a party is no longer able to safely provide acute patient care due to an internal or external emergency situation. It would also include requesting hospitals that request personnel or other resources pursuant to this MOU in order to adequately respond to an emergency causing a medical surge.

"Assisting hospital" means a hospital that is not directly impacted by an emergency. This would include receiving hospitals' that are asked and able to provide acute patient care to patients being transferred from an "affected" evacuating hospital. It also includes hospitals that consider requests and potentially provide personnel or other resources pursuant to this MOU, otherwise called lending hospitals.

"Contractor" means a healthcare professional who provides healthcare services at a hospital, but is not under the direct control of the hospital and exercises independent judgment and discretion.

"Designated representative" means an individual and at least one alternative designee identified by a party as having the authority to issue, receive, and answer requests for resources pursuant to this MOU.

"DOC" means Department Operations Center.

"Emergency" means an emergency, catastrophic event, disaster, public health crisis, or other exigency as defined in the jurisdiction(s) in which the parties are located, such as earthquake, wildfire, fire/explosion, floods, avalanche, hazardous materials events, extended utility outage, structural failure, pandemic influenza, or acts of terrorism.

"Emergency declaration" means the official declaration by an authorized government official of a state of emergency in the jurisdiction in which one or more parties is located.

"Employee" means a healthcare worker at a hospital who is employed to render healthcare services under the direct control of the hospital.

"EOC" means Emergency Operations Center.

"HCC" means Hospital Command Center.

"Healthcare coalition" means a member of the healthcare system involved in patient care at some point along the continuum of care from birth to death, from home to hospice.

"Healthcare services" means the provision of medical treatment, care, advice, or other services, or supplies, related to the health of individuals or human populations.

"Healthcare professional" means an individual licensed under state law to provide healthcare services.

"Healthcare surrogate" means the parent, court-appointed legal guardian, or other individual lawfully authorized to make health care decisions for a minor or individual who lacks the legal capacity to make decisions on his or her own behalf.

"Healthcare worker" means an individual, including a healthcare professional, who provides healthcare services.

"Hospital" means a general acute care facility licensed as such by the Licensing and Certification Program of the California Department of Public Health.

"Hospital Mutual Aid Network (H-MAN)" means the collective group of hospitals that are parties to the MOU.

"ICEMA" means the Inland Counties Emergency Medical Agency, which is the multi-county local emergency medical services agency for Inyo, Mono, and San Bernardino Counties.

"License to practice healthcare service" means the state authorization of an appropriately trained healthcare professional to provide healthcare services that would otherwise be unlawful without the authorization.

"MHOAC" means the Medical-Health Operational Area Coordinator, who functions in a support and coordination role and acts as the single point of contact for situation reporting and resource requesting as the Medical and Health Branch Director under the Operations Section of any Operational Area EOC that is established.

"National Incident Management System (NIMS)" means the federal coordinating program overseen by the Department of Homeland Security (DHS) requiring hospitals to formulate emergency plans including mechanisms to facilitate mutual aid in the event of inter-jurisdictional emergencies.

"Partners" means other individuals, programs, entities, departments, or agencies that support and coordinate with parties to this MOU in responding to emergencies, such as the MHOAC, ICEMA, local emergency management, and the structures they may activate, such as a DOC, EOC, and Unified Command.

"Party" means a hospital that has executed this MOU.

"Prescribing Power" means the authority to dispense prescription drugs for healthcare purposes pursuant to state licenses and institutional privileges.

"Scope of practice" means the extent of the authorization to provide healthcare services granted by a license to practice healthcare services in the state in which the healthcare professional practices. Scope of practice may be further limited by privileging and credentialing requirements imposed by the state or the hospital in which the healthcare professional practices.

"Standard of care" means the degree of prudence and skill that a healthcare professional, healthcare worker, or healthcare entity must provide to a patient based on prevailing circumstances and existing best practices.

"Unified Command" means the structure created by government officials to manage a response to an emergency.

"Volunteer health practitioner (VHP)" means a healthcare worker licensed or registered in one or more states who is not an employee or contractor of a requesting hospital and who voluntarily provides healthcare services at a requesting hospital, irrespective of individual compensation.

"Worker's compensation" means the government administered system for providing benefits to an individual injured or killed in the course of employment, regardless of fault.