COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

AGENDA
Thursday, February 25, 2021 – 12:00 PM

ON MARCH 16, 2020, GOVERNOR GREG ABBOTT TEMPORARILY SUSPENDED PART OF THE TEXAS OPEN MEETINGS ACT TO HELP MITIGATE THE SPREAD OF COVID-19. SPECIFICALLY, THIS AMENDMENT ALLOWS FOR LOCAL GOVERNMENTS TO CONVENE VIRTUALLY SO LONG AS MEMBERS OF THE PUBLIC ARE PROVIDED A MEANS BY WHICH THEY CAN HEAR AND PROVIDE COMMENT TO THE GOVERNING BODY.
The Coastal Health & Wellness Governing Board will convene for its regularly scheduled February meeting by utilizing Zoom, which will allow for Board members and the public alike to partake in and/or view the meeting either online or over the phone.

CONNECTING VIA INTERNET:
Access the URL: https://zoom.us/j/97498936863?pwd=M3lTYzA3RVhVa2x4SE9MN3VFYWcrQT09
Meeting Password: 944866
An automated prompt should appear on your screen; when it does, click "Open Zoom Meetings"

1. If you would prefer to use your computer for audio connection, please do the following:
   a. When prompted, select "Join Audio"
   b. Another popup box will appear, select the tab, "Computer Audio"
   c. Now click the box stating, "Join with Computer Audio." Your connection to the meeting will be automatically established upon doing so.
2. If you would prefer to utilize a phone for your audio connection, please do the following:
   a. Mute your computer's volume;
   b. When prompted, select "Join Audio"
   c. Another popup box will appear, select the tab, "Phone Call"
   d. You will be presented with a Dial-In, Audio Code, and Participant ID. Call the Dial-In number from your phone and follow the subsequent voice prompts. Your connection to the meeting will be automatically established upon doing so.

CONNECTING VIA PHONE (AUDIO ONLY):

1. Dial 346-248-7799
2. You will be prompted to enter the Meeting ID, which is 974 9893 6863# Meeting Password: 944866
3. Finally, you will be instructed to enter your Participant ID. When this occurs, merely select the pound (hashtag) key without entering any numbers. Your connection to the meeting will be automatically established upon doing so.

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

REGULARLY SCHEDULED MEETING

Meeting Called to Order

*Item #1**ACTION**..Agenda

*Item #2**ACTION**..Excused Absence(s)

*Item #3**ACTION**..Consider for Approval Minutes from January 28, 2021 Governing Board Meeting

*Item #4**ACTION**..Policies Approved by United Board of Health as Authorized Under the Shared Services Agreement
a) All Hazards Emergency Plan
b) Criminal and Motor Vehicle Record Background Checks Policy
c) Purchasing Policy

Item #5..Executive Reports
a) Executive Director
b) Medical Director
c) Dental Director

Item #6**ACTION**..Consider for Approval January 2021 Financial Report

Item #7**ACTION**..Consider for Approval 2021/2022 Sliding Fee Scale

Item #8**ACTION**..Consider for Approval Revision to the Coastal Health & Wellness Sliding Fee Policy

Item #9**ACTION**..Consider for Approval Coastal Health & Wellness Infection Control Plan

Next Regular Scheduled Meeting: April 1, 2021 (March Meeting)

Appearances before the Coastal Health & Wellness Governing Board

The Coastal Health & Wellness Governing Board meetings are conducted under the provisions of the Texas Open Meetings Act, and members of the public that wish to address the Board about an item presented on the agenda shall be offered three minutes to do so. The Board cordially requests that individuals desiring to make a such a statement notify the Board of their intention by writing their name on the sign-in sheet located at the Boardroom's main entrance.

A citizen desiring to make comment to the Board regarding an item not listed on the agenda shall submit a written request to the Executive Director by noon on the Thursday immediately preceding the Thursday of the Board meeting. A statement of the nature of the matter to be considered shall accompany the request. The Executive Director shall include the requested appearance on the agenda, and the person shall be heard if he or she appears.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

Governing Board
February 2021
Item#2
Excused Absence(s)

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Governing Board
February 2021
Item#3
Consider for Approval Minutes from January 28, 2021
Governing Board Meeting

Coastal Health & Wellness
Governing Board
January 28, 2021

Board Members Conference Call:	**Staff:**
Samantha Robinson	Kathy Barroso, Executive Director
Milton Howard, DDS	Hanna Lindskog, DDS
Virginia Valentino	Eileen Dawley
Flecia Charles	Richard Mosquera
Jay Holland	Mary Orange (phone)
Elizabeth Williams	Debra Howey (phone)
Victoria Dougharty	Tikeshia Thompson-Rollins
Barbara Thompson, MD	

Excused Absence:
Unexcused Absence: Miroslava Bustamante, Dorothy Goodman

Items 1-5 Consent Agenda
A motion was made by Virginia Valentino to approve the consent agenda items one through five. Victoria Dougharty seconded the motion and the Board unanimously approved the consent agenda.

Item #6 Consider for Approval Resolution Recognizing Mary Jane Griggs, Unit Receptionist-Medical Team Leader, and her 24 Years of Service to Coastal Health & Wellness
Samantha Robinson, Board Chair, presented the resolution recognizing Mary Jane Griggs, unit receptionist-medical team leader, and her 24 years of service to Coastal Health & Wellness. A motion to accept the resolution as presented was made by Jay Holland. Virginia Valentino seconded the motion and the Board unanimously approved.

Item #7 Executive Reports
Kathy Barroso, Executive Director, presented the January 2020 Executive Report to the Board. Kathy informed the Board Coastal Health & Wellness underwent a HRSA virtual operational site visit on November 17th-19th. The final report denoted one element (Documentation of Hospital Admitting Privileging or Arrangements) that will need to be submitted within 90 days. Kathy also updated the Board on COVID vaccine and will send out communication regarding COVID vaccine waitlist to all Board members.

Kathy Barroso, Executive Director, provided the Board with the following updates on behalf of Dr. Ripsin, Medical Director:

COVID testing:
- For the month of January 2021 sixty tests were conducted at CHW and 30% were positive for COVID. One person is currently hospitalized.
- CHW staff have received their first COVID vaccination and most have received their second vaccine with the remainder being vaccinated this week.
- Last week we were able to vaccinate 120 of our high-risk patients.
- Our nursing director, Tiffany Carlson has done a great job managing the logistics of setting up the vaccine clinics for staff and patients as well as helping GCHD vaccinate the general public, and Patient Services

Manager Pisa Ring and her staff have successfully managed the difficult job of getting CHW patients scheduled for their vaccines on very short notice.

- The entire medical staff is prepared to assist GCHD in the event of a medical emergency during their vaccine efforts and thankfully none has yet occurred.

For non-COVID patients managed in clinic so far in 2021:

- 77% have been seen in the clinic and the remainder managed via phone.
- Our IT department is putting the final touches on our telehealth equipment so we can expand our telephone visits to include real time video.
- We are averaging 37 new patients per week.

We received a grant to use smart phone technology to better manage our patients with hypertension. This will allow us to buy the equipment but will also fund a Health Educator which will be a tremendous asset to the care we provide for all our patients.

Dr. Lindskog, Dental Director, updated the Board on dental services in the Coastal Health & Wellness Clinic:

- The Dental Clinic continues to use Batelle N95 decontamination program and the CDC reuse protocol for N95 respirators. Batelle will now only decontaminate the respirator 4 times.
- We continue to follow all COVID-19 Dental State board requirements and CDC recommendations while providing all dental services.
- The Galveston Dental Clinic is open Tuesday, Wednesday and Thursday and Texas City is open Monday-Saturday.
- Our part time hygienist started working 3 days a week this month.
- We have three dental assistant openings and one dental assistant out on FMLA. We are working short staffed and adjusting the patient schedule as needed.
- The infection control nurse, dental assistant supervisor and I have attended various sessions of the OSAP Boot Camp this week. OSAP is a premier Dental Infection Control and Safety organization.
- We will see our first patient under the Ryan White grant on February 2, 2021.

Item #8 Consider for Approval November 2020 And December 2020 Financial Report

Mary Orange, Business Office Manager, presented the November and December 2020 financial report to the Board. A motion to accept the financial report as presented was made by Jay Holland. Virginia Valentino seconded the motion and the Board unanimously approved.

Item #9 Consider for Approval Quarterly Visit and Collection Report Including a Breakdown of New Patients by Payor Source for the Period Ending 12/31/20

Mary Orange, Business Office Manager, presented the quarterly visit and collection report. A motion to accept the report as presented was made by Virginia Valentino and seconded by Elizabeth Williams. The Board unanimously approved the motion.

Item #10 Consider for Approval Quarterly Access to Care Report for the Period Ending 12/31/20

Kathy Barroso, Executive Director, presented the quarterly access to care report for the period ending 12/31/2020. Kathy informed the Board that the utilization rates are up in Medical for both Texas City and Galveston. No show rate for medical in Texas City is 17% and Galveston 21%, Dental in Texas City 15% and Galveston 16%, Dental Hygienist 29%, and Counseling 33%. A motion to accept the access to care report as presented was made by Dr. Howard and seconded by Virginia Valentino. The Board unanimously approved the motion.

Item #11 Consider for Approval Patient Satisfaction Survey Results for the Period Ending 12/31/20

Kathy Barroso, Executive Director, presented the patient satisfaction survey results for the period ending 12/31/2020. Kathy informed the Board that we had overall average of a 4.79 for this quarter in comparison to 4.64 average last quarter. A motion to accept the patient satisfaction survey results was made by Victoria Dougharty and seconded by Virginia Valentino. The Board unanimously approved the motion.

Item #12 Consider for Approval Quarterly Compliance Report for the Period Ending 12/31/20

Richard Mosquera, Chief Compliance Officer, asked the Board to consider for approval the quarterly compliance report for the period ending 12/31/2020. A motion to accept the compliance report as presented was made by Virginia Valentino and seconded by Victoria Dougharty. The Board unanimously approved the motion.

Item #13 Consider for Approval Coastal Health & Wellness Emergency Operation Plan

Kathy Barroso, Executive Director, presented the Coastal Health & Wellness Emergency Operation Plan to the Board. There were no significant changes noted in the plan. A motion to accept the plan as presented was made by Virginia Valentino and seconded by Victoria Dougharty. The Board unanimously approved the motion.

Item #14 Consider for Approval Annual Report on Infection Control Goals 2020

Debra Howey, Infection Control Nurse, presented the annual report on the Infection control goals for 2020. Debra informed the Board that there were 16 goals for 2020 and all were met. A motion to accept the report as presented was made by Flecia Charles and seconded by Victoria Dougharty. The board unanimously approved the motion.

Item #15 Consider for Approval Revisions to the Coastal Health & Wellness Credentialing and Privileging Policy

Eileen Dawley, Chief Nursing Officer, asked the Board to consider for approval revisions to the Coastal Health & Wellness Credentialing and Privileging Policy per HRSA recommendations. A motion to accept the policy as presented was made by Virginia Valentino and seconded by Elizabeth Williams. The board unanimously approved the motion.

Item #16 Consider for Approval Modification to Re-Privileging Rights for Unsil Keiser, DDS

Dr. Lindskog, Dental Director, asked the Board to consider for approval a modification to the privileging rights for Unsil Keiser, DDS. A motion to accept the modification of privileging rights for Unsil Keiser, DDS was made by Jay Holland and seconded by Dr. Howard. The board unanimously approved the motion.

Item #17 Consider for Approval Re-Privileging Rights for Suma Shetty, DDS

Dr. Lindskog, Dental Director, asked the Board to consider for approval re-privileging rights for Suma Shetty, DDS. A motion to accept re-privileging rights for Suma Shetty, DDS was made by Dr. Howard and seconded by Virginia Valentino. The board unanimously approved the motion.

The meeting was adjourned at 1:10p.m.

______________________	______________________
Chair	Secretary/Treasure
______________________	______________________
Date	Date

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Governing Board
February 2021
Item#4
Policies Approved by United Board of Health as Authorized Under the Shared Services Agreement

a) All Hazards Emergency Plan
b) Criminal and Motor Vehicle Record Background Checks Policy
c) Purchasing Policy

GALVESTON COUNTY HEALTH DISTRICT

ALL HAZARDS EMERGENCY MANAGEMENT PLAN

2021

APPROVAL & IMPLEMENTATION

ALL HAZARDS
EMERGENCY MANAGEMENT PLAN
for the Galveston County Health District

This plan is hereby accepted for implementation and supersedes all previous editions.

Kathy Barroso
Chief Executive Officer

1-29-2021
Date

RECORD OF CHANGES

Basic Plan

Change #	Date of Change	Change Entered By
1	4/18/07	Brian Rutherford
2	9/21/07	Brian Rutherford
3	10/18/07	Brian Rutherford
4	10/22/08	Jack Ellison
5	11/18/09	Michael Carr
6	11/01/10	Michael Carr
7	6/01/11	Jack Ellison
8	11/21/12	Lanny Brown
9	11/14/13	Lanny Brown
10	11/18/14	Lanny Brown
11	1/15/15	Jack Ellison
12	12/17/15	Tyler Tipton
13	12/21/15	Randy Valcin
14	1/6/16	Tyler Tipton
15	1/14/16	Randy Valcin
16	1/5/17	Tyler Tipton
17	10/24/17	Tyler Tipton
18	1/11/18	Randy Valcin
19	2/28/18	Tyler Tipton
20	10/17/18	Ruth Kai
21	12/28/18	Richard Pierce
22	1/2/2019	Randy Valcin
23	9/5/2019	RUTH KAI
24	1/6/2020	TYLER TIPTON
25	1/27/2021	TYLER TIPTON

Emergency Telephone Numbers

Galveston County OEM: Main Number 281-309-5002 or 24/7 on call (888) 384-2000

Public Health Emergency Preparedness Manager
Tyler Tipton (409) 938-2275 or cell (409) 392-1884

Director of Public Health Surveillance Programs:
Randy Valcin (409) 938-2322 or cell 832-368-5058

GCHD After Hours Answering Service
(888) 241-0442

Galveston Sheriff Department (409) 766-2330

Bomb Disposal: Galveston County Sheriff Dept.

Local Response: Noted in Attachment 1

Hazardous Materials Information:

TCEQ Spill Reporting: 1-800-832-8224

Poison Control Center: 1-800-222-1222

Utilities: Gas: Noted in Attachment 1

Electric: Noted in Attachment 1

Water: Noted in Attachment 1

Telephone: Noted in individual Facility Plans for appropriate locations

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LOCAL HEALTH DEPARTMENT BASIC PLAN

I. AUTHORITY

A. Federal

1. Robert T. Stafford Disaster Relief & Emergency Assistance Act, (as amended), 42 U.S.C. 5121
2. Emergency Planning and Community Right-to-Know Act, 42 USC Chapter 116
3. Emergency Management and Assistance, 44 CFR
4. Hazardous Waste Operations & Emergency Response, 29 CFR 1910.120
5. Homeland Security Act of 2002
6. Homeland Security Presidential Directive. *HSPD-5,* Management of Domestic Incidents
7. Homeland Security Presidential Directive, *HSPD-3,* Homeland Security Advisory System
8. National Incident Management System
9. National Response Plan
10. National Strategy for Homeland Security, July 2002
11. Nuclear/Radiological Incident Appendix of the National Response Plan
12. Presidential Policy Directive 8 – National Preparedness

B. State

1. Government Code, Chapter 418 (Emergency Management)
2. Government Code, Chapter 421 (Homeland Security)
3. Government Code, Chapter 433 (State of Emergency)
4. Government Code, Chapter 791 (Inter-local Cooperation Contracts)
5. Health & Safety Code, Chapter 81 (Communicable Disease Act)
6. Health & Safety Code, Chapter 121 (Local Public Health Reorganization Act)
7. Health & Safety Code, Chapter 508 (Area Quarantine for Environmental and Toxic Agent)
8. Health & Safety Code, Chapter 778 (Emergency Management Assistance Compact)
9. Executive Order of the Governor Relating to Emergency Management
10. Executive Order of the Governor Relating to the National Incident Management System
11. Administrative Code, Title 37, Part 1, Chapter 7 (Division of Emergency Management)
12. Administrative Code, Title 25, Part 1, Chapter 85 (Health Authorities)
13. *The Texas Homeland Security Strategic Plan,* Parts I and II, December 15, 2003
14. *The Texas Homeland Security Strategic Plan*, Part III, February 2004
15. *The Texas Homeland Security Strategic Plan, 2005-2010,* November 2005

C. Local

1. Galveston County Emergency Management Plan
2. Inter-local Agreements and Contracts

II. PURPOSE

This Basic Plan outlines Galveston County Health District's (GCHD) approach to emergency operations. It provides general guidance for public health support of emergency management activities and an overview of our methods of mitigation/prevention, preparedness/protection, response, and recovery. The plan describes our emergency response organization and assigns responsibilities for various emergency tasks. It is intended to provide a framework for more specific functional Appendixes that describe in more detail who does what, when, and how.

This plan applies to all GCHD staff including those working away from GCHD headquarters. The primary audience for the document includes our staff leadership, program staff, and supporting volunteers who have assignments under this All-Hazards Emergency Management Plan. It is intended to address public health emergency response within Galveston County for which the district serves as the supporting health department, and thus aspects of this plan will be shared with emergency management officials.

III. EXPLANATION OF TERMS

A. Acronyms

AAR	After Action Report
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
DDC	Disaster District Committee
DHS	U.S. Department of Homeland Security
DSHS	Department of State Health Services
EOC	Emergency Operations or Operating Center
ESC	Emergency Support Center
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency, an element of the U.S. Department of Homeland Security
GCHD	Galveston County Health District
Hazmat	Hazardous Material
LHD	Local Health Department
HSPD-5	Homeland Security Presidential Directive 5
ICP	Incident Command Post
ICS	Incident Command System
IP	Improvement Plan
JFO	Joint Field Office
IT	Information Technology
IMT	Incident Management Team
JIC	Joint Information Center
LHA	Local Health Authority
NIMS	National Incident Management System
NRP	National Response Plan
OEM	Office of Emergency Management

PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
POD	Point of Dispensing Clinic
RCC	Regional Coordination Center
RSS	Receipt, Store, Stage site for SNS Operations
RUC	Regional Unified Command
SNS	Strategic National Stockpile
SOP	Standard Operating Procedures
SOGs	Standard Operating Guidelines
SOC	State Operations Center
TPHRA	Texas Public Health Risk Assessment Tool

B. Definitions

1. Area Command (Unified Area Command). An organization established (1) to oversee the management of multiple incidents that are each being managed by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Sets overall strategy and priorities, allocates critical resources according to priorities, ensures that incidents are properly managed, and ensures that objectives are met and strategies followed. Area Command may become a Unified Area Command when incidents are multijurisdictional.

2. Disaster District. Disaster Districts are regional state emergency management organizations mandated by the Executive Order of the Governor relating to Emergency Management whose boundaries parallel those of Highway Patrol Districts and Sub-Districts of the Texas Department of Public Safety.

3. Disaster District Committee. The DDC consists of a Chairperson (the local Highway Patrol captain or command lieutenant), and agency representatives that mirror the membership of the State Emergency Management Council. The DDC Chairperson, supported by committee members, is responsible for identifying, coordinating the use of, committing, and directing state resources within the district to respond to emergencies.

4. Emergency Operations Center. Specially equipped facilities from which government officials exercise direction and control and coordinate necessary resources in an emergency situation.

5. Public Information. Information that is disseminated to the public via the news media and other communication platforms before, during, and/or after an emergency or disaster.

6. Emergency Situations. As used in this plan, this term is intended to describe a *range* of occurrences, from a minor incident to a catastrophic disaster. It includes the following:

    a. Incident. An incident is a situation that is limited in scope and potential effects. Characteristics of an incident include:

        1) Involves a limited area and/or limited population.
        2) Evacuation or in-place sheltering is typically limited to the immediate area of the incident.

3) Warning and public instructions are provided in the immediate area, not community-wide.
4) One or two local response agencies or departments acting under an incident commander normally handle incidents. Requests for resource support are normally handled through agency and/or departmental channels.
5) May require limited external assistance from other local response agencies or contractors.
6) For the purposes of the NRP, incidents include the full range of occurrences that require an emergency response to protect life or property.

b. Emergency. An emergency is a situation that is larger in scope and more severe in terms of actual or potential effects than an incident. Characteristics include:

1) Involves a large area, significant population, or important facilities.
2) May require implementation of large-scale evacuation or in-place sheltering and implementation of temporary shelter and mass care operations.
3) May require community-wide warning and public instructions.
4) Requires a sizable multi-agency response operating under an incident commander.
5) May require some external assistance from other local response agencies, contractors, and limited assistance from state or federal agencies.
6) The EOC will be activated to provide general guidance and direction, coordinate external support, and provide resource support for the incident.
7) For the purposes of the NRP, an emergency (as defined by the Stafford Act) is "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of catastrophe in any part of the United States."

c. Disaster. A disaster involves the occurrence or threat of significant casualties and/or widespread property damage that is beyond the capability of the local government to handle with its organic resources. Characteristics include:

1) Involves a large area, a sizable population, and/or important facilities.
2) May require implementation of large-scale evacuation or in-place sheltering and implementation of temporary shelter and mass care operations.
3) Requires community-wide warning and public instructions.
4) Requires a response by all local response agencies operating under one or more incident commanders.
5) Requires significant external assistance from other local response agencies, contractors, and extensive state or federal assistance.
6) The EOC will be activated to provide general guidance and direction, provide emergency information to the public, coordinate state and federal support, and coordinate resource support for emergency operations.
7) For the purposes of the NRP, a *major disaster* (as defined by the Stafford Act) is any catastrophe, regardless of the cause, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster federal assistance.

d. Catastrophic Incident. For the purposes of the NRP, this term is used to describe any natural or manmade occurrence that results in extraordinary levels of mass

casualties, property damage, or disruptions that severely affect the population, infrastructure, environment, economy, national morale, and/or government functions. An occurrence of this magnitude would result in sustained national impacts over prolonged periods of time, and would immediately overwhelm local and state capabilities. All catastrophic incidents are *Incidents of National Significance.*

7. Hazard/Risk Analysis. Appendixes to this plan, identifies the local hazards that have caused or possess the potential to adversely affect public health and safety, public or private property, or the environment.

8. Hazardous Material (Hazmat). A substance in a quantity or form posing an unreasonable risk to health, safety, and/or property when manufactured, stored, or transported. The substance, by its nature, containment, and reactivity, has the capability for inflicting harm during an accidental occurrence. Is toxic, corrosive, flammable, reactive, an irritant, or a strong sensitizer, and poses a threat to health and the environment when improperly managed. Includes toxic substances, certain infectious agents, radiological materials, and other related materials such as oil, used oil, petroleum products, and industrial solid waste substances.

9. Incident of National Significance. An actual or potential high-impact event that requires a coordinated and effective response by and appropriate combination of federal, state, local, tribal, nongovernmental, and/or private sector entities in order to save lives and minimize damage, and provide the basis for long-term communication recovery and mitigation activities.

10. Inter-local Agreements. Agreements between governments or organizations, either public or private, for reciprocal aid and assistance during emergency situations where the resources of a single jurisdiction or organization are insufficient or inappropriate for the tasks that must be performed to control the situation. Also referred to as a mutual aid agreement.

11. Mutual Aid Agreements. Arrangements between governments or organizations, either public or private, for reciprocal aid and assistance during emergency situations where the resources of a single jurisdiction or organization are insufficient or inappropriate for the tasks that must be performed to control the situation. Also referred to as inter-local agreements.

12. Stafford Act. The Robert T. Stafford Disaster Relief and Emergency Assistance Act authorizes federal agencies to undertake special measures designed to assist the efforts of states in expediting the rendering of aid, assistance, emergency services, and reconstruction and rehabilitation of areas devastated by disaster.

13. Standard Operating Guidelines. Approved methods for accomplishing a task or set of tasks. May also be referred to as Standard Operating Procedures (SOPs). SOPs are typically prepared at the department or agency level.

IV. SITUATION AND ASSUMPTIONS

A. Situation

Galveston County is exposed to many hazards, all of which have the potential for disrupting the community, causing casualties, and damaging or destroying public or private property. According to the Texas Public Health Risk Assessment Tool (TPHRA) completed in January 2013, Hurricane/Tropical Storms, Biological terrorism, Tornadoes, Biological terrorism, Hazardous materials incidents, and chemical terrorism are high risks due to Galveston's proximity to the Gulf and geographic location to industries. A full report of Galveston County's Hazards and risks can be found in the TPHRAT Report 2013. A summary of our major hazards is provided in Figure 1 below.

Figure 1			
GALVESTON COUNTY HEALTH DISTRICT HAZARD SUMMARY			
	Likelihood of Occurrence*	**Estimated Impact on Public Health & Safety**	**Estimated Impact on Property**
Hazard Type:	(See below)	**Limited Moderate Major**	**Limited Moderate Major**
Natural			
Drought	Occasional	Moderate	Major
Earthquake	Unlikely	Limited	Major
Flash Flooding	Occasional	Moderate	Major
Flooding (river or tidal)	Occasional	Moderate	Major
Hurricane	Highly Likely	Major	Major
Subsidence	Occasional	Moderate	Moderate
Tornado	Occasional	Moderate	Major
Wildfire	Occasional	Moderate	Major
Winter Storm	Unlikely	Limited	Moderate
Infectious Disease Outbreak	likely	Major	Limited
Technological			
Dam/Levee Failure	Unlikely	Moderate	Major
Energy/Fuel Shortage	Occasional	Moderate	Limited
Hazmat/Oil Spill/ Explosion (fixed site)	Highly Likely	Major	Major
Hazmat/Oil Spill (transport)	Likely	Major	Moderate
Major Structural Fire	Occasional	Moderate	Major
Nuclear Facility Incident	Unlikely	Limited	Major
Water System Failure	Unlikely	Moderate	Moderate
Human Caused			
Civil Disorder	Unlikely	Moderate	Moderate
Enemy Military Attack	Unlikely	Major	Major
Biological Terrorism	Unlikely	Major	Limited
Chemical Terrorism	Unlikely	Major	Limited
Radiological Terrorism	Unlikely	Major	Limited
Nuclear Terrorism	Unlikely	Major	Major
Explosive Terrorism	Unlikely	Major	Major
* **Likelihood of Occurrence**: Unlikely, Occasional, Likely, or Highly Likely			

B. Assumptions

The Galveston County Health District is responsible for coordinating resources to meet the health and medical needs of Galveston County during emergency situations. Emergency tasks to be performed may include:

- Assessing the numbers of dead and injured, types of injuries, anticipated health and sanitary conditions in the disaster area, and status of applicable medical facilities;

- Coordinating medical care for patients and special needs populations who cannot be moved, or must be moved at great risk, before a disaster strikes, if applicable, or after the disaster has occurred;

- Points of Dispensing (POD's) for distributing and dispensing prophylactic medications such as antibiotics to healthy people during a large-scale public health emergency. How this is to be accomplished is outlined in detail in GCHD's SNS and 48-Hour Dispensing Plan

- Coordinating the location, procurement, screening, and allocation of health and medical supplies and resources, including human resources, required to support health and medical operations;

- Providing health and medical information to the public and the medical community regarding the potential for human and animal disease and methods to combat the threat (Infectious Disease Emergency Response Plan);

- When applicable, activation of GCHD's continuity of operations plan (COOP) for reassignment of duties, utilizing alternative facilities and modes of communication

- Conducting inspections to assure the safety of food, water, and sewer disposal systems after an emergency.

- Assisting in the coordination of animal health issues. How this is to be accomplished is outlined in detail in GCHD's Animal in Disaster Response Plan

- Assisting in the coordination of behavioral health counseling to disaster victims, emergency workers, and others suffering trauma due to the emergency incident;

- Developing and disseminating emergency public health regulations and orders;

- Communication with county and city emergency management, local hospitals and providers, respective public information officers and stakeholders as needed (Risk Communication Plan)

Assisting in the coordination of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents. Coordinating with emergency management to identify health hazard policies and plans of action of community partners in order to mitigate identified disaster health risks. Such identified community partners include the American Red Cross, Gulf Coast Center, UTMB, Mainland Medical Hospital, and other local and regional agencies. These agencies will be contacted dependent on the jurisdiction's needs, at-risk population, and public health emergency. **V. CONCEPT OF OPERATIONS**

A. **Objectives**

The objectives of our emergency management program is to protect public health and safety and preserve public and private property, as these relate to public health.

B. **General Concept of Operations**

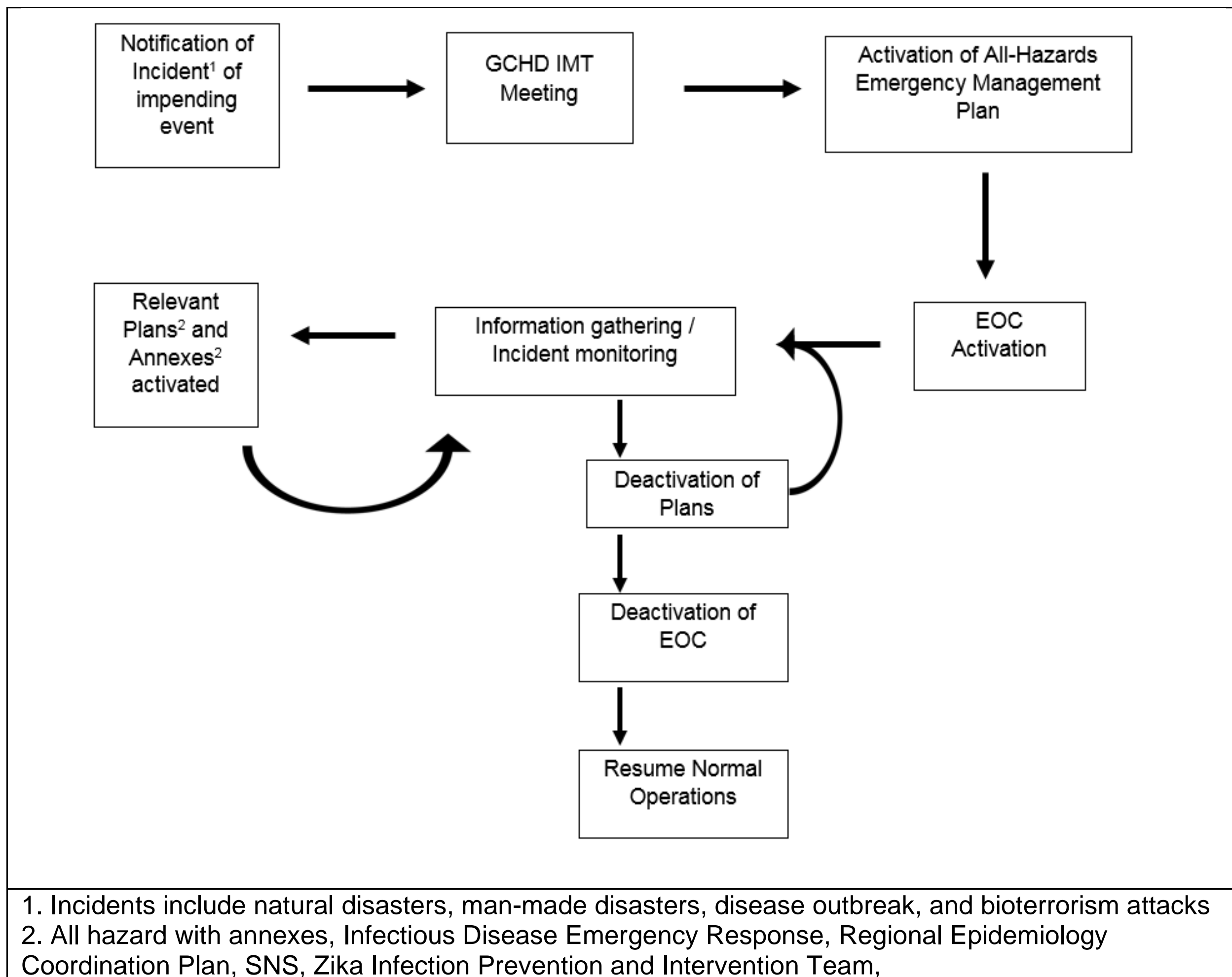
The normal day to day operations of the Galveston County Health District is the responsibility of the Health District administration. In a normal condition GCHD will function under the specific guidelines as directed by administration staff.

In the event of an emergency/disaster or impending threat the scope of normal operations could change resulting in the activation of The All Hazard Emergency Management Plan. The Incident Management Team (IMT), which is a group of essential GCHD Tier 3 personnel, will meet to confer what actions need to be taken. The Health District will then operate based on established emergency operating procedures under the direction of the incident commander (CEO, Director of Public Health Surveillance Programs, or designee). In the event the Mid-County Annex is compromised due to weather, disease outbreak, cyber, or terror attack, GCHD would activate the Continuity of Operations Plan (COOP - Annex J).

In emergency/disaster situations, decisions will be made by GCHD Administration through utilization of the All Hazards Emergency Response plan. Potentially threatening situations or actual events should be reported to the PHEP Manager immediately. **The district will coordinate their response through the Incident Command Structure (ICS), which in turn will make the proper notifications and requests to the proper organization(s).**

The ICS will evaluate information gathered and determine what actions will be taken by the district. The CEO or their designee will notify the district of any change in operations to include facility closures, as well as disruptions or discontinuation of services.

When the IMT convenes and a determination is made for ICS activation, during this first meeting immediate, long-term, and final actions needed to accomplish the incident objectives will be outlined and adhered to with the caveat of updates to come when needed



1. Incidents include natural disasters, man-made disasters, disease outbreak, and bioterrorism attacks
2. All hazard with annexes, Infectious Disease Emergency Response, Regional Epidemiology Coordination Plan, SNS, Zika Infection Prevention and Intervention Team,

C. **Operational Guidance**

Public health emergency response will be conducted under the direction of the CEO and the Local Health Authority (LHA) in concert with other local and state agencies and partners. When required, assistance will be requested from the Galveston County Office of Emergency Management. Consultation regarding public health issues may be made with the DSHS Regional Office.

D. **National Incident Management System (NIMS)**

GCHD has adopted the principles and concepts of NIMS.

E. Incident Command System (ICS)

An example of GCHD ICS is illustrated in the organization chart shown in Attachment 4. This organization is designed to support the worst case known threat response, and sections may be activated or deactivated as dictated by the incident.

F. ICS - EOC Interface

GCHD will activate an emergency operations center as dictated by the emergency situation.

The CEO or his/her designee acting in the capacity of Incident Commander can activate or deactivate sections of the incident command organization, or call into action other GCHD staff, as dictated by the emergency situation.

G. State, Federal, and Other Assistance

State and Federal Assistance

a. When the emergency situation is of such a magnitude as to require the activation of the Galveston County Emergency Operations Center (GCEOC), at the request of the County Emergency Management Coordinator, we will staff the GCEOC with a GCHD representative.

b. If local health and medical resources are inadequate to deal with a public health emergency situation, we will request assistance through the GCEOC in the form of a State of Texas Assistance Request (STAR). State assistance furnished to local governments is intended to supplement local resources and not substitute for such resources, including mutual aid resources, equipment purchases or leases, or resources covered by emergency service contracts. Cities must request assistance from the county before requesting state assistance. Local and regional mutual aid agreements must be used before requesting state or federal resources.

c. Local jurisdiction requests for state assistance must be made through the GCEOC first to the Regional Unified Command (RUC). If the RUC is unable to fill the need, the request is then made to the DDC by the chief elected official (County Judge). The DDC Chairperson has the authority to utilize all state resources within the district to respond to a request for assistance, with the exception of the National Guard. Use of National Guard resources requires approval of the Governor.

d. The Disaster District staff will forward requests for assistance that cannot be satisfied by state resources within the District to the State Operations Center (SOC) in Austin for action.

e. Requests for health and medical resources through the DDC will be handled like any other request. Any assistance/resource that GCHD requires from DSHS Austin will be requested by the DDC from the SOC. The SOC staff will forward the request to the DSHS representative at the SOC for action.

2. Other Assistance

a. If resources required to control an emergency situation are not available within the State, the Governor may request assistance from other states pursuant to a number of interstate compacts or from the federal government through the Federal Emergency Management Agency (FEMA).

b. For major emergencies and disasters for which a Presidential declaration has been issued, federal agencies may be mobilized to provide assistance to states and local

governments. The *National Response Plan (NRP)* describes the policies, planning assumptions, concept of operations, and responsibilities of designated federal agencies for various response and recovery functions. The *Nuclear/Radiological Incident Appendix* of the *NRP* addresses the federal response to major incidents involving radioactive materials.

c. FEMA has the primary responsibility for coordinating federal disaster assistance. No direct federal disaster assistance is authorized prior to a Presidential emergency or disaster declaration, but FEMA has limited authority to stage initial response resources near the disaster site and activate command and control structures prior to a declaration and the Department of Defense has the authority to commit its resources to save lives prior to an emergency or disaster declaration.

d. The NRP applies to Stafford and non-Stafford Act incidents and is designed to accommodate not only actual incidents, but also the threat of incidents. Therefore, NRP implementation is possible under a greater range of incidents.

e. When a disaster declaration has been issued, the County Judge and/or the Mayor's or City Managers may use all available local resources to respond to the disaster and temporarily suspends statutes and rules, including those relating to purchasing and contracting, if compliance would hinder or delay actions necessary to cope with the disaster. When normal purchasing and contracting rules are suspended, it is incumbent on Galveston County and the finance section chief and the joint resolution jurisdiction finance section chief to formulate and advise government employees of the rules that are in effect for emergency purchasing and contracting.

f. Volunteer Management will contact Regional MRC and local partner agencies, CERT, VOAD and faith -based organizations on an as-needed basis.

H. Emergency Authorities

1. Key federal, state, and local legal authorities pertaining to emergency management are listed in Section I of this plan.

2. Texas statutes and the Executive Order of the Governor Relating to Emergency Management provide local government, principally the chief elected official, with a number of powers to control emergency situations. If necessary, we shall use these powers during emergency situations. These powers include:

   a. Emergency Declaration. The County Judge/Mayor may request that the Governor issue an emergency declaration for this jurisdiction and take action to control the situation.

   b. Disaster Declaration. When an emergency situation has caused severe damage, injury, or loss of life or it appears likely to do so, the County Judge/Mayor may, by executive order or proclamation, declare a local state of disaster. The County Judge/Mayor may subsequently issue orders or proclamations referencing that declaration to invoke certain emergency powers granted the Governor in the Texas Disaster Act *on an appropriate local scale* in order to cope with the disaster. These powers include:

1) Suspending procedural laws and rules to facilitate a timely response.
2) Using all available resources of government and commandeering private property, subject to compensation, to cope with the disaster.
3) Restricting the movement of people and occupancy of premises.
4) Prohibiting the sale or transportation of certain substances.
5) Implementing price controls.

A local disaster declaration activates the recovery and rehabilitation aspects of this plan. A local disaster declaration is required to obtain state and federal disaster recovery assistance.

c. Authority for Evacuations. In accordance with HB 3111 (79^{th}R) a County Judge or Mayor has the authority to order the evacuation of all or part of the population from a stricken or threatened area within their respective jurisdictions.

d. Public Health Control Measures. In the event of an infectious disease outbreak requiring the imposition of control measures, GCHD will follow DSHS guidance as stated in The Emerging and Acute Infectious Disease Investigation Guidelines. A control measure imposed by the LHA may be revoked or modified by DSHS.

e. Health Authority. A health authority is a physician appointed under Health and Safety Code Chapter 121 to administer state and local laws relating to public health within the jurisdiction. In the absence of such an appointment, the DSHS regional director has these powers (Health and Safety Code Sec. 121.007, Title 25 TAC Sec. 85.1)

f. Area Quarantine for Environmental or Toxic Agent. A control measure imposed by the health authority or the commissioner of DSHS under Texas Health and Safety Code Chapter 508.

g. Public Health Disaster. In accordance with Health and Safety Code Sec. 81.003, a public health disaster requires a declaration of disaster by the governor, and a determination by the commissioner of DSHS that a communicable disease threat exists. This declaration streamlines the imposition of communicable disease control measures under Chapter 81 of the Health and Safety Code. The LHA is the final decision-making authority on escalation and de-escalation of interventions implemented by the Health District

I. Galveston County and Neighboring Jurisdictions

Actions by Phases of Emergency Management

1. This plan follows an all-hazard approach and acknowledges most responsibilities and functions performed during an emergency are not hazard specific. Likewise, this plan accounts for activities before and after, as well as during emergency operations. These are commonly referred to as the four phases of emergency management and consist of the following:

   a. Mitigation
   Mitigation actions are taken to eliminate or reduce the degree of long-term risk to personnel and district property from natural and technological hazards.

   b. Preparedness
   Preparedness activities serve to develop the response capabilities needed in the event an emergency should arise. Planning and training are among the activities conducted under this phase.

   c. Response
   Response is the actual provision of emergency services and conduct of emergency operations during a crisis. These activities help to reduce casualties and speed up

the recovery process. Response activities include warning, evacuation, rescue, and other similar operations.

d. Recovery
Recovery is both a short-term and long-term process. Short-term operations seek to restore vital services to the district. Long-term operations focus on all aspects of returning the district to its normal or improved state of affairs. The recovery phase is also an opportune time to institute mitigation measures, particularly those related to the recent emergency/disaster.

VI. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. Organization

1. GCHD will establish an incident command organization with the following minimum General Staff identified: Incident Command, Operations, Planning, Finance, and Logistics. Supporting sections and teams will be organized and activated as determined by the situation and will comply with the first responder safety plan as stated in (Annex X).

2. The assignment of responsibilities for the Galveston County Health District consists of the following:

B. Assignment of Responsibilities

Chief Executive Officer
The Chief Executive Officer (CEO) and/or his or her designee are responsible for the general management of the Health District and all related personnel and equipment resources. For emergency activities the CEO is responsible for:

- Overseeing district emergency planning and operations.
- Assigning a reliable and authoritative emergency coordinator for the district.
- Assuring that all personnel are familiar with emergency and disaster plans.
- Authorizing and managing district emergency operations as prescribed by planning or direction of the GC Emergency Management Coordinator.
- Supporting and participating in emergency management training and exercises.
- Supporting centralized emergency operations at the Emergency Operations ~~CenterConsulting~~Center Consulting with local, state, and federal experts about established treatment and
control measures for disease outbreaks and other public health threats.

Office of Fiscal Services / Accounting

- Tracking and documenting expenditures related to response efforts
- Tracking and documenting GCHD employee time spent conducting response activities.
- Provide logistical support to GCHD response operations.

Public Health Emergency Preparedness

- Implementing and coordinating all emergency activities for GCHD.

- Managing the development of emergency plans, procedures, training, and exercises.
- Participating with the Office of Emergency Management in all aspects of the emergency management program, to include both simulated and actual emergency operations.
- Establish and coordinate communications with Office of Emergency Management and their respective agencies (medical, fire, police, public works, etc.), as appropriate
- Requesting needed resources from County Emergency Management to support GCHD emergency operations.
- Coordinating planning and response activities with other agencies and social organizations with a role in response. Partner organizations include medical, mental/behavioral health professionals, faith-based, volunteer and professional organizations.
- Coordinating and organizing Galveston County Medical Reserve Corps response, training, and recruiting activities.
- Developing, conducting, and documenting an incident action plan for emergency events including conducting post incident ~~hotwashes~~hot washes.
- Developing and documenting lessons learned from response activities through improvement plans.
- Educating all GCHD employees on emergency and disaster plans.
- Develop annual Multiyear Training and Exercise Plan (MYTEP) in conjunction with appropriate county and city stakeholders.

Public Information Services

The role of Public Information Services is to provide accurate, timely, and consistent messages to the general public during a public health emergency. How this is to be accomplished is outlined in detail in GCHD's *Risk Communication Plan*.

Epidemiology

- Compiles, maintains, and analyzes surveillance data and vital statistic information.
- Sends out Health Alerts to healthcare providers and other stakeholders.
- Provides accurate and timely updates to the , Director of Public Health Surveillance Programs ,CEO, and LHA regarding disease investigation and outbreaks.

Office of Environmental Health Services

- Coordinate inspection of food products, water, sanitary sewer systems and other consumables that were exposed to the hazard.
- Coordinate inspection of damaged buildings for health hazards
- Coordinate the implementation of measures to prevent or control disease vectors such as flies, and rodents.
- Monitor food handling and sanitation in emergency facilities.
- Coordinate with local jurisdictions in debris management issues.
- Respond to citizen concerns associated with environmental issues.

Office of Community Health Services

- Conduct mass vaccination and/or mass medication dispensing campaigns
- Access health and medical needs among affected populations.
- Link patients with needed medical, mental health and social services
- Provide assistance in repackaging medications during a public health emergency

Office of Emergency Medical Services

- Respond to the scene with appropriate emergency medical personnel and equipment
- Upon arrival at the scene, assume an appropriate role in the ICS.
- Triage, stabilize, treat, and transport the injured
- Coordinate with local and regional hospitals to ensure casualties are transported to the appropriate facilities
- Establish and maintain field communications and coordination with other responding emergency teams (medical, fire, police, public works, etc.) and radio and/or telephone communications with hospitals, as appropriate.

Information Technology

- Developing an enterprise-wide disaster recovery and business recovery plan.
- Coordinate strategic relationships between internal IT resources and other departments and external entities.
- Develops Information Services/Technology policies, standards, practices and security measures.

VII. DIRECTION AND CONTROL

A. General

The GCHD CEO or their designee is responsible for directing the public health emergency response and recovery activities in Galveston County. The PHEP Manager is responsible for assuring coordinated and effective emergency response systems are developed and maintained. The district will perform emergency activities closely related to those they perform routinely. The Health District will retain control over its personnel and equipment unless directed otherwise. Actions taken by the Health District are by the authority previously stated and under the medical authority of the LHA.

B. Emergency Facilities

- An EOC will be established at GCHD headquarters located at 9850-A Emmett F. Lowry Expressway in Texas City, Texas for most public health managed incidents.

- Large scale incidents requiring a county wide response will be operated from GCEOC Building located at 1353 FM 646 in League City, Texas. This site will also function as an alternate EOC for GCHD in the event our primary EOC becomes unusable.

- Alternative Continuity Sites: secondary work sites are identified to house GCHD Operations if the present location is compromised. As of January 2018, an MOU has been signed with the Galveston Housing Authority. Sites are selected due to their geographic distance away from GCHD and the availability of facilities to house all operations.

- A command and control vehicle operated by the Public Health Preparedness Program may be used as a mobile incident command post.

- GCHD Public Health Preparedness Program has two multi emergency response trailers
- which may be used to transport Point of Dispensing Equipment to operate as a mobile command post.

- GCHD has one mobile medical clinic unit available to provide mobile point of dispensing services.

C. Line of Succession

The line of succession for the Chief Executive Officer is:

1. LHA
2. Chief Nursing Officer

In the absence of the LHA or a designated alternate, the Department of State Health Services (DSHS) Medical Director for PHR 6/5S would by statute assume the duties of health authority for Galveston County & Cities.

VIII. READINESS LEVELS

Many emergencies follow some recognizable build-up period during which actions can be taken to achieve a gradually increasing state of readiness. We use a four-tier system.

The following Readiness Levels will be used as a means of increasing our alert posture.

1. **Level 4: Normal Conditions**. Planning, training, drills and other preparedness activities are conducted. Emergency equipment is maintained and tested. Emergency incidents might occur that require district staff to respond to. Limited assistance might be required from other jurisdictions pursuant to established inter-local agreements.

2. **Level 3: Increased Readiness**. Increased Readiness refers to a situation that presents a greater potential threat than "Level 4", but poses no immediate threat to life and/or property. General readiness actions may include increased situation-monitoring, a review of plans and resource status, determining staff availability and placing personnel on-call when the situations affecting public health occur. This condition includes situations that could develop into a hazardous condition, such as the following:

- A tropical weather system has developed having the potential to impact the local area. Readiness actions may include situation monitoring, a review of plans and resource status, determining staff availability, and placing personnel on call.

- Tornado Watch: Issued to alert persons to the possibility of tornado development in our area, for a specified period of time. Persons in the watch areas should maintain their daily routine however, be prepared to respond to a tornado warning.

- Flash Flood Watch: Issued to alert persons to the possibility of flash flooding in our area due to heavy rains occurring or expected to occur. Persons should remain alert and be prepared to take immediate action.

- Winter Storm Watch: Issued when there is a threat of severe winter weather in our area.

- International situation that deteriorates to the point that enemy attack is probable. This condition would allow sufficient time for an orderly evacuation.

- Small-Scale localized civil unrest is present or when the increased predictable threat of terrorist activity exists.

- Hazardous Materials emergency conditions in an adjacent area.

3. **Level 2: High Readiness**. High Readiness refers to a situation with a significant potential and probability of causing loss of life and/or property. This condition will normally require some degree of warning to the public. Actions could be triggered by severe weather warning information issued by the National Weather Service such as:

    - Tropical Weather Threat: A tropical weather system may impact the area within 72 hours. Readiness actions might include monitoring storm forecasts, participating in Emergency Management conference calls, increasing preparedness of personnel, and preparing to address facility issues.

    - Tornado Warning: Issued when a tornado has actually been sighted in the area or indicated by radar, and may strike in the vicinity.

    - Flash Flood Warning: Issued to alert persons that flash flooding is imminent or occurring on certain streams or designated areas, and immediate action should be taken.

    - Winter Storm Warning: Issued when heavy snow, sleet, freezing rain are forecast to occur separately or in combination.

    - Condition 2 actions could be generated when the international situation has deteriorated to the point that enemy attack is probable. This condition may/may not allow sufficient time for an orderly evacuation.

    - Condition 2 actions could also be triggered by civil disorder with relatively large-

scale localized violence or terrorist incident has occurred or is imminent.

4. **Level 1: Maximum Readiness.** Maximum Readiness refers to a situation that hazardous conditions are imminent. This condition is used to denote a greater sense of danger and urgency than found in condition 2. A condition one will be declared when 39 mph winds are expected to reach our area between 24-12 hours. The threat is better defined in terms of time and proximity. For example:

   - 39 mph winds predicted in 24-12 hours or less
   - Tornado sighted especially close to, or moving in the path of the facility.
   - Flooding is imminent or occurring.
   - Condition 1 actions could be generated when an enemy attack is imminent based upon the evaluation of intelligence data. This warning is declared and disseminated by the Federal Emergency Management Agency (FEMA) National Warning System (NAWAS).
   - Condition 1 actions could also be implemented when civil disorder precipitates large-scale and wide-spread violence or an area that has received a terrorist threat.
   - Level 1 actions could be triggered by a significant local chemical release, transportation accident or fire situation that requires active intervention in a public health role. Level 1 actions can be triggered by local public health emergencies including imminent disease outbreaks, infrastructure vulnerability, or contamination of the food supply that requires active intervention in a public health role.

IX. ADMINISTRATION AND SUPPORT

A. Administration

In general, emergency activities for GCHD will be conducted from the designated Health District Emergency Operations Center area. The PHEP Manager will be the contact between the district and the County Emergency Operations Center Support

Requests for assistance during an emergency/disaster will be forwarded to the PHEP Manager. In the event the scope of the incident is beyond the capabilities of the district, the PHEP Manager will request assistance through the Galveston County Emergency Operations Center.

B. Recovery

All employees should check in with their supervisor as soon as possible after an emergency event occurs, for job assignments or to report if they are able to assist in

recovery efforts. Employees can also call into the Inclement Weather Line at (409) 938-2489 and/or listen to radio station KTRH 740 AM to find the status of District operations and when recovery operations for their program will commence.

C. **Disaster Re-Entry Plans**

GCHD personnel will have to provide two picture ID's, they should be the employee's ID badge and their driver license with a current address. All critical personnel will be issued a GCHD magnetic car door signs for use of re- entry

Tier 1 (entry level) includes public health professionals that carry out day-to-day tasks of the HPH and are not in management positions. Responsibilities of these public health professionals may include basic data collection, fieldwork, outreach activities, programmatic support, and other organizational tasks.

Tier 2 (management) includes professionals with program management and/or supervisory responsibilities as well as program development/implementation/evaluation, maintaining community relations, managing timelines and work plans, and recommending public health policies.

Tier 3 (leadership) focuses on individuals in senior management or leadership positions. This level includes responsibility for program functions, organizational strategy and vision, and establishing/maintaining the organization's professional culture.

1. **Tier 1 <u>Normal Operations</u>**
   i. Non-responders, don't have an immediate job expectation to respond to emergency, but their secondary role in emergencies will require a basic understanding of ICS. Return to participate in recovery efforts and establish normal operations.

2. **Tier 2 <u>Recovery</u>**
   i. Return when conditions permit to assist in recovery operations.

3. **Tier 3 <u>Essential</u>**
   i. Ride out storm in secure locations or return ASAP to conduct response and recovery activities.

Employees in all Tier categories must remain in their positions prior to an anticipated emergency event (such as a hurricane) to assist in preparation until released by their supervisor. All employees are subject to re-direction of job duties to assist in response and recovery operations.

D. **Policy**

All employees are expected to fulfill their emergency response activities to maintain employment with the District.

If a public health emergency/disaster situation occurs or a Disaster Declaration is issued for any jurisdiction which may incorporate crucial services provided by the District or its employees, both exempt and non-exempt employees may be compensated in accordance with the following clauses.

1. **Non-essential Employees** released from duty by the Chief Executive Officer or his/her designee may receive compensation (disaster pay) at their regular rate of pay until they are required to return to work.

2. **Essential Employees** performing District responsibilities during declared emergencies shall be paid in accordance with the terms set forth below.

During such circumstances, non-exempt employees shall be paid their regular wage for the first forty (40) hours they work during the work week, which shall always begin and reset each Thursday at 12:01 am, and one-hundred fifty percent (150%) their regular wage for every hour worked thereafter. Exempt employees undertaking District responsibilities during a declared emergency may, at the discretion of the Chief Executive Officer be paid at a ~~straight-rate~~straight rate of their average respective hourly pay (individual weekly salary/40) for every additional hour worked in ~~access~~excess of forty (40) hours. Likewise, the work week for exempt employees shall begin and reset every Thursday at 12:01 am.

This policy may be modified in emergency situations as deemed necessary by the Chief Executive ~~Officeror~~Officer or designee. Each emergency approval made by the Chief Executive Officer or his/her designee will be brought to the next board meeting for review and ratification.

E. Agreements and Contracts

Should GCHD resources prove to be inadequate during an emergency; requests for assistance will be made pursuant to mutual aid agreements (see Attachment 5); and if those prove insufficient, requests will be made for assistance from the supporting Disaster District Committee and DSHS Austin. Such assistance may include equipment, supplies, or personnel. All agreements will be entered into by authorized officials and should be in writing whenever possible. Agreements and contracts should identify the local officials authorized to request assistance pursuant to those documents.

F. Reports

Reports shall be managed to the extent possible in WebEOC.When WebEOC cannot be used, alternative methods of communication will be used. WebEOC automatically documents and records information entered into the WebEOC system. All reports must be maintained in such a manner that they may be retrieved.

Initial Emergency Report. This short report should be prepared and transmitted upon recognition of an emergency incident affecting public health. In WebEOC this requires the creation of a new incident. Should the incident have already been created, the region's initial report shall be by Situation Report.

Situation Report. The Situation Report is a continuously updated WebEOC standardized report screen.

Other Reports. Other reports may be required during the emergency and may be incorporated or kept separate from WebEOC and other electronic reporting methods.

G. Records (Record Keeping for Emergency Operations)

GCHD has established administrative controls necessary to manage the expenditure of funds and to provide reasonable accountability and justification for expenditures made to support emergency operations. This shall be done in accordance with the established local fiscal policies and standard cost accounting procedures. Records should be collected and centrally stored by event, to the maximum extent possible.

1. Activity Logs. All emergency facilities shall maintain accurate logs recording key response activities, including:

    i. Activation or deactivation of emergency facilities.
    ii. Emergency notifications to local, state and federal agencies.
    iii. Significant changes in the emergency situation.
    iv. Major commitments of resources or requests for additional resources from external sources.
    v. Issuance of protective action recommendations to the public.
    vi. Evacuations and shelter operations.
    vii. Casualties.
    viii. Containment or termination of the incident.

    ix. Incident Costs. All department and agencies shall maintain records summarizing the use of personnel, equipment, and supplies during the response to day-to-day incidents to obtain an estimate of annual emergency response costs that can be used as in preparing future department or agency budgets.

    x. Emergency or Disaster Costs. For major emergencies or disasters, all programs participating in the emergency response shall maintain detailed of costs for emergency operations to include:

        1. Personnel costs, especially overtime costs
        2. Equipment operations costs
        3. Costs for leased or rented equipment
        4. Costs for contract services to support emergency operations
        5. Costs of specialized supplies expended for emergency operations

    These records may be used to recover costs from the responsible party or insurers or as a basis for requesting financial assistance for certain allowable response and recovery costs from the state and/or federal government.

Preservation of Records

    xi. In order to continue normal government operations following an emergency situation disaster, vital records must be protected. These include legal documents as well as health, financial, and other supporting records. The principal causes of damage to records are fire and water; therefore, essential records should be protected accordingly.

xii. If records are damaged during an emergency situation, we will seek professional assistance to preserve and restore them.

I. Training

All staff will be trained in NIMS-compliant incident command systems, and possess an appropriate level of training, experience, credentialing, physical and medical fitness, or capability for any positions they are tasked to fill.

J. Post-Incident and Exercise Review

The PHEP Manager or designee is responsible for organizing and conducting a critique following the conclusion of a significant emergency event/incident or exercise. From this evaluation an After Action Report (AAR) will be written, and will entail both written and verbal input from all appropriate participants. All drills or exercises completed by PHEP will have an AAR. Any event that elicits the activation of the all hazard emergency operations plan will have an AAR. These events would include:

- foodborne outbreaks
- waterborne outbreaks
- infectious disease outbreaks
- environmental public health hazards
- natural disasters

Furthermore, any other response by GCHD, as deemed necessary by the CEO or designee, will have an AAR. The AAR will be provided to DSHS Austin within 90 days of the exercise or event completion. An Improvement Plan will be written addressing identified deficiencies, corrective measures, and correction timelines identified. This Improvement Plan will be forwarded to DSHS Austin. A retest of those areas found deficient will be conducted within 180 days and results forwarded to DSHS Austin.

X. PLAN DEVELOPMENT AND MAINTENANCE

A. Plan Development

The GCHD CEO will direct the development of the All Hazards Plan. Approval of the plan will be granted by the United Board of Health. The creation of policy, plans, and procedures to new or emerging threats will follow similar processes utilizing legal counsel and subject matter experts to ensure a broad, comprehensive approach is achieved.

B. Distribution of Planning Documents

1. When approved, the All Hazards Plan shall be promulgated to the United Board of Health, the Galveston County Office of Emergency Management, and the DSHS 6/5S Regional Office, Community Preparedness Section.

2. The plan will be placed on the GCHD intranet site for access by all GCHD staff.

3. The All-Hazards Plan should include a distribution list (See Attachment 2 to this plan) that indicates who receives copies of this plan and the various Appendixes to it. In general, individuals who receive copies of Appendixes to this plan should also receive a copy of this document.

4. Changes to the All Hazards Plan and Appendixes will be distributed to document holders listed in Attachment (2) herein.

5. The digital copy of this plan can be found online at gchd.org on the employee extranet, under policies/plans. The physical copy of this plan is maintained in the office of the PHEP Manager. New employees are told where to find the plan during their onboarding orientation with Human Resources.

C. Review and Update

1. This plan will be updated based upon deficiencies identified during actual emergency situations, exercises and when changes in threat hazards, resources and capabilities, or agency structure occur.

2. The Basic Plan and its Appendixes must be revised or updated by a formal change yearly. The responsibility for coordinating the revision of the Basic Plan and Appendixes is assigned to the PHEP Manager.

3. Scenario specific plans, such as Continuity of Operations Plan (COOP), Infectious Disease Emergency Response Plan (IDER), Zika Infection Prevention and Intervention Team Plan (ZIPIT), and others will be updated annually and as needed based on updates made to the All Hazards Plan.

Revised or updated planning documents will be distributed as outlines in Section X.B above.

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ATTACHMENTS:
1. First responders contact procedures
2. Distribution List
3. References
4. ICS Organization chart for Emergencies
5. Summary of Agreements & Contracts
6. National Incident Management System

ATTACHMENT 1: 1ST RESPONDER CONTACT PROCEDURES

In order to contact all first responders in the county, GCHD will communicate through GCOEM (who can be contacted via phone at 888-384-2000). The county OEM will contact the respective city emergency managers, who will in turn contact the city's first responders. This communication tree will serve as the basis of contact between entities.

ATTACHMENT 2: DISTRIBUTION LIST

Jurisdiction/Agency Plan	All-Hazards Plan	Appendixes
United Board of Health	1	
Galveston County Office of Emergency Management	1	All
DSHS Region 6/5S	1	All

ATTACHMENT 3: REFERENCES

1. Texas Department of Public Safety, Governor's Division of Emergency Management, *Local Emergency Management Planning Guide*, DEM-10

2. Texas Department of Public Safety, Governor's Division of Emergency Management, *Disaster Recovery Manual*

3. Texas Department of Public Safety, Governor's Division of Emergency Management, *Mitigation Handbook*

4. FEMA, Independent Study Course, IS-288: *The Role of Voluntary Organizations in Emergency Management*

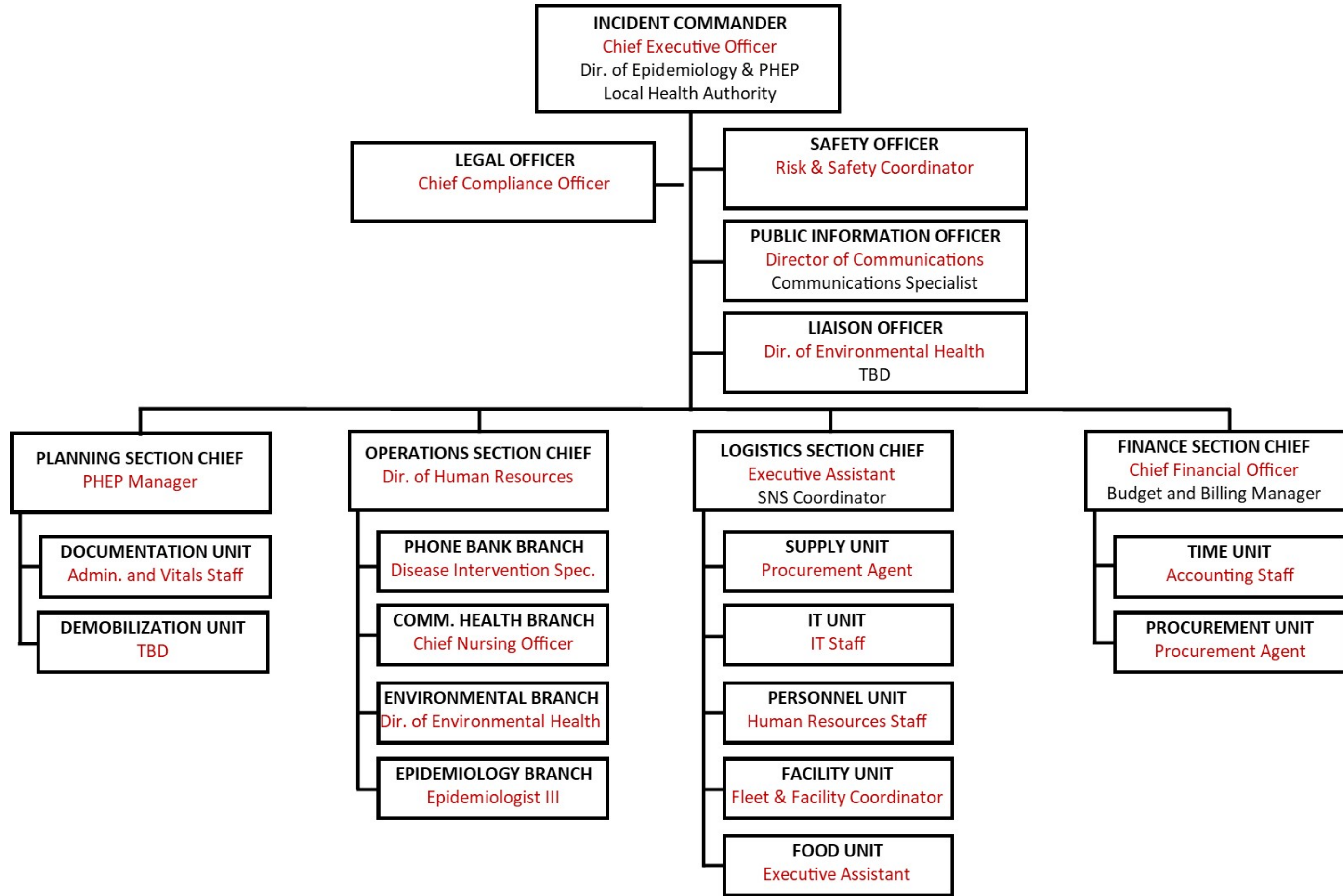
5. FEMA, *State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning*

6. U. S. Department of Homeland Security, *National Response Plan*

7. 79th Texas Legislature*, House Bill 3111*

8. Emergency Management Plan for Galveston County and Participating Cities

ATTACHMENT 4: ICS EXAMPLE CHART



ATTACHMENT 5: SUMMARY OF AGREEMENTS & CONTRACTS

Agreements

Description: *Memorandum of Understanding with College of the Mainland and the Independent School Districts of Clear Creek, Dickinson, Friendswood, Galveston, High Island, Hitchcock, La Marque, Santa Fe, and Texas City.*

Summary of Provisions: *To provide the use of school facilities, office equipment, supplies, and staff in the event of a public health emergency*

Officials: *Authorized to Implement:*

Costs*: None Specified. GCHD will seek reimbursement for supplies used in the course of response to a public health emergency.*

Copies Held By**:** GCHD Contract Analyst

ATTACHMENT 6: NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) SUMMARY

BACKGROUND

1. NIMS is a comprehensive, national approach to incident management that is applicable to all jurisdictional levels and across functional disciplines. This system is suitable across a wide range of incidents and hazard scenarios, regardless of size or complexity. It provides a flexible framework for all phases of incident management, as well as requirements for processes, procedures, and systems designed to improve interoperability.

2. NIMS is a multifaceted system that provides a national framework for preparing for, preventing, responding to, and recovering from domestic incidents.

COMPONENTS

1. Command and Management. The incident management structures employed by NIMS can be used to manage emergency incidents or non-emergency events such as celebrations. The system works equally well for small incidents and large-scale emergency situations. The system has built-in flexibility to grow or shrink depending on current needs. It is a standardized system, so personnel from a variety of agencies and geographic locations can be rapidly incorporated into a common management structure.

   a. Incident Management System. A system that can be used to manage emergency incidents or non-emergency events such as celebrations.

FEATURES OF ICS

ICS has a number of features that work together to make it a real management system. Among the primary attributes of ICS are:

a) Common Terminology. ICS requires the use of common terminology, such as the use of standard titles for facilities and positions within an organization, to ensure efficient and clear communications.

b) Organizational Resources. All resources including personnel, facilities, major equipment, and supply items used to support incident management activities must be “typed” with respect to capability. This typing will minimize confusion and enhance interoperability.

c) Manageable Span of Control. Span of control should ideally vary from three to seven. Anything less or more requires expansion or consolidation of the organization.

d) Organizational Facilities. Common terminology is used to define incident facilities, the activities conducted at these facilities, and the organizational positions that can be found working there.

e) Use of Position Titles. All ICS positions have distinct titles.

f) Reliance on an Incident Action Plan. The incident action plan, which may be verbal or written, is intended to provide supervisory personnel a common understanding of the situation and direction for future action. The plan includes a statement of objectives, organizational description, assignments, and support material such as maps. Written plans are desirable when two or more jurisdictions are involved, when state and/or federal agencies are assisting local response personnel, or there has been significant turnover in the incident staff.

g) Integrated Communications. Integrated communications includes interfacing disparate communications as effectively as possible, planning for the use of all available systems and frequencies, and requiring the use of clear text in communications.

h) Accountability. ICS is based on an orderly chain of command, check-in for all responders, and only one supervisor for each responder.

UNIFIED COMMAND

Unified Command is a variant of ICS used when there is more than one agency or jurisdiction with responsibility for the incident or when personnel and equipment from a number of different agencies or jurisdictions are responding to it. This might occur when the incident site crosses jurisdictional boundaries or when an emergency situation involves matters for which state and/or federal agencies have regulatory responsibility or legal requirements.

ICS Unified Command is intended to integrate the efforts of multiple agencies and jurisdictions. The major change from a normal ICS structure is at the top. In a Unified command, senior representatives of each agency or jurisdiction responding to the incident collectively agree on objectives, priorities, and an overall strategy or strategies to accomplish objectives; approve a coordinated Incident Action Plan; and designate an Operations Section Chief. The Operations Section Chief is responsible for managing available resources to achieve objectives. Agency and jurisdictional resources remain under the administrative control of their agencies or jurisdictions, but respond to mission assignments and direction provided by the Operations Section Chief based on the requirements of the Incident Action Plan.

AREA COMMAND

An Area Command is intended for situations where there are multiple incidents that are each being managed by an ICS organization or to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command becomes Unified Area Command when incidents are multijurisdictional.

The organization of an Area Command is different from a Unified Command in that there is no operations section, since all operations are conducted on-scene, at the separate ICPs.

MULTIAGENCY COORDINATION SYSTEMS.
Multiagency coordination systems may be required for incidents that require higher level resource management or information management. The components of multiagency coordination systems include facilities, equipment, EOCs, specific multiagency coordination entities, personnel, procedures, and communications; all of which are integrated into a common framework for coordinating and supporting incident management.

PUBLIC INFORMATION.
The NIMS system fully integrates the ICS Joint Information System (JIS) and the Joint Information Center (JIC). The JIC is a physical location where public information staff involved in incident management activities can collocate to perform critical emergency information, crisis communications, and public affairs functions. If applicable to the incident or establishing a physical JIC is not optimal, a Virtual JIC can be established by the leading response entity. More information on JICs can be obtained in the DHS *National Incident Management System* Plan, dated March 2004.

Preparedness. Preparedness activities include planning, training, and exercises as well as certification of response personnel, and equipment acquisition and certification. Activities would also include the creation of mutual aid agreements and Emergency Management Assistance Compacts. Any public information activities such as publication management would also be preparedness activities.

Resource Management. All resources, such as equipment and personnel, must be identified and typed. Systems for describing, inventorying, requesting, and tracking resources must also be established.

Communications and Information Management. Adherence to NIMS specified standards by all agencies ensures interoperability and compatibility in communications and information management.

Supporting Technologies. This would include any technologies that enhance the capabilities essential to implementing the NIMS. For instance, voice and data communication systems, resource tracking systems, or data display systems.

Ongoing Management and Maintenance. The NIMS Integration Center provides strategic direction and oversight in support of routine review and continual refinement of both the system and its components over the long term.

APPENDIX A: HURRICANES

When a hurricane threatens Galveston County, several increased readiness activities need to occur. The Galveston County Health District will complete the following increased readiness actions prior to anticipated landfall:

Condition 4: Normal Conditions

Prior to hurricane season, certain actions should be taken for staff to be adequately prepared to address the threats from hurricanes and tropical storms.

- Review the Health District Emergency Plan and Annexes for responsibilities and update as needed.
- Complete training of personnel.
- Update Personnel directory.
- Review Stock of emergency supplies.
- Test emergency generators and other equipment.
- Encourage employees to develop personal evacuation plans and complete a hurricane relocation form to give to their supervisor. (See form below)

Condition 3: Increased Readiness

A tropical weather system has developed in the Gulf and has the potential to impact the local area

- Back-up computer systems
- Coordinate Tier Personnel.
- Update Employee Hurricane Relocation lists.

Condition 2:

Condition 2 will be declared as conditions worsen or become more severe. If 39 mph winds can impact Galveston County in 72-hours or less a condition 2 level will be declared by the Emergency Management Coordinator. During condition 2 the following actions should be taken:

- Secure and protect office.
- Fuel district vehicles and arrange to transport them out of the surge area.
- Purchase fuel for generators. Properly secure fuel containers to prevent spillage during storm.
- Close offices.

- District administration will determine which Tier 3 employees will fulfill needed public health roles during condition 1. These employees will be allowed to leave before the storms strikes to secure their personal property. They will then be required to return to

work to fulfill their role.

- Those employees not assigned specific duties during condition 1 should evacuate depending on the location of their residences and recommendations from Emergency Management. Tier 3 personnel not needed to report to the Office of Emergency Management should also evacuate but be ready to return as soon as it is safe to do so to assist in recovery operations.

CONDITION 1:

Condition 1 will be declared when 39 mph winds are predicted in 24 hours or less. Condition 1 denotes a greater sense of danger and urgency than condition 2. During the condition 1 stage the following actions will be taken by the personnel at the district:

The PHEP Manager, or designee, will request any necessary assets to accommodate response and recovery efforts via STAR request (medical supplies, vaccines, diabetic medications and supplies). Other organizations that provide resources such as Direct Relief or The American Red Cross will be contacted as well. These requests will be made before landfall, at the earliest convenient time.

Note: *At this point the Emergency Operations Center should be activated and operations will continue through the PHEP Manager and the Office of Emergency Management under the requirements and guidelines of the Galveston County Emergency Management Plan. Appropriate Tier 3 personnel (Liaison) will report to the County Office of Emergency Management or other secure locations. The Liaison at the EOC will physically communicate with GCOEM, TxDOT, and all appropriate partners to keep GCHD EOC apprised of current situation and any changes.*

AFTER THE STORM

Employees should listen to KTRH Radio AM740 for updates about the status of district operations. They can also call the Inclement Weather Number at 409-938-2489 for the status of district operations. The PHEP Manager or designee will utilize the i-Info system to communicate with GCHD staff via text messages, call outs, and standard emails.

Galveston County Health District
Employee Hurricane Location Plan Form

We urge you to make a plan now for a hurricane evacuation: Know where you're going and have an emergency kit with food, water, medications, first aid supplies, etc. ready to take with you.

Date: ____________________ **Department**: ______________________________

Name: ____

Phone (home): ____

Phone (Cell): _______________________________________

Emergency Contact

Name: ____

Phone(s): ____

Relationship to contact person: _________________________________

Where will you go during a hurricane evacuation?

____
____

Address:

____

____

Phone(s): ____

Please provide a name and telephone number of a person with whom we can leave a message for you. This person should be outside of the Houston/Galveston area and able to contact you daily.
Name: ____

Phone(s): ____

Relationship to contact person: ____

This form should be given to your manager and/or supervisor. Managers and/or supervisors will keep the original and forward a copy to Tyler Tipton, PHEP Manager
Revised 01/03/2019

APPENDIX B:BOMB THREAT

The district can receive a bomb threat at any time. Generally, bomb threats are made for two reasons. One reason is the caller may have definite knowledge, or a strong belief, that an explosive device has been placed somewhere in the facility. This caller may be the person who placed the device or someone else who has become aware of such information. The second reason is the caller may want to create an atmosphere of panic and anxiety, which will result in the disruption of normal activities, even if no device has been placed.

All threats made to GCHD will be taken seriously and noted as being credible until proved otherwise by the police/sheriff's office. The bomb threat checklist on page 18 will be utilized and completed for each incident relating to bomb threats.

Personnel of the district will be responsible for:

- Being aware of where to find the Bomb Threat Checklist.
- Maintaining a copy of the Bomb Threat Checklist in their work area.
- Contacting their respective manager up on receiving a bomb threat via telephone or mail.
- Completing the Bomb Threat Checklist each time a threat is received.
- Remaining calm when receiving a threat.
- Documenting the date, time call received, time call ended, person receiving call, and program receiving the call.
- Assisting law enforcement when requested in identifying any items in work areas that are unusual or appear to be out of place.

CREDIBILITY

Until the credibility of the threat is established, personnel in the district will take the following precautions:

- Avoid using 2-way radios in or within 300 feet of the facility.
- Do not attempt to locate the device.
- Leave all areas in the facility undisturbed.
- Do not turn on or off any light switches or other electrical devices.
- Do not move anything.
- Immediately evacuate the facility when directed.

- Upon evacuating, report to the respective program manager for personnel accountability.
- Account for all personnel in your program.

Program Managers

Program Managers will be responsible for:

- Notifying the Risk and Safety Coordinator and the CEO and/or their designee, that a threat has been made to the district.
- Ensuring the Bomb Threat Checklist is completed by the individual receiving the threat.
- Delivering the checklist to assist the local law enforcement agencies.
- Directing their employees to evacuate when orders are given.
- Accounting for program personnel.
- Conducting a quick search of the area to ensure personnel are out of the facility.
- Reporting any personnel unaccounted for.
- Updating and Informing personnel of activities.
- Notifying personnel when to return to work.

BOMB THREAT CHECKLIST

Date of Call: ________________ Time of Call: _________ Time the caller Hung Up _____________

Phone/Ext. Number where call was received: ____
Location where the call was received: ____

QUESTIONS TO ASK:

1. **When is the bomb going to explode? _______________________________________**
2. **Where is it right now?**
   ____
3. **What does it look like? ____**
4. **What kind of bomb is it?**
   ____
5. **What will cause it to explode? ____**
6. **Who placed the bomb?**
   ____
7. **Why was the bomb placed? ____**
8. **Where are you calling from? ____**
9. **What is your name?**
   ____

EXACT WORDS OF THE CALLER:

____
____
____

(Use other side of the page for more space)

DESCRIPTION OF CALLER□S VOICE:

____Male _____Female _______Young _____Middle Age ______Old _________Race

TONE OF CALLER'S VOICE:

____Calm ____Lisp _____Deep ____Cracking Voice _____Slurred ____Angry ____Slow

_____Ragged ____Clearing Throat _____Disguised ____Excited ____Rapid _____Loud

____Deep breathing _____Accent ____Nasal ____Soft _____Laughter ____Normal _____Familiar

___Stutter ____Raspy _____Crying ____Distinct

THREAT LANGUAGE OF CALLER:

______Well Spoken (Educated) _________Incoherent ______Foul _________Taped

______Irrational ______Message read by Threat Maker

BACKGROUND SOUNDS:

___Street Noises ___House Noises ___Clear Other________ ___Crockery ___Motor _Static ___

___Voices __Office Machinery ___Local ________________PA System ___Factory Machinery

Long Distance ___Music ___Animal Noises ___Booth

PERSON WHO RECEIVED THE THREAT: --

APPENDIX B

BOMB THREAT ACTION CHECKLIST

ACTION TO BE TAKEN	Yes	No
Bomb Threat Checklist Completed		
Police Department Notified		
Sheriff's Department Notified		
Emergency Operations Center notified		
Personnel notified		
Law enforcement assisted in locating device		
Facility evacuated		
Personnel/Citizen Accountability log completed?		
Was the threat credible?		
Search of the facility completed		
Documentation completed (bomb threat checklist information)		
Documentation turned in to the Risk and Safety Coordinator		

APPENDIX C: HAZARDOUS MATERIAL INCIDENTS

Hazardous material incidents can occur with little or no warning. The district's facilities are in close proximity to transit routes and various exposure risks. These areas are heavily traveled by trucks, trains, and pipelines transporting hazardous materials and incidents/releases can occur at any time, therefore, it is important for district personnel to follow the instructions of the PHEP Manager, or designee, as well as the local law enforcement agencies.

Hazardous material incidents are generally handled by evacuating or sheltering in place. These actions will be handled in the following manner:

SHELTERING IN PLACE

In some cases it may be necessary to shelter in place. The decision to shelter in place will be made by the GCHD CEO or designee after consulting with the GCOEM and representatives from the fire department or law enforcement. Sheltering in place is the safest method to use if it is determined that personnel can't be evacuated safely from an area prior to the arrival of a toxic cloud. The sheltering in place method used for the department consists of the following:

- Get inside the building. Close and secure the entrance.
- Listen to the radio (KTRH 740AM) to determine the status of the incident.
- Stay away from glass doors.
- Avoid drinking water from water fountains or faucets, as they may become contaminated.
- Allow individuals that want to leave the facility the opportunity to do so prior to department lock-down.

Note: Health District personnel can't force individuals to remain in the facility. Inform the individual of the dangers and let them make their own decision. However, inform the individual that once the facility is locked down, it will remain in a secure mode until the threat is removed.

- Follow instructions from the CEO or designee.

EVACUATION

In some cases it may become necessary to evacuate the facility. In such cases personnel will evacuate in the following manner:

- Turn off any electrical equipment (Coffee pots, Computers, etc.)
- Secure work area
- Proceed to the nearest exit
- Follow instructions from the CEO, PHEP Manager, or designee
- Ensure your name is on the list of personnel present during the incident by reporting to the area Safety Captain or the Risk and Safety Coordinator upon evacuating the facility.

Program Managers

The Program Managers are responsible for:

- Informing the individuals in the facility when the threat of the incident is diminished.

APPENDIX C
HAZARDOUS MATERIALS INCIDENTS
ACTION CHECKLIST

ACTIONS TO BE TAKEN/SHELTERING IN PLACE	Yes	No
Blankets/Towels placed under doors		
Openings and Doors Taped Up		
Individuals Given the Opportunity to leave facility		
Documentation complete listing of personnel in the program		
Informing individuals the event is over		
Documentation of sequence of events		
ACTIONS TO BE TAKEN/ EVACUATION		
PHEP Manager documentation of personnel complete		
Personnel in facility evacuated		
Persons with disabilities evacuated/if applicable		
All personnel accounted for		
Personnel notified when the event is over		
Documentation of Event completed/turned in to PHEP Manager		

APPENDIX D: HEALTH DISTRICT CLOSURE

In some circumstances it may become necessary to close one or more GCHD facilities. Several conditions can arise in which the closure of one or more facilities is necessary to maintaining the safety and health of district personnel and citizens. Refer to Annex J – COOP for detailed information. The following situations are few examples of conditions in which district facilities might close:

- Severe weather that threatens the safety of personnel
- Winter storms that can block the ability of safe travel of personnel arriving to and from work
- Hazardous Material Incident
- Flooding in the building
- Onset of gale force winds associated with a hurricane
- Power failure
- Tornado activity
- Bomb threat
- Loss of water service that results in unsanitary conditions
- Any other situation that affects the safety and health of personnel, or that puts the individual at risk.
- Any situation that the Chief Executive Officer, and/or his or her designee, or PHEP Manager deems appropriate to close the facility.

Program Managers

Program Managers are responsible for:

- Informing the personnel in their programs on issues relating to facility openings and closures
- Ensuring their programs take the necessary steps to shut-down operations safely
- Informing the PHEP Manager of any events or problems that warrant the closure

of facilities.

- Ensuring that vital records are properly stored in a safe area

- Documenting actions taken during the shutdown of the facility.
- Assisting with evacuation when necessary
- Assisting and coordinating with the PHEP Manager on district closure requirements.

APPENDIX D

HEALTH DISTRICT CLOSURE CHECKLIST

ACTION TO BE TAKEN	Yes	No
Decision made to close the facility		
Individual assigned to assist with shutdown		
Program manager Notified		
Emergency Operations Center notified		
Equipment turned off		
Vital Records Secured		
Actions And Sequence Of Events Documented on log		
Documentation Turned In To The PHEP Manager		
PHEP Manager Notified When The Event Is Over		
Personnel Notified When The Event Is Over		
Evacuation (If Applicable)		

APPENDIX E: TORNADOS

Tornados are extremely violent localized windstorms. A tornado is characterized by a funnel cloud, which reaches to the ground with wind velocities inside the funnel as high as 200 miles per hour. Tornados most frequently are associated with other violent weather conditions, primarily large thunderstorm systems, and often accompany hurricanes.

Personnel in the district must realize common terms associated with tornados such as:

Tornado Watch: Conditions exist that are right for tornado formation.

Tornado Warning: A tornado has been sighted or there is an immediate threat of a tornado in a particular area.

During incidents involving the threat of a tornado to GCHD, personnel will be responsible for the following:

During a Tornado

- If you are under a tornado warning, seek shelter immediately. Although there is no completely safe place during a tornado, some locations are much safer than others. Here is how you can remain safe in the following locations.

Indoors

- Move personnel and patients/customers to a safe part of the building preferably an interior room or central hallway in the facility.
- Avoid areas with windows or large amounts of glass

In a Vehicle

- DO NOT STAY IN A VEHICLE, TRAILER, OR MOBILE HOME DURING A TORNADO. These items can turn over during strong winds. Even trailers and mobile homes with a tie-down system cannot withstand the force of tornado winds.
- PLAN AHEAD. If you live in a mobile home, go to the lowest floor of a nearby building, preferably one with a basement. If there is no shelter nearby, lie flat in the nearest ditch, ravine, or culvert and protect your head with an object or with your arms.

- DO NOT TRY TO OUTRUN A TORNADO IN YOUR CAR. If you see a tornado, stop your vehicle and get out. Do not get under your vehicle. Follow the directions for seeking shelter outdoors (see Outdoors section).

Outdoors

If you are caught outside during a tornado and there is no adequate shelter immediately available:

- Avoid areas with many trees.
- Avoid vehicles.
- Lie down flat in the nearest ditch, ravine, or culvert.
- Protect your head with an object or with your arms

After the tornado

- Check people around you for injuries. Begin first aid or seek help if necessary. Always cooperate with local officials.
- Check utility lines and appliances for damage. If you smell gas, open the windows and turn off the main valve. Don't turn on lights or appliances until the gas has dissipated. If electric wires are shorting out, turn off the power.
- When you go outside, watch for downed power lines.
- Assess facility damage and notify the PHEP Manager.

Appendix E: Tornados
TORNADO CHECKLIST

Actions To Be Taken	Yes	No
Personnel In Safe Area		
Emergency Operations Center Notified		
Documentation Completed		
Tornado Threat Diminished/ PHEP Manager Notified		
Personnel notified		
Quick Damage Assessment completed		
Facility Re-Opened		

APPENDIX F: SEVERE WEATHER

Different severe weather events such as floods, high winds, thunderstorms, and lightning can occur on occasion in Galveston County. Although in general the response may be similar, in some cases they will vary

FLOODING

In the event that the Galveston County Health District should become vulnerable to flooding by means of heavy rainfall, water leaks, etc., measures must be taken to lessen the effects to the district and personnel.

PROGRAM MANAGERS AND SUPERVISORS

During an event involving flooding, program managers and supervisors will be responsible for:

- Notifying personnel of the situation
- Securing any records that can be damaged by rising water
- Documenting names of personnel in the facility.

THUNDERSTORMS AND LIGHTNING

During severe thunderstorm and lightning situations several precautions need to be taken to lessen or eliminate damages to the district and danger to personnel. These precautions will be handled in the following manner**: PROGRAM MANAGERS AND SUPERVISORS**

Program managers and supervisors will be responsible for:

- Instructing personnel not to use telephones, except for emergencies during a thunderstorm (as long as thunder can be heard)
- Keeping personnel informed of the situation
- Disconnecting any equipment that can be damaged from a power surge (i.e., computers, TVs, VCRs, coffee pots, etc.)

HIGH WINDS

In the event of high winds the following actions will be taken:

PROGRAM MANAGERS AND SUPERVISORS

Program managers and supervisors will be responsible for:

- Informing personnel in their program of the situation
- Documenting program personnel activities during the event
- Ensuring personnel stay away from glass doors and windows

APPENDIX F
SEVERE WEATHER
CHECKLIST

ACTIONS TO BE TAKEN	Yes	No
Personnel Notified of situation		
Personnel located in a safe area		
Emergency Operations Center notified		
Evacuation completed (if applicable)		
All personnel accounted for		
Personnel with disabilities assisted as necessary		
Records secured as appropriate		
Sensitive equipment disconnected (computers, electrical, etc.)		
Documentation logs completed		
Quick damage assessment completed (damage reported to Emergency Operations Center).		

APPENDIX G: WINTER STORMS

Winter storms in the form of freezing rain or sleet, ice, and heavy snow, although not frequent in Galveston County can on occasion occur and pose a hazard. Winter storms can include any of the following:

FREEZING RAIN

Rain that freezes as it strikes the ground and other surfaces forming a coating of ice.

SLEET

Small particles of ice usually mixed with rain. (Can make travel hazardous)

SNOW FLURRIES

Periods of snow falling for short durations at intermittent periods.

WINTER STORM WATCH

Severe winter weather conditions that may affect the area.

BELOW FREEZING TEMPERATURES

Temperatures may reach or go below freezing for an extended period bringing about the potential for damage to water systems and sensitive equipment.

WINTER STORM WARNING

Severe winter weather conditions are imminent.

TRAVELERS ADVISORIES

Issued to indicate that falling, blowing, or drifting snow, freezing rain or drizzle, sleet, or strong winds may make driving difficult.

ACTIONS TO BE TAKEN BY THE DISTRICT

In the event the district is threatened by severe conditions, such as those listed above, the following actions will be taken to protect the personnel and equipment in the district.

PHEP Manager
The PHEP Manager will be responsible for:

- Contacting the Emergency Operations Center to determine if the Health District offices should be closed
- Advising personnel to evacuate before hazardous driving conditions develop

After special precautions for the freezing temperatures have been completed proceed to Appendix D for additional guidelines on district closures.

APPENDIX G
WINTER STORMS
CHECKLIST

ACTION TO BE TAKEN	YES	NO
Emergency Operations Center contacted to determine if the district should be closed		
Personnel evacuated before hazardous driving conditions develop.		

ANNEX H: FIRE/EXPLOSIONS

In the event of a fire or explosion in any GCHD facility the following actions will be taken:

- Evacuate the building by using the closest of the exits.
- All personnel will meet in parking lot.
- Notify Fire department by calling (9-1-1) or by activating the fire alarm.
- Ensure that all personnel are evacuated from the building
- Ensure that any personnel with disabilities are assisted with evacuation

APPENDIX H
FIRE/EXPLOSIONS
CHECKLIST

ACTION TO BE TAKEN	Yes	No
Building evacuated		
Fire Department Contacted		
Personnel with disabilities assisted		
Personnel accounted for		
Emergency Operations Center notified		
Documentation completed		
Damage assessment completed and Emergency Operations Center contacted		

APPENDIX I: HOSTAGE SITUATIONS

A hostage situation can take place anytime, anywhere, and without warning. The GCHD will take all steps possible to ensure the safety of personnel in the vicinity, especially hostages. Actions to be taken by personnel consist of the following:

- Do not initiate discussions with the perpetrator if you are in the immediate area
- Contact the local Police or Sheriff's Department, if possible
- Evacuate the immediate area, if possible
- Do not attempt to rescue the hostage
- Remain calm
- Do not discuss the situation with anyone other than law enforcement personnel. Only the Chief Executive Officer or his/her designee will address media inquiries.

APPENDIX I
HOSTAGE SITUATIONS
CHECKLIST

ACTION TO BE TAKEN	YES	NO
Police Notified		
Personnel evacuated (if possible)		
Emergency Operations Center notified		
Chief Executive Officer or designee addresses media		

APPENDIX J: ASSISTANCE FOR PEOPLE WITH DISABILITIES

During any incident that affects the health and safety of the personnel in the district, it may become necessary to evacuate or relocate to another location. This re-location may be difficult or impossible for personnel in the district that have a disability. During an emergency the following actions should be taken to assist people with disabilities:

PROGRAM MANAGERS AND SUPERVISORS

The program managers and supervisors will be responsible for:

- Evaluating the personnel in their program to determine if any personnel will need assistance during an emergency

- Ensuring personnel are assigned to assist any personnel with a disability in the program with evacuation and relocation needs

- Informing personnel in their program of emergency situations

APPENDIX K: EXAMPLE OF READINESS CONDITION CHART

Status	Hurricanes/Tropical Storms	Floods/Extreme Tides	Tornadoes/Sever Thunderstorms/Winter Storms	Fire/Hazardous Materials	Terrorist/Threat Attack
CONDITION 4	Beginning of Hurricane Season More than 72-hours before (39 MPH Winds) impact the Texas Coast Weather System outside of the Gulf with the potential to Enter (Review Hurricane Plan and education staff)	RAINFALL IN THE AREA, BUT NO FLASH FLOOD WATCH YET THREAT OF ABNORMAL HIGH TIDES (REMOTELY MONITER RAINFALL & TIDAL INFORMATION)	CONDITIONS EXIST FOR SEVERE ACTIVITY. NWS ISSUES A SEVERE WEATHER ADVISORY	LEVEL 2 OR ABOVE CHEMICAL SPILL / OR MAJOR FIRE WITH NO ASSISTANCE REQUIRED FROM OEM (MONITER SITUATION)	NOTIFIED OF TERRORIST THREAT/ OR UNVERIFIED REPORT OF A TERRORIST DEVICE
CONDITION 3	72 - 60 HRS BEFORE (39 MPH WINDS) IMPACT TEXAS COAST NATIONAL WEATHER SERVICE FORCAST TROPICAL STORM OR HURRICANE IN THE GULF (TOTAL PROBABILITY…COLUMN E…>10% FOR GALVESTON OR FREEPORT) LIMITED ACTIVATION OF COUNTYEOC	FLOOD OR FLASH FLOOD WATCH IN EFFECT GENERAL STREET FLOODING & POTENTIAL FOR BAY OR AREA BAYOUS & LAKES TO REACH THE TOP OF THEIR BANKS TIDE GAUGES READING 3.5' FOOT LIMITED ACTIVATION OF COUNTY	NWS ISSUES A TORNADO WATCH OR A SEVERE WEATHER WATCH LIMITED ACTIVATION OF COUNTYEOC	ASSISTANCE REQUESTED FROM INCIDENT COMANDER AT SCENE SIZE OF INCIDENT WILL HAVE SIGNIFICANT ECONOMIC OR DIRECT IMPACT ON LARGE POPULATION LIMITED ACTIVATION OF COUNTYEOC	HIGH PROBABILITY OF ATTACT OR CONFIRMATION THAT A TERRORIST DEVICE HAS BEEN LOCATED LIMITED ACTIVATION OF COUNTYEOC
STATUS	HURRICANES/ TROPICAL STORMS	FLOODS/ EXTREME TIDES	TORNADOES/SEVERE THUNDERSTORMS/ WINTER STORMS	FIRE/HAZARDOUS MATERIALS	TERRORIST THREAT/ ATTACK

CONDITION 2	TROPICAL STORM OR HURRICANE WATCH ISSUED FOR UPPER TEXAS COAST 59 - 36 HRS PRIOR TO (39MPH WINDS) ON THE TEXAS COAST PROBABILITY COLUMNS ABC TOTAL….>15% FOR GALVESTON OR FREEPORT (HEALTH DISTRICT CEASES TO FUNCTION IN A NORMAL FASHION, EMPLOYEES FOCUS ON HURRICANE OR STORM PREPERATIONS) (36-48 HOURS COUNTY WIDE EVACUATION COMMITTEE MEETING HELD)	FLOOD, FLASH FLOOD, OR COASTAL FLOOD WARNING IN EFFECT. EXPECT HEAVY RAINFALL AND STREET FLOODING WITH SOME BAYS, BAYOUS OR LAKES OUT OF THEIR BANKS. RECOMMENDED ACTIVATION OF COUNTY EOC, TIDE GAUGES READING 4’	NWS ISSUES A TORNADO AND/OR A SEVERE WEATHER WARNING RECOMMENDED ACTIVATION OF COUNTY EOC,	LIMITED EVACUATIONS OR SHELTERING IN PLACE NECESSARY. PRESENCE REQUESTED TO ASSIST IC RECOMMENDED ACTIVATION OF COUNTY EOC, ,	EVACUATIONS OR SHELTERING IN PLACE NECESSARY. RECOMMENDED ACTIVATION OF COUNTY EOC,
CONDITION 1	35-12 HRS (39 MPH WINDS) NWS FORCAST TROPICAL STORM OR HURRICANE WARNING (EOC IS FULLY ACTIVATED) DANGER IS IMMINENT	COUNTY WIDE FLOODING (EOC IS FULLY ACTIVATED)	NWS INDICATES TORNATIC ACTIVITY IN THE AREA CONFIRMED TORNADO STRIKES (EOC ACTIVATED, ACTIVATE DAMAGE ASSESMENT TEAMS)	MAJOR EVACUATIONS OR SHELTERING IN PLACE NECESSARY. POSIBILITY OF LARGE POPULATION BEING EFFECTED (EOC FULLY ACTIVATED)	TERRORIST EFFECTS IMMINET OR EXPLOSION HAS OCCURED (FULL EOC ACTIVATED)

APPENDIX L: EVACUATION INFORMATION

Person Authorized to Order Evacuation

Designated Official____

PHEP Manager____

CEO or Designee____

Fire Department or Emergency Medical Services official in charge___________

Evacuation Signals:

Fire: Describe method of notification for complete or partial evacuation

____

____

Explosion or Gas Leak: Describe method of notification for complete or partial evacuation.

____

____

Suspicious Object: Describe method of notification for complete or partial evacuation.

____

____

Alternate Site: (describe or give address)

____

____

Telephone Numbers

Building Reentry

Method of recalling employees____

____

Building entry control method: ____

APPENDIX M: EMERGENCY EVENT LOG

Date	Time	Event/Action	Comments	Initial

APPENDIX N: PERSONNEL / CITIZEN ACCOUNTABILITY LOG

NAME	SSN#	ADDRESS	PHONE	EMPLOYEE Y/N

APPENDIX O: INFORMATION TECHNOLOGY INFRASTRUCTURE EMERGENCY OPERATIONS PROCEDURES

Purpose

This document provides information about the tasks and schedules that must be followed ~~in the event that~~if operations for the GCHD and/or Coastal Health and Wellness are shut down due to a noted condition (hurricane, bioterrorism incident or the like).

Explanation of Terms

GCHD	Galveston County Health District
IT	Information Technology Department
WAN	Wide Area Network
LAN	Local Area Network
DNS	Domain Naming Services
DHCP	Dynamic Host Configuration Protocol
WINS	Windows Internet Naming Service
CUCM	Cisco Unified Communications Manger
SMTP	Simple Mail Transfer Protocol
OWA	Outlook Web Access
DMZ	Demilitarized Zone
IIS	Internet Information Server
VPN	Virtual private Network
FTP	File Transfer Protocol
NAS	Network Attached Storage

Description of Information Technology Infrastructure

The Information Technology Infrastructure consists of all components that make up the following:

- Wide Area Network: Include all services, hardware and software for interoffice and internet connectivity. This includes technology associated with our Metro Ethernet fiber service, T1, firewalls, routers, modems (DSL/cable) used to connect the sites of GCHD together as well as to the internet Local Area Network: Includes all services, hardware and software for internal connectivity. This includes technology associated with routers, switches, hubs, wireless, DMZ and VPN used to connect desktops and users to network resources.

Two Data Center facilities which include the production data facility at the county EMF 3rd floor and the MCA MDF data center in the IT suite. Core Services: Includes all services, hardware and software for mission critical operations. Desktops & Local Peripherals

Mission critical Information technology Infrastructure includes:

- WAN/LAN (routers, firewalls, network switches, ~~etc~~etc.)

- Telephone – Cisco VOIP switches
- Telephone – Voice mail systems
- Active Directory Domain Controllers
- Network services: DNS, DHCP & WINS
- Symantec Anti-virus Server
- SMTP / Exchange Email / OWA
- Barracuda Spam Firewall
- File servers and SAN
- Virtual Server environment and their Host Servers
- email Firewall - IRONPORT

Core applications include:

- ESO Suite (GAAA)
- Vitals database (CityOn)
- Envision Connect (Decade) – Environmental and CHS
- TCEQ / Ceeds / Pollution Control database
- STD/HIV databases
- Internet connectivity for web based applications (IMMTRAC, TWICES)
- NextGen –EHR
- Chameleon

Strategic Core IT Operations

In the event of emergency conditions that do not affect the County EMF ability to maintain operations; the GCHD production core data services will remain online. IT will facilitate access to approved staff with remote internet capabilities where practical through the use of remote ssl internet connectivity.

Alternative Operations (In the case county EMF facility becomes unviable)

In the event the EMF is no longer online – preparations and network configurations must be changed to bring the MCA online as a production data center. Additional network routing protocol configuration must be completed and stored server replicas must be brought online from nightly backups.

APPENDIX P: STANDARD OPERATING PROCEDURES

Standard Operating Procedure –
Emergency Supplies

- Emergency supplies will be kept in designated areas within each facility.
- Check inventory of emergency supplies.
- Supplies should include masking tape, electronic storage media (diskettes, CDs, etcetc.…) storage boxes, and plastic.
- Ask office personnel for special needs or suggestions.
- Order supplies that are running low or lacking.
- Place labels on emergency supplies instructing "**Emergency Supplies – Use only in an Emergency.**"

Standard Operating Procedure

COORDINATION OF TIER 3 PERSONNEL

- Appropriate health district personnel will be assigned to the Emergency Operations Center to direct and coordinate GCHD operations.
- Tier 3 Personnel will be released to take care of personal business so they may return to the office.
- Tier 3 Personnel, upon their return, will receive instructions from their supervisor regarding their role in preparing for and responding to the emergency.
- Verify evacuation location of all personnel.

Standard Operating Procedure

SECURE AND PROTECT OFFICE

- Move all important record file cabinets and desk files to secure locations.
- Turn off and unplug all office equipment.
- Move office equipment, supplies, and furniture away from windows to the open area of the office and cover with plastic.
- Place loose items on desks and in work stations into storage boxes.
- Use masking tape to secure wrapping of plastic.
- Make sure all office equipment, storage boxes, and supplies are on high ground to avoid water damage.

Standard Operating Procedure

CLOSURE OF OFFICE

- The PHEP Manager will notify the Chief Executive Officer and/or the designated person of the situation.
- Tier 2 and 1 Personnel will be released from duty.
- Designated Tier 3 Liaison will be sent to the Galveston County Office of Emergency Management Emergency Operations Center if necessary.
- Place a ***CLOSED*** sign on office door.
- The **PHEP** Manager will notify the Emergency Operations Center that the department is closed, secured, and preparations are complete.
- Turn off all lights.
- Lock office door.

Standard Operating Procedure

OPERATIONS AT THE EMERGENCY OPERATIONS CENTER

- Verify necessary Tier 3 personnel are present at the Emergency Operations Center.
- Tier 3 Personnel will coordinate public health operations with Emergency Operations staff.
- Upon completion, Tier 3 Personnel may leave the Emergency Operations Center.
- Tier 3 Personnel must notify GCHD Emergency Management staff of their departure.

-Approved
UBOH 01/27/2021
-Effective
01/26/2017

Criminal and Motor Vehicle Record Background Check Policy

Audience

This policy applies to all Galveston County Health District, Galveston Area Ambulance Authority and Coastal Health & Wellness (collectively "the District") employees.

Policy

All offers of employment at the District are contingent upon satisfactory results of the subsequently denoted background checks. Background checks shall be conducted only after a pending job offer has been made to the applicant. No applicant shall be denied employment on the basis of simply having a criminal record. Factors that will determine eligibility of hire are provided below.

Background checks will include:

- **Social Security Verification:** validates the applicant's Social Security number, date of birth and last seven years of former addresses.
- **Criminal History:** includes a review of the applicant's criminal convictions. The following factors will be considered when determining if applicants with a criminal history shall be rendered an offer of employment:
    - The nature of the crime and its relationship to the position;
    - The time of the conviction;
    - The number (if more than one) of convictions; and
    - Whether hiring, transferring or promoting the applicant would pose an unreasonable risk to the business, or to its employees, customers and/or vendors.

The following additional background searches will be required, if applicable to the position:

- **Motor Vehicle Records:** provides a report of an individual's driving history in the state(s) requested. This search will be conducted on any employee operating a company owned vehicle. Employees subject to such checks as a condition of employment will undergo these checks annually.

Procedure

Applicants must complete a background check authorization form AFTER a pending offer of employment is extended to the applicant and shall return the completed authorization form to Human Resources. Human Resources will order the background check upon receipt of the signed authorization form. Human Resources and/or contracted employment screening services will conduct the checks. All results will be reviewed by Human Resources.

In instances where negative or incomplete information is obtained, Human Resources shall assess the potential risks and liabilities related to the job's requirements and determine whether the applicant is fit to be hired. If a decision not to hire a candidate is made based on the results of a background check, the candidate shall receive a Fair Credit Reporting Act (FCRA) Adverse Action letter from Human Resources that shall also notify the candidate of the contracted screening service issuing these results. Background check information will be maintained in a file separate from

employees' personnel files. The District shall reserve the right to modify this policy at any time without notice.

Supervisor Responsibilities

Supervisors are responsible for communicating program specific expectations to assigned employees and providing feedback to Human Resources if a supervisor becomes aware that the employee has received a traffic violation and/or been convicted of a crime.

Violation

Violation of this policy and/or a poor background check may result in corrective action up to and including termination of employment, or the revocation of the offer of employment.

-Approved
UBOH: 1/27/2021
Effective: 7/30/18

Purchasing Policy

AUDIENCE

This policy applies to all Galveston County Health District, Galveston Area Ambulance Authority, and Coastal Health & Wellness (collectively "the District") employees.

PURPOSE

The purpose of the District Purchasing Policy is to comply with the laws and procedures governing District purchasing in order to provide reasonably priced, high-quality goods and services to end users, while preserving organizational and financial accountability. This policy is applicable to all procurements regardless of funding source.

STATEMENT OF GENERAL POLICY

It is the policy of the District that all purchasing shall be conducted strictly on the basis of economic and business merit. To avoid violation of or the appearance of violation of the policies, District officials and employees are prohibited from:

- Seeking or accepting, directly or indirectly, any loans, services, payments, entertainment, trips or gifts of merchandise or money in any amount from a business or an individual doing or seeking to do business with the District.

- Participating in the selection, award and administration of a contract if he or she has a real or apparent conflict of interest. A conflict of interest would arise when the employee, any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other tangible personal benefit from a firm considered for a contract.

It is important to remember that the District Purchasing Department operates in full view of the public. The District intends to maintain a cost effective purchasing system conforming to good management practices.

PURCHASING AUTHORITY

Authority to make District purchases resides in the appropriate Board(s) or in Administration as delegated by the Board(s). The Purchasing Department is responsible for making purchases

of supplies, materials, equipment and for negotiating and making contracts for services and repairs to District owned and/or leased property. Purchases made using competitive bids shall be reviewed by the GCHD Chief Executive Officer or designee in accordance with the purchase contract.

GENERAL PURCHASING GUIDELINES

A. A central supply for the use of all departments will be maintained to warehouse generally used office and operating supplies. Departments may obtain items directly from Central Supply by requisition, without the necessity of a purchase order. If an item is not stocked in Central Supply, the Purchasing Department staff will use the appropriate purchasing method to obtain the item.

B. Items not normally stocked in Central Supply and not requiring competitive bids will usually be purchased through the Purchasing Department.

C. Competitive bidding is mandatory on any purchase or combination of purchases of like items and/or component purchases, separate purchases and sequential purchases which will equal or exceed $50,000. This applies to all contractual agreements and/or services and purchases or annual accumulative purchase of $50,000 or more. Any purchases made with vendors listed through the Texas Procurement and Support Services (TPASS) will satisfy the bid requirements, as will purchases which are purchased through legally constituted shared services agreements that have completed the competitive bid process including, but not limited to, HGAC, TACHC or TALHO.

D. Competition

All procurement transactions must be conducted in a manner providing full and open competition. Some of the situations considered to be restrictive of competition include but are not limited to:

- Placing unreasonable requirements on firms in order for them to qualify to do business
- Requiring unnecessary experience and excessive bonding
- Noncompetitive pricing practices between firms or between affiliated companies
- Noncompetitive contracts to consultants that are on retainer contracts
- Organization conflicts of interest

- Specifying only a "brand name" product instead of allowing "an equal" product to be offered
- Any arbitrary action in the procurement process

The District prohibits the use of statutorily or administratively imposed state, local or tribal geographical preferences in the evaluation of bids or proposals, except in cases where applicable Federal statutes expressly mandate geographical preference.

Vendors will be selected with regard to dependability and service record, nature of guarantee and warranty of product (when applicable), price and quality. The District will utilize small businesses, minority-owned firms, women's business enterprises and labor surplus area firms when possible, provided this involves no sacrifice in quality, service or price.

E. Pursuant to Texas House Bill 89 https://capitol.texas.gov/tlodocs/85R/billtext/html/HB00089I.htm and Senate Bill 252 https://capitol.texas.gov/tlodocs/85R/billtext/html/SB00252I.htm, the District must certify and verify that any business, parent company, company, affiliate, subsidiary, or "Vendor Companies" with which we have a contractual relationship:

1. Does not boycott Israel currently;
2. Will not boycott Israel during the contract term;
3. Is not identified on the Texas Comptroller's list of companies known to have contracts with, engaged in business with, or provide supplies/services to, Iran, Sudan, or a foreign organization designated as a Foreign Terrorist Organization by the U.S. Secretary of State. (See Texas Government Code § 2270.808 and 2252.151-2252.154.

Contracting for-profit entities, providing goods and services, must submit a HB 89 Certification Form (see Appendix A) which provides written verification that the company/vendor does not and during the term of the contract will not boycott Israel.

The Purchase Order Terms and Conditions (see Appendix B) include a certification clause that the vendor certifies that it is not a company identified on the Texas Comptroller's list of companies known to have contracts with, or provide supplies or services to, foreign organizations designated as a Foreign Terrorist Organization by the U.S. Secretary of State. The Vendor further certifies and verifies that neither Vendor, nor any affiliate, subsidiary, or parent company of Vendor, (if any the "Vendor Companies") boycotts Israel, and Vendor agrees that Vendor and Vendor Companies will not boycott Israel during the term of this Purchase Order.

F. Under Section 2252.908 of House Bill 1295, any business entity that enters into a contract with the District that requires Board approval must submit a "Disclosure of Interested Parties" form (see Appendix C) to the Purchasing Department. This form is mandated by the Texas Ethics Commission. https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm

G. All goods, supplies, equipment and services will be purchased with prior appropriate approval.

H. The Purchasing Department will maintain records sufficient to detail the history of procurement. These records will include rationale for the method of procurement, justification for the contractor selection/rejection, selection of contract type including justification when bids are not obtained, and the basis for the contract price.

I. Special procedures are available for and applicable to the purchase of particular goods and services, summarized under *Special Purchases*.

PURCHASE REQUISITIONS

Purchase requisitions prepared by the requesting department are required for all purchases. All purchase requisitions must be approved prior to issuing a purchase order. A Purchase Order is required prior to placing an order for supplies, goods, equipment and services unless pre-approved by the GCHD Chief Executive Officer or designee. Details for processing purchase requisitions are outlined in the *Purchasing Procedures Manual.*

PROCUREMENT METHODS

Materials and supplies not available from Central Supply are acquired through the Purchasing Department. Additionally, contracts for maintenance and repairs to facilities and equipment used by the District are handled by the Purchasing Department. Procedures for acquisitions through the Purchasing Department are outlined in the *Purchasing Procedures Manual*.

The District will use one of the following methods of procurement depending on the specifications of the purchase. The procurement methods are based on federal regulations, but with lower dollar thresholds to better accommodate the District's needs.

A. <u>MICRO-PURCHASES (Purchases less than $3,000):</u>

1. Procurement by micro-purchase is the acquisition of supplies or services in which the aggregate dollar amounts does not exceed $3,000.00. To the extent practicable, the District will distribute micro-purchases equitably among qualified suppliers.

2. Open market purchases of less than $1500.00 do not require quotes. Such purchases require staff to use their best judgement and the most appropriate and cost-effective method of acquisition on each requisition.

3. Open market purchases of $1500.00 – $2,999.99 may be made after obtaining three verbal quotes, with the exceptions referenced below in *Vehicle, Equipment and Facility Maintenance and Repair.*

4. Vehicle, Equipment and Facility Maintenance and Repair: Open market purchases for vehicle, equipment, and facility maintenance or repair do not require three verbal quotes if the service performed is less than $3,000. Because of the administrative cost of requesting quotes would likely be more than the amount saved on quote comparison, considering personnel time, types of services needed, immediacy of the circumstances, etc., obtaining three verbal quotes is not required. Purchases must still be consistent with purchasing ethics and even though quotes are not required, purchases must still be in GCHD's best interest.

B. <u>SMALL PURCHASES (Purchases in excess of $3,000 but less than $50,000):</u>

1. Small purchases are those relatively simple and informal procurement methods for securing services, supplies or other property that do not cost more than the Simplified Acquisition Threshold. For the District's purposes, this threshold has been lowered to $50,000.

2. When using this method, open market purchases of $3,000.00 - $4,999.99 may be made after obtaining three properly documented verbal quotes.

3. Open market purchases of $5,000.00 and less than $50,000.00 may be made after obtaining three written quotes.

4. Waiver of Requirements: GCHD Chief Executive Officer or designee, at his/her discretion, may, depending on the circumstances surrounding a request, authorize a waiver of purchase requirements outlined in this policy for purchases less than $10,000. It is anticipated that such authorization is granted on limited occasions due to the special circumstances such as an emergency or unforeseeable circumstance.

C. SEALED BIDS AND COMPETITIVE PROPOSALS (Purchases of $50,000 or more)

1. If the capital expenditure is budgeted and the item is $50,000 or more, it must be competitively bid or purchased through state approved vendors, such as TPASS, HGAC, or Buy Board. Such purchases will be made after obtaining sealed competitive bids or sealed Requests for Proposals.

2. A sealed bid is a procurement method in which competing contractors, suppliers, or vendors are invited by openly advertising the scope, specifications, and terms and conditions of the proposed contract as well as the criteria by which the bids will be evaluated. Competitive bidding aims at obtaining goods and services at the lowest prices by stimulating competition, and by preventing favoritism.

3. A Request for Proposal (RFP) is a procurement method in which a solicitation is made often through a bidding process, by an agency or company interested in procurement of a commodity, service or valuable asset, to potential suppliers to submit business proposals. Proposals seeks the most advantageous good or services considering the price and other factors. A proposal is handled the same way as a sealed bid with the exception of the negotiation with vendor after the opening and the bid sheet states name only, no dollar amount.

4. General Information – The Procurement Agent or designee will ensure publication of the legally required notice at least twice in one or more newspapers of general circulation in the county which the work is to be performed. No specifications or unreasonable requirements will be written with the intent to exclude a potential bidder. Competitive bidding can be either lump sum or on a unit price basis. If unit price bids are solicited, the needed quantities of each item are to be estimated in the bid specifications. These estimates are to be based on the best available information. The

successful bidder's compensation, however, will be based on the actual quantities supplied, furnished or contracted.

5. Bid or Proposal Opening – Bids/proposals will be received by the Procurement Agent or designee until the date and time specified in the bid/proposal advertisement. Bids/proposals may be submitted in hard-copy format or through electronic transmission ensuring the identification, security, and confidentiality of each response and the electronic bids/proposals remain effectively unopened until the assigned time. On the specified time, date and place, the Procurement Agent or designee will open all sealed bids/proposals. The bids/proposals will be opened in an open public forum. Anyone may attend. Bids will be read aloud and recorded on a bid receipt.

6. Emergency or Unanticipated Events – In case of an emergency or unanticipated event causing GCHD to close for business on the date of a Bid/Proposal submission deadline, the bid closing will automatically be extended to the same time of day specified in the provisions on the first business day in which normal GCHD processes resume. If conditions or any other unforeseen event causes delays in carrier service operations, GCHD may issue an addendum to all known Bidders interested in the project to extend the deadline. It will be the responsibility of the Bidder to notify GCHD of its interest in the Bid if these conditions are impacting their ability to turn in a submission within the stated deadline. GCHD reserves the right to make the final judgment call to extend any deadline.

7. Cost or Price Analysis – A cost or price analysis will be performed for procurements of $50,000 or more, including contract modifications. The method and degree of the analysis will depend on the facts surrounding the procurement. In addition, GCHD will make independent estimates before receiving bids or proposals.

8. Evaluations – Evaluations will be based on a written method and applied to all bids and proposals received and for selecting recipients.

9. Recommendations – After examining all of the bids or proposals, the Procurement Agent or designee will make recommendation to award to a vendor. The final recommendation to award will then be forwarded to the

GCHD Chief Executive Officer or Chief Financial Officer for final approval.

10. Appeal – Any actual or prospective bidder who is allegedly aggrieved in connection with the solicitation or award of the contract may appeal. The appeal will be submitted in writing to the Chief Compliance Officer within ten (10) business days of the action or decision being appealed. The protester may appeal the decision of the Chief Compliance Officer to the GCHD Chief Executive Officer who will defer policy matters to the United Board of Health. Any such appeal shall be submitted in writing within ten (10) business days of the action or decision being appealed. The decision of the Board will be final. The Galveston County United Board of Health will not consider any protests unless this procedure is followed.

11. Exceptions To Bid – Any exception to the bid specifications must be submitted in writing and attached to the bid. The GCHD Chief Executive Officer or designee will have the final decision on accepting or rejecting any exceptions, alterations.

12. Award –In determining and evaluating the best bid/proposal, the District will award to those whose bid/proposal is most advantageous. Factors that will be considered may include, but not limited to, cost, quality, equality, efficiency, utility, general terms, delivery, suitability of the service offered, and the reputation of the service in general use will also be considered with any other relevant items. In addition, consideration will be given to such matters as contractor integrity, compliance with public policy, record of past performance, and financial and technical resources.

    a. When the District only receives one bid/proposal, the bid/proposal may be accepted if such purchase is: recommended by the requesting Department and the Procurement Agent or designee; after reviewing the specifications to determine if they were restrictive; and the bid/proposal packets were sent to all known prospective bidders.
    b. If two or more responsible bidders/proposers submit identical bids, the bid award may be made by drawing lots.

13. Bonds – A vendor who is awarded a contract may be required to post bond. If it is required, the requirements will be included in the advertisement.

Requirements of a bond will be in accordance with requirements of the funding source or state laws as applied to Local Governments, whichever is most stringent.

14. Acquisition of Item After Award – Following award of a contract, the requisition is processed in the manner described in the *Purchasing Procedures Manual.*

15. Change Orders – A change order may be required when it becomes necessary to make changes after commenced contract has been made. The GCHD Chief Executive Officer or designee is authorized to approve increases to the original contract price of $10,000 or less. Change orders requiring increases to the contract price of more than $10,000 , must be approved by the appropriate Board. However, the original contract price may not be increased by 25% unless the change order is necessary to comply with a federal or state statute, rule, regulation, or judicial decision after the contract was made. The contract price may not be decreased by 18% or more without the contractor's consent. All change orders must have the written consent of the District and the contractor.

SPECIAL PURCHASES

A. Unbudgeted Capital Expenditures – Purchases of $10,000, or more not authorized in a department's current budget, or purchases necessitating an increase in department's current budget must be authorized by the appropriate Board and/or funding source prior to the purchase. Unbudgeted purchases less than $10,000 may be authorized by the GCHD Chief Executive Officer as long as sufficient funds are available from operating surplus or fund balance reserves.

B. Noncompetitive Proposals – Items otherwise required to be competitively bid may be exempted from the competitive bid process by the appropriate Board if:

   1. A prompt purchase is required, due to a public calamity, to meet a necessity of the citizens or preserve public property.

   2. The purchase is necessary to preserve public health or safety of citizens.

3. An After Hours Emergency – In such instances the department must take the necessary action to obtain the needed goods or services. If, however, the department is aware that the purchase involves an expenditure of $5,000.00 or more, a reasonable effort should be made to contact the Chief Executive Officer or Chief Financial Officer and/or Procurement Agent for notification that an emergency exists. The next working day, the department should contact the Procurement Agent or designee for procedures to secure payment of the goods or services.

4. A Sole Source Item - An item available from only one source may be purchased without competitive bidding, with the approval of the GCHD Chief Executive Officer or designee. Typical items in this category include, but not limited to, patented or copyrighted material, secret processes, natural monopolies, utility services, captive replacement parts or components for equipment, and films, manuscripts or books. A Sole Source letter must be attached to the Purchase Order.

C. Work in Progress – This may be exempted by the appropriate Board and paid for by the day, after it is performed.

D. Land and Right-Of-Way Acquisition – The District generally does not purchase land. In the case that it becomes necessary, the intent to purchase must be approved by the Board and/or funding source. This is exempted by the Board from competitive bidding.

INSPECTING, TESTING AND RECEIVING

Merchandise will be received at the receiving department before it is sent to or picked up by the ordering department. It is the responsibility of each department to see that all purchased items conform to the specifications, quality and quantity on the order. Technical equipment, needing installation at that location, may be shipped directly to the department, per the direction of the IT Department. If the merchandise is not acceptable as determined by the requesting department or by receiving, the Procurement Agent or Buyer will then take action to obtain the correct merchandise.

PHARMACEUTICALS

All pharmaceuticals purchased by the District or transferred to the District for patient use, may not be given away, loaned or sold to any individual or entity.

HEALTH DISTRICT PROPERTY

A. Receipt/Tagging of New Property – the Purchasing Department will attach a property tag to all property as defined in the *Fixed Asset Guidelines*. An Asset Record Form will be completed and forwarded to the Accounting Department along with a copy of the applicable Purchase Order.

B. Disposal of Surplus or Salvage Property – An Asset Disposal Form will be completed for requests to dispose of equipment or property, with original being forwarded to the Accounting Department.

    1. Surplus property (in excess of needs, but still useful) may be disposed by competitive bids, auction, donation, or transfer to another local government with the approval of the GCHD Chief Executive Officer or Chief Financial Officer. The Purchasing Department will attempt to realize the maximum benefit to the District in selling or disposing of surplus property. If efforts to sell or dispose of the property fail, property may be disposed of in the manner most advantageous for the District. Asset tags will be removed from property sold, disposed or transferred. District employees will be given the same opportunity afforded to other persons to bid on and purchase surplus property offered by competitive bids or auction.
    2. Salvage property (valueless property of no use) may be disposed of by the Procurement Agent or designee, with the approval of the GCHD Chief Executive Officer or Chief Financial Officer, in the manner most advantageous to the District.

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Governing Board
February 2021
Item#5
Executive Reports

a) Executive Director
b) Medical Director
c) Dental Director

Governing Board
February 2021
Item#6
Consider for Approval January 2021 Financial Report

Governing Board
February 2021
Item#7
Consider for Approval 2021/2022 Sliding Fee Scale

APPENDIX A

Coastal Health & Wellness
9850-C Suite C 103 E. F. Lowry Expressway
Texas City, Texas 77591
H80CS00344

I. CHW's DISCOUNT ELIGIBILITY SCHEDULE 2021/2022

GROSS ANNUAL INCOME

% OF POVERTY		100%		125%		150%		175%		200%			
PAY CODE:	0		20		40		60		80		100		
FAMILY SIZE	From	To	From	To	From	To	From	To	From	To	Over		
1	0	12,880	12,881	16,100	16,101	19,320	19,321	22,540	22,541	25,760	25,760 +	3220	12880
2	0	17,420	17,421	21,775	21,776	26,130	26,131	30,485	30,486	34,840	34,840 +	4355	17420
3	0	21,960	21,961	27,450	27,451	32,940	32,941	38,430	38,431	43,920	43,920 +	5490	21960
4	0	26,500	26,501	33,125	33,126	39,750	39,751	46,375	46,376	53,000	53,000 +	6625	26500
5	0	31,040	31,041	38,800	38,801	46,560	46,561	54,320	54,321	62,080	62,080 +	7760	31040
6	0	35,580	35,581	44,475	44,476	53,370	53,371	62,265	62,266	71,160	71,160 +	8895	35580
7	0	40,120	40,121	50,150	50,151	60,180	60,181	70,210	70,211	80,240	80,240 +	10030	40120
8	0	44,660	44,661	55,825	55,826	66,990	66,991	78,155	78,156	89,320	89,320 +	11165	44660
For each added family member add: (to max. income)		4,540		5,675		6,810		7,945		9,080			

Effective Date 3/1/2021

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Governing Board
February 2021
Item#8
Consider for Approval Revision to the Coastal Health & Wellness Sliding Fee Policy

Coastal
Health & Wellness
Serving, Healing, Caring

-Approved: 5/28/2020
By: CHW Governing Board
-Effective 08/28/2015

Coastal Health & Wellness Sliding Fee Schedule Policy

Purpose

This policy applies to operations in the Coastal Health & Wellness (CHW) Clinics and all Coastal Health & Wellness employees.

Definitions

- FPG – Federal Poverty Guidelines
- SFDS – Sliding Fee Discount Schedule
- Family Member (size) - Family members who are considered for the eligibility criteria for the sliding fee program include the following individuals who live in the same household:
  - Patient.
  - Spouse (including same sex marriage recognized by U.S. Jurisdiction).
  - Children up to age 18 or up to age 21 if a high school or college student.
  - Elderly patients that are dependent on their children for support and are claimed as a dependent on their income taxes will be placed on a sliding fee level based on the income of their children.
  - Court-ordered guardianships of incapacitated adults and/or minors living in the household.
  - Minors living in the household which have been court-ordered or placed in the household through Child Protective Services (CPS) in custody orders.
- Income - It is CHW's policy to use the U.S. Census Bureau's standard definition of income which can be found at https://www.census.gov/programs-surveys/cps/data/data-tools/cps-table-creator-help/income-definitions.html Income includes but is not limited to the following:
  - Total cash receipts before taxes, money wages and salaries before any deductions, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Income is calculated before taxes and does not include noncash benefits (such as food stamps and housing subsidies). Capital gains or losses are excluded from the income calculation. When determining family income, add up the income of all family members (non-relatives, such as housemates, do not count).

Policy

It is the policy of Coastal Health & Wellness (CHW) to remove income as a barrier to care by offering a Sliding Fee Discount Schedule (SFDS) to all individuals and families with income levels between 101% and 200% of the Federal Poverty Guidelines (FPG). Each year when the federal poverty guidelines are published in the Federal Register, the procedure will be updated with the current information.

Sliding Fee Program

CHW will offer to all eligible patients a sliding fee discount based on income and family size and no other factor. The definition of income and family size will be based on the established current Federal Poverty Guidelines (FPG). The Federal Poverty Guidelines are a version of the income thresholds used by the U.S. Census Bureau to estimate the number of people living in poverty. Individuals and families with annual income above two hundred percent (200%) of the FPG are not eligible for the sliding fee discount program. The Sliding Fee Schedule Policy is reviewed and approved annually by the Governing Board.

Sliding Fee Discount Schedule (SFDS)

The FPG will be updated annually (typically published in January or early February in the Federal Register) and approved at the next month's board meeting with an effective date of the subsequent month in order to allow time to train staff and update systems. See Appendix A for the current year sliding fee scale.

Sliding Fee Notification

Information regarding the Sliding Fee Program will be made known to patients, through one or more of the following formats:

1) Notices/signage in waiting room and/or reception and/or service areas.
2) Staff discussions/notification.
3) CHW published patient brochures.
4) Promotional materials.
5)As part of the patient's registration process (assessment for income) unless the patient declines/refuses to be assessed.
6) CHW Website.

The communication to patients will be provided in the appropriate language and literacy levels for CHW's patient population (at a minimum English and Spanish).

Procedure

A. Application

The patients will be required to complete an Application for Discounted Services in addition to the income verification documentation. At such time, the staff will process the sliding fee application and income verification documentation directly into the patient's account in NextGen and determine the patient's eligibility and pay category for the sliding fee program based on the following information on the application form and proof of income documentation:

1) Patient's income - It is CHW's policy to use the U.S. Census Bureau's standard definition of income (See definition above).
2) Patient family size (dependents only) – Family size is defined by the patient completing the application. Family members who are considered for the eligibility criteria for the sliding fee program include individuals who live in the same household (See definition above).

Based on these two factors, the patient will be notified of their eligibility and sliding fee discount classification (pay category). CHW staff will "assign" the SFDS in the patient's NextGen account using the date the application was processed. CHW staff will be trained on other funding sources for patients, such as the county indigent program, Medicaid, and Title V, so they can encourage patients, or parents whose children or dependents may be eligible for these programs, to apply for them. This eligibility

determination process will be conducted in an efficient, respectful and culturally appropriate manner to assure that the administrative operating procedures for such determination do not present a barrier to care.

B. Proof of Income

The sliding fee program proof of income documentation to determine eligibility will require the patient to provide one of the following:

1) The Modified Adjusted Gross Income (MAGI) amount from the most current tax return.
2) Last payroll check stub(s) (gross income), one month's worth of pay (consecutively last 30 days of check stubs).
3) Social Security earnings.
4) Letter from employer may be accepted as proof of income if a patient does not file income tax returns and does not get paid with a check.
5) Self declaration – for those who do a self-declaration, eligibility will be verified and updated every three months. Individuals will also be required to fill out a form if they are self-declaring household income to be zero and provide a letter of support (See Appendix B). If applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Some patients may choose not to provide information that the health center requires for assessing income and family size, even after being informed that they may qualify for a sliding fee discount. These patients are considered by CHW as declining to be assessed for eligibility for sliding fee discounts. These patients will be charged at full rates.

C. Eligibility Period

The patient's eligibility will be valid for one (1) year except for those that have self-declared their income. Eligibility on those who self-declare their income will be verified and updated every ~~three~~ six months. The eligibility period begins on the date the application was processed. The beginning and ending date of eligibility are entered into the patient's account in NextGen. Proof of income and the application are scanned and maintained directly into the NextGen system. This process will allow management to perform QA reviews for compliance and evaluate the effectiveness of the sliding fee program.

D. Services Covered

The sliding fee discount will apply to all services within the CHW HRSA-approved scope of project, for all CHW locations. CHW has multiple SFDS's based on services/mode of delivery (see SFDS below).

E. Schedule of Fees

CHW's fee schedule is intended to generate revenue to cover the costs associated with providing services and assist in ensuring the financial viability and sustainability of the clinics. Additionally, the fee schedule will be the basis for seeking reimbursement from patients as well as third party payers. CHW's fee schedule will address all required and additional in-scope services.

CHW maintains one schedule of fees (charge master) for all patients and this fee schedule is designed to cover reasonable costs of providing services in the approved scope of project using Relative Value Units (RVU's) and adjusting as needed for consistency with locally prevailing rates. This fee schedule is approved by the Governing Board and evaluated annually to ensure it is consistent with locally prevailing rates and CHW's cost structure. (See also Fee Schedule/Charge Master formula in the Billing and Collections policy.)

F. Structure of Sliding Fee Discount Schedule (SFDS)

The Sliding Fee Discount Schedule is designed by CHW in a manner that adjusts based on ability to pay. To accomplish this, CHW has designed five discount pay classes above 100% and at or below 200% of the FPG. A nominal fee will be charged for individuals and families with annual income at or below 100% of the FPG. This nominal fee is a fixed amount and does not reflect the true value or cover costs of the services but is rather applied in order for patients to invest in their care and to minimize the potential for inappropriate utilization of services. This nominal fee is also less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100% of the FPG. The sliding fee discount will apply to all services within the CHW HRSA-approved scope of project.

% of Federal Poverty Guidelines	% of Charges Paid	% of Discount	Payment
At or below 100% of federal poverty level	0%	100%	Nominal fee $20
101 to 125% of federal poverty level	20%	80%	Deposit $25.00
126 to 150% of federal poverty level	40%	60%	Deposit $30.00
151 to 175% of federal poverty level	60%	40%	Deposit $35.00
176 to 200% of federal poverty level	80%	20%	Deposit $45.00

The Sliding Fee Schedule for Dental Contract Services is applied to the fees for services which require outside supplies for completion of patient care, such as dentures, crowns, space maintainers, or occlusal guards. Such supplies are provided by an outside laboratory and are custom made for each patient. This fee schedule is designed to cover reasonable costs of providing these services in the approved scope of project using Relative Value Units (RVU's) and adjusting as needed for consistency with locally prevailing rates. Locally prevailing rates are obtained annually based on the National Dental Advisory Pricing Guide's current year 50th percentile for our area. For Dental Contract Services, the fees for those patients who screen at a 100% discount are calculated to cover the cost of the appliances. Those who screen at over 200% of the income threshold will be charged at the full rate. The change of the fees between each category A, B, C, D, E and F is approximately 17% to equally distribute the discount for services, but still cover the costs of devices.

Dental Contract Services						
	A	**B**	**C**	**D**	**E**	**F**
Income Threshold for Sliding Fee (FPG	100%	101-125%	126-150%	151-175%	176-200%	Over 200% Must be paid in full

The above SFDS's are applied to all services CHW provides for which CHW has established charges, regardless of service type (required or additional) or the mode of delivery (directly or through contract) for which CHW is financially liable (Form 5A, Columns I & II HRSA Grant). For services that we do not provide directly but that CHW has a formal written referral arrangement (as specified in our Form 5A, Column III HRSA Grant), it is our policy to ensure the formal agreement includes language the entity/provider being referred to offers our patients a sliding fee discount that is equal or better than ours and complies with the criteria requirements outlined in the HRSA Compliance Manual. All formal agreements will be amended to include such language and all new referral agreements will automatically include the language to ensure compliance. The organization will also monitor this through a combination of patient inquiries as referrals are made and/or through annual certification by the referral provider. For referring providers that offer a discount that is better than the one provided by CHW, compliance with the HRSA Compliance manual is not required.

G. Evaluating the Sliding Fee Schedule

This sliding fee discount schedule is evaluated by the CHW Governing Board at least once every three years, to ensure it is not a barrier to care from the patient's perspective. This is accomplished by CHW using one or more of the following methods:

1) Patient focus groups and board members' feedback.
2) Advisory committees that include consumer board members.
3) Input from patient satisfaction surveys regarding evaluations of operating procedures and cost of health center services received as compared to the value received/affordability assumptions of the patient.
4) Review of co-pay amounts associated with Medicare and Medicaid for patients with comparable incomes.
5) Collection of utilization data that allows it to assess the rate at which patients within each of the discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services.
6) Other methods as considered appropriate.

The method(s) used to evaluate the effectiveness of CHW's sliding fee program from the perspective of reducing patient financial barriers to care will be shared with the Governing Board in order to assist them in determining the appropriateness of CHW's sliding fee policy. This will occur annually in conjunction with the update of the FPG.

H. Patients with Third party coverage who are eligible for SFDS

CHW's sliding fee policy is based on income and family size only. There may be patients with third party insurance that does not cover, or only partially covers, fees for certain health center services that may be eligible for CHW's sliding fee program. In such cases, subject only to potentially legal and contractual limitations, the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status. Patients with third party coverage must complete an application to determine if they are eligible for a sliding fee discount for non-covered services.

I. Applying the Policy and Training Staff

These policies and procedures will be uniformly applied across all CHW patient population. Staff will be trained to assist with the uniform implementation of the process and systems will be updated as the policy is updated to assist with compliance. Staff will be trained when hired and each time the policy is updated.

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Governing Board
February 2021
Item#9
Consider for Approval Coastal Health & Wellness
Infection Control Plan

Coastal Health & Wellness (CHW) Infection Control Plan

Draft Update 2/20/2021

Introduction

The CHW Infection Control Plan (ICP) has been developed as part of the CHW Infection Prevention and Control Program (IPCP). Its purpose is to provide guidelines, procedures, and practices to reduce the risk of spreading infectious diseases, promote safer work practices in caring for patients and others, and to assist staff in conforming to standards, evidence-based rules, regulations, and practices. This plan has been developed utilizing guidelines established by the Centers for Disease Control and Prevention (CDC), and incorporates guidelines for sterilization set forth by the Association for the Advancement of Medical Instrumentation (AAMI). The ICP will be assessed annually by the Infection Control Committee (ICC) through examination of surveillance data and risk assessment.

Responsibilities

A. All CHW staff, including volunteers and contractors, are responsible for:
   1. Adhering to the hand hygiene guidelines
   2. Adhering to the plan for the prevention and control of infections
   3. Notifying their supervisors or designee of infection related issues
   4. Reporting exposure incidents in the workplace to the Risk and Safety Coordinator and the Infection Control Nurse (ICN)

B. Supervisors are responsible for:
   1. Understanding the general guidelines and principals and those that apply to their departments or programs
   2. Orienting their new staff to the applicable guidelines
   3. Periodically training staff on the guidelines
   4. Monitoring the practices of their staff in the workplace
   5. Assuring any exposure incidents in the workplace are reported to the Risk and Safety Coordinator and Infection Control Nurse.
   6. Counseling employees who need guidance or redirection in infection control practices

C. Infection Control Nurse (ICN) is responsible for:
   1. Surveillance monitoring of outcome and processes to plan, implement, evaluate, and improve ICP strategies
   2. Orientation of new CHW staff to the ICP and its components
   3. Education and annual staff training related to infection prevention and control activities
   4. Monitoring, evaluating, and reporting program effectiveness
   5. Expanding activities as needed in response to unusual events or to control outbreaks of disease

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6. Reviewing and recommending revisions of the ICP to the ICC annually or more frequently if indicated.
7. Overseeing the seasonal influenza vaccination program for CHW staff

D. The ICC will consist of CHW staff and leadership including the CEO and/or designee, the Medical Director and/or designee, Lead Mid-Level, the Dental Director and/or designee, Infection Control Nurse , Nursing Director, Lab/X-Ray Supervisor, Supervisor of Dental Assistants, Chief Nursing Officer (CNO), Risk and Safety Officer and the Chief Compliance Officer (CCO). The committee will be chaired by the CNO and responsibilities include the following:
    1. Meet monthly to review surveillance data collected by the ICN and managers; this will include reports on handwashing data, spot audits conducted in all clinical areas (dental, lab and medical), reports on sterilization monitoring, and any other issues that might arise, such as any infectious disease trends.
    2. Report results of surveillance, data analysis and trends to the QA committee and the Governing Board (GB) QA Committee quarterly.
    3. Review any incidents that involve infection control activities.
    4. Review the annual risk assessment and develop next year's multidisciplinary Risk Assessment
    5. Develop annual Goals and Responsibilities for the IPCP and report progress and outcomes to the GB QA and the GB annually.
    6. Review and update the IPCP annually and as needed if any special circumstances arise.

Risk Assessment

An infection control risk assessment will be conducted annually and presented to the ICC, for review and recommendations. The risk assessment will include consideration of the community and population served by the CHW clinics, care and services provided, and infection surveillance data. Based upon the annual risk assessment, infection control goals and responsibilities will be established, measured, and reported upon to the ICC, the QA committee, the GB QA committee, and the Governing Board.

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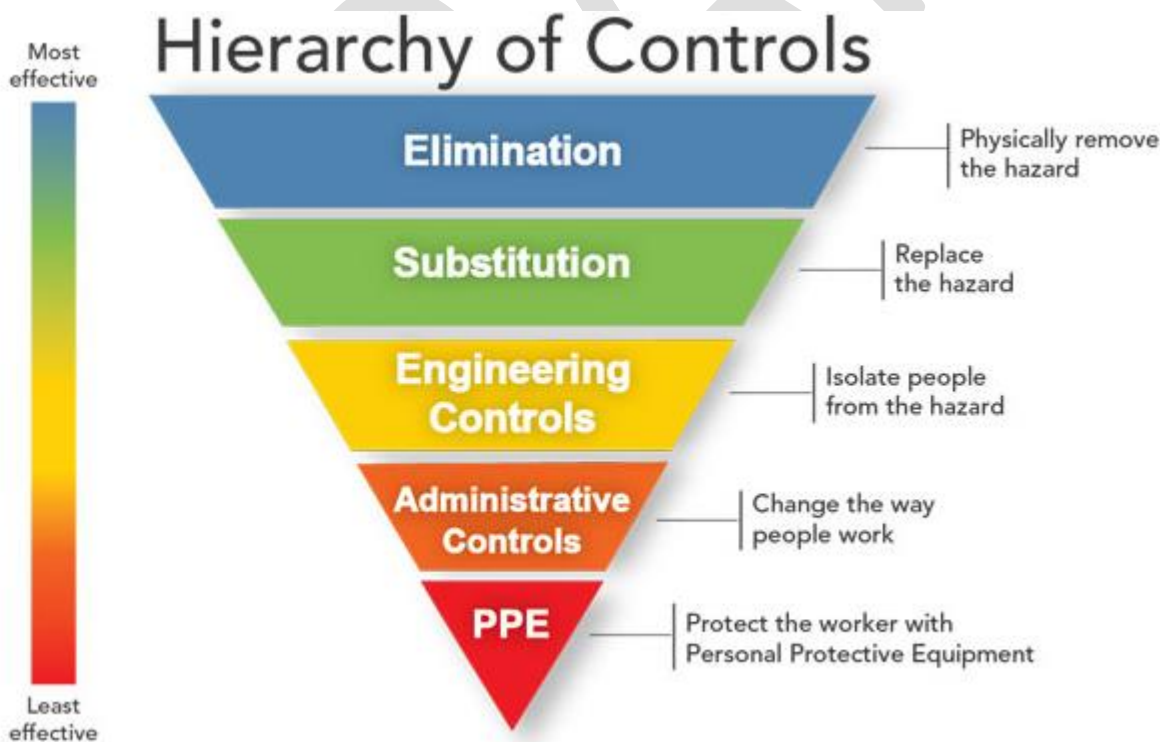
SECTION 1: Standards and Guidelines

Coastal Health & Wellness (CHW) is a "healthcare setting" where healthcare is delivered in outpatient facilities. Standards and guidelines are designed to proactively prevent the spread of infection in healthcare settings. CHW ~~clinics~~ utilize Centers for Disease Control and Prevention (CDC) guidelines ~~in the medical and dental clinics~~, The National Institute for Occupational Safety and Health (NIOSH) and Association for Advancement of Medical Instrumentation (AAMI) guidelines for sterilization are utilized in the dental clinic and medical clinics.

A Hierarchy of Controls is used as a means to determine how to implement reasonable and effective controls as an infection control strategy to prevent transmission of pathogens in a patient-care delivery system.

Hierarchy of Controls as follows, from the most effective to the least effective:

- Elimination-physically remove the hazard
- Substitution-replace the hazard
- Engineering Controls-isolate people from hazards
- Administrative Controls-change the way people work
- PPE-Protect the worker with Personal Protective Equipment



1.1 Standard Precautions

Standard Precautions are an infection control strategy to prevent transmission of pathogens and are recommended for all patient-care delivery settings. They are based on the concept that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible pathogens. Based on principle of: All patients, All times, protecting yourself, protecting patients.

Standard Precautions are intended to address all modes of transmission by any type of organism. They are based on a risk assessment and make use of common-sense practices and personal protective equipment that protect healthcare providers from infection and prevent the spread of infection from patient to patient.

All occupational exposures to blood and or other potentially infectious materials (OPIM) place healthcare providers at risk for infection with bloodborne pathogens. Standard Precautions are designed to reduce exposure to blood and other potentially infectious material (OPIM).

Standard Precautions include the following:

- **Hand hygiene**: Hand hygiene is an institutional priority for all clinical and non-clinical staff. During the delivery of healthcare, it is advised that healthcare workers protect ~~self~~ themselves and patients from potentially deadly pathogens by cleaning their hands the right way, at the right times. ~~avoid unnecessary touching of surfaces near the patient and perform hand hygiene. Clean hands by handwashing with soap and water or use alcohol-based hand sanitizer.~~
  - Hand Hygiene means cleaning your hands by:
    - Handwashing (washing hands with soap and water or antimicrobial soap and water)
    - Antiseptic hand rub (alcohol-based hand sanitizer foam or gel, 60-90% alcohol)
    - Surgical Hand antisepsis using antimicrobial soap and water or alcohol-based hand sanitizer with fast acting and persistent activity.
  - Wash hands with soap and water:
    - When hands are visibly dirty
    - After known or suspected exposure to patients with diarrhea
    - Before eating
    - After using a restroom
  - ~~Use an alcohol-based hand sanitizer for everything else~~
  - Alcohol -Based hand sanitizer for everything else
  - During routine patient care: 5 moments of hand hygiene:
    - Before patient contact
    - Before a clean/aseptic procedure
    - After body fluid exposure risk
    - After patient contact
    - After contact with patient surroundings
  - Hand Hygiene:
    - Before donning gloves
    - After removing gloves
    - Before handling medication

- Surgical Hand antisepsis using antimicrobial soap and water **or** alcohol-based hand sanitizer with fast acting and persistent activity is recommended before donning sterile gloves when performing surgical procedures. Remove ~~rings~~ jewelry that could potentially tear sterile surgical gloves. Remove debris from under fingernails before starting hand hygiene.
  - Using and antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacture, usually 2-6 minutes. ~~Long scrub times (e.g., 10 minutes) are not necessary.~~
  - When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol product, prewash hands and forearms and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves

~~Perform hand hygiene in the following clinical situations:~~

- ~~Before having direct contact with patients~~
- ~~Before handling medication~~
- ~~Before donning gloves~~
- ~~After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressing~~
- ~~After contact with a patient's intact skin (e.g., taking a pulse)~~
- ~~If hands will be moving from a contaminated body site to a clean body site during care~~
- ~~After contact with inanimate object (including medical equipment) in the immediate vicinity of the patient~~
- ~~After removing gloves~~
- ~~After contact with patient's environment~~

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- **Personal Protective Equipment (PPE):** Use PPE whenever there is an expectation of possible exposure to infectious material/agents. Specialized equipment is to be worn by an employee for protection against infectious materials, to reduce the risk of infection. Appropriate PPE is provided for employees as follows:
  - **Gloves** –Protect hands and use when touching blood, body fluids, secretions, excretions, contaminated items, and for touching mucous membranes and non-intact skin. Wearing gloves is not a substitute for hand hygiene and hands should always be cleaned before donning and after removing gloves.
  - **Mask, eye protection and face shield** – Wear a disposable face mask, mask with attached eye protection, fluid resistant surgical mask, and eye protection (goggles) or a full-face shield to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood or body fluids, secretions, and excretions.
  - **N-95 Respirators:** NIOSH approved/fit tested, used for "aerosol-generating procedures" or "airborne transmission" with a full-face shield. Use of N-95 respirators due to response of international emergence of COVID-19.

- **Gowns** – Wear a gown (fluid-resistant, ~~if~~ when possible) to prevent soiling or contamination of clothing during procedures and patient care activities when contact with blood, body fluids, secretions or excretions is anticipated.

- **Respiratory Hygiene/Cough Etiquette:**

    - Employees are expected to contain respiratory secretions by covering the nose/mouth when coughing or sneezing, use tissues to contain respiratory secretions and dispose of used tissues in the nearest no-touch receptacle (foot-pedal-operated lid or open, plastic lined waste basket) and to perform hand hygiene after contact with respiratory secretions.
    - Signs will be posted at entrances and common meeting areas with instructions to patients to cover their mouths/noses when coughing and sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.
    - Respiratory stations will be stocked, cleaned, and maintained at the entrance to the clinic.
    - Staff will be instructed to provide masks to patients who are actively coughing when they present at the clinic for care, or if guideline for all to don face covering/mask when entry to clinic. Due to COVID-19, ~~CHW require~~ all who enter CHW ~~clinic area will~~ are required ~~to~~ to wear ~~mask/~~face-covering nose and mouth, while in the facility. Also, hand hygiene before entry.
    - Patients suspected of having an airborne communicable disease should be placed in an area away from others, such as in an exam room.; this is based on the Infectious Disease Guidelines/Nursing staff decision. See Infectious Disease Guidelines for room assignments.
    - Avoid touching your eyes, nose, and mouth, and clean your hands often.

- **Ensure appropriate patient placement -** Include the potential for transmission of infectious agents in patient-placement decisions. Based on transmission-based precautions used in addition to standard precautions.
    - Place patients who pose a risk for transmission to others in an exam room as soon as possible. This decision is based on Infectious Disease Guidelines/Nursing staff decision.
- **Properly handle and properly clean and disinfect patient care equipment and instruments/devices** - Protocols and procedures should be established for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids.
    - Remove organic material from instruments/devices using recommended cleaning agents to enable effective disinfection and sterilization processes.
    - Wear PPE (personal protective equipment), such as gloves and gowns according to the level of expected contamination, when handling patient-care equipment and instruments/devices that are visibly soiled or may have been in contact with blood or body fluids.

- **Clean and disinfect the environment appropriately**
  Establish protocols and procedures for routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling.
    - Clean and disinfect surfaces likely to be contaminated with pathogens, including those near the patient and surfaces in the patient-care environment that are frequently touched (doorknobs, light switches) on a more frequent schedule compared to that for other surfaces such as horizontal surfaces in waiting rooms.
    - Use EPA-registered disinfectants that have microbicide activity against the pathogens most likely to contaminate the patient care environment. Use according to manufacturer's instructions. Use Cleaning/Disinfecting Wipes: List N: Disinfectants for use Against SARS-CoV-2 (COVID-19)

- **Follow safe injection practices**
    - Use clean or aseptic technique, in ~~a~~ clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medication and sterile injection equipment
    - During preparation, visually inspect the medication for particulates, discoloration, or other loss of integrity

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- Disinfect the rubber septum on a medication vial, with alcohol before piercing or according to medication IFU's.
- Do not re-use needles or syringes to enter medication vial or solution, even when obtaining additional doses for the same patient.
- Do not administer medications from a syringe to multiple patients.
- Needles, cannulas, and syringes are single patient use items.
- ~~Use~~ Single-dose vials, ampules or pre-filled syringes are intended for use on only one patient. Use whenever possible.
- If there are medications that do not come in single use vials, then the multidose vial must be discarded after the first use. Exceptions are specific vaccines, PPD skin test and Insulin.
- Do not use a single-dose vial or ampule for several patients or combine contents of several vials.

- **<u>Ensure healthcare worker safety including proper handling of needles and other sharps</u>** - Engineering, work practice, and environmental controls have all been developed to prevent and control the spread of infection related to the use of needles and other sharps in the healthcare setting. Refer to the CDC Workbook for Designing, Implementing , and Evaluating a Sharps Injury Prevention Program.
    - Requirements for handling sharps states that: **contaminated sharps** are needles, blades (such as scalpels), scissors, and other medical instruments and objects that can puncture the skin. Contaminated sharps must be properly disposed of immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom, and color-coded or labeled with a biohazard symbol.
    - Discard needle/syringe units without attempting to recap the needle unless it is unsafe to do so.
    - Always activate self-capping needle protector.
    - If a needle must be recapped, **never** use both hands. Use the single hand "scoop" method by placing the cap on a horizontal surface, gently sliding the needle into the cap with the same hand, tipping the needle up to allow the cap to slide down over the needle, and securing the cap over the needle with the same hand. Dental uses Pro Tector/Needle Sheath Prop-One-Handed Recapper.
    - Never break or shear needles.
    - To move or pick-up needles, use a mechanical device or tool, such as forceps, pliers, or broom and dustpan.
    - Dispose of needles in labeled sharps containers only; sharps containers must be accessible and maintained upright. When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.
    - When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.
    - Fill the sharps container up to the fill line or two thirds full. Do not overfill the container.
    - Sharps containers are secured in place while in use in the clinical area.
    - In healthcare setting no sharing of fingerstick devices or insulin pens.
    - Blood glucose meters must be cleaned and disinfected according to manufactures instructions between uses.
    - Creation of a team to review and evaluate Sharps Injury Prevention Devices.

1.2 <u>Transmission Based Precautions</u>

In additional to Standard Precautions, which are used with all patients, some patients require additional precautions known as transmission-based precautions. Transmission-based precautions are measures to protect against exposure to a suspected or identified pathogen. There are three types (or combination) of transmission-based precautions: Contact, Droplet and Airborne.

- **<u>Contact Precautions</u>**

  Contact precautions are designed to minimize transmission of organisms that are easily spread by contact with hands or objects. CDC Contact Precautions are summarized below:

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- Use of Personal Protective Equipment
  - Put gloves on upon entry into the exam room
  - Put on a gown upon entry and remove and perform hand hygiene before leaving the exam room
  - After removal of gown, ensure clothing and skin do not contact environmental surfaces in the patient-care area.

- Patient Transport
  - Limit transport and movement of patients outside of the exam room unless medically necessary.
  - If it is necessary to move the patient, ensure infected area of the patient's body is covered.
  - Remove and dispose of contaminated personal protective equipment and perform hand hygiene prior to transporting, (leaving exam room).
  - Don clean personal protective equipment to handle the patient at the transport destination.

- Patient-Care Equipment and Instrument/Devices/Cleaning and disinfecting room
  - Handle equipment and instruments/devices according to Standard Precautions.
  - Use disposable equipment or implement patient-dedicated use. If common use is unavoidable, clean and disinfect before use on another patient.
  - Place contaminated reusable noncritical patient-care equipment in a plastic bag for transport to a soiled utility area for reprocessing.
  - Exam room/area cleaned and disinfected prior to use by another patient, focus on frequently touched surfaces and equipment.

- **Droplet Precautions**

  Droplet precautions are designed to prevent transmission of diseases easily spread by large-particle droplets produced when the patient coughs, sneezes, talks or during the performance of procedures.
  - Place suspected infectious patient in an exam room as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations.
  - Source control: put a mask on the patient
  - Staff will wear a mask upon entry into the exam room, use PPE appropriately and limit transport of patient outside the room.

- **Airborne Precautions**

  Airborne Precautions are designed to prevent transmission of diseases spread by the true airborne route.
  - Identify patients requiring Airborne Precautions.
  - Put a surgical mask on the patient, instruct in respiratory hygiene/cough etiquette, and place in an examination room, based on Nursing recommendations for room assignment.
  - Restrict number of healthcare personnel from entering the room
  - Healthcare personnel use appropriate PPE, including a fit-tested NIOSH approved N-95 respirator, cover with full-face shield.
  - Caregivers should wear a mask when entering the patient's room.
  - Limit transport or movement of patient out of the room
  - Once the patient leaves, the room should remain vacant for two hours to allow full exchange of air. Exam room/area terminally cleaned and disinfected with an EPA registered disinfectant: Tuberculocidal used according to manufacturer instructions, prior to use by another patient.

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1.3 Tuberculosis (TB) Exposure Control Plan

Tuberculosis has long been recognized as a risk in health care settings, and the emerging incidence of drug resistant and multi-drug resistant (MDR) TB illustrates the need to monitor for possible TB exposure in the CHW clinics. TB rates in the county are monitored by the Texas DSHS Tuberculosis Control Program and the GCHD TB Program.

The CHW clinics have been identified through a TB Risk Assessment (CDC, Texas DSHS form) as low risk settings where exposure to TB is unlikely. An annual assessment is conducted, and if any suspected/confirmed cases of TB are identified, a new assessment will be conducted at that time.

As a condition of employment, see Employee and Pre-hire Immunization and Screenings Policy (last approved UBOH 09/02/2020):

TB screenings for new employees: all new employees must provide a current (less than 12 months from date of hire) TST (tuberculin skin test) or IGRA (Interferon Gamma Release Assay) prior to their start date. In the event a new hire employee is a prior positive reactor, a chest X-ray (done less than 12 months from date of hire) will suffice for clearance. Any employee exposed to active TB will undergo post-exposure repeat screening.

Positive reactors will be evaluated by the GCHD TB Program Manager. Any employee found to have active pulmonary TB will be excluded from the workplace while contagious.

TB Exposure Control Procedures for Suspected or Known Active TB Cases

Provide a surgical mask for the person to wear to contain droplets. Recognize the signs and symptoms of active TB - these include hemoptysis, fatigue, fever, chills, night sweats, loss of appetite and weight loss.

- Any suspected or known case of tuberculosis in a patient or employee must be reported to the GCHD TB Program (ext. 2217 or 2218). After hours reporting number is 1-888-241-0442. Call Ami Cotharn, RN, TB Program Manager 409-938-2218. TB Fax line 409-938-2220.

The examining room used as a holding area should be closed for 2 hours and terminally cleaned after the patient has left and then disinfected with an EPA registered disinfectant: Tuberculocidal used according to manufacturer instructions.

SECTION 2: Medical Surveillance

Healthcare workers face risks to their own health when taking care of patients. The elements of a medical surveillance program are used to establish an initial baseline of workers' health and then monitor their future health as it relates to their potential exposure to hazardous agents. This information can be used to identify and correct prevention failures leading to disease. Early identification of health problems can also benefit individual workers.

2.1 Employee Health

- All employees will follow established policies regarding immunizations and tuberculosis skin tests. Refer to "Employee and Pre-Hire Immunizations" policy.
- Employees who may be infected with a communicable disease transmitted through airborne or casual contact may not return to work until released by their medical provider who deems them non-infectious. Supervisors who suspect that an employee has a communicable illness may require the employee seek medical attention and a release to return to work.
- Employees are strongly encouraged to obtain a yearly seasonal influenza vaccine; if an employee is unwilling or unable to be vaccinated, they will be required to wear a surgical mask while engaged in direct patient contact during flu season.

2.2 Infectious Diseases and Occupational Health Strategies

Several standards and directives are directly applicable to protecting workers against transmission of infectious agents: These include

- Bloodborne Pathogens Training OSHA Standard 1910.1030
- CDC Guidelines
- Personal Protective Equipment
- Respiratory Protection/OSHA Standard 1910.134

Bloodborne Pathogens Training

CHW provides bloodborne pathogens training for all workers who may encounter blood and other potentially infectious materials (OPIM) in their jobs, based on Occupational Safety and Health Standards (OSHA) 1910.1030 Bloodborne Pathogens

- This training includes information on bloodborne pathogens and diseases, methods used to minimize risk and control occupational exposure, hepatitis B vaccine, and medical evaluation and post-exposure follow-up procedures.
- CHW offers this training for new hires, annually thereafter, and when new or modified tasks or procedures affect a worker's occupational exposure.

CDC Guidelines

- To prevent transmission of bloodborne pathogens to healthcare workers, the CDC recommends:
  - Strict adherence to sharps safety guidelines and Standard Precautions
  - Hepatitis B vaccination of healthcare worker
  - Post-exposure prophylaxis and counseling in the event of exposure incident.

Personal protective equipment

- Surgical masks are used as a physical barrier to protect the user from hazards, such as splashes of large droplets of blood or body fluids; they also protect other people against infection from the person wearing the surgical mask. Such masks trap large particles of body fluids that may contain bacteria or viruses expelled by the wearer.

- When there is identified potential occupational exposures, staff will don appropriate PPE, including gloves, gowns, face shields, masks, and eye protection.
  - Wear gloves (clean, nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient, and clean hands immediately to avoid transfer of microorganisms to other people or environments.
  - Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Disposable gowns are utilized in the CHW clinics. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove and dispose of soiled gowns as promptly as possible and clean hands to avoid transfer of microorganisms to other people or environments.
  - Wear a mask and eye protection or a face mask to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

- **Respiratory Protection :** N-95 respirators, OSHA Standard 1910.134

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- N95/filtering facepiece respirator,(NIOSH-certified respirator) filter efficiency of 95%-is a personal protective device worn on the face, covers at least nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particle (e.g.) dust and infectious agent(s).Intended use and purpose: reduces wearer's exposure to particles including small particle aerosols (only non-oil aerosols) and large droplets. Use N-95/surgical mask with a full-face shield anytime when performing aerosol-generating procedures.
- N-95- Initial fit test for each HCP with the same model, style, and size respirator that the worker will be required to wear. Initial fit testing to determine if the respirator fits the worker and can provide the expected level of protection. Repeat fit test if changes in employees' physical condition that could affect respirator fit or need to change brand or model and yearly (when supplies are available).
- Training during fit test procedure or general training
- Respirator Medical Evaluation Questionnaire prior to fit testing
- Qualitative fit testing: Saccharin or Bitter Solution Aerosol Protocol
- Recordkeeping: retained in HR
- N-95-tight-fitting face seal, User Seal Check required each time the respirator is donned

2.3 Exposure Control Plan

~~Protecting healthcare workers from disease is accomplished in many ways, including:~~ Establish an exposure control plan and update annually.

- Use of Standard Precautions with all patients, especially hand hygiene
- Use of additional transmission precautions (e. g., Contact, Droplet and Airborne)
- Vaccination (e.g., influenza and hepatitis B)
- Identify and use engineering controls.
- Identify and ensure the use of work practice controls
- Provide Personal Protective Equipment (PPE)
- Post-exposure ~~control plan and prophylaxis~~ evaluation and follow-up
- Communication of hazards to employees, use labels and signs
- Provide information and training to staff, maintain records
- Environmental hygiene to reduce exposure to pathogens in healthcare settings
- For all sharp's and Bloodborne Pathogens exposures, WITHOUT DELAY, healthcare worker needs a post-exposure evaluation by a medical provider ~~is necessary~~, which must include a discussion and documentation of the risks and benefits of post-exposure prophylaxis follow-up as indicated by the exposure.
- Procedures for evaluating the circumstances surrounding an exposure incident including identifying and testing the source individual by Risk/Safety Coordinator
- ~~Communication of hazards to employees~~
- ~~Training and recordkeeping~~

If a healthcare worker has an on-the-job exposure to a communicable disease, the Supervisor and Risk/Safety Coordinator should be notified without delay. This will allow for evaluation of the circumstances and prevent exposure of others, as well as coordinate with appropriate medical follow-up.

2.4 Healthcare Workers and Communicable Diseases

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Healthcare workers are responsible for reporting to their supervisor when they have any **signs or symptoms of a communicable disease**. Symptoms that should be reported and evaluated typically include:

- Fever
- Unusual rash
- Skin infections, such as boils and impetigo
- Exudative (weeping) dermatitis
- Sore throat with fever
- Gastrointestinal symptoms (vomiting, diarrhea)
- Jaundice
- Symptoms suggesting active tuberculosis (chronic cough with unexplained weight loss, fever, night sweats and hemoptysis).

Preventing transmission of infection is the responsibility of the facility and the individual healthcare worker.

2.5 Emergency Procedures for Exposure to Blood and Body Fluids

Employers are required to implement these preventative measures to reduce or eliminate the risk of exposure to bloodborne pathogens. OSHA Standard 1910.1030

EMERGENCY STEPS FOLLOWING AN OCCUPATIONAL EXPOSURE

If an occupational exposure to blood or other body fluids occurs, the following CDC National Institute for Occupational Safety and Health (NIOSH), steps should immediately be taken:

1. Wash needle stick injuries and open wounds with soap and water
2. Flush splashes to nose, mouth, or skin with water
3. If exposed, irrigate eyes with clean water, saline or sterile irrigation
4. Use eye wash stations if exposed in clinical areas
5. Report the incident to Supervisor and Risk and Safety Officer
6. Immediately seek medical treatment

Emergency: Seek immediate medical care at the nearest facility or **call 911**

Non-emergency: find a provider within the *Alliance Directory* http://www.pswca.org

During Business Hours: Contact Risk and Safety Coordinator by phone (409) 938-2425 or email, and to the employee's supervisor or designee immediately.

After Business Hours: It is the employee's responsibility to seek **immediate** medical attention at a local emergency room for blood borne pathogen exposures. Notify your supervisor or designee immediately.

Injured Employee:

1. Get a prescription “First Fill Card” if necessary
2. Complete an *Employee Incident/Injury Report* even if no medical treatment is sought
3. Labs for all hepatitis and HIV need to be drawn within the first 24 hours and then repeated based upon stated recommendations, usually in 3 months, 6 months and 1 year
4. A notarized affidavit in exposure situations must be submitted to the Risk and Safety Coordinator within 10 days
5. If medical treatment was sought, obtain a Work Status Report from your doctor, and submit to the Risk and Safety Coordinator or HR before returning to work

Supervisors:

1. Assist employees in obtaining medical attention
2. Ensure notification to Risk and Safety Coordinator
3. Ensure an Employee Incident/Injury Report is completed and sent to Risk and Safety Coordinator
4. If a worker sustains several occupational exposures, the direct supervisor and the worker should review the duties and procedures of the job.

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5. Modifications of procedures and appropriate corrective action should be taken in accordance with policy and circumstances.
6. Work with HR on the employee returning to work

Risk and Safety Coordinator:
If applicable, coordinates reports of employee injury to the workers' compensation insurance carrier, notifies the Clinical Compliance Specialist, the applicable department head, CNO, and the Director of Epidemiology of the incident; and tracks and trends employee exposures, review and or revise exposure control plan yearly and as needed.

SECTION 3: Regulated Medical Waste Management
Regulated Medical Waste requires careful disposal and containment. Standards are designed to protect workers who generate medical waste and those who manage the wastes from point of generation to disposal (Transporter). Personnel responsible for medical waste management must receive appropriate training in handling and disposal methods. The transport of Regulated Medical Waste is regulated by the United States Department of Transportation (DOT). All affected employees (those who perform the functions of either packaging or signing the shipping papers) must complete DOT hazards material training initially and every three years, thereafter.

Regulated medical waste includes:
- Liquid or semiliquid blood or other potentially infectious materials
- Items contaminated with blood or other potentially infectious materials (OPIM) and which would release these substances in a liquid or semiliquid state if compromised
- Items that are caked with dried blood or OPIM and are capable of released these materials during handling
- Contaminated sharps
- Pathological and microbiological wastes containing blood or OPIM

3.1 Handling Waste
Regulated waste must be placed in containers that are:
- Closable
- Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping
- Labeled with Biohazard sticker/label or color-coded; red, or orange red
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage transport, or shipping.

If outside contamination of the regulated waste container occurs, it must be placed in a second container meeting the above standard.

3.2 Needles, Syringes and Other Sharp Objects
Sharps should be placed in containers that are labeled with the universal biohazard symbol and the word *biohazard* or be color-coded red. Sharps containers must be maintained upright throughout use, locked in place, replaced routinely, and not be allowed to overfill. Sharps containers should not be filled past the marked “fill line”, over ¾ full, or if there is any difficulty disposing of the sharp. Nothing should be allowed to hang outside or protrude outside of the sharp’s container.

Sharp materials must be placed in a puncture-resistant container designated for sharps waste. All sharps containers must be properly closed “locked” prior to being placed in a secondary container. No loose sharps are permitted outside of sharps containers.

Regulated Medical Waste

Containers must be:

- Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
- Placed in a secondary container if leakage is possible; the second container must be:
  - Closeable
  - Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping
  - Labeled or color-coded
- Reusable containers must not be opened, emptied, or cleaned manually or in any other manner that would expose employees to risk by percutaneous injury.

- All closed sharps containers: closed and locked, ¾ full or to fill line and small red biohazard bags (twisted and tied) are placed inside large red biohazard bag lining the cardboard box.

- When large box is ¾ full or at a maximum weight limit of full container 43 pounds, the red bag is to be twisted several times, folded over, and tied to prevent leakage. Bag may be twisted and folded over and secured with 2-inch pressure or poly tape, if not able to tie.

- Cardboard boxes (secondary containers) must be closed and sealed with 2-inch pressure or poly tape on the top and bottom. Closed bags must not be visible once the secondary container is closed and the box must not be bulging. The outside of the box must be clearly labeled with a biohazard mark, and the clinic bar code label is attached to the outside of the box in the indicated area. Label has address of Generator and Transporter.

- All regulated medical waste is stored in a locked Biohazard room, monitored by the ICN and Risk & Safety Coordinator.

3.3 Biohazard Warning Labels

Biohazard warning labels are to be affixed to containers of regulated medical waste; refrigerators and freezers containing blood or OPIM; and other containers used to store, transport, or ship blood or OPIM. These labels are fluorescent orange, red or orange-red. Bags used to dispose of regulated waste must be red or orange-red, and they too must have the biohazard symbol in a contrasting color readily visible upon them.

3.5 Practices and Controls

In addition to the precautions described above, CHW has other practices and controls in place to prevent and control infection. These include:

- Engineering Controls
- Work practice Controls
- Environment Controls

- **Engineering Controls** refer to measures that isolate or remove a hazard from the workplace and that must be used when feasible. These include the following:
  - Sharps disposal containers
  - Self-sheathing needles
  - Sharps with engineered sharps injury protections

- **Work practice controls** reduce the likelihood of exposure to pathogens by changing the way a task is performed, such as:
  - Practices for handling and disposing of contaminated sharps
  - Handling specimens
  - Cleaning and disinfecting contaminated surfaces and items
  - Performing hand hygiene

- **Environmental controls** help prevent the transmission of infection by reducing the concentration of pathogens in the environment. Such measures include but are not limited to:
  - General housekeeping

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- Cleaning and disinfecting strategies
- Sterilizing patient equipment
- Disposal of regulated medical waste
- DOT Training

SECTION 4: Good Work Practices

~~4.1~~ ~~Handwashing~~ Hand Hygiene

- Hand hygiene shall be practiced before and after routine patient care activities, including entering and exiting the patient care environment, before and after removing gloves, and after hand-contaminating activities
- Hand hygiene shall be practiced before handling medication
- All employees are required to wash, rinse, and dry their hands ~~or apply an alcohol-based hand sanitizer~~ before beginning work, after using the rest room, and prior to leaving work
- When not visibly soiled, an alcohol-based hand rub (ABHR) or alcohol-based hand sanitizer or alcohol-based hand sanitizing wipes may be used routinely for hand hygiene in place of an ~~antimicrobial~~ soap and water handwash
- Hands that are grossly contaminated must be washed with soap and water or antimicrobial soap and water.
- ~~Antimicrobial-impregnated wipes are not as effective as ABHRs or washing hands with antimicrobial soap and water for reducing bacterial counts on the hands of healthcare workers and will not be used as a substitute for using an alcohol-based hand rub or antimicrobial soap~~

Procedures:

A. Handwashing procedure with antimicrobial soap and water:
   1. Wet hands first with warm water
   2. Apply an amount of product recommended by manufacturer to hands
   3. Rub hands together making lather for at least 20 seconds, covering all surfaces of the hands and fingers, front and back
   4. Rinse thoroughly by keeping hands down so that run off will go into the sink and not down the arm, avoid use of hot water
   5. Dry well with paper towels and use paper towel to turn off faucet
   6. Discard paper towels into the appropriate container

B. Hand antiseptic procedure with ABHR Alcohol Based Hand Rub
   1. If hands are visibly soiled, wash hands with antimicrobial or plain soap and water according to procedure prior to applying alcohol hand rub
   2. Apply enough alcohol hand rub/sanitizer to cover the entire surface of hands and fingers
   3. Rub hands together with the solution ~~vigorously~~ into hands until dry
   4. Alcohol based hand sanitizing wipes used according to manufactures IFU.
   5. Use of alcohol hand rubs may result in a sticky residue on the hands. Wash with soap and water periodically to remove the hand rub residue
   6. Nails should be kept clean and nail polish should be in good repair (no chipped nail polish). Attention must be given to cleaning around the base of the nails, cuticles, and nail tips when washing hands.
   7. Healthcare workers with direct patient care must keep nails short. Natural nails shall be trimmed so they are no longer than 1/4 inch past the tip of the finger.
   8. Artificial fingernails or extenders (including resin bonding, extensions, tips, gels, acrylic overlays, resin wraps, or acrylic nails) shall not be worn by healthcare providers that provide

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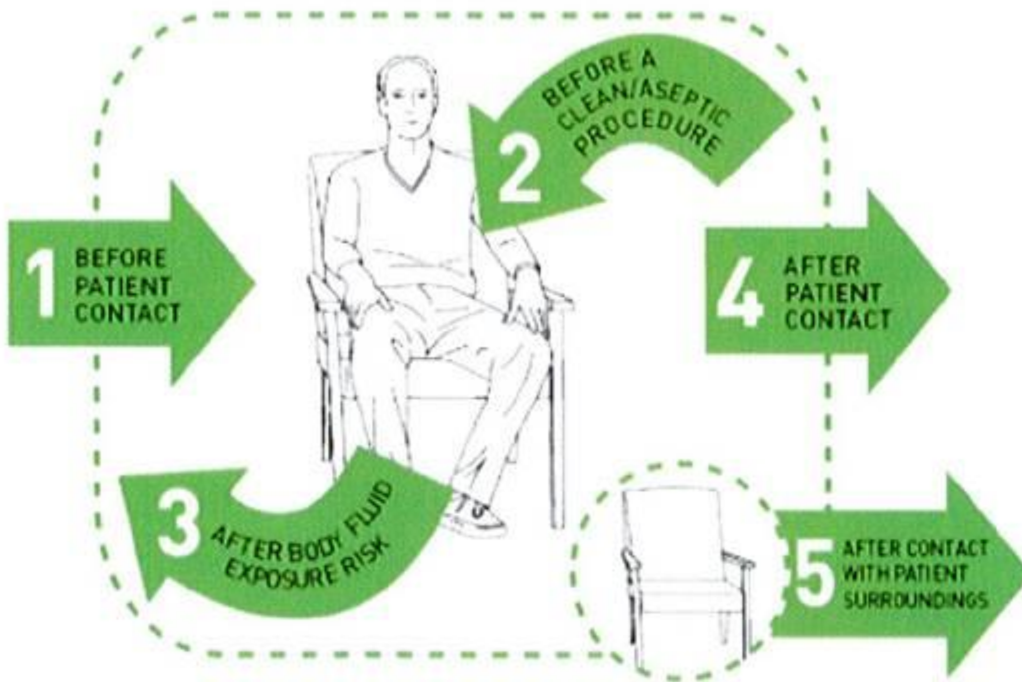
direct patient care

C. Lotions
   1. Use moisturizing lotion to maintain healthy hand skin integrity and prevent dryness or irritation
   2. Moisturizing lotion must be an approved hand lotion to avoid risk of incompatibility and/or inactivation of the active ingredients in hand hygiene products and gloves



Process and Outcome Measurement

It is the responsibility of staff and managers to monitor and remind others of hand hygiene procedures. Hand hygiene audits are performed according to the 5 Moments of Hand Hygiene, as outlined in this procedure (see graphic).

Hand hygiene audits:
   a. Should reflect a cross section of clinic staff
   b. Should reflect a cross section of the patient care episodes in a range of settings and not prolonged observation of single episode of patient care
   c. Audits will be reviewed in Infection Control Committee and action plans will be developed to improve compliance Remove graphic with patient in hospital bed

4.2 Personal Protective Equipment

Gloves are the most common type of PPE. They are used for patient care as well as environmental service. Gloves can be sterile or nonsterile and single use or reusable. Because of allergy concerns, latex products have been eliminated in the CHW clinics, and materials used for gloves are synthetics such as vinyl or powder-free nitrile.

Most patient-care activities require the use of single pair of nonsterile gloves. Vinyl gloves are frequently available and work well if patient contact is limited. However, some gloves do not provide a snug fit on the hand, especially around the wrist, and should not be used if extensive contact is likely. Gloves should not tear or damage easily. ~~as they are sometimes worn for several hours, and need to stand up to the task.~~ Gloves should be available is sizes to provide a snug fit on the person wearing the gloves; small, medium, large, and X-large.

Sterile surgical gloves are worn when performing sterile patient procedures.

Proper glove use includes:

- Working from clean to dirty
- Limiting touch contamination (e.g., adjusting eyeglasses, touching light switches, etc.) when wearing gloves that have been in contact with the patient.
- Changing gloves during use if torn or when heavily soiled and after use on each patient.
- Disposing of gloves in proper receptacle
- Performing hand hygiene before putting on and following removal of gloves
- **Never** washing or reusing disposable gloves or applying ABHR or ABHS to clean the gloves

The CDC describes when and how to wear gloves and states that wearing globes is not a substitute for hand hygiene. Hands should always be cleaned after removing gloves.

- **Gloves** - Steps for glove use:
  - Choose the right size and type of gloves for the task.
  - Wear disposable medical examination gloves for providing direct patient care.
  - Wear disposable medical examination gloves, decontamination glove for use with chemicals and 16-inch extended cuff, or reusable utility gloves for cleaning the environment and medical equipment. When available powder-free nitrile with 16-inch extended cuff and fingertip thickness 11mil, to be used for decontamination of surgical instruments.
  - Put on gloves before touching a patient's non-intact skin, open wounds, or mucous membranes, such as the mouth, nose, and eyes.
  - Change gloves during patient care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face).
  - Remove gloves after contact with patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.
  - Clean hands before putting on gloves for a sterile procedure.
  - Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
  - Remove gloves promptly after use and perform hand hygiene immediately.

- **Gowns** - Wear a gown that is appropriate to the task to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

  - Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.
  - Remove gown and perform hand hygiene before leaving the patient's room.
  - Do not reuse gowns, even for repeated contacts with the same person.

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- **<u>Masks, Eye Protection and Face Shields</u>**
  - Face and eye protection are used during patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
  - Masks protect the nose and mouth and should fully cover them to prevent fluid penetration.
  - Goggles protect the eyes and should fit over and around them snuggly. Personal prescription glasses are not a substitute for goggles.
  - Face shields protect the face, nose, mouth, and eyes. A face shield should cover the forehead, extend below the chin, and wrap around the sides of the face

- **<u>Putting on and Removing PPE</u>**
  - Specific procedures to be followed when putting on and removing PPE include: See CDC sequence for putting on PPE and removal example 1 and 2. See Summary of recent changes 6/9/2020 PPE for COVID-19.
  - PPE should be donned in the following sequence:
    1. Gown
    2. Mask
    3. Face shield or goggles
    4. Gloves

  - Contaminated PPE should be removed in the following sequence:
    Either-
    1. Gloves
    2. Face shield or goggles
    3. Gown
    4. Mask or respirator

    Or-
    1. Gown and gloves
    2. Goggles or face shield
    3. Mask or respirator

Hand hygiene must be performed immediately after removing all PPE.

4.3 <u>Eyewash Station and Spill Clean Up Supplies</u>

Employees will be trained where the emergency eyewash stations are in each clinical area. Eyewash stations are monitored, checked/tested weekly by clinical staff to ensure that water flows through each correctly and actions are logged appropriately. Staff are also trained on where the chemical (based on SDS) and biological (bodily fluids) spill supplies are located in each clinical area and where other safety equipment is located.

4.4 <u>Refrigerators</u>:

There must be separate refrigerators for food, specimens, and medications, each with a cleaning schedule. Signs must be affixed to indicate its designated use. A biohazard label must be affixed to the outside of refrigerators used to store specimens. Refrigerators must be monitored for temperature and cleanliness, which includes daily or twice daily temperature checks, weekly and as needed cleaning, and routine inspection of contents. Laboratory specimens requiring refrigeration while awaiting transport may not be stored in the same refrigerator as medications, juices or water stored for the purpose of dispensing with medication. Refrigerators for lab specimens are in lab area only.

4.5 <u>Food and Drink Precautions</u>

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Confine food and drink to designated employee break areas. Covered drinks may be acceptable in some non-patient care areas.

4.6 Storage of Sterile Solutions:
Sterile solutions are one-time use, once open, used and remaining fluid discarded.
~~Upon opening sterile solutions, staff may write the date on the label. All open solutions will be discarded on the first working day of the month or upon expiration date, whichever is the earliest. Sterile stock solutions should be checked prior to use for turbidity, leaks, cracks, particle matter, discoloration, and expiration date. Need to review~~

SECTION 5: Cleaning, Disinfecting, and Sterilizing.

5.1 General Environmental Surface Cleaning
Environmental cleaning is critical for reducing pathogen contamination of surfaces. Environmental cleaning involves physical action of cleaning surfaces to remove organic and inorganic material, application of a disinfectant, and employing monitoring strategies to ensure that these practices are carried out appropriately.

Healthcare environment surfaces can be divided into two groups: 1) those with minimal hand contact, such as floors and ceilings, and 2) those with frequent hand contact, such as doorknobs and light switches, that require cleaning and/or disinfecting more frequently than those with minimal hand contact.
The number and type of pathogens present on environmental surfaces are affected by:

- Number of people in the environment
- Amount of activity
- Amount of moisture
- Presence of material able to support microbial growth
- Rate at which organisms suspected in the air are removed
- Type of surface and orientation (horizontal or vertical)

Horizontal surfaces with infrequent hand contact (e.g., windowsills, hard-surface flooring) in routine patient-care areas require cleaning on a regular basis, when soiling or spills occur. Disinfectants used in environmental cleaning are not sporicidal or tuberculocidal but can kill most other microorganisms.
Cleaning solutions should be replaced frequently, and soiled or disposable cloths and mop head should be replaced each time a bucket of detergent/disinfectant is emptied and refilled.

5.2 Cleaning up spills
All environmental and working surfaces must be cleaned and decontaminated after contact with blood or OPIM. Protective gloves and other PPE should be worn as necessary, and an appropriate disinfectant/germicidal should be used. ~~Such disinfections can be a diluted bleach solution or~~ EPA-registered antimicrobial products such as tuberculocidal, and label claim ~~sterilant,~~ or products registered against ~~HIV/HBV.~~ Bloodborne pathogens (HBV,HCV, and HIV)

After putting on personal protective equipment:

- Block off area to protect patients and other staff if the spill is large.
- Wipe up the spill with paper towels or other disposable absorbent material and discard the contaminated materials in an appropriate, labeled biohazard container.
- Use a spill kit to clean up the spill if it contains sharps such as needles, scalpels, broken glass, blood tubes or capillary tubes, or if there is a large volume of liquid. Properly dispose of sharps immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom and color-coded or labeled with a biohazard symbol.
- Clean up all blood or OPIM thoroughly before applying the disinfectant.

- Apply the disinfecting solution, spray or disposable wipes, onto all contaminated areas of the hard non-porous surface.
- Let surface remain wet, in contact with disinfectant for the number of minutes based on the manufacturer's directions~~. (When using a diluted bleach solution, contact time is the length of time it takes for the solution to dry.)~~ Bleach germicidal disposable wipe (sodium hypochlorite) is an appropriate disinfectant to use for decontaminating blood spills.

If a spill involves a chemical, refer to SDS and follow appropriate procedures.

5.3 Medical Instruments

It is the practice of CHW ~~to use only disposal sterilized instruments~~ to use only disposable instruments in the medical clinics; no sterilization of medical equipment is done.

5.4 Low-level disinfection

Items that touch intact skin for a brief period are usually considered non-critical surfaces. **Noncritical items** include environmental surfaces and equipment such as:

- Echocardiogram
- Nebulizers
- Sphygmomanometer/Blood pressure cuffs
- Thermometers
- Pulse Oximeters
- Stethoscopes
- Otoscope/Ophthalmoscope

Most noncritical reusable items may be decontaminated where they are used. Virtually no risk has been documented for transmission of infectious agents to patients through noncritical items if they do not contact non-intact skin and/or mucous membranes.

Noncritical items are disinfected using low-or intermediate-level disinfectants, which include:

- Ethyl or isopropyl alcohol
- Sodium hypochlorite (Diluted household bleach solution)
- ~~Diluted household bleach solution~~
- ~~Phenolic germicidal detergent~~
- ~~Iodophor germicidal detergent~~
- Quaternary ammonium, germicidal detergent solution (low level only) Chemical name: dimethyl benzyl ammonium chloride

5.5 Intermediate-level disinfection

Intermediate-level disinfection kills most viruses, bacteria and mycobacteria using a chemical germicide registered as tuberculocidal by the EPA. It does not kill bacterial spores. It is often used to clean up blood spills and other environmental cleaning and is not licensed for disinfection of patient-care equipment that touches mucous membranes. These disinfectants are typically labeled as tuberculocidal to give evidence that they kill the bacterium that causes tuberculosis as well as HBV and HIV. They may be available as a liquid or as disposable wipes.

Intermediate-level disinfectants include:

- Ethyl or isopropyl alcohol
- Sodium hypochlorite Diluted household bleach solution

- ~~Phenolic germicidal detergent~~
- ~~Iodophor germicidal detergent~~

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5.6 Dental Equipment Procedures

Reusable devices become soiled and contaminated when used and must undergo reprocessing, which is a detailed, multistep process to clean and then disinfect or sterilize them. Devices can be safely used more than once if reprocessing is done correctly following labeled instructions/IFU'S

Reprocessing involves three steps:

1. Initial decontamination and cleaning at point of use to prevent drying of blood, tissue, other biological debris and contaminants.
2. Transfer of the device to the reprocessing work area, where it is thoroughly cleaned.
3. Either disinfection or sterilization, depending on the intended use of the device, and the materials from which it is made. The device is then stored or routed back into use.

The dental clinic at CHW utilizes the Spaulding Classification System, which is an instrument classification system used for reprocessing decisions (see table below).

Classification	Definition	Examples	Requirements
Critical	Where there is entry or penetration into sterile tissue, cavity, or blood stream	• Extraction kit • Forceps • Burs (unless single use, disposed of after use) • Surgical handpiece • ~~Scalpel blades~~ • Periodontal scalers	Cleaning followed by Sterilization
Semi-Critical	Where there is contact with intact non-sterile mucosa or non-intact skin	• ~~Mouth mirrors~~ Cotton Pliers • ~~Restorative instruments~~ • ~~Dental tweezers~~, probes • ~~Metal impression trays~~ • ~~Auto matrix~~ • BOBCAT Pro Ultrasonic Scaler	Cleaning followed by High-Level Disinfection
Non-Critical	Where contact is made with intact skin	• Protective eyewear • Blood pressure cuff • ~~Light handles~~ • Instrument trays • ~~Bracket table~~ • Chair controls • Environmental surfaces: Floors, walls, doors, handles, high-touch surfaces	Cleaning followed by Low-Level Disinfection

5.7 Sterilization

Sterilization is required for reusable patient-care instruments that touch sterile tissue or the vascular system and require the absence of microbial contamination. Sterilization describes a process that destroys or eliminates all forms of microbial life. Most of these should be purchased as sterile or be sterilized with steam.

Steam sterilization is the most widely used and the most dependable method. It is used whenever possible on all critical and semi-critical items that are heat-and moisture-resistant. Steam sterilization is rapidly microbicide, sporicidal, and rapidly heats and penetrates fabrics. Each item is placed in a steam sterilizer (autoclave) and exposed to direct steam at the required temperature and pressure for a specific time.

Sterilization will be performed by manufacturer's recommendation for the steam sterilizers accordingly along with manufacturer's recommendations of instrumentation.

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A. All reusable instruments, equipment, and used surfaces will be decontaminated, disinfected, or sterilized prior to use on a patient. The infection control guidelines for cleaning, disinfecting and sterilization of patient care equipment, instruments and patient care environment will be determined according to the Spaulding Classification System.

B. Manufacturers' directions and facility policies and procedures for reprocessing reusable instruments and equipment, including directions for use of the reprocessing equipment will be followed.

C. Personnel

- Personnel wear clean scrub attire and no outer wear (i.e., jackets)
- Wear a fluid resistant cover gown (~~tied~~ secured in back, at neck and waist). ~~and~~
- Heavy-duty disposable utility gloves (extended cuff nitrile) or general-purpose utility gloves that are discarded if any evidence of deterioration or at the end of the day, should be worn ~~gloves~~ during the decontamination process
- Wear fluid-resistant disposable face mask and ~~or mask with face shield attached eye protection, goggles, or~~ a full-length face shield over mask or mask with splash visor, to protect against splashes or sprays.
- Disposable hair cover, to protect against splashes or sprays
- Staff will follow the hand hygiene guidelines
- Personnel must have proper training on processing instruments with competency testing during orientation to their jobs and annually. Documentation of training should be maintained in the employee's personnel file. ~~and unit file.~~ Continuing education (including training for all new instrumentation, devices, and equipment) is conducted at regular intervals.
- Utility gloves are utilized during designated steps of the sterilization process.

Design

Location: Sterile processing area will be divided into two (2) areas, designated as "clean" and "dirty," physically divided, and the integrity of each area will be maintained through traffic and instrument/equipment flow

- The "dirty" area will be used for decontamination of all soiled instruments
- The "clean" area will be used for processing and sterilization of clean items, to include the preparation and packaging of instruments. Sterilizers are in this area.

Procedures:

A. Pre-Cleaning

Contaminated items should be wiped or sprayed at point of use to keep them moist prior to cleaning; they should not be cleaned or decontaminated in the scrub or hand sinks

B. Transport

- Contaminated items will be contained during their transport from the point of use to the decontamination area in covered containers marked as "Biohazardous"
- Sharps and delicate instruments should be kept separate from other items
- Items will be kept moist until cleaning and decontamination can be performed

C. Cleaning in decontamination area

- Cleaning of patient care items must occur prior to beginning of sterilization and/or decontamination, should remove all visible soil, and should occur as soon as practical after use. Cleaning solutions

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and/or detergents should be measured, mixed, labeled, and discarded appropriately according to the manufacturer's directions for use and should be compatible with the instruments and equipment for which they are used.

- Proper protective equipment (PPE) must be used when cleaning an item if a risk of aerosolization exists (spraying of particles into air) and for protection against exposure to the chemicals used as directed by the Safety Data Sheet (SDS)
    - The manufacturers' specifications for the quality of water used for cleaning should be followed (i.e., sterile, distilled, de-ionized)
    - Completely disassemble each item prior to cleaning; all jointed instruments must be open and/or unlocked from transport to the completion of sterilization
    - ~~The brushes used for cleaning should be disposable~~. Disposable brushes are used for cleaning instruments and discarded after each use. ~~decontaminated at least once a day. Worn out brushes should be disposed.~~ ~~All brushing should be done underwater.~~ Clean/brush immersible instruments under water to minimize aerosolization.
    - Mechanical cleaning equipment should be used whenever possible according to IFU; test and maintain equipment as per manufacturer's instructions
    - If lubrication is necessary, instrument will be wiped down according to IFU and placed in lubricating/cleaning machine or a non-toxic or water-soluble spray will be used
    - Appropriate sharps which are contaminated with blood or other potentially infectious materials should not be stored or processed in a manner which requires employees to reach by hand into the container where these sharps have been placed; rather, such instruments should be placed in drainage type baskets prior to submerging in cleaning solutions
    - Traffic between the decontamination, preparation, and assembly areas must be minimized; decontamination attire should be removed, and personnel should wash their hands upon leaving the decontamination area
    - Visually inspect each item (using magnifying light if necessary) to be certain they are clean prior to placing in dryer
    - If the item is visually soiled at the point of inspection, it will be manually cleaned and/or reprocessed in the ultrasonic machine

D. Inspection

Suitable lighting will be provided for optimal inspection

- Each instrument needs to be clean and dry prior to packaging
- Each item will be inspected for functionality, safety, and sharpness prior to packaging
- If an item is not suitable to use, it will be removed from service

E. Packaging

- Assure adequate drying time of instruments and equipment prior to packaging for sterilization
- Review and follow the manufacturer's instructions for type of wrap or container that may be used, shelf life, and storage recommendations; wrap all packages separately
- Internal and external steam indicator will be used for all peel-pack pouches
- A Type 5, steam chemical integrator strip is placed inside the peel-pack pouch
- Hinged instruments must be in open position when processed
- Sharp items should be protected from damage. Tip protectors, if used, should be used according to manufacturer's written IFU.
- Peel packs should not be placed inside of packages or containerized sets

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- Document on the plastic side (on label) of sterilization pouches:
    - Assistant's Initials
    - Cycle Number, including the name of the sterilizer
    - Operatory number
    - Date of Sterilization

F. Sterilization

- Select the appropriate method of sterilization according to the instrument or equipment manufacturer's instructions.
- Steam is the preferred method for sterilization of critical instruments not damaged by heat
- Loading of Sterilizer:
    - Positions biological indicator according to sterilizer and monitoring IFU
    - Arrange on rack or carriage to present least possible resistance to the passage of steam; textile packages on top, peel pouches on edge, instrument sets flat, rigid containers under wrapped packages
    - Do not overload sterilizer; items should never touch sterilizer chamber walls
    - Basins, trays, test tubes, etc. must be set on edge or upside down so air will flow out freely as steam flows in
- Removing Load from Sterilizer:
    - Proper temperature and exposure time must be known; chart and temperature gauge must be checked to see that these are achieved
    - Load should be dry and cool when removed
    - It is critical to follow the recommendations and time frames for drying the instruments and trays that have been sterilized
    - If packs are wet when removed, they must be re-sterilized
    - Care must be taken to keep sterile items separated from non-sterile items
- Documentation
    - The sterilizer identification
    - The type of sterilizer and cycle used
    - Load Contents
    - The critical parameters such as time, temperature, and pressure
    - The results of the sterilization process monitors
    - The operator's name, initials, or identification
    - The results of BI testing will be documented in the logbooks in the sterilization area
- Immediate-Use sterilization will not be performed

G. Storage and Distribution

- Integrity of clean and sterile equipment and supplies shall be assessed prior to use
- Determination of shelf life of packaged items:
    - Inspect all packages before use; if intact, they are considered sterile
    - Packaging will be considered non-sterile (compromised) when certain events occur:
        - Holes/tears
        - Broken or no seal
        - Dropped
        - Moisture
        - Unsealed dust cover

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- Store items in a manner that prevents crushing or binding together so packaging is not compromised
- Place lighter items on heavier ones
- Store items in closed cabinets; if this is not possible, store items on wire shelves in a restricted storage area with the bottom shelf being solid
- Arrange storage areas in a manner that prevents splashing from personnel or housekeeping
- Rotate stock so that older items are used first
- Store liquids below dry sterile goods or in a separate section
- Store materials at least 18" below the ceiling and/or sprinkler head
- Do not store sterile items under plumbing values and traps
- Cleaned delivery carts shall be used to transport clean and sterile supplies
- Sterile storage area will be a well-ventilated area that provides protection against dust, moisture, insects, and temperature and humidity extremes

H. Quality Assurance

- Monitoring

  Mechanical (physical), chemical, and biological monitors must be used to assure that the sterilization process has been effective

  - Physical monitors include time, temperature, and pressure gauges, displays, recorders, and digital printouts. At the end of each cycle, the operator should read and sign the printout to verify that:
    a. The printer is functioning properly
    b. The cycle identification number has been recorded
    c. All cycle parameters have been met
  - Chemical indicators (internal and external) should be used with every load
  - Use a biological indicator as follows:
    a. Steam sterilization: BI is performed daily when the clinic is open, and instruments are quarantined until the BI is read
    b. Same lot number for biological indicator in the load and for the control
    c. Biological control will be processed prior to disposal

- Recall Process:
  a. Upon notification that a physical, chemical, or biological indicator demonstrates a lack of sterility, or sterilizer cycle did not meet expectations, an incident report will be completed as soon as reasonably possible.
  b. Notify Dental Director and Dental Assistant Supervisor immediately.
  c. In the case of a failed spore test, remove the sterilizer from service; review sterilization procedures and work practices to determine whether the failed test could be the result of operator error.
  d. After correcting any identified procedural problems, retest the sterilizer by using biological, mechanical, and chemical indicators.
  e. If the repeat spore test now verifies that mechanical and chemical indicators are within normal limits, put the sterilizer back in service.
  f. If the repeat spore test also fails, do not use the sterilizer until it has been inspected and/or repaired.
  g. Dental assistants will check all shelf supplies and instruments in the clinic and pull from inventory any item with a corresponding date, autoclave number, and cycle number, from all loads since last negative biological indicator.

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h. All recalled supplies and instruments will be repackaged and re-sterilized
i. For any supply or instrument that is not located, begin the investigation to identify potential patients that may have been affected by a breach of sterilization and notify the Dental Director. All instruments are quarantined.
j. The cycle/autoclave indicator tag will be retained and attached on the incident report as noted by positive biological indicator.
k. After reviewing all available data, the Dental Director or Dental Assistant Supervisor will determine if the autoclave will remain in service or be taken out of service until causative factors are resolved through service, repair, and validation.
l. After correction of identified cause, immediately re-challenge
m. Documentation of sterilizer details, causative factors, follow-up action and results of validation testing will be maintained in the sterilizer repair log, as well as on the sterilization log.

- Maintenance

  Cleaning, maintenance, and record keeping/documentation of equipment will be performed according to manufacturer's IFU.

SECTION 6: Specific Dental Practices

6.1 Dental Unit Waterline Quality

- CHW routinely tests and documents dental unit water quality to verify the dental unit water measures less than or equal to 500 colony forming units of heterotrophic bacteria per milliliter (≤500 CFU/mL) of water, the standard set for drinking water by the Environmental Protection Agency (EPA)
- CHW employs multiple methods to aid in reducing the amount of biofilm in the dental unit water lines (DUWLs)
  - Use self-contained water bottle delivery systems
  - Use spring water as the 'source water'
  - Use sterile water or saline for the 'source water' when completing surgical procedures. Not used in the self-contained water system.
  - Discharge water and air for a minimum of 20-30 seconds after each patient from any device connected to the dental water system that enters a patient's mouth (handpieces, ultrasonic scalers)
  - Use approved products to complete periodic 'shocking' of DUWLs
  - Use approved products to maintain DUWLs between shocking procedures
- See "Protocol for Use of the A-Dec Self Contained Water System", "Monitoring Waterline Quality procedures according to A-Dec recommendations" and "Procedure for collecting water sampling" for more information regarding specific procedures

6.2 Dental Operatory Disinfection

- All members of the healthcare team will comply with the current Center for Disease Control and Prevention (CDC) recommendations for proper usage of surface disinfecting agents
- Barriers must be used on clinical contact surfaces which are 'difficult to clean', including, but not limited to
  - Air/water control buttons

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    - Suction control levers
    - Overhead light handles
    - Chair control buttons
- All clinical contact surfaces that are not barrier-protected are cleaned and disinfected by utilizing a two-wipe process after each patient
    - Step 1: The first "cleaning" wipe removes visible debris and large numbers of microorganisms from surfaces
    - Step 2: The second "disinfecting" wipe kills organisms on surfaces and items that cannot be heat sterilized. Follow manufacturer's Instructions for Use (IFU) for the recommended contact time of how long the surface needs to remain "wet" to achieve the TB Kill Time
    - Between Step 1 and 2, gloves must be removed, hand hygiene performed, and new gloves must be donned

6.3 <u>Dental Radiation Safety</u>

- CHW follows Texas State guidelines to implement radiation safety through the ALARA ("as low as reasonably achievable") principles
- Dental radiographs are prescribed based on the American Dental Association dental radiographic recommendations
- Individuals who operate only dental x-ray machines are exempt from individual monitoring requirements (Texas Administrative Code §289.232(d))
- Appropriate barriers, PPE and patient shielding are used while taking x-rays
- In order to maintain the integrity of the protective shields (aprons/capes), they should be
    - Hung with no crimping or folding
    - Visually inspected before each use
- All dental radiation equipment is certified by a qualified radiation inspector on a regular basis

Section 7: Medication and Safety Injection Practices

7.1 <u>Sharps and Injection Related Practices and Controls</u>
Engineering, work practice and environmental controls have all been developed to prevent and control the spread of infection related to the use of needles and other sharps in the healthcare setting.

7.2 <u>Sharps Handling</u>
Contaminated sharps are needles, blades (such as scalpels), scissors, and other medical instruments and objects that can puncture skin. Contaminated sharps must be properly disposed of immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom and color-coded or labeled with a biohazard symbol.

- Discard needle/syringe units without attempting to recap the needle whenever possible.
- If a needle must be recapped, NEVER use both hands. Use the single-hand "scoop" method by placing the cap on a horizontal surface, gently sliding the needle into the cap with the same hand, tipping the needle up to allow the cap to slide down over the needle, and securing the cap over the needle with the same hand.
- Never break or shear needles.
- To move or pick up needles, use a mechanical device or tool, such as forceps, pliers, or broom and dustpan.
- Dispose of needles in labeled sharps containers only; sharps containers must be accessible and maintained upright. When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.
- When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.

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- Fill a sharps container up to the fill line or two thirds full. Do not overfill the container

7.3 Safe Injection Practices

Unsafe injection practices put patients and healthcare providers at risk for infection. Safe injection practices are part of Standard Precautions and are aimed at maintaining a basic level of patient safety and provider protections.

Recommended practices for injection:

- To the extent possible, prepare medications in dedicated medication rooms.
  - Draw up medications in the medication room or a designated clean area, free of any items potentially contaminated with blood or body fluids (e.g., syringes, needles, blood collection tubes and needle holders).
  - Multi-dose vials should not be accessed in the immediate patient treatment area. If a multi-dose vial enters the immediate patient-care area, it should be dedicated to that patient and discarded after use.
- Use an aseptic technique to access parenteral medications.
- Perform hand hygiene before handling the medication.
- Disinfect the rubber septum with alcohol and allow alcohol to dry prior to piercing. This includes newly opened medication (either multi-vial or single dose) as well. Or according to medication IFU.
- Always use a new sterile syringe and sterile needle to draw up medication and avoid contact with a nonsterile environment during the process.
- Never leave a needle inserted into the septum, of a vial for multiple draws.
- Ensure that any device inserted into the septum is used in accordance with the manufacturer's instructions and does not compromise the integrity of the remaining vial contents.
- Discard medications:
  - According to the manufacturer's expiration date (even if not opened) and whenever sterility is compromised or questionable.
  - Single dose vials that have been opened or accessed should be discarded according to the manufacturer's time specifications or at the end of the case/procedure for which it is being used. Do not store for future use.
  - Multi-dose vials that have been opened or accessed should be dated with the date opened and discarded within 28 days. The disposal date should also be included on the vial.
- Never administer medications from the same syringe to more than one patient, even if the needle is changed.
- Never enter a vial with a used syringe or needle.
- Never use medications packaged as single-dose vials for more than one patient.
- Assign medications packed in multi-dose vials to a single patient whenever possible.

Safe injection practices include:

- Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted below. Shearing or breaking of contaminated needles is prohibited.
- If an employer can demonstrate no alternative that is feasible or that such an action is required by specific medical or dental procedure, bending, recapping, or needle removal must be accomplished using a mechanical device or one-handed "scoop" technique.
- Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. Reusable sharps are that contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the container.

SECTION 8: Reporting Communicable Diseases

The list of communicable notifiable conditions required by Texas Department of State Health Services to be reported is attached. See Texas Notifiable Conditions -2021, rev. 1/21/21 expires 1/31/22. In addition to these conditions,

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any outbreaks, exotic diseases, and unusual group outbreaks of disease must be reported. All cases shall be reported by name of patient, age, sex, race/ethnicity, DOB, address, telephone number, disease, date of onset, method of diagnosis, and name, address, and telephone number of providers.

The list indicates when to report each condition. Cases or suspected cases of illness considered being public health emergencies, outbreaks, exotic diseases, and unusual group expressions of disease must be reported to the GCHD epidemiology department immediately (ext. 2238, 2208, or 2215). These incidents are also to be reported to the Medical Director, Dental Director (if a dental patient), the CEO and the CNO. Other diseases for which there must be a quick public health response must be reported within one working day. All other conditions must be reported to the epidemiology department within one week. After hours reporting number is 1-888-241-0442.

SECTION 9: Emergency Management and Planning

Emergency management of infectious patients is directed at early detection and swift isolation. In the event an emergency results in the inability of the facility to continue providing services in a safe manner, CHW will initiate its plan for continuity of services as described in the "CHW Emergency Operations Plan"**.**

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References:

a. Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care, Center for Disease Control, version 2.3-September 2016

b. AAMI-Association for the Advancement of Medical Instrumentation. ANSI/AAMI ST79-Comprehensive Guide to Steam Sterilization and Sterility Assurance in the Health Care Facilities. Arlington, VA: Association for the Advancement of Medical Instrumentation; 2017.

c. Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care, Center for Disease Control

d. Updated U. S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Post exposure Prophylaxis, MMWR June 29, 2001/Vol. 50/ No. RR-11

e. ~~Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis, MMWR September 30, 2005 / Vol. 54 / No. RR—9~~

f. ~~Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, MMWR, December 30, 2005/Vol.re/No. RR-17~~

g. Guidelines MMWR June 6, 2003 / Vol. 52 / No. RR--10

h. ~~Guidelines for Infection Control in Health Care Personnel, 1998 CDC Special Article~~

i. La Esperanza Clinic, Inc. Infection Control Manual, revised 2018

j. http://www.nnoha.org/nnoha-content/uploads/2018/10/IPC-NNOHA-Power-Point-2018.pdf

k. https://www.cdc.gov/sharpssafety/pdf/sharpsworkbook_2008.pdf

l. https://www.dshs.texas.gov/IDCU/disease/tb/forms/PDFS/TB-600.pdf

m. https://www.gchd.org/home/showpublisheddocument?id=8805

n. https://dshs.texas.gov/IDCU/investigation/Reporting-forms/Notifiable-Conditions-2021-Color.pdf

Appendices:

~~a. GCHD Plan for Pandemic Influenza and Highly Infectious Respiratory Diseases~~
   i. https://www.gchd.org/home/showdocument?id=5108

~~b. GCHD Employee and Pre-Hire Immunization Policy~~
   i. https://www.gchd.org/home/showdocument?id=6069

~~c. GCHD Volunteer Policy~~
   i. https://www.gchd.org/home/showdocument?id=5194

d. ~~GCHD Safety Manual Overview~~
   i. https://www.gchd.org/home/showdocument?id=4570
e. U. S. Public Health Service Guidelines for the Management of Occupational ~~Exposures to HBV, HCV and HIV and Recommendations for Post exposure Prophylaxis~~
   i. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
f. ~~GCHD 24/7 Disease Reporting Protocol~~
   i. www.gchd.org/notify
g. CHW Emergency Operations Plan
   https://www.gchd.org/home/showdocument?id=6151

Forms

1. Employee Incident or Injury Report:
   a. http://www.gchd.org/home/showdocument?id=5448
2. Infectious Disease Reporting Form
   a. www.gchd.org/reports
3. Notifiable Conditions
   a. www.gchd.org/notify
4. DSHS Congregate Settings *Tuberculosis Risk Assessment* form

Annual reviews by Infection Control Committee, QA & GB QA conducted Jan/Feb 2021

Approved by the Coastal Health & Wellness Governing Board:

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Chairman, Coastal Health & Wellness Governing Board Date

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