



## Health and Medical Coordinating Coalitions Questions & Answers

The following is a list of questions and answers received by the Massachusetts Department of Public Health (MDPH) Office of Preparedness and Emergency Management (OPEM) during stakeholder outreach presentations that took place during the fall of 2013 as well as questions submitted in writing at the December 2, 2013 Orientation to Regional Stakeholder meetings.

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### HMCC Description and Rationale

#### What are Health and Medical Coordinating Entities [Coalitions]?

A Health and Medical Coordinating Coalition (HMCC) will be a multi-agency coordination entity with associated staffing that supports Emergency Support Function 8 (ESF8) activities, public health and medical services, at a local and regional level.

Core disciplines in the HMCC will be:

- Community health centers and large ambulatory care organizations,
- Emergency medical service providers (public and private),
- Hospitals,
- Local public health, and
- Long-term care facilities.

HMCC will also reach out to include key ESF8 supporting partners such as home health, pharmacies, dialysis centers, mental and behavioral health providers, urgent care, and social services agencies. By June 30, 2017, one HMCC will be established in each of the six existing Massachusetts Department of Public Health Hospital Preparedness regions.

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Each HMCC will conduct capabilities-based planning to advance regional health and medical capacity to prepare for, respond to, recover from, and mitigate the impact of large scale emergencies and disasters. Planning activities will be consistent with the healthcare and public health preparedness capabilities, as established by the Assistant Secretary of Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC). HMCC staff will build strong connections with emergency management and public safety/first responder organizations within the region, as well as other public and private organizations with a role under ESF8.

### **HMCC Functional Activities**

Each HMCC will be active across all phases of the disaster management cycle, and will be tasked with:

- Coordinating regional ESF8 planning, and assuring alignment with local plans
- Supporting local planning and preparedness
- Maintaining 24/7/365 capacity to support emergency response, with staff who will coordinate with DPH staff as well as voluntary response elements (e.g., Medical Reserve Corps, MA Responds, mutual aid)
- Providing multi-agency coordination, advice on incident management questions, and resource coordination as determined in regional plans
- Coordinating regional information sharing for situational awareness and common operating picture
- Supporting regional recovery operations following emergencies and disasters
- Participating in regional health and medical risk assessment and mitigation activities
- Participating in cooperative training and exercising of regional plans
- Conducting after action reviews and developing appropriate improvement plans

**Are we doing this – because CDC is requiring it? Tell us specifically what the CDC requirements are for this new HMCC organization/entity (i.e., HMCC structure and functions).**

We are establishing Health and Medical Coordinating Coalitions to enhance state and local capacity to address health and medical needs that arise from an emergency or disaster. Recent large scale emergencies in the Commonwealth have highlighted the need for regional, multi-disciplinary coordination during events and across the disaster management cycle to enhance the capabilities of ESF8 partners to build resilient communities and effectively respond to disasters at the local and regional level. Additionally, the healthcare and public health Capabilities issued by Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) program strongly emphasize integration of public health and healthcare preparedness activities at the state, tribal, and local levels, and the development of multi-disciplinary healthcare coalitions that are active across all phases of the disaster management cycle. HMCC will bring together the core ESF8 disciplines to strengthen regional partnerships and support effective cross-disciplinary planning, response, recovery, and mitigation.

Specifically, the Joint HPP-PHEP requirements under the current BP2 Funding Opportunity Announcement (FOA) provide that

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“Awardees are expected to continue to develop or refine healthcare coalitions as outlined in ASPR’s Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness, Capability 1: Healthcare System Preparedness, Function 1: Develop, refine, and sustain healthcare coalitions; and in Capability 10: Medical Surge, Function 1: The healthcare coalition assists with the coordination of the healthcare response during incidents that require medical surge. PHEP awardees should strongly encourage and promote local health department participation in healthcare coalitions to the maximum extent possible.”

Federal guidance also provides that partnerships and healthcare coalitions must:

- Integrate plans and activities of all participating healthcare entities into the jurisdictional response plan, and the State response plan; Increase medical response capabilities in the community, region and State;
- Prepare for the needs of at-risk populations in their communities in the event of a public health emergency;
- Coordinate activities to minimize duplication of effort and ensure coordination among Federal, State, local, and Tribal planning, preparedness, and response activities (including the State Public Health Agency, State Medicaid Agency, State Survey Agency, State Administrative Agency and Emergency Management Assistance Compact); and
- Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations.

### If there is already willingness to share supplies, why do we need to have these arrangements?

HMCC provide an opportunity to do more than just share supplies; they will further the collaborative planning across ESF8 partners; enhance information sharing before, during, and after emergencies; facilitate coordination of training and exercises; and support a region’s activities across all phases of the disaster management cycle. While some of these activities happen with certain disciplines and in certain parts of the Commonwealth, it is not consistent across all disciplines and in all regions. HMCC will help build that capacity statewide.

### How were the regions chosen?

We chose the existing boundaries of the MDPH Hospital Preparedness Regions to minimize disruption of existing relationships. In selecting these boundaries, we considered other existing regional boundaries (e.g., MEMA regions, Homeland Security Planning Council Regions, EMS regions), as well as existing working relationships, population distribution, and distribution of acute care facilities.

For Regions 1, 2, 3, 4c, and 5, these boundaries mirror the public health preparedness region boundaries, although this represent a change in operations for the existing public health coalitions within Regions 1, 3, and 5. Public Health Regions 4a and 4b would be served by a single HMCC established within the existing Hospital Preparedness Region 4ab, building upon lessons learned from activities originally begun through the Partnership for Effective Emergency Response (PEER) effort that included Regions 4a, 4b, and 4c. We recognize that there are concerns in both 4a and 4b about use of the hospital region boundaries, and that discussion of the concerns will be a significant part of the facilitated discussions.

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### **EMS in my town is in a different region from the Fire Department. This disconnect is an issue.**

As described above, HMCC regions were decided upon with a focus on the five core disciplines. These disconnects that occur should be identified in regional stakeholder facilitated meetings and be incorporated into HMCC multi-disciplinary emergency planning.

## **HMCC Operations: Multi-disciplinary Coordination, Roles, Responsibilities**

### **What are expectations of the five core disciplines and do we incorporate as one entity?**

Once contracts have been awarded in early 2015, each regional HMCC coordinating agency and the five core disciplines will develop a governance structure and multi-agency coordination plan that will determine how the HMCC partners coordinate during all stages of the disaster management cycle. HMCC emergency planning efforts will consider what capabilities are being conducted by which discipline and seek opportunities for the disciplines to complement one another's capabilities, expertise, and resources to develop an enhanced ability for all disciplines to meet health and medical needs in an emergency.

At a minimum, each core discipline organization and local jurisdiction in the HMCC will:

- Continue to develop and maintain organization and jurisdictional plans
- Coordinate plans with the HMCC
- Represent their organization or jurisdiction to the HMCC
- Represent the HMCC to their organization or jurisdiction
- Participate in HMCC planning, exercises, and evaluation

### **How will coordination with hospitals occur if a hospital covers communities in another HMCC region?**

We hope that the decision to follow the current MDPH hospital region boundaries will minimize the likelihood this occurring, but recognize that it may occur in some areas. This issue should be identified and discussed in the HMCC regional stakeholder facilitated meetings as well as planning meetings that will occur once HMCC are established.

### **Four of the five core disciplines already interface, and by necessity, work with each other. Public health is the odd "man" out. How will this be addressed?**

In some regions, all five of the core disciplines do currently interface, although they may not be fully integrated across all phases of the disaster management cycle. The regional stakeholder facilitated meetings are designed to ensure each of the disciplines, including public health, is included in the discussions. Each of the disciplines brings specific expertise to the table that will be critical to creating an effective ESF8 capacity. Once HMCC are established, the disciplines will work together through a common governance structure and participate in multi-disciplinary planning, training, and exercising to identify complementary roles and resources that contribute to enhanced response.

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**Hospitals (acute/chronic) tend to individual care needs and have profit/cost considerations. This is not a public health orientation/perspective.**

*Similar questions:*

*- Hospitals have a bottom line (profit) which is different. Clarify – with and without HMCC. Use a better model.*

*- We are concerned about competition for funding. Our focus is on public health and hospitals' concern is for the bottom line. This conflicts with our work, and will be a problem for these collaborations.*

Each of the core disciplines, including public health, has its own mission and financial constraints, but all have essential roles and responsibilities under ESF8. HMCC will bring together related but distinct ESF8 disciplines and entities including public, private, for-profit, and not-for-profit. The HMCC will work to enhance overall capacity, to promote resilient communities, and to respond to public health emergencies coordinating the complementary roles and resources of the partners.

**Hospitals do not currently integrate well with local towns and local public health i.e., they don't play or provide resources. How will HMCC's improve this situation?**

Involvement of the core disciplines varies across the regions. By bringing all of the core disciplines together within the HMCC, we will identify existing resources and gaps, and encourage and facilitate multi-disciplinary health and medical planning to address them.

**How can we preserve the excellent relationships between South Shore Hospitals (Region 4) & the northern communities of Plymouth Coalition (Region 5)?**

We encourage stakeholders in Region 4 and Region 5 to discuss this issue during the regional stakeholder facilitated meetings. Our goal is to establish HMCC that complement existing working relationships.

**How can community health centers participate in states of emergency when it is very difficult to operate during normal circumstances?**

In general, the role of each of the five core disciplines may vary from situation to situation depending on the type of emergency and the impact to the discipline or organization and its available resources which may include personnel, supplies, space, or situational information among others. Community health centers played a key role during the H1N1 pandemic by providing vaccination for their patients, for example, and might have translation or other resources that could support a regional response in the future.

**Can you give an example of an event in which hospitals, EMS, community health centers, or long term care would contact public health for support? (How will the HMCC be a two-way street?)**

Each of the five core disciplines brings certain expertise and resources to a coordinated response. Common areas of expertise for local public health agencies are environmental health, disease surveillance and investigation, and conducting health activities at the community level. So for example, in a Hepatitis A outbreak, public health could take the lead in coordinating public information and dispensing of the Hepatitis A immune globulin if indicated. This could alleviate a

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potential surge of “walking well” patients reporting to emergency departments or community health centers.

### **What resources (e.g., staff to help) will the HMCC bring to local public health in a pandemic or bioterrorism event, in a flooding scenario, or in the event of widespread environmental contamination?**

We expect HMCC to conduct capability-based, rather than scenario-based, planning. Links to the HPP and PHEP Capabilities can be found in previous sections of this document. In general, HMCC staff will be able to coordinate resources and information at a regional, multi-disciplinary level – a capacity we don't currently have in all areas of the Commonwealth. Specific resources and activities will be identified at the HMCC level; however, potential resources could include regional situation reports, regionally coordinated public messaging and information gathering, and regionally coordinated resource tracking or scheduling.

### **These HMCC are focused on hospitals and EMS - what is the local public health role? How will these HMCC benefit local public health? We need hospitals to give us personnel to run emergency dispensing sites because we cannot rely on a volunteer model to deliver medications.**

The HMCC are not focused on hospitals and EMS, but rely on participation of all five core disciplines to support regional disaster management. The facilitated discussions will provide an opportunity for stakeholders to discuss how the disciplines can best support one another in terms of planning for and responding to various emergencies affecting the region, from pandemics to severe weather to terrorism. HMCC staff will be fully versed in the capabilities and resources in the region and will be able to support and communicate local needs, and connect needs with resources. We believe that a regionally grounded HMCC will serve local communities and organizations better than the current practice of funneling local information from all disciplines directly up to the state.

### **Clarification regarding responsibility for sheltering/minimum standards: What is a region's responsibility? What is an individual community's responsibility?**

Specific responsibilities for sheltering are determined at the local level. There is state and federal guidance concerning shelter requirements. We recommend you review the Massachusetts Statewide Mass Care and Shelter Coordination Plan and Local Toolkit (available at: <http://www.mass.gov/eopss/agencies/mema/massachusetts-mass-care-shelter-coordination-plan.html>) and PHEP Capability 7: Mass Care (available at: <http://www.cdc.gov/phpr/capabilities/capability7.pdf>). PHEP Capability 7: Mass Care identifies four functions for health and medical partners. These include 1) determine public health role in mass care operations, 2) determine mass care needs of the population, 3) coordinate public health, medical, and mental/behavioral health services, and 4) monitor mass care population health.

### **Why is it assumed that Boards of Health or Health Departments are responsible for shelters and MRC volunteers?**

We are not operating under an assumption the local public health is responsible for shelters. Local public health is often involved with shelter operations and the activities of MRC volunteers, but responsibility is established at the local level and described in the local plan. We strongly encourage local public health agencies to work with local emergency management and local

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officials to determine the public health role in mass care operations within their jurisdiction, as provided in PHEP Capability 7: Mass Care.

### **Will the communication structure be two fold (i.e., vertically with the SEOC ESF8 and horizontally across regions)?**

At present, we are certain that HMCC will communicate within their region and with ESF8 at the state level. We welcome suggestions for establishing formal communication protocols across regions and encourage the input of stakeholders as we discuss the development of HMCC.

### **I fear that this is the creation of another layer of bureaucracy. Who is this duty officer who will be controlling access to resources? On this planning committee - who is their local representative?**

The HMCC are intended to support broader and more timely information sharing and more efficient coordination of resource needs by relying on staffing dedicated to the region. The HMCC and its staff will serve a multi-agency coordination role, not a command and control role. Therefore, the duty officer\* will act in accordance with the governance structure and emergency plans and procedures that have been developed by the HMCC stakeholders. The size, structure, and composition of governing committees have not been determined, and there are likely to be differences in the specific governance structures of the six HMCC that reflect regional needs. MDPH is committed to ensuring that each of the five core disciplines has a seat and a voice at the table.

\*Additional information about the duty officer function is provided in the HMCC Administration section of this document.

## **HMCC Integration with Emergency Management and Existing Entities**

### **How is this different from the State EOC?**

The State EOC is a state-level operations center that has the ability to activate all emergency support functions depending on the needs of the incident. It also functions as the state multi-agency coordinating center. In contrast, HMCC will fill a regional, ESF8 health and medical role only. ESF8 focuses on identifying and meeting the public health and medical needs arising from major disasters or public health and medical emergencies.

### **Disconnect – we are doing emergency response planning for emergencies we are not in charge of. We may or may not have responsive EMDs.**

The HMCC and the partners will be tasked with planning for the ESF8 (health and medical) response to major disasters or public health and medical emergencies. It will be important that HMCC develop relationships with and mechanisms to link to emergency management and public safety so that ESF8 can be integrated into the overall response.

### **What is the specific mechanism/structure of coordinating with emergency management?**

The emergency support functions provide a structure to guide coordination. Specific coordination mechanisms will be determined through HMCC multi-disciplinary planning.

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### **Why is this HMCC process developing separately from the traditional emergency management infrastructure (i.e., from Local emergency managers to MEMA to FEMA)?**

Identifying and developing a strong ESF8 coordinating agency complements the existing emergency management structure and is not inconsistent with or separate from state and federal practice. At the federal level, the US Department of Health and Human Services is the ESF8 Coordinator working with FEMA. At the state level, MDPH is one of the ESF8 Responsible Agencies working with MEMA. HMCC represent a regional ESF8 function that supports and enhances local health and medical entities working with their emergency management agencies/departments.

### **Emergency managers (part time, non-existent) they are an integral part.**

It will be important to connect the ESF8 work of the HMCC with local and organizational emergency managers. At this stage of the process, however, we are focusing on health and medical disciplines to develop coordinated regional ESF8 activities.

### **How is this being coordinated with REPC's, NERAC and others so we're not establishing another layer who doesn't coordinate with others?**

MDPH OPEM has met with multiple emergency preparedness and response entities to provide information about plans to establish HMCC in Massachusetts. We are scheduled to meet with REPC representatives in Hopkinton in January, and are working to schedule a meeting with the EMS Committee of the Fire Chiefs Association. We welcome suggestions for additional outreach opportunities. There is significant variation in the different local and regional emergency planning and response entities across the state; therefore, we expect the discussions about coordination to occur at the regional level with health and medical stakeholders, MDPH, and the REPCs, NERAC, or similar entities so that the regional HMCC complements and coordinates with the specific resources in each region.

### **How do the MMRS groups fit in?**

Although not identified as a core discipline, MMRS groups have various capabilities and resources that could be integrated into HMCC activities and enhance overall response. MMRS may be included as an additional HMCC partner if present in the region.

### **Region 5 has multiple infrastructure & geographical issues that need to be taken into consideration during an MCI or other catastrophic events.**

*#1 Infrastructure: No Certified Trauma Centers.*

*#2 Geographical: Cape Cod & the Islands supply lines being cut off (e.g., bridge closures, ferry shutdowns etc.).*

*HMCC needs to meet with Barnstable County Emergency Planning Committee (Sean O'Brien is the Coordinator). Most players already sit at the table - committee formed out of necessity (police, fire, EMS, health agents, hospitals etc.). Region 5 has multiple CMEDs (Barnstable, Plymouth, Bristol). Some hospitals (e.g., Toby) deal with multiple CMEDs. Ambulances travel through Region 5 heading to trauma centers outside region and deal with multiple CMEDs.*

We encourage stakeholders in Region 5 to discuss this issue during the regional stakeholder facilitated meetings in 2013-2014 and during the emergency planning discussions that will take place once the HMCC is established in 2015.



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**How would an HMCC coordinate with multiple CMEDs, WebEOC, town-based dispatch, etc. for communication of capacity and demand of healthcare supplies and staff? Medical control – where some places have multiple medical control in catchment area.**

This will vary according to the unique circumstances in each HMCC region. Specific coordination mechanisms will be determined through HMCC multi-disciplinary planning.

**The HMCC core disciplines include EMS, and EMS is through the fire department in my community. Has MDPH [OPEM] met with fire departments yet? Won't it be a problem with their different regions?**

MDPH OPEM has been in contact with the Fire Chiefs' Association but has not yet been able to schedule a meeting with their EMS Committee. We have also had initial conversations with Regional EMS councils and OEMS. EMS regions are almost identical to MDPH Hospital Regions, with limited exceptions. HMCC planning within each region will have to reflect multiple regional structures.

**I expected to hear that all facets of emergency response would be represented and involved in “new regions” (fire, police, MEMA, sheriff, etc.) – a truly unified response.**

Initially MDPH is engaging those five health and medical disciplines that have received federal funding from OPEM for preparedness planning. These disciplines will develop a regional ESF8 capacity that integrates with corresponding emergency management, public safety, and their corresponding ESF. Greater involvement of these disciplines and other facets of emergency response will likely evolve once HMCC are established and emergency planning activities begin.

**MEMA, ESF8, HHAN, MA Responds, Red Cross, and (if a declared Disaster) Military/National Guard: How will these integrate?**

HMCC will integrate into the response as a regional ESF8 function. Please see the following link for a description of emergency support functions:

<http://www.phe.gov/preparedness/support/esf8/pages/default.aspx>. The HHAN, WebEOC, and MA Responds are tools that support the communication and coordination activities of various response entities including those mentioned above.

**Another communication system in an emergency in addition to local communication (e.g., EMS)?**

There are some coordination/communication systems that exist for specific, single disciplines (MassMAP for long-term care, CMED for EMS, KCER for dialysis, etc.). This may feel redundant; however, it is our intention that HMCC complement the structures and resources that exist in a given region. We believe one benefit of the regional HMCC is that it will be able to provide shared situational awareness across several health and medical disciplines in a given region.

**Can WebEOC be expanded to be the central repository for situational status and resource requests/needs for public health, long-term care, emergency management agencies, etc. for HMCC coordination?**

The MDPH WebEOC system will be used by the HMCC and their partners for situational awareness, resource requests, and other communication needs. At present, hospitals and local

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public health have been trained and provided access to WebEOC. MDPH OPEM expects to train and provide access to the remaining core disciplines in the coming budget periods.

### **HMCC Administration: Coalition Models, Staffing, Funding, Legal**

#### **What is “best practice” now (i.e., Region 2 or nationally)?**

There is no “one-size-fits-all” or “best practice” model that works nationally or even in Massachusetts. This is especially true in home-rule Massachusetts which lacks functioning county governments in most places. We have an opportunity to create a structure to meet the particular circumstances in each region and satisfy federal guidance. Models of healthcare coalitions in Massachusetts and nationally have been studied and will be shared as part of the regional stakeholder planning process.

#### **Will local health coalitions exist as is going forward?**

We encourage you to raise that question in the facilitated regional discussions as part of the process of prioritizing activities currently funded (please see Question D in the funding section, below). There was no change to the structure of local public health coalitions in BP2 (7/1/13 – 6/30/14) and no planned change for BP3 (7/1/14 – 6/30/15) although some deliverables related to HMCC development may be included in the BP3 contracts. At the start of BP4 (7/1/15 – 6/30/16), MDPH plans to engage in contracts with six regional, multi-disciplinary HMCC instead of the existing single-discipline coalitions. However, this does not mean that single disciplinary or sub-regional workgroups cannot exist under the HMCC umbrella if HMCC partners determine this is the most effective way to accomplish the work and provide value to partners.

#### **Will we still have regional coordinators and monthly meetings?**

Please refer to the question below concerning regional coordinators. Regarding monthly meetings – we don’t know. As HMCC models, governance structures, and planning priorities are established, the HMCC will identify what meeting structure makes sense to accomplish the work required by the HMCC contract and partners.

#### **What role, if any, will Regional DPH Coordinators play in the HMCC?**

This has not been definitively determined, and we encourage discussion in the facilitated meetings about how OPEM staff can work most effectively with staff in the HMCC. In parallel with the regional stakeholder discussions, MDPH OPEM must also consider how our staff, in regional offices and at headquarters, can most effectively support multi-disciplinary HMCC.

#### **What agencies have 24/7 capacity other than hospitals who could respond to the RFR? *(It seems to eliminate everyone except hospitals)***

HMCC will be expected to establish a regional 24/7 on-call or duty officer function similar to the 24/7 duty officer function the MDPH OPEM maintains. This does not mean that an office or operations center will be staffed 24/7 but that someone is on-call 24/7 should an incident occur outside of normal work hours and someone from the HMCC needs to be reached. It is likely that on-call responsibility would rotate between different staff. There are a variety of agencies that could have the capacity to develop this function, with HMCC funding, including but not limited to a hospital, public health department, EMS council, or MMRS. Please note that this is not an

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exhaustive list, and we encourage discussion of these and other options, such as regional DPH offices, during the regional stakeholder facilitated meetings.

### **Why can't this work be done out of the new local regional offices?**

Situating HMCC within the MDPH Regional Offices has not been ruled out and can be discussed during the regional stakeholder facilitated meetings.

### **Consider local health office staff for 24/7 position. Western Mass Charlie Kaniecki, Soloe Dennis, Barbara Coughlin, Pam Smith, Don and Gail and others.**

We will be discussing how OPEM staff will work and coordinate with the HMCC staff in all of the regions, but we do not believe OPEM will provide the 24/7 capacity needed in an HMCC. We are not considering staff from other bureaus and offices to provide staffing to HMCC.

### **What will be the mechanism to continue to fund the Coalitions once the cooperative agreements end with ASPR/CDC?**

The current cooperative agreement with ASPR/CDC ends on June 30, 2017, and it is not known whether federal funding will continue after that point and if so, at what level. We will work with HMCC to identify sustainability plans and will share models that have been developed in other parts of the country.

### **Original PHEP funds required a certain percentage be spent on local health and have local health approval; has that changed?**

According to the CDC, the PHEP Cooperative Agreement has never prescribed a specific percentage of funds to be spent on local health. Earlier Funding Opportunity Announcements (FOA) provided that a "majority" of PHEP funds should be used to support local health preparedness, but the Joint HPP-PHEP FOA issued in 2012 for the current 5-year Cooperative Agreement does not include language indicating that a specific proportion of PHEP funds must be used to support local health preparedness activities.

The PHEP concurrence requirement is still in place. According to the BP2 FOA, the state must consult with local health departments and federally recognized American Indian/Alaska Native Tribes "to reach consensus, approval, or concurrence with overall strategies, approaches, and priorities described in their work plans." We anticipate following the process that has been in place for the past several years.

### **What does ASPR funding look like to hospitals after 6/30/14?**

We have been advised to anticipate a significant cut in HPP funding for BP3, but it is too early to have any details about funding levels. We have not determined how HPP funding will be distributed for BP3. Please see the question above for BP4 and beyond.

### **What happens to MRC funding as the HMCC are developed?**

We have not considered changes in MRC funding and welcome stakeholder suggestions during the facilitated discussions. DPH OPEM currently provides funding for local MRCs through state matching funds. State matching funds may be affected, however, if there is a significant decrease in federal funding in BP3.

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**Local funding: 1) The “things” that we have purchased (like laptops) have short lifespans; we will need funding to update/replace. 2) Some of this money is currently used for infrastructure like hours for public health nurses. How do we continue?**

At the January regional stakeholder facilitated meetings, representatives will be asked to discuss the activities that are currently funded (for each discipline) that will be priorities for continuation under HMCC funding. If the items above are priorities, we encourage you to identify them at the January meeting.

**Current funding streams for the regions are NOT just for supplies or planners. We also use them for training (staff, volunteers) which is a perpetual expense.**

A portion of funding that will go to HMCC will be used to support multi-disciplinary training and exercises, and MDPH will continue to prioritize support for training through LPHI, CEEPET, and DelValle Institute.

**Clarify - HMCC money versus PHEP money: same or different? And, money for planning and money for operation—is it where the regional operations center is?**

HMCC will be funded primarily with federal emergency preparedness dollars, but state match dollars may also be used to supplement funding. This funding will be used to support HMCC activities across all phases of the disaster management cycle. One of the goals of the facilitated regional discussions is to identify current use of emergency preparedness dollars, and prioritize funding for activities needed to maintain the progress that has been made in local public health and healthcare system preparedness. HMCC will be encouraged to identify additional sources of funding to support activities that further the HMCC’ objectives in the region.

Regarding the question about regional operations centers - HMCC will be responsible for providing multi-agency coordination, situational awareness, and communications between regional partners and state-level ESF8 during emergencies. The HMCC will determine where these activities will be conducted.

**Will the RFR include both response duties and financial management of funding?**

Yes.

**Is there a thought of any legislative activities either for continued funding or codifying the operations?**

Legislation is not under consideration, but please let us know if you have specific suggestions.

**What about the legal authority - without it coordination is a gentlepersons agreement?**

It’s important to note that HMCC will conduct multi-agency coordination and information sharing, and are not command and control entities. Governance and legal issues will be discussed during the regional stakeholder facilitated meetings. We have contracted with Boston University School of Public Health to provide technical assistance regarding these issues.

**What are the liability issues?**

This is a broad question. We encourage you to discuss specific issues with your colleagues and ensure they are identified in the regional stakeholder facilitated meetings. Further, MDPH OPEM

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has contracted with Boston University School of Public Health to provide technical assistance regarding governance and legal issues related to the HMCC.

### **Regional Stakeholder Planning Process**

#### **For consistency of information sharing and knowledge base shouldn't the alternate be allowed to attend the meetings?**

MDPH OPEM has heard concerns from local public health that they may not be able to provide sufficient information at the facilitated discussions with one representative from each Public Health Coalition. So that this issue doesn't become an obstacle to information gathering, we are inviting the designated primary and alternate representative from each of the five core ESF8 disciplines to attend their regional discussions. This will likely result in an unequal number of representatives from each discipline at the facilitated discussions. Since these meetings will focus on information gathering, and will not involve voting, we will ensure that the perspective of each discipline is heard.

#### **What has the response been with presentations to various entities since you began in September 2013?**

Many believe that establishing HMCC is a move in the right direction and the general response has been positive. However, we recognize that each of the core disciplines has concerns about how this work will be accomplished. While OPEM has conducted much research and planning for this transition, some questions cannot be answered fully at this time (e.g., future federal funding levels), or will be affected by the existing resources, gaps, and infrastructure within a particular region. Over the course of the facilitated discussions, we will continue to answer as many questions as possible, and to clearly identify those questions that remain to be answered. Throughout this process, OPEM will continue to work with stakeholders to identify strategies to support public health and healthcare system preparedness in Massachusetts, and to communicate information about the ongoing stakeholder discussions.

#### **In order for this to work, not only do all disciplines need to be included but also require equitable representation. How will this be ensured?**

In terms of the facilitated discussions, the facilitated meetings will focus on information gathering, and will not involve voting; the meeting facilitator will ensure that the perspective of each discipline is heard. The discussions will be an opportunity for these health and medical disciplines to share information about resources and gaps, and strengthen regional connections. What we learn about each region through this process will inform development of an RFR that will support regional coordination of information and resource sharing while being flexible enough to allow for variation in HMCC models across regions. The RFR, when it is drafted during the summer of 2014, will require that applicants demonstrate a clear connection with the core disciplines and describe what policies and procedures will be in place to ensure representation of and participation by each of the core disciplines.