Health and Medical Coordinating Coalitions

Resource Book

June 26, 2014

Issued by:

OFFICE OF PREPAREDNESS AND EMERGENCY MANAGEMENT

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Boston University School of Public Health

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June 26, 2014

Dear Colleagues,

Over the past year, the Office of Preparedness and Emergency Management (OPEM) at the Massachusetts Department of Public Health has been meeting with stakeholders to gather information for the development of six regional Health and Medical Coordinating Coalitions (HMCC), using the boundaries of our existing hospital preparedness regions. These HMCC will coordinate regional health and medical planning, response, recovery and mitigation activities and support a more integrated model of emergency preparedness and response across the Commonwealth. They will enhance regional health and medical capacity to respond to emergencies and disasters, and meet our federal funding guidance.

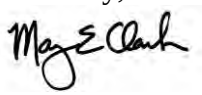
OPEM began the stakeholder engagement process with an introductory webinar in September 2013, sharing information about the changing federal funding priorities and the role and potential benefits of HMCC. In December, OPEM held a statewide kick-off meeting of representatives from the five core HMCC disciplines: community health centers, emergency medical services (EMS), hospitals, local public health, and long-term care facilities to begin the facilitated meeting process. Between January and June, 2014, we held three facilitated meetings in each of four regions (1, 3, 4AB, and 5) to support relationship building and information sharing among the representatives chosen by each discipline. In these meetings, the regional meeting participants explored five key questions about existing regional assets, potential HMCC partners, possible operating and governance models, and desirable attributes and capacities for a regional HMCC coordinating agency. On a parallel course, regions 2 and 4C continued to build on their existing multi-disciplinary efforts. On June 26, a second statewide meeting brought together the discipline representatives from the regional meetings to share themes from the regional meetings and plans next steps.

This resource book is provides a compendium of the materials developed through the process described above. The annotated table of contents, which follows, offers a description of each document contained within the resource book. My hope is that these materials, which are also available online at http://www.bu.edu/sph-coalitions, will be useful as we move into the next phase of HMCC development.

In June, 2014, OPEM will post and publicize a Request for Information (RFI) to gather additional information and input regarding HMCC. The information collected through the RFI will inform to drafting of a Request for Responses (RFR) to be released in late October 2014. The RFR will provide initial funding starting in April 2015 for initial operations for six HMCC. In July, OPEM will sponsor a webinar to share information about HMCCs and the process to date with interested stakeholders statewide. In September, a conference will offer an opportunity for interested parties to hear from others within Massachusetts and elsewhere in the country about existing HMCC-like efforts. These steps are intended to ensure broad dissemination of information about HMCC and the process in Massachusetts, as well as provide opportunities for stakeholder input to inform the drafting of RFR that will allow each region to establish a successful HMCC that can be operational by June 2017. We will provide more information on these steps at http://www.bu.edu/sph-coalitions and share information broadly through our normal listservs.

Thank you for your interest in HMCCs and your work to make the Commonwealth a safe and healthy environment for all residents.

Sincerely,



Mary E. Clark, JD, MPH
Director, Preparedness & Emergency Management
Massachusetts Department of Public Health

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1. Who are partners (other than 5 core disciplines) who should be involved/engaged in the regional HMCC?

2. What are resources/capacities in the region that can be adapted &/or inform regional HMCC planning?

3. What are the desirable attributes & capacities for the HMCC regional coordinating agency?

4. What are possible operating/program models for meeting required functions of a regional HMCC?

5. What are the pros/cons of possible governance models?

Case for Change:

Forming Health and Medical Coordinating Coalitions in Massachusetts

August 2013

Issued by:

EMERGENCY PREPAREDNESS BUREAU

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Boston University School of Public Health

Case for Change: Forming Health and Medical Coordinating Coalitions in Massachusetts

August 2013

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Executive Summary

In 2012 the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) began to more closely align the requirements of the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness program (PHEP) cooperative agreements. HPP and PHEP now require a more integrated approach to emergency preparedness and response that builds capacity across all phases of the disaster cycle: preparedness, response, recovery, and mitigation.

In Massachusetts, six regional Health and Medical Coordinating Coalitions (HMCC) will be established, one in each hospital preparedness region, to carry out the functions of healthcare coalitions as described in the federal capabilities. These multi-disciplinary HMCC will simultaneously respond to changing national priorities and fill a critical gap in the current system in Massachusetts that exists because of a general lack of functioning county government or other regional infrastructure. During an emergency, the HMCC will serve a multi-agency coordination function for agencies within a region, providing for more efficient coordination of health and medical activities under Emergency Support Function 8 (ESF-8).

An HMCC is a formal collaboration among public and private public health and healthcare organizations that is organized to prepare for and respond to an emergency, mass casualty, or other catastrophic health event. During a response, the HMCC staff can provide multi-agency coordination, advice on decisions made by incident management, information sharing, and resource coordination. An HMCC can coordinate preparedness and response in ways that individual agencies cannot.

At a minimum, the core disciplines in each HMCC will include: acute care facilities; community health centers and other large ambulatory care organizations; emergency medical service providers (public and private); long-term care facilities; and public health agencies. Other health care disciplines (e.g., home health providers, dialysis centers, mental health agencies) and public safety partners (e.g., police, fire, emergency management) will be incorporated, as appropriate, in each region.

The Emergency Preparedness Bureau (EPB) recognizes the operational and funding concerns of the agencies and organizations that will be affected by this change and has created a multi-year, phased approach to implementation. A webinar to be held on September 11, 2013 will provide background and the opportunity for questions and answers. The webinar will be archived for viewing at a later date. EPB is also interviewing key informants and meeting with discipline groups as the Commonwealth prepares for the transition. A website has been developed by Boston University School of Public Health (BUSPH), which will be updated throughout the planning and implementation process to provide easy access to information and model documents relevant to HMCC.

Introduction

The 2006 Pandemic and All-Hazards Preparedness Act (PAHPA) directed the Secretary of the U.S. Department of Health and Human Services (HHS) to develop a National Health Security Strategy[1] (NHSS) which was presented to Congress in December 2009. The purpose of the NHSS is to refocus the patchwork of disparate public health and medical preparedness, response, and recovery strategies in order to ensure that the nation is prepared for, protected from, and resilient in the face of health threats or incidents with potentially negative health consequences. The goals of the NHSS are to (1) build community resilience, and (2) strengthen and sustain health and emergency response systems. The NHSS, and the NHSS Implementation Plan[2] issued in May 2012, provides the national framework and direction for public health and health care preparedness activities.

In 2012 the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) began to more closely align the requirements of the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness program (PHEP) cooperative agreements. HPP and PHEP now require a more integrated approach to emergency preparedness and response that builds capacity across all phases of the disaster cycle: preparedness, response, recovery, and mitigation. Specific health care system[3] and public health[4] capabilities, with accompanying program and performance measures, have been developed to guide planners in identifying gaps in preparedness, determining and evaluating specific priorities, and developing plans to build and sustain regional health care and public health systems that are prepared to respond successfully to emergencies and recover quickly from all hazards. HPP and PHEP grant guidance have identified the development and support of sub-state healthcare coalitions as the cornerstone of a system that will provide better treatment for disaster survivors and improved public health for our communities that will lead to better health outcomes on a day-to-day basis.[5]

Regional Health and Medical Coordinating Coalitions (HMCC) will be developed in Massachusetts to carry out the functions of healthcare coalitions as described in the federal capabilities. These multi-disciplinary HMCC will simultaneously respond to changing national priorities and fill a critical gap in the current system in Massachusetts that exists because of a lack of functioning county government or other regional infrastructure. By enhancing regional capacity to plan for, respond to, recover from,

[1] http://www.phe.gov/Preparedness/planning/authority/nhss/Pages/default.aspx
[2] http://www.phe.gov/Preparedness/planning/authority/nhss/ip/Pages/default.aspx
[3] http://www.phe.gov/Preparedness/planning/hpp/Pages/default.aspx
[4] http://www.cdc.gov/phpr/capabilities/
[5] http://www.hhs.gov/news/press/2012pres/07/20120702a.html

and mitigate the impact of a wide range of public health threats through establishment of formal collaborations among healthcare, public health, health system entities, and other response partners, Massachusetts will make significant strides toward ensuring resilient communities and a resilient health care system. During an emergency, the HMCC will serve a multi-agency coordination function for agencies within a region, providing for more efficient coordination of health and medical activities under Emergency Support Function 8 (ESF-8).

In Budget Periods 1 and 2 (July 1, 2012 through June 30, 2014) the Emergency Preparedness Bureau is working with Boston University School of Public Health (BUSPH) to conduct a series of stakeholder meetings and facilitated discussions across the Commonwealth to gather input that will inform the development and implementation of six regional HMCC. Further information about the work in each budget period can be found in Section 3. EPB will provide guidance and technical assistance throughout the process and will assess the connection between ESF-8, the six HMCC, and existing public health and hospital coalitions and staff.

Key Points

EPB will:

- Engage in a series of facilitated meetings and discussions with stakeholders
- Use a phased, multi-year approach to plan for and implement six regional HMCC
- Provide technical assistance to support development of HMCC

HMCC Description

A Health and Medical Coordinating Coalition will be a formal collaboration among public and private healthcare organizations and public health that is organized to prepare for and respond to an emergency, mass casualty, or other catastrophic health event. Dedicated staffing for the HMCC, working with MDPH staff, will support mitigation, preparedness, response, and recovery activities related to disaster operations. Activities will include planning, organizing, equipping, and training HMCC organizations to respond to a disaster, and providing 24/7/365 on-call support for the members. During a response, the HMCC will provide multi-agency coordination, advice on decisions made by incident management, information sharing, and resource coordination. An HMCC can coordinate preparedness and response in ways that individual agencies cannot.

1) **How can a Health and Medical Coordinating Coalition help my community?** *By Region 2 Staff*

Several years ago, the health and medical planning committees in Region 2 (Worcester area) identified the need for central coordination of resources during large scale events that have the potential to significantly impact the public health and medical community. To meet this need, the Region established a Regional Medical Coordination Center (RMCC) that provides the functions of a health and medical coordinating coalition. The primary goal of the RMCC is to coordinate resources and assets for patient care (placement, tracking, and transportation) and to enhance communication within and across disciplines in the region. The RMCC is available to any health or medical facility experiencing an event that they believe requires external support. There are currently 40 trained RMCC responders from seven diverse health and medical disciplines in Region 2 that can be called upon for assistance if need be.

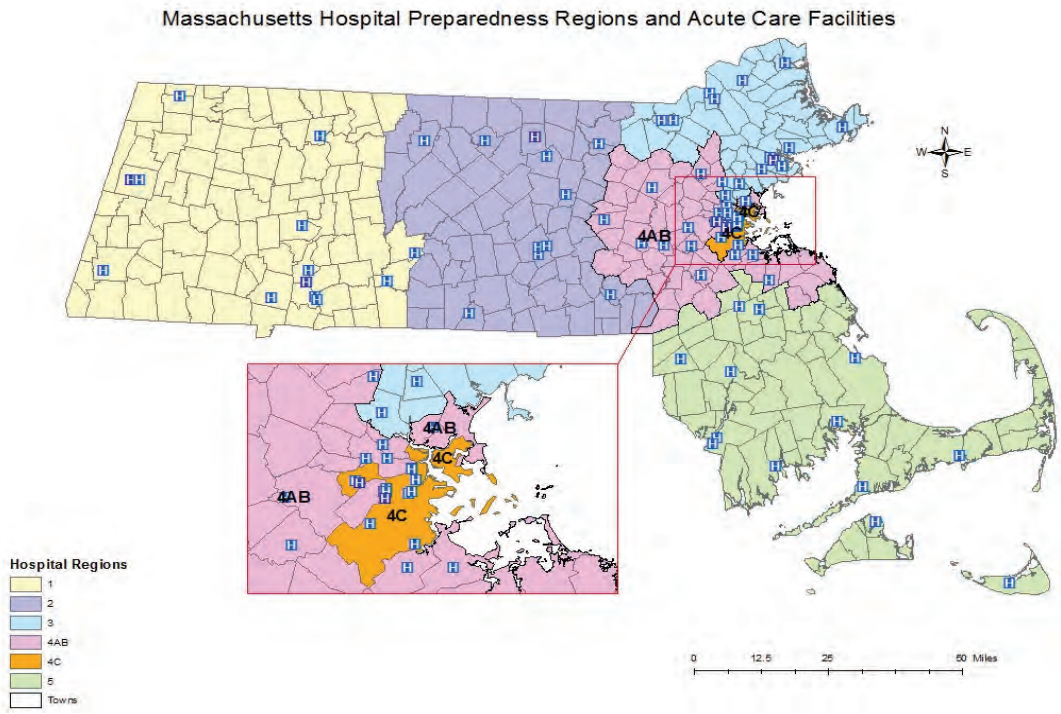
In May 2013, the RMCC was an available asset for the impending University of Massachusetts Medical Center University Campus (UMass) nurses strike. UMass management was working with both local and state partners to prepare for the strike and to develop a plan to significantly decrease patient census should the strike occur. The RMCC was able to assure UMass that they could activate and assist with patient transport and placement as well as communications.

In preparation for the potential event, a situational awareness alert was sent to RMCC responders. If activation had been requested, an additional alert would have been sent requesting responders report to the RMCC. The healthcare mutual aid plan (HMAP) and the long term care plan (Mass MAP) would have been utilized by RMCC responders, in collaboration with UMass, to identify and place patients throughout the area.

Ultimately, the strike was averted and the RMCC was not activated. Had a strike occurred, the RMCC resources of the functioning health and medical coalition would have been available to support efforts to avoid negative impacts on patient care. Regional capacity to coordinate response support activities has added great value to the public health and medical organizations in Region 2.

Regional Structure

EPB considered current practices and studied many of the existing regional structures in determining that six regional HMCC will be established, one in each hospital preparedness region, to carry out the functions of healthcare coalitions as described in the federal capabilities.



At a minimum, the disciplines in each HMCC will include:

- Acute care facilities such as hospitals
- Community health centers and other large ambulatory care organizations
- Emergency medical service providers (public and private)
- Long-term care facilities
- Public health agencies

Other health care disciplines (e.g., home health providers, dialysis centers, mental health agencies) and public safety partners (e.g., police, fire, emergency management) will be incorporated, as appropriate, in each region's HMCC.

2) Roles and Responsibilities of the HMCC

An HMCC is a regional coalition with dedicated staffing support that is organized for the purpose of preparing for and responding to an emergency, mass casualty, or other catastrophic event affecting the health of Massachusetts residents; HMCC will have a role in every phase of the disaster cycle. The HMCC will meet state and federal requirements for multidisciplinary healthcare coalitions and will build connections with local and state ESF-8 agencies as well as with emergency management agencies and with public safety/first responder entities.

HMCC Planning and Response Functions

- Conduct regional planning and develop regional plans that address all phases of the disaster cycle
- Participate in cooperative training and exercising of regional plans
- Develop and maintain an emergency response structure with required response roles filled by paid personnel. This will be complemented with voluntary response elements such as public health mutual aid, Medical Reserve Corps volunteers, etc
- Coordinate a cohesive regional response with a single, 24/7 point of contact for communication in the region and with MDPH
- Aggregate pertinent information to maintain and communicate situational awareness
- Coordinate requests for assets and resources
- Assist with recovery and mitigation efforts

3) Transition Plan

EPB recognizes the operational and funding concerns of the agencies and organizations that will be affected by this change and will undertake a multi-year, phased approach to implementation. During BP2, EPB, with support from BUSPH, will connect with our stakeholders and conduct a series of facilitated, multi-discipline discussions about the establishment of regional Health and Medical Coordinating Coalitions.

Outreach

EPB will host a webinar to be held on September 11, 2013. The webinar will be open to all core discipline organizations across the state, and will provide background information as well as an opportunity for questions and answers. The webinar will be archived for viewing at a later date.

Initially, EPB will interview key informants and attend single-discipline coalition meetings to provide information about HMCC and the need for changes. EPB will also meet with professional organizations representing public health and healthcare disciplines and facilities, including but not limited to: Mass Senior Care; Massachusetts League of Community Health Centers; Massachusetts Hospital Association; Massachusetts Medical Society; Home Care Alliance of Massachusetts; Coalition for Local Public Health (includes MPHA, MA Health Officers Association, MA Environmental Health Association, MA Association of Public Health Nurses, and MA Association of Health Boards); Massachusetts EMS Councils; American Red Cross; and Massachusetts Ambulance Association.

EPB will also work with representatives from other MPDH bureaus (e.g., Health Care Quality and Safety, Bureau of Environmental Health, Bureau of Infectious Disease, Bureau of Community Health and Prevention) as well as other state agencies (e.g., MEMA, Department of Mental Health, Office of the Chief Medical Examiner, Department of Fire Services) with whom we partner on planning, response, recovery, and mitigation activities. Additional agencies will be added as identified.

A website has been developed by BUSPH to provide easy access to model documents and information relevant to HMCCs and will be updated throughout the planning and implementation process. (http://www.bu.edu/sph-coalitions)

Facilitation

Immediately following the EPB outreach work in Fall 2013, BUSPH will initiate a series of facilitated multi-disciplinary meetings in each region. The purpose of the facilitated meetings is to prepare each region for successful HMCC planning and creation. In support of these efforts, EPB will provide clear expectations for what must be determined prior to application for funding, and provide access to technical assistance about governance, communications and member recruitment. In meetings with volunteer representatives from all disciplines in all regions facilitators will:

1. Ensure that participants are clear about the roles and responsibilities of an HMCC and the timeline for establishing the HMCC
2. Assist groups in the establishment of timelines and processes for on-going planning
3. Lead discussions to identify regional public health and health care practices and tools that will support regional planning
4. Describe the requirements for what must be accomplished to establish HMCC.

Ongoing Questions

There are significant unanswered questions that will be addressed over the course of the facilitated discussions. While EPB 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 may depend upon the resources and structure within a particular region. As questions are raised and answered, the information will be compiled and posted on the website in a running Frequently Asked Questions (FAQ) document. Throughout this process, EPB will continue to work with stakeholders to identify funding strategies to support public health and healthcare system preparedness in Massachusetts, and to communicate information about the ongoing stakeholder discussions.

Milestones

A schedule of anticipated accomplishments for HMCC during development appears below.

Milestones for each HMCC	
By end of budget period (BP) 2 (June 30, 2014)	• Participate in regional multi-discipline facilitated planning meetings • Assess regional strengths, best practices, gaps • Study other states' examples (governance, communication, participants) • Identify regional participant organizations/disciplines • Discuss lead agency characteristics, options
By Fall of 2014 (BP3)	• Regions identify lead agency and participating organizations • EPB releases HMCC RFR (Date TBD – November target)
By end of BP 3 (June 30, 2015)	• Initial HMCC funding distributed • Identify staff roles and establish operations, including 24/7/365 coverage
During BP 4 and 5 (July 1, 2015 – June 30, 2017)	• Conduct regional all-hazards planning • Participate in regional training and exercises • Assume regional coordination function to respond to emergencies through a single point of contact for the region and with EPB • Aggregate information to maintain and communicate situational awareness • Assist with recovery and mitigation efforts
By end of BP 5 (June 30, 2017)	• Six fully operational regional HMCC • All HMCC have exercised operational plans

June 2014 HMCC Regional Representatives Meeting

June 26, 2014
Tower Hill

Meeting objectives

As the facilitated process wraps up, we want to:

- Thank you for your participation
- Present themes and highlights
- Share materials
- Offer national and local perspectives
- Provide information on upcoming activities

Key Questions

1. What are resources/capacities in the regions that can be adapted and/or information regional HMCC planning? (January)
2. What are possible operating/program models for meeting required functions of a regional HMCC? (March)
3. Who are partners who should be involved/engaged in the regional HMCC? (March)
4. What are the desirable attributes and capacities for an HMCC regional coordinating agency? (May)
5. What are the pros/cons of possible governance models? (May)

Themes and Highlights from exploration of the key questions

Question 1:
What are the resources/capacities that can be adapted and/or inform HMCC planning?

Health and medical assets

- Although <u>many</u> assets/capacities exist, few common assets were identified across all four regions and five disciplines
- Across the four regions and five disciplines, the common assets identified were:
  - internal resources/infrastructure (chemPAKs, generators, web database access)
  - Relationships (mutual aid)
  - communication capacity/infrastructure (radio communications)
  - Staff/personnel (MRCs and nurses)

Highest priorities for continuation under HMCC funding

Community Health Centers/Ambulatory Care :

- Collaboration & information/resource sharing (i.e., MRC, epi support, MLCH) (all regions)
- Supplies & equipment
- Staff time for emergency preparedness
- Training and education

EMS:

- MCI Trailer supplies (all regions)
- MCI-related training/exercises
- ChemPAK

Highest priorities for continuation under HMCC funding

Hospitals:

- Preparedness related training & drills (all)
- RX caches/supplies
- Decon supplies/equip/facilities
- Med/Surg assets
- Communication equipment
- Coordinators (EOC, Hospital EP, OPEM Regional)

Highest priorities for continuation under HMCC funding

Public health:

- Exercises, training & drills (all)
- Communication technology/supplies
- EDS supplies & equipment
- Planning staff and Tech support/expertise
- MRC training

Long-term care:

- Continued support for MassMAP (all)

Question 2:

What are possible operating/program models for meeting required functions of a regional HMCC?

Identified important aspects of operational models

- Multiple partners & disciplines for ESF-8 support
  - Scope broader than hospitals
- Address ASPR & PHEP guidance & capabilities
- All-hazards approach
- Staff similar to the COTs Healthcare Incident Liaison role
- 72 hour readiness/capability
- Training/education component

Question 3:

Who are partners who should be involved/engaged in the regional HMCC?

Brainstorm – Who might we work with in a response?

Reported by all four regions (1,3, 4AB, 5):

- Behavioral/mental health providers & organizations
- Colleges/universities including their health services
- Public works
- Faith-based organizations
- Emergency management agencies

Also frequently reported (3 regions):

- MRCs, pharmacies, home health, HAM radio operators, transportation, volunteer organizations, vets/animal care, food banks & suppliers

Many others particular to only one or two regions

Brainstorm – who might need support during a response

Reported by all four regions (1,3, 4AB, 5):

- Organizations that support individuals with functional needs (e.g., home health, assisted living)

Also frequently reported (3 regions):

- Dialysis centers and behavioral health facilities

Several others particular to only one or two regions

Question 4:

What are the desirable attributes and capacities for an HMCC regional coordinating agency?

Common desirable attributes/capacities across regions

- Ability to engage partners in all disciplines
- Knowledgeable about the work and the region
  - ESF-8
  - ICS
  - All-hazards planning
- IT and Communications technology capacity
- Fiduciary capacity
  - Manage sub-contracts
  - Manage resources among disciplines fairly

Question 5:

What are the pros/cons of possible governance models?

What are considerations for possible governance models?

- Organization types
  - Public, private or non-profit
- Authority and functionality
- Procurement
- Governance
- Fiduciary duty
- Provisions for dissolution

Health care coalitions: Success factors nationally

Paul Biddinger, MD, FACEP

Chief, Division of Emergency Preparedness

Medical Director, Emergency Department Operations

Massachusetts General Hospital

The Cape Cod multi-disciplinary experience

Sean O'Brien

Coordinator, Barnstable County Regional Emergency Planning Committee

Gains and concerns discussion

What questions have been answered?

What is better understood now?

What is still to be answered?

Outreach Presentations

Boston Healthcare Coalition Executive Committee

Coalition for Local Public Health

League of Community Health Centers

Local State Advisory Committee

Massachusetts Association of Public Health Nurses

Massachusetts Chiefs of Police Association

Massachusetts Emergency Management Agency

Massachusetts Emergency Management Agency- Statewide Emergency Management Conference

Massachusetts League of Community Health Centers Government Affairs Committee

Massachusetts Medical Society, Committee on Preparedness

Massachusetts Municipal Association

Massachusetts Senior Care Association

MetroWest Regional Emergency Planning Committee

Hospital Preparedness Coalitions:

Region 1
Region 2
Region 3
Region 4AB
Region 4C
Region 5

Public Health Preparedness Coalitions:

Region 1A, Berkshire County
Region 1B, Franklin County
Region 1C, Hampshire County
Region 1D, Hamden County
Region 2
Region 3A
Region 3B
Region 3C
Region 3D
Region 3E
Region 4A
Region 4B
Region 4C
Region 5 Bristol County
Region 5 Cape & Islands
Region 5 Plymouth County

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3	Helen	Magliozzi	Mass Senior Care	Long Term Care	hmagliozzi@maseniorcare.org
3	Paul	Mahoney	Rosewood Nursing & Rehab Center	Long Term Care	pmahoney@banecare.com
3	Kevin	Prendergast	Atlantic EMS	Emergency Medical Services	kprendergast@cataldoambulance.com
3	Gloria	Riley	North Shore Community Health	CHC/Large Ambulatory Care	gloria.Riley@nschi.org
3	Karen	Rose	Medford	Local Public Health	krose@medford.org
3	Wes	Russell	Tyngsboro Fire and Lowell General Paramedics	Emergency Medical Services	Wesley.Russell@lowellgeneral.org
3	Charlotte	Stephanian	Merrimac	Local Public Health	cestep25@verizon.net
3	Philip	Stoner	Hospital Preparedness Coordinator	Massachusetts Department of Public Health	philip.stoner@state.ma.us
3	David	Trout	Public Health Preparedness Coordinator	Massachusetts Department of Public Health	david.trout@state.ma.us

Region	Name	Last	Organization	Discipline	email
3	Rick	Westhaver	Hallmark Health Corporation	Hospital	rwesthaver@hallmarkhealth.org
4AB	Archana	Joshi	Public Health Preparedness Coordinator	Massachusetts Department of Public Health	Archana.joshi@state.ma.us
4AB	Paula	Kaminow	Edward M. Kennedy Community Health Center	CHC/Large Ambulatory Health	paula.kaminow@kennedychc.org
4AB	Shawn	Kraft	Soldiers' Home in Chelsea	Long Term Care	shawn.kraft@state.ma.us 5
4AB	Christian	Lanphere	Cambridge Health Alliance	Hospital	clanphere@challiance.org
4AB	Helen	Magliozzi	Mass Senior Care	Long Term Care	hmagliozzi@maseniorcare.org
4AB	Kitty	Mahoney	Framingham	Local Public Health	kcm@framinghamma.gov
4AB	Leigh	Mansberger	Public Health Preparedness Coordinator	Region 4B Public Health preparedness Coordinator, Cambridge	lmansberger@challiance.org
4AB	Josh	Margulies	Mount Auburn Hospital	Hospital	jmarguli@mah.harvard.edu
4AB	Mary	McKenzie	Chelsea	Local Public Health	mmckenzie@chelseama.gov
4AB	Bill	Mergendahl	Pro EMS	Emergency Medical Services	wmerg@proems.com
4AB	Christine	Paschal	Edward M. Kennedy Community Health Center	CHC/Large Ambulatory Health	christine.paschal@kennedychc.org
4AB	Susan	Rask	Concord	Local Public Health	srask@concordma.gov
4AB	Sonja	Rivera	Harvard Vanguard Medical Associates	CHC/Large Ambulatory Health	Sonja_rivera@vmed.org
4AB	Lynn	Schoeff	Cambridge	Local Public Health	lschoeff@challiance.org
4AB	Linda	Shea	Westwood	Local Public Health	lshea@townhall.westwood.ma.us
4AB	Sean	Tyler	Fallon Ambulance	Emergency Medical Services	styler@fallonambulance.com
4AB	Tina	Wright	Massachusetts League of Community Health Centers	CHC/Large Ambulatory Health	twright@massleague.org
4AB	Judy	Bernice	Hospital Preparedness Coordinator	Massachusetts Department of Public Health	judith.bernice@state.ma.us
4AB	Derrick	Congdon	Metropolitan Boston Emergency Medical Service Council	Emergency Medical Services	dcongdon@mbemsc.org
4AB	Joan	Cooper-Zack	South Shore Hospital	Hospital	Joan_Cooper-Zack@sshosp.org
4AB	Mary	Devine	Hospital Preparedness Coordinator	Massachusetts Department of Public Health	mdevine@cobeth.org
4AB	Linda	Foote	Harvard Vanguard Medical Associates	CHC/Large Ambulatory Health	LindaC._Foote@vmed.org
4AB	Leah	Gallivan	Edward M. Kennedy Community Health Center	CHC/Large Ambulatory Health	leah.gallivan@kennedychc.org
4AB	Jim	Garrow	MassMAP	Long Term Care	JGarrow@phillipsllc.com
4C	Mike	Colanti	Boston Public Health Commission		mcolanti@bphc.org
4C	Brendan	Kearney	Boston EMS	Emergency Medical Services	KEARNEY@bostonems.org
5	Diane	Brown-Couture	Public Health Preparedness Coordinator	Massachusetts Department of Public Health	diane.brown-couture@state.ma.us
5	David	Camara	Southcoast Hospital Group, Inc.	Hospital	camarad@southcoast.org

Region	Name	Last	Organization	Discipline	email
5	Lisa	Cullity	Pembroke	Local Public Health	lcullity@townofpembrokemass.org
5	Cathleen	Drinan	Halifax	Local Public Health	cdrinan@town.halifax.ma.us
5	Dave	Faunce	Southeastern MA EMS Council	Emergency Medical Services	execdirector@semaems.com
5	William	Flynn	Cape and Islands EMS	Emergency Medical Services	director@ciemss.org
5	Jim	Garrow	Mass Senior Care	Long Term Care	JGarrow@phillipsllc.com
5	Ed	Hennegan	Hospital Preparedness Coordinator	Massachusetts Department of Public Health	ed.hennegan@state.ma.us
5	George	Heufelder	Barnstable County	Local Public Health	gheufelder@barnstablecounty.org
5	Pam	Kavanaugh	Greater New Bedford Community Health Center	CHC/Large Ambulatory Care	pkavanaugh@gnbchc.org
5	Helen	Magliozzi	Mass Senior Care	Long Term Care	hmagliozzi@maseniorcare.org
5	Jeanette	McGillicuddy	Brockton Hospital	Hospital	jmcgillicuddy@signature-healthcare.org
5	Matt	Muratore	Plymouth Rehab & Health Care Center	Long Term Care	mmuratore@plymouthrhcc.com
5	Sean	O'Brien	Barnstable County	Local Public Health	sobrien@barnstablecounty.org
5	Jacqueline	O'Brien, RN	Attleboro	Local Public Health	healthnurse@cityofattleboro.us
5	Suzanne	Robbins	Community Health Centers of Cape Cod	CHC/Large Ambulatory Care	srobbins@chcofcapecod.org
5	Jean	Roma	Barnstable County Health	Local Public Health	jroma@barnstablecounty.org
5	Bob	Salomaa	Hannah B. Griffith Shaw Home for the Aged	Long Term Care	bsalomaa@theshawhome.org
5	Henry	Vaillancourt, MD	Fall River	Local Public Health	hvaillancourt@fallriverma.org
5	Sheila	Wallace	Steward Good Samaritan Medical Center	Hospital	sheila.wallace@steward.org
5	Aaron	Wallace	Office of Emergency Management Plymouth Fire Department		AWallace@townhall.plymouth.ma.us
	Nazmim	Bhuiya	Institute for Community Health		nbhuiya@challiance.org
	Mary	Clark	Office of Preparedness and Emergency Management	Massachusetts Department of Public Health	mary.clark@state.ma.us
	Harold	Cox	BU School of Public Health		hcox@bu.edu
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	Kerry	Dunnell	BU School of Public Health		kdunnell@bu.edu
	Seth	Eckhouse	BU School of Public Health		seckhous@bu.edu
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	John	Grieb	Office of Preparedness and Emergency Management	Massachusetts Department of Public Health	john.grieb@state.ma.us
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	Tom	Hutton	Office of Preparedness and Emergency Management	Massachusetts Department of Public Health	tom.hutton@state.ma.us

Region	Name	Last	Organization	Discipline	email
	Lynn	Ibekwe	Institute for Community Health		libekwe@challiance.org
	Katie	Kemen	Office of Preparedness and Emergency Management	Massachusetts Department of Public Health	katherine.kemen@state.ma.us
	Hope	Kenefick	Facilitator		hopewk@comcast.net
	Kathleen	MacVarish	BU School of Public Health		kmcvarish@bu.edu
	Patricia	Pettis	HHS ASPR Hospital Preparedness Program		patricia.pettis@hhs.gov
	Jen	Tsoi	BU School of Public Health		jtsoi@bu.edu

December Facilitated Meeting

All regions: December 2nd 2013, 09:30 – 3:00. Tower Hill Botanic Garden, 11 French Dr., Boylston

January Facilitated Meetings

Region 1: January 30th 2014, 11:00 – 1:30. Pittsfield Senior Center, 330 North St, Pittsfield

Region 3: January 10th 2014, 10:00 – 12:30. Tewksbury Public Library, 300 Chandler St, Tewksbury

Region 4AB: January 29th 2014, 10:00 – 12:30. Massachusetts Medical Society, Commonwealth Room, 860 Winter Street, Waltham

Region 5: January 15th 2014, 11:00 – 1:30. Plymouth Fire Station, Cedarville Community Room, 2209 State Road, Plymouth

March Facilitated Meetings

Region 1: March 11th 2014, 11:00 – 1:30. Greenfield Community College, Downtown Center, 270 Main Street, Greenfield.

Region 3: March 28th 2014, 10:00 – 12:30. Tewksbury Public Library, 300 Chandler Street, Tewksbury

Region 4AB: March 18th 2014, 10:00 – 12:30. Massachusetts Medical Society, 860 Winter Street, Waltham

Region 5: March 27th 2014, 11:00 – 1:30, Middleborough Town Hall, 10 Nickerson Ave., Middleborough, Middleborough

May Facilitated Meetings

Region 1: June 2nd 2014, 11:00 – 1:30 (rescheduled due to facility emergency on original date). Northampton DPH Office, 23 Service Center, Northampton

Region 3: May 5th 2014, 10:00 – 12:30. Tewksbury Public Library, 300 Chandler Street, Tewksbury

Region 4AB: May 20th 2014, 10:00 – 12:30. Massachusetts Medical Society, 860 Winter Street, Waltham

Region 5: May 8th 2014, 11:00 – 1:30, Middleborough Public Library, 102 North Street, Middleborough

June Facilitated Meeting

All regions: June 26th 2014, 09:30 – 2:00. Tower Hill Botanic Garden, 11 French Dr., Boylston

HMCC Orientation Meeting

December 2nd, 2014

On December 2, 2013, MDPH convened the initial meeting of designated representatives who will participate in the Health and Medical Coordination Coalition (HMCC) facilitation process. 70 representatives from the five core disciplines - community health centers and large ambulatory care organizations, emergency medical services, acute care hospitals, local public health departments, and long-term care facilities - met at Tower Hill Botanical Garden for an orientation to the upcoming series of facilitated regional discussions about the development of HMCC. Mary Clark, director of the MDPH Office of Preparedness and Emergency Response (OPEM), provided an overview of the HMCC process and answered questions from the participants. Katie Kemen, senior public health preparedness coordinator for OPEM, described how an HMCC might operate in response to a large scale winter storm with an impact similar to the 2008 ice storm. Hope Kenefick, who will facilitate the regional discussions, provided an overview of the regional discussions and identified key questions to be addressed by the regional representatives.

During a working lunch, participants submitted a range of questions about HMCC and the process for regional discussions. The meeting was closed out with break-out sessions for Regions 1, 3, 4ab, and 5, with participants providing input about needs for additional clarification from OPEM, what information about health and medical resources in their region would be useful for discussions about HMCC, and what kinds of technical assistance would be helpful. Regions 2 and 4c, which have HMCC partially in place, did not participate in regional breakout sessions.

The notes from each of the regional breakout sessions are included below.

Region 1 HMCC Breakout Group Notes
Dec. 2, 2013 Orientation to Regional Stakeholders Meeting

Items in need of clarification:

- Specificity about what the HMCC must be and do (detailed minimum requirements for an HMCC)
- Specificity about the requirements for a coordinating agency.
- Clarification as to whether the HMCC will be a MAC or a response organization
- Clarification regarding the future of the existing coalitions - Will they be funded? At what level/for what?
- Clarification about the legal authority and liability of HMCCs
- Clarification about whether multiple agencies can carry out the functions of the coordinating agency (e.g., one for fiscal, another for planning)
- Clarification about how MDPH will get buy-in from municipal leaders to ensure HMCC work will not be undermined locally in an emergency
- Clarification about why the HMCC RFR will be a competitive process when other RFRs from DPH have not
- Clarification about whether the funding formula for the PHEP funds will be the same going forward
- Clarification about the required IT capabilities that the coordinating agency must have

- Clarification about whether/how the regional health offices can support regional HMCCs (e.g., serve as coordinating agency, Providing staffing or other resources)

Lists/data needed:

- Lists of MRCs (and % of those that actually respond) and EDS (number that can actually be stood up if needed)
- Communities in Region 1 that have signed on to the statewide MOU
- Current dollars MDPH provides to the core disciplines for EP
- Other dollars MDPH provides that could be leveraged for regional HMCC support
- Lists of pharmacies, behavioral health (MH and substance abuse) providers/facilities, veterinarians, minute clinics in the region (and other lists as new partners are identified

Models/guidance needed:

- for relationship building across a large geographic expanse and multiple disciplines
- about how to ensure integration of the HMCCs with existing entities (e.g., emergency managers/EOCs/MEMA)
- for how partners who bill for services (LTC, health ctrs., hospitals) can be reimbursed (and in a timely way) for services provided for mutual aid
- about possible governance models

Technical Assistance needed:

- Regarding legal liability of HMCC
- How to create a 501c3
- Related to the development of governance structure
- IT support that will be available to the HMCC to ensure effective linkage with WebEOC

Region 3 HMCC Breakout Group Notes
Dec. 2, 2013 Orientation to Regional Stakeholders Meeting

Clarification

- Need to clarify funding? How will money be used? What are sources of money? Please clarify about money soon since we are currently working on budgets.
- Will HMCCs mirror Homeland Security councils? Can we learn from the HSCs?
- Why can't alternates be involved in the process?
- Are there other uses for the HMCC s—so that it is not only focused on emergency responses?
- Provide clarification of how the current HMCC structure was conceived. Is there a way to have smaller HMCCs
- What are criteria for RFPs and who within region is available/willing /able to meet criteria?
- What is the exact wording of the CDC deliverable?
- Need to keep in mind other guidances/requirements that exist due to regulations (such as TJC)
- Clarify funding distribution—who is responsible for it? Who has authority within the group?

- Has there been attempt to talk to other regional entities to try to merge together…this would be best way to build a coordinated system
- How do we interact between regions

Information

- We need list of equipment (resources each entity has)
- Clarify about volunteer resources, availability
- List benefits of HMCC…what is it going to do

General Questions

- What does it mean to go from being part of a small group to being part of a large group?
- How do you ensure full participation within the larger group?
- Will people participate if there is no money associated with it?
- What does it mean to work with new partners, especially outside of your geographic area?
- How do you keep this new model from becoming another layer of hierarchy? How do you ensure it is effective?
- Overlapping regional activities need to coordinate together
- Existing structures have been effective. How do we ensure that they will be maintained?
- Will the EDS structure change from local?
- What are end results of the group—identify goals and objectives
- Clarify various other entities—how will they work within the HMCC structure
- How do you factor in personal relationships—will this be replaced by the HMCC

Region 4ab HMCC Breakout Group Notes
Dec. 2, 2013 Orientation to Regional Stakeholders Meeting

More information

- Regional stakeholders (name and contact information)
- More complete mission and description of each core discipline (some confusion about why Harvard Vanguard was present and how ambulatory care centers were defined)
- Complete list of all five core discipline organizations (CHC incomplete and what about free clinics?)
- Any discipline limitations (i.e., FQHC, EMS destinations, scope of practice, shelter operations)
- Explanation of umbrella councils/organizations that represent some disciplines (i.e., MBEMS, MLCHC) and how they will be involved in the stakeholder process and in the HMCC. Don't forget groups such as MA School Nurses and Occupational Health Nurses.
- Public health (board/department) staffing and volunteers
- Lists of other types of hospitals, group practices, pharmacies
- Lists of schools (all levels)
- MEMA type of data (armories, airports, military assets)

- EMS and other types of contracts and task forces (as these might reduce available assets during an emergency)
- Communication systems used by disciplines organizations
- What disciplines and organizations can and will share (internal policies)
- UDS data and zip codes of clients (for relocation purposes)

More clarity:

- Role of HMCC (ESF8) and interface with local and regional emergency management
- HMCC membership (core disciplines or others? What about private physicians/practices?).
- How/when local response moves to HMCC (especially if non-health and medical assets/resources are needed)
- How and when information will be shared (especially confidential information)
- Communication among regional stakeholders (now through June)—a conference call before the Jan. meeting was suggested
- What happens if core disciplines or organizations within a discipline 'opt out'?
- What happens if the cost of establishing and running an HMCC exceeds the available funds?

General questions/comments:

- Why can't DPH regional offices function as the regional HMCC?
- Where will HMCC authority come from?
- How can one person represent their entire discipline through this stakeholder process?
- Training and drilling elements must be built in
- What can we learn from Region 2? Especially how they integrate public health and health and medical facilities and share resources.
- We need local and regional EM participation (LEPC, REPC)
- Can Mass Map questionnaire and other documents help with HMCC?

Region 5 HMCC Breakout Group Notes
Dec. 2, 2013 Orientation to Regional Stakeholders Meeting

Clarify:

- Will the HMCC staff have an asset manager (procurement officer role) to address asset allocation – fairly and with proper priorities?
- What is the HMCC function?
- How do we do this in a region with no trauma centers?
- How will we address the impact that multiple funding streams can have on regional planning?
- Can the HMCC identify minimum standards, because we cannot plan without knowing the numbers and tasks we are responsible for. (Should I buy enough cots for 10% of my population? OR should I buy enough for all town hall staff?)
- What is the line of authority for decision making? (e.g., how do you decide which hospitals get generators if 3 hospitals are out and you only have 2 generators?)
- What is the regional variability allowance? How different can the regions be in structure? How similar do they have to be? Same question posed for two different reasons. 1) Want to know that

there will be similar capacities/structures in other regions to reach out to for help 2) Want to know if they can do something very different from other regions
- How does it all fit together?
- Is the regional boundary required? Will Mary Clark say that?
- Can we create sub-regions?
- Will the state want a fiscal agent and a lead agency, or will it be one organization? (Currently the state requires that there be a separate fiscal agent)
- We think we need to include EM in this process. Can we connect with Emergency management via a regional representative? This would be easier because there are so many local EMs.
- We also need tribe/Indian health services as part of this process.
- We need to involve police and fire too.
- We need this to be manageable so that it can accomplish something.

Big Questions:
- How can we structure to be efficient with money and staff?
- How can hospitals, LTC, CHC and EMS coordinate to address bed needs and staffing needs?
- How can asset requests be made uniform?
- How will they talk to each other?
- What will the request flow be when there are HMCC?

Information:
- Can protocols from the MACC be shared? Is there a way to use these to create the HMCC?
- What existing processes for accessing resources does each discipline have?
- What best practices are out there for multi-disciplinary work?
- How do community health centers fit into these models? What does Boston know or have learned? What does Region 2 do?
- Who are the EM people in each municipality? And are they full time/part time/volunteer/ dual role.
- How can we use WebEOC? Can it be modified for HMCC access?
- What is Indian Health services doing?
- What are dialysis center locations and capacities?
- What are urgent care facilities? Satellite OR facilities? Satellite ER facilities?
- We need an emergency preparedness org chart.
- What is the request flow currently from individual organizations?
- What is the number of MRC volunteers? What percentage responds to events?

Technical Assistance:
- How do we get people to the table for the regional HMCC?
- How do we get local politicians to understand how this works?
- How do we connect with private partners?
- How will we make this legal?

Group Summary: Issues are Assets, Communication and Governance.

HMCC Facilitated Meetings

January, 2014

The first round of facilitated regional meetings with representatives from the five core disciplines (Community health centers/large ambulatory care practices, EMS, hospitals, local public health, and long-term care) took place in Regions 1, 3, 4AB, and 5 in January. The overall purpose of the facilitated meetings is to gather and share information across disciplines that will support future planning of an HMCC in each region. In the round one meetings, representatives in each discipline tackled the key question, "What are the resources/capacities in the region that can be adapted and/or inform regional HMCC planning?" To that end, representatives from each discipline shared information about their discipline-specific health and medical assets, such as mutual aid agreements and equipment, that exist in the region, as well as the activities supported by MDPH (in each discipline) that are priorities for continuation under HMCC funding

Region 1 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Pittsfield Senior Center
January 30 2014

Present.
Gail Bienvenue, Hospital Preparedness Coordinator
Lucy Britton, Berkshire Medical Center
Joel Camp, Renaissance Manor on Cabot
Kerry Dunnell, BU School of Public Health
Jeanne Galloway, West Springfield
Jim Garrow, MassMAP
Katie Kemen, MDPH Office of Preparedness and Emergency Management
Hope Kenefick, Facilitator
Mary Kersell, Hampshire County
Laura Kittross, Berkshire County
Ed Lesko, Hatfield
Sandra Martin, Berkshire County
Gina McNeely, Montague
John Meany, North Adams Ambulance Service
Robert Moore, Holyoke Medical Center
Linda Moriarty, Western MA Emergency Medical Services
Nikki Nixon, Hampden County
Tracy Rogers, Franklin County
Ed Sayer, Hilltown Community Health Center
Ann Shea, Mercy Medical Center
Chief Alan Sirois, Agawam Fire Dept.
Jennifer Wilkinson, Community Health Programs

Introductions. After brief introductions and review of ground rules, Hope reviewed the agenda with the group, starting with the Key Question for this round of meetings.

What are the resources/capacities in the region that can be adapted and/or inform regional HMCC planning?

Hope explained that this question was broken down into 2 parts:
A. What other health and medical assets, such as mutual aid agreements and equipment, exist in the region, in addition to those listed on the fact sheets?

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

Hope asked that the participants work their discipline groups to address these questions, and provided guidance about time.

After a period of brainstorming, each discipline had developed lists to answer both questions. Each discipline group had a spokesperson report out their results to the room.

Exact transcripts of each disciplines' list of assets follow. Priorities worksheets for each discipline are scanned.

Community Health Centers

1) Physicians
2) Nurses
3) Behavioral Health
4) Dental
5) CHWs
6) Generators
7) Space to provide shelter
8) Storage capacity for medications
9) Pharmacy on-site (Holyoke)
10) Lab
11) Translation services
12) Connected to local emergency officials
13) Walkie-talkies for staff communication on-site
14) Some limited capacity for texting
15) Guys and gals with chain saws and excavators
16) Mobil medical van

Priorities

Education of staff – emergency

1) On-site coordinator (point person)
    a. Policies and procedures
2) Funds for the CHC collaborations

Region 1 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Pittsfield Senior Center
January 30 2014

EMS

1) Fire/EMS mobilization plan – allows for large EMS mobilization
2) MCI trailers (supplies for 50 patients each)
3) Communications infrastructure
    a. CMED
    b. Radio caches
4) Mass Decon Units
5) ChemPaks
6) ISU/IMT (Incident Support Units/Incident Management teams)
7) Non-acute transfer assets (e.g., chair vans and buses)

Priorities

1) MCI trailers
    a. Host site funding
    b. Equipment and supplies replacement
2) MCI Training

Hospitals

Bridge ASPR (Assistant Secretary for Response) and Joint Commission standards

1. Standardization of forms and processes (ICS)
2. Regional go-kits
3. Collaboration with public safety, public health, MEMA
4. *Medical coordination Group/Plan with Memorandum of Understanding (MOA)
    a. Networks formed
    b. Information sharing
    c. Subject matter experts
5. Medical surge beds
6. *Decontamination Capabilities (access to MDUs – not on site)
7. Notification processes through the HHAN
8. Knowledge base/collective skill set
9. PPE (personal protective equipment) trailers (2)
10. Group purchases
    a. Standardization of equipment
    b. Landing zone lights
    c. Lights
    d. Satellite phones
    e. Ham radios
    f. PAPR (powered air purifying respirator) filters and batteries
    g. Ventilators
    h. ChemPaks
    i. Fatality management supplies
    j. Pharmaceutical cache for force protection
11. Statewide work groups (e.g. Surge)
12. Participation in regional workgroups (e.g., Western Region Homeland Security Advisory Council WRHSAC)
13. *Multidisciplinary trainings and exercises

Region 1 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Pittsfield Senior Center
January 30 2014

Local Public Health

1. Public health coalitions (planners)
2. Medical Reserve Corps (MRC)
3. DART (Disaster Animal Response Teams)
4. Local/regional plans and SOGs (standard operating guides)
    a. Sheltering
    b. FNSS
    c. SUV
    d. PIO
    e. EDS
    f. Food and water
    g. Mass casualty incident (MCI)
    h. Disaster recovery (FC)
5. Local Boards of Health ~101
6. Districts
7. Regional Emergency Preparedness Councils (REPC)
8. Regional Planning Authority (RPA)
9. Regional DPH Office
10. Agents
11. Nurses
12. Board of Health members
13. Animal Inspectors
14. BCBOHA-CPHSA
15. WAG
16. MAG
17. Homeland Security Council
18. MEMA
19. Sherriff
20. Regulatory Authority
21. Community Organizations Active in Disaster (COAD)
22. Faith and social service agency collaborations
23. Food bank

Equipment

1. Shelter Supplies
2. Animal shelter supplies
3. Hampshire radio system
4. Ham radios
5. Trailer
6. EDS signs/kits
7. Satellite phones
8. Generators
9. Radios
10. Inspection supplies and equipment
11. Vaccination supplies

Facilities

1. Regional office (DPH

2. Westover
3. "5 College facilities"
4. Pharmacies
5. Schools (for Emergency Dispensing sites and shelters)

Skills

1. Planning
2. Disease surveillance
3. Isolation and quarantine
4. Nursing
5. Health education
6. Sanitarian (environmental health)
7. Write and pass local regulations
8. Condemnation
9. Risk communication - JIS (Joint information S)
10. Burial permits

Long-term Care

1. Mass MAP (Massachusetts Mutual Aid Plan) members in Region 1 = 56
    a. State == 500
    b. Long-term care
    c. Assisted living
    d. Rest homes
2. MASSMAP plan components
    a. Activation algorithms
    b. Communications (HHAN)
    c. Transportation – member equipment, vans etc
    d. Resident tracking
    e. Identify supplies and equipment
    f. Surge planning
    g. Identify evacuation locations (top 10)
    h. Plan forms
    i. Evacuation forms
    j. Resident medical records and equipment
    k. Influx forms
    l. MOU with all members
3. Website
    a. Facility information and contacts (management)
    b. Identification of all generator information
    c. # of beds and categories of care
        i. Vents
        ii. Dementia patients
    d. Equipment
    e. Supplies
    f. Transport vehicles
    g. Transportation evacuation survey
    h. Vendors for each facility
    i. Patient tracking status

4. Emergency reporting (100% accountable)
    a. open beds
    b. facility operational issues
    c. identify resources for disaster struck facility
5. Long-term care coordinating center
    a. Located at Jewish Geriatric/Longmeadow
6. 100 % accountability to facilities
7. Monitor facility operational issues
8. Coordinate resident placements/evacuations
9. Access to CMP funds (civil monetary penalties) to fund dues and paid for facilities to join in 2013 (LTC only, not rest homes and assisted living facilities)

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

See scanned in documents.

Wrap up & next steps

Hope thanked all for their participation and explained that notes would be distributed via email. The March meeting will be held on March 11 from 11:00-1:30 at Greenfield Community College.

Region 3 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Tewksbury Public Library
January 10, 2014

Present:
Paul Brennan, Lawrence General Hospital
Sharon Cameron, Peabody
Joel Camp, MassMAP
Thomas Carbone, Andover
Arlene Champey, Steward Holy Family Hospital
Ruth Clay, Wakefield/Melrose/Reading
Deb Cronin-Waelde, Hallmark Health Corporation
Rich Day, Chelmsford
Chuck Derosier, Harvard Vanguard Medical Associates
Kerry Dunnell, BU School of Public Health
Amy Ewing, Methuen
Linda Foote, Harvard Vanguard Medical Associates
Derek Fullerton, Middleton
Jim Garrow, MassMAP
Mike Kass, NorthEast Emergency Medical Services, Inc.
Katie Kemen, MDPH Office of Preparedness and Emergency Management
Hope Kenefick, Facilitator
Sheryl Knutsen, Public Health Coalition 3A
Gloria Riley, North Shore Community Health
Wes Russell, Tyngsboro Fire and Lowell General Paramedics
Charlotte Stephanian, Merrimac
Philip Stoner, Hospital Preparedness Coordinator
David Trout, Public Health Preparedness Coordinator

Introductions. The meeting start was delayed because of weather – snow had created significant traffic delays. After brief introductions and review of ground rules, Hope reviewed the agenda with the group, starting with the Key Question for this round of meetings.

What are the resources/capacities in the region that can be adapted and/or inform regional HMCC planning?

Hope explained that this question was broken down into 2 parts:
A. What other health and medical assets, such as mutual aid agreements and equipment, exist in the region, in addition to those listed on the fact sheets?

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

Hope asked that the participants work their discipline groups to address these questions, and provided guidance about time.

After a period of brainstorming, each discipline had developed lists to answer both questions. Each discipline group had a spokesperson report out their results to the room.

Exact transcripts of each disciplines' list of assets follow. Priorities worksheets for each discipline are scanned.

Ambulatory Care

Communicable Disease Plans, Natural disaster plans, Closed POD Planning, Member vaccination with reportable information
ER Surge Mediation plans – phone triage, center triage
Supplies – routine and pandemic

Staff Resources –
Providers (MD, RN, nursing, VNA, clinical support staff/admin support staff)
IT – IT/EMR, web portals – acute care facilities telecom, telemedicine
Services – pharmacy, imaging, laboratory

EMS

Coordination Medical Emergency Direction (CMED)
Hospital/Ambulance Communication System – region wide using UHF, VHF, microwave radio systems
Coordinating EMS mutual aid
Maintaining DPH Bed Availability/Diversion website
Mutual Aid EMS radio network - Every EMS service radio supplied by the region
Fire Mobilization Ambulance Task Force Participation
Service Zone Plans
SMART Triage System
EMS Council Staff
Committees – Med Services, Nursing, Pre-hospital (systems, coordination & communications working group), Training & Education
Medical Oversight – regional medical director
Continuing education oversight – approval of credits, auditing
Technical assistance
Liaison with OEMS and Ambulance services and DPH
MCI Disaster response preparedness and coordination
National Registry EMT Conversion ('unaffiliated EMTs')
Represents region on Statewide EMS Preparedness & Planning Committee
Assist hospitals and LTC with incident management
Provide Training and education – CPR, ITLS
Other Regional Equipment
Generator, Satellite phones
MCI Trailers
AmbuBus and Evacuation Bus

Region 3 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Tewksbury Public Library
January 10, 2014

Hospitals

All Hospitals have ER, MedSurge, Surgery, ICU and CCU, Dialysis, BeSafe Program.
Trauma care - Lowell General, Anna Jacques, Salem, Lawrence, Beverly
CathLab – Beverly, Lowell, Lawrence, Holy Family, Salem, Melrose Wakefield
ObGyn- Lowell, Holy Family, Anna Jacques, Salem, Lawrence, Beverly, Melrose Wakefield
Pedi – Lowell, Lawrence, Beverly, Salem, Melrose Wakefield
ALS – Lowell
BLS/ALS – Lawrence
On-site MDU – Lowell, Saints, Merrimack Valley, Lynn
ChemPak – 6
Vents – Saints, Beverly (available to add via plan)
Psych – Holy Family, Merrimack Valley, Beverly @Bayridge, Salem

Local Public Health

VNAs/MRC, Public Health Nurses, School Nurses,
Pharmacists, Pharmacies,
Environmental Health,
Mass in Motion, Substance Abuse Prevention, Tobacco Control, Wells, Onsite Wastewater, Multiple mutual aid agreements, equipment caches, computers, radios, software, translation services, durable/non-durable medical supplies, emergency planners, emergency plans, NERAC equipment caches, relationships both inter- and intra- municipal, statutory authority, shelter plans, shelter experience, immunizations, food and water safety, public education, risk communication, Reverse 911/Code Red, EDS plans and sites, COOP plans, HHAN, MHOA, Call-in info centers.

Long-term Care

Long-term care facilities, assisted living facilities and rest homes
Mutual Aid/MOUS –
Communication, transport of people and materials, resident tracking, staffing, suppliers and equipment, surge planning and evacuation
Website –
Facility contacts, bed count/type of bed, resources survey (#vehicles, vendors, general) emergency reporting (beds, operational issues), quantify available beds, staff, supplies and equipment
Long-term care coordinating centers
Population vaccination
Funding via Civil Monetary Penalty (CMP) funds

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

See scanned in documents.

Wrap up & next steps

Hope thanked all for their participation and explained that notes would be distributed via email. The time and location for the March meeting will be confirmed. Location will be Tewksbury Library again. Time and date are pending schedule confirmation with the library.

Next Meeting March 28 from 10:00-12:30 at the Tewksbury Public Library.

Region 4AB Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Massachusetts Medical Society, Waltham
January 29, 2014

Present.
Mark Berman, Lasell House
Judy Bernice, Hospital Preparedness Coordinator
Derrick Congdon, Metropolitan EMS Council
Joan Cooper-Zack, South Shore Hospital
Mary Devine, Hospital Preparedness Coordinator
Kerry Dunnell, BU School of Public Health
Linda Foote, Harvard Vanguard Medical Associates
Leah Gallivan, Edward M. Kennedy Community Health Center
Archana Joshi, Public Health Preparedness Coordinator
Katie Kemen, MDPH Office of Preparedness and Emergency Management
Hope Kenefick, Facilitator
Kitty Mahoney, Framingham
Leigh Mansberger, Public Health Preparedness Coordinator
Mary McKenzie, Chelsea
Bill Mergendahl, Pro EMS
Christine Paschal, Edward M. Kennedy Community Health Center
Susan Rask, Concord
Sonja Rivera, Harvard Vanguard Medical Associates
Linda Shea, Westwood
Tina Wright, Massachusetts League of Community Health Centers

Introductions. After brief introductions and review of ground rules, Hope reviewed the agenda with the group, starting with the Key Question for this round of meetings.

What are the resources/capacities in the region that can be adapted and/or inform regional HMCC planning?

Hope explained that this question was broken down into 2 parts:
A. What other health and medical assets, such as mutual aid agreements and equipment, exist in the region, in addition to those listed on the fact sheets?

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

Hope asked that the participants work their discipline groups to address these questions, and provided guidance about time.

After a period of brainstorming, each discipline had developed lists to answer both questions. Each discipline group had a spokesperson report out their results to the room.
Exact transcripts of each disciplines' list of assets follow. Priorities worksheets for each discipline are scanned.

Community Health Centers/Ambulatory Care

Assets

1) 45+ Facilities – many conveniently located on MTBA lines
    a. Harvard Vanguard MA- 2500 clinical staff b.
    b. CHCs – Edward M. Kennedy CHC (EMKCHC) in Framingham – 20 clinical staff other CHCs in region tba
2) Access to Vaccines and Ability to track vaccines
3) Medical supplies and equipment (primary care related)
4) All sites/facilities have Emergency plans and Continuity of Operations plans
5) Mass Vaccination plans
6) Available Services include
    a. X-ray
    b. Primary Care
    c. Urgent care
    d. Specialty
    e. On-site labs
    f. Behavioral health
    g. Dental (chcs)
    h. Pharmacies
    i. Social services (CHWs)
        i. Language services Medical interpreters and Multi-lingual providers
    j. Electronic health records
    k. Short-term generators at HVMA and EMKCHC
    l. Pandemic stockpile at HVMA

MDPH Supported Activities
CHCs only

1) Annual EP activities
    a. Updating plans – emergency operations plans (EOP) and business continuity plans (BCP)
2) Training and Education
    a. Drills and exercises
    b. Systems
3) Local and statewide collaborations
    a. Regional hospital meetings
    b. Coalitions
    c. Medical reserve corps
4) Equipment purchases (limited)
5) Incident Response and Recovery support
6) MA DPH WebEOC

MDPH Supported activities (both CHCs and HVMA)

1) Infectious disease guidance
2) Strategic national stockpile access
3) Alert system notifications (HHAN)

Region 4AB Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Massachusetts Medical Society, Waltham
January 29, 2014

EMS

1) Regional Trailers
2) Strike teams/task forces
3) Service trailers (vary by service)
4) Individual mutual aid agreements between services (not coordinated at higher level)
5) Boston Ambulance Mutual Aid Radio Channel
6) Equipment caches (Regional & some services)
7) Ambulance-to-hospital communications/coordination (CMED)
8) Fire mutual aid communications/fire districts
9) NEMLEC teams & Similar (tactical teams)
10) Priorities? Regional EMS Response & Staff (Liaison & Logistics)
    (education materials, dispensing site/immunizations tracking system, CMED communications)
11) WebEOC (some entities locally)
12) Patient tracking (developing in some areas)
13) Staff (varies by location)
14) Air assets for transport
15) Radio caches (numbers vary by location)
16) Bat Signal!

Hospitals

Assets

1) 4AB Hospital Mutual Aid Agreement (MACE)
    a. Hospital specific for staff, stuff and space
2) Some access to Homeland Security assets thru NE and SE Homeland Security Councils and UASI
3) Parking structures
4) Helicopter pads
5) 2 hospitals with ambulance assets
6) Ham radio – SE Mass
7) Redundancy – 72 Hour plans (For utilities, NOT for water)
8) Designated hospitals with nerve agent antidotes – ChemPak (federal asset)
9) Add to fact sheet – BID Needham and Somerville
10) Mass decon units to all acute care hospitals
11) Migrating to electronic medical record
12) 24/7/365 capability
13) Broad range of medical care
    a. maternity, psych, trauma
    b. Labs
    c. radiology
14) HIGHLY REGULATED

DPH supported Priorities *All important – not a rank ordering per se*

1) ChemPak*
2) Exercises*
3) Training – local and national*
4) Financial Support for Hospital-based EP coordinators*
5) Mass decon units*
6) Communication sxs*
    a. Ham radio and satellite phones
7) Regional coordinators and OPEM staff*
8) Existing supply replacement*

Region 4AB Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Massachusetts Medical Society, Waltham
January 29, 2014

Local Public Health

Stuff

1) Shelter Supplies (cots, blankets, etc)
2) Medical Cots
3) Repeater with FCC license and radio bay stations
4) Radio caches (#varies per town)
5) Portal – website and databases(DMS- Document Management System; VMS – Volunteer Management System; RRD – Regional Resources Database) Region 4B
6) MIMS – electronic inventory management system
7) Signage – Pictograms for EDS/Shelters
8) Social Media
9) Code Red/Reverse 911 systems
10) Trailers with equipment

Staff

1) Region 4B MOUs
    a. ARES
    b. Red Cross
    c. Interpretation Services
    d. All 27 towns
2) School nurses (MSNO)
3) Occupational Health Nurses (MAOHN)
4) Technical Expertise
    a. Health directors
    b. Agent
    c. Inspectors
    d. Nurse
5) Legal Authority- Boards of Health
6) Medical Reserve Corps

Spaces

1) MOUs (informal) with corporations
    a. Bose, Staples, EMC – during H1N1
    b. School buses
2) Airstrips
    a. Norwood
    b. Stow
    c. Hanscom
    d. Marlboro
    e. Framingham – helipad
3) Schools & Senior centers/Community Centers
4) Malls – informal MOUs
5) Colleges

Priorities

1) Communications/Technology
   24/7/365 coverage
2) Trainings
3) Staff

Long-term Care

MassMAP mutual aid plan – MOU
Stop-over sites
Database
- Equipment
- Vendors
- Vehicles
- Staff
- Drivers

Reimbursement
Generators
Facility information
Back-up
Open Bed listing
DPH 10% waiver
Regional Coordinating Centers

Wrap up & next steps

Hope thanked all for their participation and explained that notes would be distributed via email. The March meeting will be held on March 18 from 10:00-12:30 at Massachusetts Medical Society in Waltham.

Region 5 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Plymouth
January 15, 2014

Participants:
Diane Brown-Couture, Public Health Preparedness Coordinator
David Camara, Southcoast Hospital Group, Inc.
Lisa Cullity, Pembroke
Kerry Dunnell, BU School of Public Health
Dave Faunce, Southeastern MA EMS Council
William Flynn, Cape and Islands EMS
George Heufelder, Barnstable County
Pam Kavanaugh, Greater New Bedford Community Health Center
Katie Kemen, MDPH Office of Preparedness and Emergency Management
Hope Kenefick, Facilitator
Matt Muratore, Plymouth Rehab & Health Care Center
Sean O'Brien, Barnstable County
Jacqueline O'Brien, RN Attleboro
Suzanne Robbins, Community Health Centers of Cape Cod
Sheila Wallace, Steward Good Samaritan Medical Center

Introductions. After brief introductions and review of ground rules, Hope reviewed the agenda with the group, starting with the Key Question for this round of meetings.

What are the resources/capacities in the region that can be adapted and/or inform regional HMCC planning?

Hope explained that this question was broken down into 2 parts:
A. What other health and medical assets, such as mutual aid agreements and equipment, exist in the region, in addition to those listed on the fact sheets?

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

Hope asked that the participants work their discipline groups to address these questions, and provided guidance about time.

After a period of brainstorming, each discipline had developed lists to answer both questions. Each discipline group had a spokesperson report out their results to the room.

Exact transcripts of each disciplines' list of assets follow. Priorities worksheets for each discipline are scanned.

Community Health Centers
Space – Exam rooms, generator
Equipment – Oxygen, Medical Supplies, Pharmaceuticals, Vaccines
Staff – Medical (MD, NP, PA, RN, MA, MPH, Nutritionists)
Staff- non-clinical (medical interpreters, office staff, security, maintenance)
Locations on bus routes
Federally funded entities
Large % of community comes to CHC for services – we are trusted

GAPS –
Limited MOUs with hospitals, suppliers, EMS
Additional facilities not recognized (i.e., Indian Health Services)
Knowledge of what CHC assets are throughout the emergency preparedness community
Communication with external entities
EMP and COOP not integrated regionally or within the community

EMS
Mutual aid
State – Fire/EMS mobilization task forces
Regional/County – Fire/EMS mobilization task forces
Region V –
8 MCI trailers (3 on cape, 5 on mainland)
Statewide Universal triage system
3 CMED centers for medical/hospital coordination during major MCI/medical incidents
Developing air evacuation process for Islands (USCG and National Guard Air Medical)
3 Mobile Command units (1 each county sheriff)
IFT for Hospital and hospital transfers EMS/US Hospital Plans
MPDH ASPR for MCI Trailers/Coordination/Planning
ChemPak Program – coordinated through region

Region 5 Health and Medical Coordinating Coalitions Facilitated Meeting # 1
Plymouth
January 15, 2014

Hospitals

Staff – Can both flex up staffing and house staff in advance of a weather emergency. Can project staffing needs at 8-12-24 hour intervals
Census for beds 8-12-24 hours
Licensed offsite clinical space (and staff for that space)
Offsite business occupancy space (and staff for that space)
Medical supplies – regular collaboration among hospitals to address supply needs
Communications –
Telephone, text, ham radios (staffed and volunteer HAMS)
3 I Pads per facility to enable WebEOC access
Supplies – PPE equipment (standardized across the region for all facilities)
Portable radios for internal communication
Medical staff—cross-credentialed with same policy for all facilities (same policy in all Steward facilities too)
MDUs
Decon Capacity – some internal to facility
Portable Isolation Centers (PICs) – 12 beds
ChemPak
Region 5 mutual aid

Local Public Health

MRC & CERTS
Distribution of resources
Town non-emergency personnel
Mutual Aid agreements with Red Cross,
Procurement agreements for food, medical, snow removal, transport
PIO resources
Blended communication (Police/fire/health HAM
Inspectional services water/food/environmental
Incident management team - resource

Long-term Care

MassMAP – mutual aid system (all nursing homes, assisted living and rest homes, includes chains and independents)
2x/year evacuation drills
All organizations are on the HHAN
Database of staff, stuff (meds, food, fuel information, generator specs for each facility), space (bed types)
Ability to surge to 10% over licensed beds
Fall River Coordination center (volunteer staffing)
Resources at each facility for power outages – walkie-talkies, cell phone, radio, Emergency medical kits

B. What activities are you currently funded for (each discipline) that will be priorities for continuation under HMCC funding?

See scanned worksheets for each discipline.

Wrap up & next steps

Hope thanked everyone for their participation and explained that notes would be distributed by email. The date time and location for the next meeting were announced as March 27 from 11:00-1:30 at Middleborough Town Hall.

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

EMS Region 1

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
☆ (1) MCI trailers host site funding Equipment replacement & supplies ☆ (2) MCI training (3) Chem PAK plan development (4) Chem PAK Plan - training (5) Duo Dotes (6) Mobilization plan training	(1) response to mass casualty (2) staging at mass events	(1) No similar capability in Region

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Regional Public Health

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of ***highest*** importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of ***highest*** importance, why should they continue to be funded in the future?
Coalition. 1. Build local capacity. 2. Emergency planning 3 expertise; time) Regional perspective of local need.. local knowledge 4. Regional templates 5. Exercises. /Training. 6 Interdisciplinary Collaborations) 3 REPCS 5 college Pub Safety 7 Regional Collaborations 8 Grants to local Boh	All emergencies are local and for an effective response need trained staff with - knowledge of who they need to work with	

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

+ Hospitals Regional

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
Bridging ASPR funding w/ Joint Commission standards Standardization of forms/ processes (ICS) * Medical Coordination Group Activities and Purchases (MCG) - Planning and regional MOU - Regional Go kits - i2 Lights, MCI Lights - Sat phones - HAM radios - Surge beds - ventilators * - PPE + Decon equipment + trailers (PAPRs, Filtersetc) - Pharmaceutical caches for force protection - Fatality mgmt. supplies - Med Surge beds/cots * Training + Exercises - Regional + national training - Multidisciplinary / multijurisdictional exercises - Workgroups + planning groups - HHAP drills participation	MCG activities + purchases support regional planning, mitigation, response + recovery and maximize the funding support. PPE + Decon requires: ongoing replacement of supplies; training and re-training every 3yrs: exercising with the Fire Dept. and other community responders annually. Training and Exercises strengthen our ability to respond to and recover from catastrophic events in a timely and very effective manner. (Boston Marathon is a perfect example)	Reimbursement is low. Staffing is lean. Hospitals do not have the funds to support EP activities and purchases of supplies to the extent that the grant does. Community expectations are high. Lessons Learned show the value of training + exercises, planning + preparedness

MASS MAP.

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Regional LTC

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
- CMP FUNDS. CIVIL MONEY PENALTY 2013 & 2014 - 2013 COUNCIL ANNUAL DUES ~~WERE~~ AND PAID for ALL FACILITIES to JOIN IN 2013.* LTC ONLY -	-	CONTINUED SUPPORT OF CMP FUNDS

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

CHC's Region 1

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of ***highest*** importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of ***highest*** importance, why should they continue to be funded in the future?
HVA/RISK ASSMT COOP - MEDRSV CORPS COORDINATOR TIME @ HEALTH CTR. Business Continuity MOU's Emergency operations COALITIONS.	- PREPARE OUR RESOURCES - ALLOWS STAFF TO BE ALLOCATED	- NECESSARY TO SUSTAIN RESOURCES

EMS Region 3

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
☆ 1. 3 - Regional Mass Casualty Incident Supply Trailers	1. Provide extra supplies + equip ready to deploy to MCI across Region	1. Life Safety - Supporting EMS 1st Response.
☆ 2. Regional EMS Preparedness Coord. part-time	2. Maintains readiness of MCI Trailers Coordinates Reg MCI Planning, Responds to MCI to assist in Mgmt.	2. Essential role to maintain MCI Readiness
☆ 3. S.M.A.R.T. Triage Tag System	3. Common Triage Tag/System used across the State	3. Essential for tracking Pt's During MCI
☆ 4. MCI Triage + Mgmt Training	4. Training for EMS & 1st Responders in Triage System + MCI Mgmt.	4. Essential for preparing EMS to manage MCI.
☆ 5. C-MED Infrastructure	5. Contributes to the support of C-MED w/ coordinates All Ambulance + Hospital Communications + EMS Mutual Aid, EMS Task Force During MCI.	5. Essential for Coordination of EMS + Hospital Resources + communication, Patient Tracking

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes) HOSPITALS Region 3

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
PREPAREDNESS: ☆ TRAINING ☆ MOBILE MEDICAL ASSETS EMERG. OPS. COORD. INFO SHARING ☆ CELL BANK W/ACTIVE PLANS ☆ BESAFE → REQ BY NERAC DIGITAL UPGRADE ☆ CRITICAL INFRASTRUCTURE PRO. RESPONDER ☆ DECON CAPABILITIES ☆ PHARM CACHE FATALITY MANAGEMENT PLAN HOSP. EP COSTS. EVACUATION SIP	↳ TRAINING: EXPAND PREPAREDNESS → RESPONSE CAPABILITY (SUPPORTS EQUIP.)	INDISPENSABLE; SELF-EXPLANATORY
	↳ CELL PHONE BANK W/ACTIVE PLANS: INTEROPERABLE REDUNDANT COMM SYSTEMS	HISTORY OF GRANT FUNDING FOR REDUNDANT EMERGENCY COMMO. REQUIRED
	↳ BESAFE → PARTICIPATION REQ BY NERAC FOR FUNDING	NERAC FUNDING PRE-REQUISITE (EQUIP.)
	↳ INTEROP. COMMO. EQUIPT. DIG. RADIO SYSTEM UPGRADES FOR EMERG OPS. COMMS.	EXTERNAL RESPONSE PARTNERS (FD, OPS, PD) Δ → DIGITAL ALREADY: NOW NOT COMPATIBLE
	↳ [redacted] CIP: H/VA RISK MITIGATION	IDENTIFIED RISK MITIGATION
	↳ DECON CAPABILITIES INCREASE RESPONSE CAPABILITY (SUPPORTS EQUIP.)	INDISPENSABLE; SELF-EXPLANATORY
	↳ PHARM CACHE: STOCKPILE EMERG MEDS.	PROTECT RESPONDERS

Region 3
Hospitals

NSMC:

- Swampscott ~~Family~~ Urgent Care
- Salem State College; GE Infirmary
- North Shore Physicians Group
- North Shore Cardiology
- NSMC Women's Health Center Danvers
- Mass General North Shore Danvers
- North Shore Cancer Center
- North Shore MRI
- Mass General for Children North Shore
- Children's Hospital North Shore Danvers
- Salem Hospital: LIII Trauma Gr. / Birthplace
  Interv. Cath Lab
- Union Hospital

HHS

- Cancer Ctr.
- HHS cath lab
- UMH UCC
- Reading UCC
- HH medical center
- HH medical Associates
- HH MRI/Radiation

LGH

- Main Lowell Campus + MOB
- ~~Boston~~ Saints Campus
- Lowell Walk In Center
- Westford Walk In + MOB
- N. Andover MOB
- Tyngsboro Common Center
- Chelmsford Surgical Day + 2 MOB (Cardiac + Ortho)

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Public Health Region 3

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
EDS planning EDS supplies Communications: laptops phones, radios, ipads, Reverse 911/ code Red ☆ Education/Training Drills/ Exercises Refrig / freezers Funding staff - Health Dept ☆ \ Emergency Planning Staff \ Regional tech Support (DPH) State Lab MRC Consultants - back fill / planning activities	Communications: used during emergencies to communicate Funding staff: help supplement and provide services to Health Dept. Emergency planning: develop emergency plans. Regional Tech support (DPH) Coordinators who helps coordinate activities, response and asset sharing.	→ without communication assets we cannot respond effectively to emergencies → without staff we cannot respond to emergencies effectively. → plans will not be developed or updated. → Efficient, response to emergencies with strong relationships across coalition boundries

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Region 3 — Linda Tosta, Harvard Vanguard

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be ~~funded~~ provided in the future?
Harvard Vanguard Ambulatory Care We receive no direct funds from DCoC-MDPH we do receive communicable disease/epi support and ~~pi~~ vaccine from MDPH. we also receive vaccine for EM. Dispensing and strategic stockpile supplys	access to pandemic/emergency meds/supplies access to MDPH for essential clinical guidance.	to prevent surge to acute care facilities

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Region 3 LTC / MASSMAP

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
- DPH FUNDS (CMP FUNDS) * 2013 - ◦ FUNDS USED TO BRING ALL LONG TERM CARE FACILITIES INTO MASSMAP, ◦ FUNDS USED TO PAY FOR ALL LTC MAP MEMBERS ANNUAL DUES 2014 - CMP FUNDS BEING USED TO PAY ANNUAL DUES FOR ALL MEMBERS. GRANT DOLLARS TO MAINTAIN OPERATIONS.		

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

CHC/Amb
Region 4A/B

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of ***highest*** importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of ***highest*** importance, why should they continue to be funded in the future?
★EP activities – Updating Plans - ECP/BCP HVAs ★Training & Education ★Staff Time - attendees meetings - local/State wide • Region Hosp Mtgs • Coalitions • MRCs ★Equip. purchases (limited) ★Incident Response & Recovery Support • PCA EM Manager & Support Staff		

EMS

Region 4AB

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
- Regional MCI Support units (3) - Regional PPE caches for EMS - Educational roll outs for EPB - Communications upgrades for on scene MCI Communications ~$35,000 a year for all functions Chempack Plan Transport agencies - Mass/Dispensing/Immunization site Tracking $ computers → Task force radios (each service) SAT phones	- mobile supplies that can be rapidly moved to preplanned events and disaster scenes for treatment & patients - PPE caches are stored strategically to augment local provider supplies during manufacturer shortages. Started during H1N1 events. - Communications upgrades - MCI trailers have consolettes for coordination c Hospitals through CMED. These are used by field staff on scene for coordination - Interoperability radios - each trailer houses portable radios for interops on scene for EMS Branch operations - Maintenance of Regional chempack plan. - Immunization Tracking Computers for clinics that EMS assist with. January meetings	All of it for maintenance We actually provide support to DPH through the regions services.

Hospital Sheet: 4A/4B.

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
1. Chem pack 2. Exercises 3. Training • local • national 4. Financial Support for Hospital E.P Coordinators • Consulting 5. Mass Decon Units 6. Communicatron sxs • HAM Radio • satellite 7. OPEM/Regional Coordinators staff 8. Existing supply replacement. 9. HHAN/WEB EOC	1. life and death 2. Regional & local preparedness	1. life and death 2. Regional & local preparedness

Region 4AB LPH

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
Reverse 911 * Communication/Tech cell phones - Ipads Reverse911 computer * Training - staff + MRC's + volunteers Supplies * staff - emergency planning; technical expertise; capacity in staff (nurses, dilec Coord)	cellphones; Ipads reverse 911; computer monthly fees/service staff; MRC; volunteers nurses, emergency planning - regional staff Public health activities keeping current with all threats training new staff added drilling existing staff Capacities needed to communicate across multiple elements (phone, internet, HHAN, ESF8, E911 etc.)	7day/wk 365/24hr coverage current w/ ICS - EM prep - Deliverables cont. w/ legal requirements

LTC

Region 4AB

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of ***highest*** importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of ***highest*** importance, why should they continue to be funded in the future?
* Mass MAP	* Mass MAP membership?	

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

EMS Region 5

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
MCI TRAILERS Coordination/ Planning / Exercise for MCI's	Money Provides upkeep / Repair of TRAILERS / Supplies MCI Planning & Exercise & Deployment of Trailers Coordination	Boston Marathon Coordination of EMS & Hospitals & Planning

Bristol Plymouth Cape & I **Worksheet for Exercise 2B** Public Health Region 5

(Please provide completed worksheet to the facilitator for use in session notes)

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
- Pays Planners - to write/update - EDS / All Hazards -plans themselves - Training for public Health - funds for Training - Drills / WalkThrus. - MRC - Activities - Equipment. - Training - Recruitment - Communications Equipment - reoccuring costs. - Shelter Equipment. - EDS Equipment. - medical - support equipment. - Administration $ for Grant	- Emergency Planners - MRC Support - Planners Keep people engaged and on point. - Keep plans current and accurate MRC - - is critical for incident support. - we could not respond w/o people	- Emergency Planners - MRC

LTC

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

Long Term Care Region 5

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of ***highest*** importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of ***highest*** importance, why should they continue to be funded in the future?
DPH funds Mass Map - Mutual aid planning including the MassMap.org website. - disaster drills	This is the highest of importance for this to continue due to the fact close to a majority of skilled nursing facilities, assisted livings + rest homes are now part of the group ~~Prior to~~ Prior to this, less than half joined due to the cost	The importance of the website help enhance communication on such things as open beds, transportation needs, supply needs, staff needs, etc... this is critical info to know within an hour of a HHAM Message being pushed out by DPH

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes)

CHCS Regions

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produce)?	For those activities of *highest* importance, why should they continue to be funded in the future?
3* Training	→ EMP Coordinator responsible for training all staff	Ability to respond to emergency situations mitigation planning
(1*) Equipment	→ Generator	
5* Staff (pays small portion of Salary)	→ Coordinates all EMP activities.	
(2*) Monthly maintenance of generator	→ Vaccine Storage Computer Server	→ safety of vaccine integrity
4* MLCH Resources (Tina Wright)	→ Communication with Community Health Centers - Education - Templates - Updates	

Worksheet for Exercise 2B

(Please provide completed worksheet to the facilitator for use in session notes) Region 5 Hosp

List current emergency preparedness activities that MDPH funds support in your discipline. ☆ those considered most important to continue when the regional HMCC exists.	For those activities of *highest* importance, what is the purpose of each (i.e., what EP related outcome(s) does the activity produces)?	For those activities of *highest* importance, why should they continue to be funded in the future?
- Staff training ☆ - Communication + Information Sharing - Deaf/translators - Regional Drills ☆ - Equipment Purchases: (incl replacement/upgrades) - Infrastructure - Communication equipment - IT equipment - Laboratory Network - Medical Surge - ACS - Evacuation planning + training + equipment - Pharmaceutical Supplies - Consultants - Social Workers onsite - Supply - MOU's - Translators	Standardization Ability to share resources Assets	Hospitals lack funds + resources. Not a business priority. Encourages interfacility cooperation, collaboration + integration. Encourages standardization

HMCC Facilitated Meetings

March, 2014

During the second round of the facilitated regional Health and Medical Coordinating Coalition meetings, the multidisciplinary representatives reviewed summary information on eight existing healthcare coalition models across the country, and made observations and generated questions about each model. The observations and questions will be used to gather additional information on the models for representatives and will also inform MDPH Office of Preparedness and Emergency Management planning for HMCCs in MA. Each Region also identified the kinds of organizations within their region that the five core disciplines will want to partner with when the regional HMCC is operational.

Review of existing models worksheet Region 1

Across the country, there are many different health and medical coalition models. HMCCs need to:

- Conduct regional all-hazards ***planning***
- Develop and maintain ***emergency response capacity*** with roles filled through identified staffing complemented with voluntary response elements (e.g., public health mutual aid, MRC)
- Support a ***coordinated health and medical response*** with a regional point of contact for ***communication***
- Coordinate ***information sharing*** for situational awareness and a common operating picture
- Plan for ***sustainability*** of the regional HMCC

Review the existing models and discuss your observations. Also, note anything that is confusing or about which you would like more information. Space is provided below for recording the details of the discussions.

Region 1

Models Activity Group 1:

Michigan Region 8; Northern Utah Healthcare Coalition; and Mountain Area Trauma Regional Advisory Committee, North Carolina

Observations	Items that require clarification/more information
• They are all rural like us but bigger, at least geographically • They all seem hospital centric and it's not clear if/how public health is involved. Northern Utah mentioned public health but it isn't clear the percent/number of public health departments involved. • Michigan's is the only one that mentions staffing but the staff seems very small. • Michigan's model is based on a MAC, which would make sense for us to consider too. • Michigan seems like it just does planning/advising; sort of like a consultant role (no actual role in response) but then how could they do more given how small the staff is and how big the area is **VS**. Michigan's seems like the most comprehensive of the three models. • Northern Utah and North Carolina seem to have a narrow focus (just on surge) • Northern Utah seems very collaborative. It's not clear whether they have a "governance" structure. Perhaps their model works as a collaborative without governance. • Northern Utah includes volunteer management among its activities. • It's hard to tell if there is real commitment, especially with the Northern Utah model, to doing the work of an HMCC. • North Carolina has a focus on improving medical care, which seems to make a lot of sense for that to be part of the work. • North Carolina talks about the disciplines involved and ESF8 • It's good that North Carolina has a clear mission/role. We will need that and to be very inclusive. We may be able to find one when we get more information that will be close to what we need and we can modify it for our purposes. • The North Carolina model seems to engage physician's offices, which is challenging but important.	• What are the governance and fiscal structures, and the budget and source of funding for all three? • How are all three staffed and what are the roles and qualifications of the staff? • How do all three get their work done? Staff, volunteers, both? Are they centralized? Decentralized? • Where does the work get done? Local level, county level, regional level? • Who is involved in response for these models? • What is the legislative definition of what the three do? Is there state-level law/code for operations, funding, etc.? If so, what are the mandates? • Can we get the demographics and more information on the geographic areas and all of the facilities/partners so we can assess staffing levels, funding, etc. based on these factors? • Which disciplines are involved and how are they involved and what is the public vs. private breakdown. • How and to what extent is public health involved in these models? • How do these models engage doctors in the community (e.g., group practices)? • Are there MMRSs that interact with these models and, if so, how? • How are they evaluating their efforts and who is conducting the evaluation? What have they learned thus far and what would they change? • How effective have they been and what have they learned about the relationship between size and effectiveness? • What do these three do about public education? • What is the timeline for these models? When were they established and where are they now (e.g., Are the descriptions of what they have done so far and is there more they will be doing?) • What is Medical Control Authority? • Does the Michigan model provide any communication or anything other than planning and advice? • How does Michigan's MAC structure work? • Who are the Michigan partners? • Are the models the same across each state? For ex. MATRAC s one of eight in North Carolina. Are the other seven the same? Or do they vary and, if so, how?

Region 1

Model Activity Group 2: Central Ohio Trauma System; Metro Health & Medical Preparedness Coalition, Minneapolis-Hennepin County, Minnesota; Northwest Healthcare Response Network (Formerly Seattle-King County Healthcare Coalition)

Observations	Items that require clarification/more information
COTS: • There is no mention of public health in this description. • There is a lot of work, how do they get it done? • The Healthcare Incident Liaison role is included in plans. (This role sounds like the Region 1 Hospital MCG plan) • The regional alert system is a plus. • This appears to be a trauma system that grew. • This group goes further with response descriptions. • This is similar to MESH, but with more technical assistance. • This group is not inclusive. • This group mentions other disciplines but it is not clear what the services are for them. • There is a fiduciary focus. • The HIL role is interesting. • There is no mention of mass care or sheltering. • This is hospital based and patient focused. • Prevention and education aspects are positives. • Best practice dissemination is a positive. • There is no mention of EDS. • There is no mention of EMS. • The mission is all about hospitals. • This appears to be longer –existing. • Includes mention of collection of prevention data. • There appears to be more information sharing than 'doing.' • This is a trauma centric system.	**COTS:** • Who is the board? How do they decide who are board members? • How big is the staff? • Can a regional alert system like this one work here in an environment with strong home rule and charters? • How do you get $ if you are not a part of COTS? • Is the notification system for all participants or just hospitals? • How is the HIL part of these organizations plans? How did they get them included? • How is the money spread among the disciplines? • Does COTS, HIL respond? • HIL role is not clear as a response piece. • This is a voluntary system, but how do you get $ if you don't participate?

Region 1

Model Activity Group 2: Central Ohio Trauma System; Metro Health & Medical Preparedness Coalition, Minneapolis-Hennepin County, Minnesota; Northwest Healthcare Response Network (Formerly Seattle-King County Healthcare Coalition)

Observations	Items that require clarification/more information
Metro Health & Medical Preparedness Coalition, MN • The coalition list is good, and inclusive, includes mention of Homeland Security too. • Information sharing activities are a positive. • They show an improvement planning focus. • They have a good substructure of work groups. • They do lots of convening. • This is the first model we've seen that mentions Homeland Security and EMS as partners. • This is a hospital with ESF8 responsibility for the region. • The staffing doesn't mention the other disciplines. • This appears to be a more complete coalition. • There is no information on response. • They focus on planning. • Staff focuses on hospitals. • They conduct a lot of trainings & convene conferences. This looks more EMS-like.	**Metro Health & Medical Preparedness Coalition, MN** • What are the other functions? • Would be good to explore the substructure. • Why is there no mention of response? • How do they add response to the planning work? • Does the addition of response change or add to the planning function? • Is it possible that the demographics dictate the structure? • What does "health care services" include? • What is the role of the medical director? • Is the hospital coordinator role similar to that of the MA Hospital Coordinators? • Is there other staff? • What is the degree of involvement for other disciplines? Voting, Exercising, Training, etc. • Is there Public Health staff? EMS? LTC? CHC?
Observations	**Items that require clarification/more information**
NWHRN • This is a public health emergency preparedness coalition that grew, plus EMS. • This is the only model that mentions public safety. • There is limited mention of hospitals. • This area has big wealthy companies that will support a group like this. • There is no mention of the Washington State. • No mention of Joint information center. • This seems to duplicate DPH at the regional level. That doesn't make sense to duplicate. • Is this surge planning? • This is all-inclusive. • It is Mass MAP like in its activities. • It has very explicit groups. • The MOU aspect stands out. • This is administered by Public health. • Public health administered is a plus. • The list of activities is like activities I would like to see in MA.	**NWHRN** • How do the other disciplines connect? • What are the definitions of staff roles? • Where is the response discussion? • How do they make decisions? Who decides? • What does governance look like in this public-private partnership? • Is the county structure an advantage? • Do they have other sources of $? Fees, grants? • Are there other sources of $ • How does public health participate? It is not listed in the groups. • How truly inclusive of all players is this? How does this work? • Is there a response role? • Do the staff actually do stuff? • What do they mean by "develop or support?" • Is this active engagement or just approval? • Why don't they include sheltering? • Why don't they mention functional needs?

Region 1

Models Activity Group 3: Northern Virginia Healthcare Alliance; MESH Coalition, Indianapolis, Indiana

Observations	Items that require clarification/more information
Northern VA • NVHA seems hospital-based (mostly hospital coordination). The hospitals are regional by nature. • NVHA originated as an MMRS so has a history of response. Possibly more inclusive than city/county models • Comprehensive - does what hospitals/MMRS do. • NVHA specifically identified their tasks. • They do situational awareness, resource mgmt, and trainings. • They coordinate with EMS. No coordination with LTC, CHCs or other medical providers • They work across the preparedness spectrum. • They have 72 hour response readiness. • They must have an extensive coordination budget. • There is a med surge focus/MCI • They talk about coordination with other disciplines but response tasks are hospital only • Doesn't talk about how to keep people out of hospital system. • There is no mention of coordination with public health, MRC; no health department members • They don't discuss governance, fiduciary responsibility, and staffing. • Urban area (2.5m vs. 800,000 pop) • Activities good • No mass care/shelter, dispensing, evacuation; no long-term (immediate resource distribution) and no use of volunteers • No mention of working with military -there is a lot in the area. • In general, we need to define the roles and the things people bring to the table. • #1 job - information coordination	**Northern VA**: • How do they coordinate with local communities? • What is budget size? Source of funding? • Is it sustainable? • Do they have a virtual or physical office/EOC? • What does staffing look like? • Governance -who makes decisions, on board? • Who/What is Northern VA Emergency Response System? Health care only? • Do they receive additional funding because they are part of DC beltway? DHS funding? • RHCC - do they do what DPH does (e.g., bed counts, communication, volunteer or paid? • Legal/legislative authority? • What relationships & rules exist between hospitals and other "partners?"

Region 1

Models Activity Group 3: Northern Virginia Healthcare Alliance; MESH Coalition, Indianapolis, Indiana

Observations	Items that require clarification/more information
MESH: • Funding comes from members. • It feels more collaborative, more service-oriented • Creates consistency; helps partners to do their job • Resource center! Nice to have for internal planning. • Sounds like a support agency; a consultant. • Includes recovery. • Have cache - less coordination; more distribution (cache like local SNS; cache difficult in rural area because travel may be difficult) • Sounds like Mass Map • Say little about response. They are not doing what we perceive DPH wants for HMCCs because they don't do response, less inclusive. • Do a lot of training and education but so do DelValle, CEEPET, Yale New Haven • Do legal, regulatory, policy work - potential benefit but lower priority • Non-profit org - government agency has better protections and co do what they want, make up own rules. Maybe we need a public and private/non-profit for procurement purposes. • Subscription-based (could be barrier); they probably get grants too. People don't want to get locked in; can't count on sustainability. Mass Map state pays fee. Need sustainable source of money. • Additional service -lowering costs for members • Doesn't talk about public health • Providing legal, regulatory analysis across facilities could be difficult because of own policies, proprietary info.	**MESH**: • Is "Healthcare Intelligence" situational awareness? • Is supply/RX cache centralized? Who owns it? • How does "we" get the work done? • What if you're not a subscriber? Different levels? • What/how is private-public comprised? • What is budget and staffing level? • What is the governance structure? • Who is the fiduciary agent? • Should policy decisions be at state or regional level? • What is the subscription level? Good coverage: Do people join/leave/join again? • How do they lower costs for members? Do they do group purchases?

Both:

- Northern VA - resources/hierarchical/response whereas
- MESH enables, support others, planning; Best practices by combining both.
- Legal, regulatory, policy - nice to have but not sure if our HMCC should do it.
- More advocacy
- Both seem to communicate among coalition partners but there's no public information
- We want an inclusive coalition
- MESH useful because of the TA provided between emergencies. Northern VA useful because they know how to response (but only with hospitals).
- Other observations/questions generated (not about the 8 models specifically)
- Do the regional 4c and 2 HMCCs in MA have websites
- We should look at the work of other groups in MA (MACs/Homeland Security Council Work, MCG/MMRS Springfield)
- Are there more models out there that are more multi-disciplinary?

Review of existing models worksheet Region 3

Across the country, there are many different health and medical coalition models. HMCCs need to:

- Conduct regional all-hazards ***planning***
- Develop and maintain ***emergency response capacity*** with roles filled through identified staffing complemented with voluntary response elements (e.g., public health mutual aid, MRC)
- Support a ***coordinated health and medical response*** with a regional point of contact for ***communication***
- Coordinate ***information sharing*** for situational awareness and a common operating picture
- Plan for ***sustainability*** of the regional HMCC

Review the existing models and discuss your observations. Also, note anything that is confusing or about which you would like more information. Space is provided below for recording the details of the discussions.

Region 3

Group 1 Michigan, Northern Utah and North Carolina

Observations	Items that require clarification/more information
MICHIGAN • Major mechanism is MAC • MCA seems like huge effort and another layer • Geography/population is very different • Seem to provide guidance to ICS when activated • MAC • Not clear how population is involved/informed • Not clear what the ARC are doing • Feels hospital based • This mentions evaluating	**MICHIGAN** • What facets are different than what is already here? • How much are they integrating existing organizations for 5 disciplines? • How is this different from what we have now? • Where is the MAC? What level? • MAC is assisting at what level? • Define jurisdiction • Who are the agencies in the MAC? • What are the objectives? • How old is this? • What lessons learned are there? • Who are the partners? Why? Why not?
Observations	**Items that require clarification/more information**
UTAH • No real authority but can share • How $ is distributed affects what coordination organization looks like • Big concern is how much $ will come from discipline grants • Seems to be just planning • Very specific – focus on surge • ASPR-based • Very hospital based • "Access" • Supports relationships – very important • Structure supports large region • Would seem that work must be "cookie cutter" • They have some authority	**UTAH** • Access = resource center?? • What is authority? • What will our authority be? • Is there a response function? • Coordination Committee to whom? • Who else is involved? • How are they involved with public health, emergency management, other public entities? • Funding? • Sustainability? • How does the work get done? • What is funding? • How will they sustain?
Observations	**Items that require clarification/more information**
North Carolina • Size/population determines how it is relevant to us • Looks like adapting state ESF8 Plans to regions • Single function unit • Broader health partners • Like the others – non-population based • Others acute care focused. This is broader within health • More of a response facet • Does not address environmental health concerns • Very multi-disciplinary within health • Seems to assist public sector in their response • ICS relationship is not clear	**North Carolina** • What is the size? What is the population? • How is public health involved? • How are they structured? • How are they staffed? How does the work get done? • Funding? • Can they/we make decisions? • When established? • Staffing? How does the work get done? • What is the funding? What is the sustainability? • What is the ICS relationship? • Are there similar smaller but denser population models?

Region 3

Group 2 - COTS Ohio, Metro Health Minnesota and NWHRN (Formerly Seattle King County)

Observations	Items that require clarification/more information
COTS • Support role, pass-through, clearing house • Passive assistance • Voluntary – option • Hospital resource based • Inclusion in plans • Patient focus is a positive • Not self-serving, but serving needs • Non-governmental • This is "Phil and David" • Trauma focused • From a state that has to operationalize • More substantial staffing pattern • This communication is the HHAN that we already have • We don't know enough to make any meaningful assessments • Hospital and patient focused • 1st 2 paragraphs less hopeful • Limited – pre-existing trauma system that leaves out partners • HIL – is the regional middleman • This is what exists for CMED • This is a fiscal clearing house • This has functions that we have now (CS)	**COTS** • Information on geography & population? • What are the funding sources? • How does a non-profit receive the funds? • IS there a downside to $$ - will it impact • Staffing plan? • What is the number of FTEs? • How does the $$ flow? • How do they pull in public health? How is this staffed? • Who is the board? • What is the plus/minus regarding balancing boards in a 501(c) (3)? • What does self-regulatory mean? • Is the duty officer role one that can serve a region? • Will the person at DPH that has the region 3 pager be losing their position when HMCCs come into being? • Is there any recovery activity? • What is facilitating the public health response? • How do the processes combine? • Is the HILL in all plans by statute? By regulation? How did this occur? • Who is the governing body?

Region 3

Group 2 - COTS Ohio, Metro Health Minnesota and NWHRN (Formerly Seattle King County)

Observations	Items that require clarification/more information
Metro • Size 30 hospitals • Big geography and high population • Structure come closest to MA discussions • All players included • Less mention of partners for work • Staffing • Distant from the organizations • Planning activity a plus • EPB answers pages already • WE do not know enough about this based on the web description. Challenge is whether they describe themselves well • This has a more inclusive list • The activities are focused on emergency management though. • Emphasis is on healthcare • Volunteer aspect is a problem • Who is the paid workforce?	**Metro** • Population information? • Is there staff and work for all disciplines? • Who is the decision group? • Is it hospitals only? • Who well involved? How is Emergency Management involved? • Is there staff outreach /linkage role? • Is conference $$ a revenue stream? • How do they define participation? • Is just attending a conference participation? • Is this an educational collaborative? • What are the implications of a medical director role? Is there an implication for altered standards of care? • Do we need that MC in Massachusetts? Do we want it? • Is there frequent engagement with participants? • What about response? • What is the governance structure? • How is the fee structure set? • What is the role of the medical director? • What is the contractual relationship with the hospital? Is it time? $$$ • What is the response role? • What is the relationship with public health for sustaining? • Why is the population focus missing in all of these models?

Region 3

Group 2 - COTS Ohio, Metro Health Minnesota and NWHRN (Formerly Seattle King County)

Observations	Items that require clarification/more information
NWHRN • Policy driven • Behavioral health • Access and Functional needs • Policy & planning but no response coordination • Things are ready if needed • Standardized policy is good • Considering other partners which can • Most realistic in that it does the coordinating we need to do • This is the first program that mentions mental health • Good capabilities list • Not integrated with emergency management (by description) • Active working relationship (based on presentation seen in Las Vegas) • Lots of work done to identify agreements • Level of work is done at the regional level • Similarities to MA topography – similarity in potential threats • Advantage to building on MOUs • Planning-based • Important functions – how to use them • Realistic – it gives the organizations the tools to work with regional plans • Capabilities focused • Working with local health • This is a "head with many fully functioning limbs" • It is not realistic to assess based on their web information. We need to know what kinds of responses they run and what their capabilities are.	**NWHRN** • Is this mudslide area? Do they have response experience? • Who will staff and administer the programs after the shift to 501 (c) (3)? • Why shifting to 501 (c) (3)? • Why did two regions merge? • Is there a hands -on role? • Is there a response role? • How did Seattle-King County get funds to administer? Did they bid? • Can the 5 entities decide who the administration should be? • Why moving to 501(c) (3)? • Is there a benefit? What is pushing the change? • What is the staffing arrangement? • How do you cover a big area? • Is it possible to hear directly from staff at NWHRN? • Is there a response capability • Can we please have a lot more information about this group of models please?

Region 3
Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
NVHA • Mention recovery but not included in provisions • We don't do enough recovery in MA and its critical – recovery is long-term commitment and we don't have resources now • DPH already does notification and sharing EPI info through HHAN and MAVEN • Health care alliance that partners with others • We may want to build in 72 hour self sustaining capability • HMCC can work on vendor competition issues • Pharmacy cache requires legal status to maintain and distribute. HMCC could do it HVA (regional) warrants. • Must have good funding to do so much training • Multiple disciplines supporting a common goal • Hospital –based • Lots of training hours – good • ESF-8 activities • Notification that event has occurred is important. Public safety often leaves health and medical disciplines out • Volunteer agencies (MRCs, Red Cross) should be a part on our HMCCs • No discussion about serving non-English speaking populations – that is vital here. • None of the bulleted items include planning or training • Training focused on hospital employees – should include other disciplines • Includes all phases of disaster management cycle – good. • Doesn't mention public health much – MA HMCCs will have broader scope • "Members" = hospitals; "Partners" = all others • Don't include mass care, infrastructure, environmental activities in response • Strong training and exercise focus • We want our HMCC to include public education/public preparedness	• Who is the fiduciary? Are they a 501(c) (3)? Where is the funding from? • What's the governance? • What kind of public safety/EM structure existed before NVHA and how easy was it to integrate? • What is the staffing required? • Is mental/behavioral health included? • How does county/local interact? What are roles? Capacity? • What is driving force – who wants this work? Healthcare facilities, federal government, local government? • What is/are the funding source? • Are the trainings "group" trainings or sum of individual member trainings? • Is situational awareness/information sharing the only role for local public health? • Are volunteer agencies involved? Red Cross? • Is NVERS a separate planning agency? What is relationship to NVHA?

Region 3
Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
MESH	**MESH**
• Sounds like a consultant	• Does the self-regulation/standardization supersede CDC, ASPR/JCHO requirements?
• Education/resource sharing organization. We want a group more engaged in operations.	• How do we ensure HMCC staff have our interests in mind? And know who we/our organizations are, that we understand/know each other if facilitation/groups don't participate in HMCC our interests won't be represented
• Self-regulate/standardize in their area.	
• Cache of Rx requires licensing – we should steer away from this, seems beyond the scope of a new coalition	
• Relies on member subscriptions – cost will be an issue. Need other ways to sustain. Will exclude those serving most vulnerable populations.	• Do subscribers come from outside of Marion County?
	• Do they offer services nationwide?
• Has an advisory/consultant role – like DelValle or Yale New Haven. We want operations/response	• What do they mean by "Healthcare intelligence?"
• Doesn't appear that they do a MACC in an emergency	• How do they lower costs? Is it through shared training? Rx/supply cache? Group purchases?
• Education and planning are good services we should have	
• Policy analysis could be useful. HMCC could advocate to legislature.	• We want to talk about volunteer management and how to credential volunteers to work in alternate care site or healthcare facilities
• There should be more standardization with codes in MA (Code Blue, Pink, etc). Standardization in regions and between regions.	
	• What are the roles and relationships between NVHA and NVERS? RHCC?
• Not clear what it is/does	• What is governance? Is NVHA just fiscal agent?
• Need to pay to play. Can't deny ASPR/CDC services to groups not paying	• Who is actually a part of the coalition? Who gets planning and response benefits?
• Also a good way to sustain	• Who is responsible for 24-7 response?
• Legal analysis – with limited resources this should be a focus; may also conflict with MDPH legal analysis	• Is public health part of their mission?
• MOU development/designing will rely on an agency/facility legal counsel	
• Focus on planning/training- limited response and recovery – not enough	
• Patient focused; we want population focus as well	
• Standardized local/individual protocols is different than having a regional plan	
• Doesn't include non-health care	
• Doesn't "MESH"M with our needs. ☺	

Region 4AB Review of existing models worksheet

Across the country, there are many different health and medical coalition models. HMCCs need to:

- Conduct regional all-hazards ***planning***
- Develop and maintain ***emergency response capacity*** with roles filled through identified staffing complemented with voluntary response elements (e.g., public health mutual aid, MRC)
- Support a ***coordinated health and medical response*** with a regional point of contact for ***communication***
- Coordinate ***information sharing*** for situational awareness and a common operating picture
- Plan for ***sustainability*** of the regional HMCC

Review the existing models and discuss your observations. Also, note anything that is confusing or about which you would like more information. Space is provided below for recording the details of the discussions.

General questions raised by groups

Where is the buy-in incentive for these organizations? Public health has mandates that are not being addressed.
How were these models chosen?
How do these models interact with the state ESF-8? No models were clearly state-based? Is there a model with a strong or defined public health role? Can we see it?

Group 1 Michigan, Northern Utah and North Carolina

Observations	Items that require clarification/more information
MICHIGAN • Very rural/spread out. Small population. Michigan is smaller than ours will be. ~300,000 vs. more than 1 million. • Seems health care centered, hospital centered. • It is multi-agency. • Comprehensive/impressive. • Mentions fiduciary agent. • Seems to be "traditional" healthcare definition. • Large region with small population (travel). • Public health is not included, seems very hospital centric. • Michigan seems to be doing what HMCC will do. This appears to be a MACC.	**MICHIGAN** • Who are partners? • How is public health involved and at what level? • Who are the partners in the MAC group? • What is the staffing? Who? How? Descriptions? • What are they trying to accomplish? • Please get more information about structure/governance/budget. • How is county/local government involved? • What is "health organizations"? • How do they get the work done? • Who is on the board? How many people on the board? • Would like more information on medical/jurisdiction areas they respond to. • Is there an evaluation plan? Can we see those findings? • Can we get a copy of their MOU? • What authority do they have? • What is their sustainability plan? • Outside of hospitals, who is involved? • How do they support response? How are they involved in response? • Who is responsible for their website? What is the purpose of the website? • What are they doing around recovery? (e.g., restaurant inspections, hospital food inspections) • What about sheltering? • Do they share a database? • Do they have a WebEOC type system? • Do they have a resource management system?

Observations	Items that require clarification/more information
Northern Utah • Population size is small in a large area. • Broad mission/purpose, and very unclear. • Responds to ASPR guidelines. • Strategic plan is good. • Working in accordance with capabilities. • Very focused but doesn't speak to some Emergency Preparedness and Response aspects (e.g., sheltering) • Clear mission and purpose. • Mention of volunteer management. • Talks about 8 healthcare capabilities, not the 15 as would be if public health was included.	**Northern Utah** • How many people? • How many municipalities? • Do they have an MOU? Can we get copies? • Who are the partners? • What is the governance? How are they staffed? What is their budget? • Do they have plans for sustainability? • What authority do they operate under? • Can we see the by-laws? • How is public health involved? • How is city/county involved? • Is it limited to one area or is it all-hazards? • What are other models if any from other states (e.g., Colorado) • What is public health's involvement?
Observations	**Items that require clarification/more information**
North Carolina • Public health is not mentioned. • Community is included. • Seems very hospital-centered. • Seems more specific and does not seem to include public health. • Great model for medical surge. • Good start with partners but we would need to be more comprehensive. • May go beyond region. Plan for both rural and suburban. • There are 8 regions; are all the same? • What are the sustainability and long-term plans?	**North Carolina** • Are they an ESF-8 desk? Do they have an on-call person? • How is the public education re: med surge done? • How do they prevent surge/prevent people going to hospitals? • Can we see their charter, their MOU? • How are they structured? • What are the members or stakeholder roles?

Group 2 COTS, Metro, Northwest Healthcare Response Network

Observations	Items that require clarification/more information
COTS • Hospital- trauma driven. • First responders. • Inclusion of prevention and research are pluses. • HIL role written in plans. HIL 24-7 is a plus. • There is a strong hospital voice in this description—is there a public health voice? • Mission of injury reduction is interesting. Perhaps because of other funding source requirements. • HIL role written in to all plans, functioning like an ESF-8 desk. • This group is doing what the MA DPH does now. • Run by a 501 (c) (3). • Staff serves as HIL. • Healthcare focused. • Hospital-led based organization. • Public health feels there is nothing for them. • Information sharing network is a plus. • Telephone notification system is a plus.	**COTS** • How long have they been in existence? • What is the public health role in a patient driven system? • What is the benefit of 501(c) (3) status? • Is there a negative to local aspect? • Is this a MACC? • What is the response role? • Are they situational awareness providers? • What the strengths/weaknesses of the organization for participants? • How do they manage the large organization or community /small organization or community variable needs? • What is the population? Geographic size? • Where do they get their authority to operate? • What is the budget? • How many staff? • Do they only notify hospitals? • What does OH DPH do, since this group does what MA DPH is doing now? • Is there county/local relationships? • What happens to those who don't volunteer to participate, if they have an emergency? • What do they mean by self-regulatory? • What do they mean by voluntary? • How is it voluntary? • How is it self-regulatory? • How does government participate in a 501(c) (3)? • How many staff? • What are the staff roles? • How is local public health involved? • How is $$ distributed among the disciplines? • Governance is not addressed – what is the governance? • What is the local public health role? • How does this benefit local public health?

Observations	Items that require clarification/more information
NWHRN • Administered by public health; this likely looks different than local public health in MA. • More public health functions (BH, MCM, FAC) • Model is worth looking into. • Inclusive. • This is not an organization that is buying stuff. PH feels that this is good. There is also the reality of organizations that rely on the purchase of stuff for resupply. • They are using $$ to do MOUs and planning. • This seems more similar to the MA charge to develop HMCC. • Inclusive; a broad group. • Public health lead. • Development is positive for both public health and hospitals. • Looks to be more inclusive planning. • Seems to be more planning than response. • Not hospital-centric. • Ambulatory care participation is a positive. • The only mention of public health is administration.	**NWHRN** • Why 501(c) (3)? • What is the budget? • How many staff do they have? What do they do? • What authority does the organization have? • Is health department administration still the case when they shift to 501 (c) (3)? • How does the health department role change with this shift? • Is public health role just in administration? What is the public health involvement? • Is there a response role? • Is there a MACC? • Is there 24-7 coverage?
Observations	**Items that require clarification/more information**
Minnesota • All partners are included. • Closer to our charge to be HMCC. • Acts as regional coordination center. • Staff doing grant administration. • ESF-8 functions. • Large metropolitan area with 7 counties. • This seems most like 'us'. • Healthcare system focused. No public health. • Bringing in multiple parties. • Planning aspect, includes understanding others issues. • Has all the organizations that we want in HMCC. • There is no mention of volunteers. • This is an ESF-8 function. • Training is a big part of their focus.	**Minnesota** • What is the budget? • How many staff do they have? What do they do? • What authority do they operate with? • How do they accomplish their work? • What is the population of the region? • How do they 'measure' organizations participation? How frequently do they meet? • Are all organizations equal in the coalition? • Is there an MRC? • Is environmental health part of this? • What is the recovery role? • What is the content of the trainings they provide? Is it for all disciplines? How do they decide what training to provide? • What is the response role? • IS there an alert system? • Is there a communication component? • Is the organizations work grant management, or is there more to it? • Do they use tools such as WebEOC? Do they have their own? How do they access it?

Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
Northern Virginia • Hospital-driven. • Public health included only for situational awareness. • Wouldn't work for meningitis and other public health driven events. • Excellent exercises and training. • Good to assign responsibilities for preparedness, mitigation, response and recovery. • 14 hospitals and 6 EDs but doesn't coordinate 60 communities. • Doesn't include long-term care. • All-hazards good. • Multiple agencies involved including law enforcement/fire/public health. • Most of the work still relates to medical surge. Public health is only involved with situational awareness and information sharing. • Metropolitan area is similar to 4AB. • Include mention of federal aid. • Cache is clinical – we would want more, non-clinical (shelter, radios, etc). • Good to ID who is in the coalition, includes law enforcement, fire, emergency management. • Well-established, has had academic and private $$. Proximity to DC brings more $$ opportunity. • $$ drives what you can do. • County structure, levels of authority make them different. • They involve EMS a lot! Good. • They have clearly defined objective (sustainable 72 hours). A lot of Virginia hospitals are part of the same hospital chain, if the system buys in you get all of the hospitals. • Their county/infrastructure has been around a long time. We are starting from scratch.	**Northern Virginia** • Is there a volunteer coordination function or use of volunteers? • Are all stakeholders involved in exercise/training? • What are partners doing? (Public safety, fire, EMS, etc) What are their roles? • How do they interact with the Healthcare coalition? • Are the roles/responsibilities divided by discipline? • Are there two coordinating entites- RHCC and NVERS? • How do they sustain response for 72 hours? On-call? Staff? • Does inventory management include tracking local supplies and non-clinical supplies? • What is command role, if any of Healthcare coalition? • Is it correct to assume that: Functions provide for flexibility- only one function or discipline could be lead depending on incident? • Coalition's job is to support incident commander, not to be in charge? • Will federal money go to the lead discipline for the response? Will federal money go to coordinating entity or to individual organizations? • How would we involve law enforcement, fire and Emergency management across so many local jurisdictions? How do they in NV do it? • What does funding structure/sources look like? Are locals involved or just county? • How do they maintain the supply cache (ventilators, fluids, etc)? What is the storage space, who pays, who controls supply, dedicated staff? • How do they communicate within/between different organizations? Coordinating centers, systems used, EMS/law/fire to health/medical on large/regional level. Do they have operational frequencies accessible by all? • How are they governed? • How many FTEs? What do they do?

Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
MESH • Not a lot of detail regarding who is involved and how work is done? • Concentrates more on clinical training: light on public health education. • Like best practices clearinghouse, information sharing. Legal/regulatory analysis because it centralizes this analysis for all disciplines in one place and is independent analysis. • ESF-8 regarding healthcare inter. • Encouraging that they've existed since 2008; they must have had buy in, there must have been a need. • Population is smaller than 4AB. • Looks similar to COBTH. • Group assisted by a best practices/consulting agency & during responses it share information. • Good that is embraces training and education. • The approach is to create consistence among healthcare providers and facilities is in a vacuum, not much community/partnership building. • Good to consolidate policy analysis. • Cost/benefit financial analysis – public health may be disadvantaged. • Subscriptions. • One county. We cover 5 but that doesn't make much difference. • Non-profit. Opens up more $/grant opportunities. • Sustainable through subscribers. City/town budgets won't be able to support fees. • Group 3 models closer to future, 4AB model. • Urban, similar population size, similar disciplines involved except for law enforcement/fire/etc. • Maybe non-profit to be able to collect subscriptions. • Parallel to mosquito control program. If you are not a member you don't get services.	**MESH** • Who are "healthcare providers"? • Is cache of Rx available only to hospitals? • How much is subscription and is number different for different members? • Who are governmental and NGO agencies involved? • What does it mean that entities support it? Is there a federal match for subscriptions? • Where does HCC's authority come from? Is there any statutory authority? • Why did they choose to be non-profit? • What happens to hospitals/others who don't subscribe? • How did they get people to pay? • How many FTEs? What do they do? Titles?

Debrief observations.

1) Hospital-centric.
2) Models fall into 2 general categories.
    a) Governance structures
    b) Consulting business with subject matter experts.
3) Important to know how much $$ and what other sources of funds the models get
4) They all are 501 (c) (3) – why?
5) Who is in charge of the website and information?
6) Are the websites only a public information tool or is there a coordinating function there too?

Review of existing models worksheet- Region 5

Across the country, there are many different health and medical coalition models. HMCCs need to:

- Conduct regional all-hazards ***planning***
- Develop and maintain ***emergency response capacity*** with roles filled through identified staffing complemented with voluntary response elements (e.g., public health mutual aid, MRC)
- Support a ***coordinated health and medical response*** with a regional point of contact for ***communication***
- Coordinate ***information sharing*** for situational awareness and a common operating picture
- Plan for ***sustainability*** of the regional HMCC

Review the existing models and discuss your observations. Also, note anything that is confusing or about which you would like more information. Space is provided below for recording the details of the discussions.

Questions raised for all models: What were their obstacles? How have they sustained $$ over the years? Are HMCCs viable if a group pulls out? How do you make sure services and $$ are equitably distributed? Is the region unavoidable? Who makes the decision of what is equitable? What is the basis for equity? Population? Size? Summer population or winter population? How is $$ distributed? What is the organization? Will all organizations be there?

Group 1 Michigan, Northern Utah and North Carolina

Observations	Items that require clarification/more information
Michigan: • There are a lot of hospitals involved/strong hospital base and interest • Seems strong in operations • It's a MAC • Very rural, not like us; they have 300,000 people and we have 1.2million • Looks like a regional hospital EOC; we would need to include LPH and LTC. Doesn't look like LTC and LPH are involved. • They address all phases of emergencies • The partners don't seem to be full partners (see hospital coordinator) • It looks like it was designed to meet JCAHO requirements • It has member organizations • There is very little staffing • Seems like they have a stronger county structure than us • "Advisory" is interesting. Not sure what they do. Not clear if they are part of response or if their contribution is coordinated planning. • There is a MD in part-time medical director role.	**Michigan:** • Does the area include tribal governments? If so, how do they work with them? • Are they focused on natural disasters and environmental issues (in other words, beyond mass casualties) • How are they involved in all phases of emergencies; what do they do? How do they function? • How are they funded? What are costs? • What is their plan for sustainability? • Are they a public/private partnership? If so, who are the partners? • Who are the health care organizations involved? • How does the work get done/who does it? • How do they govern themselves? • What does "member" mean? What is involved? • Could we see their org charts and by-laws? • What is the structure of their coordinating group? How are they run and how often? • Are there other staff in addition to the two positions mentioned? Could we see all staff job descriptions? • What is the "assistance" they provide? • Are they an EOC? • What are their lessons learned (e.g., what to include/do and what not to include/do)? • Do they do exercises? If so, what kind, how often and who is involved? • Who do they report up to? • How do they govern themselves and how are the counties and towns represented?

Group 1 Michigan, Northern Utah and North Carolina

Observations	Items that require clarification/more information
Utah: • It is focused on med surge and just hospitals • It seems like they are about where we are in their planning and are addressing the things we will address. • It seems like one component of a bigger system • It could be like a CMED • Really focused on MCI; nothing on natural disasters or environmental health mentioned • Seems like it may be based on the previous funding requirements and its being adapted for new guidance • Seem very rural, not like us • Designed to support organizations that are located very far apart in their networking with one another	**Utah:** • EMA, EMS, LPH, LTC, CHC - are these partners? • Who are their members? • How do they do relationship building? • Is this located/situated within county government? • Are tribal governments in their area? If so, how do they work with them? • What are the demographics of the area and the square mileage they cover? • What are their lessons learned (e.g., what to include/do and what not to include/do)? • Can we get copies of their org chart, job descriptions, by-laws? • What is their governance model and staffing model? • How are they funded and what is their plan for sustainability? What are their costs? • How do they function? • Do they do exercises? If so, what kind, how often and who is involved? • Where are they headed? ESF8? • What is their implementation plan? • How are they activated?
Observations	**Items that require clarification/more information**
North Carolina: • Doesn't seem to include LPH or EMA; very hospital/health focused with an advanced medical focus • They define their partners; There is a health care provider emphasis but it does seem broader than just hospitals • There is no information on operations or on the hazards they address • It seems like they probably address MCI and infectious disease but not environmental health and natural disasters • Looks like it could be a good model for coordinating medical resources (kind of like COBTH in Boston) • Seems like a single component of a larger model • This doesn't seem like it would work for us given what we are expected to do. • This seems like what we are currently doing in MA • It says it works outside of its region • They seem more focused on response than the others	**North Carolina:** • Do they do operations/response? • Are there other non-medical partners? Who? • How do they interface with other partners? • What is their governance model? Can we see by-laws? • How are they staffed and how does work get done? If staffed, can we see job descriptions? • Is there one oversight organization for each of the eight coalitions or is there one oversight organization for all eight (i.e., all report up to the same entity)? • How do they function? Do they have an operations role or is it oversight only? • How often are they stood up and exercised? If so, what kind, how often and who is involved? • What are their lessons learned? • How are they funded and what is their plan for sustainability? What are their costs? • Did they focus as they did to make the work more manageable/doable? • How do they integrate with other ESFs?

Group 2 - COTS Ohio, Metro Health Minnesota and NWHRN (Formerly Seattle King County)

Observations	Items that require clarification/more information
COTS • More inclusive of disciplines • Clear definitions • 365-24-7 coverage is a positive • Pad staff to work the system is good vs. relying on volunteer staff) • Very different intent that models in other group • Mentions sustainability • Voluntary • Trauma system • Data collection and research • Built on the needs of members • Kind of like Stone Soup • Forum, clearing house – passive • In other plans, not its own plan • Adjunctive • What we are not, not what we expect to accomplish • Trauma focus – limiting • Hospital focus • Clearing house is very passive • Focus on patients throughout the system • No mention of LTC or LPH • Not all hazards – MCI focused • HIL is a legitimate part of structure • Buy-in is apparent • Trauma system that grew	**COTS** • How is this self-regulatory? How is it voluntary? • Is it like the MRC? • What is the clearing house function? DO they order materials? Provide education? Provide information? • Who runs this place? • What is the org chart? • How was the HIL role written into plans? • Do communities call for assistance? • Discuss volunteer vs. voluntary • What does volunteer mean? • How do $$ to orgs work? • Why is there an injury prevention mission? Is this funding related? Trauma level related? • What is Data collection and research related to? Trauma? • What is this self-regulatory? • How are they governed? • What about planning? • Are they operational? • What is this augment? How do they augment? • Is there coordination activity? • What is systems improvement? • Are there evaluators? Are they changers? • What is the prevention? Is this grant driven language? • What is self-regulatory? • What is voluntary? • What is incentive for organizations to work with them? • How is the county related? • What are the demographics? • Do they have other funding sources?

Group 2 - COTS Ohio, Metro Health Minnesota and NWHRN (Formerly Seattle King County)

Observations	Items that require clarification/more information
METRO • Inclusiveness critical for HMCC to work • All partners present • All phases – including training exercise • More involved • A medical center is at head of the staff • Clearer delineation of responsibility • They have a structure • Annual conference • Drills and exercises • County medical center responsible for everything "the buck stops here" • Grant admin staff • Quality improvement • Regional working groups • Similar to the HSPH exercise group, but more disciplines • Big smiley face • Idealized HMCC for Local public health view • More active than COTS • Includes ALL the groups we want • Highly connected to Emergency management and emergency response • Includes tribes too • All activities • Opportunities for input • Appears to be an EM that grew	**METRO** • How does it filter? • How is training arranged? What is the training? How is it delivered? • What are their lessons learned about healthcare coalitions? • What barriers did they encounter? How were the barriers overcome? • What do they feel needs improvement? Ask them "if you had it to do again…..what would you change, do the same, etc… • How do you use this structure in response? • What is the $$ they get? Sources, how much • Does HMCC provide funding to orgs? • Is this ASPR program manager? Is it PHEP manager? • Is there staff beyond the hospital? • What is the $$ piece for LTC, PH, CHCs • What is the relationship between health resource center and metro health authorities? This is an important question – goes to how do you do what you do? How do they avoid conflict of interest with the hospital organization?
Observations	**Items that require clarification/more information**
NWHRN • Big partner list is a plus • Similar to Mass MAP – standard agreements • Work list is accurate and appropriate • Good example for Region 5 because of merger activities • Strong local public health relationships • Organization is good – MOAs good • Strong pre-existing structure (multi-county (10) health org) • Very patient care provider focused • Local public health is after thought • Reflects WA state approach to public health • Within health care structure • MOU maintenance – passive • No natural hazard information • JACHO flavor to it • No mention of tribal	**NWHRN** • How long has this been in existence? • How did they get partners? MOUs? MOAs? • Who is in charge? • What is the accountability? • Are there systems that operate in different regions? • Are any of the hospitals non-profit hospitals? How is the $ distributed? What is the priority setting process? • Is there a different way for organizations with different needs and abilities? • What about environmental health? Infectious disease? • What emergencies are you set up for? • What degree of local health involvement? • Is there an Emergency Management response portion? • What about pandemic? Natural hazards?

Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
NVHA • Hospital-based. • Situational awareness, resource management and trainings. • Originated as an MMRS – history of response. • Coordinate with EMS. • Across preparedness spectrum. • Must have extensive, coordinated budget. • No coordination with LTC, CHCs, other medical providers. • 72 hour response readiness. • Med surge focus/MCI. • No mass care/shelter, dispensing, education. • No long-term (immediate resource distribution). • No usage of volunteers. • MMRS that grew. Possibly more inclusive than city/county models. • NO mention of coordination with public health, MRC. • Urban area (25 Million vs. 800,000 population) • Activities good. • Mostly hospital coordination. • No health department members. • No mention of working with military-- there is a lot in the area. • Hospital-based – hospitals regional by nature. • Specifically identify their tasks. • Comprehensive – does what hospitals/MMRS do. • Does discuss governance, fiduciary responsibility and staffing. • Talk about coordination with other disciplines but response tasks are hospital only. • Doesn't talk about how to keep people out of the hospital system. • In general we need to define the roles and things that people do/bring to the table. • Established non-hospital partners (EM, EMS, LPH, etc) • Lots of training hours; lots of resources to train/exercise, created readiness, training focus has to be on HMCC goal • HMCCs should have list similar to bulleted objectives. HMCCs can do some of this work – individual facilities do it now – LTC doing it on a regional/state level now • Seems more sustainable because of broader focus • Hospitals in Longwood area all worked together – this seems like dense are, probably similar, "alliance" makes sense • Defined scope: communication and resource coordination • Probably have available funding because near DC	**NVHA** • How do they coordinate with local communities? • What is the budget size? Source of funding? • Is it sustainable? • What does the staffing look like? • Virtual or a physical office/EOC? • Who makes decisions on board? • Who/what is the Northern Virginia Emergency Response System? (health care only?) • Do they receive additional funding because they are part of the DC beltway? DHS funding? • What is governance structure? Staffing arrangement? • RHCC – do they do what MDPH does (e.g., bed counts, communication?) Is it volunteer or paid? • Do they have legal/legislative authority? • What is the level of involvement of hospitals vs. free standing EDs? • What relationships and rules exist between hospitals and other "partners"? • What is the scale of the exercises? Did they follow full HSEEP process? • What KINDS of training are offered? • What co0nducts training? Who participates? What is the funding source? • Do they have data on training effectiveness? • IS there a board or a team that everyone reports to? IS there an org chart? • What is chain of command? • Any legislative authority? • Who carries out operational goals and objectives during response? • How long did it take to develop? • Who are "other healthcare facilities?" • How does regional system fit within state system? • Is their "ESF-8" only inclusive of healthcare? • How are they governed? How are they funded? • How do you get hospitals to work together? • Is there more than just hospital work/planning? • What do they mean by 'goals and objectives take an all-hazards approach'? • What is the RHCC and is it different than the NVHA?

NVHA OBSERVATIONS continued • Have to consider proximity to one another when planning • Outline asses and how they work with patients – clear • Sound like Region 5 hospital meetings – coordination, develop relationships • We (different disciplines) don't see each other regularly in MA • Might have grown out of hospital coalition with existing relationships and added ESF-8 • Do we just want to focus on health? What about mass care? • Hospital group – other partners are an afterthought. • Activities don't include other activities like mass care. • MCI response organization primarily. • Good work but needs to include more partners. • 72 hours isn't very long – disasters can last longer. • Like an ECO/ MACC (info, resources). Like Barnstable County MACC. • Strong operational model for response (bulleted items) but not truly all-hazards because so hospital focused. (needs more environmental, infectious disease, large, long-term natural disaster) Good detail; good description of what they do.	

Group 3 – Mesh Coalition and NVHA

Observations	Items that require clarification/more information
MESH • Funding from members. • Feels more collaborative, more service-oriented. • Creates consistency, helps partners do their job. • Resource center. Nice to have for internal planning. • NVHA has resources and hierarchical response, while MESH enables, supports others, planning. • Best practices by combining • Legal, regulatory, policy, more advocacy -- nice to have it, not sure if our HMCC should do it • Communication among coalition partners but no public information • We want an inclusive coalition • MESH is useful because of TA provided between emergencies • NVHA useful because they know how to respond (but only with hospitals) • Sounds like a support agency, a consultant • Include recovery. • Have cache. Less coordination, more distribution • Sounds like Mass MAP. • Rx cache – like local SNS. Cache difficult in a rural area because travel may be difficult. • No doing what we perceive MDPH wants for HMCCs because don't do any response, and are less inclusive • Subscriber only • Do a lot of training and education, but so do DelValle, CEEPET, Yale/New Haven • Does legal/regulatory/policy work –a potential benefit, but lower priority for us. • #1 job – information coordination • Non-profit organization. Government agency has better protections and can do what they want, make up own rules • Maybe we need a public and a private non-profit for procurement purposes • Subscription-based -- BARRIER. Probably also get grants. People don't want to get locked, can count on sustainability. Mass MAP – state pays fee. Need sustainable $ source. • Additional service – lowering costs for members – providing legal, regulatory analysis across facilities could be difficult because of own policies and proprietary information • Doesn't talk about public health • Basically clearing house for education and training. Someone writing policies and trying to use them in other facilities – standardization • Similar to what Russell Phillips does for LTC/Mass MAP	**MESH** • DO they include other health partners? • Is "Healthcare Intelligence" situational awareness? • Is supply/Rx cache centralized? Who owns it? • How does "we" get the work done? • What if you are not a subscriber? Are there different levels? • What/how is private-public comprised? • What is the budget size? • What is staffing arrangement? • What is the governance structure? • Who is the fiduciary agent? • Should policy decisions be at the state or region level? • What is the subscription? Good coverage, do people join/leave/join again? • What are the staffing levels? • How do they lower costs for members? Do they do group purchases? • What kind of agency/board runs MESH? What do their by-laws look like? • Are subscribers only healthcare or are government and non-government subscribers? • Does MESH go into subscriber facilities and offer training? • How does subscription work? How much is it? • Do they have legislative authority? • Are there sources of funding beyond subscriptions? • What is healthcare intelligence? • Who are "MESH Preparedness Advisors"? • How do they decide what supplies to have on hand? Do they have work groups? • How do they have equipment, supplies everyone can use? • "Subscribing organizations" – does this exclude local public health? • How do they bring in other agencies? (EMA, EMS, LPH etc) • What is there responsibility in a response, if any? • What does policy analysis mean? Include? • What are their operation capabilities? • Are there tribal governments (with Indian Health Services) in Marion County? • How big is the staff?

MESH OBSERVATIONS CONTINUED

- Strong on education – important
- Feels like it is missing other players (law enforcement, state agencies, vendors, health departments) by only focusing on subscribers
- No problem with subscription (if reasonable price) but needs to include more partners
- Legal/policy analysis might conflict with internal organization analysis
- "What I call Ed Hennegan for"
- Some other entity doing work in support of the hospitals – does the legwork
- Supply-based, doesn't describe interaction with community or response actions
- Have a supply cache is good. Group purchases can be difficult because facilities use different models. Nice to have someone else to maintain supplies.
- Chempaks are coordinated regionally (in MA). That's good.
- Regional people know people, facilities, region – makes it easy to respond and coordinate regionally.
- They've been working on it since 2008
- Mostly hospital.
- Sounds like a think tank (egalitarian)
- Subscription – will keep groups out of the system
- Help lower costs – good.
- Sounds like a trade association. Might supplant existing resources, SMEs, etc, that already exist in MA.
- Critical components: Education, training, planning.
- WE already have resources like DelValle/ CEEPET, MA League, Hospital Association, MMS, State, so we don't need another "resource center".
- Cater to subscribers – we want broader participation.
- We want more operational/response capacity.
- Sounds like they do healthcare Continuity of Operations. We would need multi-disciplinary COOP planning.

Region 1 Possible HMCC Partners Activity Results

What types of organizations, in addition to the 5 core disciplines and emergency management and public safety, should be involved/engaged when the regional HMCC is in place? Space is provided below and on the back of this sheet to capture the brainstorming discussion about three categories of possible partners (in case you wish to take your own notes). The three categories of partners about which we'll brainstorm are:

- Health and Medical Organizations that have ***some ability to support response***, other than the five core disciplines (e.g., VNAs, home health)
- Health and Medical Organizations that will ***need to be sustained with support from the HMCC*** because of possible adverse impact to clients/patients and the health/medical system (e.g., dialysis centers)
- Organizations in ***other ESFs that may be partners in response*** (e.g., behavioral health and social service organizations, local senior centers, businesses)

ESF8 Health and Medical Organizations that have some ability to support a response

Types of organizations:
MRC Pharmacies VNA, home health, home care agencies School nurses Parish nurses Students: nurses, dental, social work/mental health, MPA Mental health providers (strike response team)

ESF8 Health and Medical Organizations that will need to be sustained with support from the HMCC because of possible adverse impact to clients/patients and the health/medical system

Types of organizations:
Providers for individuals with functional needs: • Independent Living Centers • Behavioral Health inpatient settings; group homes • Specialty schools • DV shelters • Councils on Aging • Rehab hospitals • Specialty Care Hospitals • Substance Abuse facilities • Social service agencies with medical services

Organizations in other ESFs (NOT ESF8) that may be partners in response

Types of organizations:
United Way VOAD/COAD (e.g., Meals on Wheels, food bank, faith-based orgs, Red Cross, Salvation Army MEMA regional office Colleges/universities Schools Berkshire and Franklin Sheriff Departments DART/CERT Independent Living Centers HAM radio operators Local responders (LEPC, REPC) DPWs

Fire Departments
HazMats
Regional Transit Authorities
Durable Medical Equipment vendors
North Western MA Incident Management Team
Funeral Directors
Veterinarians
Dept of Agriculture
MWRA
MA DEP
City water/Natural Resources ESF
Military ESF/ROTC volunteers
Jails
Media
Social Services agencies
Elected officials
Fuel providers
Vendors in general
Food facilities/companies

Possible HMCC Partners Activity Worksheet for Region 3

What types of organizations **in addition to the 5 HMCC core disciplines, emergency management and public safety**, should be involved/engaged when the regional HMCC is in place? Space is provided below and on the back of this sheet to capture the brainstorming discussion about three categories of possible partners in case you wish to take your own notes. The three categories of partners about which we'll brainstorm are:

- ESF 8 Health and Medical Organizations that have ***some ability to support response***,
- ESF-8 Health and Medical Organizations that will ***need to be sustained with support from the HMCC*** because of possible adverse impact ***to clients/patients and the health/medical syste*****m** (e.g., dialysis centers)
- Organizations in ***other ESFs that may be partners in response*** (e.g., human service organizations, local senior centers, businesses)

Your materials include handouts with detailed descriptions for both Emergency Support Function 8 and Massachusetts Emergency Support Functions.

ESF-8 Health and Medical Organizations with some ability to support a response

Types of organizations:
Home health care providers
College/university medic al providers; students in health programs; health tech students
Behavioral health providers/ crisis intervention and those within the CHCs
Out-patient mental health providers
In-patient mental health providers

ESF -8 Health and Medical organizations & facilities that may require support to continue providing care or services.

Types of organizations:
Dialysis facilities
Addiction detox centers
Group homes – people with disabilities
In-patient mental health facilities
In-patient adult day care facilities
In-patient mental health programs
Out-patient mental health providers

Organizations from other ESFs that may be partners in response

Types of organizations:	
Local Senior Center	Big public and private businesses for information dissemination, staff and facilities
Public works	Communications – regional and local partners
ESF-6	Ham radio operators
Shelters	Durable medical equipment suppliers
Emergency Management Agencies	Water suppliers
Faith-based organizations	
Police	
Sheriff's Department	
Military facilities (for moving/transportation/decontamination)	
Department of Corrections	
Colleges/universities facilities for sheltering	

Possible HMCC Partners Activity Worksheet - Region 4AB

What types of organizations **in addition to the 5 HMCC core disciplines, emergency management and public safety**, should be involved/engaged when the regional HMCC is in place? Space is provided below and on the back of this sheet to capture the brainstorming discussion about three categories of possible partners in case you wish to take your own notes. The three categories of partners about which we'll brainstorm are:

- ESF 8 Health and Medical Organizations that have ***some ability to support response***,
- ESF-8 Health and Medical Organizations that will ***need to be sustained with support from the HMCC*** because of possible adverse impact ***to clients/patients and the health/medical syste*****m** (e.g., dialysis centers)
- Organizations in ***other ESFs that may be partners in response*** (e.g., human service organizations, local senior centers, businesses)

Your materials include handouts with detailed descriptions for both Emergency Support Function 8 and Massachusetts Emergency Support Functions.

ESF-8 Health and Medical Organizations with some ability to support a response

Types of organizations:
Pharmacies, including pharmacy-based clinics
Durable medical equipment suppliers
Behavioral health organizations (and response teams)
Rehab hospitals
Home health/home care agencies
MRCs
Health care-based interpreter services
Health services at colleges/universities
Occupational health/businesses

ESF -8 Health and Medical organizations and facilities that may require support so that they can continue providing care or services.

Types of organizations:
Pharmacies
Organizations that support individuals with functional needs (e.g., home health providers)
Dialysis centers
Chemotherapy centers
Interpreter services groups

Organizations in other ESFs that may be partners in response

Types of organizations:	
HAM radio operators and other communications supports	Regional rehab units
Public works	DEP
CERT	
The Ride and other transportation providers, including school buses	
Veterinarians and animals supports	
MEMA -CISD for first responders	
Language/interpreter services providers	
Volunteer organizations (e.g., Red Cross)	
Faith-based organizations	
Big Box stores, supermarkets, etc.	
Colleges and universities (food services/shelter)	

Possible HMCC Partners Activity Worksheet for Region 5

What types of organizations **in addition to the 5 HMCC core disciplines, emergency management and public safety**, should be involved/engaged when the regional HMCC is in place? Space is provided below and on the back of this sheet to capture the brainstorming discussion about three categories of possible partners in case you wish to take your own notes. The three categories of partners about which we'll brainstorm are:

- ESF 8 Health and Medical Organizations that have ***some ability to support response***,
- ESF-8 Health and Medical Organizations that will ***need to be sustained with support from the HMCC*** because of possible adverse impact ***to clients/patients and the health/medical syste*****m** (e.g., dialysis centers)
- Organizations in ***other ESFs that may be partners in response*** (e.g., human service organizations, local senior centers, businesses)

ESF-8 Health and Medical Organizations with some ability to support a response

Types of organizations:
Home health care providers
MRC and other medical volunteer organizations
Behavioral health
University health centers
Pharmacies
Assisted Living
Durable Medical Equipment providers (including those who supply outside of our area of the country)

E**SF -8 Health and Medical organizations and facilities that may require support so that they can continue providing care or services.**

Types of organizations:
Dialysis facilities
All of the organizations on the ESF8 response partner list
Funeral homes
Refrigerator trucks
Housing authorities/large congregate housing

Organizations in other ESFs that may be partners in response

Types of organizations:
Local Senior Center
Volunteer organizations (e.g., Red Cross)
DARTS and animal care providers
Cultural groups/organizations
Emergency Management
Public and private transportation
Large housing/congregate housing
Chamber of Commerce and business groups
Faith-based organizations
Schools (for communications and facilities)
Public works
Hotels
Food banks and food suppliers
Big Box stores
Utilities

HMCC Facilitated Meetings

May, 2014

Desirable Attributes and Capacities for HMCC coordination agencies identified by each region

The third Facilitated HMCC meetings occurred during the month of May (with one date in June due to an emergency re-scheduling of one of the region's meetings) and representatives addressed three questions:

- Review and discuss pros and cons of possible governance models for the HMCC
- Brainstorm desirable attributes and capacities for an HMCC regional coordinating agency
- Provide an opportunity for representatives to identify implementation questions.

Desirable Attributes and Capacities for HMCC coordination agencies identified by each region

Region 1	Region 4AB
• Specificity about the IT, fiscal, and HR capabilities • Transparency around decision making • For the coordinating organization to be prepared to work with a governance structure that has regional/geographic and discipline representation • An organization that is already engaged in the work and understands how the region operates • A demonstrated history of working with coalitions/sharing governance and a culture of collaborative planning and problem solving* • An organization that is visionary and that can think creatively about opportunities such as funding possibilities • Ability to manage subcontracts • Someone with a history of and/or feasible plan/strategies for engaging partners at the local/organizational level • Facility with IT/communications and plan for using them • Someone who can coordinate the HMCC cost-effectively • Hampden County would like the coordinating agency to be located in Hampden County • Effective at engaging partners from across the region.	• Givens: 24/7 capacity during response and IT, HR, and fiscal capabilities • Have physical structure/support for long-term operations and back-up facility • Share information, resources, decision-making responsibilities • Have the ability to engage multi-disciplinary partners and mediate differences • Access to legal counsel during planning and response • Have the ability to communicate across sectors and an ability to translate from the language of one discipline so others understand it (e.g., public health acronyms to health center representatives) • Have knowledge of resources in the region • Be unbiased and not favor their own discipline or existing relationships in term of money or in other ways • Have an understanding of ESF8 • Be trained in ICS • Have the capacity to start up/maintain multi-disciplinary resource data base • In the future: Multi-disciplinary staff who represent the core disciplines, job action sheets
Region 3	**Region 5**
• Overlapping knowledge of players such as Public health and EMS • Keep local health and hospitals engaged thru relationships; keep the interest • Keep things updated • Able to accept fiduciary responsibility, manage money	• Existing Infrastructure • 24-7 capability including pager coverage • Good communications capacity in place or acquirable • All hazards view – not focused on just one aspect • Able to work with different organizational cultures • Integration with MEMA • Develop connections with NGOs in region such as faith-based organizations like the Cape Cod Council of Churches • Ability to address regional volunteer management – spontaneous volunteers

Health and Medical Coordinating Coalitions (HMCC)

Models Activity Summary

March 2014 Regional Meetings

Institute for Community Health
Building sustainable community health, together
A collaboration of the Cambridge Health Alliance, Mount Auburn Hospital, and Partners Healthcare

OVERVIEW

In March 2014, Boston University School of Public Health's Office of Public Health Practice (BUSPH) conducted facilitated meetings in Regions 1, 3, 4AB, and 5 with representatives from the five core disciplines—Community Health Centers/Ambulatory Care (CHC/AMB), Emergency Medical Service (EMS), Acute Care Hospitals, Local Public Health (PH), and Long-term Care (LTC).

In each regional meeting, three small groups of multi-discipline representatives reviewed and discussed their observations about existing health and medical coalition models from across the country. Each of the three groups reviewed examples of two to three models. These models were categorized as either a local/regional structure, local/regional government structure, or non-governmental structure. HMCC representatives compiled a bulleted list of observations on the various models and BUSPH gathered the notes at the end of the meeting. These lists were shared back with the respective regions.

The Institute for Community Health (ICH), who provides evaluation services for these facilitated meetings, analyzed the lists and identified common assets and concerns of the models as well as noted general observations made by the representatives. Observations were categorized into six domains:

- model structure;
- staffing structure;
- funding source;
- role/activities;
- collaborators/participating disciplines;
- geography and population.

This report summarizes the common observations for each model across Regions 1, 3, 4AB, and 5 organized by the domains listed above.

KEY FINDINGS

The facilitated meetings in Regions 1, 3, 4AB, and 5 with representatives from the five core disciplines noted observations on various aspects of the models. Their comments may be useful as MA DPH considers the development of operational models appropriate for HMCCs in MA. In summary, participants identified the following as important aspects of any operational model for the HMCCs:

- include various partners/multiple disciplines including public health;
- broader scope than hospital-based;
- address ASPR guidelines and capabilities;
- use all-hazards approach including environmental health and natural disasters;
- have a staff similar to a Healthcare Incident Liaison who is part of emergency response plans;
- have 72 hour readiness/capability; and
- include training/education component.

The following sections provide an overview of the comments about each of the models presented to the representatives. Only common remarks discussed by the representatives have been included in this report, and they have been organized as observations, assets, and concerns. It is to be noted that some of the notes were more detailed than others, and the brevity of some notes made it difficult to determine whether or not the group thought it was a concern or an asset. The evaluators combined observations and held conversations with BUSPH to determine how to best categorize the observations.

LOCAL/REGIONAL STRUCTURE

Michigan Region 8

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- staffing structure;
- role/activities;
- collaborators/participating disciplines;
- geography and population.

One asset of the model was mentioned while three concerns were identified. All regions expressed concern about the model being hospital-centric. No common observations, assets, or concerns were noted on funding source.

The table below highlights the common observations, assets and concerns mentioned by representatives across the participating regions.

Michigan Region 8			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• MAC mechanism (Regions 3 and 5)	• MAC model (Regions 1 and 4AB)	• None listed
Staffing Structure	• None listed	• None listed	• Limited staffing (Regions 1 and 5)
Funding Source	• None listed	• None listed	• None listed
Role/Activities	• Consultant/advising role/guidance (Regions 1, 3, and 5)	• None listed	• Hospital-based/centric (Regions 1, 3, 4AB, and 5)
Collaborators/Participating Disciplines	• None listed	• None listed	• Public health not involved/included (Regions 1 and 4AB) o This point was noted by Region 5 as an observation as opposed to a concern
Geography & Population	• Rural (Regions 1, 3, 4AB, and 5) • Smaller/different population (Regions 3, 4AB and 5)	• None listed	• None listed

Mountain Area Trauma Regional Advisory Committee, Flat Rock, North Carolina

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- role/activities;
- collaborators/participating disciplines.

Four assets of the model were listed while three concerns were mentioned. No common observations, assets, or concerns were noted on staffing structure, funding source, geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Mountain Area Trauma Regional Advisory Committee			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• None listed	• Model good for medical surge (Region 4AB) and coordinating medical resources (Region 5)	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• None listed	• None listed	• None listed
Role/Activities	• Focused more on response (Regions 3 and 5) • No information on operations or hazards they address (Regions 3 and 5) • Works outside of its region (Regions 4AB and 5)	• Broader focus within health/hospital (Regions 3 and 5)	• Hospital/health focused (Regions 1, 4AB, and 5) • Does not address environmental health (Regions 3 and 5)
Collaborators/Participating Disciplines	• None listed	• Multidisciplinary partners/broader health partners (Regions 1, 3, and 5) • Includes physicians' offices/healthcare providers (Regions 1 and 5)	• Public health not mentioned (Regions 4AB and 5)
Geography & Population	• None listed	• None listed	• None listed

LOCAL/REGIONAL GOVERNMENT STRUCTURE

Northern Utah Healthcare Coalition, Bear River, UT

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- role/activities;
- collaborators/participating disciplines;
- geography and population.

Three assets of the model were mentioned while two concerns were identified. No common observations, assets, or concerns were noted on staffing structure and funding source.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Northern Utah Healthcare Coalition			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• Governance structure unclear (Regions 1 and 3)	• MAC model (Regions 1 and 4AB)	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• None listed	• None listed	• None listed
Role/Activities	• Volunteer management (Regions 1 and 4AB)	• Responds to ASPR guidelines and working with capabilities (Regions 3, 4AB, and 5)	• Hospital-based/centric (Regions 1, 3, and 5) • Narrow focus → medical surge (Regions 1, 3, and 5)
Collaborators/Participating Disciplines	• None listed	• Supports relationships/ networking (Regions 3 and 5)	• None listed
Geography & Population	• Rural (Regions 1 and 5) • Structure design supports large region and organizations located far apart (Regions 3 and 5)	• None listed	• None listed

NON-GOVERNMENTAL STRUCTURE

Central Ohio Trauma System (COTS)

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- funding source;
- role/activities;
- collaborators/participating disciplines.

Six assets of the model were mentioned while three concerns were identified. All four regions listed Healthcare Incident Liaison as an asset, and all regions indicated hospital/healthcare and trauma focus as concerns. No common observations, assets, or concerns were noted on staffing structure and geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Central Ohio Trauma System			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• Voluntary organization (Regions 3 and 5)	• Healthcare Incident Liaison (HIL) is part of structure/emergency response plans (Regions 1,3, 4AB, and 5)	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• Fiduciary focus/fiscal clearinghouse (Regions 1 and 3)	• None listed	• None listed
Role/Activities	• Data collection and research (Regions 1, 4AB, and 5) • Pre-existing trauma system that grew (Regions 1, 3, and 5)	• Inclusion in other plans (Regions 3 and 5) • Communication system (Regions 1, 3, and 4AB) • Built on serving needs of members (Regions 3 and 5) • Supports prevention (Regions 1 and 4AB)	• Hospital/healthcare focused (Regions 1,3, 4AB, and 5) • Trauma focused (Regions 1, 3, 4AB, and 5)
Collaborators/Participating Disciplines	• None listed	• More inclusion of disciplines (Regions 1 and 5)	• No mention of Local Public Health (Regions 4AB and 5)
Geography & Population	• None listed	• None listed	• None listed

Metro Health & Medical Preparedness Coalition, Minneapolis-Hennepin County Minnesota

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- staffing structure;
- role/activities;
- collaborators/participating disciplines.

Three assets of the model were mentioned while one concern was identified. No common observations, assets, or concerns were noted on funding source and geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Metro Health & Medical Preparedness Coalition			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• Structure similar to MA/HMCC work (Regions 3 and 4AB)	• None listed	• None listed
Staffing Structure	• Regional work groups (Regions 1 and 5) • Grant administration staff (Regions 4AB and 5)	• None listed	• None listed
Funding Source	• None listed	• None listed	• None listed
Role/Activities	• Improvement planning/QI focus (Regions 1 and 5) • ESF8 functions (Region 1 and 4AB) • Focus/connected to emergency management (Regions 3 and 5)	• Includes a focus on training/exercises and drills (Regions 1, 4AB, and 5) • Convenes conferences (Regions 1 and 5)	• Healthcare focus (Regions 3 and 4AB)
Collaborators/Participating Disciplines	• None listed	• Inclusive list of partners (Regions 1, 3, 4AB, and 5)	• None listed
Geography & Population	• None listed	• None listed	• None listed

LOCAL/REGIONAL STRUCTURE (shifting to non-governmental structure)

Northwest Healthcare Response Network (NWHRN) [formerly Seattle-King County Healthcare Coalition]

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- funding structure;
- role/activities;
- collaborators/participating disciplines.

Five assets of the model were mentioned while no concerns were identified. No common observations, assets, or concerns were noted on staffing structure, geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Northwest Healthcare Response Network			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• Based on existing structure/coalition (Regions 1 and 5)	• None listed	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• $ to support network (Regions 1 and 4AB)	• None listed	• None listed
Role/Activities	• MassMAP like activities (Regions 1 and 5) • Multiple public health functions (Regions 3 and 4AB) • Work focus on planning (Regions 3 and 4AB) • Administered by Public Health (Region 1 and 4AB)	• MWHRN's activities appropriate/realistic for MA (Regions 1,3, and 5) • Not hospital-centric (Regions 1 and 4AB)	• None listed
Collaborators/Participating Disciplines	• None listed	• MOU/MOA (Regions1, 3, and 5) • Inclusive/comprehensive list of partners (Regions 1, 4AB, and 5) • Work with Local Public Health (Regions 3 and 5)	• None listed
Geography & Population	• None listed	• None listed	• None listed

NON-GOVERNMENTAL STRUCTURE

Northern Virginia Healthcare Alliance (NVHA)

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- funding structure;
- role/activities;
- collaborators/participating disciplines.

Four assets of the model were mentioned while eleven concerns were identified. All four regions listed hospital-based and limited coordination with public health as concerns. No common observations, assets, or concerns were noted on staffing structure, geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Northern Virginia Healthcare Alliance			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• Originated from an existing structure (Regions 1, 4AB, and 5)	• None listed	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• Strong funding support (Regions 1, 3, 4AB, and 5)	• None listed	• None listed
Role/Activities	• Do situational awareness, resource management, and training (Regions 1 and 5) • Strong focus on training and exercise (Regions 3 and 4AB) • ESF8 activities (Regions 3 and 5)	• Common goal/clearly defined objective/scope (Regions 3, 4AB, and 5) • Includes all phases of disaster management cycle/preparedness spectrum (Regions 1, 3, 4AB, and 5) • 72 hour readiness/capability (Regions 1, 3, 4AB, and 5)	• Hospital-based/driven (Regions 1, 3, 4AB, and 5) • Focus on medical surge/MCI (Regions 1, 4AB, and 5) • Does not include mass care/shelter in response (Regions1, 3, and 5) • Does not include public education (Regions 3 and 5) • Immediate recovery is mentioned but not long term (Regions 1, 3, and 5)
Collaborators/Participating Disciplines	• None listed	• Multiple disciplines/agencies involved (Regions 1, 3, and 4AB)	• Limited coordination with public health (Regions 1, 3, 4AB, and 5) • No mention of working

Northern Virginia Healthcare Alliance			
Model Aspect	**Observations**	**Assets**	**Concerns**
			with military (Regions 1 and 5) • No mention of volunteer or volunteer agencies (1, 3, and 5) • Involves EMS (1, 4AB, and 5) • No coordination with LTC (Regions 1, 4AB and 5) • No coordination with CHCs and other medical providers (Regions 1 and 5)
Geography & Population	• None listed	• None listed	• None listed

MESH Coalition, Indianapolis, IN

Across the four regions, representatives noted common observations on the following aspects:

- model structure;
- funding structure;
- role/activities;
- collaborators/participating disciplines.

Nine assets of the model were mentioned while eight concerns were identified. All four regions listed focus on policy analysis/work and training and education as pluses and expressed concerns about subscription-based membership. No common observations, assets, or concerns were noted on staffing structure, geography and population.

The table below highlights the common observations, assets, and concerns mentioned by representatives across the participating regions.

Northwest Healthcare Response Network			
Model Aspect	**Observations**	**Assets**	**Concerns**
Model Structure	• None listed	• None listed	• None listed
Staffing Structure	• None listed	• None listed	• None listed
Funding Source	• Funding comes from members (Regions 1, 3, 4AB, and 5)	• Could be sustained through subscribers (Regions 3 and 4AB)	• None listed
Role/Activities	• Consultant role [like DelValle and Yale New Haven] (Regions 1, 3 and 5) • Best practices, information sharing/resource center (Regions 1, 4AB, and 5) • Similar to MassMAP (Regions 1 and 5)	• Creates consistency among healthcare facilities and providers (Regions 1, 4AB, and 5) • Helps partners do their jobs (Regions 1 and 5) • Includes recovery in activities (Regions 1 and 5) • Includes planning in activities (Regions 1, 3, and 5) • Focus on training and education (Regions 1, 3, 4AB, and 5) • Policy work/analysis (Regions 1, 3, 4AB, and 5) • Lowers costs of additional services for members (Region 1	• Limited focus on response (Regions 1, 3, and 5) • Having caches of pharmaceuticals and hospital supplies (Regions 1, 3, and 5) • Legal/regulatory analysis (Regions 1, 3, and 5) [though Region 4AB sees as beneficial] • Patient/hospital-based (Regions 3 and 5)

Northwest Healthcare Response Network			
Model Aspect	**Observations**	**Assets**	**Concerns**
		and 5)	
Collaborators/Participating Disciplines	• None listed	• Collaborative (Regions 1 and 5)	• Does not include non-health care agencies (Regions 1, 3, and 5) • Does not include public health (Regions 1 and 5) • Not much community/partnership building (Regions 4AB and 5) • Subscription-based (Regions 1, 3, 4AB, and 5)
Geography & Population	• None listed	• None listed	• None listed

This summary was prepared by the Institute for Community Health in June 2014.

Health and Medical Coordinating Coalitions (HMCC)

Partners Activity Summary

March 2014 Regional Meetings

Institute for Community Health
Building sustainable community health, together
A collaboration of the Cambridge Health Alliance, Mount Auburn Hospital, and Partners Healthcare

OVERVIEW

In March 2014, Boston University School of Public Health's Office of Public Health Practice (BUSPH) conducted facilitated meetings in Regions 1, 3, 4AB, and 5 with representatives from the five core disciplines— Community Health Centers/Ambulatory Care (CHC/AMB), Emergency Medical Service (EMS), Acute Care Hospitals, Local Public Health (PH), and Long-term Care (LTC). In each regional meeting, small groups of multi-discipline representatives brainstormed and discussed the following:

- ESF8 Health and Medical organizations that have some ability to support a response;
- Organizations in other ESFs that may be partners in response.
- ESF8 Health and Medical organizations and facilities that may require support so that they can continue providing care or services

BUSPH gathered the notes containing the lists of possible organizations from each of the small group discussions. These lists were shared back with the respective regions.

The Institute for Community Health (ICH), who provides evaluation services for these facilitated meetings, analyzed the notes to identify common types of organizations across the four regions. This report provides a list of common partner organizations for the three categories outlined above brainstormed by the representatives participating in the regional meetings.

KEY FINDINGS

The facilitated meetings in Regions 1, 3, 4AB, and 5 with representatives from the five core disciplines identified ESF8 organizations that are able to provide support in a response and those that need to be sustained to provide services. Additionally, representatives listed other ESF organizations that may be partners in response.

- The common types of organizations that have some ability to support a response identified across all four regions include:
  - Behavioral/mental health organizations/providers,
  - Colleges/university health centers.

- Common other ESF organizations that may be partners of HMCCs in response include:
  - Colleges/universities/schools;
  - Public Works;
  - Faith-based organizations;
  - Emergency management agencies

- The types of organizations/facilities that were commonly identified as needing additional support from the HMCCs are those that support individuals with functional needs (e.g., group homes, home health providers, Assisted Living, and Independent Living Centers)

These types of organizations should be taken into consideration when identifying key players to engage and their role when regional HMCCs are in place.

The following pages of this report provide a more detailed overview of common and unique partners that each region identified as being important to consider when planning for emergency response.

ESF8 ORGANIZATIONS SUPPORTING RESPONSE

Across the four regions, representatives identified two common types of organizations that have some ability to support an emergency response. These included:

- Behavioral/mental health organizations/providers,
- Colleges/university health centers.

The table below highlights the commonalities in ESF8 health and medical organizations that have some ability to support a response across all regions. It also lists organizations noted in a single region.

ESF8 Health and Medical Organizations – Ability to Support A Response	
Common Types of Organizations Listed	**Types of Organizations Listed by Only One Region**
Listed in *Four* Regions • Behavioral/mental health • Colleges/university health centers **Listed in *Two or Three* Regions** • MRC (Regions 1, 4AB, and 5) • Pharmacies (Regions 1, 4AB, and 5) • Students in health programs (Regions 1 and 3) • Home health care agencies/providers (Regions 1, 4AB, and 5) • Durable medical equipment suppliers (Regions 4AB and 5)	• School nurses (Region 1) • Parish nurses (Region 1) • Rehabilitation hospitals (Region 4AB) • Health care-based interpreter services (Region 4AB) • Occupational health/businesses (Region 4AB) • Assisted Living (Region 5) • Other medical volunteer organizations in addition to MRCs (Region 5)

OTHER ESF ORGANIZATIONS PARTNERING IN RESPONSE

Across the four regions, representatives identified four common types of organizations that may be partners in response. These include:

- Colleges/universities/schools;
- Public Works;
- Faith-based organizations;
- Emergency management agencies.

The table below summarizes the types of organizations/facilities that may be partners during an emergency. Responses have been categorized into broader types of organizations, followed by the specific type noted in each region. The table also lists types of organizations noted in multiple regions and ones noted by a single region.

Other ESF Organizations – To Partner in Response	
Common Types of Organizations Listed	**Types of Organizations Listed by Only One Region**

Listed in *Four* Regions
• Colleges/universities/schools
• Public Works
• Faith-based organizations
• Emergency management agencies
  o MEMA-CISD for first responders (Region 4AB)
  o Regional MEMA office (Region 1)
Listed in *Three* Regions
• Ham radio operators (Regions 1, 3, and 4AB)
Transportation providers (e.g., private, public, The Ride, Regional Transit Authority) (Regions 1, 4AB, and 5)
• Volunteer organizations (e.g., Red Cross, VOAD/COAD) (Regions 1, 4AB, and 5)
• Veterinarians/animal care providers (Regions 1, 4AB, and 5)
• Food banks/food suppliers (Regions 1, 4AB, and 5)
  o Big Box stores (Regions 4AB and 5)
Listed in *Two* Regions
• Law enforcing departments (Regions 1 and 3)
  o Sheriff's Department (Regions 1 and 3)
  o Police (Region 3)
• Senior Centers (Regions 3 and 5)
• Military (Regions 1 and 3)
(e.g., facilities, Military ESF, ROTC volunteers)
• CERT (Regions 1 and 4AB)
	Government agencies/officials
	• Dept. of Agriculture (Region 1)
	• Elected officials (Region 1)
	Emergency management/responders
	• Local responders (LEPC, REPC) (Region 1)
	• Fire Departments (Region 1)
	• HazMats (Region 1)
	• ESF-6 (Region 3)
	Support services/groups
	• Social service agencies (Region 1)
	• Language/interpreter service providers (Region 4AB)
	• Regional rehabilitation units (Region 4AB)
	• Cultural groups/organizations (Region 5)
	Other
	• United Way (Region 1)
	• Funeral Directors (Region 1)
	• Media (Region 1)
	Housing
	• Independent Living Centers (Region 1)

Other ESF Organizations – To Partner in Response	
Common Types of Organizations Listed	**Types of Organizations Listed by Only One Region**
• DART (Regions 1 and 5) • Department of Corrections/jail (Regions 1 and 3) • DEP (Regions 1 and 4AB) • Durable medical equipment suppliers (Regions 1 and 3) • Water suppliers; MWRA/city water/Natural Resources ESF (Regions 1 and 3) • Businesses (Regions 3 and 5) • Utilities (Regions 1 and 5) o Fuel providers (Region 1)	• Shelter (Region 3) • Large housing/congregate housing (Region 5) • Hotels (Region 5)

ESF8 ORGANIZATIONS REQUIRING SUPPORT

Across the four regions, representatives identified one common type of organization that may require support to continue providing care or services. This includes:

- Organizations that support individuals with functional needs.

The table below highlights the commonalities in ESF8 health and medical organizations/facilities that may require support to continue providing care or services from the HMCCs across all regions. These organizations/facilities need continued support because of possible adverse impact to clients/patients and the health/medical system. It also lists organizations noted by representatives from a single region; this list has been categorized into broader types of organizations.

ESF8 Health and Medical Organizations – Require Support	
Common Types of Organizations Listed	**Types of Organizations Listed by Only One Region**

Listed in *Four* Regions
• Organizations that support individuals with functional needs
  o Group homes (Regions 1 and 3)
  o Home health providers (Regions 4AB and 5)
  o Independent Living Centers/Assisted Living (Regions 1 and 5)
 	
Listed in *Two or Three* Regions
• Dialysis centers/facilities (Regions 3, 4AB, and 5)
• Behavioral health/mental health facilities/programs (Regions 1, 4AB, and 5)
  o In-patient (specified by Regions 1 and 4AB)
• Pharmacies (Regions 4AB and 5)
• Substance abuse facilities (Regions 1 and 3)
	Medical Care
	• Rehabilitation hospitals (Region 1)
	• Specialty care hospitals (Region 1)
	• In-patient adult day care facilities (Region 3)
	• Out-patient mental health providers (Region 3)
	• Chemotherapy services (Region 4AB)
	• University health centers (Region 5)
	
	Social Support
	• DV shelters (Region 1)
	• Social service agencies with medical services (Region 1)
	• Housing authorities/large congregate housing (Region 5)
	• Interpreter services groups (Region 4AB)
	
	Suppliers
	• Durable medical equipment suppliers (Regions 5)
	• Refrigerator trucks (Region 5)
	
	Other
	• Councils on Aging (Region 1)
	• Specialty schools (Region 1)
	• Funeral homes (Region 5)
	• MRC and other medical volunteer organizations (Region 5)

This summary was prepared by the Institute for Community Health in June 2014.

What's next?

Overview

- Upcoming Key Tasks
  - Request for Information (RFI)
  - Webinar
  - Conference
  - Request for Responses (RFR)
  - HMCC Establishment Phase

Request For Information (RFI)

- A **Request for Information (RFI)** is a type of Notice of Intent that may be used by program staff to conduct a needs assessment or solicit information, comments, and advice from other departments, contractors, or interested parties prior to the writing of a Request For Response (RFR)

Request For Information (RFI)

- RFIs
  - Identify industry standards
  - Best practices, and potential performance measures
  - Cost or price structures
  - Ascertain level of interest of prospective bidders in current or future procurements
- Goal of this RFI
  - Submission of documents that identify issues, standards and potential problems
- There is no obligation to use comments or recommendations made during RFI process in writing the Request For Response
- Participation in the RFI process cannot be a prerequisite to submitting a response to an RFR
- An RFI is a procurement tool and not a procurement

What's Next Presentation

Timeline

Task or Event	Projected Date
Request For Information posted	6/30/14
HMCC Webinar	July TBD
RFI responses due	7/30/14
HMCC Conference	September TBD
Request For Response (RFR) Posted	10/20/14
RFR responses due	12/5/14
HMCC Start Date (Initial Phase)	4/1/15

Coalition Websites

Central Ohio Trauma System (COTS)
www.goodhealthcolumbus.org/cots

The Central Ohio Trauma System's (COTS) mission is to reduce injuries and save lives by improving and coordinating trauma care, emergency care and disaster preparedness systems in Central Ohio. COTS supports prevention, education, data collection and research initiatives. COTS' purpose is as a forum for addressing issues affecting the delivery of trauma and emergency healthcare services primarily in Central Ohio.

MESH Coalition
www.meshcoalition.org

MESH, Inc. is an innovative non-profit, public-private coalition located in Marion County, Indiana (Indianapolis) that enables healthcare providers to respond effectively to emergency events, and remain viable through recovery. It is one of only a handful of privately managed emergency preparedness healthcare coalitions in the United States. MESH enables healthcare providers to effectively respond to emergency events and remain viable through recovery.

Metro Health & Medical Preparedness Coalition, Minneapolis-Hennepin County Minnesota
www.metrohealthready.org

The Metro Health & Medical Preparedness Coalition comprises hospitals, clinics, and long term care facilities; public health and emergency medical services; Homeland Security and Emergency Management, and emergency management agencies serving the seven-county Twin Cities metro area including thirty hospitals.

Michigan Region 8
www.reg8.org

The Region 8 Healthcare Coalition Planning Board is a collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recover, and mitigation activities related to healthcare organization disaster operations. The primary function of the Region 8 Healthcare Coalition includes regional healthcare system emergency preparedness activities involving the member organizations.

Mountain Area Trauma Regional Advisory Committee, Flat Rock, North Carolina
www.matrac.com

MATRAC is one of eight Healthcare Coalitions in North Carolina. A healthcare coalition is a group of healthcare organizations located in a specified geographic area that agree to work together to enhance the efficiency and effectiveness of collective preparedness and response in its community, including interface with jurisdiction authorities. Healthcare organization is defined as: inpatient facilities and centers (e.g. trauma, State and Federal, veterans, long-term, children's, Tribal), outpatient facilities and center (e.g. behavioral health, substance abuse, urgent care), and other entities (e.g. poison control, emergency medical service, community health center (CHC's), nursing, etc.

Northern Utah Healthcare Coalition, Bear River, UT
www.nuhc.org

Its mission is to serve its communities through collaboration, coordinated communication, and resource sharing for effective medical surge management before, during and after a disaster response. Its purpose is to provide its members with access to networking, relationship building, training, education, discussion, regional planning, and resource sharing to fulfill their mission.

Northern Virginia Hospital Alliance (NVHA)
www.novaha.org

The Northern Virginia Hospital Alliance (NVHA) is a not-for-profit coalition formed in 2002 to organize a regional hospital preparedness program that would enable the hospitals of Northern Virginia to collectively respond to and recover from major emergencies. The membership of the NVHA includes all 14 acute care hospitals that operate within the Virginia portion of the National Capital Region. NVHA exists to coordinate emergency preparedness, response and recovery activities for the member hospital and healthcare systems in cooperation with Local, Regional, State and Federal response partners.

Additional Resources

Northwest Healthcare Response Network (NWHRN)
www.nwhrn.org

The Network is a coalition of healthcare organizations and providers working together to strengthen emergency preparedness and response in Washington's Puget Sound region. The Network develops the relationships, plans and tools that are necessary for effective, coordinated regional responses to healthcare emergencies. Over 300 healthcare organizations are part of NWHRN, including ambulatory, mental health, hospital, in-home service, long-term care, pediatric, safety-net, and specialty providers. NWHRN also will work closely with emergency management, fire, Emergency Medical Services, and law enforcement partners.

The National Healthcare Coalition Resource Center
http://healthcarecoalitions.org

The National Healthcare Coalition Resource Center (NHCRC) provides a forum for sharing ideas, innovations and best practices for building and growing coalitions. NHCRC is a joint not-for-profit program founded and operated by MESH, the Northern Virginia Hospital Alliance and the Northwest Healthcare Response Network. While the NHCRC supports coalitions attempting to meet HHS/ASPR HPP and CDC PHEP grant program requirements, the Center is independent and exists for coalitions, by coalitions.

Oklahoma Regional Medical Planning Groups
http://www.ok.gov/health/Disease,_Prevention,_Preparedness/Emergency_Preparedness_and_Response/Hospital_&_Medical_System_Partners/Regional_Medical_Planning_Groups/

Oklahoma was not included in the original materials, but was identified as another potential model of interest based on a presentation at the 2014 NACCHO Summit. Oklahoma has a county public health system and the state runs 68 of the 70 county public health departments. Healthcare coalitions are referred to as Regional Medical Planning Groups (RPMGs). RPMG members include public health, EMS, and hospitals, as well as long term care and specialty providers like dialysis centers. Most RPMGs are coordinated by MMRS organizations in OK. The RPMGs themselves are not incorporated or formal organizations so cannot apply for and receive funding. The Western District has 4 staff persons – 2 state employees and 2 contract employees. Focus is on planning and exercising

Federal Guidance

Healthcare Preparedness Capabilities released by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR).
www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf

Public Health Preparedness Capabilities as released by the U.S. Department of health and Human Services Centers for Disease Control and Prevention (CDC).
www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

Hospital Preparedness Program (HPP) Cooperative Agreement Measure Manual: Implementation Guidance for the HPP Program Measures *Budget Period 2 (BP2): 1 July 2013 – 30 June 2014 (subject to revision):*
www.phe.gov/Preparedness/planning/evaluation/Documents/hpp-bp2-measuresguide-2013.pdf

Public Health Emergency Preparedness (PHEP) Cooperative Agreement /Budget Period 2 Performance Measure Specifications and Implementation Guidance July 1, 2013 – June 30, 2014 (subject to revision): **www.phe.gov/Preparedness/planning/evaluation/Documents/hpp-bp2-measuresguide-2013.pdf**