

**Maryland Department of Health and Mental Hygiene**

***Framework for Development of Healthcare  
Preparedness Coalitions***



**Version 1.1**

**April 2014**

[This page intentionally left blank.]

# Maryland Department of Health and Mental Hygiene

## Framework for Development of Healthcare Preparedness Coalitions

### *Contents*

*Foreword*

*Executive Summary*

### *Part One – Maryland Framework*

#### *I. Introduction*

##### **A. Purpose**

##### **B. Scope and Applicability**

#### *II. Planning Background*

##### **A. Review of Existing Healthcare Coalitions: Summary of Findings**

##### **B. Federal Guidance for Healthcare Preparedness Coalition Development**

#### *III. State of Maryland Requirements and Recommendations for Regional Healthcare Preparedness Coalitions*

##### **A. Organization and Structure**

##### **B. Leadership**

##### **C. Membership and Voting Rights**

##### **D. Coalition Documentation: Formal Agreements**

##### **E. Role of Regional Coordinator**

##### **F. Regional Planning: Functions and Responsibilities of Coalitions**

##### **1. Grants Management: Fiduciary Responsibilities**

##### **2. Regional Resource/Assets Management**

##### **3. Regional Preparedness Planning**

#### **4. Coalition Strategic Planning**

##### *IV. Guidance for Future Coalition Development*

###### **A. Expansion of Coalition Membership**

###### **C. Formation of Nonprofit Organizations**

###### **D. Role of Healthcare Coalitions in Emergency Response**

##### *V. References*

##### *VI. Definitions*

### ***Part Two – Appendices***

Appendix A Detailed Findings from Review of Existing Healthcare Coalitions

Appendix B Summary Matrix: *Healthcare Preparedness Capabilities* Guidance for

###### **A. Coalition Development**

Appendix C Hospital Preparedness Program Regional Coordinator Scope of  
Work

Appendix D Acronyms

Appendix E Healthcare Preparedness Coalition Framework Work Group

## Foreword

The U.S. Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) has developed a national guidance document for healthcare system preparedness called the *Healthcare Preparedness Capabilities*. This document is intended to assist health departments and healthcare system partners to identify gaps in preparedness, determine specific priorities, and develop plans for building and sustaining healthcare specific capabilities. It also sets the parameters for hospitals, healthcare systems, and Emergency Support Function (ESF) #8 partners to prepare for, respond to and recover from incidents that have a public health and medical impact. One of the primary functions outlined in the *Capabilities* concerns the collaboration of states and healthcare partners for development of regional coalitions to support healthcare system preparedness.

According to the *Healthcare Preparedness Capabilities*, healthcare coalitions are "a collaborative network of healthcare organizations and their respective public and private sector response partners within a defined region." They consist of members from multiple disciplines, including healthcare, public health, emergency management, and behavioral health. Acting as multi-agency coordinating groups, healthcare coalitions assist emergency management and ESF #8 with preparedness, response, recovery, and mitigation activities related to the disaster operations of healthcare organizations. As such, they are essential to ESF #8 and are a key component in a comprehensive, all-hazards preparedness planning system.

The State of Maryland recognizes five health and medical geographic regions, each of which is represented by a healthcare preparedness coalition. Regions I and II plan together and share a collaborative coalition, while Regions III, IV, and V each have an individual healthcare coalition. The *Maryland Framework for Development of Healthcare Preparedness Coalitions* has been created in an effort to bolster these four coalitions, both individually and as a group making up part of Maryland's ESF #8 response.

This document is a result of the collaborative efforts among the Department of Health and Mental Hygiene (DHMH) Office of Preparedness and Response (OP&R), healthcare system partners, local health department representatives, and healthcare coalition members. The final framework incorporates comments and suggestions received from a variety of stakeholders.

Users of this Framework are encouraged to recommend changes that will improve the clarity, utility and application of the document. Questions or comments should be directed to:

Maryland Department of Health and Mental Hygiene  
Office of Preparedness and Response  
300 W. Preston Street, Suite 202  
Baltimore, MD 21201  
410-767-0823

[This page intentionally left blank.]

## Executive Summary

The State of Maryland recognizes five health and medical geographic regions, each of which is currently represented by a healthcare preparedness coalition. These coalitions are:

- Regions I and II Health Care Council
- Region III Health and Medical Task Force
- [Region IV] Delmarva Regional Healthcare Mutual Aid Group (DRHMAG)
- Region V Emergency Preparedness Coalition

The purpose of this guidance document—the *Maryland Framework for Development of Healthcare Preparedness Coalitions*—is to outline standards, recommendations and minimum requirements in order to facilitate successful implementation of regional healthcare coalitions in the state. This *Framework* has been created to support the development of the four coalitions named above, both individually and as a group making up part of the state's ESF #8 response.

The contents of this *Maryland Framework* are consistent with the goals and objectives outlined in ASPR's *Healthcare Preparedness Capabilities* and the Centers for Disease Control and Prevention's *Public Health Preparedness Capabilities*. Areas of specific guidance include: coalition establishment and structure, leadership, membership and voting rights, the role of Regional Coordinators, and regional preparedness planning responsibilities. Recommendations for future coalition development are also addressed in the document.

The *Maryland Framework for Development of Healthcare Preparedness Coalitions* is the result of the collaborative efforts of DHMH/OP&R, healthcare system partners, local health department representatives, and regional healthcare coalition members and stakeholders. The information herein was assembled through review and analysis of best practices from established healthcare coalitions around the country, as well as consideration of existing coalitions in Maryland and current state preparedness priorities.

This *Framework* is not meant to stand alone as a sole source of guidance, nor is it intended to be the final word on healthcare preparedness coalitions in Maryland. It should be considered a living document that can and will evolve as our coalitions continue the process of growth and development.

[This page intentionally left blank.]



## Part One — Maryland Framework

### II. Introduction

#### A. Purpose

The purpose of the *Maryland Framework for Development of Healthcare Preparedness Coalitions* is to outline standards, recommendations, and minimum requirements to facilitate the successful implementation of regional healthcare preparedness coalitions in Maryland. Areas of specific guidance and recommendations include coalition establishment and structure, leadership, membership and voting rights, role of Regional Coordinators, and regional planning responsibilities.

#### B. Scope and Applicability

The *Maryland Framework for Development of Healthcare Preparedness Coalitions*:

1. Will be used by and applied to the Maryland Regions I and II Health Care Council, Region III Health and Medical Task Force, Region IV Delmarva Regional Healthcare Mutual Aid Group (DRHMAG), and Region V Emergency Preparedness Coalition.
2. Is intended as a guide and supplement to current federal guidance included in the ASPR Hospital Preparedness Program (HPP) and Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) Cooperative Agreements, and within ASPR's *Healthcare Preparedness Capabilities* and the CDC's *Public Health Preparedness Capabilities*.
3. Establishes standards, recommendations, and minimum requirements for the building, maintenance, and improvement of healthcare coalitions in Maryland.

[This page intentionally left blank.]

### III. Planning Background

In 2012, DHMH OP&R convened a work group to develop a Healthcare Coalition Framework. Representatives to the group were selected from Maryland healthcare system partners, local health departments, EMS, and regional healthcare coalition members and stakeholders. This document represents the product of work group efforts.

#### A. Review of Existing Healthcare Coalitions: Summary of Findings

As a first step in creating this framework, the work group conducted research to gather information on existing healthcare coalitions. The following organizations were chosen from among various well-established organizations around the country:

1. DC Emergency Healthcare Coalition - Washington, DC
2. First Coast Disaster Council - Northeastern Florida
3. MESH - Indianapolis, IN
4. Miami-Dade County Hospital Preparedness Consortium - Florida
5. Northern Utah Healthcare Coalition
6. Northern Virginia Hospital Alliance (NVHA)/Northern Virginia Emergency Response System (NVERS)
7. Northwest Healthcare Response Network (NWHRN)- King County and Pierce County, WA
8. Partnership for Effective Emergency Response (PEER) - Boston, MA

For detailed information on each of these healthcare coalitions, see Appendix A.

#### Characteristics of Established Regional Healthcare Coalitions

Each of the selected coalitions was reviewed using a specific set of criteria. These criteria included organization type and structure, leadership, membership and voting rights, meeting frequency, establishment documentation [e.g. charter, By-laws, Memorandum of Understanding (MOU)], response roles, and regional planning. The research indicated that while these coalitions all serve essentially the same overarching purpose, they vary widely in terms of structure, membership, and how they function as organizations.

##### 1. Organization Type

Various organization types were observed among the healthcare coalitions studied. For discussion purposes, they can be divided into two general categories:

- Committee-like, voluntary organizations with open membership
- Nonprofit organizations [e.g. 501(c)(3) or 501(c)(6)]

The first group—committee-like, voluntary organizations—range from fairly loosely structured coalitions to more tightly organized groups with specific

membership and participation requirements. These groups are more comparable to the existing coalitions in Maryland. Two examples are the Northern Utah Healthcare Coalition and the Northwest Healthcare Response Network. Both are true regional coalitions in that they cover multiple jurisdictions in their respective states. At the time that research was conducted, both were hosted and administered by local health departments. [Northwest Healthcare Response Network is currently exploring incorporation as a 501(c)(3)]. Both of these coalitions are primarily funded with grant dollars from the DHHS, ASPR Hospital Preparedness Program (HPP).

Several of the coalitions studied are incorporated as nonprofit organizations, and therefore have status as legal entities (e.g. First Coast Disaster Council, MESH, Northern Virginia Hospital Alliance). These coalitions exist independent of local, state or federal agencies. There is no need for a separate fiduciary agent, because as legal entities these organizations can receive and administer funds on their own behalf. Likewise, they can secure additional sources of funding beyond existing federal preparedness grants (e.g. membership fees, donations, or corporate contributions).

Three single-jurisdiction coalitions were also included in the research cohort: the DC Emergency Healthcare Coalition, First Coast Disaster Council, and the Miami-Dade County Hospital Preparedness Consortium. All of Maryland's coalitions are multi-jurisdictional, and therefore are not strictly comparable. However, to assess best practices it was deemed worthwhile to also examine these single-jurisdiction coalitions—especially in light of the fact that those selected are well-established and very active in their respective communities.

## 2. Leadership

ASPR's *Healthcare Preparedness Capabilities* document indicates that healthcare coalitions should have a formal leadership structure for collaborative oversight and coordinated decision-making. The coalitions studied showed a variety of governance arrangements, depending on the organization type and its underlying structure. Some had elected officers, such as President and Vice-President or Chair and Vice-Chair. Others had an Executive Council, or a lead committee acting in that capacity. Some coalitions were led by an Executive Director or Chief Executive Officer (CEO). The Miami-Dade County Hospital Preparedness Consortium has a unique leadership arrangement that features three Co-Chairs, each serving as the leader of a separate standing committee.

## 3. Coalition Structure and Membership

Coalition membership arrangements tend to follow from the organization type or directly reflect the underlying group structure. A key feature of several of the coalitions, particularly those with open membership, is the use of committees to

organize the group and divide up the work. Some coalitions have standing committees, while others form sub-committees or work groups as needed for specific purposes. For example, the Northwest Healthcare Response Network (NWHRN) is a very large organization that has several standing committees for conducting coalition business. These include the Disaster Clinical Advisory Committee, In-Home Service Providers Committee, Nursing Home Steering Committee, and the Pediatric Committee and Task Force. In contrast, the much smaller Northern Utah Healthcare Coalition has no standing committees other than an Executive Committee. Instead, NUHC forms work groups from the membership to address specific tasks.

The three nonprofit organizations reviewed each had different structures and membership arrangements. The First Coast Disaster Council (FCDC) has an open, voluntary membership policy. FCDC includes representatives from all sectors of the healthcare community, as well as traditional response entities, mass transit agencies, and federal partners. Due to its specific mission, the membership of the Northern Virginia Hospital Alliance is limited to hospital and healthcare system partners only. MESH has a unique membership structure that consists of Subscribing Healthcare Partners and Coalition Partners. The Subscribing Partners, primarily hospital and healthcare systems, pay fees to participate (on a sliding scale basis) and have contractual obligations to the coalition. MESH's Coalition Partners pay no membership fees. They include representatives of the Indiana Department of Health and Indiana Department of Homeland Security, as well as Indiana University's School of Medicine and School of Nursing.

#### 4. Voting Rights

The work group was not able to obtain specific information on voting arrangements for every coalition. When this information was available, the key differences observed among the coalitions involved whether all participants have equal access to decision-making processes—i.e., whether or not all coalition members get a vote. The Northern Utah Healthcare Coalition and Miami-Dade County Hospital Preparedness Consortium both have voting arrangements to ensure that certain partner groups retain a voting majority in the coalition. NUHC allows hospitals a set number of seats (and therefore votes) on the Executive Committee. The Miami Consortium, as described above, has a two-tiered membership structure. Full coalition members are representatives from Miami-Dade County hospitals, all of whom have voting privileges. Associate Members are representatives from other organizations who are participants in the Consortium, but do not have voting privileges.

#### 5. Frequency of Meetings

All of the coalitions reviewed have a set meeting schedule. The frequency of meetings appears to be related to the overall size and structure of the coalition.

For some coalitions, the full membership meets on a regular monthly, bi-monthly or quarterly basis. Within other organizations, the committees and work groups meet with greater frequency, while meetings of the full membership occur much less often. For example, the Northern Virginia Hospital Alliance holds monthly meetings of the hospital Emergency Managers and bimonthly hospital executive meetings, while the full membership meets only once a year. Similarly, the Northwest Healthcare Response Network holds quarterly meetings of its Executive Council. The full coalition, which has a membership numbering in the hundreds, meets only on an annual basis.

#### 6. Formal Documentation of Establishment

ASPR's *Healthcare Preparedness Capabilities* document indicates that coalitions should have a formal, written document showing the establishment of the organization for the purposes of emergency preparedness. Many of the existing coalitions reviewed had some type of formal documentation in place. For example, First Coast Disaster Council maintains Letters of Agreement (LOA) between the organization and each of the participating hospitals. These agreements dictate hospital response actions in the event of an emergency. The Northern Utah Healthcare Coalition has a formal charter for the organization, as well as a Memorandum of Understanding (MOU) signed by members.

#### 7. Regional Coordinators

Since DHMH has opted to fund HPP Regional Coordinators to work with Maryland's healthcare preparedness coalitions, this feature was selected as one of the review criteria. The work group was not able to obtain detailed information on the use of regional coordinators (or persons serving in a similar role or function) for every coalition. When this information was available, it was apparent that the use of personnel in this role depended largely on the organization type and structure. Among the coalitions reviewed, the following ones have regional coordinators, or designated personnel that serve in a comparable role: Miami-Dade County Hospital Preparedness Consortium (perhaps not applicable, since this is a single-jurisdiction coalition), Northern Utah Healthcare Coalition, and the Northwest Healthcare Response Network.

#### 8. Regional Planning

Planning is an important function of a regional healthcare preparedness coalition. Presumably, all of the existing coalitions that were reviewed engage in preparedness planning; however, the planning processes of multi-jurisdiction coalitions is of particular interest for our purposes in Maryland. Some of these coalitions have written documentation that demonstrates the products of planning processes (e.g. formal written plans, MOU/MOAs, Interagency Agreements). For example, the Northern Utah Healthcare Coalition has a Regional Medical Surge Plan, which was approved by the Executive Council and

enacted by vote of the entire coalition. The plan is reviewed on an annual basis, exercised often, and revised or updated as needed. The Northwest Healthcare Response Network has a very robust regional planning process. The large membership of this coalition allows for the formation of subcommittees that engage in focused preparedness planning (e.g. Disaster Clinical Advisory Committee, Hospital Strategy Workgroup, Nursing Home Steering Committee).

#### 9. Emergency Response Role

The coalitions reviewed vary widely with regard to roles and functions in emergency response. The single-jurisdiction coalitions tend to have active, operational roles; however, the First Coast Disaster Council is an exception. FCDC is a 501(c)(3) organization that represents Florida's Jacksonville/Duval County jurisdiction. It operates in supportive role via ESF#8 in an emergency or disaster, with the coalition represented at the command level by proxy through the local health department. In contrast, the DC Emergency Healthcare Coalition has an active role in response. DC EHC maintains readiness by having a weekly Duty Officer on call (with back-up) and three Coalition Notification Centers in continuous operation. The DC EHC also has a Coalition Emergency Response Team that can be deployed when events escalate. There was little consistency among the multi-jurisdiction coalitions with regard to their roles in emergency response. The response roles and functions of these coalitions largely reflect the structure of the individual organizations, or their stated purpose and mission.

### **B. Federal Guidance for Healthcare Preparedness Coalition Development**

The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR) has published several documents to assist states and their preparedness partners in the development of regional healthcare coalitions. The yearly HPP-PHEP joint Funding Opportunity Announcements (FOA), the *Healthcare Preparedness Capabilities* document, and the HPP Program Measures all contain information that is intended to support the coalition development process.

#### HPP-PHEP Joint Funding Opportunity Announcement (FOA)

The following language was excerpted from the HPP Budget Period 1 (FY 2012) FOA:

Awardees (i.e. states) are expected to develop or refine healthcare coalitions as outlined in the following:

- Capability 1: Healthcare System Preparedness; Function 1: Develop, refine, and sustain healthcare coalitions; and
- Capability 10: Medical Surge; Function 1: The healthcare coalition assists with the coordination of the healthcare organization response during incidents that require medical surge.

The FY 2012 FOA also outlined a process for staged development of healthcare coalitions during the current HPP five-year project period. This staged approach was based on initial assessment of the capabilities, functions, and associated resource elements of Capability 1, Function 1. The following outlines the three proposed stages of healthcare coalition development:

Stage 1:

- Determine regional approach and boundaries
- Establish awardee support and partnership
- Determine governance structure
- Establish the healthcare coalition for purposes of preparedness through appropriate documentation

Stage 2:

- Maintain the above healthcare coalition Stage 1 requirements through sustainment and preparedness activities
- Perform preparedness activities as outlined in Capability 1: Healthcare System Preparedness

Stage 3:

- Determine how healthcare coalitions will address multiagency coordination during response and perform regional exercises to test this capability. Healthcare coalition multiagency coordination is outlined in Capability 3: Emergency Operations Coordination and Capability 10: Medical Surge

[Refer to Appendix B of this document for a Summary Matrix of the federal guidance contained in *Healthcare Preparedness Capabilities*, Capability 1: Healthcare Systems Preparedness and Capability 10: Medical Surge.]

HPP Program Measures

In recent years, ASPR/HPP has sought a means of accurately assessing overall national healthcare preparedness, as well as demonstrating awardee progress in meeting the program's established goals and objectives. The HPP Program Measures (formerly referred to as "performance measures") were developed to meet this need, providing "critical information needed to assess and report on how well this federal investment has improved the nation's ability to prepare for and respond to medical emergencies." The Program Measures also contain guidance for healthcare preparedness coalition development—including specific benchmarks and targets that align with the *Healthcare Preparedness Capabilities* and the National Health Security Strategy (NHSS).

In FY 2012, the performance measures underwent realignment with the National Health Security Strategy. As a result of this process, the initial set of eight performance measures have now been re-categorized under two broad HPP Program Measures: Medical Surge and Continuity of Healthcare Operations. The Medical Surge Program



Measure is intended to evaluate the increase in surge capacities and capabilities of awardees (e.g. states), healthcare coalitions, and their member organizations for preparedness, response, recovery and mitigation activities. The Continuity of Healthcare Operations measure is intended to assess the maintenance of vital public health and medical services to allow for optimal federal, state and local operations in the event of a public health emergency. The successful completion of the activities outlined in these Program Measures will ultimately enhance community resilience through the continued delivery of essential healthcare services to the community post-disaster, as well as establish a strong emergency response system that will provide effective management for surges of patients, deaths and concerned citizens.

The Program Measure refinement process has also resulted in the creation of a Healthcare Coalition Developmental Assessment Factors Tool (HCCDA), which is intended to assess how well healthcare coalitions are functioning within the Hospital Preparedness Program. The HCCDA was designed to assess: (1) the processes involved in developing and forming a coalition; (2) how coalitions are functioning to meet the goals and objectives of HPP; and (3) the reliability of work plans and program indicators in monitoring progress over time.

For more information on the Program Measures, see the *Hospital Preparedness Program Measure Manual: Implementation Guidance for the HPP Program Measures*. Healthcare partners are encouraged to refer to these and other federal resource documents for additional guidance as the coalition development process continues.

[This page intentionally left blank.]

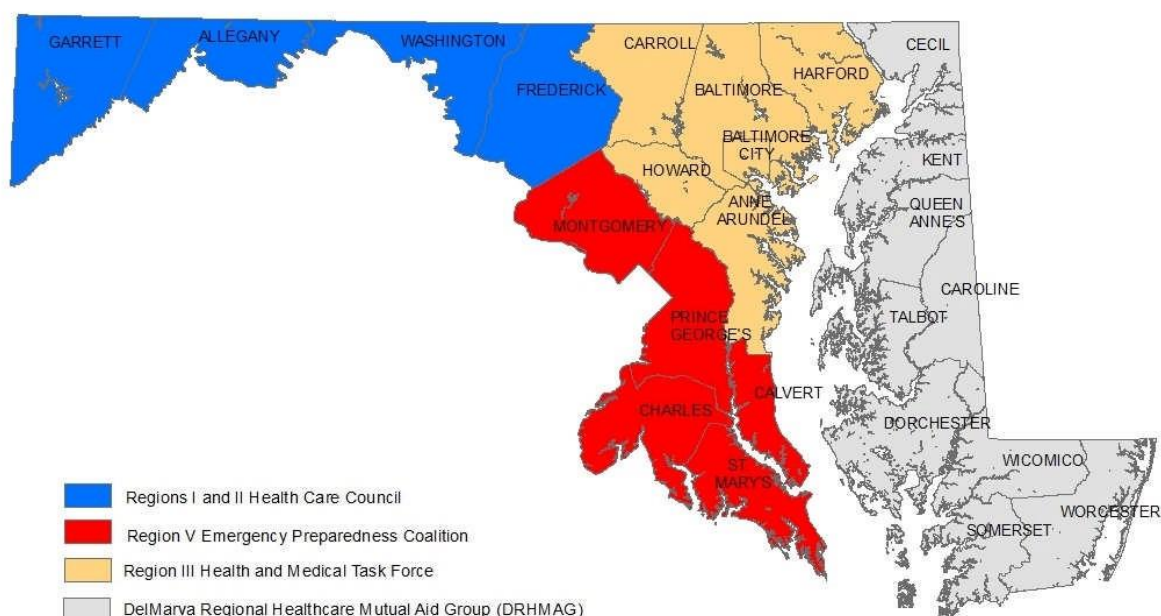
## IV. State of Maryland Requirements and Recommendations for Regional Healthcare Preparedness Coalitions

### A. Organization and Structure

Maryland's healthcare preparedness coalitions are not limited to a particular type of organization or structure. The coalition may function as a component of a larger organization, or be incorporated into a pre-existing planning body (e.g. a regional EMS coalition). Alternatively, regional partners may choose to develop entirely new organizations. Once the coalition is firmly established, partners may seek to incorporate as a nonprofit organization [e.g. 501(c)(3) or other designation]. [For additional guidance on this topic, refer to Section IV. Guidance for Future Coalition Development.]

DHMH has determined that the five pre-defined health and medical regions recognized by the state of Maryland will serve as boundaries for the coalitions. For the purposes of administering ASPR/HPP regional funds for healthcare preparedness, Regions I and II shall be combined into one region and be served by a single regional coalition. Therefore, DHMH officially recognizes four (4) healthcare preparedness coalitions for the state of Maryland [see Figure 1].

**Figure 1. Regional Healthcare Preparedness Coalitions in Maryland**



## **B. Leadership**

The healthcare coalition must have a clearly defined, documented governance structure. There are various types of leadership arrangements that may be employed, depending upon the needs of the coalition. Examples of viable leadership structures include, but are not limited to:

- President, Vice-President, Secretary, etc.
- Chair (with or without Vice Chair)
- Co-Chairs
- Executive Committee or Council
- Executive Director (with Board of Directors)

DHMH recommends that coalition leaders be elected by a majority vote of the membership. Election of leaders should be conducted according to formally agreed upon procedures and should take place at set, regular intervals.

Because these coalitions are intended to foster comprehensive healthcare system preparedness, DHMH strongly recommends that the executive or most senior coalition leader be selected from among healthcare system representatives (excluding public health). Examples of a senior level leadership position include Chair, President, or Executive Director. If the coalition opts to form an Executive Council, that body must contain healthcare system representation. For coalitions that opt to use Co-Chairs, DHMH strongly recommends that one of them be selected from among healthcare system representatives. [For the purposes of this Framework, the term "healthcare system" refers to all agencies, organizations and facilities that provide healthcare within a specified geographic area—not just hospitals. This includes Community Health Center/FQHCs, DHMH State Facilities, and long-term care/skilled nursing facilities.]

## **C. Membership and Voting Rights**

### Membership

The ASPR *Healthcare Preparedness Capabilities* document indicates that the role of healthcare coalition members is to provide input for preparedness and ensure the proper coordination of response and recovery activities. Primary or core membership in the coalition is dependent to a certain extent on how the coalition is organized. Regardless of a coalition's structure or voting arrangements, membership should reflect those partners who are essential to ensure the proper coordination of preparedness, response and recovery activities for the entire region. This includes all relevant community healthcare and response organizations and stakeholders.

The following are examples of essential preparedness partners that should be represented in healthcare coalition membership:

- Acute care hospitals
- Community Health Centers/FQHCs
- Core Service Agencies (community mental/behavioral health)
- DHMH (as non-voting members)
- DHMH State Facilities
- Fire Departments
- Local Area Agencies on Aging
- Local EMA
- Local EMS
- Local public health
- Long-term care providers
- Maryland Hospital Association (as non-voting members)
- State of Maryland regional EMA (MEMA)
- Regional EMS (MIEMSS)

Because each region in Maryland is unique, each has its own particular preparedness challenges and considerations. Healthcare coalitions are encouraged to seek active participation from additional community partner organizations and subject matter experts (SMEs) as relevant for their respective regions. Examples of these additional organizations include:

- Community-based and Faith-based organizations (CBOs, FBOs)
- Federal entities
- Local law enforcement
- Primary care providers
- Private and/or non-governmental organizations
- Public Works
- Specialty service providers (e.g. dialysis, pediatrics, woman's health, urgent care)
- Support service providers
- Voluntary Organizations Active in Disaster (VOAD)
- Volunteer medical organizations (e.g. American Red Cross)

The state role in healthcare coalitions is to form a partnership with and provide support for healthcare organizations in the effort for multiagency coordination. The multidisciplinary component is one of the most essential aspects of the healthcare preparedness coalitions. Having a diverse set of partners allows for more comprehensive and effective planning and preparedness efforts.

### Voting Rights

Regional healthcare coalitions should have a formal decision-making process that allows for direct input of members and member organizations. For purposes of preparedness planning and decision making with regard to HPP grant-funded projects and activities, DHMH recommends one vote per organization/agency as a minimum requirement for coalitions. For example:

- 1 vote per each acute care hospital
- 1 vote per each Community Health Center/FQHC parent organization
- 1 vote per region on behalf of Core Service Agencies
- 1 vote per region on behalf of DHMH State Facilities
- 1 vote per region on behalf of EMS
- 1 vote per region on behalf of local Area Agencies on Aging
- 1 vote per each local health department (jurisdictional)
- 1 vote per each Long Term Care facility parent organization
- 1 vote per State of Maryland regional EMA organization

Alternatively, regional healthcare coalitions may choose a voting arrangement that includes a mix of voting and non-voting members (for example, a two-tiered structure with "full members" who have voting rights and "associate members", who participate in the coalition but do not have voting rights).

One of Maryland's healthcare preparedness coalitions is unique in that its boundaries extend outside the state. DRHMAG, the Region IV coalition, also includes partner organizations from Delaware and Virginia (located at the northern and southern ends of the Delmarva Peninsula). These entities work together across state lines on a daily basis; therefore, it is certainly appropriate that they would collaborate for the purposes of regional preparedness planning. However, for the purposes of decision making on HPP-funding related matters, only recognized entities within the state of Maryland should be allowed to vote. Organizations from out of state may not participate in decisions regarding the allocation of Maryland HPP funding.

The status of voting members and any other participatory requirements as they relate to voting members will be established by each healthcare coalition. However, coalition voting arrangements for the conduct of HPP funding-related business are subject to DHMH approval to ensure the appropriate partner representation in the decision-making process.

DHMH encourages healthcare coalitions to develop more inclusive voting arrangements based on their particular regional preparedness needs. Coalition leaders may find that granting participation in the decision-making process via voting rights fosters active involvement from a wider range of partners.

#### **D. Coalition Documentation: Formal Agreements**

ASPR's *Healthcare Preparedness Capabilities* guidance indicates that coalitions must have a formal, written document showing the establishment of the organization for the purposes of emergency preparedness. Acceptable types of documentation may include a formal charter, a set of by-laws, memorandum of understanding (MOU) or agreement (MOA), an interagency agreement (IAA), or a formal contract. The document should include, at a minimum, the rules and guidelines for participation in the coalition, as well

as roles and responsibilities of each member type or organization. The chosen form of documentation must be approved, enacted and signed (if applicable) by coalition member organizations.

#### **E. Role of Regional Coordinators**

As evidenced by the new *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*, ASPR's preferred approach is now one of collaborative planning, with regional healthcare coalitions playing a key role. In response to this paradigm shift, DHMH OP&R established five (5) contract positions for HPP Regional Coordinators (four regional field placements, plus a Coordinator Team Lead to be based at the main office in Baltimore). This section will describe the intended purpose and scope of work for the field-based Regional Coordinator positions.

Maryland's HPP endorses four (4) regional healthcare preparedness coalitions, whose boundaries correspond to the state's designated health and medical regions. These coalitions are:

- Regions I and II Health Care Council
- Region III Health and Medical Task Force
- Delmarva Regional Healthcare Mutual Aid Group (DRHMAG)
- Region V Emergency Preparedness Coalition

[Regions I and II plan together and share a collaborative coalition.] Each field-based HPP Regional Coordinator is assigned to work directly with a regional coalition. The overarching purpose of the HPP Regional Coordinator position is to assist the Maryland HPP, regional healthcare coalitions, and participating partners with identifying and carrying out the emergency preparedness goals and objectives of each region, as well as the state's overall goals.

#### **HPP Regional Coordinators: Scope of Work**

HPP Regional Coordinators are full-time, contract employees of the state of Maryland who are based within local health departments. Placing the Regional Coordinators out in the field has distinct advantages. It allows the Coordinators to be more visible and available to local level partners, which is key to facilitating communication and building relationships. Additionally, being placed in the field provides greater opportunities for direct participation in local and regional preparedness planning and activities.

A significant portion of Regional Coordinators' responsibilities are associated with the regional healthcare preparedness coalitions. It is DHMH's expectation that the Coordinators will play a key role in strategic planning, relationship development, and project management for the coalitions. They should be fully engaged in all aspects of the regional planning process. The following section describes activities that fall within the Regional Coordinators' scope of work.

1. Regional Planning and Project Management
  - a. Providing coordination to ensure regional integration of the Governor's Core Goals for preparedness, as well as the goals and objectives of HPP for Healthcare System Preparedness and CDC for Public Health Emergency Preparedness (PHEP).
  - b. Close collaboration with healthcare coalition partners in the planning, design, implementation and evaluation of HPP-funded regional projects and activities.
  - c. Active, regular participation in regional healthcare coalition meetings, as well as meetings of local-level preparedness organizations (e.g. ESF-8, HERC, LEPC, etc.).
  - e. Providing coordination for activities related to the completion of jurisdictional public health risk assessments and healthcare situational assessments.
  - f. Assisting coalition leadership with the preparation and submission of yearly regional funding applications.
  - g. Assisting coalition leadership with meeting regional grant reporting requirements and programmatic deadlines.
2. Inventory Management
  - a. Maintaining a comprehensive, accurate, and up-to-date inventory of regional supplies and materials.
  - b. Ensuring that regional supplies and materials have appropriate asset and property tags and are entered and tracked in the State's inventory management system.
  - c. Ensuring that regional supplies and materials are properly stored and maintained for optimal use.
3. Training and Exercises
  - a. Collaboration with coalition partners to identify preparedness training gaps and needs through review of risk assessments, gap analyses and improvement plans.
  - b. Assisting with development, conduct and evaluation of regional drills and exercises in collaboration with the DHMH Exercise Coordinator and regional partners.
  - c. Assisting with coordination of regional training events in collaboration with the DHMH Training Coordinator and regional partners.
  - d. Promoting training events to ensure that partners are aware of available regional and state-level training opportunities.



#### 4. Procurement and Expenditure Tracking

- a. Close collaboration with coalition leadership, OP&R's Procurement Officer, and HPP staff to submit regional projects and purchases for processing through DHMH Procurement.

**-OR-**

- b. Close collaboration with coalition leadership, designated regional fiduciary agent, and HPP staff to process regional projects and purchases.
- c. Development of regional spending plans in collaboration with coalition leadership in order to ensure appropriate allocation of funding and resources.

#### 5. Technical Assistance

- a. Providing technical assistance to partners with completion of HPP facility-level funding applications (giving instructions, answering questions, interpreting federal and state-level program guidance, etc.).
- b. Providing technical assistance to partners with completion of HPP facility-level Mid- and End-of-Year reporting requirements.

#### 6. Emergency Response

In the event of public health emergency or disaster, HPP Regional Coordinators may be required to participate in the response effort. The Coordinators do not have a set, pre-designated role in a response; rather, this position has the flexibility to perform multiple roles as assigned by DHMH, OP&R. The types of activities Regional Coordinators may be asked to perform in a public health response include, but are not limited to the following:

- Serving as a regional liaison with healthcare and local public health in order to facilitate communication/information sharing among regional healthcare preparedness coalition members, response partners, and the State.
- Serving as a member of the DHMH OP&R Emergency Response Team. [Regional Coordinators have been designated as emergency essential staff members.]
- Serving as a DHMH Liaison Officer at the State Emergency Operations Center (SEOC).

### **F. Regional Planning: Functions and Responsibilities of Coalitions**

Maryland's healthcare preparedness coalitions, as recipients of HPP regional grant award funding, have certain responsibilities with regard to financial management, assets management, and regional planning. The following activities are to be undertaken by

the healthcare coalitions in collaboration with their respective Regional Coordinators and designated regional fiduciary agents, as applicable.

1. Grants Management: Fiduciary Responsibilities

Regional healthcare coalition leaders (or their designees) will:

- a. Serve as point of contact with DHMH, OP&R for administration, management, and reporting related to HPP regional grant awards.
- b. Collaborate with HPP Regional Coordinators to conduct procurement activities for the coalition.
- c. Collaborate with HPP Regional Coordinators to monitor activities supported by HPP award funds, ensuring compliance with ASPR and DHMH requirements.
- d. Establish and maintain accounting systems and financial records to accurately track funds distributed and purchases made.

2. Regional Resource/Assets Management

Regional healthcare coalition leaders (or their designees) will:

- a. Collaborate with HPP Regional Coordinators to conduct planning related to regional resource management.
- b. Collaborate with HPP Regional Coordinators to conduct inventory assessments and monitor supplies and materials purchased on an ongoing basis. Associated tasks include the following:
  - Labeling of materials with DHMH property tags and HPP asset tags as appropriate.
  - Entering data on supplies and materials purchased with HPP funds into the state's inventory management system and tracking on an ongoing basis.
- c. Collaborate with HPP Regional Coordinators to maintain HPP supplies and materials, rotating items as applicable. This will ensure the optimal shelf life and functionality of the items.

3. Regional Preparedness Planning

Healthcare coalition leaders will also be responsible for the conduct of regional-level planning activities. These include, but are not limited to the following:

- a. Development of local and state all-hazards and ESF #8 plans, including annexes to address specific healthcare delivery priorities (e.g. Medical Surge Management, Fatality Management, Communications, etc.).

- b. Conducting healthcare system situational assessments to identify and prioritize potential threats, as well as identify the critical healthcare assets and essential services that are vital for healthcare delivery.
- c. Participation in regional Medical Surge planning activities.

In recognition of the fact that Maryland's existing healthcare preparedness coalitions represent diverse populations and geographic areas, coalition partners are encouraged to engage in sub-regional planning as appropriate to address their individual preparedness goals and objectives. Coalitions are encouraged to form work groups or subcommittees to address the needs and concerns of particular sub-regional areas.

#### 4. Coalition Strategic Planning

Strategic planning is a process that is commonly used to foster organizational development. A formal, written "strategic plan" is only one of the products of this process. A strategic plan describes an organization and what it intends to achieve (i.e. goals, objectives) within a given time frame—usually three to five years—and outlines strategies that the organization will use to reach the stated goals and objectives. Maryland's healthcare preparedness coalitions are expected to engage in a formal strategic planning process that includes the input and participation of their membership.

As part of the strategic planning process, healthcare preparedness coalitions should complete the following tasks, at minimum:

- Compose a mission statement for the coalition that describes its overall purpose and overarching goal(s).
- Identify the primary or core membership of the coalition ("stakeholders").
- Identify the essential partners who should also be involved in order for the organization to achieve its mission ("partners").
- Develop a governance structure, with a clearly defined process for coalition members to select and appoint leadership.
- Clearly define the roles and responsibilities of participating members, especially regarding disaster preparedness, response and recovery.
- Develop a strategy to engage healthcare system executives in coalition activities.
- Begin planning for financial sustainment of the coalition beyond the availability of federal funding.

The ASPR *Healthcare Preparedness Capabilities* and the HPP Program Measures both contain additional detailed guidance on preparedness planning activities that are relevant for healthcare coalitions.

[This page intentionally left blank.]

## V. Guidance for Future Coalition Development

At present, Maryland's healthcare preparedness coalitions are still in a relatively early phase of development. Preparedness partners should refer to ASPR's three stages of coalition development (as outlined in Section II.B. of this document) to determine the benchmarks that have been met, and those that their coalition has yet to attain. These stages can be broadly described as follows:

- *Stage One* deals with activities related to establishing a coalition.
- *Stage Two* addresses coalition sustainment and engaging in preparedness-related activities.
- *Stage Three* involves sustaining preparedness activities and determining how the coalition will address multiagency coordination during response.

ASPR's *Healthcare Preparedness Capabilities* provides additional detailed guidance for healthcare coalition development. Capability 1: Healthcare System Preparedness and Capability 10: Medical Surge are especially applicable for organizations that are still in the earlier stages of development. [For a graphical summary of the guidance contained in these two capabilities, see Appendix B of this document.]

Each healthcare coalition must take charge of its own development process, according to the particular regional preparedness goals and objectives that have been identified. However, it is DHMH's recommendation that coalitions should have substantially met the requirements of a given stage of development before moving ahead to address the next one. This will allow each coalition to establish a firm foundation and set a clear vision for continued growth. DHMH has set the target that all Maryland healthcare coalitions should be addressing Stage 3 requirements by the end of the current HPP funding cycle (June 2017).

### A. Expansion of Coalition Membership

Given that Maryland's healthcare preparedness coalitions are still in the earlier stages of development, their membership may not include all of the partners deemed essential for ensuring the proper coordination of preparedness, response and recovery activities. Bringing all of the relevant community healthcare and response organizations and stakeholders to the planning table on a consistent basis can be a challenge. Coalitions are encouraged to work as a group to identify their primary stakeholders and essential partners based on the coalition's mission, core services, and the area it represents. Coalitions should create and implement a plan to engage these partners and encourage and facilitate their active participation in regional preparedness planning.

### B. Formation of Nonprofit Organizations

A number of healthcare coalition partners and stakeholders in Maryland have expressed interest in incorporating their organizations as nonprofit entities. There are a wide

variety of nonprofit types and classifications; as such, it is beyond the scope of this document to outline the benefits and drawbacks of each. However, if coalitions elect to seek legal status as nonprofit entities, the following recommendations should be taken into consideration.

1. Coalition Status: Establishment, Membership

It is DHMH's recommendation that healthcare preparedness coalitions should be firmly established prior to beginning the process of incorporation as a legal nonprofit. Coalitions should have a formal, written document that demonstrates the establishment of the organization for purposes of emergency preparedness. [For additional details, see Section III.D.] In addition, it is strongly recommended that the full complement of essential preparedness partners and all necessary ESF #8 response organizations and stakeholder agencies be represented in coalition membership prior to beginning this process [see Section III.C.]. This is key to ensuring the proper coordination of preparedness, response and recovery activities.

2. Local Health Department Participation in Nonprofits

Given that local health departments are key preparedness planning and response organizations, it is essential that they be represented in the membership of regional healthcare coalitions. However, given that local health department staff are employees of the State of Maryland, the potential for conflict of interest (actual or perceived) may arise from local health department participation in private nonprofit organizations. DHMH has received specific guidance on this topic from the Office of the Maryland Attorney General.

In order to minimize the risk of inadvertent conflict of interest arising from participation in the governance of nonprofit organizations, the following measures are recommended:

- a. Local health officer position descriptions (State form MS-22) may be amended expressly to authorize the health officer or his/her designee to participate in the governance of the organization. Suggested language may include:
  - "With the approval of the appointing authority, the Health Officer (or his or her designated staff of the local health department) may represent the local health department and serve, without compensation, as an *ex officio* member of the governing board of a body that has been designated as the local health planning agency for a county, a local health

improvement coalition, or other private nonprofit community health organization."

- b. The healthcare coalition's charter and by-laws should expressly provide for local health department representation in the organization's governing body, and should indicate that the local health officer (or his/her duly designated representative) shall serve without compensation in an *ex officio* capacity.
- c. The local health officer (or his/her duly designated representative) who serves in the regional healthcare coalition may wish to apprise the organization that he/she is required to recuse him/herself from deliberations and decisions on any business matters (including but not limited to procurement, grants, contracts, and hiring of personnel) that would provide a direct monetary benefit to the local health department or its programs or staff. Further, the health officer or his/her designee should be prepared to recuse him/herself from deliberating and voting on such matters.
- d. Local health officers may also wish to consult with the Maryland State Ethics Commission to assure that any special circumstances specific to their participation in the regional healthcare coalition are in accordance with the State's Public Ethics Law.

### C. Role of Healthcare Coalitions in Emergency Response

As demonstrated by the review of existing organizations from around the country, healthcare preparedness coalitions vary widely with regard to their roles and functions in emergency response. Some coalitions have more active, operational roles, with an organizational structure and designated personnel to support such activities. Other coalitions have little to no actual function as an organization during response. Instead, they may simply be represented by proxy through the auspices of another agency (e.g. local health department). Given that Maryland's healthcare preparedness coalitions are still relatively young, the role that they will serve in an emergency response is still being defined. It is necessary to take existing state rules and regulations (i.e. the current operational environment) as well as federal guidance for coalition development into account when considering this issue.

In Maryland, the authority rests with local jurisdictions in an emergency response. Because our coalitions are regional bodies that represent multiple jurisdictions, defining an *operational* response role for the coalitions may not be feasible. However, it is essential that healthcare organizations have a voice in incident management decisions during a response. Through robust planning and proper coordination, this representation can be ensured.

Healthcare preparedness coalitions will be expected to serve two main functions during an emergency incident: (1) Information Sharing, and (2) Resource Allocation.

1. Information Sharing

The *Healthcare Preparedness Capabilities* document describes "information sharing" as the multijurisdictional, multidisciplinary exchange of medical and public health related information and situational awareness among healthcare system partners; local, state and federal levels of government; and the private sector. It is a process that is intended to foster the ongoing exchange of information to support an incident common operating picture during emergency response.

Healthcare preparedness coalitions that receive HPP funds will be required to develop a coordinated Information Sharing Plan that contains the following:

- a. Protocols for healthcare organizations to provide multiagency coordination of information to and from the ESF #8 liaison/incident management.
- b. Protocols for healthcare organizations to provide and receive information about the incident, the status of healthcare delivery in the community and the operating status of healthcare organizations, and healthcare organization immediate resource needs.

The coalition's Information Sharing Plan should also identify the healthcare "essential elements of information" to be reported and shared during response. [For additional guidance on healthcare essential elements of information, refer to the *Healthcare Preparedness Capabilities*, Capability 6: Information Sharing.]

Healthcare preparedness coalitions should conduct the necessary planning to determine how they will operate during a response. This includes developing an ICS structure for the coalition to support and facilitate information sharing.

2. Resource Allocation

The second essential function of healthcare preparedness coalitions during an emergency response is resource allocation. Activities to support resource allocation during response begin prior to the onset of an emergency. Healthcare coalitions should conduct the necessary planning to ensure that resources are allocated in the most efficient and effective manner possible. This includes the development of MOUs and resource management plans; conducting healthcare organization resource assessments that identify and prioritize essential assets and services, and identify resource gaps for incident response; and establishing processes for healthcare organizations to request and obtain resources during emergency response and recovery.



## VI. References

1. A Survey of Hospitals to Determine the Prevalence and Characteristics of Healthcare Coalitions for Emergency Preparedness and Response (September 2012).  
<http://www.ncbi.nlm.nih.gov/pubmed/22857783>
2. Advancements in HPP Regional Healthcare Coalitions: Utah's Experience (2012).  
[http://www.integratedtrainingsummit.org/presentations/2012/main\\_training\\_summit/13-advancements\\_in\\_coalitions\\_final.pdf](http://www.integratedtrainingsummit.org/presentations/2012/main_training_summit/13-advancements_in_coalitions_final.pdf)
3. Baseline Evaluation of the DC Emergency Healthcare Coalition (June 2008).  
[http://www.law.georgetown.edu/oneillinstitute/documents/2008-06-11\\_DC\\_Baseline-evaluation-report.pdf](http://www.law.georgetown.edu/oneillinstitute/documents/2008-06-11_DC_Baseline-evaluation-report.pdf)
4. DC Emergency Healthcare Coalition (DC EHC): A "Tier Two" Response Organization (2011). <http://www.slideshare.net/stevemabley/dc-emergency-healthcare-coalition>
5. Emergency Preparedness and Community Coalitions: Opportunities and Challenges (November 2012). <http://www.hschange.com/CONTENT/1323/1323.pdf>
6. Miami-Dade County Hospital Preparedness Consortium and Health Council of South Florida Collaboration.  
<http://www.healthcouncil.org/CountyHospitalPreparednessConsortium.asp>
7. Northern Utah Healthcare Coalition Executive Council and Membership Roster (May 2013). <http://www.brhd.org/documents/northern-utah-healthcare-coalition/229-rosterforwebpage6-13/file.html>
8. Northern Utah - Coalition Strategic Plan 2012-2013 (2012).  
<http://www.brhd.org/documents/northern-utah-healthcare-coalition.html>
9. Northern Utah Regional Medical Surge Capacity Plan (December 2010).  
<http://www.brhd.org/documents/northern-utah-healthcare-coalition/183-medsurgeplan112/file.html>
10. Northwest Healthcare Response Network 2011-2012 Annual Report (2012).  
<http://nwhrn.pushdesign.net/media/2011-2012-King-County-Healthcare-Coalition-Annual-Report.pdf>
11. Northwest Healthcare Response Network 2011 Executive Council Report (September 2011). [http://www.kingcountyhealthcarecoalition.org/media/Sept-2011-management-report\\_Final.pdf](http://www.kingcountyhealthcarecoalition.org/media/Sept-2011-management-report_Final.pdf)

12. Northwest Healthcare Response Network: Frequently Asked Questions on the Merger (January 2013). <http://nwhrn.pushdesign.net/media/FAQ-About-the-Merger.pdf>
13. Northwest Healthcare Response Network: Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (April 2010). [http://www.healthlawyers.org/Members/PracticeGroups/THAMC/EmergencyPreparednessToolkit/Documents/V\\_EMAC/F\\_RegionalMedicalEvacuationPatientTrackingMutualAidPlan.pdf](http://www.healthlawyers.org/Members/PracticeGroups/THAMC/EmergencyPreparednessToolkit/Documents/V_EMAC/F_RegionalMedicalEvacuationPatientTrackingMutualAidPlan.pdf)
14. Partnership for Effective Emergency Response - Membership. [http://sph.bu.edu/otlt/peer/about\\_partners.php](http://sph.bu.edu/otlt/peer/about_partners.php)
15. Taking a Regional Healthcare Coalition Approach to Mitigating Surge Capacity Needs of Mass Casualty or Pandemic Events (McElwee, 2012).
16. U.S. Department of Health and Human Services, Office of the Assistant Secretary of Preparedness and Response, From Hospitals to Healthcare Coalitions: Transforming Health Preparedness and Response in Our Communities (2009). <http://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-healthcare-coalitions.pdf>
17. U.S. Department of Health and Human Services, Office of the Assistant Secretary of Preparedness and Response, Healthcare Preparedness Capabilities (January 2012).
18. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Public Health Preparedness Capabilities (March 2011).

## VII. Definitions

### **501(c)(3) Organization and 501(c)(6) Organization**

These are tax-exempt, nonprofit organizations—usually public charities or private foundations. The numerical designations refer to the specific portion of the U.S. Internal Revenue Code [26 U.S.C. § 501(c)] that provides the guidelines for exemption from federal income taxes.

### **By-laws**

By-laws are written rules and regulations enacted by an organization, association, or corporation that provide a framework for operation and management. They generally describe committees and duties of officers, as well as outline procedures for meetings, election of officers, and other routine conduct. By-laws constitute a contract among an organization's members, and must be formally adopted and/or amended.

### **Community Based Organization**

Community based organizations (CBOs) are public or private nonprofits (including churches or religious entities) that are representative of a community or a significant segment of a community, and are engaged in meeting community needs in the areas of education, the environment, or public safety.

### **Core Service Agencies**

Core Service Agencies (CSAs) are the authorities responsible for planning, managing, and monitoring public mental health services at the local level. Within their jurisdictions, they manage a full range of treatment and rehabilitation services for persons with serious mental illness. A CSA may operate as a unit of county government (e.g. health department), as a quasi-public authority, or as a private, nonprofit corporation.

### **Emergency Support Function (ESF) #8**

Emergency Support Function (ESF) #8 – Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing health and medical emergency.

### **Faith Based Organization**

Faith Based Organization (FBO) refers to a wide range of religious organizations and other charitable entities that are affiliated or identified with religious organizations. They may be religious congregations, or they may be organizations, programs, or projects sponsored by a congregation. FBOs may also include specialized religious organizations, such as schools, social service providers, disaster relief agencies and community development corporations.

### **Federally Qualified Health Center**

Federally Qualified Health Centers (FQHCs) are “safety net” providers intended to enhance the provision of primary care services in underserved urban and rural communities. They include

all organizations that receive grants under Section 330 of the Public Health Service Act (PHS) and qualify for enhanced reimbursement from Medicare and Medicaid.

**Fiduciary Agent**

A fiduciary agent is an agency or organization appointed to act, confidently and ethically, on behalf of another party (in this case, a regional healthcare coalition) with regard to all financial matters. Healthcare coalition fiduciary agent responsibilities will include: receipt and management of grant funds, conducting procurement activities on behalf of the coalition, maintaining systems to track financial data, monitoring and reporting on grant-related activities and expenditures, and ensuring compliance with ASPR and DHMH requirements related to the expenditure of grant funds.

**Governor's Core Goals**

The Governor's Core Goals for a Prepared Maryland (also known as Maryland's Strategic Goals and Objectives for Homeland Security), were introduced by Governor Martin O'Malley as a strategic plan for enhancing the overall preparedness of the state in twelve (12) basic capability areas (e.g. Interoperable Communications, HazMat/Explosive Device Response, Mass Casualty/Hospital Surge).

**Healthcare Preparedness Coalition**

A multi-agency coordinating group of made up of healthcare organizations and their respective public and private sector emergency response partners and stakeholders.

**Interagency Agreement**

An interagency agreement (IAA) is a written agreement executed between two state or federal agencies (the term may be used interchangeably with Memorandum of Understanding or Agreement). Interagency agreements may be highly formalized, or they may be intended for an operational or local level, and therefore less formal in nature.

**Letter of Agreement**

A letter of agreement (LOA) is one of several types of instruments that exist for drawing up a mutual aid agreement between agencies, organizations or jurisdictions. An LOA outlines the agreed upon conditions and practices under which participating members will operate to provide mutual aid in an emergency or disaster situation. An LOA, once activated by official signatures from all participating leadership, can act as a legally binding document.

**Local Area Agencies on Aging**

Local Area Agencies on Aging (AAA) refers to the nationwide network of state and local programs that advocate for older adults. Established under Federal law in 1973 (the Older Americans Act), AAAs respond to the needs of people aged 60 and over in local communities. Local AAAs develop and implement programs and services (e.g. social services and nutrition services for elders, support for caregivers, etc.) to meet the needs of older adults. Most services coordinated by AAAs are provided through community service providers at the local level.

**Memorandum of Agreement (MOA) / Memorandum of Understanding (MOU)**

These are formal, written documents that demonstrate an agreement between two or more separate agencies or organizations and outline an agreed-upon purpose or common course of action—for example, to provide mutual aid in the event of a disaster or emergency. MOAs and MOUs are intended to assist healthcare systems, state and local public health, and emergency response officials in sharing information, supplies, personnel or equipment by outlining the conditions under which the provision of such aid would occur. [Note: the terms MOA and MOU are often used interchangeably. The literature reviewed showed a range of opinion regarding the extent to which they constitute legally binding contracts.]

**Multiagency Coordinating Group**

A Multiagency Coordinating Group (also referred to as Multiagency Coordination Group) is made up of organizational representatives with decision making authority who facilitate strategic coordination in an emergency or disaster by providing policy guidance, resolving issues, and ensuring appropriate resource allocation.

**Pandemic and All-Hazards Preparedness Act (PAHPA)**

In 2006, Congress passed and the President signed the Pandemic and All-Hazards Preparedness Act (PAHPA), Public Law No. 109-417, which has broad implications for preparedness and response activities of the U.S. Department of Health and Human Services (DHHS). According to DHHS, PAHPA's purpose is “to improve the Nation’s public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural.” PAHPA amended the Public Health Service Act to establish the Office of the Assistant Secretary for Preparedness and Response (ASPR) and provided new authorities for a number of programs, including advanced development and acquisition of medical countermeasures.

**Voluntary Organizations Active in Disaster (VOAD)**

VOAD is an umbrella organization of diverse disaster relief agencies that include nonprofits, governmental departments and agencies, faith-based groups, and other non-governmental organizations. Its purpose is to bring together disaster relief and voluntary organizations to foster more effective response and recovery in times of disaster.

[This page intentionally left blank.]

## *Part Two — Appendices*

[This page intentionally left blank.]



## *Appendix A - Detailed Findings from Research on Existing Healthcare Coalitions*

### 1. DC Emergency Healthcare Coalition - Washington, DC

- A single-jurisdiction coalition, DC EHC bills itself as a "Tier 2 Response Organization"; coordinates with healthcare organizations (HCOs), emergency management, jurisdiction, and surrounding states
- Two main committees: Emergency Management and Grants Steering
  - Emergency Management Committee: sets goals and direction; approves work products (meets monthly)
  - Grants Steering Committee: acts as an executive council to provide strategic oversight and spending approval
- Individual work/task groups formed to accomplish needed objectives
- Membership is voluntary; members have full autonomy
  - Members include acute-care hospitals, Veterans Administration (VA) hospital, specialty hospitals. Poison Control, mental health clinics, DC Primary Care Association, DC Medical Society
- DC EHC has a Healthcare Coalition Response Team to facilitate situational awareness, track resource availability, coordinate strategy, and facilitate mutual aid
- Three (3) Coalition Notification Centers in continuous operation and a Duty Officer on call weekly with backup to serves as a decision point for alerting and evacuation

### 2. First Coast Disaster Council - Northeastern Florida

- Established in 1983 as a private company; now a 501(c)(3) non-profit
- Coalition describes itself as covering "northeastern Florida"; however, technically a single-jurisdiction coalition for Jacksonville/Duval County
- Uses committee structure due to large number of disciplines represented
  - Committees include: EMS Advisory; Jacksonville Fire and Rescue Department; Special Needs; State Medical Response Team; Training and Education
- Leadership: elected President, Vice-President, Secretary, and Treasurer
- Coalition meets monthly; committees report to membership at each meeting
- Membership open to all agencies and disciplines in healthcare community
  - Members include hospitals, specialty facilities, EMS, Fire/Rescue, public health, NGOs, private partners, law enforcement, mass transit entities, NDMS, State Medical Response Team
- Letters of Agreement between FCDC and all participating hospitals
- FCDC has no defined role in response; operates in a supportive role via ESF #8, represented at command level by proxy through local health department

### 3. MESH - Indianapolis, IN

- MESH is a non-profit 501(c)(3) organization; a public-private emergency preparedness healthcare coalition that is privately managed
- Has a three-tiered structure (Tier 1: CEO and Chief Medical Officer, Tier 2: Board of Directors, Tier 3: Staff)
- Membership consists of Subscribing (i.e. fee-paying) Healthcare Partners and Coalition Partners from various disciplines
  - Fee-paying members have contractual obligations to organization
- MESH Preparedness Advisors provide technical and planning assistance, healthcare intel, and policy analysis for providers and institutions
- MESH has a pharmaceutical cache and a cache of hospital supplies in the event of disaster
- For additional information: <http://www.meshcoalition.org/>

### 4. Miami-Dade County Hospital Preparedness Consortium - Florida

- Single-jurisdiction coalition sponsored by Miami-Dade Health Department
- Mission: "to assure that the Miami-Dade healthcare community employs a unified approach to all hazardous events"
  - "Acts as a forum for hospitals to discuss best practices to comply with national standards, including the elements of performance for the Joint Commission Emergency Management Standards"
- Has three committees and three Co-Chair positions:
  - Clinical and Ethical Issues Committee, Exercise and Training Committee, and Steering Committee
- Consortium meets bi-monthly and has two levels of membership:
  - Members: representatives from Miami-Dade County hospitals; have voting privileges
  - Associate Members: representatives from other organizations; do not have voting privileges
- For additional information: <http://www.mdchospitals.org/>

### 5. Northern Utah Healthcare Coalition

- NUHC is a true regional coalition; covers six northernmost counties in Utah
- Administered by the Bear River Health Department (Logan, UT) as a sub-grantee of the Utah Department of Health (as HPP funding awardee for state)
- MOU and a Charter developed by a task force of coalition members
- NUHC has bi-monthly meetings of full coalition and Executive Committee
- Executive Committee is empowered to make interim decisions:
  - Consists of Chair, Vice Chair, Immediate Past Chair, 5 hospital representatives, 1 health officer, 1 clinic representative, 1 EMS representative, 1 county emergency manager

- Hospital members retain voting majority; Chair, Vice Chair, Immediate Past Chair are always hospital members
- Coalition has Members and Ad Hoc Members:
  - Members include hospitals, local health, county emergency managers, county EMS, and representatives from long term care, community health centers and private primary care clinics
  - Ad Hoc Members: behavioral health, dispatch, home health, hospice, Division of Emergency Management regional liaison, Department of Transportation, Highway Patrol, and city Emergency Managers
- Has Regional Medical Surge Director serving in a role similar to that of Maryland's HPP Regional Coordinators
- Has a Regional Medical Surge Plan; however, control is local, not regional
- Coalition has no defined response role
- For additional information:  
[http://www.brhd.org/index.php?option=com\\_content&task=view&id=457&Itemid=31](http://www.brhd.org/index.php?option=com_content&task=view&id=457&Itemid=31)

#### 6. Northern Virginia Hospital Alliance (NVHA)/Northern Virginia Emergency Response System (NVERS)

- A not-for-profit coalition formed in 2002
- Mission: to coordinate preparedness, response and recovery activities for member hospital and healthcare systems in cooperation with local, regional, state and federal response partners
- Membership includes all 14 acute care hospitals that operate within the Virginia portion of the National Capital Region (NCR)
- Leadership includes an Executive Director and a Board of Directors
  - The board is comprised of senior executive leadership from each member hospital
- NVHA has employees for inventory management, planners, training and education development staff, Regional Hospital Coordinating Center operators, a financial administrator, and administrative support staff (no "Regional Coordinator" equivalent)
- One annual meeting for all regional partners for networking, training and exercises; other meetings are periodic:
  - Bimonthly Hospital Executive Meeting
  - Monthly Hospital Emergency Managers Meeting
- NVHA has a robust strategic planning process; also has a Regional Emergency Operations Plan and has conducted a regional HVA
- NVHA is "a coalition within a coalition" in that it makes up the hospital/healthcare system membership of the Northern Virginia Emergency Response System (NVERS); NVERS and is the response wing for the counties of northern Virginia

- NVERS partners (EMS, fire and rescue, emergency management, hospital and healthcare, public health, law enforcement, public information) meet monthly on a monthly basis to discuss emergency response activities and projects
- NVERS mission: "a regional approach to coordinated preparedness, response, mitigation and recovery... through strategic planning, priority-setting, information sharing, training, exercises... and policy-making"
- For additional information: <http://www.novaha.org/> and <http://nvers.org/>

#### 7. Northwest Healthcare Response Network - King County and Pierce County, WA

- Relatively new coalition; formed by merger of two pre-existing organizations: the King County Healthcare Coalition and the Pierce County Coalition for Healthcare in Emergencies
- Administered by Public Health - Seattle & King County in collaboration with the Tacoma-Pierce County Health Department
  - Currently exploring feasibility of incorporating as a 501(c)(3)
- Coalition structure: Executive Council with committees
  - Executive Council sets mission and strategic direction; reviews and approves budget; provides policy-level oversight of work groups and projects; approves regional and health sector emergency plans
  - During response, Executive Council represents the Coalition and advises local Health Officer on healthcare policy issues
- Coalition staff: Program Manager, Development Manager, Business Manager, planners, training and exercise staff, administrative support staff
- Membership includes more than 300 healthcare organizations:
  - All hospitals and major medical systems in King and Pierce counties; community health centers, long-term care, behavioral health, in-home services, safety net, and specialty care providers
  - Active engagement with critical response partners in public health, emergency management, emergency medical services, utilities and other community organizations
  - Members are periodically required to sign "commitment forms" as documentation of their intent to participate in coalition activities
- Executive Council meets quarterly; led by elected Chair and Vice-Chair
- Annual meeting for full coalition membership
- Coalition has several MOUs and MOAs created to fill various needs (e.g. Home Health Home Care MOA, Hospital and Palliative Care MOU, Opioid Treatment Program MOA)
- Response role: Coalition Executive Council members sit on the Multi-Agency Coordinating (MAC) Group, which is a policy decision-making body within the Health and Medical Area Command
- For additional information: <http://www.nwhrn.org/>

---

#### 8. Partnership for Effective Emergency Response (PEER) - Boston, MA

- PEER is a "consortium" of local coalitions; made up of members from local hospital and public health coalitions that serve the 62 cities and towns of the greater Boston metropolitan area:
  - 2 hospital preparedness coalitions, 3 public health preparedness coalitions, organizational representatives from EMS, long-term care, and community health centers
- Administered by Boston University School of Public Health, Office of Public Health Practice
- PEER meets quarterly; leadership functions are performed by an Executive Committee
- No overarching PEER MOU signed by all member coalitions; instead, there are MOUs for each discipline and local coalition
- Coalition staff of one: Project Manager (staff of Boston University)
  - This role is advisory only in nature; Project Manager has no designated role in response
- PEER has a Duty Officer at the Massachusetts Department of Public Health
  - PEER members notify the Duty Officer under certain specified set of circumstances (e.g. when a PEER member group has activated its EOP)
- For additional information: <http://sph.bu.edu/otlt/peer/>

[This page intentionally left blank.]

## Appendix B - Summary Matrix: Healthcare Preparedness Capabilities Guidance for Coalition Development

HPP Capability 1: Healthcare System Preparedness	
<p>Healthcare system preparedness is the ability of a community's healthcare system to prepare to, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, community and faith-based partners, state, local, and territorial governments to do the following:</p> <ul style="list-style-type: none"> <li>• Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community</li> <li>• Provide timely monitoring and management of resources</li> <li>• Coordinate the allocation of emergency medical care resources</li> <li>• Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders</li> </ul> <p>Healthcare system preparedness is achieved by a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.</p>	
<b>Function 1: Develop, refine, or sustain Healthcare Coalitions</b>	<p>Develop, refine or sustain Healthcare Coalitions consisting of a collaborative network of healthcare organizations and their respective public and private sector response partners within a defined region. Healthcare Coalitions serve as multi- agency coordinating groups that assist Emergency Management and Emergency Support Function (ESF) #8 with preparedness, response, recovery and mitigation activities related to healthcare organization disaster operations. The primary function of the Healthcare Coalition includes sub-state regional healthcare system emergency preparedness activities involving the member organizations. Healthcare Coalitions also may provide multi-agency coordination to interface with the appropriate level of emergency operations in order to assist with the provision of situational awareness and the coordination of resources for healthcare organizations during a response.</p>
	<p><b>P1. Healthcare Coalition regional (geographic) boundaries</b></p> <ul style="list-style-type: none"> <li>• The State and Coalition member organizations identify the geographic boundaries of the Healthcare Coalition (e.g. healthcare catchment area, trauma or EMS region, public health district or county jurisdiction, or some other type of functional service region).</li> </ul>

<b>Healthcare System Preparedness, Function 1 (cont'd.)</b>	<p><b>P2. Healthcare Coalition primary members</b></p> <ul style="list-style-type: none"> <li>• <u>Establish the primary members of the coalition</u> <ul style="list-style-type: none"> <li>○ Healthcare organization participation in preparedness and planning may include formation of Healthcare Coalitions as a component of a larger planning organization or region (e.g. EMS or EMA regions).</li> <li>○ Healthcare organizations may also form Healthcare Coalitions around healthcare delivery areas and obtain input for preparedness from relevant response organizations and stakeholders.</li> <li>○ <u>State role in Healthcare Coalitions</u>: to form a partnership with or provide support to healthcare organizations in efforts for multi-agency coordination for preparedness and response.</li> </ul> </li> </ul>
	<p><b>P3. Healthcare Coalition essential partner membership</b></p> <ul style="list-style-type: none"> <li>• The State and the Healthcare Coalition member organizations encourage development of essential partner memberships from community's healthcare organizations and response partners; memberships may be dependent upon area, participant availability, and relevance to coalition.</li> <li>• Active membership must be evidenced by written documents such as MOUs, IAAs, letters of agreement, charters, or other supporting evidence documents. <ul style="list-style-type: none"> <li>○ <i>For a list of suggestion prospective essential partners, refer to <u>Healthcare Preparedness Capabilities, Capability 1: Healthcare System Preparedness.</u></i></li> </ul> </li> </ul>
	<p><b>P4. Additional Healthcare Coalition partnerships/memberships</b></p> <ul style="list-style-type: none"> <li>• Coalitions should include subject matter experts (SMEs) for improved coordination of preparedness, response, and recovery activities. These memberships may be dependent on the area, participant availability, and the Coalition's unique needs.</li> <li>• Active membership must be evidenced by written documents such as MOUs, MAAs, IAAs, letters of agreement, charters, or other supporting evidence documents: <ul style="list-style-type: none"> <li>○ May also include correspondence [e.g. emails, meeting minutes], but such documents must clearly demonstrate that SME input has been coordinated.</li> <li>○ Potential SME partners include, but are not limited to: Faith Based and Community Based Organizations (FBOs, CBOs), non-governmental organizations (NGOs), non-profits, private organizations, Public Works, and volunteer organizations.</li> </ul> </li> </ul>



<b>Healthcare System Preparedness, Function 1 (cont'd.)</b>	<b>P5. Healthcare Coalition organization and structure</b> <ul style="list-style-type: none"> <li>Healthcare Coalition members establish a collaborative oversight and coordination structure that at a minimum should include:             <ul style="list-style-type: none"> <li>A leadership structure determined and appointed by the Healthcare Coalition</li> <li>An advisory board-like function with multi-agency representation from Coalition members to provide informed input into key decisions and ensure integrated planning similar to that of a multi-agency coordinating group</li> <li>Clear structure that can coordinate w/local, State emergency operations center:                 <ul style="list-style-type: none"> <li>This includes a primary point of contact (POC) and/or a process that serves as the liaison/method to communicate with ESF #8 and Emergency Operations Centers (EOCs) during response.</li> </ul> </li> <li>Clearly defined roles and responsibilities for each participating member as it relates to disaster preparedness, response, and recovery.</li> <li>Strategies to empower and sustain the Healthcare Coalition as an entity:                 <ul style="list-style-type: none"> <li>Documents outlining guidelines, participation rules, and roles and responsibilities of each agency in the Coalition</li> <li>Plans for the financial sustainability of the Coalition in the absence of federal funding</li> <li>Processes to document and implement the administrative responsibilities needed to maintain the Healthcare Coalition.</li> </ul> </li> </ul> </li> </ul>
	<b>P6. Multi-agency coordination during response</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalition, in coordination with healthcare organizations and all relevant response partners and stakeholders, will develop a plan to ensure healthcare is represented in incident management decisions during an incident.</li> <li>Options for achieving representation may include (1) a response role as a part of Multi-Agency Coordination System (MACS), or (2) by providing plans for incident management to guide decisions regarding healthcare organization support.</li> <li>Whether coordination is done via actual response or by planning, it should guide protocols for:             <ul style="list-style-type: none"> <li>Healthcare organization coordination with ESF #8, as well as coordination with incident management at the Federal, State, and local government levels</li> <li>Information sharing procedures between healthcare orgs and incident mgmt</li> <li>Resource support to healthcare organizations</li> </ul> </li> </ul>

<p><b>Healthcare System Preparedness</b></p> <p><b>Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster</b></p>	<p>Coordinate with emergency management to develop local and state emergency operations plans that address the concerns and unique needs of healthcare organizations. Plans should encompass the ability to deliver essential healthcare services during a response, including the assessment phases of planning to determine needs and priorities of healthcare organizations and the development of operational courses of action used during responses.</p> <p><b>P1. Healthcare system situational assessments</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, will coordinate to develop a situational assessment of local healthcare delivery areas that comprise Coalition regions. The situational assessment will (1) be adapted from local hazard vulnerability and risk assessments; (2) include a prioritization of threats to the community's ability to deliver healthcare during response; (3) include estimates of possible casualties and fatalities based on identified risks.             <ul style="list-style-type: none"> <li>○ <i>Refer to Healthcare Preparedness Capabilities, Capability 1: Healthcare System Preparedness for details on the required components of the situational assessment and how it should be conducted.</i></li> </ul> </li> </ul> <p><b>P2. Healthcare System disaster planning</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, collaborate to develop local and State all-hazards and ESF #8 plans. Plans should include, but are not limited to the following elements that:             <ul style="list-style-type: none"> <li>○ Include healthcare organizations' objectives and priorities for response based on HVA and risk assessment</li> <li>○ Assist healthcare organizations to perform capabilities required to prevent, protect against, respond, and recover from all-hazards events</li> <li>○ Coordinate vertically and horizontally with the appropriate departments, agencies, and jurisdictions</li> <li>○ Provide a process to request local, State, Federal assistance for healthcare organizations</li> <li>○ Provide the processes for requesting assistance from community partners, stakeholders and other healthcare organizations</li> <li>○ Coordinate healthcare organization operations with local or State emergency operations center to assist with disaster response</li> <li>○ Define healthcare organization roles and responsibilities for response</li> <li>○ Coordinate the development of plan annexes that include specific healthcare delivery priorities; including, but not limited to Medical Surge Management, Information Management, Communications, Continuity of Operations, Fatality Management.</li> </ul> </li> </ul>
---	--

<p><b>Healthcare System Preparedness</b></p> <p><b>Function 3: Identify and prioritize essential healthcare assets and services</b></p>	<p><b>P1. Identify and prioritize critical healthcare assets and essential services</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and relevant response partners and stakeholders, perform community healthcare assessments to identify and prioritize assets and essential services that are vital for healthcare delivery. Assessments should identify the following critical services and key resources (not inclusive):             <ul style="list-style-type: none"> <li>Critical medical services (e.g., trauma, radiology, critical care, surgery, pediatrics, EMS, decon, isolation)</li> <li>Critical medical support services (e.g., patient transport services, pharmacy, blood banks, laboratory, medical gas suppliers)</li> <li>Critical facility management services (e.g., power, water, sanitation, generators, heating, ventilation and air conditioning [HVAC], elevators)</li> <li>Critical healthcare information systems for information management/communications (e.g., failover and back up, remote site hosting)</li> <li>Key healthcare resources (e.g., staffing, equipment, beds, medical supply, pharmaceuticals)</li> </ul> </li> </ul> <p><b>P2. Priority healthcare assets and essential services planning</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain resource management processes to assist healthcare organizations with resources support. Support should assist healthcare organizations to maintain priority healthcare assets and continue essential services during a response.             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities</u>, <u>Capability 1: Healthcare System Preparedness</u> for details on the required components of the resource management plans and processes.</i></li> </ul> </li> </ul> <p><b>E1. Equipment to assist healthcare organizations with the provision of critical services</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, assess the need for equipment to assist healthcare organizations with essential services in a disaster.             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities</u>, <u>Capability 1: Healthcare System Preparedness</u> for details on the types of equipment and intended uses.</i></li> </ul> </li> </ul>
<p><b>Function 4: Determine gaps in healthcare preparedness and identify resources for mitigation</b></p>	<p>Perform resource assessments and develop plans to assist healthcare organizations in addressing gaps associated with planning, training, staffing and equipping to improve resource availability during response and recovery. This is an ongoing process in the preparedness cycle guided by healthcare organization resource needs. These needs are determined based on the outcome of gap analyses; the evaluation of training, exercises, and actual incidents/events; and subsequent corrective actions.</p>

<b>Healthcare System Preparedness, Function 4 (cont'd.)</b>	<b>P1. Healthcare resource assessment</b> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, perform a healthcare organization resource assessment in order to identify: <ul style="list-style-type: none"> <li>○ Healthcare organization resource gaps for incident response, including those in communication, transportation, manpower (e.g. to stabilize/maintain staff after event), equipment and supplies, surge or alternate care space, specialty services, and other resources identified by gap analyses/corrective actions</li> <li>○ Categorization of available assets within the region that could be used to address resource gaps</li> <li>○ Available resource assistance from accessible public or private caches</li> <li>○ Mutual aid agreements for resources from the public and private sector (if the healthcare organization is willing to participate)</li> <li>○ Local, State and Federal resources available through request processes</li> <li>○ Deconfliction of over-allocated resources (competing priorities for the same resource at the same time)</li> </ul> </li> </ul>
	<b>P2. Healthcare resource coordination</b> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain coordinated resource processes to assist healthcare organizations with effectively obtaining resources during response and recovery. This should include processes that assist healthcare organizations to: <ul style="list-style-type: none"> <li>○ Immediately request and obtain resources from available caches</li> <li>○ Retain viable options for resource allocation and sharing that involves the community, private sector, and other stakeholders</li> <li>○ Request resources from the local, State and Federal level of emergency operations (e.g., NDMS Teams).</li> </ul> </li> <li>• <i>For supporting information, see Capability 3 – Emergency Operations Coordination.</i></li> </ul>
	<b>P3. Address healthcare information gaps</b> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain plans that address information gaps in order to: <ul style="list-style-type: none"> <li>○ Ensure communications and data interoperability for healthcare organizations and response partners</li> <li>○ Assist with information sharing between local and State partners during an incident or event</li> </ul> </li> <li>• <i>For supporting information, see Capability #6 – Information Sharing.</i></li> </ul>

<b>Healthcare System Preparedness</b>  <b>Function 5: Coordinate training to assist healthcare responders to develop the necessary skills to respond</b>	<p>Coordinate training for healthcare responders and supporting agencies in order to provide the required knowledge, skills and abilities needed to prepare and respond to a disaster. Training curricula are based on assessments, strategies, improvement plans, and ongoing evaluation efforts. Training is coordinated with ongoing training initiatives from healthcare and response partners, and should include appropriate National Incident Management System (NIMS) or equivalent training.</p>
	<p><b>P1. Healthcare organization — National Incident Management System (NIMS) training</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain healthcare strategies that assist healthcare organizations with NIMS training. This includes processes and strategies to: <ul style="list-style-type: none"> <li>○ Promote NIMS adoption with healthcare organizations</li> <li>○ Support NIMS implementation with healthcare organizations</li> <li>○ Assist healthcare organizations to revise and update healthcare organization Emergency Operation Plans (EOPs) to incorporate NIMS and NRF components</li> <li>○ Assist healthcare organizations to develop, refine, and sustain interagency mutual aid agreements, (e.g., agreements with public, private sector, and nongovernmental organizations)</li> <li>○ Assist healthcare organizations with FEMA 100, 200, 700 level training or equivalent training</li> <li>○ Assist healthcare organizations with FEMA 800 level or equivalent training</li> <li>○ Integrate NIMS concepts and principles into healthcare organization-related training and exercises</li> <li>○ Promote and encourage healthcare organization protocols, equipment, communication, and data interoperability to facilitate the collection and distribution of consistent and accurate information with State and local partners during an incident</li> <li>○ Promote application of common and consistent terminology during response</li> <li>○ Ensure all emergency incidents, exercises, and preplanned (recurring/special) events are managed with a consistent application of ICS organizational structures, doctrine, processes, and procedures</li> <li>○ Assist healthcare organizations with adoption of the principle of Public Information, facilitated by use of the Joint Information System (JIS) and Joint Information Center (JIC).</li> </ul> </li> </ul>
	<p><b>S1. Training to address healthcare gaps and corrective actions</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, provide training to address identified healthcare response gaps and corrective actions. Training should be based on specific needs (i.e. knowledge, skills, and abilities) identified by healthcare organizations.</li> </ul>

<b>Healthcare System Preparedness</b>  <b>Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation</b>	<p>Coordinate an exercise, evaluation, and corrective action program to continuously improve healthcare preparedness, response, and recovery. Exercises should assess and validate the effectiveness and efficiency of capabilities and the adequacy of policies, plans, procedures, and protocols. Exercises should be coordinated vertically and horizontally with healthcare and emergency response partners. Evaluation and improvement planning should track corrective actions associated with identified healthcare capability deficiencies observed during exercises and incidents.</p>
	<p><b>P1. Exercise plans</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain coordinated exercise plans to guide exercise implementation. Coordinated exercise plans should include, but are not limited to the following elements:             <ul style="list-style-type: none"> <li>○ Exercise schedule</li> <li>○ Annual update plan</li> <li>○ Approach for testing healthcare system capabilities</li> <li>○ Roles and responsibilities of the participating healthcare entities.</li> </ul> </li> </ul>
	<p><b>P2. Exercise implementation and coordination</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, should exercise capabilities based on identified gaps and subsequent corrective actions. Exercise implementation and coordination should include:             <ul style="list-style-type: none"> <li>○ Exercises based on the guidance and concepts of HSEEP or equivalent program</li> <li>○ The encouragement of healthcare organization participation to address gaps in capabilities</li> <li>○ Horizontal and vertical coordination with relevant response partners and stakeholders, to include Federal, State and local response teams (e.g. DMATs).</li> </ul> </li> </ul>
	<p><b>P3. Evaluation and improvement plans</b></p> <ul style="list-style-type: none"> <li>• The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, implement evaluation methods to inform risk assessments, manage vulnerabilities, allocate resources, and guide the elements of preparedness. Evaluation methods should include but are not limited to:             <ul style="list-style-type: none"> <li>○ HSEEP (or equivalent) based capability assessment guidance</li> <li>○ The coordination of After Action Reports (AAR) for exercises/actual incidents</li> <li>○ Coordination of improvement plans for exercises/actual incidents</li> <li>○ Integration of findings from the improvement plan into the next planning, training, exercise, and resource allocation cycle.</li> </ul> </li> </ul>

<b>Healthcare System Preparedness, Function 6 (cont'd.)</b>	<b>P4. Best practice and lessons learned sharing</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, develop, refine, and sustain a means to share best practices and lessons learned.</li> </ul>
	<b>S1. Exercise and evaluation training</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and all relevant response partners and stakeholders, provide exercise and evaluation training to assist healthcare organizations with the concepts of exercise coordination, implementation, and evaluation.</li> </ul>
<b>Function 7: Coordinate with planning for at-risk individuals and those with special medical needs</b>	<p>Participate with planning to address at-risk individuals and those with special medical needs whose care can only occur at healthcare facilities. This includes coordination with public health and ESF #6 mass care planning to determine transfer and transport options for individuals with special medical needs to and from shelters/healthcare facilities. It also includes continued involvement with public health planning initiatives for at-risk individuals with functional needs so that assistance or guidance can be provided to healthcare organizations regarding activity that may affect healthcare.</p>
	<b>P1. Healthcare planning for at-risk individuals and functional needs</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations, ESF #6, public health, emergency management, ESF #8, and relevant response partners and stakeholders, participate in planning to determine appropriate protocols regarding individuals with functional needs so that assistance and guidance can be provided to healthcare organizations upon request.</li> </ul>
	<b>P2. Special medical needs planning</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations, engage with the appropriate agencies and participate in planning for individuals with special medical needs and whose care can only occur at healthcare facilities. Plans should include:             <ul style="list-style-type: none"> <li>Courses of action to ensure individuals will be seen by the appropriate healthcare personnel during an incident</li> <li>Coordination with EMS to improve transport capabilities</li> <li>Coordination with alternative transportation capable of supporting individuals with special medical needs</li> <li>Coordination with public health and ESF#6 mass care planning to determine the transfer and transport options and protocols for individuals with special medical needs to and from shelters/healthcare facilities.</li> </ul> </li> </ul>

<b>HPP Capability 10: Medical Surge</b>	
The Medical Surge capability is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community. This encompasses the ability of healthcare organizations to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.	
<b>Function 1: the Healthcare Coalition assists with coordination of healthcare organization response during incidents that require medical surge</b>	Develop, refine and sustain processes to ensure incident management decisions during medical surge incidents are coordinated through multi-agency collaboration that is representative of the community healthcare organizations' needs and priorities. Coordination is achieved by ensuring that there are plans and protocols in place to guide decisions made by incident management. It may also be achieved through real time multi-agency coordination by healthcare organizations during a response.
	<b>P1. Healthcare Coalition preparedness activities</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all relevant response partner agencies and stakeholders, will develop, refine, and sustain medical surge plans. <ul style="list-style-type: none"> <li>Refer to <a href="#">Healthcare Preparedness Capabilities</a>, <i>Capability 10: Medical Surge</i> for details on the purpose of plans, what information plans should include, and how the planning process should be conducted.</li> </ul> </li> </ul>
	<b>P2. Multi-agency coordination during response</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all relevant response partner agencies and stakeholders, will develop, refine, and sustain plans to ensure that healthcare orgs are represented in incident management decisions during medical surge incidents. <ul style="list-style-type: none"> <li>Refer to <a href="#">Healthcare Preparedness Capabilities</a>, <i>Capability 10: Medical Surge</i> for details on the purpose of plans, what information plans should include, and how the planning process should be conducted.</li> </ul> </li> </ul>
<b>Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations</b>	Coordination between the State, healthcare organizations and Healthcare Coalitions with EMS operations and medical oversight to develop, refine and sustain protocols for information sharing and communications. These protocols should assist with the coordination of transport decisions and options during a medical surge incident. These protocols also assist healthcare organizations to understand EMS disaster triage, transport, documentation, and CBRNE treatment methodologies during mass casualty incidents resulting in medical surge.



<b>Medical Surge, Function 2 (cont'd.)</b>	<b>P1. Healthcare organization coordination with EMS during response</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with public and private EMS and all relevant response partner agencies and stakeholders, will develop, refine, and sustain a plan that includes processes to coordinate information sharing and surge resources. <ul style="list-style-type: none"> <li>Refer to <u>Healthcare Preparedness Capabilities</u>, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul> </li> </ul>
	<b>P2. Coordinated disaster protocols for triage, transport, documentation, CBRNE</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with public and private EMS and all relevant response partner agencies and stakeholders, will develop, refine, and sustain a plan to assist with training and guidance to understand the local disaster EMS protocols for triage, transport, documentation, and decontamination. <ul style="list-style-type: none"> <li>Refer to <u>Healthcare Preparedness Capabilities</u>, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul> </li> </ul>
	<b>S1. Training on local EMS disaster triage methodologies</b> AND
	<b>S2. Coordinated CBRNE training</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all relevant partner agencies and stakeholders, will assess the need to provide training for healthcare organizations that includes the local EMS disaster triage methodology and local EMS CBRNE protocols. Training should focus on developing a common understanding of critical operations between the healthcare organization and EMS.</li> </ul>
<b>Function 3: Assist healthcare organizations with surge capacity and capability</b>	<p>The rapid expansion of the capacity and capability of the healthcare system to provide the appropriate and timely clinical level of care in response to an incident that causes increased numbers (capacity) or special types of patients (capability) that overwhelm the day-to-day acute care medical resources. This encompasses the appropriate decisions regarding patient care that require multi-agency coordination between healthcare organizations and incident management during medical surge operations.</p>
	<b>P1. Medical surge planning</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will coordinate plans to ensure the priorities/needs of healthcare organizations are addressed in local and State emergency operations plans. <ul style="list-style-type: none"> <li>Refer to <u>Healthcare Preparedness Capabilities</u>, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul> </li> </ul>

<b>Medical Surge, Function 3 (cont'd.)</b>	<p><b>P2. Medical surge emergency operations coordination</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, develop, refine, and sustain a plan to provide multi-agency coordination for information sharing and resource decisions to assist healthcare organizations during surge operations. These decisions require either:             <ul style="list-style-type: none"> <li>Real-time, multi-agency coordination representing healthcare organizations,</li> <li>OR</li> <li>Plans that ensure incident management is informed before making resource decisions affecting healthcare organizations.</li> </ul> </li> </ul>
	<p><b>P3. Assist healthcare organizations maximize surge capacity</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain a plan to maximize surge capacity for medical surge incidents.             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities, Capability 10: Medical Surge</u> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</i></li> </ul> </li> </ul>
	<p><b>P4. Assist healthcare organizations maximize surge capability</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain a plan to maximize surge capability for medical surge incidents.             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities, Capability 10: Medical Surge</u> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</i></li> </ul> </li> </ul>
	<p><b>P5. Medical surge information sharing</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, develop, refine, and sustain a process to provide ongoing communication regarding the status of medical surge operations (including incident status, surge status, availability of resources, and healthcare organization operational status).             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities, Capability 10: Medical Surge</u> for details on purpose of plans, what information plans should include, and how planning process should be conducted. For additional information, refer to <u>Capability 6: Information Sharing</u>.</i></li> </ul> </li> </ul>
	<p><b>P6. Healthcare organization patient transport assistance</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain patient transport processes for medical surge incidents. These processes address patient transport needs above routine healthcare organization transport agreements due to the number and severity of patients. Methods used to transport may vary, but medical and legal obligations for patient transport should be considered and factored into transportation processes.             <ul style="list-style-type: none"> <li><i>Refer to <u>Healthcare Preparedness Capabilities, Capability 10: Medical Surge</u> for details on what these processes should address.</i></li> </ul> </li> </ul>

<b>Medical Surge, Function 3 (cont'd.)</b>	<p><b>P7. Medical surge considerations for at-risk individuals and those with special medical needs</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will participate in planning for at-risk individuals and those with special medical needs for medical surge incidents (including at-risk patients requiring medical treatment at a healthcare facility that may contribute to medical surge [e.g. dialysis patients, home care ventilator patients]).</li> </ul>
	<p><b>E1. Specialty equipment to increase medical surge capacity and capability</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will assess the need for equipment to augment existing capacity and capability. As part of the planning process for purchase of additional equipment, operational plans (SOPs, ConOps) should be developed.             <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on types and purpose of equipment.</li> </ul> </li> </ul>
	<p><b>S1. Special training to maximize medical surge competency</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations, will provide training to develop, refine, and sustain medical surge capabilities. This may include training that is based on an existing need and determined by pre-defined priorities of the healthcare organizations and the State. Examples may include:             <ul style="list-style-type: none"> <li>Burn, trauma, and pediatric training to enhance the specialty capabilities for providers in facilities that do not regularly care for these types patients</li> <li>Additional types of training to enhance the specialty capabilities to treat types of patients not routinely cared for but encountered during a disaster.</li> </ul> </li> </ul>
	<p><b>P8. Mobile medical assets for surge operations</b></p> <p>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain plans for using mobile medical assets during medical surge operations.</p> <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul>
	<p><b>E2. Mobile Medical Assets</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will assess the need for procurement and use of mobile medical assets to be strategically located in the local or regional area, for use by healthcare organizations.</li> <li>These assets should have ability to increase medical surge capacity and capability and include an operational and sustainment plan.             <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on types and purposes of assets.</li> </ul> </li> </ul>

<b>Medical Surge, Function 3 (cont'd.)</b>	<b>P9. Decontamination assistance to healthcare organizations</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations, HazMat response authorities and all relevant response partners and stakeholders, will develop, refine, and sustain decontamination plans to provide assistance during incidents that overwhelm the existing decon ability of the healthcare organization. <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul> </li> </ul>
	<b>E3. Decontamination assets</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and HazMat response authorities, will assess the need for use of decontamination assets and strategically locate them in the local or regional area for use by healthcare organizations. <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on types and purposes of assets, as well as what information should be included in operational plans.</li> </ul> </li> </ul>
	<b>S2. Decontamination training</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations and HazMat response authorities, will provide decontamination training. <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> For specific details on how the trainings should be coordinated, training methodologies, etc.</li> </ul> </li> </ul>
	<b>P10. Mental/Behavioral health support</b> <ul style="list-style-type: none"> <li><b><i>This resource element refers to a State-level activity;</i></b> activities are coordinated by the State in conjunction with healthcare organizations and providers.</li> </ul>
<b>Function 4: Develop Crisis Standards of Care guidance</b>	<b><i>This function is currently a State-level activity; guidance will be developed in coordination with healthcare organizations, Healthcare Coalitions, and public health and medical authorities.</i></b>
<b>Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations</b>	<b>P1. Healthcare organization evacuation and shelter-in-place plans</b> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain a plan for large scale (multiple healthcare organizations and multiple local jurisdictions/regions) evacuation and sheltering-in-place operations. <ul style="list-style-type: none"> <li>Refer to Healthcare Preparedness Capabilities, <i>Capability 10: Medical Surge</i> for details on purpose of plans, what information plans should include, and how planning process should be conducted.</li> </ul> </li> </ul>

<b>Medical Surge, Function 5 (cont'd.)</b>	<p><b>P2. Healthcare organization preparedness to receive evacuation surge</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, develop a plan for receiving a large-scale evacuation (multiple healthcare orgs, multiple local jurisdictions/regions) from other regions of State or other states.             <ul style="list-style-type: none"> <li><i>Refer to Healthcare Preparedness Capabilities, Capability 10: Medical Surge for details on purpose of plans, what information plans should include, and how planning process should be conducted.</i></li> </ul> </li> </ul>
	<p><b>P3. Transportation options for evacuation</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with all partner agencies and stakeholders, will develop, refine, and sustain patient transport processes for evacuation.             <ul style="list-style-type: none"> <li><i>Refer to Healthcare Preparedness Capabilities, Capability 10: Medical Surge for details on what these processes should address.</i></li> </ul> </li> </ul>
	<p><b>E1. Specialized equipment needed to evacuate patients</b></p> <ul style="list-style-type: none"> <li>The State and Healthcare Coalitions, in coordination with healthcare organizations, will assess need for local or regional cache of evac equipment for use by healthcare organizations for evacuation or shelter-in-place (e.g., evac chairs, transport ventilators).</li> <li>There should be SOPs or ConOps documents for the equipment that outline the process to request the resources and provide guidelines for deployment, set-up and operation.</li> </ul>

[This page intentionally left blank.]

## *Appendix C - Hospital Preparedness Program Regional Coordinator Scope of Work*

Hospital Preparedness Program (HPP) Regional Coordinators are full-time, contract employees of the state of Maryland who are based within local health departments. A significant portion of Regional Coordinators' responsibilities are associated with activities of the regional healthcare preparedness coalitions. It is DHMH's expectation that the Coordinators will play a key role in relationship development, strategic planning, and project management for the regional coalitions. As such, they should be fully engaged in all aspects of the regional planning process.

The scope of work for an HPP Regional Coordinator extends across several areas. These are:

- Regional Planning and Project Management
- Inventory Management
- Training and Exercises
- Procurement and Expenditure Tracking
- Technical Assistance
- Emergency Response

The following section describes specific duties and responsibilities of the HPP Regional Coordinators within each category.

### Regional Planning and Project Management

HPP Regional Coordinators are responsible for:

- Providing coordination to ensure regional integration of the Governor's Core Goals for preparedness, as well as the goals and objectives of HPP for Healthcare System Preparedness and CDC for Public Health Emergency Preparedness.
- Collaborating closely with healthcare coalition partners in the planning, design, implementation and evaluation of HPP-funded regional projects and activities.
- Keeping coalition partners informed on status of regional projects and activities, as well as preparedness initiatives at the state and federal level.
  - HPP-related business should be a standing agenda item at each regional healthcare coalition meeting, giving Regional Coordinators the opportunity to provide the needed updates.
- Active, regular participation in regional healthcare coalition meetings.
  - This may include performance of certain administrative duties, such as scheduling meetings, documenting attendance and participation, recording and disseminating minutes, etc.

- Active, regular participation in meetings of local-level preparedness organizations (e.g. ESF-8, HERC, LEPC, etc.).
- Providing coordination for activities related to completion of jurisdictional public health risk assessments and healthcare situational assessments.
- Assisting coalition leadership with the preparation and submission of yearly regional funding applications:
  - This may include preparation of some or all of the required application forms and supporting documentation, as needed.
- Assisting coalition leadership with meeting all regional grant reporting requirements and programmatic deadlines:
  - This may include preparation of some or all of the required regional Mid-Year and End-of-Year reporting forms, as needed. Coordinators may be also expected to collect and submit the necessary regional supporting documentation.
  - Coordinators may also be required to assist in data collection for periodic ad-hoc surveys that may be needed to satisfy HPP requirements and/or statewide preparedness activities.

### Inventory Management

Regional Coordinators are responsible for keeping track of regional inventories of HPP-funded preparedness supplies and materials. These activities include:

- Maintaining a comprehensive, accurate, and up-to-date inventory of regional supplies and materials.
- Ensuring that regional supplies and materials have the appropriate asset and property tags and are entered and tracked in the State's inventory management system.
- Ensuring that regional supplies and materials are properly stored and maintained for optimal use.

### Training and Exercises

Regional Coordinators are responsible for the following activities related to preparedness education, training and exercises:

- Collaboration with coalition partners to identify regional preparedness training gaps and needs through review of risk assessments, gap analyses and improvement plans.
- Assisting with development, conduct and evaluation of regional drills and exercises in collaboration with the DHMH Exercise Coordinator and regional partners.
- Assisting in the coordination of regional training events in collaboration with the DHMH Training Coordinator and regional partners.



- Ensuring that partners are aware of available regional and state-level training opportunities.

#### Procurement and Expenditure Tracking

Regional Coordinators are responsible for the following activities related to regional procurement and expenditure tracking:

- Working closely with coalition leadership, OP&R's Procurement Officer, and HPP staff to submit regional projects and purchases for processing through DHMH Procurement.

**-OR-**

- Working closely with coalition leadership, the designated regional fiduciary agent, and HPP staff to process regional projects and purchases.
- Development of regional spending plans in collaboration with coalition leadership in order to ensure appropriate allocation of funding and resources; assures that all expenditures are matched to the plan.
- Assuring that regional requests for budget redirections or reallocations are submitted to HPP Program Manager for consideration in a timely fashion.

#### Technical Assistance

Regional Coordinators are responsible for providing technical assistance to participating healthcare system partners. This may include the following types of activities:

- Providing technical assistance to partners with completion of HPP facility-level funding applications (giving instructions, answering questions, interpreting federal and state-level program guidance, etc.).
- Providing technical assistance to partners with completing HPP facility-level Mid- and End-of-Year reporting requirements (giving instructions, answering questions, interpreting federal and state-level program guidance, etc.).

#### Emergency Response

In the event of public health emergency or disaster, Regional Coordinators may be required to participate in the response effort. The Coordinators do not have a set, pre-designated role in a response; rather, this position has the flexibility to perform multiple roles as assigned by DHMH, OP&R. The types of activities Regional Coordinators may be asked to perform in a public health response include, but are not limited to the following:

- Serving as a regional liaison with healthcare and local public health in order to facilitate communication/information sharing among regional healthcare preparedness coalition members, response partners, and the State.

- Serving as a member of the DHMH OP&R Emergency Response Team [Regional Coordinators have been designated as emergency essential staff members].
- Serving as a DHMH Liaison Officer at the State Emergency Operations Center (SEOC).

## Appendix D - Acronyms

ASPR	Office of the Assistant Secretary for Preparedness and Response <b>CBO Community-based Organization</b>
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
DHHS	U.S. Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DRHMAG	Delmarva Regional Healthcare Mutual Aid Group
EMA	Emergency Management Agency
EMS	Emergency Medical Services
ESF	Emergency Support Function
FBO	Faith-based Organization
FCDC	First Coast Disaster Council
FOA	Funding Opportunity Announcement
FQHC	Federally Qualified Health Center
HERC	Healthcare Emergency Response Coalition
HPP	Hospital Preparedness Program
IAA	Interagency agreement
ICS	Incident Command System
LEPC	Local Emergency Planning Committee
LOA	Letter of Agreement
MAC	Multi-agency Coordinating Group
MEMA	Maryland Emergency Management Agency
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NHRN	Northwest Healthcare Response Network

NUHC	Northern Utah Healthcare Coalition
NVERS	Northern Virginia Emergency Response System
NVHA	Northern Virginia Hospital Alliance
OP&R	Office of Preparedness and Response
PAHPA	Pandemic and All-Hazards Preparedness Act
PEER	Partnership for Effective Emergency Response
PHEP	Public Health Emergency Preparedness
SEOC	State Emergency Operations Center
SME	Subject Matter Expert
VOAD	Voluntary Organizations Active in Disaster

## Appendix E - Healthcare Coalition Framework Work Group

- B. The Maryland Department of Health and Mental Hygiene, Office of Preparedness and Response organized a Work Group to coordinate the development and review of this Maryland Framework for the Development of Healthcare Preparedness Coalitions. The group was comprised of representatives from healthcare coalitions and stakeholder organizations from the state, regional and local levels. Below is a list of the work group members.**

Dianna Abney	Charles County Department of Health Sherry
Sherry Adams	DHMH Office of Preparedness and Response
Meghan Allen	Maryland Hospital Association
Mark Arsenault	Region V Emergency Preparedness Coalition / Dimensions Healthcare System
Veronica Black	DHMH Office of Preparedness and Response
Lori Brewster	Wicomico County Health Department
Meghan Butasek	Baltimore City Health Department
Lisa Chervon	Maryland Institute of Emergency Medical Services Systems
Elizabeth Copp	Delmarva Regional Healthcare Mutual Aid Group (DRHMAG) / University of Maryland Shore Medical Center at Chestertown
Chas Eby	DHMH Office of Preparedness and Response
Nathan Fecik	DHMH Office of Preparedness and Response
Artensie Flowers	DHMH Office of Preparedness and Response
Rodney Glotfelty	Garrett County Health Department
William Hardy	Regions I and II Health Care Council / Western Maryland Health System
Christina Hughes	Region III Health and Medical Task Force / MedStar Franklin Square Medical Center
Danielle Royal	DHMH Office of Preparedness and Response
Rick Sanders	Delmarva Regional Healthcare Mutual Aid Group (DRHMAG) / Peninsula Regional Medical Center
Donna Sasenick	Region V Emergency Preparedness Coalition / Suburban Hospital - Johns Hopkins Medicine
Kay Webster (Lead)	DHMH Office of Preparedness and Response
Mallory Wright	DHMH Office of Preparedness and Response