Nonurban Health Care Coalitions Emergency Preparedness Plan

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INTRODUCTION

Purpose

This plan provides the framework to guide the regional health care coalitions (HCCs) in nonurban Missouri communities to prepare for and respond to incidents among diverse health and medical entities supporting ESF-8 functions.

The HCCs' role in regional health and medical preparedness requires coordination among hospitals, emergency management, public health and emergency medical services. This also incorporates representation from mental/behavioral health providers, community and faith-based partners, as well as state, local and territorial governments.

Scope

HCCs are promoted as a method to prepare for and respond to incidents among diverse ESF-8 health and medical entities within a geographic region. Tiered, scalable and flexible coordination among varied agencies will facilitate more effective, efficient and timely situational awareness and coordination of resources, resulting in an overall improved health care emergency response. The role of HCCs is to communicate and coordinate; HCCs never replace or interfere with official command and control structure authorized by state and local emergency management.

The formation of HCCs is based on multiple scholarly and federal resources but specifically aligns with and is directed by the following grant programs.

The Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) focuses on activities that establish or maintain ready health care systems through strong HCCs and the individual organizations that engage in preparedness and response. These activities are outlined specifically in the *2017-2022 Health Care Preparedness and Response Capabilities.*

The Centers for Disease Control and Prevention continues to advance development of effective public health emergency management and response programs. Specifically, guidance is provided in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (PHEP).

Administrative Support

MHA is the fiscal and administrative agent for Missouri nonurban healthcare coalitions, and in this role, facilitates the following activities.

- Establish and execute annual workplans and budgets as directed by the HPP program.
- Coordinate HCC advancement through planning, training, exercises and evaluation.
- Maintain documentation, to include this document, ensuring semiannual review by HCC leadership at standing council meetings and annual review and approval by the full membership.

COALITION OVERVIEW

Organization and Process

To ensure an established system of preparedness and response among HCC members and among the nonurban coalitions, the HCC follows the process outlined below.

- formally convene at regular intervals – see the coalition-specific governance documents for more detail
- maintain current coalition membership attendance records in the EMResource® eICS library
- maintain current contact information, using and routinely testing the EMResource® applications for HCC monitoring, notification and document maintenance
- conduct an annual Hazard Vulnerability Analysis (HVA) in collaboration with regional partners, which are consensus-based and conducted to identify overarching risks within the geographic region
- annually conduct a formal exercise as a coalition to ensure compliance with HPP exercise requirements

Role of Healthcare Coalitions

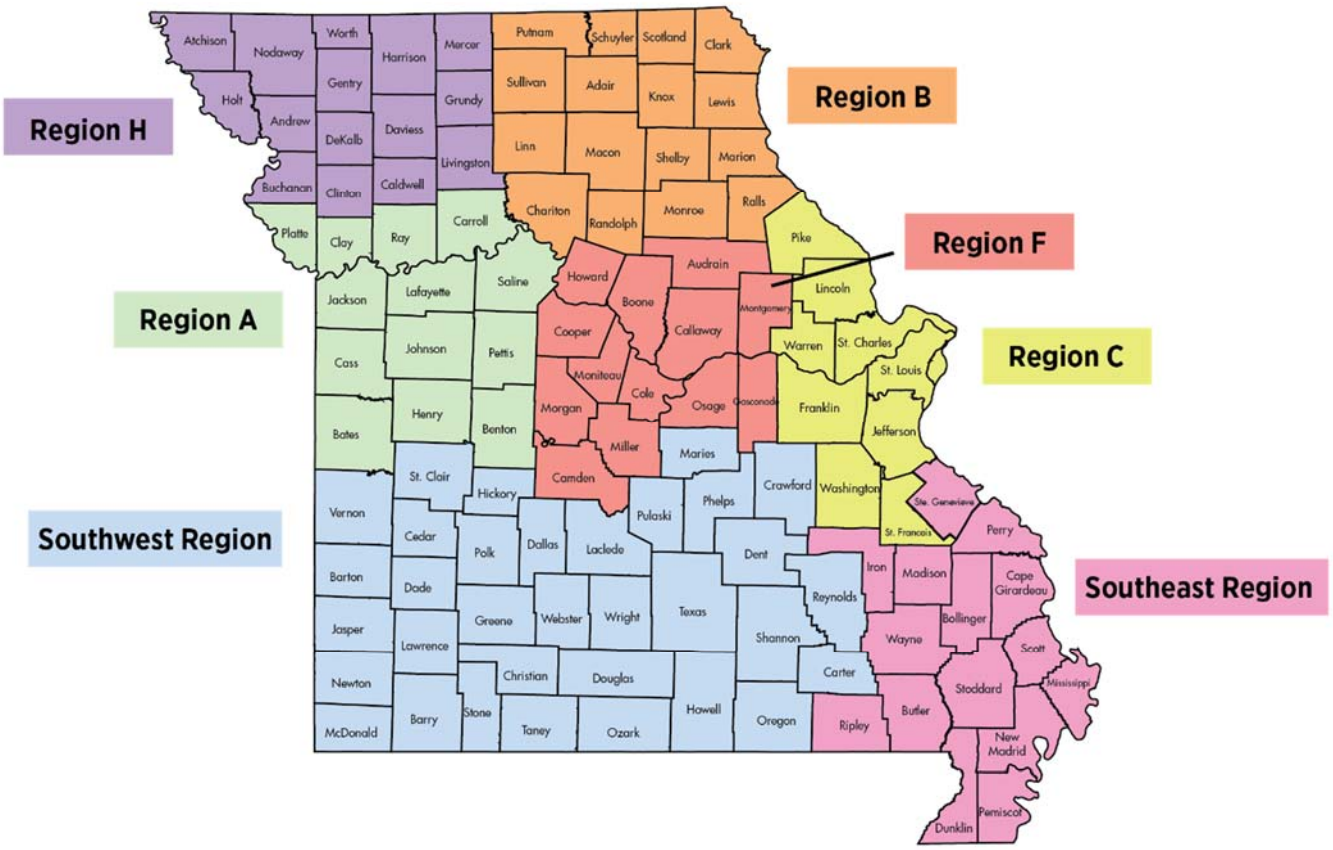
To improve all-hazard health and medical coordination for Missouri's nonurban areas through effective all-hazards planning and coordinated exercises, and to collaborate among regional Health Care Organizations Emergency Responders, Local/Regional Emergency Management Directors, LEPCs & LEOCs, State and Local Public Health Departments, FQHCs, SEMA and other regional and state emergency response planning partners.

Through effective vertical and horizontal planning integration, the health care coalition aspires to be recognized by its regional partners as having a formally defined and exercised role that is integrated into the state emergency operations plan to facilitate the communication and coordination of health and medical response during a disaster.

Coalition Boundaries

Currently, there are five nonurban Missouri health care coalitions structured primarily on the Missouri highway patrol districts and emergency management planning regions, as illustrated in the following map. As the coalitions have matured, a few have modified their boundaries based on existing health care service catchment areas, regional EMS regions and established partnerships. Further details are outlined in each health care coalition governance document.

Missouri Health Care Coalitions



Coalition Members

An HCC member is defined as an entity within the HCC's defined boundaries that actively contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management.

HCC membership requires representation from each of the following core disciplines.

- hospitals
- EMS
- public health
- emergency management

Membership also may include but is not limited to community health centers, primary care and specialty clinics, and long-term care facilities.

In Missouri, there are several large health care systems that cross HCC boundaries. These systems provide a variety of health care services within their communities beyond inpatient care. This could include but is not limited to emergency medical services, home health, hospice, dialysis, ambulatory surgery and long-term care. These established relationships provide a solid foundation for HCCs to build depth and breadth in reaching community providers.

Across Missouri, specialty patient referral centers, which may include pediatric, burn, trauma and psychiatric centers, are members of the HCC within their geographic boundaries. However, many serve as referral centers to other HCCs where that specialty care does not exist.

Additional HCC members are listed in each governance document.

Sustainability

Missouri's nonurban health care coalitions have established a model based on existing relationships and coordination systems used in day-to-day operations. This approach assists the HCCs with sustaining operations despite limited resources.

Organizational Structure/Governance

Missouri nonurban HCCs have implemented structures and processes to execute activities related to health care delivery system readiness and coordination. The elements of governance include organizational structures, roles and responsibilities, mechanisms to provide guidance and direction, and processes to ensure integration with the ESF-8 leadership during an activation. The following outline the established structures that guide specific actions.

Coordinating Council

The MHA Coordinating Council directs the collaborative efforts of each nonurban Missouri health care coalition to ensure that coalition plans align for a coordinated statewide response. The council convenes through face-to-face meetings and calls at regular intervals to standardize and strengthen HCC plans and processes. Council membership includes the leadership of each of the nonurban health

care coalitions and the identified subject matter experts for the following content areas, as appropriate.

- emergency operations coordination
- information sharing
- exercise development and evaluation
- clinical and executive leadership
- medical surge
- responder safety and health

Coalition-specific Governance

In addition to this preparedness plan, each HCC developed a governance document with specific details, which includes but is not limited to the following.

- HCC membership.
    - In cases where there are multiple entities of an HCC member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC.
- Their organizational structure to support HCC activities, including committees, election or appointment processes, and any necessary administrative rules and operational functions.
- Member guidelines for participation and engagement that consider each member and region's geography, resources and other factors.
- Policies and procedures, including processes for making changes, orders of succession and delegations of authority.
- HCC integration within existing state, local and member-specific incident management structures and specified roles, such as a primary point of contact who serves as the liaison to the ESF-8 lead agency and EOCs during an emergency.

Memorandum of Understanding

A regional nonurban coalition memorandum of understanding has been developed to serve as a voluntary agreement among organizations that have as their primary mission the purpose to provide or support health care services within their community. The MOU establishes formal roles and responsibilities of the membership. Organizations may agree to serve as either a primary or a support agency. Below outlines the expectation for each type of participation.

<u>Primary Agency Participation</u>

A. Entity must have a primary focus on health care as defined by Emergency Support Function (ESF)-8 – Public Health and Medical.
B. Entity will attend and contribute to at least 75 percent of meetings and engage in the planning of the annual coalition exercise, to include participation in the exercise.
    a. Routine, discipline-specific coordination can occur within other established committee structures if a liaison proactively provides bilateral situational awareness to both the health care coalition and the discipline-specific committee.
C. Entity acts as a signatory, or has not opted out, on statewide mutual aid agreements, within

their respective discipline.

D. Entity will contribute subject matter expertise related to health care mitigation, preparedness, response and recovery to all-hazard incidents.
E. Entity participates in coalition-based planning, development and decision-making.
F. Entity participates in coalition-based exercise development and deployment activities.
G. All primary agencies will be automatically entered into the eICS application as facilities and are expected to respond during drills, exercises and real-world incidents.
H. Entity agrees, as appropriate, to serve in the Coalition Duty Officer role.
I. Primary agencies will accept responsibility to proactively agree to serve, as able, in one of the following roles during a disaster response.
    a. assisting organization
    b. receiving facility
    c. surge facility

Support Agency Participation

A. All support agencies will have the option of being listed in the eICS notification process. Response is encouraged during exercises, drills and real-world incidents to help facilitate communication and coordination of resources.
B. HCC members are encouraged to develop partnerships with other essential community members and organizations to strengthen coordinated response during an incident.
C. Partnerships may be dependent on the area, participant availability and relevance to the HCC.

Regional emergency preparedness planning, education, training, exercises and support provided through the ASPR HPP program will be directed to and through the health care coalitions.

A full copy of the Memorandum of Understanding is available in Appendix A.

Engagement of Key Stakeholders

Coalition members serve on committees within their respective facilities or communities to communicate the direct and indirect benefits of HCC membership.

MHA staff, through established boards and committees, routinely advise and seek input from health care system executives and clinical leaders on the execution of emergency preparedness initiatives. This is accomplished through the following platforms.

- daily executive e-newsletter
- ad hoc publications on relevant and noteworthy topics
- regional convening of health care executives within each of MHAs districts
- annual report to MHA Board of Trustees (executive)
- semi-annual strategic quality advisory council (clinical)
- semi-annual emergency preparedness and safety advisory council (operations)
- guide and direct the development of hospital-based community health needs assessments (community)

Health Care Executives

Health care executives formally endorse their organization's participation in the HCC by becoming a signatory of the HCC MOU. Members regularly inform health care executives through internal committees of HCC activities and initiatives through reports and inviting executives to participate in meetings, trainings and exercises. Health care executives also are encouraged to attend debriefs related to exercises, planned events and real-world events. Members also make an effort to reach out to executives to share debriefs if they are not available to attend scheduled meetings.

Clinicians

HCC members continually engage health care clinical leaders to provide input, acknowledgement and approval regarding strategic and operational planning. Clinicians from a wide range of specialties are included in HCC activities on a regular basis to validate medical surge plans and to provide subject matter expertise to ensure realistic training and exercises. Clinicians with relevant expertise help lead health care provider training for assessing and treating various types of illnesses and injuries.

Risks and Gaps

The HCCs identify risks and gaps annually through a Hazard Vulnerability Assessment process. The regional HVA summarizes key risks of concern to the coalition members, as well as potential gaps in response systems and resources. The HCC and its members use the information about these risks and needs to inform training and exercises and prioritize strategies to address preparedness and response gaps in the region.

To inform its preparedness efforts, the coalition conducts several planning activities.

- HVA
- coalition assessment tool
- align or engage in an annual Threat Hazard and Identification Risk Assessment (THIRA)
- inventory regional health care resources
- prioritize resource gaps and mitigation activities
- obtain and review de-identified data from emPOWER every six months and data available through the Social Vulnerability Index annually
- assess community planning for children, pregnant women, seniors, and individuals with access and functional needs, including people with disabilities, and others with unique needs
- identify regulatory compliance requirements

Compliance Requirements

HCC leadership recognize that each participating member has individual requirements based on their provider type and their funding sources. Below outlines the most common funding sources and their relevant requirements.

Hospital Preparedness Program (HPP)

Funding Sources: ASPR

Recipients: MHA, on behalf of five nonurban HCCs through a subcontract with DHSS. MHA allocates money to each HCC and specific organizations that provide services to meet the deliverables of the grant program.

Document

Requirements

TASK	BP-1 (17-18)	Sup BP-1 (18-19)	BP-3 (19-20)	BP-4 (20-21)	BP-5 (21-22)
HVA	X	X	X	X	X
Surge Exercise	X	X	X	X	X
Two Redundant Communication Drills	X	X	X	X	X
MOU	X				
Preparedness Plan	X				
MOU to ensure core membership	X				
Response Plan		X			
Recovery Plan			X		

Public Health Emergency Preparedness (PHEP)

Funding Source: CDC

Recipients: LPHAs through subcontracts with DHSS

Document

Requirements

TASK	ANNUALLY	BI-ANNUAL	ONCE IN 5-YEAR BUDGET PERIOD
Participate in JRA	X		
Participate in MCM Operational Readiness Review		X	
PHEP-HPP Joint Exercise			X

Emergency Management Program Grant (EMPG)
Funding Source: Homeland Security
Recipients: County-level jurisdictions at the discretion of the emergency manager
Requirements:

TASK	ANNUALLY	ONCE EVERY 3 YEARS
Tabletop, discussion-based, full-scale exercise	X	
Full-scale exercise		X
Conduct or participate in Training and Exercise Plan Workshop (TEPW)	X	
Utilize WebEOC during incidents, events and trainings	X	
Participate in Threat and Hazard Identification and Risk Assessment (THIRA)	X	

Healthcare Organization CMS Conditions of Participation
Funding Source: Centers for Medicare & Medicaid Services
Recipients: 17 provider and supplier types receiving reimbursements for services from CMS

- hospitals
- critical access hospitals
- rural health clinics and federally qualified health clinics
- long-term care and skilled nursing facilities
- home health agencies
- ambulatory surgical centers
- hospice
- inpatient psychiatric residential treatment facilities
- programs of all-inclusive care for the elderly
- transplant centers
- religious nonmedical health care institutions
- intermediate care facilities for individuals with intellectual disabilities
- clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech language pathology services
- comprehensive outpatient rehabilitation facilities
- community mental health centers

Legal Authorities

Mutual Aid

As outlined in the nonurban HCC MOU, it is the expectation that members actively engage as a signatory on statewide mutual aid agreements within their respective discipline. As such, the HCC may coordinate, but does not direct or execute, mutual aid activities. To date, established mutual aid systems exist for the following disciplines.

Hospital
Facilitated by: MHA
Mutual Aid Agreement

Local Public Health Agencies
Facilitated by: MOSCOPE
Under development

EMS
Facilitated by: MOSCOPE
Mutual Aid Plan

Emergency Management
Facilitated by: MOSCOPE
Under development

COALITION OBJECTIVES

Planning Objectives

- identify mitigation strategies in response to hazards for local and regional planners
- identify training and exercise needs at the local and regional level
- identify and capitalize on regional strengths
- identify shortcomings of critical resources
- maintain a regional plan and collaborate with other regional planners

Response Objectives

- facilitate information sharing to promote situational awareness
- facilitate resource support through the mutual aid process
- facilitate the coordination of incident response actions for coalition members
- facilitate interface with jurisdictional authorities in regional LEOCs and MACC

Appendix A

Missouri Regional Healthcare Coalition Memorandum of Understanding ("MOU")

I. Introduction

Certain critical incidents in or surrounding the state of Missouri, either regionally or statewide, may generate large numbers of patients including those requiring specialized medical care (hazmat injuries, trauma surgery, burn treatment, infectious disease isolations) and those with special needs (e.g., equipment dependent, behavioral health, pediatric, access and functional needs) that exceed the resources of an individual health care entity. Such critical incidents may include, but are not limited to, catastrophic accidents, pandemics, terrorist attacks or severe natural disasters such as earthquakes or tornados. For purposes of this Memorandum of Understanding, a medical disaster is defined as a critical incident that exceeds the effective response capability of an individual health care entity.

II. Purpose and Expectations of this Memorandum of Understanding

The purpose of this statewide Memorandum of Understanding is to be a voluntary agreement among organizations that have as their primary mission a purpose to provide or support health care within their community or region. These organizations may include but are not limited to hospitals, emergency medical services, community health centers, local public health agencies, primary care and specialty clinics and long-term care facilities.

This agreement serves to establish formal roles and responsibilities of a regional health care coalition member for emergency preparedness, response, recovery and mitigation as appropriate. In a response role, the health care coalition will serve as the medical coordination center referenced in the MHA Hospital Mutual Aid Agreement, section VI: Communication.

Specifically, this MOU:

A. Is intended to augment, not replace, each facility's emergency operations plan;

B. Focuses on coordinating preparedness and response activities between and among participating Missouri health care organizations located within geographic proximity;

C. Focuses on communicating situational awareness during an incident to facilitate a coordinated regional health care response: and,

D. Follows the framework for regional coalition preparedness, response, recovery and mitigation provided by two documents: 1) the United States Department of Health and Human Services Assistant Secretary of Preparedness and Response, Hospital Preparedness Program Guidance for Healthcare System Preparedness; and, 2) the Missouri Hospital Association Healthcare Coalition Framework and Emergency Coordination Guide. A copy of each of these agreements is available from the regional healthcare coalition's fiscal intermediary to Missouri Department of Health and Senior Services.

Specifically, this MOU will not:

A. Serve as the mechanism to lend and receive resources, including staff during a disaster response. Instead, respective statewide Mutual Aid Agreements will be used for that purpose. For example, hospitals needing to receive or lend resources will refer to the previously executed Missouri Hospital Mutual Aid Agreement.

B. Replace the need for health care entities to operate under the principles of the Incident Command System; instead, the health care coalition will serve as a coordination mechanism to facilitate response with the local emergency operations center and emergency managers within appropriate jurisdictions.

III. Definitions

A. Health Care Coalition (HCC) - A collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary functions of a healthcare coalition are planning, organizing and equipping, training, exercises and evaluation. During response, Healthcare Coalitions should represent healthcare organizations by providing multi-agency coordination support to incident management through information and resource coordination for healthcare organizations. This includes either a response role as part of a multi-agency coordination group to assist incident management (area command/unified command) with decisions, or through coordinated plans to guide decisions regarding healthcare organization support.

B. Coalition Primary Agency—organizations that have, as their primary mission, a focus on health care services and have signed this MOU.

C. Coalition Support Agency—an entity that may attend and participate in the Coalition, but represents organizations that are not singularly focused on health care. Examples include: emergency managers and public safety officers.

D. Coalition Duty Officer – Lead officer for healthcare coordination during regional incident activation.

E. Incident Command System (ICS) - A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

F. Assisting Organization – An entity capable of facilitating coalition communication and coordination, assisting in the deployment of regional resources and conducting basic supportive patient care such as triage, minor treatment and vaccinations.

G. Receiving Facility (Resources and patients) – An HCO capable of providing care, including triage, treatment, transport and limited trauma services. Despite this capability, the receiving facility does not have the capacity to surge a large influx of patients or for a prolonged surge.

H. Surge Facility – An acute care facility capable of receiving a large influx of patients for an extended period of time, and serves as a trauma facility for the region. The surge facility should be recognized with a trauma designation.

IV. Primary Agency Participation

J. Entity must have a primary focus on healthcare as defined by Emergency Support Function (ESF) 8 – Public Health and Medical.
K. Entity will attend and contribute to at least 75% of meetings, and engage in the planning of the annual coalition exercise, to include participation in the exercise.
    a. Routine, discipline-specific coordination can occur within other established committee structures, if a liaison proactively provides bilateral situational awareness to both the healthcare coalition and the discipline-specific committee.
L. Entity acts as a signatory, or has not opted out, on statewide mutual aid agreements, within their respective discipline.
M. Entity will contribute subject matter expertise related to healthcare mitigation, preparedness, response and recovery to all-hazard incidents.
N. Entity participates in coalition-based planning, development, and decision-making.
O. Entity participates in coalition-based exercise development and deployment activities.
P. All primary agencies will be automatically entered into the eICS application as facilities and are expected to respond during drills, exercises and real-world incidents.
Q. Entity agrees, as appropriate, to serve in the Coalition Duty Officer role.
R. Primary agencies will accept responsibility to proactively agree to serve, as able, in one of the following roles during a disaster response:
    a. Assisting Organization – An entity capable of facilitating coalition communication and coordination, assisting in the deployment of regional resources and conducting basic supportive patient care such as triage, minor treatment and vaccinations.
    b. Receiving Facility (Resources and patients) – An HCO capable of providing care, including triage, treatment, transport and limited trauma services. Despite this capability, the receiving facility does not have the capacity to surge a large influx of patients or for a prolonged surge.
    c. Surge Facility – An acute care facility capable of receiving a large influx of patients for an extended period of time, and serves as a trauma facility for the region. The surge facility should be recognized with a trauma designation.

V. Support Agency Participation

D. All support agencies will have the option of being listed in the eICS notification process. Response is encouraged during exercises, drills, and real-world incidents to help facilitate communication and coordination of resources.
E. HCC members are encouraged to develop partnerships with other essential community members and organizations to strengthen coordinated response during an incident.
F. Partnerships may be dependent on the area, participant availability and relevance to the HCC.

Regional emergency preparedness planning, education, training, exercises, and support provided through the ASPR HPP program will be directed to and through the health care coalitions.

V. General Provisions

A. Term and Termination
    a. The term of this Memorandum of Understanding is three (3) years commencing May 1, 2017. Thereafter, for all participants, other than those that opt out of this MOU, the MOU will automatically renew for consecutive one (1) year terms commencing upon July 1 of each year until amended or terminated. Any participating organization may terminate its participation in this MOU at any time by providing written notice to MHA and other participating organizations not less than sixty (60) days prior to the effective date of such termination.

    b. If a signatory to this agreement consistently does not fulfill the participation requirements outlined in provision IV B., they may be asked leave the group.

B. Approval
    a. The participants, by executing this MOU, represent and warrant that they have the authority to commit their respective organizations to the terms of this MOU.

C. Review and Amendment
    a. This MOU may be amended in writing signed by all participants. Failure to agree to an amendment will result in the participant opting out of this MOU.

D. Counterparts
    a. This MOU may be signed in counterparts, each of which shall be deemed an original and all of which, when taken together, shall constitute one and the same instrument.

E. Severability
    a. If any of the provisions of this MOU shall be determined to be illegal or unenforceable by a court of competent jurisdiction, those provisions shall be severed from this MOU and the remaining terms of this MOU shall remain in full force and effect.

F. Effective Dates
    a. This MOU is effective upon the date cited above, or upon the date of execution, whichever is later.

I have read the foregoing Regional Memorandum of Understanding and agree to the terms set forth therein including role designation. By signing this MOU, I have confirmed that my agency is an active signatory, or has not opted out of, a discipline-specific mutual aid agreement.

PARTICIPATING AGENCY

_____
Organization

☐ Primary Agency

☐ Support Agency

_____
Signature

_____
Printed Name

_____
Title

_____
Date