MHPC
METROLINA HEALTHCARE PREPAREDNESS COALITION

Healthcare Coalition Preparedness Plan
Metrolina Healthcare Preparedness Coalition
January 2021

Record of Changes

Date of Change	Description of Change	Change made by
6/25/19	1. Updated changes to Regional HVA for FY 18-19 2. FY 16-17 After Action Report removed 3. MHPC Steering Committee Bylaws updated to reflect June voting	H. Gompers
12/9/19	1. Updated changes to Regional HVA for FY 19-20	H. Gompers
1/20/2020	1. Updated SVI Data to reflect 2016 census data 2. MHPC Succession Plan included	H. Gompers
11/11/2020	1. Richmond County removed – moved to MidCarolina Coalition 2. Governance Document added to consolidate all related documents – Appendix D	H. Gompers
1/21/2020	1. Updated changes to Regional HVA for FY 20-21. Sections 2.5 and 2.6 reflect changes 2. Signature page added to Governance Document	H. Gompers

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1. INTRODUCTION

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
1.1 Purpose of Plan	N/A	**Introduction:** This plan describes the roles and responsibilities of the Metrolina Healthcare Preparedness Coalition (MHPC) in responding to health care emergency events in Anson, Burke, Catawba, Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Stanly, Scotland, and Union counties in North Carolina. **Purpose:** To provide a basic organizational structure and framework with operational guidelines for the provision of ESF #8 support across the Healthcare Coalition. It is built upon a scalable, flexible, and adaptable coordinating structure to align key roles and responsibilities of the partners within the Healthcare Coalitions in North Carolina.	
1.2 Scope	N/A	The Emergency Operations Plan describes how the MHPC will respond to disasters that cause healthcare emergencies and affect participating healthcare organizations and the local jurisdiction, the region, and/or state that may be sufficient to overwhelm health care capabilities. In accordance with National Incident Management System (NIMS) principles and guidance provided by the Assistant Secretary for Preparedness and Response (ASPR) concerning medical surge capacity and capability, the healthcare partners and coalitions in	Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)

		North Carolina utilize a tiered structure for response and recovery operations. Key points for operations within this structure include: • Response to an event may be initiated at any level of organization and should follow the plans, policies, and procedures applicable at the level of response. • Incidents must be managed at the lowest possible jurisdictional level and supported by additional capabilities from the next higher tier when needed. **Objectives:** • Facilitate information sharing among healthcare organizations and jurisdictional authorities to promote common situational awareness. • Facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members and supporting the request and receipt of assistance from local, State, and Federal authorities. • Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response. • Facilitate the interface between the Healthcare Coalition and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge	

1.3 Administrative Support	1.3 2.1.2	This plan requires the approval of the membership of the Metrolina Healthcare Preparedness Coalition and may be reviewed/approved by the elected MHPC Steering Committee. The plan will be reviewed and approved on a yearly basis by the MHPC staff, Steering Committee, and any other member within the Coalition that wishes to participate in the review. During the review of this plan, MHPC staff and Steering Committee members will identify and gaps within the plan and define strategies to address the gaps on a regional level.	

2. COALITION OVERVIEW

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
2.1 Introduction/Role/Purpose of Coalition	N/A	The purpose of the Metrolina Healthcare Preparedness Coalition is to facilitate the coordination and cooperation throughout the Metrolina region so partners can mitigate against, prepare for, respond to, and recover from emergent health and medical events. Members of the Metrolina Healthcare Preparedness Coalition including regional hospitals, EMS agencies, Public Health, County Emergency Management, and Continuing Care/Long-Term Care facilities. In addition, the Metrolina Healthcare Preparedness Coalition works in accordance with guidance from ASPR and NCOEMS-HPP.	

2.2 Coalition Boundaries	1.1.1	The Metrolina Healthcare Preparedness Coalition serves thirteen counties in portions of Central and Western North Carolina. The counties served are determined by NCOEMS-HPP in conjunction with the Level I Trauma Center that serves the area. Counties covered by the Metrolina Healthcare Preparedness Coalition include: • Anson • Burke • Cabarrus • Catawba • Cleveland • Gaston • Iredell • Lincoln • Mecklenburg • Scotland • Stanly • Union In addition, the Metrolina Healthcare Preparedness Coalition is a part of the following regionally based groups: • Metrolina Trauma Advisory Committee • CRI Region – Public Health Preparedness and Response • Public Health Preparedness and Response – Western Region • North Carolina Domestic Preparedness Regions: 6,7, and 8	Appendix B: MHPC Regional Map

		Activities conducted with the Metrolina Region are coordinated with all lead ESF-8 agencies within the defined boundaries.	

2.3 Coalition Members	1.1.2	Core Members of the Metrolina Healthcare Preparedness Coalition include:
		
		• Hospitals
		  ○ Atrium - Anson
		  ○ Atrium – Carolinas Medical Center
		  ○ Atrium - Cleveland
		  ○ Atrium - Lincoln
		  ○ Atrium - Mercy
		  ○ Atrium - Cabarrus
		  ○ Atrium - Pineville
		  ○ Atrium - Union
		  ○ Atrium - University
		  ○ Atrium - Blue Ridge
		  ○ Atrium - Kings Mountain
		  ○ Atrium – Stanly
		  ○ Atrium – Valdese
		  ○ CaroMont Regional Medical Center
		  ○ Catawba Valley Medical Center
		  ○ Frye Regional Medical Center
		  ○ Lake Norman Regional Medical Center
		  ○ Novant Health – Presbyterian
		  ○ Novant Health – Huntersville
		  ○ Novant Health – Matthews
		  ○ Novant Health – Mint Hill
		  ○ Scotland Memorial Hospital
		• Public Health
		  ○ Public Health CRI Region
		  ○ Anson County Health Department
			Appendix C: Additional HCC Members

		○ Burke County Health Department ○ Cabarrus Health Alliance ○ Catawba County Health Department ○ Cleveland County Health Department ○ Gaston County Health Department ○ Iredell County Health Department ○ Lincoln County Health Department ○ Mecklenburg County Health Department ○ Scotland County Health Department ○ Stanly County Health Department ○ Union County Health Department • EMS ○ NC Office of EMS ○ Anson County EMS ○ Burke County EMS ○ Cabarrus County EMS ○ Catawba County EMS ○ Cleveland County EMS ○ Charlotte Fire Department ○ Gaston County EMS ○ Lincoln County EMS ○ Mecklenburg EMS ○ Scotland County EMS ○ Stanly County EMS ○ Union County EMS • Emergency Management Agencies ○ NC Emergency Management – Central Branch ○ NC Emergency Management – Western Branch ○ Anson County Emergency Management	

		○ Burke County Emergency Management ○ Cabarrus County Emergency Management ○ Catawba County Emergency Management ○ Cleveland County Emergency Management ○ Gaston County Emergency Management ○ Iredell County Emergency Management ○ Lincoln County Emergency Management ○ Charlotte-Mecklenburg Emergency Management ○ Scotland County Emergency Management ○ Stanly County Emergency Management ○ Union County Emergency Management Additional members of the Metrolina Healthcare Preparedness Coalition can be found in Appendix C: Additional HCC Members	

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
2.4 Organizational Structure/Governance	1.1.3	The MHPC Governance Document includes the Bylaws of both the Coalition and the MHPC Steering Committee, Coalition Succession Plan, Code of Ethics, Financial Polices and Processes Project Funding Process, and Coalition Financial Sustainability is reviewed every two years by Coalition members and Steering Committee members. Governance documents address, but are not limited to the following: • HCC membership • Organizational structure to support HCC activities • Member guidelines for participation and engagement • Policies and procedures for making changes, orders of succession, and delegations of authority HCC integration within state and local incident management structures can be found in Appendix F: RHSC Activation	Appendix D: Metrolina Healthcare Preparedness Coalition Governance Document Appendix E: RHSC/HISS Activation
2.4.1 Role of Leadership within Member Organizations	1.5.2	Healthcare Coalition Membership Responsibilities and Expectations include: 1. Provide representation at coalition meetings and activities and ensure attendance to a minimum of 75% of regularly scheduled meetings. 2. Participate in collaborative regional planning efforts.	

		3. Participate in the development of surge capacity plans, inter-organizational agreements, and collaborative emergency response plans. 4. Contribute to meeting coalition priorities, goals, and contractual deliverables. 5. Vote on questions placed before the membership 6. Respond to regional emergencies and disasters in collaboration with other members, as available. 7. Participate in sub-committees and workgroups as requested by members and organized under the umbrella of the coalition. *Formal endorsement by health care executives forthcoming.*	
2.5 Risk	1.2.1	HVA and corresponding summary/gap analysis to be performed annually. Risks identified from the 2020 Regional HVA include: • Infectious Disease Pandemic • Cyberattack • IT Failure (EMR, network, internet, etc) • Regional Critical Supply/Pharmaceutical Shortage • Infectious Disease Outbreak • Personnel Shortage	Appendix F: MHPC Regional HVA 2020 and County Social Vulnerability Indexes
2.6 Gaps	1.2.2	Regional Gaps from the 2019 HVA include the following: • Infectious Disease Pandemic/Outbreak o Potential for more common conditions to become more frequent with an extremely high potential impact for all agency types o Reflective of COVID situation	

		• Cyberattack
		  ○ Ability to cripple healthcare organizations
		  ○ Internal review of processes
		• IT Failure
		  ○ No additional method to gain access to patient charts, virtual visits/sitters
		  ○ Consider backup method
		• Regional Critical Supply/Pharmaceutical Shortage
		  ○ Seen during the current COVID situation
		  ○ Most agencies/systems rely on one or two vendors
		  ○ Vendors are limiting amounts that agencies/systems are able to acquire
		• Personnel Shortage
		  ○ Reflective of COVID situation
		  ○ Not enough specialty healthcare providers to go around (respiratory therapists, ICU nurses
		  ○ Unknown long-term impacts	

2.7 Compliance Requirements/Legal Authorities	1.2.5	The MHPC is informed by the following legal and regulatory requirements for preparedness and response: • CMS: The Metrolina Coalition assists members with emergency operation plan development in accordance with the CMS Emergency Preparedness Requirements for Medicare and Medicare Participating Providers • Joint Commission: The Metrolina Coalition supports members who seek accreditation through the Joint Commission and provides assistance with emergency operation plan development based upon TJC standards	

		• HIPPA privacy rule and requirements • EMTALA requirements • Federal disaster declarations processes and public health authorities • EPA requirements • OSHA requirements • ESF-8 partners and lead agencies • NCOEMS • ASPR	

3. COALITION OBJECTIVES

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
3.1 Maintenance and Sustainability of HCC	1.5	**Healthcare Readiness:** The Metrolina Healthcare Preparedness Coalition (MHPC) is comprised of regional healthcare partners such as hospitals, EMS, public health, emergency management, public safety and other healthcare entities with the purpose of enhancing the ability of the region to be more resilient in a disaster. The coalition provides a forum for all partners who have a role in healthcare disaster planning, response, and/or mitigation to plan together. The MHPC staff facilitate the planning initiatives with the coalition. *The activities of the Coalition are based upon the regional needs, the Healthcare Preparedness Capabilities*	Appendix G: MHPC Strategic Plan

		developed by ASPR, and the North Carolina Office of EMS. Within the region, the MHPC is guided by the elected Steering Committee with additional input from the regional partners. A quarterly planning meeting is conducted to provide an opportunity to share best practices, information and develop initiatives. Coalition activities have included annual regional exercises, coordination of education and training, development of decontamination capabilities within hospitals and EMS, and the provision of VMN radios to all hospital and EMS partners. All initiatives are funded through the ASPR Healthcare Preparedness Program Grant and through in-kind support from regional partners. The mission and purpose the Metrolina Healthcare Preparedness Coalition can be found in Appendix I: MHPC Strategic Plan **Healthcare Coalition Sustainability:** The Metrolina Healthcare Preparedness Coalition promotes sustainability through in-kind donation of time by volunteers and resources. Financial support comes from outside resources that promote the mission of the Coalition and continued engagement with HCC members and the community. Examples of Coalition sustainability include, but are not limited to: • Offering technical assistance in meeting the CMS Emergency Preparedness Rule (HVA/EOP guidance, Conditions of Participation education)	

		• Development of a financing structure, and documentation of the funding models that support HCC activities • Determining ways to cost share with regional partners for exercises and education • Incorporating leadership succession planning into the Coalition governance and structure **Lessons Learned and Practice Sharing:** The Metrolina Healthcare Preparedness Coalition is actively involved in sharing best practice information and lessons learned with other Healthcare Coalitions within the state of North Carolina and regional partners. Lessons learned and practice sharing are done through the use of after-action reports. The MHPC shares information with other coalitions including: • Long-Term Care Engagement and CMS Emergency Preparedness Education • Regional and State Exercise Coordination • Healthcare Information Sharing System • Statewide Education courses	
3.2 Engagement of Partners and Stakeholders	1.5	The Metrolina Healthcare Preparedness Coalition promotes engagement of partners and stakeholders through the following: • Quarterly meetings of the Coalition; monthly/bi-monthly meetings of the Steering Committee • Bi-monthly meetings of work groups • Expenditure of grant funds for regional projects that promote healthcare readiness and response	

		• Regular correspondence with partners to assess needs and capabilities • Division of Metrolina Region into sub-regions that promote a more dedicated approach to partners and their needs. The Metrolina Healthcare Preparedness Coalition is based upon its members and their guidance. It is through our partners that the MHPC is able to work collaboratively across a wide variety of disciples to develop and maintain disaster health and medical capabilities within the Metrolina region. Partners who wish to become members of the Metrolina Healthcare Preparedness Coalition can send a letter of inquiry to metrolinahpc@atriumhealth.org or contact any of the MHPC staff. In order to remain an active member of the Coalition, partners must follow the Coalition Bylaws as defined in Appendix D: Metrolina Healthcare Preparedness Coalition Bylaws.	
3.2.1 Healthcare Executives	1.5.2	Engaging healthcare executives is an extremely important aspect of maintaining the Coalition's purpose and mission. The Coalition regularly informs healthcare executives of the initiatives, educational programs, and activities through yearly reports and meetings where quarterly reports are provided. They are also highly encouraged to participate in meetings, trainings, and exercises provided by the Coalition. In regard to real-world events, healthcare executives are provided opportunities to participate in debriefs and a chance to review the after-action report before it is published to regional and state Coalition partners.	

		The benefits of having healthcare executives participate in the Coalition include: • The ability to share information in regard to meeting regulatory and accreditation requirements • Information and best practice sharing among leadership representatives • Developing interdependent relationships • Sharing leading practices • Networking amongst peers • Reducing risk • Addressing community and facility-based needs	
3.2.2 Clinicians	1.5.3	The Metrolina Healthcare Preparedness Coalition engages a variety of healthcare delivery system clinical leaders in order to provide input, acknowledgement, and approval regarding strategic and operational planning, including: • Physicians practicing as EMS Directors • Trauma physicians • Emergency Department physicians • Long-Term Care/Skilled Nursing physicians and Directors of Nursing	
3.2.3 Community Leaders	1.5.4	The Metrolina Healthcare Preparedness Coalition is involved in community engagement and working with community leaders through our partners.	
3.2.4 Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs	1.2.5	Planning and response for Children, Pregnant Women, Seniors, and Individuals with Access and Functional needs is a part of the MHPC's approach to whole community disaster planning. MHPC assists these individuals by doing the following: • Supporting public health agencies with situational awareness and tools already in use that can	

		identify special populations with unique needs (emPOWER map, reports provided by NCOEMS on Medicare beneficiaries who rely on electricity-dependent medical and assistive equipment) • Supporting public health and emergency management agencies in developing or augmenting existing response plans for these populations, including mechanisms for family reunification • Assess needs and contribute/work with ESF-8 lead agency to promote medical planning that may enable individuals to remain in their residences or inclusion of medical care at shelter sites • Coordinate with the ESF-8 lead agency to assess medical transport needs for these populations • Assess specific treatment and access to care needs	

4. Work Plan

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources

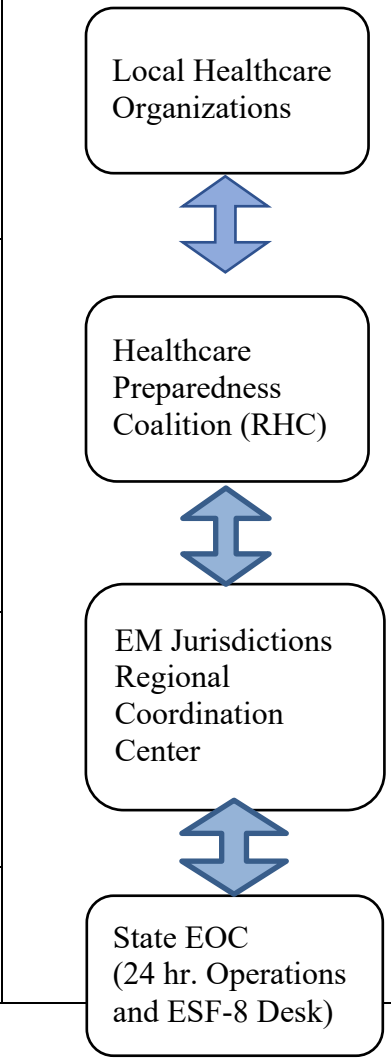
4.1 Roles and Responsibilities	1.1
	1.3
	1.4
		• Policy Development and Process
		  ○ SOG Development: Standard Operating Guidelines are development in coordination with Coalition Members and Staff. Guidelines are developed with the purpose of providing a uniformed response to Coalition policies and procedures.
		  ○ Strategic Plan Development: The Strategic Plan is initially developed by Coalition Staff in conjunction with items that the Coalition has deemed of importance. Once the initial Strategic Plan has been developed, it is shared with the Coalition Executive Board (Steering Committee) and edited based on what they believe the priorities for the upcoming year and subsequent years should be. The Strategic Plan is then disseminated to the entire Coalition as a reference document
		• Educational Material Development
		  ○ Educational material development is based upon what type of education is requested from Coalition Partners. Education is provided using a variety of resources including vendors, state and federally
			Appendix G: MHPC Strategic Plan

		provided courses, and shared educational opportunities with other Coalitions in North Carolina • Evaluate exercises and response to emergencies ○ MHPC uses HSEEP AAR/IP forms to gather the information regarding exercises and the EEG HSEEP forms for actual evaluation of exercises. A majority of the exercises MHPC participates in with our partners results in not receiving their AAR/IPs. If there is any information that is gathered/evaluated, it is from our perspective only. ○ At the end of the year, the Exercise Specialist gathers as much information as possible regarding events and exercises and compiles them into one AAR/IP. The information is used to build the next fiscal year's exercise and training programs, as well as any other processes that may need adjustment. ○ MHPC uses the evaluation information by implementing the identified changes and/or improvements that need to be made for any future real-world events. If no real-world events occur, then MHPC considers conducting at least a table top to test the new ideas. Most of the time however, MHPC is able to apply what is learned in the exercises.	

5. APPENDICES

Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)
Appendix B: MHPC Regional Map
Appendix C: Additional HCC Members
Appendix D: Metrolina Healthcare Preparedness Coalition Governance Document
Appendix E: RHSC Activation
Appendix F: MHPC Regional HVA *2020* and County Social Vulnerability Indexes
Appendix G: MHPC Strategic Plan

Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)

Overview of Health/Medical Support in the State Medical Response System (SMRS)		
Tier 1	**Organization:** Hospital, Nursing Home, Clinic, etc. **Level of Response:** Internal and mutual aid **Info Sharing**: Tier 2 **Resource Support:** Tier 2 (through Local EM).	
Tier 2	**Organization:** Healthcare Preparedness Coalition **Level of Response:** Local to State-wide (when SMRS activated) **Info Sharing**: Tier 3 & 4 **Resource Support:** Tier 2 & 4 (through ESF-8 Desk)	
Tier 3	**Organization:** Local/Region EM agencies **Level of Response:** Local to State-wide (when RCCs activated) **Info Sharing**: Tier 1-4 **Resource Support:** Tier 2 (Local) & Tier 4 (Regional)	
Tier 4	**Organization:** NCOEMS - HPR&R Program **Level of Response:** Regional to State-wide **Info Sharing**: Tier 2 & 3 **Resource Support:** Interstate (Region IV) & Federal	

Tier 1 – Local agencies and healthcare organizations that deliver "point of service" medical care within a municipal, geographic, or healthcare delivery area. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. Notify Tier **2 and/or 3 organizations of the event. Refer to** Notification-Process**.**
2. Execute internal plans and agreements to utilize their resources and the resources of their mutual aid partners to mitigate event hazards.
3. **Request additional support/resources, as necessary, to mitigate hazards and minimize the disruption of service within healthcare delivery area. Refer to** Section IV Assets and Resource Requests**.**

Tier 2 – Regional coalitions of healthcare partners that share health/medical information and resources within their established Healthcare Preparedness Region. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. **Notify appropriate Tier 3 and/or 4 organization(s) of the event. Refer to** Notification-Process.
2. Execute regional health/medical plans and agreements to:
   a. Share incident information,
   b. Exchange resource status information to support mutual aid,
   c. Interface with local/regional jurisdictional authorities to exchange information,
   d. Provide health/medical and logistic resources to support Tier 1 (local), Tier 2 (other coalitions), Tier 3 (local/regional emergency management jurisdictions), and Tier 4 (State ESF-8) organizations as necessary to mitigate event hazards.

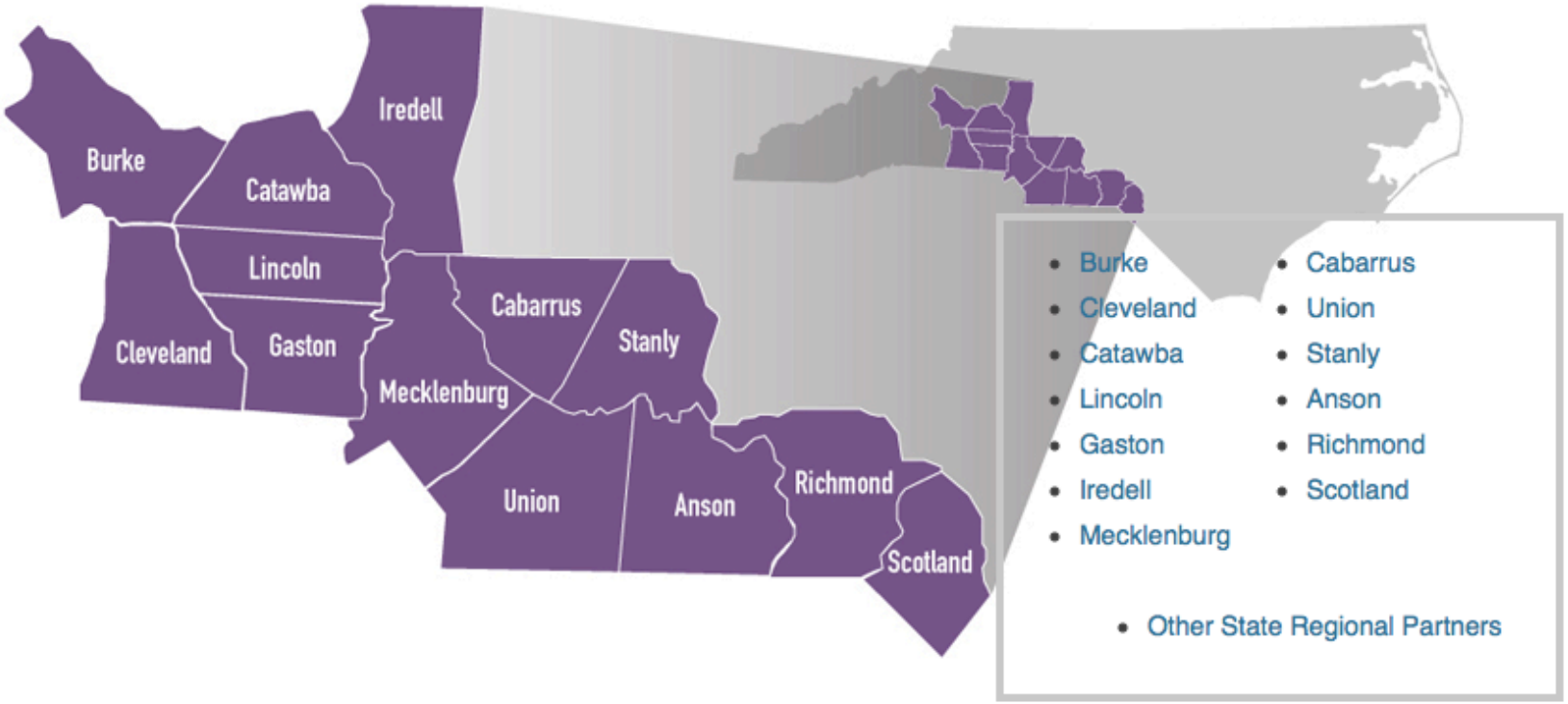
Tier 3 – Local/regional agencies with jurisdiction over the impacted areas and overall responsibility for response/recovery and support operations. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. Notify appropriate Tier 2 and/or 4 organizations of the event.
2. Execute local/regional emergency operations plans and agreements to mitigate event hazards.
3. Coordinate, as appropriate, with Tier 1, 2, or 4 organizations for the provision of health/medical information and resources.
4. Receive, stage, and execute local/regional requests for health/medical support from Tier 1, 2, or 4 organizations

Tier 4 – State-level health/medical (ESF-8) organizations that support Tier 1-3 organizations by managing statewide and sub-State regional coordination of the healthcare response. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. **Notify Tier 2 organizations of the event.**
2. Execute state health/medical plans and agreements to mitigate event hazards in coordination with Tier 2 and Tier 3 organizations.
3. C**oordinate, monitor, and support the sharing of health/medical information and provision of state-level ESF-8 resources within one or more Healthcare Preparedness Regions.**

Appendix B: MHPC Regional Map



Appendix C: Additional HCC Members

Behavioral Health Services
Alexander Youth Network
Children's Hope Alliance
Mecklenburg County DSS
Behavioral Health Charlotte/Davidson – Atrium Health
Metrolina Medical Reserve Corps
Dialysis Centers
Fresenius Dialysis
Federal Facilities
VA Outpatient Clinic - Charlotte
Home Health Agencies
Healthy at Home – Atrium Health
Local Public Safety Agencies
Cabarrus County Sheriff Department
Charlotte – Mecklenburg Police Department
Non-Governmental Organizations
Red Cross
Outpatient Health Care Delivery
Schools and Universities
University of North Carolina – Charlotte
Central Piedmont Community College
Long-Term Care Facilities
PACE of the Southern Piedmont
Senior TLC – PACE Organization
Jessie Helms SNF – Atrium Health
Sardis Oaks SNF – Atrium Health
Huntersville Oaks – Atrium Health
Cleveland Pines SNF – Atrium Health
Stanly Manor SNF – Atrium Health
5-Star Senior Living
Aldersgate
Brian Center - Gastonia
Autumn Care Shelby
Brookdale Shelby
Clear Creek Nursing and Rehab
Covenant Village
House of Peace Family Care
Lakewood Continuing Care
Lincolnton Rehabilitation Center
Monroe Rehabilitation
Peak Resources – Cherryville/Shelby

Royal Park of Matthews
Sharon Towers
Southminster
Stanly Total Living Center
Summit Place of Mooresville
The Pines at Davidson
Trinity Ridge
White Oak Manor – Shelby/Kings Mountain/Rutherfordton
Hospice Agencies
Hospice of Scotland County
Hospice of Cleveland County
Hospice of Burke County
Hospice and Palliative Care Charlotte Region
Novant Hospice
Hospice of Union County – Atrium Health
Hospice of Cabarrus County – Atrium Health
Catawba Regional Hospice
Hospice and Community Care
Hospice of Stanly
The Carolinas Center
Federally Qualified Health Centers
Gaston Family Health Services
Rowan – Cabarrus Family Health Services
Medical Examiners
Mecklenburg County Medical Examiner

Appendix D: Metrolina Healthcare Preparedness Governance Document

Metrolina Healthcare Preparedness Coalition Governance Documents

Metrolina Healthcare Preparedness Coalition (MHPC) Bylaws

Adopted: 7/2013
Updated: 12/2014
Updated: 6/2015
Updated: 12/2017
Updated: 12/2018
Updated: 2/2020
Reviewed: 09/2020

Article 1 - Organization

The name of this organization shall be called Metrolina Healthcare Preparedness Coalition

Article 2 - Mission

The mission of the Metrolina Healthcare Preparedness Coalition is to facilitate coordination and cooperation throughout the Metrolina region to ensure partners have the capability and capacity to mitigate against, prepare for, respond to, and recover from emergent health and medical events.

Article 3 - Purpose

1. To coordinate the emergency preparedness efforts of its members across the region to enhance the likelihood of an effective and efficient response in a disaster.
2. To coordinate medical and health response activities and services during a disaster.
3. Foster communication between local, regional, and state entities on a community wide emergency planning and response.
4. Ensure overall readiness through the coordination of community wide training and exercise related to medical and health issues.
5. Promote preparedness in the healthcare community through use of efficient and effective standardized practices and integration of medical and health capabilities elements with other partner resources
6. Develop and manage the Assistant Secretary for Preparedness and Response (ASPR) Healthcare Preparedness Program (HPP) grant in a fiscally prudent manner to meet the APSR Healthcare Capabilities and other Department of Health and Human Services requirements germane to health and medical preparedness.
7. Maintain resources and assets of the MHPC HPP program and MHPC SMAT II

Article 4 - Membership

Section A. Membership to the Metrolina Healthcare Preparedness Coalition is based on the following:

1. Essential Partners: Hospitals and other healthcare providers, EMS Systems, Public Health, Long Term Care facilities, Emergency Management Agencies, Public Safety, mental and behavioral health providers, private entities associated with healthcare, specialty service providers, support service providers, primary care providers, community health centers, tribal entities, federal entities and MHPC Staff based in the Metrolina region
    a. Includes law enforcement, fire departments, schools, social services, public works, and transportation services
2. Regional agencies who would assist in a medical and health response to a disaster are invited to participate as *non-voting members*. This would include behavioral health agencies, Red Cross or any volunteer agencies or schools and colleges
    a. Any state agency (i.e. NC Department of Public Safety – Emergency Management, NC Office of EMS, NC Hospital Association, NC Public Health) who would assist in the planning or response may be included as *non-voting members*.
3. Healthcare and Emergency Management planning regions and associations that support healthcare preparedness. (i.e. Urban Area Security Initiative (UASI), NCEM Domestic Preparedness Regions (DPR), Public Health Preparedness & Response Regional Representatives, NC Association of EMS Administrators, NC Hospital Association, NC Emergency Management Association, NC Association - Long Term Care, NC Assisted Living Association, NC Law Enforcement Officers' Association, etc.)

Each entity shall designate a primary and secondary representative.

Section B. Membership Responsibilities

8. Provide representation at coalition meetings and activities and ensure attendance to a minimum of 75% of regularly scheduled meetings.
9. Participate in collaborative regional planning efforts.
10. Participate in the development of surge capacity plans, inter-organizational agreements, and collaborative emergency response plans.
11. Contribute to meeting coalition priorities, goals, and contractual deliverables.
12. Vote on questions place before the membership
13. Respond to regional emergencies and disasters in collaboration with other members, as available.
14. Participate in sub-committees and workgroups as requested by members and organized under the umbrella of the coalition.

Section C: Contact List

A contact list of member organizations will be maintained by MHPC staff and updated bi-annually. This contact will be published with the agenda of the coalition meeting and will be housed on the secure pages of the MHPC website (http://www.metrolinapreparedness.org)

Section D. Voting Privileges

Although the MHPC encourages consensus, at times votes will be required. For the purposes of voting, the following rules shall apply:

- For general business, all member agency or facility will be vested with one vote. Only one vote per organization will count.

- ASPR HPP Grant Approval: Essential Partners in Membership Section A1 will be vested with one vote per agency or facility.

Electronic Voting –MHPC voting may be conducted in an electronic format. Only one vote from each agency or organization will be counted toward the results. The electronic voting will remain open for a minimum of three (3) business days.

Section E. Conflict of Interest

Good faith - Members shall exercise good faith in all transactions touching upon their duties to the MHPC. In their dealings with and on behalf of the MHPC, they are each held to a rule of honesty and fair dealings between themselves and the MHPC. They shall not use their positions as members, or knowledge gained there from, to their personal benefit and to the detriment of the MHPC.

Exclusion from voting - Any member having a conflict of interest on a matter shall disclose such interest and abstain from voting as appropriate.

Section F. Conflict Resolution

It is essential that all members maintain a high standard of discernment, discretion, and good judgment in relationships with MHPC members. All matters should be discussed with mutual respect and a desire to benefit the Coalition. Conflicts within the Coalition or with Steering Committee Members shall involve a meeting of the Steering Committee and relevant members. Ample time will be allowed for presentation of concern and discussion of differing viewpoints. Concerns will be weighed per reasonableness and fairness.

The desired outcome is a consensual resolution. If after a reasonable amount of time, a resolution cannot be found, the final decision will be made by the Steering Committee with a 75% consensus of members. The decisions will be binding.

Section G. The following Hospitals, EMS Systems, and Public Health are listed for MHPC Region

County	**Hospital**	**EMS**	**Public Health**
Anson	Atrium Health - Anson	Anson EMS	Anson Public Health
Burke	Atrium Health-Morganton Atrium Health-Valdese	Burke EMS	Burke Public Health
Cabarrus	Atrium Health – Cabarrus *Free Standing EDs* Atrium Health – Kannapolis	Cabarrus EMS	Cabarrus Health Alliance

	Atrium Health - Harrisburg		
Catawba	Catawba Valley Medical Center Frye Regional Medical Center	Catawba EMS	Catawba Public Health
Cleveland	Atrium Health - Cleveland Atrium Health - Kings Mountain	Cleveland EMS	Cleveland Public Health
Gaston	Caromont Regional Medical Center	Gaston EMS	Gaston Public Health
Iredell	Lake Norman Regional Medical Center	Iredell EMS	Iredell Public Health
Lincoln	Atrium Health - Lincoln	Lincoln EMS	Lincoln Public Health
Mecklenburg	Atrium Health - Mercy Atrium Health - Pineville Atrium Health - University Atrium Health – CMC Atrium Health – Levine Children's Hospital Novant Health – Presbyterian Medical Center Novant Health – Matthews Medical Center Novant Health - Huntersville Novant Health – Mint Hill Medical Center Novant Health – Charlotte Orthopedic Hospital Novant Health – Hemby Children's Hospital *Free-Standing EDs* Atrium Health - Huntersville Atrium Health – Steele Creek Atrium Health – Southpark	Mecklenburg EMS	Mecklenburg Public Health
Scotland	Scotland Hospital	Scotland EMS	Scotland Public Health
Stanly	Atrium Health - Stanly	Stanly EMS	Stanly Public Health
Union	Atrium Health – Union Atrium Health – Waxhaw (Free Standing ED)	Union EMS	Union Public Health

Section G. There are no membership dues.

Section H. Terms of Membership

1. There are no limits on membership terms.
2. Any member may resign by giving notice to the Chair or Coordinator of the Coalition to be effective upon date of receipt or other date specified in notice.
3. Members who breach conflict of interest/ confidentiality may be removed by a majority vote of the members present. The issue would be brought to the Steering Committee for consideration by the full membership.

OFFICERS

Officers shall include

- Chair
- Vice-Chair

These positions will be elected by the Steering Committee and will serve the function for both.

Article 5 - Meetings

Section A.

Meetings are held quarterly. Each meeting is announced by email one month, then two weeks in advance of the meeting. In the case of a special meeting, such notice will state the purpose of the meeting and will be sent five (5) business days in advance. Additional MHPC sub-committees meet as needed determined by the MHPC Regional Healthcare Preparedness Coordinator and/or MHPC Steering Committee.

Section B.

The ASPR Grant Application requires recipients of funding to send a representative to the quarterly meetings. Attendance will be monitored at MHPC meetings and other HPC related meetings and voting members or designees shall maintain a minimum of a 75% attendance record at both the MHPC and sub committee meetings to be eligible for ASPR funding per steering committee discretion.

Article 6 – Sub-Committees

Section A. The following standing sub-committees have been established.

1. Steering Committee
2. Exercise/ Education Committee
3. Other sub-committees as needed

Section B. Each committee shall be tasked with assignments based on the needs of the Region and directives outlined in the "Scope of Work" for the Regional Healthcare Preparedness Coordinator or as determined by the Steering Committee.

Section C. The Regional Healthcare Preparedness Coordinator and/ or the Steering Committee shall appoint sub-committees to address the needs of the Region.

Article 7 – Parliamentary Procedure

Section A. The members present, physically or via use of telephone or web-based communication, at any properly announced meeting will be considered a quorum. All issues to be voted upon will be decided by a simple majority of those present at the meeting or by electronic voting unless otherwise specified in the bylaws.

Article 8 - Amendments

Section A. These By-Laws may be amended at any properly announced meeting by two-thirds (2/3) vote of those present and voting or by electronic voting as specified in the bylaws.

Metrolina Healthcare Preparedness Coalition Steering Committee Bylaws

Updated: 2/2020
Reviewed: 9/2020

Article 1 - Organization

The name of this organization shall be called Metrolina Healthcare Preparedness Coalition Steering Committee (MHPC-SC)

Article 2 - Mission

Facilitate coordination and cooperation throughout the Metrolina region to ensure partners have the capability and capacity to mitigate against, prepare for, respond to, and recover from emergent health and medical events.

Facilitate the development of the MHPC program initiatives and ensure they are consistent with current funding guidelines of the ASPR Grant, the MHPC strategic plan, and ASPR Healthcare Preparedness guidelines.

Article 3 - Purpose

1. Develop and maintain the strategic plan for the Metrolina Healthcare Coalition
2. Coordinate regional approach to community wide emergency planning, training and response.
3. Specify the composition and direct the activities of sub-committees based upon information received from the Metrolina Healthcare Preparedness Coordinator or consensus of the MHPC membership.
4. Consider for approval recommendations made by sub-committees and work groups
5. Develop and approve regional projects for the ASPR HPP grant submissions
6. Define and recommend processes and/or standard operating guidelines of the MHPC to include, but not limited to, review of the MHPC Regional Response and Recovery Plan.
7. Assist the Metrolina Healthcare Preparedness Coordinator with decisions regarding resource allocation, when requested
8. Additional activities as requested

Article 4 - Membership

Section A. Membership to the Metrolina Healthcare Preparedness Coalition – Steering Committee is chosen by the members of the MHPC. It will include representation from the following disciplines:

- Hospital 1
- Hospital 2
- EMS Agency

- ❖ County Public Health
- ❖ County Emergency Management
- ❖ Continuing Care/Long Term Care Facilities
    - Includes Long Term Care Facilities, Skilled Nursing Facilities, Assisted Living Facilities, Hospice, PACE, Federally Qualified Health Center, and Home Health organizations
- ❖ Ad Hoc 1
    - Ad Hoc members can be from any discipline that participates in the health and medical preparedness and response. This might include hospitals, EMS, fire, law enforcement, home health, etc.
- ❖ Ad Hoc 2
- ❖ Metrolina Healthcare Preparedness Coordinator

Section B: Terms of Appointment:

Members will serve a term of 2 calendar years and may be re-elected.

- Hospital 1, EMS Agency, Continuing Care/Long Term Care Facilities, Ad Hoc 1 are elected to begin a term in June of even years
- Hospital 2, Public Health, Emergency Management, Ad Hoc 2 are elected to begin a term in June of odd years

Section C: Term Limits: Each elected member will be allowed to serve a maximum of two (2) consecutive terms. After one term off the board, the person will be eligible for re-election.

Section D: Nomination and Election: Candidates may be nominated by any member of the committee, the regional healthcare preparedness coordinator (HPC), or the assistant regional healthcare preparedness coordinator (AHPC). A person must receive a majority of the votes of those present for the meeting or by electronic voting.

Section E: Resignation and Replacement Election: If a member finds it necessary to resign from the committee, they are encouraged to remain until a replacement can be selected and to provide as much notice as possible. A replacement will be nominated and elected by the above standards. If a member resigns in the middle of the term, the new committee member will serve the rest of the term.

Section F: Attendance Expectations/ Removal from the Committee: Regular attendance is vital to the purposes of the committee. A Member may be automatically removed from the committee if (s)he misses two (2) consecutive posted meetings or 30% of the scheduled meetings in any year without arranging for a proxy.

Section G: Vacancies: In the event that a committee member seat is vacant, the Committee will nominate a replacement to the MHPC for approval.

Section H: Proxies: A committee member wishing to vote by proxy must prepare a statement in writing and submit it to the Metrolina HPC Coordinator stating their authorization of a

specifically named alternate from their discipline to attend the meeting and/ or cast a vote in his/ her absence. A proxy shall only be valid at the meeting for which it is executed.

Article 5 - Meetings

Meetings are held monthly or at least quarterly. Additional meetings may be scheduled by the HPC or the Steering Committee.

Each meeting is announced by email one month, then two weeks in advance of the meeting. In the case of a special meeting, such notice will state the purpose of the meeting and will be sent 5 business days in advance.

Article 6 – Steering Committee Officers

Section A: Officers of the Committee: The following officers will be elected from the Steering Committee Membership:

1. Chair
2. Vice-Chair

*Note: Secretary – The role of Secretary will be filled by a member of the MHPC Staff and is not elected by the Steering Committee

Section B: Restrictions on Number of Offices Held

- No person shall hold more than one office on the Steering Committee
- Officers of the Committee may hold subcommittee officer positions on various subcommittees

Section C: Election: Officers will be elected once per year. There will be no term limits for these positions.

Section D: Duties of the Officers

The Chair

- Establish the agenda based on coalition development and grant directives based upon information received from the MHPC Coordinator;
- Preside over meetings of MHPC – SC;
- Call special meetings when necessary;
- Ensure that the MHPC – SC is represented and a report of committee activities is provided to the MHPC quarterly meeting;
- Perform other duties as directed by the MHPC – SC.

The Vice-Chair

- Perform the duties of the Chair in the Chair's absence;
- Request and receive status reports from the sub-committee chairs and distribute them to the MHPC – SC.

Secretary – Role to be assumed by MHPC Staff Member

- Assure meeting attendance roster is maintained;
- Ensure dissemination of all notices as required by the bylaws;
- Ensure minutes are maintained and are provided to the Members of the MHPC and MHPC – SC within five (5) business days.

Article 7 – Parliamentary Procedure

Section A. The members present at any properly announced meeting will be considered a quorum. All issues to be voted upon will be decided by a simple majority of those present at the meeting or by the electronic voting deadline as determined by the Chair unless otherwise specified in the bylaws.

Section B. Voting Privileges

Each Member shall be vested with one vote.

Electronic Voting- MHPC – SC voting may be conducted in an electronic format.

Section C. Conflict of Interest

Good faith - Members shall exercise good faith in all transactions touching upon their duties to the MHPC. In their dealings with and on behalf of the MHPC, they are each held to a rule of honesty and fair dealings between themselves and the MHPC. They shall not use their positions as members, or knowledge gained there from, to their personal benefit and to the detriment of the MHPC.

Exclusion from voting - Any member having a conflict of interest on a matter shall disclose such interest and abstain from voting as appropriate.

Article 8 - Amendments

Section A. These By-Laws may be amended at any properly announced meeting by two-thirds (2/3) vote of those present at an MHPC meeting or by electronic voting as specified in the bylaws.

Coalition Succession Plan

MHPC Leadership Succession 2019-2022

	Name	Title	Phone Number	Alt Phone Number
Head of Department/Unit	Hannah Gompers	Regional Preparedness Coordinator	704-579-4150	
Successor	Kariena Bernesser	Assistant Regional Coordinator	704-258-8966	
Successor	Scott Hess	Assistant Regional Coordinator	704-221-2818	
Successor	Michael Tessari	Assistant Regional Coordinator	704-351-8832	
Successor	NC Office of EMS	NC Office of EMS		

Metrolina Healthcare Preparedness Coalition Code of Ethics

In order to achieve the MHPC mission, it is imperative that all those associated with the Coalition, including the Steering Committee Members, Coalition Members, staff and volunteers, uphold the highest ethical and moral standards while representing the Coalition. The Code of Ethics was developed to define basic principles and guidelines for conduct and should not be taken as a set of absolute rules.

All Members, Steering Committee Members, staff and volunteers of the Metrolina Healthcare Preparedness Coalition shall:

a) Conduct themselves professionally, with the highest level of integrity, accuracy, fairness, and responsibility to the public
b) Act in the best interest of the Coalition, rather than in the furtherance of personal interests or interests of third parties
c) Disclose the existence of any real or potential conflicting or competing interest that may impact your ability to act in the best interest of the Coalition. This includes but is not limited to any employment, contract or investment interest.
d) Not to use the Coalition logo or not use any materials, products or services developed by the Coalition for proprietary objectives
e) Ensure that the Coalition's financial resources are used wisely and only to further the Coalition's mission, goals, and objectives.
f) Not intentionally communicate false or misleading information about the Coalition or its Members
g) Endeavor to actively promote the mission, goals and objectives of the Coalition
h) Not discriminate based on race, religion, national origin, sex, age, sexual orientation, economic or physical or mental disability or illness.
i) Report any perceived or actual violation of the Code of Ethics by a Coalition Member to the MHPC Steering Committee or to the Healthcare Preparedness Coordinator.

By entering my name below, I accept and agree to abide by the Coalition Code of Ethics.

Name

Date

Financial Policies & Processes

Accounting: The Coalition staff, in particular the Healthcare Preparedness Coordinator and Senior Assistant Coordinator, will maintain an accounting database, pay invoices, balance and account for funds by contract and type, and prepare monthly Contract Expenditure Report for submission to NCOEMS.

Budget: At the beginning of each contract/grant year, the Healthcare Preparedness Coordinator will prepare and present to the MHPC Steering Committee a proposed budget for the upcoming contract/grant year. The MHPC is responsible for approving all budgets and subsequent budget revisions during the contract/grant year.

Contracts/Agreements: The MHPC Steering Committee must approve any contract or agreement into which the Coalition will enter. The MHPC Steering Committee may authorize the Healthcare Preparedness Coordinator to execute contracts or agreements in specific instances, such as contracting with consultants within an approved contract amount. Following approval from the Healthcare Preparedness Coordinator and MHPC Steering Committee, and contracts or agreements must also be approved by the NC OEMS Business Office.

Financial Decision Making: Expenditures for each contract/grant year are determined by yearly goals, completion of ASPR capabilities, regional MYTEP, and the regional HVA (hazard vulnerability analysis.)

Spending Plans/Yearly Budget: The Healthcare Preparedness Coordinator will prepare and submit spending plans as required by contract/grant. An annual spending plan for each contract/grant year will be provided to the MHPC Steering Committee for approval.

Travel Procedures: The Coalition utilizes the State of North Carolina travel reimbursement guidelines for all staff and member travel.

Project Funding Process

The Metrolina Healthcare Preparedness Coalition projects are outlined in the annual work plan approved by the Steering Committee. These projects are designed to build and sustain the ASPR Healthcare Preparedness Program capabilities.

All members, including Steering Committee members, are encouraged to submit additional project proposals to be ready in the event that additional funding becomes available. These proposals will be reviewed and ranked by each Steering Committee member using the following criteria:

- Projects must address an identified capability gap or sustain a capability
- Projects will not be considered if they supplant normal business expenses/core mission requirements
- Projects will not be considered if they are eligible for funding under other federal funding processes
- Project is cost effective, realistic, and achievable

Projects will be approved based on ranking or if there are not enough projects submitted, approved by a vote of yes or no. Projects will be funded until funds are depleted.

Coalition Financial Sustainability

The Metrolina Healthcare Preparedness Coalition is set up in the following financial manner:

a. **Federal HPP Funding:** A majority of funding for the HCC is from the ASPR HPP Grant and is issued out each year on July 1st. All invoices must be paid dated no later than June 30 of the given grant year. Any remaining funding from the grant year will be sent back to NCOEMS-HPP.
b. **Contributed Revenue:** Any additional funding that is made by the Coalition during the year is placed in a separate account with Atrium Health and is not tied to a particular grant year. All purchases from this account must be approved by NCOEMS Business Office.
c. **In-Kind:** MHPC is required to meet an in-kind match to the yearly grant amount. This amount is equal to or greater than 10% of the grant amount. The in-kind match is met in the following ways
    a. Volunteer Time
    b. In-kind Donations
    c. Facilities and Administrative (F&A) Rates from Atrium Health – Sponsored Programs Administration

Strengthening Organizational Capacity

- Participation in the Metrolina Healthcare Preparedness Coalition has shown:
    - Improved communications both horizontally and vertically
    - Improved situational awareness
    - Improved relationships between healthcare organizations, public health, and emergency management – this includes the recognition of roles and responsibilities before, during, and after a response
    - Improved access to resources and supplies used not only during significant incidents, but also during planned events
    - Improved organizational response to local incidents following an all-hazards approach

- The Metrolina Healthcare Preparedness Coalition intends to utilize the following methods to bolster contributed revenue:

    - Offer HCC members technical assistance in meeting the CMS Emergency Preparedness Rule: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
        - MHPC will offer ***two*** educational opportunities and ***one*** community-based exercise at no cost each contract/grant year
    - Vendor presentations/exhibits at meetings
    - County support
    - Emergency Operations Plan review for County Emergency Managers of Long-Term Care facilities. EOPs will not be approved by MHPC, only reviewed for content.

- Additional in-kind support from regional and state partners

Steering Committee Approvals

_____

John Watts – Hospital Representative Date
MHPC Steering Committee Chair

_____

Sarah Seiler – Ad Hoc Representative Date
MHPC Steering Committee Vice Chair

This document requires yearly review and approval by the MHPC Steering Committee.

See next page for physical signatures. Due to COVID-19, signatures were scanned.

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- Additional in-kind support from regional and state partners

Steering Committee Approvals

John J. Watts 11-7-2020

John Watts – Hospital Representative — Date
MHPC Steering Committee Chair

11/7/2020

Sarah Seiler – Ad Hoc Representative — Date
MHPC Steering Committee Vice Chair

This document requires yearly review and approval by the MHPC Steering Committee.

Appendix E: RHSC/HISS Activation

Purpose:
This document is meant to assist the Healthcare Preparedness Coordinator (HPC) and Regional Healthcare Support Cell (RHSC) staff by defining general processes for the efficient activation and operations of the RHSC.

Concept of Operations:
General: Response actions will be based on *activation levels* as determined by the HPC or their designee and are described below. The activation level assigned for the specific incident will be determined based on the information initially obtained and is subject to change as more information becomes available. The level of activation, once assigned, will help determine the appropriate resources necessary to effectively and efficiently support incident response efforts. The response actions outlined in this Activation Plan are guidelines only.
Notification: Upon notification that an event/incident has occurred or has the potential to occur, the RHSC will activate. RHSC staff will verify the event/incident information and confer with the HPC or their designee to determine the appropriate activation level and response.
Activation Levels: Defining activation levels gives RHSC staff a basic response guideline for any given situation. The following table describes the RHSC Activation Levels, along with potential scenarios where each may apply. These are guidelines only.

RHSC ACTIVATION LEVEL	INCIDENT/EVENT DEFINITION	RHSC STATUS	EXAMPLE
0	A situation that does not require additional response from the RHSC except for situational awareness and monitoring.	**Not Open**	
1	A localized, contained incident that is quickly resolved with limited assistance. Does not affect the overall functioning of hospitals/healthcare agencies within the coalition region.	**Open** - at the discretion of RHSC Staff	
2	A serious emergency that completely disrupts one or more hospital's operations within a county or area. Outside emergency services as well as major efforts from within the hospitals will be required.	**Open -** additional RHSC staff designated to RHSC as needed	
3	A community-wide disaster that seriously impairs or is expected to impair operations of several healthcare facilities within an	**Open** - additional RHSC Staff	

	area (city, county, region, etc.). External emergency response resources from state agencies and the potential of federal assistance will likely be required.	designated to RHSC	

Activation Level Response Actions: These provide a method for effective initial and ongoing support functions by the RHSC staff. These guidelines should be utilized in conjunction with Job Action Sheets in order to orient RHSC staff to specific responsibilities for responding to the incident. Although the following response actions are presented in a step-by-step format, it is up to the HPC, or their designee, to determine the need for and/or appropriate order of actions as required for the particular event.

ACTIVATION LEVEL 0 RESPONSE (HIGH ALERT ONLY)		
Response Action		**Task**
1	**Verify the Incident.** Verify that the incident is actually occurring.	Use the following methods to verify information, if required. Call/contact the number/address received and discuss incident details with the caller. Verify the incident via credible reporting methods. Contact local first responders or emergency management in the affected area as appropriate. *Use RHSC Activation Checklist (below) for collecting event/incident information.*
2	**Contact HPC or other RHSC staff.** Update them on current situation.	Enlist support with communications as required for event / incident (e.g., update Healthcare WebEOC, develop messaging, conducting coordination). *Refer to RHSC Communications Plan for guidance.*

ACTIVATION LEVELS 1-3 RESPONSE		
Response Action		**Task**
Perform actions 1 and 2 from Level 0 above first.		
3	**Open RHSC location (if necessary).**	Open the designated RHSC location. If working remotely, determine the best location for the RHSC and/or operate a "virtual" RHSC, as resources allow (cell phone, laptop computer, connectivity, etc.).
4	**Confer with HPC/Coalition Leadership**	Regarding options for a RHSC staff to be sent to the county EOC once opened.
5	**Contact Office of Emergency Medical Services (NCOEMS)**	For activations involving the deployment or potential deployment of SMRS resources, the NCOEMS Shift Duty Officer should be notified via email DHSR.NCOEMS.SDO@dhhs.nc.gov or phone 919-855-4687.
Continue performing response actions 6-8 below until additional RHSC Staff are given assignments in the RHSC.		
6	**Notification to Off-Duty RHSC Staff**	All incidents greater than Level 0 warrant communication to be sent to off-duty RHSC Staff to apprise them of the situation. Additional RHSC staff may be required to support the event as determined by

ACTIVATION LEVELS 1-3 RESPONSE		
Response Action		**Task**
		the HPC, or their designee. In such an event, RHSC staff may be requested to do the following: **Report to the RHSC –** RHSC staff that are in or near the building in which the RHSC is located, should report to it directly to assume a role as assigned by the HPC. Bring laptop computer and other necessary equipment/materials as requested.
7	**Access and update Healthcare WebEOC and communication / information systems.**	Log into Healthcare WebEOC and provide updated status. Utilize available communication and information systems to collect and share essential elements of information as appropriate. Develop and submit Healthcare Preparedness Coalition/SMRS situation reports, ServNC staffing requests, etc. as necessary or as otherwise requested.
8	**Alert to Healthcare Preparedness Coalition Member Organizations**	Utilize available communication and information systems to alert appropriate entities (Coalition hospitals, Coalition members etc.) to notify them of the event. *Refer to RHSC Communications Plan for instructions. Messages should be as specific as possible regarding the incident and actions you need them to perform such as entering hospital-specific information into Healthcare WebEOC or SMARTT, responding to ServNC messages, or using VIPER radios for communications.*
9	**Refer to the RHSC Continuity of Operations Plan (COOP)**	For any situations in which the RHSC and **all** RHSC staff will be required to work around the clock for short or extended periods, the RHSC COOP should be consulted. Additional staffing and/or shift work may be required as described in this plan.

RHSC Deactivation: When the RHSC's incident-related responsibilities have ceased as determined by the HPC or their designee, deactivation activities may be initiated.

- **Resources:** RHSC staff should begin process for the return any mobilized/deployed resources to their original locations.
- **Notifications:** RHSC staff and other entities (hospitals, EMA, health departments, etc.) contacted at the beginning of the event may need to be contacted once again regarding event deactivation details. This should be done through the most effective method of communication available at the time.
- **Documentation:** Documentation on the details of the incident and the RHSC's response to the incident is a responsibility of the assigned Planning Section Chief, or RHSC staff as designated by the HPC. The event may also require a formal After-Action Review to be submitted by the Planning Section Chief to the HPC and/or OEMS.
- **System Demobilization:** RHSC staff should ensure that all information entered on systems utilized during the incident (Healthcare WebEOC, etc.) is saved for documentation purposes and that these systems are restored to their pre-event status.

RHSC Activation Checklist

<table>
<tr><td>Date</td><td>Hospital</td><td>Person Reporting</td><td>Contact Info
Phone:
Cell:
Email:</td></tr>
<tr><td colspan="2">HOSPITAL STATUS</td><td colspan="2">FACILITY IMPACT</td></tr>
<tr><td colspan="2">Command Center Open?

Receiving victims?

Lockdown?</td><td colspan="2">Interruption of Patient Care Services?

Damage to Facility?

Security Issues?

Emergency Power?</td></tr>
<tr><td colspan="2">POWER OUTAGE</td><td colspan="2">MASS CASUALTY INCIDENT</td></tr>
<tr><td colspan="2">Estimated time of restoration?

ED on Diversion?

Interruption of Patient Care Services?

Hospital Census?

How many ventilator patients?

Updated Healthcare WebEOC/SMARTT?</td><td colspan="2">Number of anticipated victims?
Triage Levels (how many of each have they received?)
<table><tr><td>Red</td><td>Yellow</td><td>Green</td><td>Black</td></tr><tr><td></td><td></td><td></td><td></td></tr></table>ED on Diversion?

Other Facilities receiving patients?

Change in patient care services?</td></tr>
<tr><td colspan="2">PATIENT CARE ISSUES</td><td colspan="2">IMPENDING EVACUATION</td></tr>
<tr><td colspan="2">Number of patients involved?

Number of patients admitted?

Infectious/Isolation Procedures?

Coalition agencies involved (EMA, Public Health)?</td><td colspan="2">Hospital Census?

Number of patients on ventilators?

Transportation plans in place/activated?

ED on Diversion?</td></tr>
<tr><td colspan="4">What do you need from the RHSC?

Would you like the RHSC to send a message to particular Coalition agencies? If yes, which ones (hospitals, Long Term Care, EMA, etc.) and what information do you want released?</td></tr>
</table>

Appendix F: MHPC Regional HVA 2020 and County Social Vulnerability Indexes

Metrolina Healthcare Preparedness Coalition Hazard Vulnerability Analysis 2020-2021

Introduction and Summary Findings

The Metrolina Healthcare Preparedness Coalition is required to perform a regional hazards and vulnerabilities analysis (HVA) every three (3) years with review and maintenance performed on an annual basis. This is a condition of funding and is set forth by the United States Assistant Secretary for Preparedness and Response (ASPR). While ASPR does not specify any specific methodology, the HVA must be regional in its scope and address vulnerable populations such as pediatric and geriatric.

During fiscal year 2020-2021, the HVA was accomplished using the Kaiser-based tool first utilized in the 2019-2020 process. This HVA tool utilized is similar to that created by Kaiser Permanente in that it calculates a Relative Impact and Relative Threat based on user-defined input for specific threats and hazards.

Given the regional impact of the SARS-CoV-2, the 2020-2021 HVA process was modified. Originally, regional feedback was to be solicited during the December 2020 Quarterly Meeting. This meeting was to be held virtually. However, that meeting was canceled due to regional workload in support of pandemic efforts. Instead, the HVA scoring was undertaken using a combination of regional trends and partner feedback obtained during the 2019-2020 process.

Ranked according to Relative Impact and Relative Threat, the top five threats identified during the process are:

Table 1: 2020-2021 Top Five Regional Threats

Event	**SEVERITY**	**RISK (Severity x Probability)/54**
	Relative Impact if this event occurs	**Relative Threat**
	6 to 18	**0 - 100%**
Infectious Disease Pandemic	18	100%
Cyberattack	14.5	81%
IT Faliure (EMR, network, Internet, etc.)	13.5	75%
Regional Critical Supply/Pharm Shortage	13.5	75%
Infectious Disease Outbreak	13	72%
Personnel Shortage	12.5	69%

Complete results appear on page 5 of this document (Table 2).

Background

During the 2019-2020 effort, the tool-driven approach was generally well received by regional partners and was retained for the 2020-2021 assessment. Modifications to the tool itself and to the threats and hazards were made based upon regional feedback and commentary from last year's regional HVA meeting (Table 2).

Table 2: Open Issues and Recommendations from 2019-2020 HVA

Item or Issue	Observation/Recommendation	Additional Actions
I. Scope		
"Regional" threat/hazard is poorly defined	Evaluate threat/hazard primarily according to first-order or reasonable second and third impact(s)	
II. Threat/Hazard Definitions		
Workplace violence – vague definition	Follow OSHA guidelines: https://www.osha.gov/workplace-violence	
Medical Surge – tightly define or leave intentionally open	Leave open	
Mental health-type event vague	Further define	Removed entirely as mental health consequences are already considered in the Human Impact section of the HVA Instructions
Nuclear event – differentiate failure from intentional act	Create separate threat/hazard for fixed facility compromise/meltdown vs intentional act	
IT Failure – differentiate from intentional act	Create separate threat/hazard for failure vs intentional act	*Cyberterrorism* renamed to *Cyberattack* and placed into the Man-made Events section
Large fire – differentiate from *Wildfire*	Create separate category for non-wildfire	"Urban/residential or commercial" added to *Large Fire* description
III. Scoring and Tool Guidance		
Natural events that had never occurred prior were mathematically assigned a 0% probability	Re-visit scoring criteria and introduce additional scoring considerations	0 value removed from Likelihood scoring criteria

Rationale

Ideally, this effort would be undertaken in manner consistent with the 2019-2020 HVA process, either in person or collectively via remote means. However, given the regional impacts of and efforts against the current pandemic, these options were not available.

Partner input collected during the 2019-2020 HVA process was implemented during the 2020-2021 process. This input broadly addressed three major categories: scope, threat/hazard definitions, and scoring and tool guidance. The question of scope examined two related issues. First, the idea of a regional assessment was broad in that it did not provide explicit guidance as to what constituted "regional" aside from geographic boundaries, specifically as it related to healthcare institutions and agencies. In other words, to what extent should community impacts – those not directly linked to healthcare institutions or agencies – be evaluated during the assessment? Should a water supply interruption *not* strictly originating in a hospital be considered, for example? Second, regional partners desired to better delineate scoring as it related to first, second, or third order impacts.

During the 2019-2020 HVA meeting, threats and hazards were modified to fit regional needs. Some of these threats and hazards were left open for further discussion. These modifications typically either more narrowly defined certain threats/hazards, or separated these threats/hazards from other similar ones.

Finally, the scoring process itself was problematic in that natural events (such as a pandemic or an earthquake) automatically were scored as a zero-risk event based upon probability scoring. Events that had never occurred prior were scored as "0 probability".

Methodology

Changes to some threats/hazards were made according to regional input and then scored according to a revised set of criteria. Many of the perennial regional threats/hazards were left intact and their associated scores were carried over from last year.

Weather events such as *Hurricane/Tropical Storm* and *Severe Thunderstorm* were left unchanged. Likewise, *CBRNE/Terrorism* and *Major HAZMAT Incident* remained unchanged. In both sets of examples, there have been little to no data or changes in frequency to alter event probability. Conversely, threats/hazards such as *Infectious Disease Pandemic* and *Personnel Shortage* were re-evaluated in light of recent events.

A small number of threats/hazards were modified so as to provide more clear meaning or removed altogether. The mental health component of a threat/hazard was an existing factor to be considered when scoring the Human Impact section of the HVA tool (both for patients as well as providers/staff). With that in mind, a separate category for mental health emergencies seemed unnecessarily vague and redundant.

Cyber Terrorism was moved into the Man-made or MCI category of the tool and renamed *Cyber Attack*. Cyberterrorism is narrowly defined, while cyberattack allows for state, non-state, and criminal actors. This also allows cyberattack to be viewed as a threat rather than a hazard.

In terms of scoring and tool-oriented changes, the 0 value was removed. Initially, had a naturally occurring or facility/technological event not occurred in the region, it was assigned a likelihood of 0, resulting in a total risk of 0. Changes to wording or criteria were initially proposed. However, this 0 score was removed entirely with the assumption that any event appearing in a region-specific HVA should have a non-zero likelihood. Phrased differently, if a threat or hazard has zero chance of happening, then we as a region should not be giving it any further evaluation. Finally, "[i]nput based upon assessment by applicable subject matter experts" was added to the Instructions section of the HVA tool. This is to be referenced when scoring probability and is in addition to "[k]nown Risk", "Historical Data", and "Vendor and/or Manufacturer Statistics".

Results

After modifying the tool and re-scoring, results were mixed in terms of threat/hazard category (Table 2). While many of the hazards categorized as Natural Events were largely unchanged from last year's results, the risk score for *Infectious Disease Pandemic* increased substantially. Likewise, *IT Failure* and the risk of *Cyberattack* remained consistent.

The risk of both *Regional Critical Supply/Pharmacy Shortage* and *Personnel Shortage* increased substantially. This was in part due to those events not being scored during last year's effort due to time constraints.

Previously unscored events were assessed according to the HVA tool's parameters.

Table 2: 2020-2021 Regional HVA Results

EVENT	**SEVERITY** **Relative Im**pact if this event occurs	**RISK** **(Severity x Probability)/54** Relative Threat
	6 – 18	**0 – 100%**
Infectious Disease Pandemic	**18**	**100%**
Cyberattack	**14.5**	**81%**
IT Failure (EMR, network, Internet, etc.)	**13.5**	**75%**
Regional Critical Supply/Pharm Shortage	**13.5**	**75%**
Infectious Disease Outbreak	**13**	**72%**
Personnel Shortage	**12.5**	**69%**
Med Surge	12	67%
Hurricane/Tropical Storm	11	61%
Tornado or Microburst	11	61%
Active Shooter incident	11	61%
Flood with potential for disruption/harm	9.5	53%
Workplace Violence	9.5	53%
Heat Wave	9	50%
CBRNE/Terrorism	13	48%
Winter Weather Event	8	44%
Major HAZMAT Incident	12	44%
Severe Thunderstorm	7.5	42%
Wildfire	11	41%
Fuel Shortage	11	41%
Mass Casualty Incident - General Injuries / Trauma	6.5	36%
Large Fire (urban/residential or commercial)	13	24%
Massive Transportation Disruption / Failure	11.5	21%
Regional Sewer / Water Treatment Failure	17	16%
Regional Water Disruption / Interruption	17	16%
Earthquake likely to cause structural damage - define criteria	15	14%
Regional Communications Disruption	7.5	14%
Nuclear Event	13	12%
VBIED or IED	13	12%
Regional Natural Gas Disruption	9.5	9%
Regional Electrical Failure (i.e. blackout)	8.5	8%

Discussion

The 2020-2021 HVA process was imperfect. As mentioned previously, this HVA process would have mirrored that of last year's, or, at the least, have been predicated on regional partner input. With that said, there may be some value in the findings.

The most obvious shift in risk is seen in *Infectious Disease Pandemic.* This is perhaps obvious and needs no explanation. Risk scores for both *Personnel Shortage* and *Regional Critical Supply/Pharmacy Shortage* increased as well, moving from 64% to 69% and from 0% (previously unscored) to 75% respectively. Both of these events are currently ongoing to some degree and can be seen as directly related to the SARS-CoV-2 outbreak. Though unknown, the risk of both events may be persistent, even post-pandemic, and therefore extend into 2021. Long term impacts to staffing and the availability of supplies (including personal protective equipment) remain to be seen.

During the 2019-2020 HVA meeting, the threat of *Cyberattack* was scored highly. Besides the frequency of such events, the region felt that the constant evolution of malware and its attack vectors as well as of the perpetrators themselves constituted a persistent high risk. The dynamic nature of the threat means that regional mitigation efforts are never truly sufficient. This rationale was preserved during the 2020-2021 HVA process.

Finally, events that occur reliably or maintain relatively consistent probability were scored using last year's regional input.

Future Outlook and Proposed Timeline: FY2021-2022

This document will be disseminated to regional partners for evaluation and feedback. Regional partners will be asked to examine the changes made to both the events and to the tool itself and then to approve or reject these changes. If rejected, a collaborative revision effort will be undertaken with the goal of creating an agreed-upon HVA tool.

Once a satisfactory tool is produced, the assessment process will more closely resemble that of FY2019-2020, whether in-person or via remote means.

Appendix A: HVA Tool Template

	MHPC 2020-2021 Regional HVA (12/2020)									
			Severity = Magnitude + Mitigation							
			Magnitude (negative consequences of impact)			Mitigation			SEVERITY	RISK (Severity x Probability)/54
	EVENT	Probability	Human Impact	Property Impact	Business Impact	Regional Preparedness	Internal Resources	Regional Resources		
		Likelihood this will occur	*Possibility of Patient Surge*	*Response Costs and Damages*	*Interruption of Services*	*Pre-planning*	*Type, Volume and Availability of Resources*	*Type, Volume and Availability of Resources*	*Relative Impact if this event occurs*	*Relative Threat*
	SCORE	.5 = Minimal 1 = Low 2 = Moderate 3 = High	0 = None .5 = Minimal 1 = Low 2 = Moderate 3 = High	0 = $0 1 = Low 2 = Moderate 3 = High	0 = None 1 = Low 2 = Moderate 3 = High	0 = n/a 1 = High 2 = Moderate 3 = Low	0 = n/a 1 = High 2 = Moderate 3 = Low	0 = n/a 1 = High 2 = Moderate 3 = Low	*6 to 18*	*0 - 100%*
Natural Events	Earthquake likely to cause structural damage - define criteria	0.5	2	3	3	3	2	2	15	14%
	Flood with potential for disruption/harm	3	0.5	2	2	1	2	2	9.5	53%
	Heat Wave	3	2	1	1	1	2	2	9	50%
	Hurricane/Tropical Storm	3	3	3	2	1	1	1	11	61%
	Infectious Disease Pandemic	3	3	3	3	3	3	3	18	100%
	Infectious Disease Outbreak	3	2	2	3	2	2	2	13	72%
	Large Fire (urban/residential or commercial)	1	2	3	3	3	1	1	13	24%
	Wildfire	2	1	3	3	2	1	1	11	41%
	Severe Thunderstorm	3	0.5	1	1	1	2	2	7.5	42%
	Tornado or Microburst	3	1	2	3	1	2	2	11	61%
	Winter Weather Event	3	1	2	2	1	1	1	8	44%
MCI & Man-Made Events	Workplace Violence	3	0.5	1	1	3	2	2	9.5	53%
	Active Shooter incident	3	1	2	3	1	2	2	11	61%
	CBRNE/Terrorism	2	2	3	3	1	2	2	13	48%
	Mass Casualty Incident - General Injuries / Trauma	3	0.5	1	1	1	2	1	6.5	36%
	Med Surge	3	2	2	3	1	2	2	12	67%
	Major HazMat Incident	2	1	3	3	1	2	2	12	44%
	Nuclear Event	0.5	3	3	3	1	1	2	13	12%
	Cyberattack	3	0.5	3	3	3	2	3	14.5	81%
	VBIED or IED	0.5	3	3	3	2	1	1	13	12%
Facility & Technological Events	Fuel Shortage	2	1	1	3	3	1	2	11	41%
	Personnel Shortage	3	0.5	3	3	0	3	3	12.5	69%
	IT Failure (EMR, network, Internet, etc)	3	0.5	3	3	2	2	3	13.5	75%
	Massive Transportation Disruption / Failure	1	0.5	2	2	2	3	2	11.5	21%
	Regional Critical Supply/Pharm Shortage	3	0.5	3	3	1	3	3	13.5	75%
	Regional Communications Disruption	1	0.5	1	1	3	1	1	7.5	14%
	Regional Electrical Failure (i.e. blackout)	0.5	0.5	1	2	1	2	2	8.5	8%
	Regional Natural Gas Disruption	0.5	0.5	1	1	3	2	2	9.5	9%
	Regional Sewer / Water Treatment Failure	0.5	2	3	3	3	3	3	17	16%
	Regional Water Disruption / Interruption	0.5	2	3	3	3	3	3	17	16%

Appendix A: HVA Tool Template (cont.)

Regional Healthcare Coalition Hazard Vulnerability Tool

Factors considered when determining **probability** of hazards will include, but are not limited to:

1) Known Risk (i.e, previously identified in a Hospital, Local, State or Federal HVA)
2) Historical Data
3) Vendor and/or Manufacturer Statistics
4) Input based upon assessment by applicable subject matter experts

Factors considered when determining **response** requirements will include, but are not limited to:

1) Time required to marshal an immediate response
2) Anticipated scope of response required to mitigate hazard
3) Historical challenges and best practices for responding to the specific hazard

Factors considered when determining the **human impact** of hazards will include, but are not limited to:

1) Potential for staff injury and/or death (including mental health consequences)
2) Potential for patient injury and/or death (including mental health consequences)

Factors considered when determining the **property impact** of hazards will include, but are not limited to:

1) Cost to replace or repair impacted property
2) Cost to implement and operate a temporary replacement for impacted property

Factors considered when determining the **business impact** of hazards will include, but are not limited to:

1) Projected losses due to interruption of hospital services resulting from hazard
2) Projected losses due to workers compensation claims resulting from hazard
3) Projected losses from violations of contractual / legal agreements resulting from hazard
4) Projected losses from litigation resulting from hazard
5) Projected losses from fines and/or penalties resulting from hazard
6) Projected losses from utilization of critical supplies (including restocking costs)

Factors considered when determining the level of **regional preparedness** for hazards will include, but are not limited to:

1) Status of current plans (regional, hospital and community)
2) Status of training and education (i.e., how knowledgeable are staff with respect to their role in responding to specific hazards)
3) Status and avidity of insurance
4) Status and avidity of back-up / redundant systems

Factors considered when determining the level of **internal resources** available to use in response to hazards include, but are not limited to:

1) Type of equipment, supplies and pharmaceuticals available in facilities to respond to specific hazard
2) Volume of equipment, supplies and pharmaceuticals in facilities to respond to specific hazard
3) Projected hospital staff that could be marshaled to respond to specific hazard

Factors considered when determining the level of **regional resources** available to use in response to hazards include, but are not limited to:

1) Type of equipment, supplies and pharmaceuticals available through regional agreements and caches to respond to specific hazard
2) Volume of equipment, supplies and pharmaceuticals available through regional agreements and caches to respond to specific hazard
3) Projected staff that could be marshaled through community, regional, state and federal agreements

Appendix A: HVA Tool Template (cont.)

Regionally agreed on KEY
Probability for Naturally Occurring or Facility/Technological:
.5= Event has occurred at some point in the region
1 = Event has occurred in the region within the last 10 years
2 = Event has occurred in the region within the last 5 years
3 = Event has occurred in the region within 12 months
Probability for Manmade or MCI
.5= Event has occurred somewhere on globe
1 = Event has occurred in the region or a similar region within 5 - 10 years
2 = Event has occurred in the region or similar region within the last 5 years
3 = Event has occurred in the region or similar region within 12 months
Magnitude
Human Impact:
0 = Event is likely to produce no patient surge
.5 = Event is likely to produce patient surge less than 20
1 = Event is likely to produce patient surge between 20 - 50
2 = Event is likely to produce patient surge between 50 - 100
3 = Event is likely to produce patient surge greater than 100
Property Impact:
0 = Event is likely to produce no negligible response costs.
1 = Event is likely to produce damages or additional response costs between $1 and $100k.
2 = Event is likely to produce damages or additional response costs between $100k and $500k.
3 = Event is likely to produce damages or additional response in excess of $500k.
Business Impact:
0 = Event is not likely to create any disruption of normal operations at facilities within region.
1 = Event is likely to disrupt normal operations at facilities within region for up to 24 hrs.
2 = Event is likely to disrupt normal operations at facilities within region for 2 to 3 days.
3 = Event is likely to disrupt normal operations at facilities within region for more than 3 days.
Mitigation
Regional Preparedness:
0 = N/A
3 = Event is covered by regional all-hazards plan but has no functional annex and has not been exercised
2 = Event is covered by regional all-hazards plan and has been exercised at least once.
1 = Event has a functional annex or has been exercised in the last 12 months.
Internal Resources:
0 = N/A
3 = Minimal resources exist at the facility level to respond to this event.
2 = Moderate resources exist at the facility level to respond to this event.
1 = Sufficient resources exist at the facility level to respond to this event.
External Resources:
0 = N/A
3 = Minimal resources exist at the regional level to respond to this event.
2 = Moderate resources exist at the regional level to respond to this event.
1 = Sufficient resources exist at the regional level to respond to this event.

Anson County

US Census Tract FIPS: 37007
Estimated Total Population: 25883
Estimated Total Housing Units: 11512
2016 Overall SVI Score: 0.9637 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	3961
Estimated daytime population	22,916

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	5484	22.80%	77th	No
Civilian (age 16+) unemployed estimate	1703	14.40%	99th	Yes
Per capita income estimate	17548		95th	Yes
Person (age 25+) with no high school diploma	3566	19.60%	71st	No
Percentile Ranking for Theme Summary				
94th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	4157	16.10%	31st	No
Persons aged 17 and younger estimate	5266	20.30%	33rd	No
Civilian non-institutionalized population with a disability estimate	4759	19.70%	76th	No
Single parent household with children under 18 estimate	1242	13.10%	93rd	Yes
Percentile Ranking for Theme Summary				
76th				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	14212	54.90%	87th	No
Person (age 5+) who speak English "less than well" estimate	204	0.80%	21st	No
Percentile Ranking for Theme Summary				

77th

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	54	0.50%	3rd	No
Mobile homes estimate	3220	28%	83rd	No
At household level, more people than rooms estimate	331	3.50%	90th	No
Households with no vehicle available estimate	920	9.70%	84th	No
Persons in institutionalized group quarters estimate	1810	7%	92nd	Yes
Percentile Ranking for Theme Summary				
95th				

Estimated Total Population: 89,082
Estimated Total Housing Units: 40, 618
2016 Overall SVI Score: 0.8991 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	12,004
Estimated daytime population	80,826

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	17135	19.90%	63rd	No
Civilian (age 16+) unemployed estimate	4459	10.80%	75th	No
Per capita income estimate	20775		68th	No
Person (age 25+) with no high school diploma	12888	20.40%	78th	No
Percentile Ranking for Theme Summary				
87th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	16243	18.20%	56th	No
Persons aged 17 and younger estimate	17905	20.10%	29th	No
Civilian non-institutionalized population with a disability estimate	17776	20.50%	78th	No
Single parent household with children under 18 estimate	3364	9.80%	62nd	No
Percentile Ranking for Theme Summary				
77th				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	15779	17.70%	29th	No
Person (age 5+) who speak English "less than well" estimate	1817	2.10%	71th	No
Percentile Ranking for Theme Summary				
69th				

Housing/Transportation Theme

Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	790	1.90%	47th	No
Mobile homes estimate	10400	25.60%	77th	No
At household level, more people than rooms estimate	1005	2.90%	82nd	No
Households with no vehicle available estimate	2050	6%	41st	No
Persons in institutionalized group quarters estimate	2973	3.30%	74th	No
Percentile Ranking for Theme Summary				
86th				

Cabarrus County

US Census Tract FIPS: 37025
Estimated Total Population: 192,296
Estimated Total Housing Units: 75,287
2016 Overall SVI Score: 0.4473 – low to moderate level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	20,037
Estimated daytime population	178,098

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	22324	11.70%	5th	No
Civilian (age 16+) unemployed estimate	7948	7.90%	31st	No
Per capita income estimate	27728		16th	No
Person (age 25+) with no high school diploma	13997	11.10%	11th	No
Percentile Ranking for Theme Summary				
36th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	23953	12.50%	11th	No
Persons aged 17 and younger estimate	50611	26.30%	96th	Yes
Civilian non-institutionalized population with a disability estimate	19733	10.30%	5th	No
Single parent household with children under 18 estimate	6704	9.80%	61st	No
Percentile Ranking for Theme Summary				
33rd				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	59643	31%	51st	No
Person (age 5+) who speak English "less than well" estimate	4613	2.60%	76th	No

Percentile Ranking for Theme Summary
81st

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	4541	6%	85th	No
Mobile homes estimate	5360	7.10%	8th	No
At household level, more people than rooms estimate	2456	3.60%	93rd	Yes
Households with no vehicle available estimate	3136	4.60%	16th	No
Persons in institutionalized group quarters estimate	1488	0.80%	8th	No
Percentile Ranking for Theme Summary				
38th				

Catawba County

US Census Tract FIPS: 37035
Estimated Total Population: 155,461
Estimated Total Housing Units: 68,076
2016 Overall SVI Score: 0.6543 – moderate to high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	19,577
Estimated daytime population	171,690

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	24269	15.90%	25th	No
Civilian (age 16+) unemployed estimate	6049	10.80%	31st	No
Per capita income estimate	24220		28th	No
Person (age 25+) with no high school diploma	17720	16.60%	49th	No
Percentile Ranking for Theme Summary				
61st				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	25077	16.10%	31st	No
Persons aged 17 and younger estimate	35663	22.90%	74th	No
Civilian non-institutionalized population with a disability estimate	21972	14.30%	21st	No
Single parent household with children under 18 estimate	5110	8.60%	40th	No
Percentile Ranking for Theme Summary				
37th				

Minority Status/Language Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	36298	23.30%	38th	No
Person (age 5+) who speak English "less than well" estimate	4083	2.80%	80th	No
Percentile Ranking for Theme Summary				
77th				

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	3086	4.50%	81st	No
Mobile homes estimate	10400	14.30%	21st	No
At household level, more people than rooms estimate	1005	2.70%	73rd	No
Households with no vehicle available estimate	2976	5%	24th	No
Persons in institutionalized group quarters estimate	2451	1.60%	40th	No
Percentile Ranking for Theme Summary				
62nd				

Cleveland County

US Census Tract FIPS: 37045
Estimated Total Population: 97,113
Estimated Total Housing Units: 43,285
2016 Overall SVI Score: 0.8211 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	13,867
Estimated daytime population	90,551

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	22324	20.80%	66th	No
Civilian (age 16+) unemployed estimate	7948	12.20%	88th	No
Per capita income estimate	20677		70th	No
Person (age 25+) with no high school diploma	13997	16.50%	48th	No
Percentile Ranking for Theme Summary				
85th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	16599	17.10%	43rd	No
Persons aged 17 and younger estimate	21657	22.30%	64th	No
Civilian non-institutionalized population with a disability estimate	16255	16.80%	48th	No
Single parent household with children under 18 estimate	3596	9.70%	57th	No
Percentile Ranking for Theme Summary				
70th				

Minority Status/Language Theme

Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	25675	26.40%	43rd	No
Person (age 5+) who speak English "less than well" estimate	667	0.70%	17th	No
Percentile Ranking for Theme Summary				
59th				

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	1038	2.40%	58th	No
Mobile homes estimate	7989	18.50%	39th	No
At household level, more people than rooms estimate	761	2%	37th	No
Households with no vehicle available estimate	2639	7.10%	65th	No
Persons in institutionalized group quarters estimate	1681	1.70%	47th	No
Percentile Ranking for Theme Summary				
68th				

Gaston County

US Census Tract FIPS: 37071
Estimated Total Population: 211,753
Estimated Total Housing Units: 90,212
2016 Overall SVI Score: 0.7615 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	29,176
Estimated daytime population	193,874

Socioeconomic Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Persons below poverty estimate (ACS 2012-2016)	35812	17.20%	36th	No
Civilian (age 16+) unemployed estimate	10077	9.70%	54th	No
Per capita income estimate	23710		34th	No
Person (age 25+) with no high school diploma	24323	16.80%	52nd	No
Percentile Ranking for Theme Summary				
71st				

Household Composition/Disability Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Persons aged 65 and older estimate	31800	15%	19th	No
Persons aged 17 and younger estimate	49051	23.20%	76th	No
Civilian non-institutionalized population with a disability estimate	33468	16%	39th	No
Single parent household with children under 18 estimate	8073	10.10%	67th	No
Percentile Ranking for Theme Summary				
62nd				

Minority Status/Language Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	54735	25.80%	42nd	No
Person (age 5+) who speak English "less than well" estimate	2855	1.40%	55th	No

Percentile Ranking for Theme Summary
70th

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	4786	5.30%	84th	No
Mobile homes estimate	9940	11%	12th	No
At household level, more people than rooms estimate	2300	2.90%	77th	No
Households with no vehicle available estimate	5108	6.40%	47th	No
Persons in institutionalized group quarters estimate	2933	1.40%	30th	No
Percentile Ranking for Theme Summary				
69th				

Iredell County

US Census Tract FIPS: 37097
Estimated Total Population: 167,493
Estimated Total Housing Units: 70,448
2016 Overall SVI Score: 0.4690 – low to moderate level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	20,086
Estimated daytime population	168,752

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	22114	13.30%	8th	No
Civilian (age 16+) unemployed estimate	7333	8.60%	41st	No
Per capita income estimate	28268		11th	No
Person (age 25+) with no high school diploma	13778	12.10%	19th	No
Percentile Ranking for Theme Summary				
43rd				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	24290	14.50%	18th	No
Persons aged 17 and younger estimate	40119	24%	85th	No
Civilian non-institutionalized population with a disability estimate	21669	13%	12th	No
Single parent household with children under 18 estimate	5868	9.50%	56th	No
Percentile Ranking for Theme Summary				
38th				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	39145	2.34%	40th	No
Person (age 5+) who speak English "less than well" estimate	2794	1.80%	61st	No

Percentile Ranking for Theme Summary
72nd

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	3192	4.50%	80th	No
Mobile homes estimate	9499	13.50%	18th	No
At household level, more people than rooms estimate	1687	2.70%	74th	No
Households with no vehicle available estimate	2501	4.10%	8th	No
Persons in institutionalized group quarters estimate	1313	8%	9th	No
Percentile Ranking for Theme Summary				
38th				

Lincoln County

US Census Tract FIPS: 37109
Estimated Total Population: 79,783
Estimated Total Housing Units: 33,947
2016 Overall SVI Score: 0.3903 – low to moderate level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	9,894
Estimated daytime population	64,307

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	11907	15.10%	21st	No
Civilian (age 16+) unemployed estimate	3599	8.90%	44th	No
Per capita income estimate	26352		22nd	No
Person (age 25+) with no high school diploma	8995	16.10%	45th	No
Percentile Ranking for Theme Summary				
58th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	12444	15.60%	25th	No
Persons aged 17 and younger estimate	17634	22.10%	59th	No
Civilian non-institutionalized population with a disability estimate	12204	15.40%	34th	No
Single parent household with children under 18 estimate	2215	7.20%	26th	No
Percentile Ranking for Theme Summary				
19th				

Minority Status/Language Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	11732	14.70%	22nd	No
Person (age 5+) who speak English "less than well" estimate	1178	1.60%	57th	No
Percentile Ranking for Theme Summary				
60th				

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	579	1.70%	41st	No
Mobile homes estimate	6915	20.40%	50th	No
At household level, more people than rooms estimate	651	2.10%	41st	No
Households with no vehicle available estimate	972	3.20%	2nd	No
Persons in institutionalized group quarters estimate	739	0.90%	13th	No
Percentile Ranking for Theme Summary				
22nd				

Mecklenburg County

US Census Tract FIPS: 37119
Estimated Total Population: 1,011,774
Estimated Total Housing Units: 419,325
2016 Overall SVI Score: 0.5088 – moderate to high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	140,357
Estimated daytime population	1,202,922

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	141024	14.20%	13th	No
Civilian (age 16+) unemployed estimate	44283	7.90%	31st	No
Per capita income estimate	34091		3rd	No
Person (age 25+) with no high school diploma	69510	10.40%	8th	No
Percentile Ranking for Theme Summary				
33rd				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	101483	10%	2nd	No
Persons aged 17 and younger estimate	248637	24.60%	88th	No
Civilian non-institutionalized population with a disability estimate	88116	8.80%	2nd	No
Single parent household with children under 18 estimate	40388	10.40%	70th	No
Percentile Ranking for Theme Summary				
22nd				

Minority Status/Language Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	521250	51.50%	84th	No
Person (age 5+) who speak English "less than well" estimate	44441	4.70%	95th	Yes
Percentile Ranking for Theme Summary				
94th				

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	85705	20.40%	100th	Yes
Mobile homes estimate	6536	1.60%	1st	No
At household level, more people than rooms estimate	9259	2.40%	55th	No
Households with no vehicle available estimate	25417	6.60%	55th	No
Persons in institutionalized group quarters estimate	15387	1.50%	35th	No
Percentile Ranking for Theme Summary				
57th				

Richmond County

US Census Tract FIPS: 37153
Estimated Total Population: 45,710
Estimated Total Housing Units: 20,999
2016 Overall SVI Score: 0.9624 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	6,621
Estimated daytime population	45,166

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	11443	17.10%	93rd	Yes
Civilian (age 16+) unemployed estimate	2257	10.30%	82nd	No
Per capita income estimate	19411		84th	No
Person (age 25+) with no high school diploma	6055	19.70%	71st	No
Percentile Ranking for Theme Summary				
93rd				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	7344	16.10%	31st	No
Persons aged 17 and younger estimate	10749	23.50%	80th	No
Civilian non-institutionalized population with a disability estimate	8405	18.90%	68th	No
Single parent household with children under 18 estimate	2316	12.50%	88th	No
Percentile Ranking for Theme Summary				
92nd				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	19280	42.2	71st	No
Person (age 5+) who speak English "less than well" estimate	954	2.20%	72nd	No
Percentile Ranking for Theme Summary				
86th				

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	264	1.30%	30th	No
Mobile homes estimate	4903	23.30%	64th	No
At household level, more people than rooms estimate	332	1.80%	25th	No
Households with no vehicle available estimate	1881	10.20%	89th	No
Persons in institutionalized group quarters estimate	1346	2.90%	68th	No
Percentile Ranking for Theme Summary				
81st				

Scotland County

US Census Tract FIPS: 371165
Estimated Total Population: 35,711
Estimated Total Housing Units: 15,173
2016 Overall SVI Score: 0.9933 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	4,557
Estimated daytime population	35,925

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	10480	31.50%	99th	Yes
Civilian (age 16+) unemployed estimate	1756	13.40%	95th	Yes
Per capita income estimate	16182		99th	Yes
Person (age 25+) with no high school diploma	5072	21.40%	83rd	No
Percentile Ranking for Theme Summary				
97th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	5681	15.90%	29th	No
Persons aged 17 and younger estimate	8391	23.50%	79th	No
Civilian non-institutionalized population with a disability estimate	6954	20.60%	83rd	No
Single parent household with children under 18 estimate	1996	15.20%	99th	Yes
Percentile Ranking for Theme Summary				
95th				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	19843	55.60%	90th	No
Person (age 5+) who speak English "less than well" estimate	214	6%	12th	No
Percentile Ranking for Theme Summary				
72nd				

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	456	3%	67th	No
Mobile homes estimate	3666	24.20%	69th	No
At household level, more people than rooms estimate	320	2.40%	50th	No
Households with no vehicle available estimate	1484	11.30%	94th	Yes
Persons in institutionalized group quarters estimate	2387	6.70%	90th	No
Percentile Ranking for Theme Summary				
99th				

Stanly County

US Census Tract FIPS: 37167
Estimated Total Population: 60,610
Estimated Total Housing Units: 27,282
2016 Overall SVI Score: 0.7526 – high level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	7,306
Estimated daytime population	54,981

Socioeconomic Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Persons below poverty estimate (ACS 2012-2016)	10047	17.10%	35th	No
Civilian (age 16+) unemployed estimate	3066	10.30%	67th	No
Per capita income estimate	22103		52th	No
Person (age 25+) with no high school diploma	6380	15.30%	37th	No
Percentile Ranking for Theme Summary				
73rd				

Household Composition/Disability Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Persons aged 65 and older estimate	10605	17.50%	48th	No
Persons aged 17 and younger estimate	13280	21.90%	52th	No
Civilian non-institutionalized population with a disability estimate	9390	15.90%	37%	No
Single parent household with children under 18 estimate	2150	9.10%	52nd	No
Percentile Ranking for Theme Summary				
57th				

Minority Status/Language Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Minority (all persons except white, non-Hispanic) estimate	11203	18.50%	30th	No
Person (age 5+) who speak English "less than well" estimate	607	1.10%	34th	No

Percentile Ranking for Theme Summary
59th

Housing/Transportation Theme				
Measure	Number	Percentage	Percentile Rank	SVI Flags
Housing in structures with 10 or more units estimate	347	1.30%	32nd	No
Mobile homes estimate	3590	13.20%	17th	No
At household level, more people than rooms estimate	753	3.20%	86th	No
Households with no vehicle available estimate	1595	6.80%	61st	No
Persons in institutionalized group quarters estimate	2059	3.40%	75th	No
Percentile Ranking for Theme Summary				
74th				

Union County

US Census Tract FIPS: 37179
Estimated Total Population: 217,614
Estimated Total Housing Units: 76,549
2016 Overall SVI Score: 0.1824 – low level of vulnerability

Uninsured in the total civilian noninstitutionalized population estimate	24,057
Estimated daytime population	175,486

Socioeconomic Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons below poverty estimate (ACS 2012-2016)	20772	9.70%	3rd	No
Civilian (age 16+) unemployed estimate	7538	6.80%	15th	No
Per capita income estimate	31185		5th	No
Person (age 25+) with no high school diploma	14873	10.80%	10th	No
Percentile Ranking for Theme Summary				
24th				

Household Composition/Disability Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Persons aged 65 and older estimate	24625	11.30%	8th	No
Persons aged 17 and younger estimate	61945	28.50%	99th	Yes
Civilian non-institutionalized population with a disability estimate	20390	9.40%	3th	No
Single parent household with children under 18 estimate	5895	8.20%	35th	No
Percentile Ranking for Theme Summary				
17th				

Minority Status/Language Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Minority (all persons except white, non-Hispanic) estimate	57816	26.60%	44th	No
Person (age 5+) who speak English "less than well" estimate	6037	3%	83th	No
Percentile Ranking for Theme Summary				

80th

Housing/Transportation Theme				
Measure	**Number**	**Percentage**	**Percentile Rank**	**SVI Flags**
Housing in structures with 10 or more units estimate	1270	1.70%	40th	No
Mobile homes estimate	4266	5.60%	7th	No
At household level, more people than rooms estimate	1551	2.10%	42nd	No
Households with no vehicle available estimate	1762	2.40%	0	No
Persons in institutionalized group quarters estimate	2127	1%	16th	No
Percentile Ranking for Theme Summary				
5th				

Appendix G: MHPC Strategic Plan 2017-2022

FY 2017-2018		
PRIORITIES	**OBJECTIVE**	**ACTIVITIES**
Sustainability	Develop a Coalition that is considered essential to emergency preparedness and response by the Members	• Engage the Member leadership in the development and maintenance of the MHPC • Develop initiatives relevant to Member needs • Develop and share the value of MHPC membership
Regional Capability Assessment of Essential Healthcare Services	Support regional development needs of essential healthcare needs	• Develop benchmarks for necessary capabilities • Assess the current capabilities and capacity of the MHPC through a survey and site visits • Integrate the information into the strategic plan
Evacuation/ Shelter in Place	Enhance the capacity of the region to evacuate a healthcare facility or shelter in place	• Facilitate a working group of regional partners to develop and implement a plan for evacuation/ shelter in place • Develop a resource database on the MHPC website
Situational Awareness/ Operational Support	Enhance situational awareness and incident support in a standardized manner across the region	• Facilitate a Situational Awareness working group • Evaluate current communication tools and develop recommendations for use or remediation • Develop an operational information sharing plan/ process for utilization during daily and crisis operations • Maintain the Regional Healthcare Support Cell
At Risk Populations Planning	Enhance preparedness of Licensed Care Facilities	• Conduct emergency management workshops • Develop relationships with 5 new regional/ state organizations to expand the reach of the education • Develop relationships with 10 licensed care facilities • Develop a resource database on the MHPC website
Regional Exercise Program	Develop regional exercise program that all partners are able to participate in	• Continue to develop LTC Exercise Education program • Connect local EM and LTC for county-based exercises • Develop TEPW by sub-regions for specific healthcare partners • Identify individual partner exercise plans/needs/goals

FY 2018-2019		
PRIORITIES	**OBJECTIVE**	**ACTIVITIES**
Sustainability	Develop a Coalition that is considered essential to emergency preparedness and response by the Members	• Continue to engage the Member leadership in the development and maintenance of the MHPC • Continue initiatives relevant to Member needs • Continue to share the value of MHPC membership
Regional Capability Assessment of Essential Healthcare Services	Support regional development needs of essential healthcare needs	• Assess benchmarks for necessary capabilities • Continue to assess the current capabilities and capacity of the MHPC through a survey and site visits • Integrate the information into the strategic plan
Evacuation/ Shelter in Place	Enhance the capacity of the region to evacuate a healthcare facility or shelter in place	• Facilitate a working group of regional partners to develop and implement a plan for evacuation/ shelter in place • Develop draft based on MHPC role and partners role • Maintain a resource database on the MHPC website
Situational Awareness/ Operational Support	Enhance situational awareness and incident support in a standardized manner across the region	• Facilitate a Situational Awareness working group • Evaluate current communication tools and develop recommendations for use or remediation • Update and maintain an operational information sharing plan/ process for utilization during daily and crisis operations • Maintain the Regional Healthcare Support Cell
At Risk Populations Planning	Enhance preparedness of Licensed Care Facilities	• Conduct emergency management workshops • Maintain relationships with 5 new regional/ state organizations to expand the reach of education • Develop relationships with 10 licensed care facilities • Maintain and further develop a resource database on the MHPC website
Regional Exercise Program	Develop regional exercise program that all partners are able to participate in	• Assist in region LTC education and exercises • Facilitate local EM/LYC exercise planning meeting • Consolidate sub-regional exercises • Continue to identify individual partner exercise plans/needs/goals

FY 2019-2020		
PRIORITIES	**OBJECTIVE**	**ACTIVITIES**
Sustainability	Develop a Coalition that is considered essential to emergency preparedness and response by the Members	• Continue to engage the Member leadership in the development and maintenance of the MHPC • Continue initiatives relevant to Member needs • Continue to share the value of MHPC membership
Regional Capability Assessment of Essential Healthcare Services	Support regional development needs of essential healthcare needs	• Assess benchmarks for necessary capabilities • Continue to assess the current capabilities and capacity of the MHPC through a survey and site visits • Integrate the information into the strategic plan
Evacuation/ Shelter in Place	Enhance the capacity of the region to evacuate a healthcare facility or shelter in place	• Facilitate a working group of regional partners to develop and implement a plan for evacuation/ shelter in place • Develop education and training • Maintain a resource database on the MHPC website
Situational Awareness/ Operational Support	Enhance situational awareness and incident support in a standardized manner across the region	• Facilitate a Situational Awareness working group • Evaluate current communication tools and develop recommendations for use or remediation • Update and maintain an operational information sharing plan/ process for utilization during daily and crisis operations • Maintain the Regional Healthcare Support Cell
At Risk Populations Planning	Enhance preparedness of Licensed Care Facilities	• Conduct emergency management workshops • Create coalition workgroup for education guidance • Compile data from 2017-2020 for guidance needs • Maintain resource database on MHPC website
Regional Exercise Program	Develop regional exercise program that all partners are able to participate in	• Provide exercise education • Tabletop exercise for Continuing Care Facilities • Assist regional partners in creating exercise plans based of shared calendar • Develop TEPW of Continuing Care Facilities in sub-regions • Begin TTX series

FY 2020-2021		
PRIORITIES	**OBJECTIVE**	**ACTIVITIES**
Sustainability	Develop a Coalition that is considered essential to emergency preparedness and response by the Members	• Continue to engage the Member leadership in the development and maintenance of the MHPC • Continue initiatives relevant to Member needs • Continue to share the value of MHPC membership
Regional Capability Assessment of Essential Healthcare Services	Support regional development needs of essential healthcare needs	• Assess benchmarks for necessary capabilities • Continue to assess the current capabilities and capacity of the MHPC through a survey and site visits • Integrate the information into the strategic plan
Evacuation/ Shelter in Place	Enhance the capacity of the region to evacuate a healthcare facility or shelter in place	• Facilitate a working group of regional partners to develop and implement a plan for evacuation/ shelter in place • Provide education that will assist in full-scale exercise • Maintain a resource database on the MHPC website
Situational Awareness/ Operational Support	Enhance situational awareness and incident support in a standardized manner across the region	• Facilitate a Situational Awareness working group • Evaluate current communication tools and develop recommendations for use or remediation • Update and maintain an operational information sharing plan/ process for utilization during daily and crisis operations • Maintain the Regional Healthcare Support Cell
At Risk Populations Planning	Enhance preparedness of Licensed Care Facilities	• Continue emergency management education as needed • Continue to develop Long Term Care guidance • Maintain resource database on MHPC website
Regional Exercise Program	Develop regional exercise program that all partners are able to participate in	• Maintain annual exercise calendar and regional meetings • Develop AARs from previous training and exercises • Develop consolidated Continuing Care exercises based on sub-regions • Develop regional full-scale exercise

FY 2021-2022		
PRIORITIES	**OBJECTIVE**	**ACTIVITIES**
Sustainability	Develop a Coalition that is considered essential to emergency preparedness and response by the Members	• Continue to engage the Member leadership in the development and maintenance of the MHPC • Continue initiatives relevant to Member needs • Continue to share the value of MHPC membership
Regional Capability Assessment of Essential Healthcare Services	Support regional development needs of essential healthcare needs	• Assess benchmarks for necessary capabilities • Continue to assess the current capabilities and capacity of the MHPC through a survey and site visits • Integrate the information into the strategic plan
Evacuation/ Shelter in Place	Enhance the capacity of the region to evacuate a healthcare facility or shelter in place	• Assess through Full-scale exercise if plan is viable • Improve and correct as needed • Maintain a resource database on the MHPC website
Situational Awareness/ Operational Support	Enhance situational awareness and incident support in a standardized manner across the region	• Facilitate a Situational Awareness working group • Evaluate current communication tools and develop recommendations for use or remediation • Update and maintain an operational information sharing plan/ process for utilization during daily and crisis operations • Maintain the Regional Healthcare Support Cell
At Risk Populations Planning	Enhance preparedness of Licensed Care Facilities	• Continue emergency management education as needed • Review and finalize statewide LTC education • Maintain resource database on MHPC website
Regional Exercise Program	Develop regional exercise program that all partners are able to participate in	• Maintain annual exercise calendar and regional meetings • Assess new plans/needs/goals and apply to regional calendar • Merge all partners into one calendar for reference • AAR Development and Process Improvement

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