

The Central Virginia Healthcare Coalition (“Coalition”) is a collaboration of healthcare organizations and providers, public health departments, and community partners working together to care for our community before, during and after an emergency.

**MISSION/PURPOSE**

The Central Virginia Healthcare Coalition endeavors to develop and promote the emergency preparedness, mitigation, response and recovery capabilities of local healthcare entities by:

* Strengthening community medical resiliency, surge capacity and capabilities
* Building relationships and partnerships
* Developing emergency preparedness, mitigation, response and recovery capability guidelines
* Facilitating communication, information and resource sharing
* Maximizing utilization of existing resources
* Coordinating training, drills, and exercises
* Guiding and supporting the function of the Regional Healthcare Coordinating Center

 **GEOGRAPHIC BOUNDRIES**

The Coalition is an inclusive body open to all organizations/entities that provide or support health services within the following 27 jurisdictions of Central Virginia that wish to work collaboratively on emergency preparedness, mitigation, response and recovery activities: Amelia County, Brunswick County, Buckingham County, Charles City County, Charlotte County, Chesterfield County, City of Colonial Heights, Cumberland County, Dinwiddie County, City of Emporia, Goochland County, Greensville County, Halifax County, Hanover County, Henrico County, City of Hopewell, Lunenburg County, Mecklenburg County, New Kent County, Nottoway County, City of Petersburg, Powhatan County, Prince Edward County, Prince George County, City of Richmond, Surry County, Sussex County.

**ORGANIZATION/STRUCTURE**

The Coalition has:

1. Membership that includes core and partner organizations and entities.
2. A Regional Healthcare Coordinator and other staff for day to day operations.
3. A Chair and Vice Chair whose duties are outlined in Section III.
4. An Executive Council to conduct Coalition business as directed by the membership.
5. Subcommittees and workgroups as requested and organized by the membership that will function temporarily or long-term, as needed.

The Coalition provides representation to the Virginia Hospital and Healthcare Association’s (VHHA) Hospital Emergency Management Committee (HEMC). HEMC and VHHA provide direct support and liaison to the Virginia Department of Health (VDH) in its administration of the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) Cooperative Agreement. Two HEMC members are designated as representatives by majority vote of the Coalition.

**FUNDING**

The Coalition receives some direct funding for activities, operations and staff through grants from the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Cooperative Agreements. A Coalition member’s time during Coalition planning and activities is compensated by their organization without reimbursement. The Coalition recognizes the strong need to identify sustainment funding sources.

**CENTRAL VIRGINIA HEALTHCARE COALITION BYLAWS**

1. **MEMBERSHIP**
2. **Core Organizations**
3. Core organization members of the Central Virginia Healthcare Coalition are listed in Appendix A.
4. Core organizations sign an annual *Organizational Memorandum of Understanding* with the Central Virginia Healthcare Coalition.
5. Core organizations appoint one primary and one alternate representative to the Coalition. The representative will have the authority to represent and speak on behalf of the core organization.
6. Core organization representatives serve term lengths as determined by the sponsoring organization.
7. Core organization representatives are eligible to fill Executive Council positions.
8. If an individual representing a core organization withdraws from participation, the core organization will appoint a new representative within 60 days.
9. Individuals may represent more than one core organization, but must clearly be acting in the interests of each represented core organization independently.
10. **Partner Organizations**
	1. Partner organization membership to the Central Virginia Healthcare Coalition is open to the organization types listed in Appendix B that are located within the Coalition’s geographical boundaries.
	2. Partner organizations appoint one primary and one alternate representative to the Coalition. The representative will have the authority to represent and speak on behalf of the partner organization.
	3. Partner organization representatives serve term lengths as determined by the sponsoring organization.
	4. Partner organization representatives are ~~not~~ eligible to fill Executive Council positions.
11. **Invited Guests**

Central Virginia collaborating organizations and subject matter experts may be invited to attend Coalition meetings and activities. Such invited organizations may fully engage in Coalition discussions and other activities, but have no vote.

1. **Member Responsibilities:**
2. Provide representation at Coalition meetings and activities.
3. Participate in collaborative regional preparedness planning.
4. Participate in the development of surge capacity plans, inter-organizational agreements, and collaborative emergency response plans.
5. Contribute to meeting Coalition priorities, goals, and contractual deliverables.
6. Vote on questions placed before the membership.
7. Respond to regional emergencies and disasters in collaboration with other members.
8. Guide and support the activities and operations of the Regional Healthcare Coordination Center.
9. Work to implement emergency preparedness and response capability guidelines within the organization’s activities.
10. **Membership Roster**

A current roster of member organizations, including core or partner designation and contact information, will be maintained. The roster will be published with the agenda of each Coalition meeting. A meeting attendance roster of member organizations will also be maintained.

1. **Changes in Member Representation**

All changes in member representation must be submitted in writing to the Coalition, endorsed by the representative’s organizational senior leadership.

1. **MEETINGS and VOTING**
2. **Scheduling**

Coalition meetings will be scheduled on the fourth Friday of each month at 9:00 a.m. Electronic notice and agendas for all meetings shall be transmitted at least 5 working days in advance of the meetings.

1. **Venue**

Meetings will be held at locations convenient for members. Web conferencing and online meetings are allowed.

1. **Attendance**

Meetings may be attended in person or by conference call.

1. **Emergency meetings**

Emergency meetings may be convened at the request of the Coalition Chair provided that electronic notice is given to each member at least 48 hours prior to the proposed meeting stipulating the time, place and objective of the meeting. No business may be transacted at an emergency meeting except that specified in the notice.

1. **Quorum**

Fifty percent (50%) of core organization members is a quorum. Attendance of the meeting virtually through conference call is acceptable toward a quorum.

1. **Conducting Business and Voting**
	1. A quorum is necessary to conduct official Coalition business at a meeting (except as noted in F.3).
	2. Actions in a meeting will be determined by a simple majority vote (except for bylaw changes as noted in section V).
		1. Each core membership organization will have one vote. (See Appendix C- CVHC Organizational Chart)
		2. The following partner organizations shall have one vote per the following organizational categories:
			1. Long Term Care
			2. Dialysis
			3. Supply Chain, Blood Services and Pharmaceuticals
			4. Hospice and Home Health
			5. Behavioral Health
			6. Primary Care, Community Health and Out Patient Clinics
			7. Volunteer Organizations Active in Disasters (VOADS)
			8. Community Based Organizations (CBOs)
			9. Health Educational Institutions
		3. Voting on ASPR/HPP budget and financial issues is restricted to ~~Hospital~~ eligible core and partner ~~member~~ organization members.
		4. Attendance, as defined in II.C, by a representative of the core member organization at two (2) of the last four (4) meetings (excluding emergency meetings) is required to vote.
	3. If a quorum is not present at a meeting, business will take place under the condition that any motions put forth to a vote will be presented to absent Coalition core organization members via email, conference call or other electronic means in order to receive a quorum vote. A reasonable amount of time will be allowed for receipt of absentee votes. Votes will be received no more than 5 business days from the date of the meeting. Notice will be sent no later than the next business day following the meeting. Such special votes will only be held if discussion has occurred at a previous meeting. If a quorum is not obtained the motion fails.
	4. Proxy voting is allowed. Attendance requirements apply to proxy votes. Proxy instructions must be sent to the Coalition Chair in writing prior to the meeting.

1. **LEADERSHIP**
2. **Coalition Chair**
3. Election
	1. The Chair will be elected for a two year term for each fiscal year by the core organization members.
	2. To be eligible to stand for election the individual will be a representative of a core organization, have attended two (2) of the last four (4) Coalition meetings, and may not be a paid staff member of the Coalition.
	3. The Vice Chair will be placed into nominations for Chair on the agenda of the November meeting agenda for action and election during the December meeting.
		1. A motion from the floor for additional candidate nominations may be brought up for a vote before the Coalition.
		2. With a passed motion to call for additional nominations, the floor will be opened for additional nominations to the position of Chair.
		3. Only individuals accepting a nomination will be considered for election.
		4. A motion to close nominations must be made and passed to officially identify the individuals nominated for Chair at the December meeting.
	4. In the event of the unexpected departure, resignation, or removal from office, the Vice Chair replaces the Chair, subject to a ratification of the membership at the next meeting.
4. Duties
	1. Chairs Coalition Meetings.
	2. Reviews and approves meeting agendas.
	3. Works closely with the Regional Healthcare Coordinator on current issues concerning the Coalition.
	4. Creates an environment that encourages and rewards cooperation, collective problem-solving and participative decision-making.
	5. Available to the membership for information exchange concerning the Coalition.
	6. Acts in the general interests of the Coalition and its membership.
	7. Assumes additional duties from time to time and as appropriate to facilitate the function of the Coalition.
5. **Coalition Vice Chair**
6. The Vice Chair will be elected for a two year term for each calendar year by the core organization members.
7. To be eligible to stand for election the individual will be a representative of a core organization, have attended two (2) of the last four (4) Coalition meetings, and may not be a paid staff member of the Coalition.
8. The names of individuals nominated for Vice-Chair will be listed on the November meeting agenda for action, prior to the election taking place during the December meeting.
9. Duties same as Chair except Vice Chair will not chair Coalition meetings unless Chair is absent.
10. Acts for the Chair in his/her absence or unavailability.
11. **Regional Healthcare Coordinator**
12. Hired or contracted by the Central Virginia Healthcare Coalition Executive Council with endorsement by the Virginia Hospital and Healthcare Association.
13. Responsible for management, day to day operations, and administrative support of the Coalition.
14. Supervise the Regional Healthcare Coordination Center (RHCC) Manager, Medically Vulnerable Populations Coordinator, Preparedness, Exercise and Training Coordinator and other coalition staff.
15. **Executive Council**

The Executive Council is comprised of the Chair, Vice-Chair, Past Chair (if available), and three (3) representatives at-large. If the Past Chair is unavailable or unwilling to serve, this position can be replaced with an additional representative at-large for a total of four (4) representatives at-large.

1. Election
2. To be eligible to stand for election to the Executive Council a member representative must have attended two (2) of the last four (4) Coalition meetings.
3. Elections for membership to the Executive Council will occur during the first meeting of the fiscal year.
4. Any new vacancies on the Executive Council will be filled as soon as possible by vote of the core organization members.
5. The current Executive Council may place nomination(s) for vacant position(s) on the agenda of the last meeting for action by the membership.
6. Nominations from the floor to stand for Executive Council may be made by core organization members during the last meeting of the year.
7. Executive Council members will serve for two years. (However, the first election will designate two positions that will serve for only one year in order that subsequent terms will be staggered.)
8. There is no limit to the number of successive terms an Executive Council member may serve.
9. If a fourth (4th) representative at-large is in position when the current Chair’s term expires, then the current Chair will move into the Past Chair position. The fourth (4th) member at-large will remain in place on the Executive Council until their term expires.
10. Duties and Scope of Responsibilities
	1. Lead the strategic planning process and continued development of the Coalition.
	2. Provide budgetary oversight.
	3. Provide oversight on development of regional and health sector emergency preparedness plans.
	4. Provide oversight of Coalition subcommittees, workgroups and projects.
11. **SUBCOMMITTEES and OTHER GROUPS**

The Coalition may establish subcommittees and workgroups to perform such tasks and duties as deemed appropriate by the Coalition. Members are appointed to subcommittees and workgroups as approved by the Coalition Chair and subject to approval of the core membership. The following standing workgroups have been established to ensure the operations and activities of the Coalition are maintained:

1. Budget Workgroup
2. Clinical Workgroup \*
3. Preparedness, Exercise and Training Workgroup
4. Logistical and Resource Management Workgroup
5. Regional Healthcare Coordinating Center Workgroup

\*The clinical work group shall be comprised of at least one medical doctor (MD) to meet the ASPR HPP guidance and this MD shall be listed as the Clinical Workgroup’s primary advisor.

1. **AMENDING THE BYLAWS**

Amendment of these bylaws may be proposed at any meeting of the Coalition. The amendment shall be acted on at the following meeting provided a copy of such proposed amendment(s) are distributed at least thirty (30) days in advance of such meeting or fully stated at the first meeting, and attached to the electronic notice for that meeting. A two-thirds majority vote is required for the amendment to carry.

1. **PARLIMENTARY PROCEDURE**

Except as described herein, the current edition of Roberts Rules of Order, will be used to guide the conduct of any Coalition meeting.

1. **LEGAL DISCLAIMER**

Indemnification and Limits of Liability

This Charter and Bylaws shall not be interpreted or construed to create an association, joint venture separate legal entity or partnership among the Coalition members or to impose any partnership obligation or liability upon any Coalition member. Further, no Coalition member shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other Coalition member.

No Coalition member shall be required under this Charter to indemnify, hold harmless and defend any other Coalition member from any claim, loss, harm, liability, damage, cost or expense caused by or resulting from the activities of any Coalition officers, employees, or agents acting in bad faith or performing activities beyond the scope of their duties. In the event of any liability, claim, demand, action or proceeding, of whatever kind or nature arising out of participation in a unified health and medical response to an emergency, the Coalition member agrees to indemnify, hold harmless, and defend, to the fullest extent of the law, each Coalition member, whose only involvement in the transaction or occurrence which is the subject of such claim, action, demand, or other proceeding, is the approval of this Charter.

This Charter and Bylaws shall not supersede any existing mutual aid agreement or agreements.

APPROVAL OF CHARTER and BYLAWS: The Charter and Bylaws are adopted by a 2/3rds vote of the Central Virginia Healthcare Coalition core organization membership.

Date Approved:

Chair: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

Name: \_\_\_\_**Mike Beshada**\_\_\_\_\_\_\_\_\_\_\_\_\_

Vice Chair: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

Name: \_\_\_\_**Carrie Davis**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVHC 11/22/2019**Appendix A**

**Central Virginia Healthcare Coalition Core Members**

**(As of 7/1/19)**

**Hospital Organization Members**

1. Bon Secours Memorial Regional Medical Center
2. Bon Secours Richmond Community Hospital
3. Bon Secours St. Francis Medical Center
4. Bon Secours St. Mary’s Hospital
5. Centra Southside Community Hospital
6. CJW Chippenham Hospital
7. CJW Johnston Willis Hospital
8. Henrico Doctors Hospital
9. John Randolph Medical Center
10. McGuire Veterans Affairs Medical Center
11. Parham Doctors Hospital
12. Retreat Doctors Hospital
13. Sentara Halifax Regional Hospital
14. Southern Virginia Regional Medical Center
15. Southside Regional Medical Center
16. VCU Community Memorial Hospital
17. VCU Health System

**Public Health Organization Members**

1. Local Public Health Districts within the Coalition’s geographical boundaries
2. Central Region Public Health Emergency Coordinator

**Appendix B**

**Central Virginia Healthcare Coalition Partner Members**

**(As of 7/1/19)**

1. Long Term Care Facilities
2. Veterans Administration Health Centers
3. Mental/Behavioral Health Providers & Agencies
4. Richmond Regional Planning District Commission
5. Community Pharmacies
6. Community Dialysis Clinics/Organizations
7. Primary Care Providers
8. Community Health Centers
9. Volunteer Organizations (Non-EMS and/or Fire Organizations) Active in Disaster (VOAD)
10. Community-based Organizations (CBOs)
11. Health Educational Institutions
12. Emergency Public Safety Answering Points (PSAPs), Emergency Communications Centers, 911 Centers within the Coalition’s geographical boundaries
13. Emergency Medical Services and/or Fire Protection Services that provide initial emergency medical services within the Coalition’s geographical boundaries

**Appendix C**

CVHC Members and Partners Organizational Chart