

Access the recorded webinar here: <https://attendee.gotowebinar.com/recording/256769356898835472>

Access speaker bios here:

<https://files.asprtracie.hhs.gov/documents/establishing-mocc-for-covid-19-webinar-speaker-bios.pdf>

Access Q and A here: <https://files.asprtracie.hhs.gov/documents/aspr-tracie-ta-mocc-webinar-qa-final.pdf>



Establishing Medical Operations Coordination Cells (MOCCs) for COVID-19

April 24, 2020

Unclassified//For Public Use

1



ASPR TRACIE: Three Domains



- Self-service collection of audience-tailored materials
- Subject-specific, SME-reviewed “Topic Collections”
- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences



asprtracie.hhs.gov



- Personalized support and responses to requests for information and technical assistance
- Accessible by toll-free number (1844-5-TRACIE), email (askasprtracie@hhs.gov), or web form (ASPRtracie.hhs.gov)



1-844-5-TRACIE



- Area for password-protected discussion among vetted users in near real-time
- Ability to support chats and the peer-to-peer exchange of user-developed templates, plans, and other materials



askasprtracie@hhs.gov



Resources

- [ASPR TRACIE COVID-19 Page](#)
 - [Critical Care Surge Resources](#)
 - [Hospital Triage/ Screening Resources](#)
 - [Regional Support Resources](#)
- [ASPR COVID-19 Page](#)
- [CDC COVID-19 Page](#)
- [Coronavirus.gov](#)



T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Moderator:
Meghan Treber, MS
ASPR TRACIE

Unclassified//For Public Use



T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Melissa Harvey, RN, MSPH

Hospital Team Lead, Healthcare Resilience Task Force; Director, Health System Management, Office of the Chief Medical Officer, U.S. Department of Homeland Security



Executive Summary

Some hospitals are **overwhelmed with COVID-19 patients**, while successful mitigation has created **excess capacity** in nearby hospitals, **creating an opportunity to transfer patients**

MOCCs are a **strategy to optimize patient distribution** by augmenting EOCs with clinical experts that **synthesize and coordinate healthcare capacity**

The MOCC strategy can be **implemented nationwide** (at sub-state, state-, and regional levels), through a modifiable toolkit, technical assistance, and federal funding, **permitting flexibility for states while optimizing patient distribution**



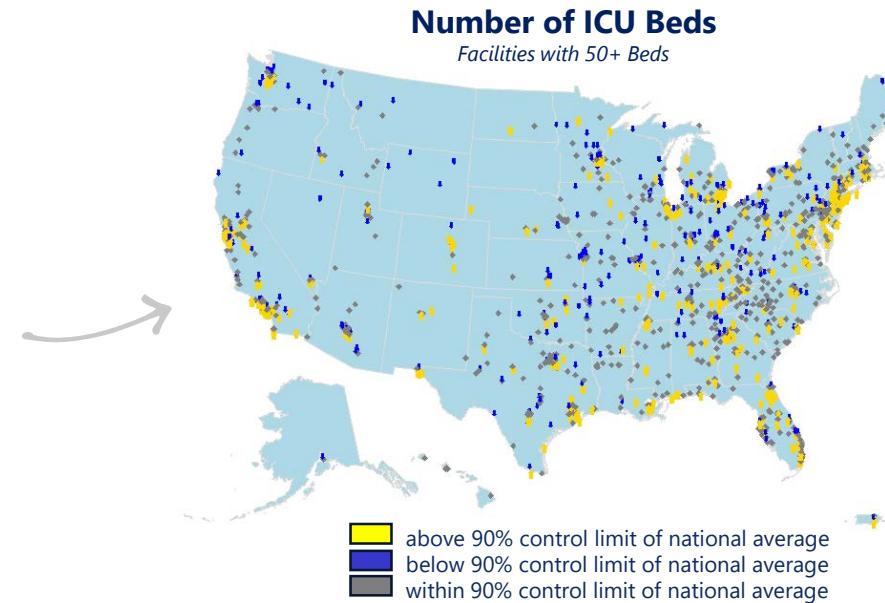
FEMA

MOCCs | Problem Statement

COVID-19 has resulted in asymmetrical hospital utilization: certain regions' healthcare systems have experienced a surge in patients, while others have excess capacity.

What are we seeing?

- Hospitals are the **preferred location for seriously ill** COVID-19 patients, due to existing patient care expertise and resources
- Most hot spots are **geographically localized**, overwhelming local healthcare facilities
- While some facilities are overwhelmed, **successful mitigation in neighboring areas has created excess capacity** in nearby hospitals, creating an opportunity to transfer patients



Patient transfer coordination, through dedicated staffing and data collection/analysis, can improve patient allocation at the sub-state, state, and federal levels

A MOCC AIMS TO:

Move **patients, staff, and supplies**



to the right **provider**



at the right **time**, in the right **way**

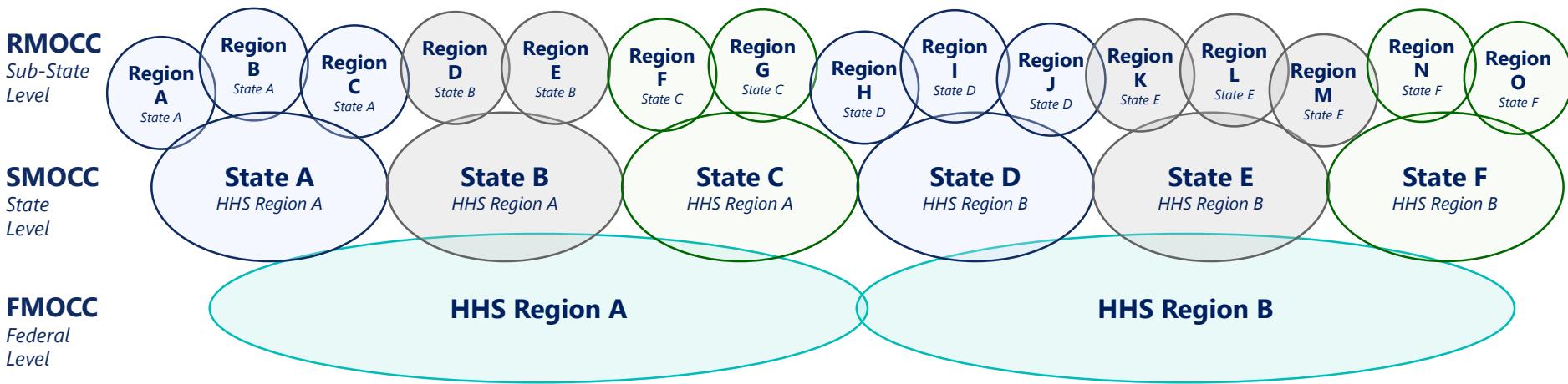


to **improve patient well-being**



MOCCs | Concept

MOCCs can be activated at the Sub-State Regional, State, and Federal levels to facilitate patient movement and resource allocation during a surge event. There are three types of MOCCs included in the concept: sub-state, Regional Medical Operations Coordination Centers (RMOCCs), State Medical Operations Coordination Centers (SMOCCs), and Federal Medical Operations Coordination Centers (FMOCCs).



Patient transfer coordination activity originates with the RMOCC. The SMOCC can help transfer patients to a facility in a neighboring sub-state region. The FMOCC can transfer patients to a neighboring state or Federal HHS Region if that is closer.



FEMA

MOCCs | General Activity Summary

MOCCs are cells within emergency operations centers (EOCs) at the sub-state, regional, state, and federal levels (FEMA/HHS regions) that facilitate patient movement and resource allocation.

MOCC PRIORITIES

- **Adding clinical staff** to existing EOCs and RRCCs
- **Establishing stakeholder agreements** that allow for collecting data regarding health system capacity, synthesizing the data to understand the needs of the system, and determining areas of the system that may be overwhelmed.
- **Facilitating movement of patients, staff, and supplies** between healthcare facilities and/or states

MOCC ROLE

- Acting as a **single point of contact (POC)** for requests from multiple stakeholders such as healthcare facilities, RMOCCs, and SMOCCs
- **Reviewing, facilitating, and processing patient movement, staffing, and supply requests and providing medical consultation** to facilitate the decompression of health systems

MOCC DATA ACTIVITIES

- **Collecting, analyzing and disseminating information** to and from stakeholders to develop comprehensive situational awareness
- **Establishing protocols, systems, and triggers** to inform operational planning, stakeholder communications, and transfer decision making



The MOCCs Toolkit contains information on funding a MOCC, standard operating procedures for each type of MOCC, including integration with ESF-8, roles and responsibilities, staffing, and transport coordination.



FUNDING

- FEMA Public Assistance
- FEMA Mission Assignment
- ASPR Hospital Preparedness Program
- CDC Public Health Emergency Preparedness/Crisis Agreement



STANDARD OPERATING PROCEDURES

- RMOCC
- SMOCC
- FMOCC

Each MOCC SOP includes details on:

- *MOCC Integration with ESF-8*
- *Roles and Responsibilities*
- *Staffing*
- *Operations*
- *Patient Movement/Medical Resource Sharing*



TRANSPORT COORDINATION

- Transportation workflows and transfer checklists

The MOCCs Toolkit will be located on [ASPR TRACIE](#)



T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Steven Mitchell, MD, FACEP

Medical Director, Western Washington Regional COVID Coordination Center;
Medical Director, Emergency Department, Harborview Medical Center

Western Washington MOCC

- First US COVID-19 case Jan 21
 - Snohomish County, WA
- First US COVID-19 death Feb 29
 - King County, WA
- First major outbreak late Feb/March¹
 - 167 cases at Long-Term Care Facility
 - 101 residents, 50 staff, and 16 visitors
 - 43 deaths

1. Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington N Engl J Med 2020 Mar 27

King County LTCF Outbreak

The New York Times

'It's Pure Panic': A Wrenching Wait at Nursing Home Where Coronavirus Took Hold

Cut off from their relatives inside a virus-stricken nursing center, families are frantically searching for help and basic information.

THE WALL STREET JOURNAL



One Nursing Home, 35 Coronavirus Deaths:
Inside the Kirkland Disaster

Single LTCF - Single Hospital

- Overwhelmed
- No coordination
- Not isolated example

Characteristics and Outcomes of 21 Critically Ill Patients With COVID-19 in Washington State

Matt Arentz, MD¹; Eric Yim, MD²; Lindy Klaff, MD²; et al

[□Author Affiliations](#) | [Article Information](#)

JAMA. Published online March 19, 2020. doi:10.1001/jama.2020.4326

Medical Operations Coordinating Cell

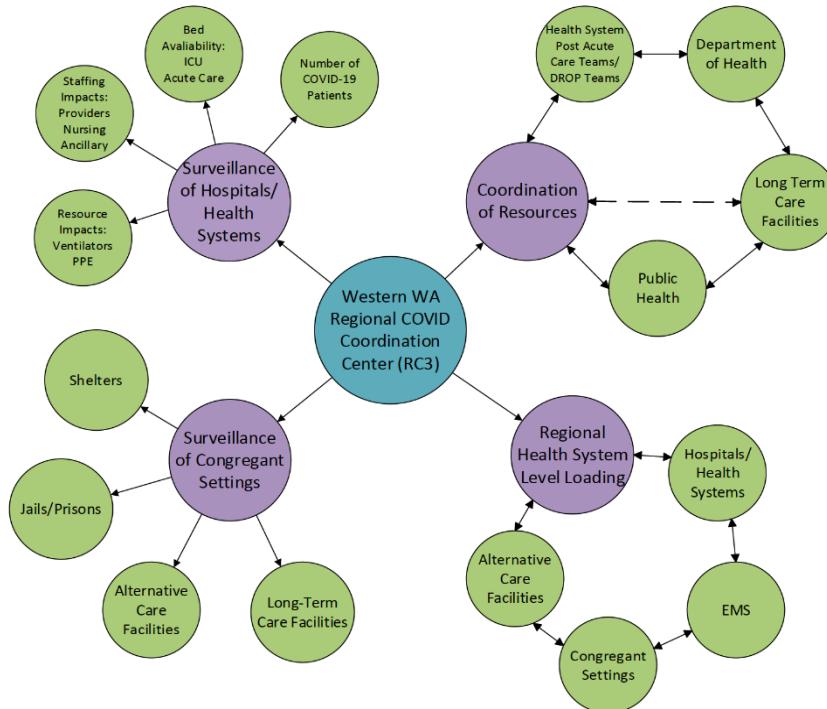
- Disaster Medical Coordination Center



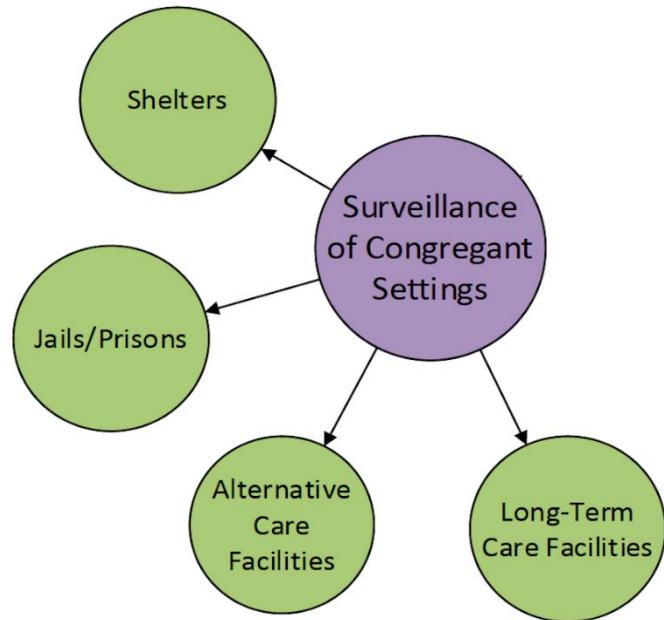
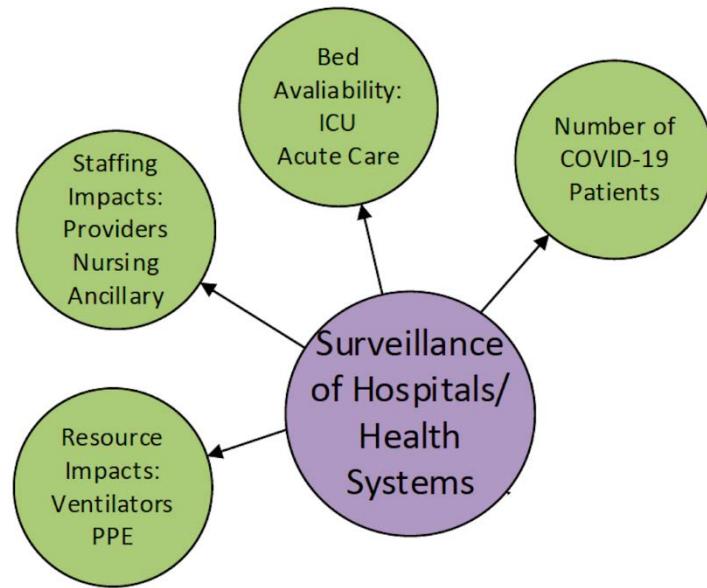
- Regional COVID Coordination Center (RC3)
 - Harborview Medical Center/King County
 - Northwest Health Response Network



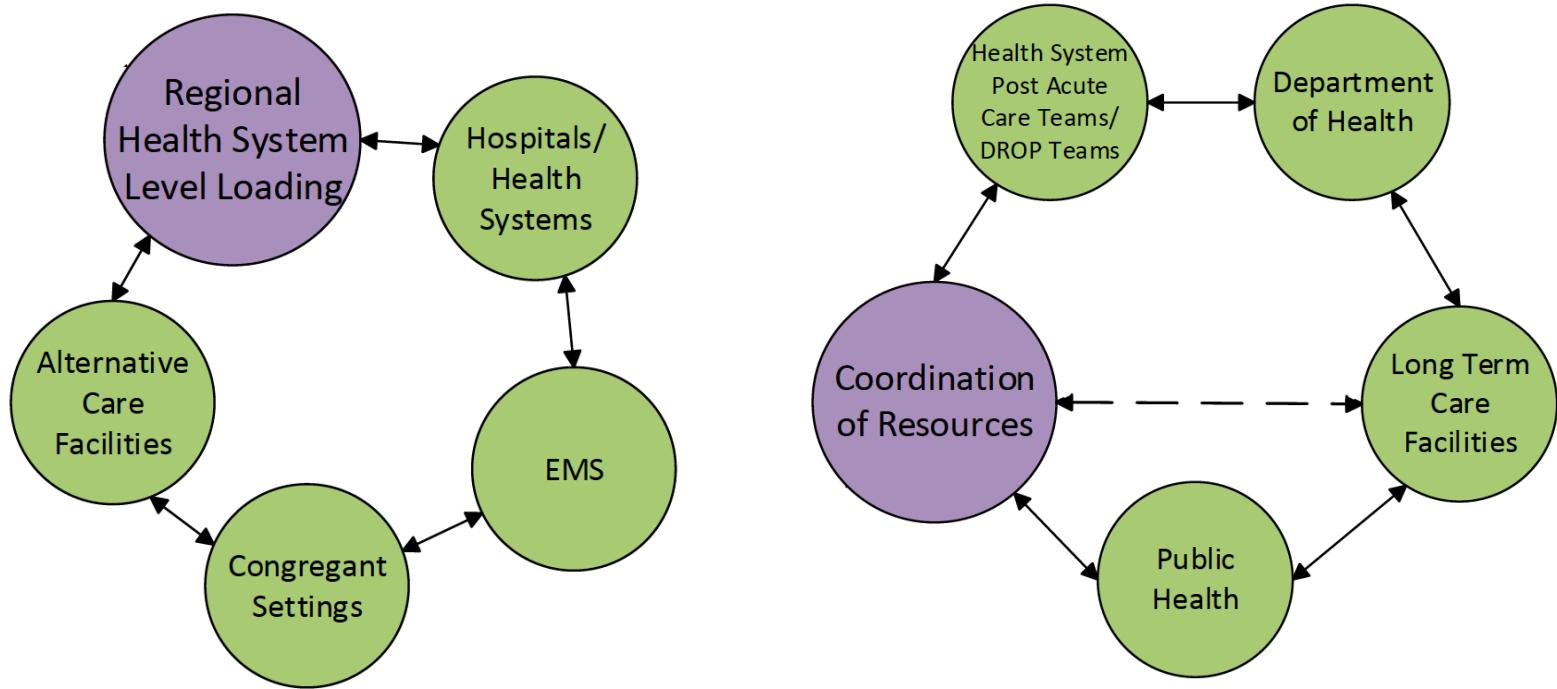
Regional COVID Coordinating Center – Western Washington



Two Surveillance Pillars of the RC3

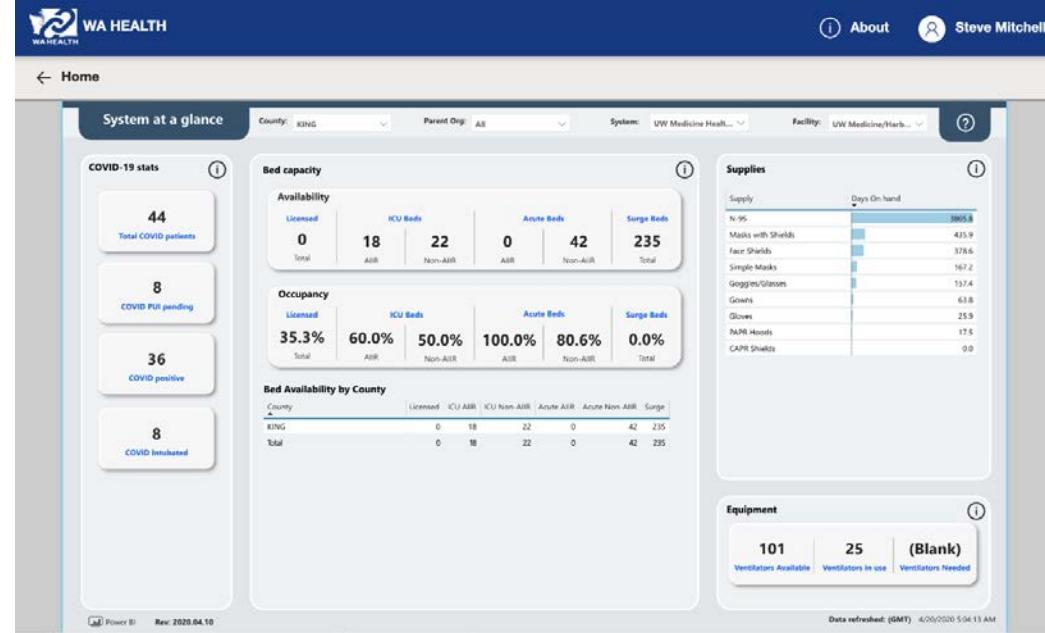


Two Coordination Pillars of the RC3



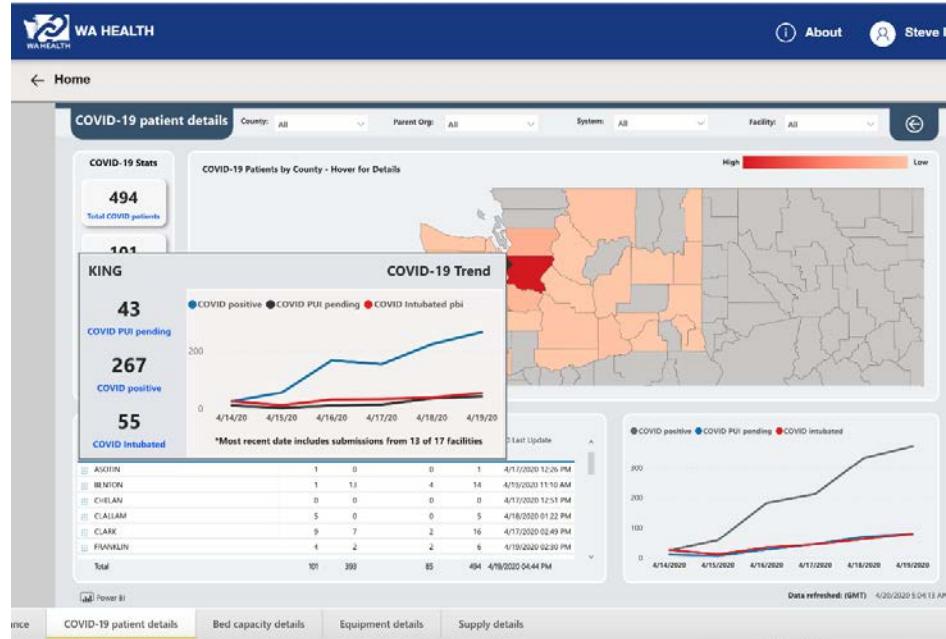
Emergency Response Platform - Microsoft

- Constrained Resources
 - Staffing
 - Beds
 - Critical Care
 - Acute Care
 - Equipment
 - Ventilators
 - PPE
 - COVID-19 patients



Emergency Response Platform - Microsoft

- Next Release
 - Long Term Care Facilities
 - COVID-19 Impacts
 - Positive Patients
 - Positive Health Care Workers
 - » % of staff impacted
 - PPE availability





T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

William Fales, MD, FACEP, FAEMS

Medical Director, Division of EMS and Trauma, Michigan Department of
Health and Human Services

Unclassified//For Public Use

22



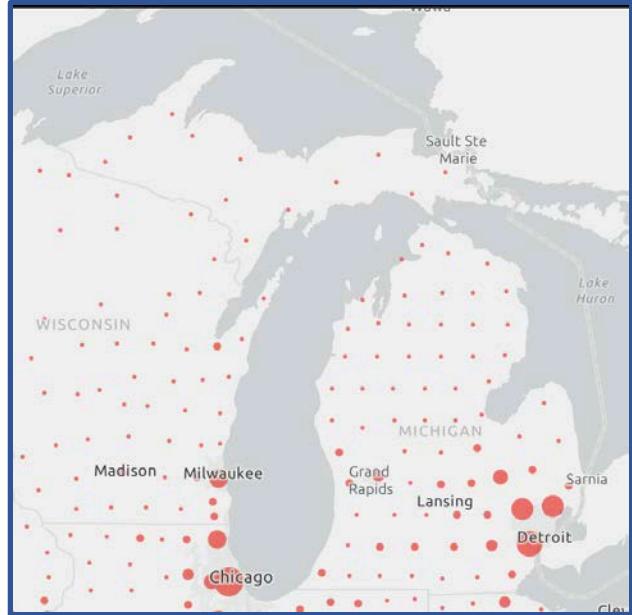
Michigan's Healthcare Preparedness Program

- Michigan Department of Health and Human Services
 - Bureau of EMS, Trauma, and Preparedness
- 8 Regional Healthcare Coalitions
 - Hospitals, EMS, LPH, EM, LTC, Tribal Health
 - Regional Coordinator, Assistant Coordinator, Medical Director (.25 FTE)
 - Regional Medical Coordination Center
 - Multi-Agency Coordination Center
 - Statewide use of EMResource by hospitals, EMS



Michigan COVID-19

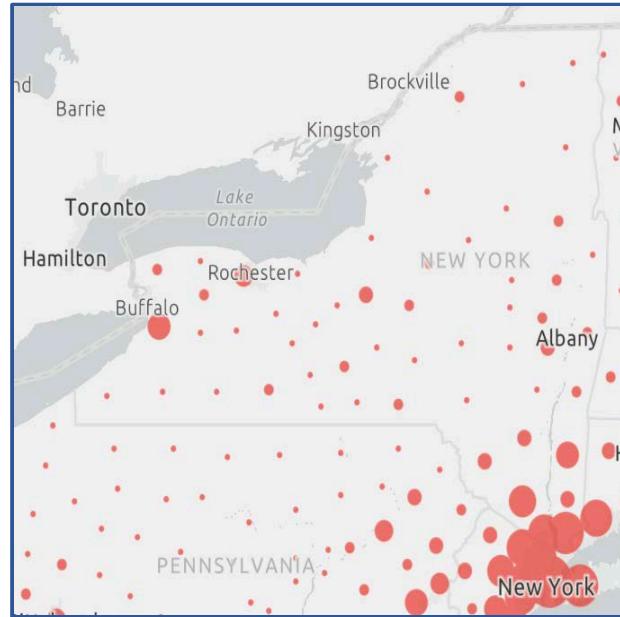
- First 2 cases – March 10
- Asymmetric epidemiology
 - SE Michigan – Extreme Activity
 - Rest of Michigan – Sporadic Activity
 - Comparable to other states
- Extreme conditions in SE MI
 - Peak hospitalizations: >4,400
 - 12-days with >1000 on ventilation
 - 1,223 on ventilation on one day
 - Peak intubations in 1 day: 176



Source: John Hopkins Coronavirus Resource Center
(Retrieved 4/21/2020)

Michigan COVID-19

- First 2 cases – March 10
- Asymmetric epidemiology
 - SE Michigan – Extreme Activity
 - Rest of Michigan – Sporadic Activity
 - Comparable to other states
- Extreme conditions in SE MI
 - Peak hospitalizations: >4,400
 - 12-days with >1000 on ventilation
 - 1,223 on ventilation on one day
 - Peak intubations in 1 day: 176

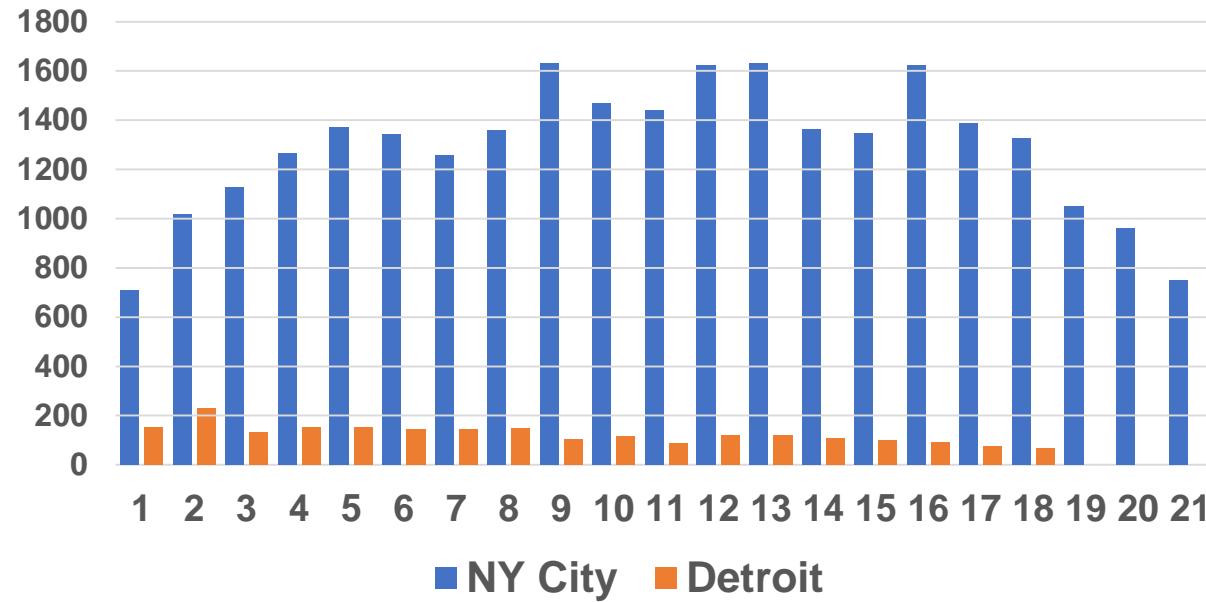


Source: John Hopkins Coronavirus Resource Center
(Retrieved 4/21/2020)



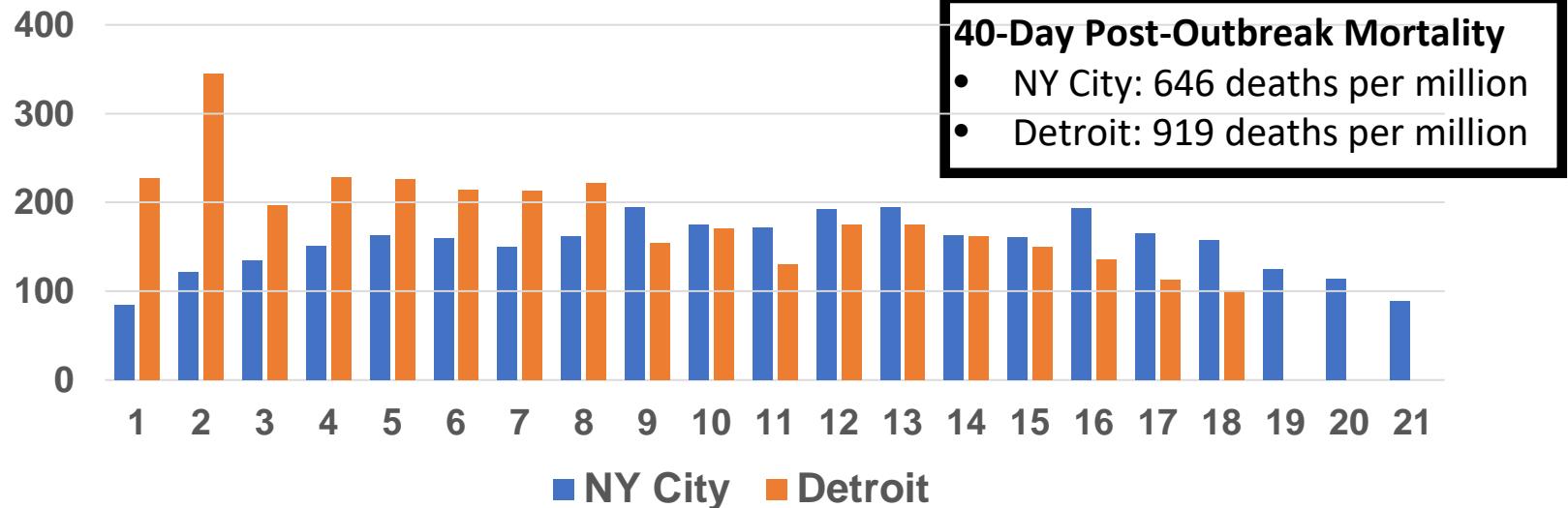
Detroit vs. New York City

COVID-19 Daily Hospital Admissions New York City vs. Detroit



Detroit vs. New York City

COVID-19 Daily Hospital Admissions
Per 1 Million Population
New York City vs. Detroit



40-Day Post-Outbreak Mortality

- NY City: 646 deaths per million
- Detroit: 919 deaths per million

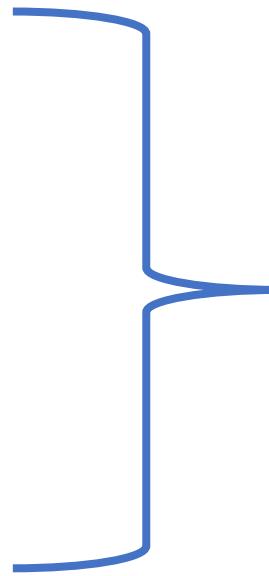
Michigan Healthcare Surge

Strategy Goal

- Save lives and reduce pain and suffering by optimizing the use of the state's healthcare resources
 - Extend conventional standards of care to as many patients as possible
 - Minimize the need for crisis standards of care
 - Especially while conventional capacity exists

Michigan Healthcare Surge Strategy Components

- Relief Hospitals
- Alternate Care Sites
 - Home Care Sites
 - Relief Personnel



Relief Hospitals vs. Alternate Care Sites

- **Relief Hospitals:** The objective is to extend the conventional standard of care to as many citizens in need as possible (i.e., minimize the need to move into crisis standards of care).
- **Alternate Care Sites (ACS):** The objective is to deliver crisis standards of care (as close to the conventional standard of care as possible) in extreme conditions in which the conventional standard of care can not be provided at overloaded hospitals.

Relief Hospital “Ask”

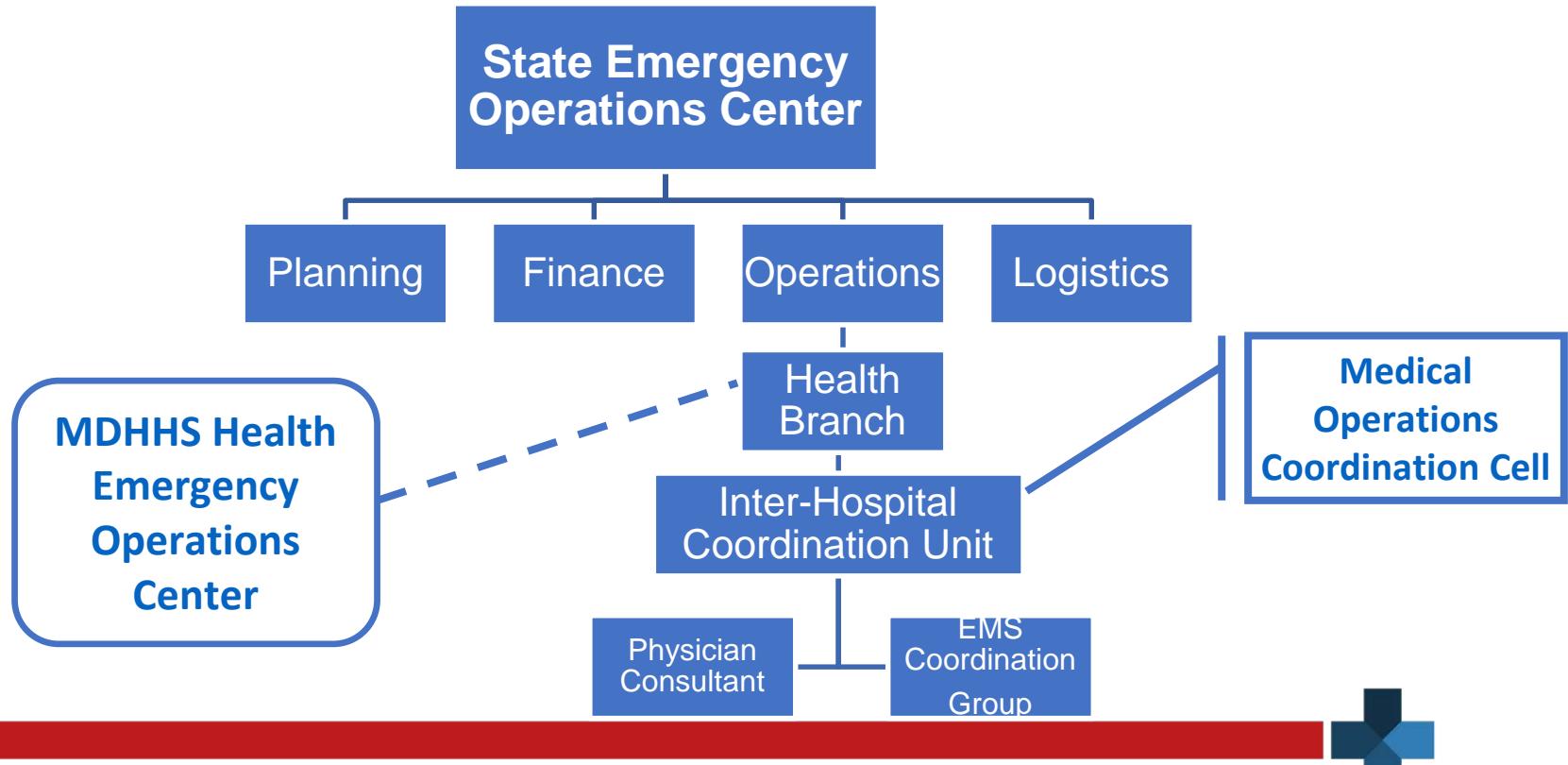
- Hospitals have been previously asked to be able to surge an additional 20% above average daily census
 - Increased to 50% “super surge”
- Relief Hospitals provide 10% of their expanded capacity to assist severely impacted hospitals
 - While preserving 50% of super-surge capacity
 - Many hospitals at very low census

Relief Hospitals and Patient Redistribution

- **Intra-Health System Transfer**
 - Coordinated by specific health system
- **Intra-Regional Transfer**
 - Coordinated by Regional Medical Coordination Center
- **Statewide Transfer**
 - Coordinated by Inter-Hospital Coordination Unit
 - AKA: Medical Operations Coordination Cell (MOCC)



Statewide Inter-Hospital Coordination Unit



MOCCs and Patient Redistribution

Regional Medical Coordination Center

- Relief hospitals declare status on EMResource
- RMCC receives request from transferring hospital
- RMCC identifies Relief Hospital(s)
- Transferring hospital contacts Relief Hospital directly
- Relief Hospital accepts patient(s)
- RMCC coordinates EMS PRN

Statewide Inter-Hospital Coordination Unit

- Relief hospitals declare status on EMResource
- IHCU receives request from RMCC on behalf of transferring hospital
- IHCU identifies Relief Hospital(s)
- Transferring hospital contacts Relief Hospital directly
- Relief Hospital accepts patient(s)
- IHCU coordinates EMS PRN

EMResource Relief Hospital Participation

	1. Critical Care Bed - COVID-19	2. Critical Care Bed - non-COVID-19	3. Non-Critical Care Bed - COVID-19	4. Non-Critical Care Bed - non-COVID-19	Willing to Take COVID-19 Patients	Willing to Take Non-COVID-19 Patients	Comment
	0	0	0	7	No	Yes	
	22	0	0	0	Yes	Yes	ABCC Google Doc ABC
	4	4	16	24	Yes	Yes	
	1	1	5	5	Yes	Yes	No ICU to ICU transfer -
th Ctr	40	8	8	10	Yes	Yes	ABCC Google Sheet AE
	1	0	5	5	Yes	Yes	All transfers are to be co
	68	13	34	51	N/A	N/A	
	1. Critical Care Bed - COVID-19	2. Critical Care Bed - non-COVID-19	3. Non-Critical Care Bed - COVID-19	4. Non-Critical Care Bed - non-COVID-19	Willing to Take COVID-19 Patients	Willing to Take Non-COVID-19 Patients	Comment
nton	0	0	0	0	No	No	
	0	0	24	3	No	No	Already exceeding critical c
e	--	--	--	--	No	No	Already exceeding critical c
	0	0	0	0	No	No	
	--	--	--	--	No	No	Already exceeding critical c
	0	--	--	--	No	No	Already exceeding critical c
	0	0	0	10	No	Yes	

MOCC-Facilitated vs Direct Contact Transfers

MOCC Facilitated

- Hospital has need to transfer
- Regional /State MOCC contacted
- EMResource reviewed by MOCC to identify Relief Hospitals
- MOCC connects transferring hospital to Relief Hospital
- Relief Hospital accepts patient(s)
- MOCC coordinates EMS PRN

Direct Contact

- Hospital has need to transfer
- Regional /State MOCC bypassed
- EMResource reviewed by hospital to identify Relief Hospitals
- Transferring hospital contacts Relief Hospital directly
- Relief Hospital accepts patient(s)
- MOCC coordinates EMS PRN

Patient Redistribution – 5 Key Elements

- Transferring Hospitals
- Coordinating entity (MOCCs)
- Situational awareness platform (EMResource)
- EMS
- Relief Hospitals



Relief Hospital Recruitment Challenges

Why were so many hospitals in minimally impacted regions resistant to accept patients?

- Fear of impending “storm”
 - “It’s just a matter of time till we’re Detroit”
- Fear of introducing bringing COVID-19 into their hospital

Need for Epidemiologic Intelligence

Michigan Patient Transfers (4/1 to 4/20)

	SE MI	SC/EC MI	West and North MI						
Region	2N	2S	1	3	5	6	7	8	TOTAL
Transferred In	322	457	41	27	38	15	34	25	959
Transferred Out	275	443	46	54	24	20	20	15	897

**~15% via MOCC-Facilitated / ~85% VIA Direct Contact
~30% Intra-System Transfers**

MOCCs in Michigan

- Role: Facilitation not control
- Staffing at State MOCC
 - Experienced paramedics / EMS control center
 - Remote component to SEO
- Physician role
 - Consultative, problem solving, medical leadership
- Use of statewide hospital status application essential
 - Allows hospitals to connect directly



Summary

- Relief Hospital concept works
- Statewide MOCC successful in coordinating transfers
- EMResource serves as an invaluable tool for identifying Relief Hospitals
- Decentralized approach where hospitals in need contact hospitals with capacity requires minimal central coordination
- Recruitment of Relief Hospitals can be challenging





TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

Ronald Stewart, MD

Chair, Department of Surgery, UT Health San Antonio, Long School of Medicine

Eric Epley, Executive Director/ CEO

Southwest Texas Regional Advisory Council for Trauma (STRAC)

Regional Disaster Response in Texas: Implementation of the RMOC Concept

Ronald M. Stewart, Eric Epley, Brian Eastridge, Dudley Wait, Joe Palifini, Dave Miramontes, Craig Cooley, Donald Jenkins, and the Southwest Texas Regional Advisory Council Team

and

Texas Emergency Medical Task Force Region Leaders

ASPR Tracie Webinar, April 24, 2020

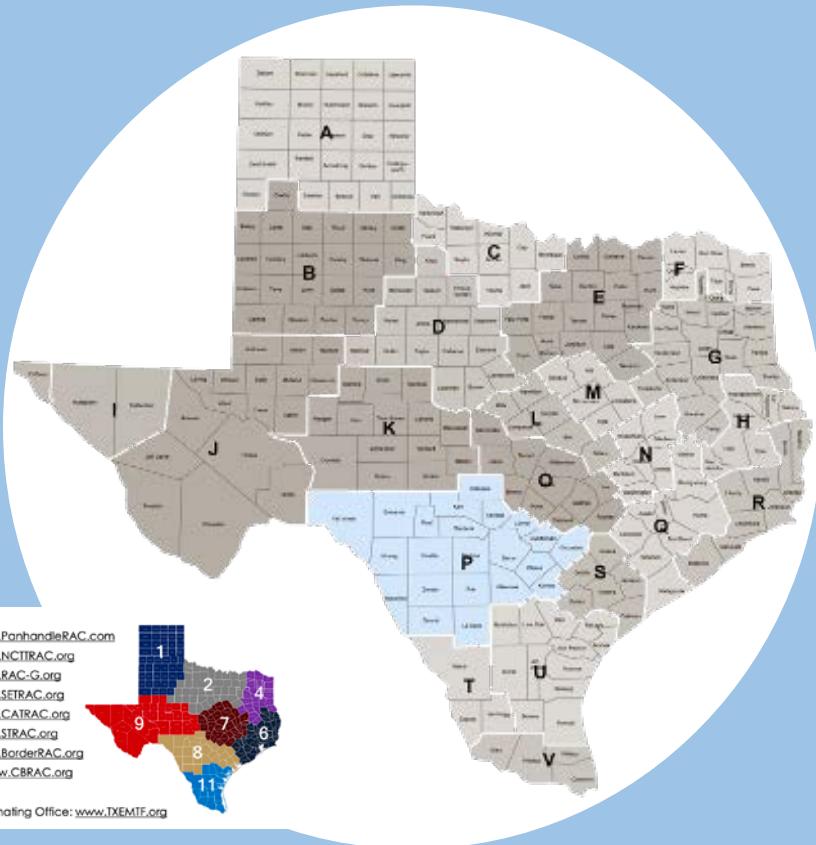


Introduction



- Trauma system development
 - Routine, multiple small-scale disasters
 - Structured cooperation and communication
- Trauma system infrastructure for
 - Disaster
 - Stroke, STEMI, Mental Health, Perinatal
- Trauma System Complete Evolution to Emergency Health Care System—Will use Trauma System and Emergency Health Care System interchangeably
 - Health Care Coalition
 - Right Patient ☐ Right Place ☐ Right Time

THE TEXAS TRAUMA SYSTEM



22 TRAUMA SERVICE AREAS



REGIONAL ADVISORY COUNCILS



TRAUMA CENTER DESIGNATIONS



STANDARDS OF CARE



HOSPITAL PREPAREDNESS GRANTS



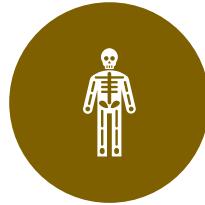
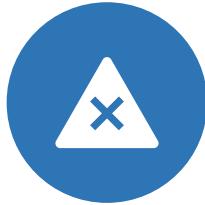
CONSISTENCY THROUGHOUT
URBAN, SUBURBAN, RURAL AND
FRONTIER

EHC System Complex Problem Solving

- Maximally inclusive with respect to stakeholders
- Dialogue and consensus centered upon:
 - What's the right thing to do for the patient or population being served?
- Timely
 - Structured cooperation
 - Communication – Robust and redundant
 - Actionable data
- Bias for action
- Performance improvement processes



911 Commission



1) FAILURE OF
IMAGINATION

2) FAILURE OF
POLICY
(A FAILURE TO
HAVE THE RIGHT
INFRASTRUCTURE
IN PLACE)

3) FAILURE OF
CAPABILITY
(A FAILURE TO
HAVE THE RIGHT
RESOURCES)

4) FAILURE OF
MANAGEMENT
(THE FAILURE TO
COORDINATE THE
AVAILABLE
RESOURCES, AND
INFRASTRUCTURE)

Challenge of Large-Scale Disaster Preparation and Management

Our Experience

A functioning regional trauma (EHC) system provides the framework for an effective response to large-scale disasters

Education and drills are not enough

**Linked regional medical operations centers (or MOCCs)
critical to effective disaster response from all causes**

Managing Wide-Scale Disasters



Acute Health Care System

- Critical for emergency response and treatment of acute illness or injury
- Mostly private and public mix
- Services to individuals
- Distributed and complex network of providers
- Decisions made clinically within minutes to hours



Public Health System

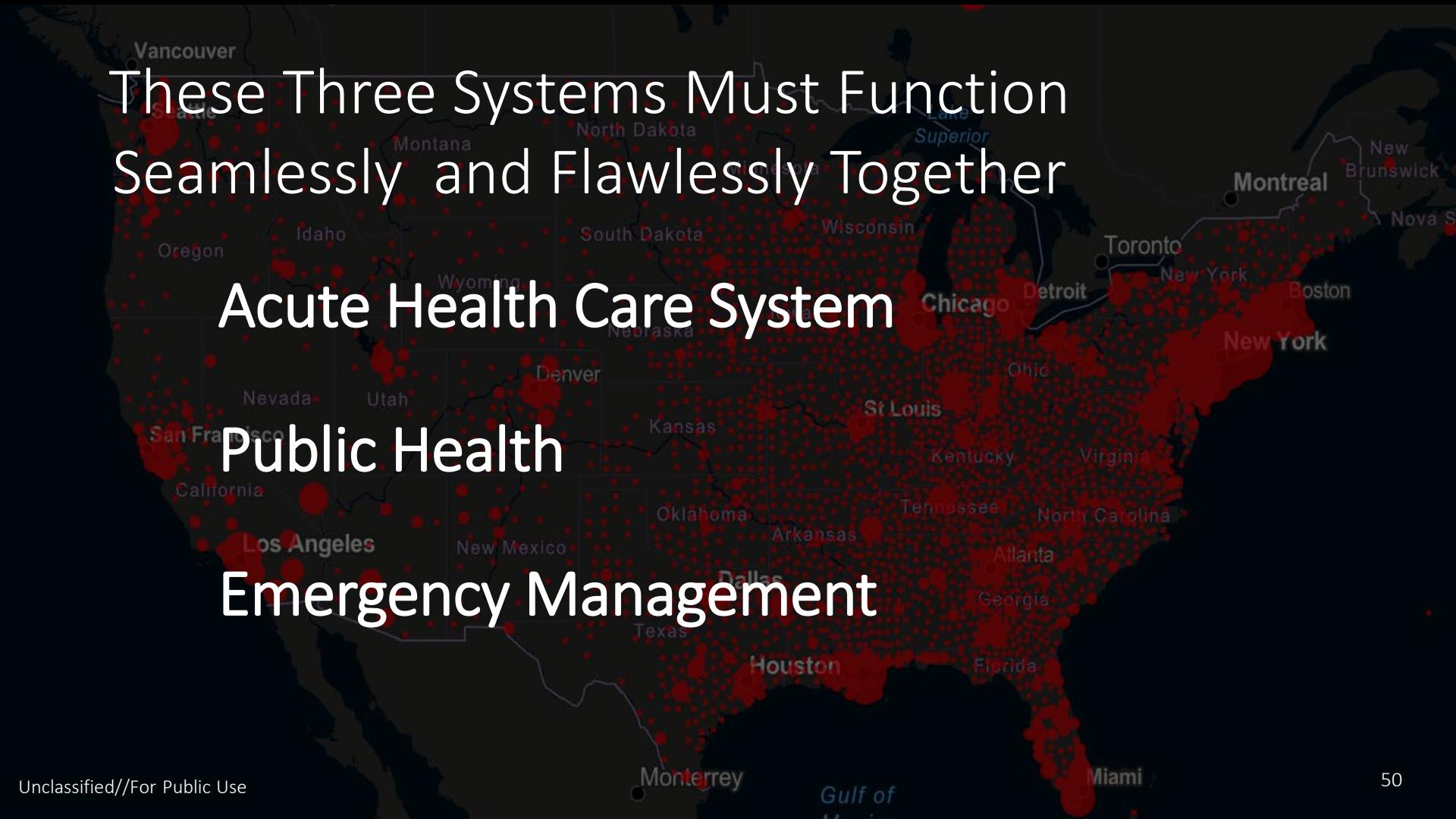
- Largely responsible for most significant health improvements
- Safety and wellbeing of populations
- Multidisciplinary science
- Mainly public with centralized communication
- Decisions with deliberation and testing usually takes days



Emergency Management System

Local
State
Federal Emergency Management Response





These Three Systems Must Function
Seamlessly and Flawlessly Together

Acute Health Care System

Public Health

Emergency Management

Problems Common to Disasters

Must have a credible and workable solution to each of these problems—if we are to improve disaster response

Communications failures

Unworkable and untested plans

Lack of coordinated response

MEDCOM

- Trauma Transfers-500/mo
- Air Medical Management
- Trauma Team Paging
- MCI load-balancing
- Navigation of mental health patients via Law Enforcement directly to psychiatric facilities



How to Integrate Disaster Acute Care and Public Health Systems?

- Trauma MEDCOM Communications Center
 - Regional Medical Operations Center
- Integrated with Local Emergency Operations Center (EOC)
- Linked to State Emergency Operations Center
- Linked to Federal Emergency Management System

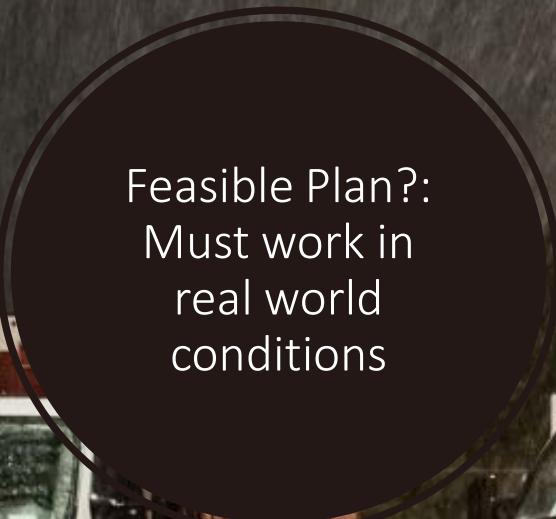
Regional Medical Operations Center (RMOC)

Upregulated MEDCOM—dramatically enhanced data and comm
Functional for 17 years in San Antonio

- Essential elements
 - Formal agreements insuring collaboration
 - Representatives of all major stakeholders in one room-physical or virtual
 - Formal communication link to the Emergency Operations Centers (EOC)
 - Fault tolerant communications systems
 - Software systems –WebEOC software
 - Monitor and coordinate all critical hospital capacity
 - Monitor all critical public health data
 - Monitor and coordinate all critical EMS agencies
- Direct tie to the EOC and SOC
- EMTF function—Ability to physically expand and adapt: Emergency Medical Task Forces & Mobile Medical Units



Regional Medical Operations Center (RMOC)

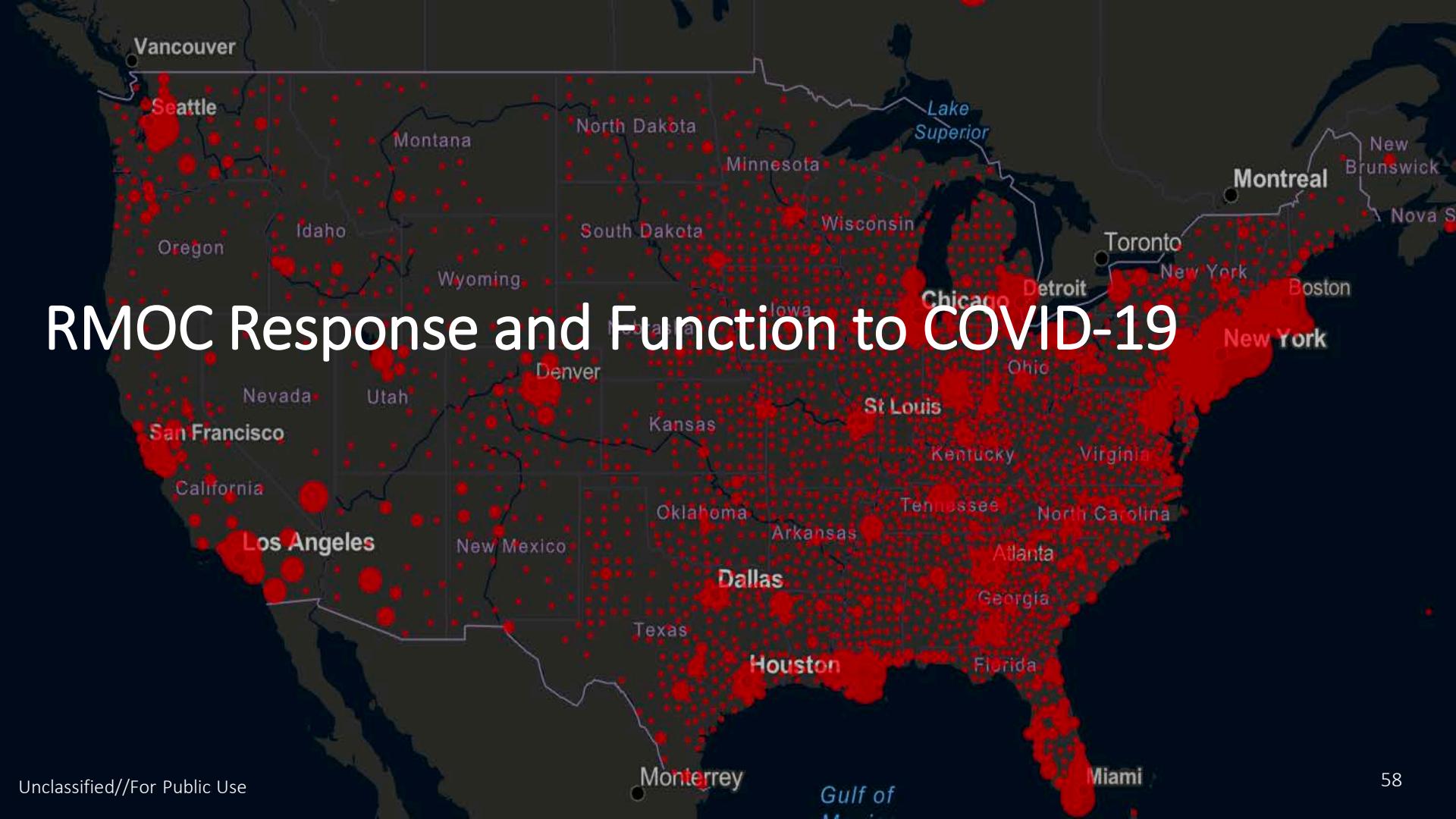


Feasible Plan?:
Must work in
real world
conditions



RMOC Abilities and Advantages

- Situational Awareness—Regional Consciousness
- Virtual expansion of bed capacity
 - Distribute to all regional facilities—not just a few –Many Hands Make Light Work
 - Proven many times over 15 years—distribution of 1,000s of patients over a few days
- Enables health care regional response teams
 - Multi-agency rescue teams—swift water rescue, etc.
 - Mobile medical units—temporary hospital replacements or augments
- Load balancing during a surge of patients
- Network with other regions –8 RMOC equivalents in Texas
- Integration of Public Health, Acute Care and Disaster Management Systems



RMOC Response and Function to COVID-19

INTERNAL REPORT - PHI DATA

This report contains Protected Health Information and is not intended for public distribution.



Date	All Healthcare Systems								
	COVID+ Patients	COVID+ in ICU	COVID+ on Ventilator	Available Vents	Total Vents	Available Vents %	Available Staffed Beds	Total Staffed Beds	Available Staffed Beds %
04/21/2020	82	41	24	554	713	78%	1,752	4,730	37%
04/20/2020	81	41	25	514	710	72%	1,792	4,700	38%
04/19/2020	81	41	24	555	704	79%	1,635	4,707	35%

Healthcare System Stress Score



Participating HCS: [REDACTED]
COVID Data as of 0815, 21-Apr-20
Vent/Bed Data as of 0910, 21-Apr-20

San Antonio Healthcare Systems COVID-19 Patient Count

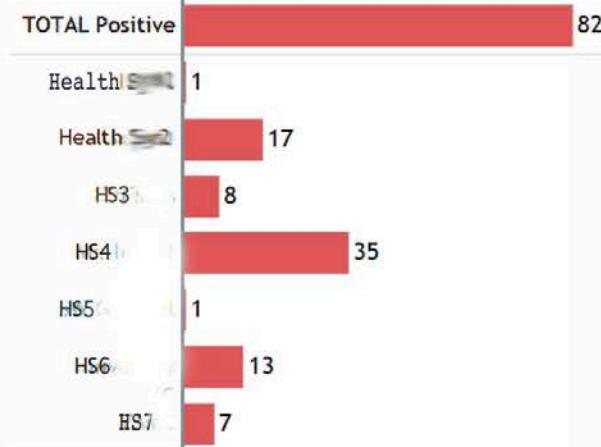
Systems Reporting Daily Morning Data

Health Sys1 Health Sys2 HS3 HS4 HS5 HS6 HS7

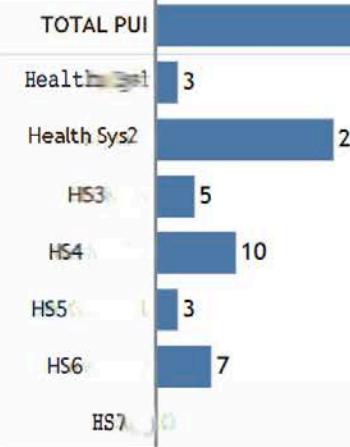
Tuesday, April 21, 2020



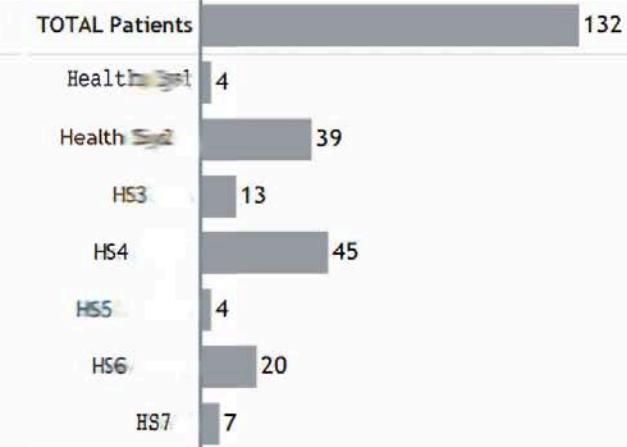
Positive Patients on 4/21/2020



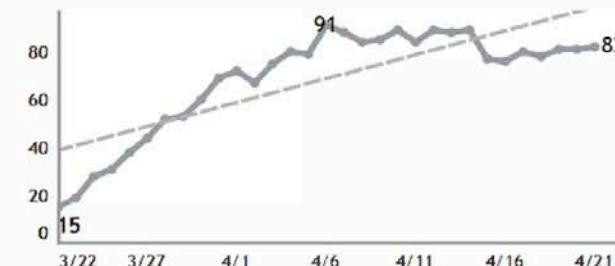
PUI Patients on 4/21/2020



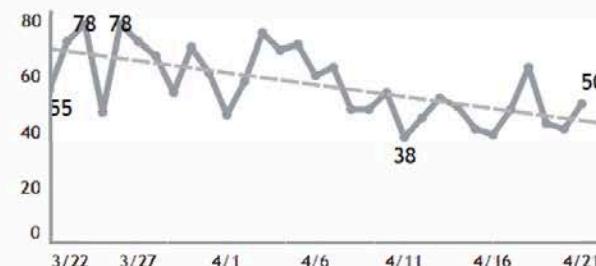
TOTAL Patients on 4/21/2020



Positive Patients Trend 3/22/2020 - 4/21/2020



PUI Patients Trend 3/22/2020 - 4/21/2020



TOTAL Patients Trend 3/22/2020 - 4/21/2020



HOSPITALS: Due **DAILY**, 09:00 hrs

Hospital PPE / IDR Materials Status

Medical Dashboard (Bed and Ventilator Status)

<https://eris.strac.org/eoc7/>

EMS: Due **WEEKLY**, Friday 12:00 hrs

<https://www.surveymonkey.com/r/EMSPPE2>

ALL OTHER Coalition and ARHC Members: Due **WEEKLY**, Friday 12:00 hrs

<https://www.surveymonkey.com/r/RMOCPPEQuery>

(Data Compiled @ 19:00 04/12/20)

Number of Regional Hospitals Reporting PPE Shortfall & Days Remaining Until Depletion				
1-4 Days	5 – 7 Days	8 – 11 Days	12 – 14 Days	15+ Days
0	0	8	14	5

*Data derived from facilities “Hospital PPE / IDR Materials Status” – Facilities listed, have indicated a disruption in their supply chain for any of the following PPE: N95s, Surgical Masks, Gowns, Gloves, Face Shields, Goggles

Weekly COVID-19 Update

Epidemiology Program



CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

1,015
Total Cases Reported

39
Total Deaths Reported

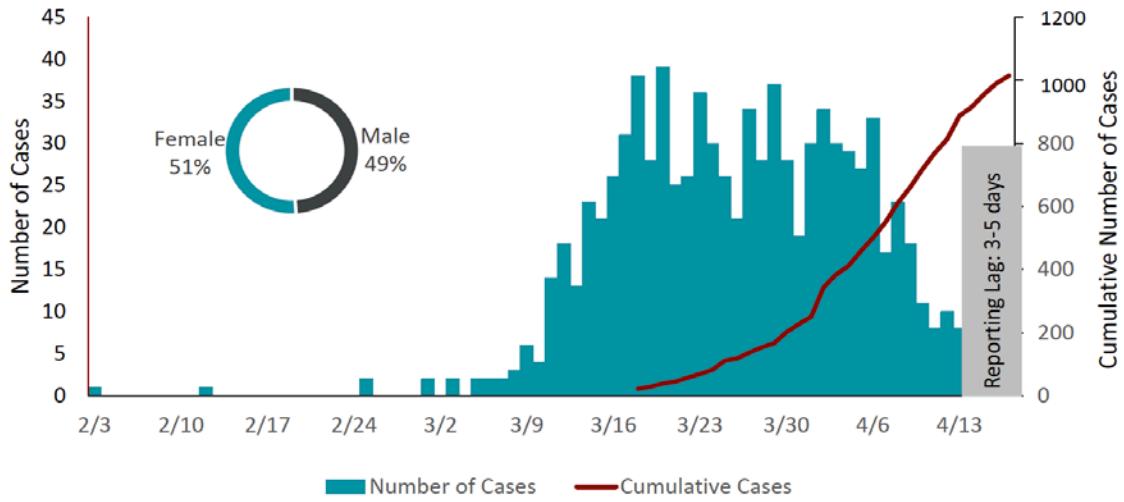
191
Ever Hospitalized

97
Admitted to ICU

50
Mechanical Ventilation

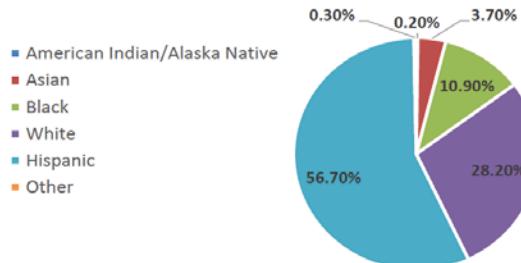
276
Recovered

Cases of COVID-19 by Date of Illness Onset (n=880)¹ and Cumulative by Date Reported, Bexar County, 4/18/2020

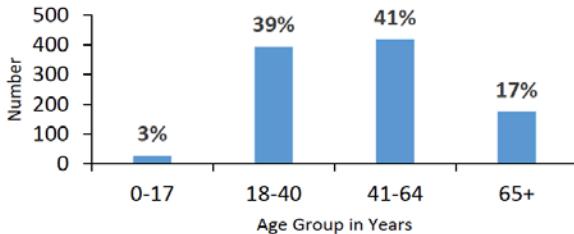


¹ Based on completed data as of 4/18/2020 at 8:00 PM; additional cases are under review.

Percentage of Cases by Race/ethnicity



Cases by Age Group



Median age – 46 years (age range: 0-100 years)

RMOCs

Mobile Drive Through COVID-19 Testing over 268,000 Square Miles



A person goes Wednesday, March 18, 2020 through the second Coronavirus testing location in Bexar County. The City of San Antonio, Bexar County and the South Texas Regional Advisory Council opened the testing center at Freeman Coliseum.
Photo: William Luther /Staff



Hot Spot Evaluation and Coordination

≡

San Antonio Express-News

SUBSCRIBE Sign In 

NEWS

Texas, San Antonio officials launch investigations of nursing home overrun by coronavirus

 Lauren Caruba | April 4, 2020 | Updated: April 4, 2020 2:22 p.m.





ASSIGNMENT DESK

COVID-19 has upended life as we knew it in Texas. Tell us the questions you want answered, and the issues you think we should be investigating. Include your email, and an Express-News journalist will follow up.

Enter your question here

RMOC Function in COVID-19 Response

- **Situational awareness**
- **Integration of public health, acute health care and disaster management functions**
- **Actionable data from consolidating public health and acute health care data sources**
- **Controlling and coordinating hot-spots**
- **Drive through testing management across the entire State**
- **Ability to Load balance across multiple health systems and organizations**



T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

John Quiroz, RN

Nurse Manager, Los Angeles County Emergency Medical Services

Unclassified//For Public Use

66





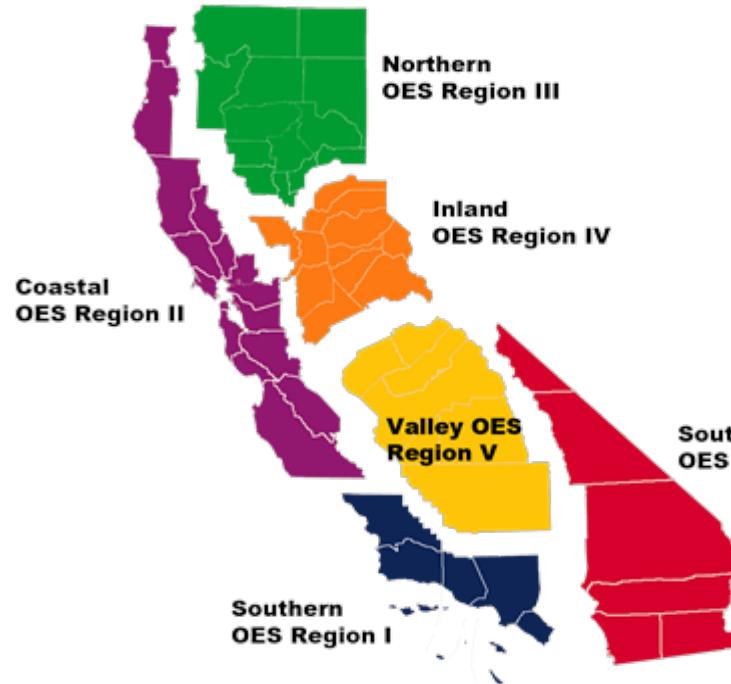
Los Angeles (LA) County Medical Operations Coordination Cell (MOCC):

- 24/7 Medical & Health Coordinator for the County and Region I
- Coordinate Patient Transfers and Transportation
- Coordinate medical and health resource management
- 911 Providers, Hospitals, LTC, Clinics, Dialysis, Surgical



Los Angeles County and Region I

California Regions



Normal Operations vs Emergency and Disaster Response

Normal Operations

- DHS Hospital and Clinic System
- EMTALA Transfers
- Air Medical
- Hyperbaric Chamber
- MCI Patient Destinations
- Transfer/Transport

Emergency Disaster

- Hospital evacuations
- Resource Request
- Alternate Care Sites
 - Mercy
 - LASH
 - Isolation/Quarantine
- Transfer/Transport
- Prehospital Care Policy

Keys to Success

- 24/7 Base of Operations
- Communications
 - Telephony, Radio, Internet, ReddiNet
- DOC Room to expand operation during disaster
- Information System to document and analyze all lines of business.
- Trained and talented staff
- Planning and exercise



T R A C I E
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

John Hick, MD
Hennepin Healthcare, MN

Unclassified//For Public Use

71

ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE

Minnesota SHCC

- Statewide Healthcare Coordination Center
- Located at State EOC as well as virtual – roughly 40 people directly engaged including regional leads
- Joint MDH, HSEM, MHA, 8 regional MN coalition construct
- Main areas of planning / response:
 - Referrals and transfers
 - Alternate care sites
 - Long term care – reactive and proactive
 - PPE policy and acquisition
 - Ventilator / medical supply acquisition



Referrals and Transfers

- Single phone number for LTC issues including hospital discharge and COVID + patient support (e.g. assisted living transfer to COVID + designated SNF)
- Co-located with SEOC public hotline but different staffing / numbers
- Single (separate) phone number for ICU referrals
 - Mainly for greater MN but also inter-metro
 - Awareness of resources on MnTrac and real-time health system information
 - Also provides direct connection to critical care consultation
 - May also be used to make triage decisions if referral needed and no resources available (care-in-place recommendations)
 - May also be used to distribute load

Staffing

- Call-taker
 - Medical background preferred
 - Gatekeeper for referral to SME
 - May connect caller with resources and then referrals handled per usual
- Shift Supervisor
 - Clinical background and experience with bed placement (e.g. house nursing supervisor)
 - Manages information / resource availability with facilities and more complicated situations
- Clinician on-call
 - Critical care
 - Contacts with each major health system critical care for ECMO and other resource allocation situations
- Unit supervisor
 - Works with SHCC manager on overall operations, processes, protocols



Triggers

- LTC
 - Difficulty obtaining hospital discharges for LTC patients
 - Achieved and hotline operational
 - (Note – hotline also coordinates connections to infection prevention/control, MDH Health Regulation Division, palliative care consultations, and can trigger strike team evaluation / staffing support / transfer support)
- ICU
 - < 10% ICU beds available statewide
 - Request from MHA or a coalition due to difficulty coordinating destinations
 - Further triggers for engagement of clinician at request or when no ICU beds available for reasonable match

Other uses / considerations

- Matching to EMS transport services
- Patient ICU transfer considerations
 - Need for higher level of care – first priority – ECMO, ventilators, etc.
 - Patients presenting to facility that lacks appropriate resources at baseline
 - Load balancing – second priority
 - Convalescent patients
 - Intubated and stable patients (regional – if significant capacity underutilized)
 - Risk/benefit considerations
 - Resource movement – e.g. ventilators (vs. anesthesia machines) or staff (virtual or in-person)



Question & Answer



Contact Us



asprtracie.hhs.gov



1-844-5-TRACIE



askasprtracie@hhs.gov