Medical Operations Coordination Cells Toolkit

First Edition

Hospital Team

Produced by the

NRCC Healthcare Resilience Task Force

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PURPOSE AND SCOPE

This Medical Operations Coordination Cells (MOCCs) Toolkit offers flexible and modifiable guidance, developed by the United States (U.S.) government, aimed to assist regional, state, local, tribal and territorial (SLTT) governments to ensure load-balancing across healthcare facilities and systems so that the highest possible level of care can be provided to each patient during the coronavirus disease 2019 (COVID-19) pandemic caused by the virus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Medical and other subject-matter experts from the U.S. government developed this Toolkit as a best-practices reference to support SLTT governments in establishing and operationalizing MOCCs.

MOCCs are cells within emergency operations centers (EOCs) at the sub-state regional, state-wide, and federal regional levels (Federal Emergency Management Agency (FEMA)/U.S. Department of Health and Human Services (HHS) regions) that facilitate patient movement, healthcare staffing, and life-saving resource allocation. The MOCCs rely upon a range of stakeholders to provide the healthcare personnel and data needed to understand current capacity and gaps in the healthcare system and facilitate load-balancing through patient transfers. Key stakeholder groups include healthcare facilities, emergency medical services (EMS), and supporting state and local governmental partners.

This Toolkit provides sample Standard Operating Procedures for MOCCs at three levels:

1. Sub-State, Regional Medical Operations Coordination Cells (RMOCCs)

2. State Medical Operations Coordination Cells (SMOCCs)

3. Federal Regional Medical Operations Coordination Cells (FMOCCs)

Sample supporting documents, including forms and checklists, may be found in the Appendix.

This Toolkit provides suggested approaches to MOCCs at the sub-state regional, statewide, and federal regional levels. All SLTT authorities are encouraged to modify these procedures to meet the specific needs of their jurisdictions and regions.

MOCCS FUNDING OVERVIEW

Funding solutions are unique to each entity based on a number of factors, including the funding target and type of emergency declaration. Entities should reach out to regional HHS and FEMA representatives for the most recent guidance. SLTT and sub-state regional governments may access several sources of federal funding (listed below) to support the establishment and operation of MOCCs. Funding from these sources is subject to program-specific cost allowability, eligibility requirements, and potential State cost-share requirements. Duplicative funding from multiple sources for the same service is not allowable under most funding agreements.

ASPR Hospital Preparedness Program

HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) annual cooperative agreement recipients (62 states, select localities, territories, and freely associated states) and subrecipients (e.g., healthcare coalitions) may utilize this funding to operationalize a MOCC. In addition, HPP's COVID-19 administrative supplement to the annual cooperative agreement includes as an allowable use of funds activities to ensure clinicians are in the state or jurisdiction's EOC to manage patient facility assignments within their state or jurisdiction; however, funding may not be used for clinical care or for staffing to provide clinical care. HPP also issued COVID-19 administrative supplements for the 10 Regional Ebola and Other Special Pathogen Treatment Centers (RESPTCs), which could also be used to support the MOCC concept at the regional level as part of their special pathogen concept of operations.

Hospital association recipients and subrecipients (hospitals and other healthcare entities) of a new HPP cooperative agreement established for COVID-19 through emergency supplemental funding may utilize funding for activities that are necessary to operationalize a MOCC. Funding may be used: (a) to update existing pandemic or emergency preparedness plans to include COVID-19 preparedness activities, such as approaches for the assessment, transport, and treatment of persons suspected or confirmed to have COVID-19; (b) to update the existing patient transport plan to include an approach that allows for intra- and inter-state transport of potential or confirmed COVID-19 patients, as necessary; (c) to provide training and technical support, as necessary, to EMS agencies and 911/Public Safety Answering Points (PSAPs) on screening 911 callers in order to direct non-acute patients to the appropriate care setting; and (d) to implement evolving protocols related to the dispatch of EMS for COVID-19 suspected patients, and EMS response in general.

For more information about these cooperative agreements, please see the HHS press release on the funding administered by HPP through the Coronavirus Preparedness and Response Supplemental Appropriations Act 2020, P.L. 116-123, or contact the Hospital Preparedness Program at HPP@HHS.gov.

CDC COVID-19 Crisis Response Cooperative Agreement

The CDC Cooperative Agreement for Emergency Response recipients may utilize funding to support MOCC operations through the cooperative agreement's COVID-19 supplemental funding. Recipients may use funding to activate the jurisdiction's EOC at the appropriate level by undertaking, for example, the following actions: Staff the EOC with the appropriate numbers and skills to support the response, to assure worker safety, and to continually monitor absenteeism; use established systems to ensure continuity of operations (COOP); and to implement COOP plans as needed. In addition, recipients may use funding to actively monitor healthcare system capacity and to develop mitigation strategies to preserve healthcare system resources.

For more information, please see the Public Health Crisis Response notice of funding opportunity here: https://www.cdc.gov/cpr/readiness/funding-covid.htm or contact your SLTT's CDC grant point of contact.

FEMA Public Assistance Program

FEMA Public Assistance (PA) is authorized for all Presidential emergency and major disaster declarations under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended, issued for the COVID-19 Public Health Emergency. SLTT governments and certain private nonprofit organizations are eligible PA applicants under a COVID-19 emergency declaration and any subsequent COVID-19 major disaster declaration. Emergency protective measures must be necessary to eliminate or lessen immediate threats to

lives, public health, or safety (see 44 CFR § 206.225). Establishment and operation of a MOCC within an EOC by a SLTT government to facilitate patient movement and resource allocation due to COVID-19, therefore, may be an eligible emergency protective measure under the PA Program. Eligible applicants should work with their respective State, Territory, or Tribe on specific eligibility.

All claimed costs must be necessary and reasonable in order to respond to the COVID-19 Public Health Emergency and are subject to standard program eligibility and other federal requirements. PA funding is subject to the cost share for the respective declaration. There may be other sources of federal funding available to support the establishment and operation of a MOCC, some of which may be provided at 100 percent federal funding (i.e., no non-federal cost share). PA funding is not available for any costs for which an applicant receives funding from another source. Pursuant to Section 312 of the Stafford Act, FEMA is prohibited from providing financial assistance where such assistance would duplicate funding available from another program, insurance, or any other source for the same costs. Eligible applicants may perform or contract for the work directly and seek reimbursement through PA. For more information, please see the FEMA Fact Sheet *Coronavirus (COVID-19) Pandemic: Emergency Medical Care* or contact your regional FEMA representative.

For more information on the FEMA Public Assistance Program, please go to: https://www.fema.gov/public-assistance-policy-and-guidance or contact your regional FEMA representative.

FEMA Mission Assignment Program

Regional FMOCCs may be established and operated within FEMA Regional Response Coordination Centers (RRCCs). Federal interagency staffing to support regional operations may be coordinated through a Federal Operations Support (FOS) mission assignment (MA) and eligible costs include overtime and travel, as required. FOS MAs are fully funded and not applicable to non-federal participation.

Federal staffing for SMOCCs and RMOCCs may be coordinated via a Direct Federal Assistance (DFA) MA issued by FEMA in response to a validated state request. SLTT governments may augment current staffing through technical assistance based on the eligibility criteria in Chapter 2:V.K. *Direct Federal Assistance* of the Public Assistance Program and Policy Guide, V.3.1. The recipient may request DFA through FEMA to support MOCCs. This DFA support is subject to the prevailing cost share for the declaration. All requests for DFA should be coordinated through the State, Territory, or Tribe acting as the recipient. FEMA will determine eligibility based on the request and in coordination with the recipient.

For more information, please see the FEMA Mission Assignment Policy FP-104-010-2 at: www.fema.gov/media-library/assets/documents/112564 or contact your regional FEMA representative. To see an example MA statement of work, please refer to Appendix G: MOCC Mission Assignment Template.

Data Systems Guidance

MOCCs at all levels may need to implement data systems that support effective resource allocation and improve patient tracking when existing data tracking systems cannot be used. In such cases, to receive federal funding for data systems, justification must be provided to support an emergent need and demonstrate that a new data system can be implemented as an immediate emergency protective measure within the time limits of the disaster declaration. To streamline the reporting of information, where appropriate, healthcare facilities should be encouraged to utilize the National Health and Safety Network (NHSN) tracking system, which most healthcare facilities already access and use. Although reporting this data through states and FEMA regions remains an

option, the NHSN is the most efficient way to submit information to the data and analysis team and provide the relevant facility-level data necessary to support decision-making.

Sub-State, Regional Medical Operations Coordination Cell

Sample Standard Operating Procedure

SUB-STATE, REGIONAL MEDICAL OPERATIONS COORDINATION CELL (RMOCC) SAMPLE STANDARD OPERATING PROCEDURE

Overview

While some hospitals are overwhelmed with COVID-19 patients, successful mitigation of the disease has produced excess capacity in other nearby hospitals, creating a need and an opportunity to transfer patients.

The goal of the Medical Operations Coordination Cells (MOCCs) initiative is to ensure load-balancing across healthcare facilities and systems so that the highest possible level of care can be provided to all patients who need that care before transitioning hospitals toward crisis measures.

A **local, sub-state Regional Medical Operations Coordination Cell (RMOCC)** focuses on the **delivery of healthcare services** and operates as a **component of the Emergency Support Function #8, Public Health and Medical Services (ESF#8)** activities, bringing the **medical aspect of ESF#8 into emergency operations centers (EOCs)** to guide the appropriate movement of patients along the care continuum.

Objectives and Priorities for RMOCC

Objective: The RMOCC makes data- and stakeholder-informed decisions to balance patient load and ensure high-quality care. RMOCC decisions direct the movement of patients and resources from one facility to another, or re-direct referrals that would usually go to an overwhelmed facility or system to one with capacity.

The **priorities** of the RMOCC include the following activities:

1. **Collecting, analyzing, and disseminating hospital-capacity information**: One of the primary roles of the RMOCC is to collect and analyze the information provided by each stakeholder (e.g., EMS, healthcare facilities). The RMOCC analyzes and disseminates data to stakeholders to support comprehensive situational awareness of the region and available resources. This does not replace broader EOC-based information / intelligence functions.
2. **Establishing protocols, systems, and triggers**: The RMOCC facilitates the collection and reporting of healthcare-specific data elements; informs operational planning and stakeholder communications; and initiates regional transfer decision-making.
3. **Acting as a single point of contact (POC) for referral requests and life-saving resources:** The RMOCC provides a single POC within the EOC for healthcare facilities seeking assistance with patient transfers and for healthcare system partners in the region that have resources that can help decompress the load in those facilities.

The RMOCC **achieves its objectives and priorities** primarily by the following activities:

- **Adding clinical staff** to existing EOCs
- **Establishing stakeholder agreements** that allow for collecting data regarding the current capacity of the region's health system, synthesizing the data to understand the needs of the system, and determining areas of the system that may be overwhelmed

Integration with Local ESF#8

For many jurisdictions, the local public health department serves as the ESF#8 lead for coordinating the response to public health and medical emergencies. Given the considerable efforts required of both public health and the medical/healthcare system in the COVID-19 response, the RMOCC focuses on **stabilizing the local healthcare system** to **help local public health departments** focus on the extensive public health response needs.

The integration of the RMOCC with the local ESF#8 lead may be established in multiple ways. Examples include assigning a public health liaison to the RMOCC to assist with the coordination of medical resource requests or establishing the RMOCC within the local EOC as the Medical Operations Branch of the Incident Command Structure.

Roles and Responsibilities

The RMOCC relies upon a **range of stakeholders** to provide the personnel and data needed (a) to understand current capacity and gaps in the region's healthcare system and (b) to facilitate load-balancing through patient transfers. Key stakeholder groups include healthcare facilities, EMS, and supporting state and local governmental partners.

The RMOCC comprises diverse stakeholders with varying missions, priorities, and capabilities. **Common principles and clear roles and responsibilities** will help **stakeholders understand their roles in and contributions to the initiative** and will help **ensure effective patient distribution.**

The following are **sample agreements** for RMOCC stakeholders:

- All stakeholders must **agree to submit data** to support situational awareness and must agree to respond in a timely manner to requests for data.
- All stakeholders, even if they are market competitors under normal conditions, must **agree to fully cooperate and communicate** with each other and the RMOCC to effectively respond to the disaster or public health emergency.
- All stakeholders must **agree to provide (virtual) POCs** who can communicate with the RMOCC and with their organizations on a continuous basis, if required.
- Relevant stakeholders must **agree to review and process RMOCC-adjudicated patient-movement requests** to ensure that the level of care needed for patients is available at the receiving facility.
- Relevant stakeholders must **agree to provide medical consultation and technical assistance and support to regional and local ESF#8 decision makers** regarding statewide bed availability, patient movement capabilities, and other resources that can be employed to coordinate patient care.
- On behalf of all stakeholders, the RMOCC **agrees to submit data to the State Medical Operations Coordination Cells (SMOCCs) to support state-wide situational awareness and agrees to respond in a timely manner to requests for data.**

RMOCCs may coordinate with or support the ESF#8 Lead Agency in identifying and engaging stakeholders within the region. Below are suggested stakeholder roles and contributions.

Hospitals

In coordination with the jurisdictional ESF#8 Lead Agency, RMOCC staff may engage and collaborate with stand-alone hospitals (e.g., acute care, specialty, and critical access hospitals), hospital networks, and corporate health systems. Hospital networks and corporate health systems comprise multiple hospitals that may coordinate healthcare delivery as a group.

To enable **effective patient distribution**, **hospitals** may perform the following activities:

- Fulfill data requests from the RMOCC.
- Define protocols and channels for communication with hospital leadership; identify POCs with RMOCC.
- Agree to accept confirmed or suspected COVID-19 patients and maximize any additional surge capacity.

Long-term Care Facilities

In coordination with the jurisdictional ESF#8 Lead Agency, RMOCC staff may engage and collaborate with long-term care facilities, including nursing homes, skilled nursing facilities, and assisted living facilities.

To enable **effective patient distribution**, **long-term care facilities** may perform the following activities:

- Fulfill data requests from the RMOCC.
- Define protocols and channels for communication with facility leadership and across facility personnel; identify POCs for the RMOCC.
- Understand the process for EMS transport to hospitals and the potential for alternate receiving hospitals, if the usual referral hospitals are overwhelmed.
- Understand and agree to maximize any additional surge capacity for low-acuity patients or residents.

Emergency Management

In coordination with the jurisdictional ESF#8 Lead Agency, RMOCC staff may engage and collaborate with jurisdictional emergency managers to support development of operational plans and provide operational support, as needed.

To enable **effective patient distribution**, **emergency managers** may perform the following activities:

- Engage and liaise with 911/Public Safety Answering Points (PSAPs), EMS and other emergency services.
- Identify and/or support the establishment of systems or dashboards for centralized reporting, data collection, communications, healthcare stakeholder triage requests and other operational functions.
- Develop and define protocols, systems and triggers for activation of complementary emergency support functions.

Emergency Medical Services (EMS)

In coordination with the jurisdictional ESF#8 Lead Agency, RMOCC staff may engage and collaborate with EMS agencies (911 and non-911 system agencies) in the region, while recognizing many in the overwhelmed area may not be able to provide transfer assistance.

To enable **effective patient distribution**, **EMS** may perform the following activities:

- Fulfill data requests from the RMOCC.
- Develop and/or define clear processes and protocols for 911 emergency transport triage.
- Develop and/or define clear processes and protocols for interfacility transport.
- Assist with identifying ground and aeromedical transport assets to support patient transfers as required.
- Obtain a standard data set for required patient support (e.g., oxygen, intravenous drips, cardiac monitoring, other personnel accompanying).
- Establish clear, reliable modes of communication and governance/decision structures for determining patient transport locations. For example, the RMOCC may honor in-system transfer requests when possible based on availability.

Governmental Partners

In coordination with the jurisdictional ESF#8 Lead Agency, RMOCC staff may engage and collaborate with other SLTT governments. SLTT departments and programs that may support RMOCC operations include the following examples:

- State Department or Division of Public Safety
- State Department or Division of Emergency Management
- State Department or Division of Human Services
- National Guard
- Medical Reserve Corps
- Governmental Mutual Aid or Emergency Management Assistance Compact (EMAC) Partners

Other Coordinating Partners

Other organizations within the jurisdiction may assist with a wide variety of tasks based on their capabilities, including those within the private sector (e.g., hospital associations, vendors, and suppliers), non-governmental organizations (e.g., American Red Cross), and volunteer agencies, as needed or requested.

RMOCC Staffing

RMOCC staff and experts are critical to its operations. RMOCC staffing should come from the local healthcare delivery system, as the load-balancing responsibilities of the RMOCC require a high degree of medical and hospital operational expertise and familiarity.

Successful RMOCCs have deployed five key types of staff:

1. **RMOCC Director** – Serves as the unit manager and oversees RMOCC operations.
   Experience: Healthcare operations and emergency management, particularly healthcare system response.

2. **Medical Officer** – Oversees the medical team, support personnel, and clinical resource allocation. Responsibilities include, but are not limited to, the following activities:

- Evaluate the clinical acuity of potential transfers.
- Evaluate the impact of transfer on clinical operations.
- Evaluate the potential need for transfer, risks, and benefits.
- Provide emergency medical consultation via phone to referring facilities, particularly smaller community hospitals that may have to manage a critically ill patient awaiting transfer for much longer than usual.

Experience: Physician with experience in emergency care, critical care, trauma, and/or mass causality.

3. **Call Takers** – Manage incoming calls to the RMOCC and ensure requests are entered in the appropriate platform by the requestor.
   Experience: Administrative staff, ideally with a background in EMS or public safety.

4. **Transfer Coordinator** – Matches the referral hospital and receiving hospital appropriate for the patient's acuity. Links the referring physician with the admitting physician at the receiving hospital, including needed clinical documentation for physician review to determine appropriateness of transfer.
   Experience: Charge nurse, nurse manager, or other hospital clinical staff with background in patient access and flow/throughput.

5. **Transport Coordinator** – Coordinates the transportation of patients between the facilities as required.
   Experience: Paramedic supervisor (preferred) or paramedic or emergency medical technician with strong knowledge of regional systems and incident management.

RMOCC Operations

Once the RMOCC is activated, it will be staffed at a minimum by an RMOCC Director, Medical Officer, Call Taker(s), and Transfer Coordinator.

The RMOCC Director will perform the following activities:

- Determine the location of the RMOCC and if staff will report on-site or virtually.
- Decide when additional staff are needed.
- Distribute the RMOCC contact number through local public health, emergency management, and member facility Incident Action Plans and Communication Plans.
- Establish robust and secure channels of communications between stakeholders, the RMOCC, and the EOC.

Once operational, all RMOCC stakeholders agree to the following activities:

- Submit data to support situational awareness and respond in a timely manner to requests for data.
- Fully cooperate and communicate with each other and the RMOCC to effectively respond to the disaster.
- Provide (virtual) POCs who can communicate with the RMOCC and with their organizations on a continuous basis, if required.

Information Sharing / Situational Awareness

Effective RMOCC coordination relies on a **common operating picture** made up of information from a range of sources.

The RMOCC **receives and shares** real-time emergency response information on the current status of the healthcare delivery system. The RMOCC may also **collect** information from other stakeholders to help local ESF#8 partners assess their resource requests and assist in their management processes (e.g., from a healthcare coalition cache, partner mutual aid, or from deployed state or federal resources).

Once activated, the RMOCC must determine the **essential elements of information (EEIs)** for the incident, the method for sharing EEIs, and the reporting time intervals.

Facility Reporting of EEIs

All member healthcare facilities (acute, non-acute, and alternate care sites) within the RMOCC boundary will report their EEIs at the request of the RMOCC through [*insert name of platform*]. The information will be updated twice daily, or at an interval defined by the RMOCC, for the duration of the incident. The following are sample healthcare facility EEIs that may be reported to the RMOCC:

- General status at the specific location
- Total number of non-ICU inpatient beds, including surge beds
- Total number of staffed available non-ICU beds
- Total number of ICU beds, including surge beds
- Total number of staffed available ICU beds
- Total number of ventilators, including converted machines
- Total number of ventilators available
- Staffing status
- Personal Protective Equipment status
- Additional resource availability, as applicable

EMS Agency Reporting of EEIs

All member EMS agencies within the RMOCC boundary will report their EEIs at the request of the RMOCC through [*insert name of platform*]. The information will be updated twice daily, or at an interval defined by the RMOCC, for the duration of the incident.

The following are sample EMS agency EEIs that may be reported to the RMOCC:

- General status of the EMS agency
- Total number of staffed Critical Care Transport ambulances
- Total number of staffed ALS ambulances
- Total number of staffed BLS ambulances
- Total number of paratransit vehicles
- Total number of staffed air medical transport assets

- Additional resource availability, such as ambulance buses and non-medical transport vehicles, as applicable

RMOCC Reporting of EEIs to SMOCC

SMOCC staff will establish the method and frequency for RMOCCs to report EEIs. These communications will optimally occur twice daily, or as otherwise specified by the SMOCC.

Patient Movement Request

The primary purpose of patient movement and tracking within the RMOCC is to decompress overwhelmed healthcare facilities through an equitable distribution of patients. The RMOCC will coordinate the inter-facility transfer of patients, including to alternate care sites, if all conventional care resources in the region have been exhausted and the SMOCC is unable to find conventional care resources in neighboring regions.

The RMOCC **does not replace 911 operations** for pre-hospital transport **of patients originating outside of the healthcare system**.

The steps for conducting a patient movement request are described below and further illustrated in Appendix A: RMOCC Patient Workflow and Data Reporting Process.

1. **Requesting Facility Communicates Request**

The request for patient movement can be made by the Requesting Facility by calling the RMOCC at [*insert RMOCC number*].

The Requesting Facility will provide the following information:

- The number of patients requiring transfer
- Each patient's age, gender, acuity, language and/or effective communication needs and level of care needed
- Each patient's COVID-19 status (positive, negative, unknown)
- Additional pertinent clinical information, including requirements for transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information as applicable)

2. **RMOCC Facilitates Patient Placement**

The RMOCC will contact the Receiving Facility(ies) based on the appropriate level of care and bed availability information, in consultation with or by the RMOCC Medical Officer.

Once a Receiving Facility has been identified and confirms acceptance of the patient(s), the RMOCC Transfer Coordinator will coordinate a clinical provider call between the Requesting Facility and Receiving Facility.

3. **RMOCC or Requesting Facility Facilitates Patient Transport**

The RMOCC may contact EMS for transport if this is not done by the Requesting Facility.

The appropriate EMS asset will be assigned based on the level of care required during the transfer, the infectious state of the patient, and the destination. EMS regulations differ widely by jurisdictions. See Appendix B: SMOCC Patient Workflow and Data Reporting Process for a sample patient transportation plan and Appendix D: Patient Transfer Checklist for a sample patient transfer checklist.

4. RMOCC or EMS Conducts Patient Tracking

Some RMOCCs may have responsibility for patient tracking, while others may leave this responsibility to the EMS agencies conducting the patient transport.

If the RMOCC tracks patient movement, [*insert name of platform or tool*] is the software platform used for entering patient data, tracking through transport, and reporting to the Receiving Facility. In this instance, the RMOCC is responsible for entering patient data into the system and verifying patient locations and dispositions. See Appendix D: Patient Transfer Checklist.

5. Receiving Facility Initiates Patient Discharge; RMOCC May Support Repatriation

The Receiving Facility will use its normal discharge planning process once a patient is able to be discharged. The RMOCC may assist with the repatriation of patients to Requesting Facilities (e.g., Long-Term Care), to their homes if they are recipients of home-healthcare or home and community-based services (HCBS) or to alternate care sites/convalescent centers until longer-term patient placements can be determined, as needed.

Medical Resource Sharing

RMOCC coordination makes possible rapid sharing of life-saving and life-sustaining medical resources, particularly those required for individual or a handful of patients.

Resource coordination within the RMOCC does not replace normal supply chain processes nor the normal ESF#8 resource request process. The RMOCC simply expedites local sharing of medical resources to save lives.

The process for sharing medical resources within the RMOCC, including staff, pharmaceuticals, supplies, and equipment, is described below.

Healthcare Staffing Request

Initiation of healthcare staffing includes the following steps:

1. Requesting Facility Communicates Request

The request for healthcare staffing can be made by calling the RMOCC at [*insert RMOCC number*].

A verbal request must be followed by written documentation through [*insert name of platform*], as soon as reasonably possible and include the following information:

- The type and number of healthcare staff
- An estimated date of when healthcare staff are requested to report for duty
- The location where the healthcare staff are to report for duty
- An estimate of how long the healthcare staff will be needed

The written request should ideally occur before healthcare staff arrive at the Requesting Facility.

2. RMOCC Identifies Staff

The RMOCC will contact potential Assisting Facilities, based on EEI reporting, to identify healthcare staffing resources.

3. Healthcare Staff and Requesting Facility Fulfill Documentation Requirements

Upon arrival at the Requesting Facility, healthcare staff from the Assisting Facility will be required to present proper identification from the Assisting Facility at location designated by the Requesting Facility's Command Center.

The Requesting Facility will be responsible for the following activities:

- Meeting the healthcare staff as they arrive (usually assigned to the Requesting Facility's Security Department or designated employee)
- Confirming the proper identification by comparing an ID badge with the list of personnel provided by the Assisting Facility
- Providing additional identification (if deemed necessary), e.g., "Assisting Personnel" badge, to the arriving personnel

The Requesting Facility will accept the professional credentialing determination of the Assisting Facility, but only for those services for which the healthcare staff are credentialed at the Assisting Facility, or the roles for which they were requested.

Facilities should agree that only staff in good standing should be shared. In addition, policies related to liability, Workers' Compensation, and pay should be agreed to ahead of time.

4. Requesting Facility Provides Supervision

The Requesting Facility's Senior Administrator or designee (the Hospital Command Center) identifies where and to whom the healthcare staff are to report, and which professional staff of the Requesting Facility supervise the assisting personnel.

The supervisor or designee will meet the healthcare staff at the point of entry of the facility and brief the assisting personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the Requesting Facility will govern assigned shifts. The healthcare staff's shift, however, should not be longer than the customary duration practiced at the Assisting Facility.

5. Requesting Facility Leads Demobilization Procedures

The Requesting Facility will provide and coordinate any necessary demobilization procedures and post-incident stress debriefing. The Requesting Facility is responsible for providing the healthcare staff transportation necessary for their return to the Assisting Facility.

Pharmaceutical, Supplies, or Equipment Request

The steps for requesting pharmaceuticals, supplies, or equipment include the following activities:

1. **Requesting Facility Communicates Request**

The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made by calling the RMOCC at [*insert RMOCC number*].

A verbal request must be followed by a written resource request, through the electronic process in [*insert name of platform*].

The Requesting Facility will identify the following information in the request:

- The quantity and exact type of requested items
- An estimate of how quickly the request is needed
- Time period for which the supplies will be needed
- Location to which the supplies should be delivered

The written request should ideally occur before the receipt of any material resources at the Requesting Facility.

The Assisting Facility will identify how long it will take them to fulfill the request and pass the information to the RMOCC. This can be accomplished and tracked via the electronic resource request process in [*insert name of platform*].

2. **RMOCC Identifies Resources**

The RMOCC will contact potential Assisting Facilities, based on EEI reporting, to identify resources.

3. **Requesting and Assisting Facilities Fulfill Documentation Requirements**

The Requesting Facility will honor the Assisting Facility's standard order requisition form as documentation of the request and receipt of the materials. The Requesting Facility's security office or designee will confirm the receipt of the material resources.

The documentation will detail the following information:

- The items involved
- The condition of the equipment prior to the loan (if applicable)
- The responsible parties for the borrowed material

The Assisting Facility is responsible for tracking the borrowed inventory through their standard requisition forms.

Upon the return of the equipment, etc., the original invoice will be co-signed by the senior administrator or designee of the Requesting Facility recording the condition of the borrowed equipment.

4. **Requesting Facility and RMOCC Coordinate the Transport of Pharmaceuticals, Supplies, or Equipment**

The Requesting Facility, in coordination with the RMOCC, is responsible for coordinating the transportation of materials both to and from the Assisting Facility. This coordination may involve government and/or private entities, and the Assisting Facility may also offer transport.

Upon request, the Requesting Facility must pay the transportation fees for returning or replacing all borrowed material.

5. Requesting Facility Supervises Borrowed Resources

The Requesting Facility is responsible for appropriate use and maintenance of all borrowed pharmaceuticals, supplies, or equipment.

6. Requesting Facility Leads Demobilization Procedures

The Requesting Facility is responsible for the rehabilitation and prompt return of the borrowed equipment to the Assisting Facility. Any consumed resources, such as pharmaceuticals and supplies, must be filled through the Requesting Facility's normal supply chain process and resupplied to the Assisting Facility.

State Medical Operations Coordination Cell

Sample Standard Operating Procedure

STATE MEDICAL OPERATIONS COORDINATION CELL (SMOCC) SAMPLE STANDARD OPERATING PROCEDURE

Overview

While some hospitals are overwhelmed with COVID-19 patients, successful mitigation of the disease has produced excess capacity in other nearby hospitals, creating a need and an opportunity to transfer patients.

The goal of the Medical Operations Coordination Cells (MOCCs) initiative is to ensure load-balancing across healthcare facilities and systems so that the highest possible level of care can be provided to all patients who need that care prior to transitioning toward crisis measures.

The **State Regional Medical Operation Coordination Cells (SMOCCs)** focus on the **delivery of healthcare services** and operate as a **component of the state's ESF#8** activities, bringing the **medical aspect of ESF#8 into state emergency operations centers (EOCs)** to guide the appropriate movement of patients along the care continuum from sub-state regions where the healthcare capacity is overwhelmed to other regions within the state that have available capacity.

This template is based on the assumption that RMOCCs are established in sub-state regions within the state. If this is not applicable and a SMOCC intends to achieve healthcare load-balancing by working with individual healthcare facilities and stakeholders, rather than by coordinating with RMOCCs, the SMOCC should use the Sub-State RMOCC Standard Operating Procedure as a guide.

Objectives and Priorities of SMOCC

Objective: The SMOCC makes data and stakeholder-informed decisions to balance patient load and ensure high-quality care. SMOCCs facilitate transfers of patients and resources from stressed facilities within regions that are or are becoming overwhelmed to facilities in sub-state regions that have the capacity to provide each patient's required level of care.

The **priorities** of the SMOCC include the following activities:

1. **Developing statewide strategies to optimize patient distribution in collaboration with the RMOCCs:** This includes informing operational planning, healthcare communications, and decision-making.
2. **Collecting, analyzing and disseminating healthcare information**: One of the primary roles of the SMOCC is to collect and analyze the healthcare capacity and capability data to provide to the RMOCCs. The SMOCC provides analysis and secure dissemination of data to the RMOCCs to support a comprehensive understanding of the entire state's healthcare situational awareness and availability of resources. This does not replace broader EOC-based information / intelligence functions.
3. **Acting as a single point of contact (POC) for referral requests:** The SMOCC provides a single POC for RMOCCs seeking assistance with patient transfers that cannot be accommodated within their regions. It reviews, facilitates, and processes patient movement requests and provides state-level medical consultation to facilitate the decompression of health systems within a sub-state region(s).

The SMOCC **achieves its objectives and priorities** primarily by the following activities:

- **Adding clinical staff** to existing state EOCs.
- **Establishing agreements with RMOCCs** that allow for collecting data regarding the current capacity of each sub-state region's health system, synthesizing the data to understand the needs of the regions, and determining regions that may be overwhelmed.

Integration with State ESF#8

For many jurisdictions the state public health department serves as the ESF#8 lead for coordinating the state's response to public health and medical emergencies. Given the considerable efforts required of both public health and the medical/healthcare system in the COVID-19 response, the SMOCC focuses on **stabilizing sub-state regions where health systems** are becoming overwhelmed to **help state public health departments** to focus on the extensive public health response needs.

The integration of the SMOCC with the state ESF#8 lead may be established in multiple ways. Examples include assigning a public health liaison to the SMOCC to assist with the coordination of medical resource requests or establishing the SMOCC within the state EOC as the Medical Operations Branch of the Incident Command Structure.

The SMOCC will be activated by triggers established by the RMOCCs.

Roles and Responsibilities

The SMOCCs' healthcare stakeholders provide the personnel and data to analyze and disseminate the current capacity and gaps of the state's healthcare system and to facilitate load-balancing through patient transfers.

SMOCC stakeholders include **RMOCCs, healthcare facilities, EMS, and supporting state, local, and federal government partners (through the Federal Region Medical Operations Coordination Cells [FMOCCs] at the FEMA regional EOCs).**

The SMOCCs will need to share information and coordinate with the FMOCCs and the RMOCCs. SMOCC staff will engage stakeholders through established information-sharing platforms, hospital professional organizations, and the state's ESF#8 network.

The SMOCC comprises diverse stakeholders with varying missions, priorities, and capabilities. **Common principles and clear roles and responsibilities** will help **stakeholders understand their roles in and contributions to the initiative** and will help **ensure effective patient distribution.**

The following are **sample agreements** for SMOCC stakeholders:

- All RMOCCs must **agree to submit data** to the SMOCC to support state-wide situational awareness and must agree to respond in a timely manner to requests for data.
- All RMOCCs must **work with their healthcare stakeholders to review and verify SMOCC-adjudicated patient-movement requests** to ensure the level of care needed for patients remains available at the receiving facility.
- The SMOCC **agrees to provide medical consultation and technical assistance and support to sub-state regional and state ESF#8 decision makers** regarding statewide bed availability, patient movement capabilities, and other resources that can be employed to coordinate patient care.

- The SMOCC **agrees to submit data to the FMOCCs to support situational awareness within the federal region and agrees to respond in a timely manner to requests for data.**

Governmental Partners

In coordination with the state ESF#8 Lead Agency, SMOCC staff may engage and collaborate with other federal governments. SLTT and federal departments and programs that may support SMOCC operations include these examples:

- State Department or Division of Public Safety
- State Department or Division of Emergency Management
- State Department or Division of Human Services
- HHS
- FEMA
- National Guard
- Medical Reserve Corps
- Governmental Mutual Aid or EMAC Partners

SMOCC Staffing

SMOCC staff and experts are critical to its operations. SMOCC staffing should come from the state's healthcare delivery system, as the load-balancing responsibilities of the RMOCC require a high degree of medical and hospital operational expertise.

Successful SMOCCs have deployed four key types of staff:

1. **SMOCC Director** – Serves as the unit manager and oversees SMOCC operations.
   Experience: Healthcare operations and emergency management, particularly healthcare system response.

2. **Medical Officer** – Oversees the medical team, support personnel, and clinical resource allocation. Responsibilities include, but are not limited to, the following activities:

   - Evaluate the clinical acuity of potential transfers.
   - Evaluate the impact of transfer on clinical operations.
   - Evaluate the potential need for transfer, risks, and benefits.
   - Provide emergency medical consultation via phone to referring facilities, particularly smaller community hospitals that may have to manage a critically ill patient awaiting transfer for much longer than usual.

   Experience: Physician with experience in emergency care, critical care, trauma, and/or mass causality.

3. **Call Takers** – Manage incoming calls to the SMOCC and ensure requests are entered in the appropriate platform by the requestor.
   Experience: Administrative staff, ideally with a background in EMS or public safety.

4. **Transfer Coordinator** – Matches the referral hospital and receiving hospital appropriate for the patient's acuity. The Transfer Coordinator links the two RMOCCs from the referring and receiving regions.

Responsibilities of the RMOCCs are to arrange communications between the referring and admitting/receiving physicians and to coordinate the transportation of patients between the facilities, as required.
Experience: Charge nurse, nurse manager, or other hospital clinical staff with background in patient access and flow/throughput.

SMOCC Operations

Once the SMOCC is activated, it will be staffed at a minimum by a SMOCC Director, a Medical Officer, Call Taker(s), and a Transfer Coordinator.

The SMOCC Director will perform the following activities:

- Determine the location of the SMOCC and if staff will report on-site or virtually.
- Decide when additional staff are needed.
- Distribute the SMOCC contact number through state public health, emergency management, and RMOCC Incident Action Plans and Communication Plans.
- Establish robust and secure channels of communications between stakeholders, the RMOCCs, the FMOCC, and the EOC.

Once operational, all SMOCC stakeholders agree to the following activities:

- Submit data to support situational awareness and respond in a timely manner to requests for data.
- Fully cooperate and communicate with each other and the SMOCC to effectively respond to the disaster.
- Provide (virtual) POCs who can communicate with the SMOCC and with their organizations on a continuous basis, if required.

Information Sharing/Situational Awareness

Effective SMOCC coordination relies on a **common operating picture** made up of information from a range of sources.

The SMOCC **receives and shares** real-time emergency response information on the current status of the healthcare delivery system.

Once activated, the SMOCC must determine the **essential elements of information (EEIs)** for the incident, the method for sharing EEIs, and the reporting time intervals.

RMOCC Reporting of Healthcare Facility EEIs

All RMOCCs will report their healthcare facility EEIs at the request of the SMOCC through [*insert name of platform*]. The information will be updated twice daily, or at an interval defined by the SMOCC, for the duration of the incident.

The following are sample healthcare facility EEIs that may be reported to the SMOCC:

- General status at the specific location

- Total number of non-ICU inpatient beds, including surge beds
- Total number of staffed available non-ICU beds
- Total number of ICU beds, including surge beds
- Total number of staffed available ICU beds
- Total number of ventilators, including converted machines
- Total number of ventilators available
- Staffing status
- PPE status
- Additional resource availability, as applicable

RMOCC Reporting of EMS Agency Reporting of EEIs

All RMOCCs will report their EMS EEIs at the request of the SMOCC through [*insert name of platform*]. The information will be updated twice daily, or at an interval defined by the SMOCC, for the duration of the incident.

The following are sample EMS agency EEIs that may be reported to the RMOCC:

- General status of the EMS agency
- Total number of staffed Critical Care Transport ambulances
- Total number of staffed ALS ambulances
- Total number of staffed BLS ambulances
- Total number of paratransit vehicles
- Total number of staffed air medical transport assets
- Additional resource availability, such as ambulance buses and non-medical transport vehicles, as applicable

SMOCC EEIs Reporting to FMOCC

FMOCC staff will establish the method and frequency for SMOCCs to report EEIs, ideally in alignment with the SMOCCs' operational reporting periods. These communications will optimally occur twice daily in the form of a morning stand-up and an evening closing call, or as otherwise specified by the FMOCCs. These calls also present an opportunity to share clinical challenges and resource issues with the other states in the federal region and to identify coordination opportunities and action items for the FMOCC.

Patient Movement

The SMOCC staff will work to coordinate the distribution of patients between RMOCCs based on the acuity and needs of the patient and the capacity and capability at the receiving facilities, working to balance need and capacity across sub-state, state, and the federal region, if necessary.

The SMOCC will work with the RMOCCs to coordinate the inter-facility transfer of patients, including to alternate care sites if all conventional care resources in the state have been exhausted and the FMOCC is unable to find conventional care resources in neighboring states.

The SMOCC and the RMOCCs **do not replace 911 operations** for pre-hospital **transport of patients originating outside of the healthcare system**.

The steps for conducting a patient movement request are described below.

1. Requesting Facility Communicates Request

The request for patient movement can be made by the Requesting Facility by calling the appropriate RMOCC.

The Requesting Facility will provide the following information:

- The number of patients requiring transfer
- Each patient's age, gender, acuity, and level of care needed
- Each patient's COVID-19 status (positive, negative, unknown)
- Additional pertinent clinical information, including requirements for transfer (oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information as applicable)

If the RMOCC cannot find an appropriate level of care within the sub-state region, contact SMOCC: The request for patient movement to another sub-state region can be made by the RMOCC by calling the SMOCC at [*insert number*]. The RMOCC will provide the SMOCC with the information collected above.

2. SMOCC and RMOCC Facilitate Patient Placement

The SMOCC will contact the neighboring RMOCCs with known capacity for the appropriate level of care, in consultation with or by the SMOCC Medical Officer.

The RMOCC will confirm availability with the individual facility. Once a Receiving Facility has been identified and confirms acceptance of the patient(s), the RMOCC will notify the SMOCC Transfer Coordinator, who will coordinate communications between the referring and receiving RMOCC Transfer Coordinators.

The RMOCC Transfer Coordinators will facilitate a clinical provider call between the Referring Facility and the Receiving Facility, to include the referring and admitting physicians.

If the SMOCC, in collaboration with the RMOCCs, is unable to identify an appropriate Receiving Facility, the SMOCC will contact the FMOCC to request a transfer to a neighboring state.

3. RMOCC Facilitates Patient Transport

The referring and receiving RMOCC Transfer Coordinators may contact EMS for transport if this is not done by the Referring Facility. The appropriate EMS asset will be assigned based on the level of care required during the transfer, the infectious state of the patient, and the destination.

EMS regulations differ widely by jurisdictions. See Appendix H: RMOCC Sample Transportation Flow.

Federal Region Medical Operations Coordination Cell

Sample Standard Operating Procedure

FEDERAL REGION MEDICAL OPERATIONS COORDINATION CELL (FMOCC) SAMPLE STANDARD OPERATING PROCEDURE

Overview

While some hospitals are overwhelmed with COVID-19 patients, successful mitigation of the disease has produced excess capacity in other nearby hospitals, creating a need and an opportunity to transfer patients among facilities to smooth demand across different jurisdictions. In many cases, metropolitan regions may cross state lines or involve multiple nearby states that may be differentially affected. This creates the potential for significantly different levels of care being provided in adjacent geographic regions, that has the potential to raise issues of access and equity.

The goal of the Medical Operations Coordination Cells (MOCCs) initiative is to ensure load-balancing across healthcare facilities and systems so that the highest possible level of care can be provided to all patients who need that care prior to transitioning toward crisis measures.

The **FMOCCs—in each of the 10 FEMA/HHS Regions—**focus on the **delivery of healthcare services** and operate as a **component of the federal regions' National Response Framework ESF#8 activities**, bringing the **medical aspect of ESF#8** into the RRCC to help guide the appropriate movement of patients across the care continuum from states where the healthcare capacity is overwhelmed to other states that may have available capacity. In federal regions where the geography may preclude interstate transfers of patients due to extended transport distances and times, little utility may derive from activating an FMOCC.

Objectives and Priorities of FMOCC

Objective: The FMOCC coordinates with SMOCCs within state EOCs and with RMOCCs to facilitate EMS transportation of patients from a state(s) with limited healthcare capacity to healthcare facilities within the federal region with additional capacity to provide the needed level of care. The FMOCC could also coordinate patient transfers to facilities located in a neighboring federal region if those facilities are closer. The FMOCC does this through a combination of resource assessments and stakeholder engagement (1) to determine areas of the federal region that could become overwhelmed, in order to match demand with areas that may have available capacity; and (2) to maintain situational awareness of capacity demands and coverage, to prevent further stress on the healthcare system.

The **priorities** of the FMOCC include the following activities:

1. **Collecting, analyzing and disseminating healthcare information**: One of the primary roles of the FMOCC is to regularly collect and analyze healthcare capacity and capability data provided by the SMOCCs. Through the SMOCCs' data feed, each FMOCC can provide a comprehensive understanding of the federal region's healthcare situational awareness and availability of resources. This does not replace broader EOC-based information / intelligence functions.
2. **Acting as a single point of contact (POC) for referral requests exceeding a state's capacity:** The FMOCC provides a single POC for SMOCCs seeking assistance with patient transfers that cannot be accommodated within their states. It reviews and facilitates patient movement requests and provides medical consultation when facilitating the decompression of health systems across state lines.

The FMOCC **achieves its objectives and priorities** primarily by the following activities:

- **Adding clinical staff** to existing RRCCs to assess emerging clinical capacity issues
- **Engaging with stakeholders** to collect data regarding the current capacity of the interstate health system and synthesizing the data to understand the emerging needs of the system

Integration with Regional / Federal ESF#8

FMOCC embeds within existing RRCCs to supplement the existing infrastructure, including healthcare liaisons, while providing additional clinical assessment capabilities to the regional response.

FMOCCs and SMOCCs will collaborate to determine triggers that should initiate FMOCC engagement and steps to take to make the request. The RRCCs should prepare to provide workspace to FMOCC personnel when those FMOCC personnel have been requested by the SMOCC. However, permanent/steady-state space for FMOCCs may not be necessary, since FMOCCs are only deployed once requested.

Roles and Responsibilities

FMOCC stakeholders include the following entities:

- SMOCCs from states within the federal region
- FEMA Regional Planning Section Chiefs, information services, or situational awareness leaders
- ASPR HPP Regional Field Project Officers
- ASPR Regional Administrators or Regional Emergency Coordinators (RECs)

The FMOCC's stakeholders provide the data to determine the current capacity and gaps of the federal region's healthcare systems and to facilitate load-balancing through patient transfers and potentially strategic movement of equipment or staff, by monitoring and facilitating EMAC resources when needed.

The FMOCC supports diverse stakeholders with varying missions, priorities, capabilities, and geographies. **Common principles and clear roles and responsibilities** will help **stakeholders understand their roles in and contributions to the initiative and ensure effective patient distribution.**

The following are **sample agreements** for FMOCC stakeholders:

- SMOCCs will submit data to support situational awareness and will respond in a timely manner to FMOCC requests for data.
- FMOCCs and SMOCCs will collaborate to determine quantitative triggers [*TBD*] that should initiate FMOCC engagement and to determine steps to take to make the request.
- All stakeholders must agree to provide (virtual) POCs who can communicate with the FMOCC and with their organizations on a continuous basis, if required.
- FMOCCs will maintain visibility on clinical challenges and on promising practices within their regions and will promote information sharing.
- Requesting and receiving SMOCCs will coordinate through the FMOCC to ensure seamless patient transfers.

Governmental Partners

Other partners that support ESF#8 federal assistance may be called upon depending upon the needs of the regions, with the following most likely partners:

- Department of Defense
- Department of Health and Human Services
- Department of Homeland Security
- Department of State
- Department of Transportation
- Department of Veterans Affairs

FMOCC Staffing

FMOCC staff and experts are critical to its operations. FMOCC leadership must include acute care clinical experts, as the load-balancing responsibilities of the FMOCC require a high degree of medical and hospital operational expertise.

Considering the positions that have proven successful in SMOCCs, and the supplemental role of the FMOCC, the following types of staff may be deployed to a FMOCC:

1. **FMOCC Manager** – Oversees the FMOCC staff and liaise with other sections within the RRCC, reporting on FMOCC status, risks, and accomplishments.
   Experience: Senior-level federal manager, with a strong understanding of health systems within the region.

2. **Clinical Lead** – Available for 24/7 consultation by the FMOCC Communications Lead; ultimate decision-making authority for identifying appropriate bed allocation and coordinating movement of patients across state lines within or between federal regions, as required; may also be required to provide real-time clinical consultation for patients being transported across state lines; may be consulted remotely via VTC/teleconference assuming full online access to FMOCC dashboard and viable lines of communications with SMOCCs; may monitor for indicators of crisis standards of care (CSC) decisions; and facilitate information-sharing calls with SMOCC Clinical Leads about clinical challenges and best practices.
   Experience: Federal clinician(s) – physicians with experience in triage, ideally with critical care, emergency medicine, and/or EMS backgrounds; familiarity with patient movement protocols and preferably an understanding of CSC decision-making, as well as state-level CSC guidance/policies.

3. **Communications Lead** – A 24/7 designated phone line with individual(s) who can communicate with FMOCC staff and engage SMOCCs within and outside respective federal region.
   Experience: Federal employee with EMS background and strong knowledge of the federal region; keen understanding of regional health systems and intra-state communication among health systems.

4. **Data Lead(s) –** The Data Lead will operate, maintain, and use a 24/7, real-time dashboard capability (ideally), or available data systems, for collating and representing resource availability across the federal region, with inputs derived from roll-up of data from each SMOCC within the respective region.

   Experience: Federal employee with strong data analytics skills and a background in data analysis using healthcare and/or public health data.

   General Staffing considerations:

   - Personnel may include permanent personnel from the federal offices within the region or those on temporary assignment from local or state EMS, public health, or hospital programs.
   - Personnel are preferably from the region of the FMOCC they are supporting and are therefore familiar with local healthcare systems and referral patterns.
   - Alternative resourcing of clinicians to support regional FMOCC operations could include the following personnel:
     - U.S. Public Health Service (USPHS) Commissioned Corps – preferably physicians with field experience during a disaster or public health emergency, including working as chief medical officers or operations leads with Incident Management Teams and/or deployed operations, such as rapid deployment teams.
     - National Disaster Medical System senior medical officers with field experience, including working as chief medical officers or operations leads with Incident Management Teams and/or deployed disaster medical assistance teams.
     - Title 10 medical officers with critical care experience and familiarity with civilian healthcare systems; ideally Reservist or National Guard medical officers from within the federal region, who also have civilian healthcare experience.
   - Clinicians should be trained and oriented to the RRCC's operations and should be particularly familiar with other SMOCC and FMOCC personnel.

FMOCC Operations

Once the FMOCC is activated, it will be staffed at a minimum by an FMOCC Manager, a Clinical Lead, Communications Lead, and a Data Lead.

The FMOCC Manager will perform the following activities:

- Decide when additional staff are needed.
- Distribute the FMOCC contact number through the SMOCCs, state public health departments, and emergency management agencies within the federal region.
- Establish robust and secure channels of communications between stakeholders, the SMOCCs, and the RRCC.

Once operational, all FMOCC stakeholders agree to the following activities:

- Submit data to support situational awareness and respond in a timely manner to requests for data.
- Fully cooperate and communicate with each other and the FMOCC to effectively respond to the disaster.

- Provide (virtual) POCs who can communicate with the FMOCC and with their organizations on a continuous basis, if required.

Information Sharing/Situational Awareness

Effective FMOCC coordination relies on a **common operating picture** made up of information from a range of sources. The table below outlines the data the FMOCC may request from the SMOCCs to ascertain the current status of the healthcare delivery system within the federal region.

Once activated, the FMOCC will confirm the **essential elements of information (EEIs)** for the incident, the method for sharing EEIs, and the reporting time intervals, working with each SMOCC to understand the EEIs developed at the state and sub-state levels. EEIs should generally flow from RMOCCs and SMOCCs to avoid the development of an entirely new dataset for the FMOCCs. Such data may be available through datasets and secure platforms already being used to report healthcare data to the federal government. FMOCCs may not require the same level of data granularity as RMOCCs and SMOCCs. The sample EEIs listed below can be scaled to meet the needs of the FMOCC and its stakeholders.

[*****]Sample EEIs available for a common picture of federal region:

	Facility EEIs by sub-region and/or state	**Emergency Medical Services (EMS) Agency EEIs by sub-region and/or state**
State EEIs *(sourced from RMOCCs and/or SMOCCs)*	• General status at the specific location • Total number of non-ICU inpatient beds, including surge beds • Total number of staffed available non-ICU beds • Total number of ICU beds, including surge beds • Total number of staffed available ICU beds • Total number of ventilators, including converted machines • Total number of ventilators available • Staffing status (including potential shortages within specialty areas, e.g., trauma, cardiac, OB, NICU) • PPE status • Additional resource availability, as applicable	• General status of the EMS agency • Total number of staffed Critical Care Transport ambulances • Total number of staffed ALS ambulances • Total number of staffed BLS ambulances • Total number of paratransit vehicles • Total number of staffed air medical transport assets • Additional resource availability, such as ambulance buses and non-medical transport vehicles, as applicable

EEIs Reporting to FMOCC

FMOCC staff will establish the method and frequency for SMOCCs to report EEIs, ideally in alignment with the SMOCCs' operational reporting periods. These communications will optimally occur twice daily in the form of a morning stand-up and an evening closing call, or as otherwise specified by the FMOCCs. These calls also present an opportunity to share clinical challenges and resource issues with the other states in the federal region and to identify coordination opportunities and action items for the FMOCC.

Data Capabilities

The FMOCC will be using currently available systems, while documenting elements for a future information technology platform to enhance the ease of coordination going forward.

Patient Movement

The FMOCC will work with the SMOCC to coordinate the inter-state transfer of patients, including to alternate care sites, if all contingency care resources in the state have been exhausted.

The FMOCC, SMOCC, and RMOCC **do not replace 911 operations** for pre-hospital **transport of patients originating outside of the healthcare system**.

The steps for conducting a patient movement request are described below.

1. **SMOCC Communicates Request**

   The request for patient movement can be made by the SMOCC if no appropriate resources are available for the patient within the state.

   The SMOCC will provide the following information*:

   - The number of patients requiring transfer and from which facilities
   - Each patient's age, gender, acuity, and level of care needed
   - Each patient's COVID-19 status (positive, negative, unknown)
   - Additional pertinent clinical information, including requirements for transfer (oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information as applicable)

   *Only the necessary information without personally identifiable information or sensitive personally identifiable information should be provided by the SMOCC to facilitate the patient transfer. If the information is collected by federal agencies, a Privacy Threshold Assessment may be required.

2. **FMOCC, SMOCC, and RMOCC Facilitate Patient Placement**

   The FMOCC will contact neighboring states' SMOCCs within the federal region to identify the appropriate location for the required level of care.

   In some instances, transfer may be made **to a neighboring federal region**, in which case the coordination will be initiated by the respective FMOCCs and then transferred to the SMOCCs upon identification of available resources. SMOCC Transfer Coordinators from the referring and receiving states will coordinate with RMOCCs, if activated, to facilitate a conversation between referring and admitting (receiving) physicians.

3. **FMOCC Facilitates Patient Transport via SMOCC and RMOCCs**

   Once the FMOCC, SMOCCs, and RMOCCs have determined the Receiving Facility, the SMOCC Transfer Coordinator and/or the RMOCC Transport Coordinator may contact EMS for transport if this is not done

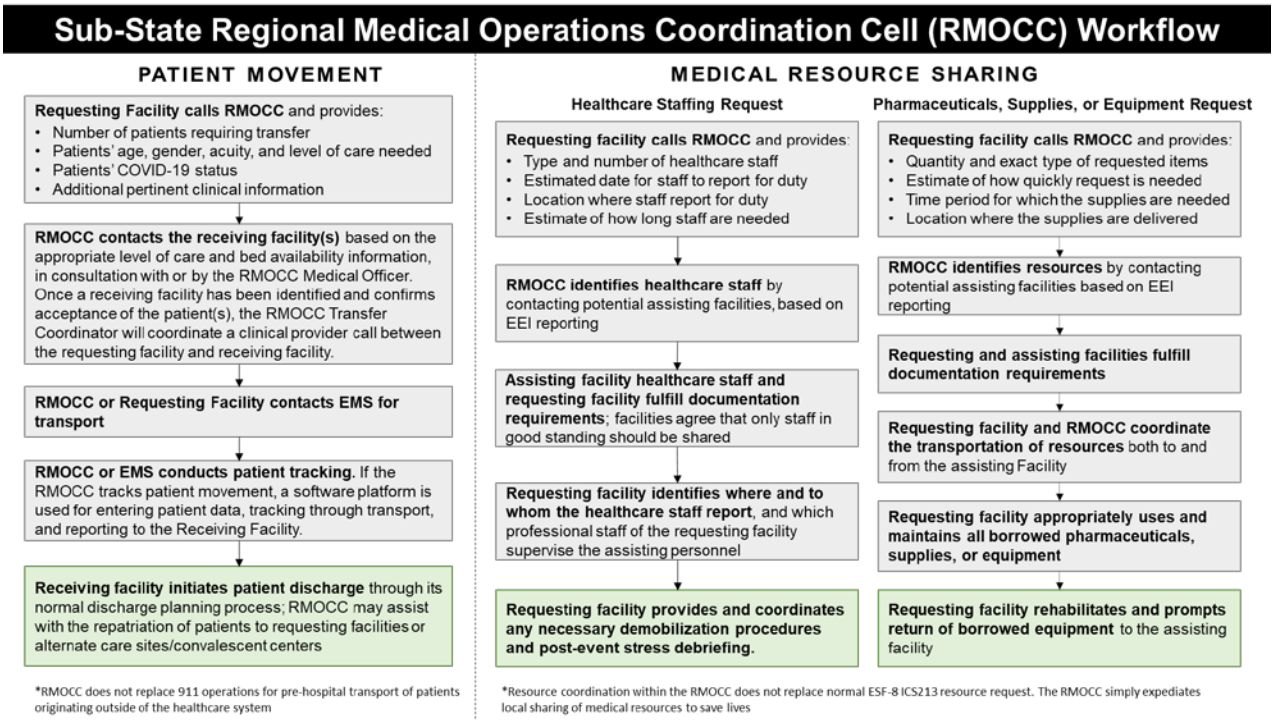
by the Referring Facility. The appropriate EMS asset will be assigned based on the level of care required during the transfer, infectious state of the patient, and destination.

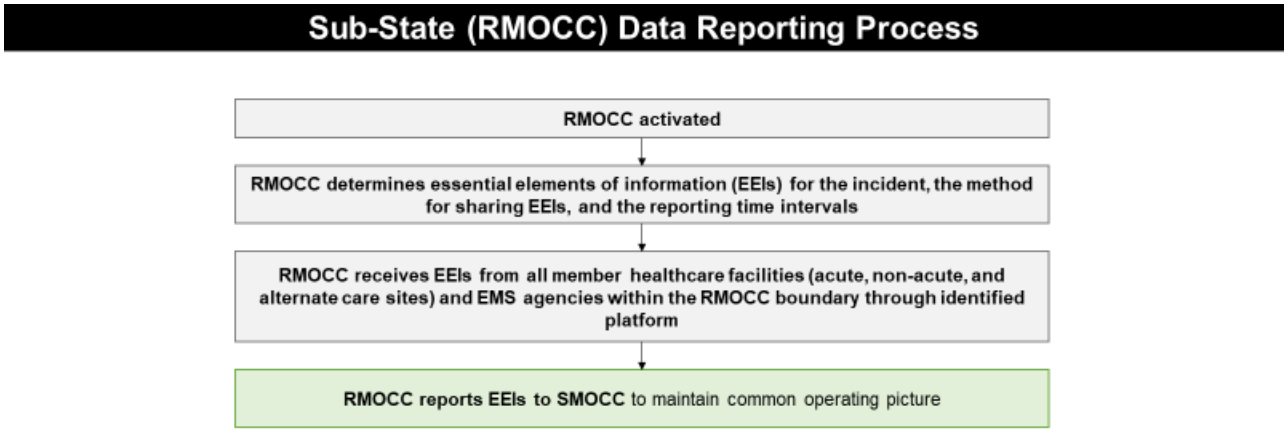
EMS regulations differ widely by jurisdictions. See Appendix H: RMOCC Sample Transportation Flow for more information.

Given that FMOCC-coordinated patient transfers may cover substantial distance and engage facilities that are less familiar to stakeholders, the following considerations are for safe patient transport:

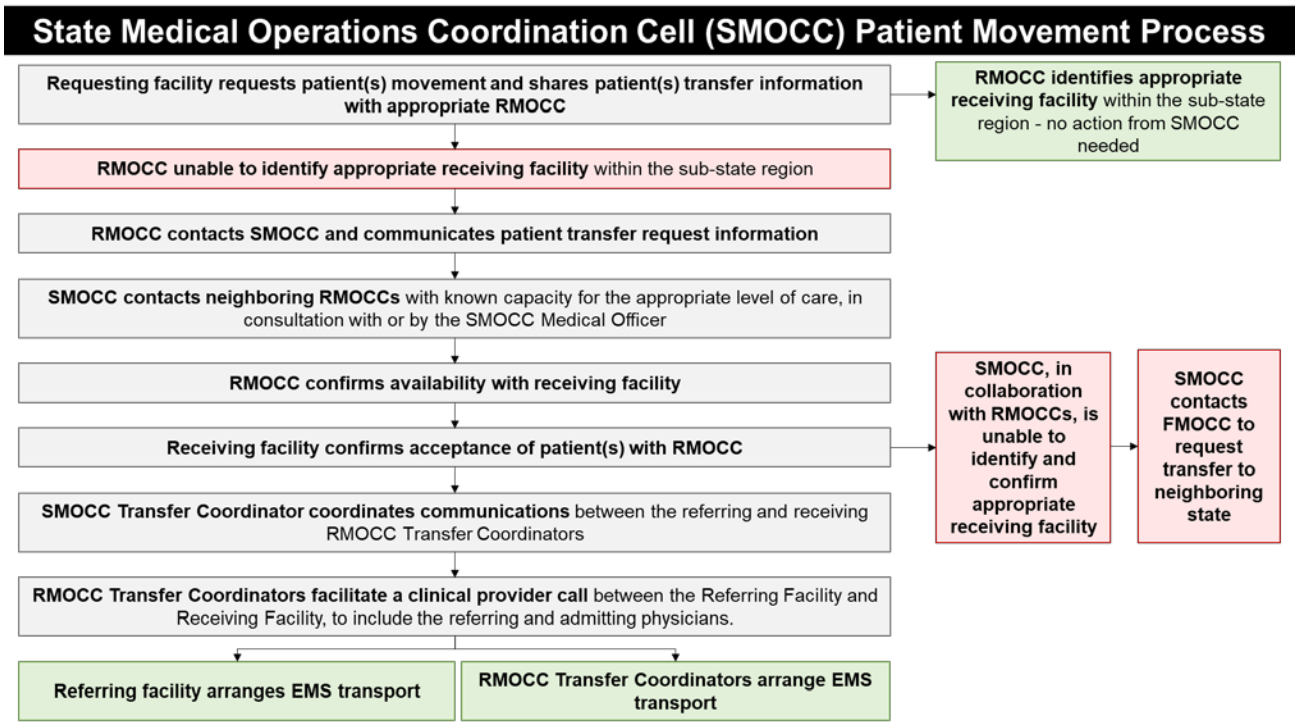
- Capacity, supplies, and capability of receiving sites
    - High intensity/complexity care is only provided at certain centers (e.g., Extracorporeal membrane oxygenation (ECMO), burn care, trauma care, cardiac care).
- Condition of patient (stable for transport or not, anticipated risk for decompensation during and after transport vs. benefits of transfer, life sustaining treatment documentation considerations)
- Capabilities of transfer crew (EMT, paramedic, critical care nurse, pediatric clinician and/or virtual health resources to augment)
- Estimated transfer time
    - Available transfer methods:
        - Fixed wing
        - Rotor-wing
        - Ground
- Triaging transfers
    - In an overcapacity situation, consider evacuation standards (e.g., transferring the most stable patients first to expedite transfers and free up capacity faster). Consider transferring multiple patients that need minimal in-transport care in higher occupancy vehicles.
    - Transfer patients that require specialized care from verified centers (e.g., ECMO, burn, trauma, stroke, or cardiac) if care cannot be provided at the originating site.
- In extreme circumstances, and under Crisis Standards of Care (CSC) protocols, transport of patients may not fit traditional models of patient regulation and a suitable alternative will be identified.

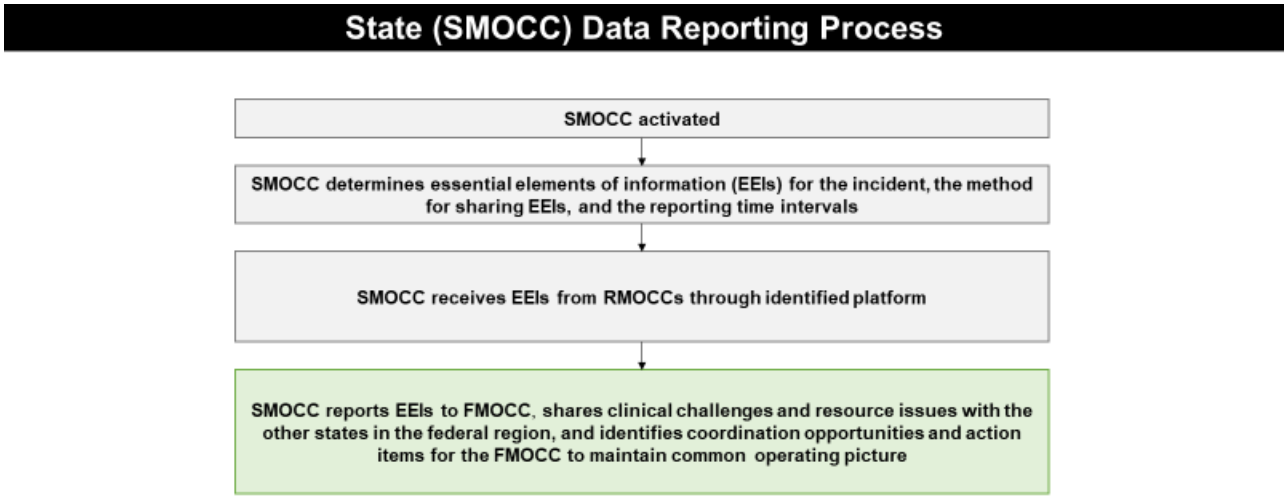
APPENDIX A: RMOCC PATIENT WORKFLOW AND DATA REPORTING PROCESS



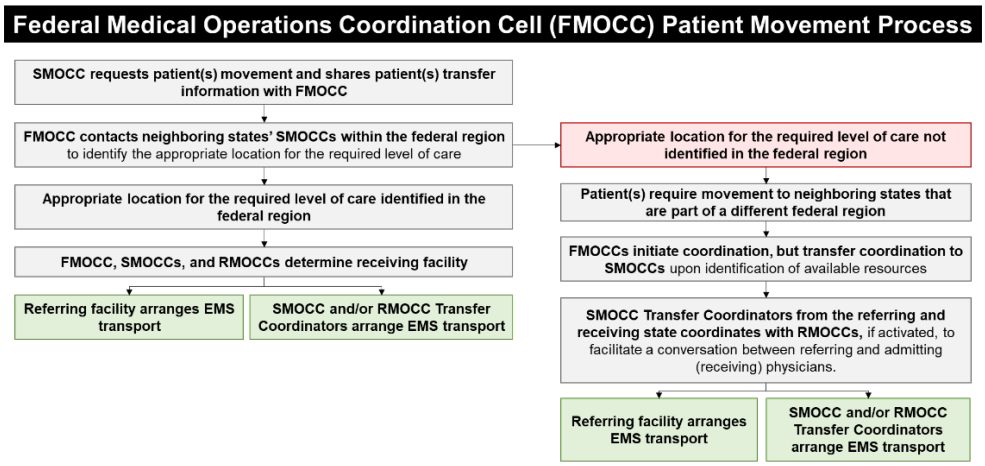


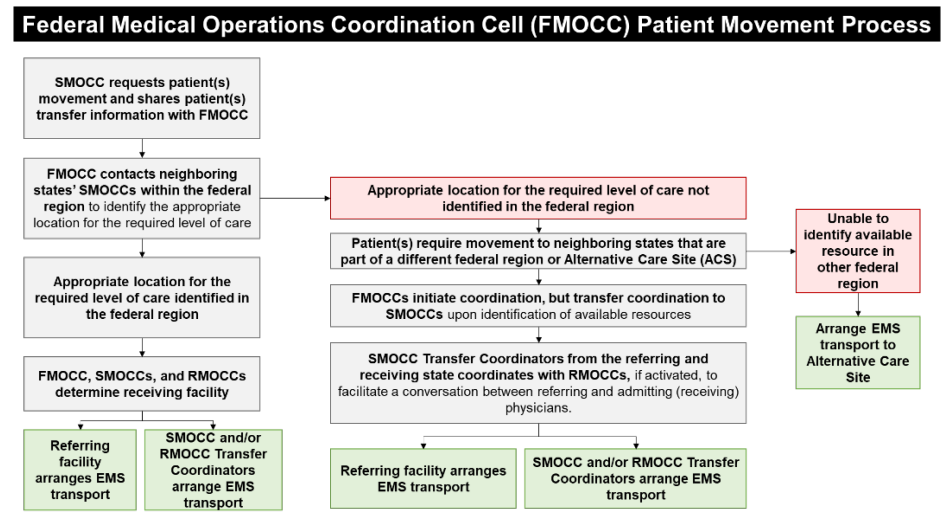
APPENDIX B: SMOCC PATIENT WORKFLOW AND DATA REPORTING PROCESS

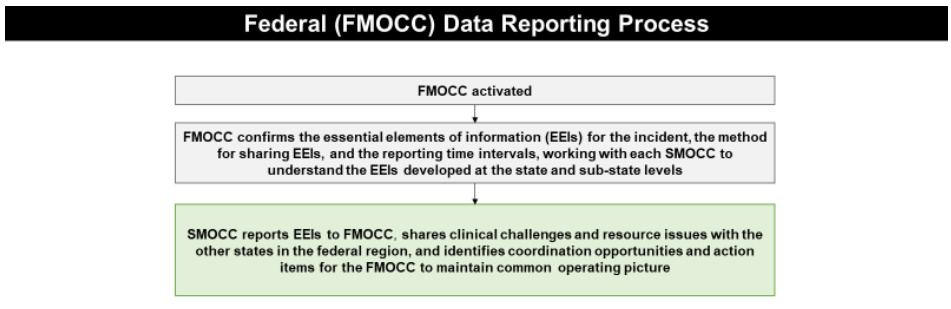




APPENDIX C: FMOCC PATIENT WORKFLOW AND DATA REPORTING PROCESS







APPENDIX D: PATIENT TRANSFER CHECKLIST

PATIENT TRANSFER CHECKLIST

TO BE COMPLETED BY SENDING PHYSICIAN OR TRANSFER COORDINATOR. ALL AREAS MUST BE COMPLETED.

Name:_____ **DOB:**_____ **Gender:** _____

Address:_____ **Phone:** _____

Emergency Contact (Name,Relationship): _____

Emergency Contact Phone #:_____

Name of referring facility:_____

Insurance Provider:_____ **Insurance ID Number:** _____

Secondary Insurance (if applicable):_____ **Insurance ID Number:** _____

Current Treatment Provider: (Name)_____ **Phone:** _
____

Admitting Diagnosis:_____

_____ **Allergies:**_____

Primary Language:_____ **Translation service needed?** ☐ **Yes** ☐ **No**

Height (inches):_____ **Weight:** _____

Special Dietary Needs (if any): _____

In addition, the requesting facility must communicate the following information to the MOCC:

- The patient's age, gender, acuity and level of care needed.
- The patient's COVID-19 status (positive, negative, unknown).
- Additional pertinent clinical information including requirements for transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information as applicable).

SUBMIT THE COMPLETED TRANSFER CHECKLIST AND HOSPITAL FACESHEET FOR PRE-ADMISSION REVIEW TO THE LOCAL OR STATE MOCC:

MOCC:

Fax:

ITEMS TO SEND WITH PATIENT AT THE TIME OF TRANSFER TO RECEIVING FACILITY:

- ☐ Copies of completed Patient Acceptance Questionnaire, Patient Transfer Checklist, and Discharge Planning and Transfer Back Agreement
- ☐ Hospital face sheet
- ☐ Reason for transfer (physician progress note or order)
- ☐ History and physical examination
- ☐ Daily progress notes
- ☐ Consultation reports
- ☐ Ancillary services notes (PT, OT, Respiratory Therapy, Case Management, etc.)
- ☐ Results of all relevant diagnostic tests, X-ray images (CD), and reports
- ☐ Medication administration record
- ☐ Advance directive
- ☐ Documentation of transfer consent

APPENDIX E: PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR AMBULANCE TRANSPORT

A Physician Certification Statement (PCS) is required to establish medical necessity for all non-emergency ambulance transports.

Transport Date:_____Origin:_____

Destination: _____

Patient's Name (print):_____Date of Birth:_____

Facility: _____

Medical Record Number (MRN): _____

Medical necessity is established when the patient's condition is such that the use of any other method of transportation would be contraindicated. In other words, no other transportation type could be used without endangering the patient's health. If the patient can be transported by any other means (e.g. wheelchair van, stretcher aid van, taxi, car, etc.) then medical necessity for an ambulance does not exist. It does not make a difference whether the other type of transportation is available in the locality at the time of service.

	YES	NO
BED-CONFINED (Patient unable to get up from bed without assistance, unable to ambulate, and unable to sit in chair or wheelchair.)	☐ Reason: _____	☐
This patient cannot be safely transported while strapped in a wheelchair that is bolted to the floor and unattended in the back of a moving wheelchair van.	☐ Reason: _____	☐
IMMOBILIZED due to recent fracture or possible fracture:	☐ Hip ☐ Leg ☐ Neck ☐ Other: _____	☐
Orthopedic Device present	☐ Type: _____	☐

CONTRACTED and **CANNOT SIT** up in a wheelchair:	☐ Upper Extremities ☐ Lower Extremities ☐ Fetal	☐
Suffers from **PARALYSIS:**	☐ Para ☐ Quad ☐ Hemi	☐
DVT that requires elevation	☐	☐
Requires **TRAINED MONITORING** for:	☐ Airway Control / Positioning or Suctioning ☐ Continuous IV Therapy ☐ Ventilator Dependent/ Advanced Airway Monitoring ☐ Cardiac Monitoring ☐ Is medicated and require monitoring ☐ Danger to self or others ☐ Palliative Support related to hospice care ☐ Acute Condition: Reason:	☐
REQUIRES RESTRAINTS	☐ Physical-Type: ☐ Chemical-Type: Reason:	☐
Requires ISOLATION PRECAUTIONS	☐ Reason:	☐

DECUBITUS ULCERS:	Stage:_____ Location: ☐ Buttocks ☐ Coccyx ☐ Hip ☐ Other:_____	☐
Requires **OXYGEN** Enroute	☐	☐
Is patient able to administer his or her own oxygen?	☐	☐
ALTERED MENTAL STATUS	Condition: ☐ New Onset ☐ Status Change Patient exhibits: ☐ Hostile ☐ Agitated Violent ☐ Violent ☐ Non-compliant	☐
Is altered mental status the result of sedation?	Type:	☐
Exhibits a DECREASED LEVEL OF CONSCIOUSNESS	☐ Unconscious ☐ Stuporous (Semi-conscious) ☐ Unresponsive ☐ Intermittent Consciousness ☐ Incoherent ☐ Hallucinating ☐ Lethargic ☐ Head injury with altered mental status	☐

Morbid Obesity:	Weight: Height: BMI:	☐
☐ **N/A:** Please check if none of the above describe the patient's condition at time of transport and document reason for transport request here:		

Hospital-to-Hospital Ambulance Transport

Reason for Transfer:

- ☐ Service(s) not available at originating facility What Services?

- ☐ Patient/ Family Request for Transfer
- ☐ Insurance Transfer

☐ **Patient Meets Medical Necessity Criteria For Ambulance Transport:**
I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I certify that this patient requires ambulance transport based on the above information. I understand that this information will be used by the Department of Health Services and the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

☐ **Patient Does Not Meet Medical Necessity Criteria For Ambulance Transport:**
I understand that the below signature authorizes the guarantee of payment from the originating facility and/or I have informed the patient of their responsibility for payment related to medical transportation services and have advised them to contact *[enter phone number]* to arrange payment prior to transport.

Signature of Physician or Healthcare Professional **(Stamped/File Signatures Not Accepted)**	Printed Name & Credentials	Date: NPI #:

If signed by a Healthcare Professional other than the attending physician, please indicate title of signer below:

☐ Physician Assistant	☐ Clinical Nurse Specialist	☐ Registered Nurse	☐ Nurse Practitioner	☐ Discharge Planner

APPENDIX F: SITUATION REPORT TEMPLATE

Regional Medical Operations and Coordination Center (RMOCC)

Situation Report Template

Event Name	
Date	
Time	
Operational Period	
RMOCC Activation Level	
Report Number	

CURRENT SITUATION:

Below is an overview of the current situation:

(Data Accessed @ *00:00 DD/MM/YY*)

GLOBAL (Non US cases)		UNITED STATES	
Confirmed Cases	Total Deaths	Confirmed Cases	Total Deaths

*Data derived from the *{Insert data source here}*

(Data Accessed @ *00:00 DD/MM/YY*)

STATE COVID-19 DATA	
Confirmed Cases	Deaths

*Data derived from *{Insert state data source here}*

(Data Compiled @ *00:00 DD/MM/YY*)

STATE PUBLIC HEALTH REGION					
County	Confirmed Cases	Deaths	County	Confirmed Cases	Deaths
TOTAL Confirmed Cases			TOTAL Deaths		

*Data derived from *{Insert state data source here}*

(Data Compiled @ *00:00 DD/MM/YY*)

CITY/COUNTY/MAJOR METROPOLITAN AREA HEALTH DISTRICT	
Confirmed Cases	Deaths

*Data derived from *{Insert state data source here}*

(Data Compiled @ *00:00 DD/MM/YY*)

***Information within this table may not reflect current DSHS/SAMHD Cases and is subject to Public Health Confirmation**

REGION INPATIENT HOSPITAL CASES	
PUI / Clinically Suspected Inpatient Cases	Confirmed Cases

SUMMARY CHARTS:

{Insert summary charts here}

KEY UPDATES:

{Insert bulleted, summary updates here}

EDCOM "COVID ALERT" TRACKING:

PREVIOUS 24 HOURS				
# Field Calls to MEDCOM	# IFT Calls to MEDCOM	# COVID-19 ALERT ACTIVATED	# DETERMINED CREDIBLE (MET PUI CRITERIA)	# DETERMINED UNLIKELY (DOES NOT MEET PUI CRITERIA)

INCIDENT TOTAL		
# COVID-19 ALERT ACTIVATED	# DETERMINED CREDIBLE (MET PUI CRITERIA)	# DETERMINED UNLIKELY (DOES NOT MEET PUI CRITERIA)

It is imperative that regional EMS providers utilize this resource as early as possible when responding to calls where COVID-19 is suspected.

Please have your EMS crew or dispatch center call *{Insert Contact Number or Information}.*

For information on the "COVID ALERT" process or prehospital screening, please contact *{Insert contact number or email address}.*

HEALTHCARE SYSTEM SUPPLY INTEGRITY:

In response to the increased supply issues, the RMOCC will request supply statuses (EEIs) from the region, due until further notice on the following schedule:

HOSPITALS:

- **Due DAILY,** *{Insert time here}*
- Hospital PPE Status
- Medical Dashboard (Bed and Ventilator Status)

EMS:

- Due WEEKLY, *{Insert day and time here}*

ALL OTHER COALITION AND RMOCC MEMBERS:

Due WEEKLY, *{Insert day and time here}*

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

*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

RMOCC Request Priority Schedule:

PRIORITY 1	PRIORITY 2	PRIORITY 3

• Hospitals or healthcare professionals in contact with or treating confirmed COVID-19 patients with potential for high loss of life.
  • *Needed to protect most critical capacity in hospitals*
  • *Losing hospital capacity will lead to increased deaths.*
• Healthcare facilities, including long-term care, supportive housing, group homes for ID/DD populations with an emerging or active outbreak (one or more cases
  • *Transmission within vulnerable/elderly/ disabled populations*
  • *High potential for multiple deaths*
	• Facilities and EMS personnel that may encounter a suspected case and interface with a vulnerable population.
	  • *Healthcare – hospitals*
	  • *Long-term care facilities, supportive housing and group homes with history of COVID-19*
	  • *Isolated patient step-down locations*
		• Healthcare facilities, providers, and first responders that have general patient encounters and needs.
		• Other healthcare settings not caring for inpatient COVID-19 patients with general need
		• Other healthcare professionals collecting specimens
		• Other first responders

Requests Received	Individual Line Items	In Queue or Unfillable	Filled	Partially Filled	RMOCC Submitted to STATE

RMOCC Assistance Request Sent to State:

ID Number	Submitted on Behalf of:	Item(s)	Status
			On track
			Risks
			Critical

The CDC technical guidance on **strategies for PPE** supply management are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

REGIONAL HEALTHCARE RESOURCES COMMITTED TO INCIDENT

Agency	Resource Kind and Type	Quantity	Status	Resource Location

RMOCC Activation Levels and General Information:

Example levels include:

- *Level I (Emergency Conditions/Full Activation)*
- *Level II (Escalated Response Conditions / Partial Activation)*
- *Level III (Increased Readiness Conditions) Level IV (Normal Conditions)*

Location: *{Insert RMOCC location}*

Operational Period: *{Insert RMOCC core hours of operation}*

Contact Info: *{Insert RMOCC email and phone number}*

Staffing:

Position	Status
Command	*Activated*
EMS Desk	*Activated (Virtual)*
Hospital Desk	*Activated (Virtual)*
Public Health Desk	*Activated (Virtual)*

Operational Priorities:

Suggested operational priorities include:

1. *Maintain the integrity of the regional healthcare system and is ability to provide care to the sick and injured of {inset state/region}.*
2. *Support coordinated response through communication and collaborative planning amongst emergency management, public health, and the acute healthcare sector (hospitals/ems)*
3. *Collect and disseminate timely, accurate incident information, resources, and materials to improve the safety of responders, healthcare workers, and others responding to the incident*

APPENDIX G: MOCC PRE-SCRIPTED MISSION ASSIGNMENT (PSMA) TEMPLATE

Title

Federal Medical Operations Coordination Cell (FMOCC)

Requested Assistance

Request the Department of Health and Human Services (HHS) activate and staff a FMOCC to support interstate patient transfer in support of Federal operations.

Statement of Work

As directed by and in coordination with FEMA, HHS will provide appropriate personnel to the RRCC to establish a FMOCC that will facilitate intrastate and interstate patient transfer planning from overwhelmed hospital systems. FMOCC will work in coordination with existing RRCC operations when facilitating interstate patient transfer. FMOCC scope is limited to monitoring state bed status, connecting bed requirements and available hospital resources, and facilitating the interstate process through establishment of host state agreements and tracking of patients until receipt at destination.

Standard language (included in all statements of work of all mission assignments):

--- Mission Assignment task orders (MATOs) may be issued by FEMA for specific requirements, personnel, location(s), date(s), and duration of assignment(s).
--- Agencies may be reimbursed for all eligible expenses pursuant to 44 CFR Pt. 206. Supporting documentation is required for reimbursement.
--- All equipment and supply purchases must be coordinated with FEMA. If approved, documentation is necessary to ensure reimbursement.
--- Activation of agency command center(s), if required, must be coordinated with FEMA as a separate MA.
--- The mission-assigned agency is responsible for ensuring that all activity is properly authorized, goods are received, services are provided, and that costs are reasonable and supported by documentation maintained by the respective agency
--- MAs shall be considered for closure after 180 days with no financial activity in accordance with FEMA CFO Bulletin #157. For MAs still operationally open, requests for additional obligations may be withheld if no invoicing, ULO Validation, or additional justification has been provided.

Total Cost Estimate

$65,000

** NOTE: Total estimated costs are for planning purposes only and are subject to change. The cost estimate does not represent all eligible costs, which could be reimbursed. **

Cost Based On

Initial cost estimate includes three (5) MOCC staff for 30 days.
- MOCC cost per team member, for 30-day operation: $13,000
Costs will include
Overtime: up to 44 hours per week, 12 hours/7 days, less regular 40hour week
Lodging and per diem at ____per day for _____ days
Travel: $ ____per person
Transportation at Duty Station: $_____

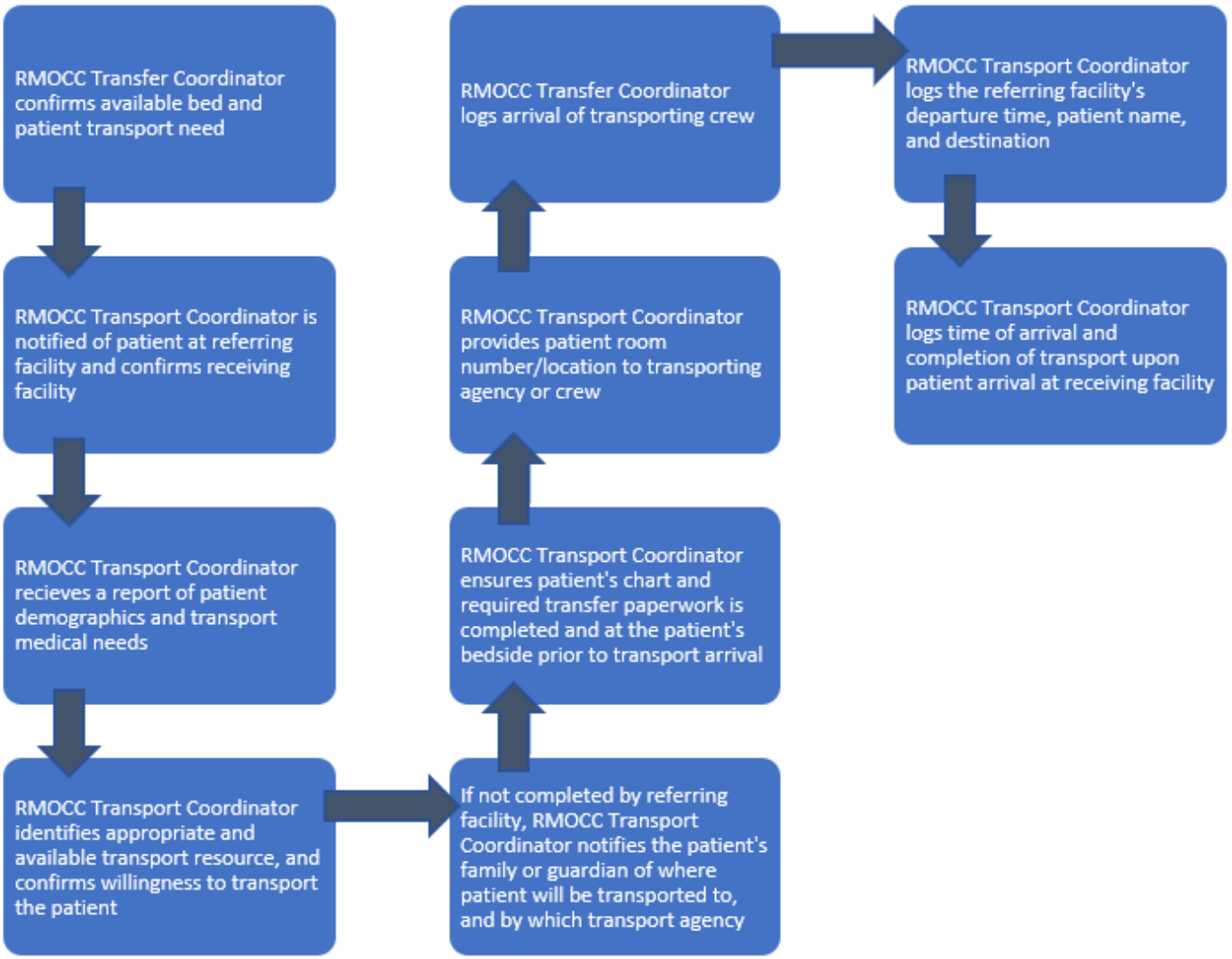
Supporting Info/Notes

Notice:

Disclaimer: Total estimated costs are for planning purposes only and are subject to change.

Federal agencies will be reimbursed only for actual eligible costs incurred.

APPENDIX H: RMOCC SAMPLE TRANSPORTATION FLOW



Additional resources may be found at:

- Interim Guidance for EMS Systems and 9-1-1- PSAP for Management of PUI for Ebola Virus Disease
- NHTSA Guide for Interfacility Transfers.
- HHS Patient Movement Resources Appendix