

Medical Operations Coordination Cells Toolkit

Second Edition

Originally 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 aimed to assist regional, state, local, tribal, and territorial (SLTT) governments to ensure load-balancing across healthcare facilities and systems. Healthcare providers can use this toolkit to deliver the highest possible level of care to each patient during the coronavirus disease 2019 (COVID-19) pandemic caused by the virus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), other disasters, or on a day-to-day basis. 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 often located 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 referrals and load-balancing through patient transfers. Key stakeholder groups include healthcare facilities, emergency medical services (EMS), and supporting SLTT governmental partners.

While MOCCs, or similar patient load balancing systems, have been used in varying ways in many jurisdictions in prior disasters, they have recently become a key part of the COVID-19 response in many states. MOCCs are a critical method of ensuring that healthcare assets are used consistently across a region—often a state, sometimes across a healthcare coalition, and more rarely across state lines. MOCCs help to promote a consistent standard of care across a region and therefore are a key tool in promotion of the optimal care given the resources available but also in ensuring equity, as hospitals serving larger proportion of at-risk populations are often impacted by [greater surges of patients](#).

MOCCs may be used on a daily basis to manage EMS traffic as well as hospital referrals, but have a critical role during disasters ([EMS Supplement for the MOCC Toolkit](#)). These may include epidemics such as COVID-19 but also mass casualty incidents, particularly those requiring specialty care referral prioritization such as burn and pediatric incidents. Key functions may include:

- Directing EMS units to hospitals with capacity.
- Directing secondary referrals to the most appropriate hospital (i.e., those with capacity and/or the most appropriate for the patient's care given the patient's condition).

Related ASPR TRACIE Resources

- [Establishing MOCCs for COVID-19 Webinar](#) and [QA](#)
- [Healthcare Coalition MOCC Resource Assessments Technical Assistance Response](#)
- [Excess Mortality and COVID-19 Surges: Defining the Problem and Solutions Webinar](#)
- [COVID-19 Regional Support Resources](#)
- [COVID-19 Patient Surge and Scarce Resource Allocation Resources](#)

Other Relevant Resources

- [Considerations for Assessing Regional Patient Load-Balancing Effects during COVID-19](#)
- [Critical Care Load-Balancing Operational Template](#)
- [Key Considerations for Transferring Patients to Relief Healthcare Facilities when Responding to Community Transmission of COVID-19 in the US](#)
- [Managing Alternate Care Site Utilization through MOCCs](#)

- Serving as a one-call referral line to achieve rapid placement of patients needing critical care, particularly when the referring hospital does not provide the services required (e.g., emergency dialysis, multi-organ failure support, management of acute respiratory distress syndrome). MOCCs can be used solely to meet critical care bed needs, but also for all bed types.
- Providing consultation with specialty medical providers when required to help prioritize a patient for transfer or receive instructions for care-in-place when this is required for a period of time.
- Convening hospitals for situational information sharing including current contingency measures and potential need for load-balancing / negotiation of load-balancing. Note that this may be a healthcare coalition (HCC) function or the state may provide this forum, but it is critical that the patient management / providers from major healthcare systems have a foundation to share this information.
- Managing load-balancing between overwhelmed facilities and those with more overall capacity.

Example MOCC Plans/Presentations

- [Michigan Community Health Emergency Coordination Center \(CHECC\)](#)
- [Nebraska Medical Emergency Operations Center \(Ne MEOC\)](#)
- [Southeast Texas Regional Advisory Council \(STRAC\) Regional Medical Operations Center](#)
- [Utah COVID-19 Medical Surge Operations Plan](#)
- [Washington Medical Coordination Center \(WMCC\) Operational Guidance](#)

Key Principles of Load Balancing:

- Any facility can request load-balancing based on voluntary cooperation of the others subject to available beds.
- The MOCC should monitor bed availability in and around their operational area to assure a common level of saturation.
- Policies should be in place that guide actions when a facility is considered overwhelmed compared to others that would “force” load-balancing to occur. This could include changes to staffing that are more dire than those taken at other facilities (e.g., using non-traditional staff in intensive care units) or involves a percentage of occupancy of beds beyond usual capacity that is more than X% different from others in the area.
- Load-balancing assumes that usual surge capacity actions have taken place and that non-emergency procedures are postponed to free up space and staff.

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, are included 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 patient load balancing needs of their jurisdictions and regions.

AUTHORITIES

No system can exist without public-private partnership. However, the MOCC must have delegated authority to “force” patient movement when necessary for load-balancing or to ensure that emergency transfers get to a hospital where the appropriate services can be provided. These authorities may be granted by a governor’s emergency order, statute, or by mutual agreement of all hospitals in the region. Some authorities for the MOCC may only exist during a declaration of emergency whereas others (e.g., daily bed counts, some baseline functions of the MOCC such as a referral call line) may exist at the agreement of the major healthcare systems.

The MOCC policy should specify the authorities under which the MOCC operates and how those change during emergency declarations.

MEDICAL DIRECTION

Medical consultation serves two critical roles at the MOCC – providing “care-in-place” instructions when the patient will need continued care at the facility awaiting transfer/placement and to help the referring facility determine what level of care is required for the patient under the current circumstances (e.g., at times critical care beds may be reserved for patients requiring blood pressure support or mechanical ventilation). A medical director is needed for the MOCC to both assist in the development of policy but also to oversee medical aspects of operation. The MOCC often has to use medical information about patients to help prioritize which patients to transfer first but also which destinations are most appropriate. These functions require a medical director with a background in emergency medicine or critical care and a deep understanding of the healthcare systems in the area. In order to provide coverage over extended operational periods the medical director should identify similarly trained alternates to serve on call. The medical director with an on-call group of providers needs to be available to provide consultation when required, 24/7.

ORGANIZATION

Many different models of MOCC operations exist. Based on the available resources and who is operating the MOCC the following are likely the four most viable models:

- Integration of the MOCC into a jurisdictional EOC (e.g., emergency management agency EOC or health department EOC)
- Integration of the MOCC into a major healthcare system referral center or healthcare coalition (with support from the state and/or other healthcare systems) (e.g., RMOCC)
- Interstate integration of RMOCC or SMOCC at the FEMA or other multi-state regional level with support and coordination from HHS regional staff (e.g., FMOCC)
- Virtual MOCC operations utilizing web-based tools and distributed personnel and answering points for a common phone number may be integrated into any of the above approaches

Each model has advantages and disadvantages. Integration of the MOCC into an existing EOC structure ensures state support and a discrete connection to the state emergency operations structure, including reimbursement and links to state operations (including EMS operations). However, changes in need for the MOCC over time cannot be integrated as easily and the MOCC is limited operationally to the hours of the EOC. Integration into a major healthcare system or HCC call center offers the opportunity to expand and contract operations according to demand and can provide a constant point of contact and support during flu season and other high-capacity times during which an EOC would not be expected to be open.

Disadvantages include the potential lack of staff, potential optics issues with having a healthcare system managing the MOCC on behalf of other systems, and cost. Virtual MOCC operations are an excellent way to distribute and rotate responsibility as well as offer flexibility for expansion and contraction of operations but rely on technological solutions such as web-based platforms, forwarding phone numbers, and still have administrative and technical costs that must be absorbed. Distribution of responsibility can often lead to problems with familiarity with process, so responsibility should not be diffused too broadly.

Interstate MOCCs build upon SMOCCs and RMOCCs to coordinate across several affected states. In this case, it is best to integrate regional HHS personnel to help coordinate and support this effort. Both rural/ frontier and densely populated areas that refer to facilities in several nearby states should strongly consider this model to ensure consistency of care and information sharing.

OPERATIONAL CONSIDERATIONS

When initiating a MOCC, many questions need to be addressed. It is best to ensure that the major stakeholders have a role in shaping the construct of the MOCC as well as the opportunity to provide input on the functions and operational policy. Common questions include:

- **When will the MOCC be activated?**
 - There are multiple situations in which a MOCC can be extremely useful. Any time the healthcare system is operating under surge conditions and patients are routinely boarding in emergency departments awaiting an inpatient bed, a MOCC process may be valuable. MOCCs can be activated during a seasonal (e.g., influenza) situation or natural disaster, with a variety of implications for location of the MOCC as well as funding and liability protections for the MOCC

staff. A pandemic such as COVID-19 that stresses multiple facilities and systems is a key indication, as are mass casualty events that require prioritized patient distribution to specialty facilities (e.g., burn or pediatric events).

- **What organization should/will operate the MOCC?**
 - This may depend on whether the MOCC is seen as solely an emergency entity of the state or whether it is an ongoing resource (e.g., for flu season) maintained by the healthcare systems. Part of this decision involves the degree to which the healthcare systems are committed to working together, the degree to which the state wishes to have control over the processes, and what options are available for current and future funding.
- **What authorities does/should the MOCC have?**
 - At minimum, the MOCC needs the authority to “force” transfers when it is clear by the data that there is a patient safety issue. These situations and the data that support these decisions should be clearly defined ahead of activation. Forcing transfers should be a relatively rare occurrence, as the primary function of the MOCC is to use data on available beds to make sure that the region uses all its resources to respond to the demand of the disaster
- **What liability protections are afforded MOCC personnel?**
 - When the MOCC is purely a state entity, liability is usually addressed under the emergency declaration. However, if the MOCC is to operate outside emergency circumstances, the functions should be examined, particularly on clinical consultation or transfer prioritization decisions that could be subject to liability. Either the state (e.g., through Medical Reserve Corps protections) or the healthcare system employing the provider should clearly document the liability protections.
- **Will the MOCC work across state lines and if so, how far and with what systems/facilities?**
 - Many traditional patient referral patterns extend across state lines, with data from hospitals and healthcare systems outside the state used to help inform transfer decisions. Because those healthcare systems often benefit from being able to refer patients into the state hosting the MOCC they are often willing to share data and accept referrals knowing that this will be a “two-way” street. If the other state has a MOCC set up, MOCC-MOCC coordination points are another option. Regional, multi-state agreements may result in a single MOCC for several states (FMOCC) depending on the incident. Understanding adjacent state plans and points of contact is critical to success, particularly during a no-notice incident.
- **How can the MOCC be reached/accessed?**
 - A common gateway phone number should be agreed upon and reserved for current and future MOCC use.
- **Who will staff the MOCC? How will staffing be expanded when needed?**
 - One of the key issues with a MOCC is that for a no-notice incident, a pre-existing roster of staff and structure must be in place to allow a rapid start-up. Operations during a no-notice event will be maximal at onset. Subject matter experts (SMEs) may be busy with response operations depending on the location of the incident and the roster should include experts in critical care, burn, pediatrics, and EMS drawn from across the region to assure availability of enough individuals. Call-takers and supervisors should ideally be drawn from healthcare systems staff that have similar daily responsibilities (although with just-in-time training and call scripts those with less background may be able to function in the role). Supervisors must have healthcare system experience with patient placement.

- **Who will set MOCC policy?**
 - Even if MOCC policy is to be set by the state, an integrated process for policy development with the hospital association and hospital leadership must occur if the system is to function well. Operational policy will need to be developed over time to cover all aspects of the MOCC from medical direction to call-taking to policies on load-balancing.
- **Who will comprise the group that will help develop and modify the policies of operation of the MOCC?**
 - The policy group will be an ongoing need of the MOCC and should represent the key private-public partner stakeholders including the state health department, emergency management, hospital association, medical direction/critical care, as well as hospital service line experts in patient placement, informatics, and other necessary disciplines
- **How will transportation / EMS be integrated into transfer decision-making?**
 - In many cases, specialized transportation may be needed or there may be competition for critical care ground or air assets that requires prioritization between patients. Integration with EMS at the state or regional level can greatly assist the MOCC functions by helping match the best available transportation resources to patient needs while attempting to balance the need for emergency EMS coverage.
- **How will EMS be reimbursed for transfers to a similar level of care?**
 - When load-balancing operations are performed, it is often difficult to bill insurance for a transfer to a hospital that provides similar services. In some cases, hourly reimbursement for the ambulance and staff time spent on transfers through state emergency funding, activation of ambulance strike teams, or utilization of ambulances through the federal ambulance contract (if the need cannot be met by state resources) may be options. Payors should engage in discussions of reimbursement for these services when conditions indicate a benefit to the patient from transfer due to surge conditions at the facility of origin.
- **Who will be the medical director for the MOCC?**
 - While public health directors may be physicians, it may not be ideal for them to direct the MOCC both because of competing priorities (the MOCC medical director may need to respond to questions at any time) and because their skill set is often not aligned with the emergency medicine/critical care knowledge that is optimal for a MOCC medical director. Medical director(s) should also be well-known in the region and have a good knowledge base of the healthcare system, ideally with prior background in emergency planning and the ability to help lead consensus-driven discussions as the majority of MOCC decisions are collaborative, and not command-based.
- **How will the MOCC provide or facilitate clinical consultation for care-in-place awaiting transfer if this is required?**
 - In some cases or during low-volume periods, the need for clinical consultation will be infrequent. However, the medical director may need to have a rotational call schedule for coverage, particularly for critical care. A roster of critical care, emergency medicine, pediatric, burn, and other specialty providers should be maintained for no-notice incident needs and rostering during prolonged incidents.
- **How will the MOCC prioritize patients for transfer when requests exceed capacity – including critical care and pediatrics?**
 - Sometimes the number of patient placement requests will exceed available resources. In these cases, a SME (e.g., critical care) should help prioritize the waiting patients for transfer, as well as

help determine the most appropriate facility. This may mean that only selected patients are referred to a children's hospital, for example. Agreeing on general written frameworks for directing referrals to specialty centers/specialty beds is helpful and can improve efficiency and decrease confusion. For example, when pediatric hospitals are full, first direct those age >12 with no major congenital or complicated health conditions to community hospital care; then shift that down to age >8 as demand increases. Knowledge of the capabilities of non-specialty hospitals can be an important part of this process.

- **How frequently and by what means will the MOCC convene the hospitals/providers on calls to review the current situation and determine what load-balancing may be required between facilities?**
 - Hospitals must have a way to share information between the critical care/patient placement providers to not only share existing contingency strategies but also provide updates and share new strategies/issues. The MOCC may not be the primary convener but should participate in these discussions and share updates. When load-balancing is required, the MOCC should have a process to convene patient placement and critical care providers from each of the major systems on a call to discuss the situation and to the degree possible agree on patient distribution (the MOCC may have ultimate authority to force transfers, but this should generally be a last resort).
- **How does the MOCC request/receive real-time information about available beds?**
 - In many cases, bed data entered into a system may be outdated. The MOCC should have a process and points of contact to assure up-to-date information. This could include "polling" when beds are needed, use of texting to update bed availability, and other means to assure that the MOCC has near real-time data.
- **Will the MOCC function be limited to ICU beds or apply to all bed types?**
 - Patients requiring critical care are the most vulnerable to deterioration and death, and are the primary reason for MOCC functions. However, knowing floor bed availability and helping match available beds to patients can be a huge benefit to the hospitals and may be included, with the understanding that this can dramatically increase the number of calls.
 - Intermediate/monitored bed placement often will involve physician input, as the criteria for these units varies not only between facilities, but often varies with the dynamic demands of the incident as patients who normally might be hospitalized in an ICU are placed on step-down units. Even for ICU bed requests when beds are not immediately available, a consultation will often be required to determine whether the patient could be care for on another unit. In some cases, critical interventions are required that do not necessarily require a specific bed type (ERCP, surgical intervention, dialysis) and may require the MOCC to determine the best available nearby hospital. Often, MOCC functions exclude specialty referrals such as trauma, pediatrics, or burn, but consideration should be given as to how these may best be handled when there are large volumes of such patients.
- **Will the MOCC be a regional coordination point for Extracorporeal Membrane Oxygenation (ECMO)?**
 - ECMO is used in selected patients when mechanical ventilation is failing to provide adequate oxygenation or for cardiovascular support. It has significant limited availability and is extremely resource-intensive. Having a regional approach to ECMO consultation and transfer is important if more than one system is providing it. The MOCC can be a natural gateway/point of entry for an ECMO regional triage process even if it does not manage the policies.

- **Does the MOCC have the ability to compel a system to accept a transfer (particularly if that transfer originates from a critical access/community hospital with a critically ill patient that cannot receive the services needed)?**
 - One of the key authorities that the MOCC should have is the ability to place (by rotation or other means) patients that are at high risk of deterioration because they are at a hospital that does not offer the services required. This mechanism should be described and should only be utilized when no appropriate critical care beds are available. This will usually mean an occasional transfer to a higher level of care between emergency departments.
- **What patient data will be collected by the MOCC staff? How will equity be ensured in this process?**
 - The MOCC should have a standardized patient information form that collects the age, diagnosis, current condition, and current major interventions to facilitate placement. The medical director/consultant may have to discuss additional specifics with the receiving facility to determine the most appropriate placement if this is not easily achievable. The MOCC should prohibit exchange of racial, financial, or other information that could subject the referral to bias and the receiving facilities should not be able to make insurance status a condition of accepting a transfer.
- **What criteria will the MOCC use to determine when load-balancing is needed (e.g., specific staffing contingencies implemented at a single facility, single facility with more than X% of patients above other facilities in the area)?**
 - The MOCC should spell out in policy the goals of load-balancing, how a facility requests load-balancing, and what criteria will trigger load-balancing. Also, the policy should specify whether or not the expectation is for acute patients to be transferred and any other expectations. For example, some hospitals have been accused during load-balancing of unloading long-term ventilator dependent patients as well as the uninsured that are out of proportion to the ICU population.
- **What data will the MOCC collect? Who is the data reported to, and how does it inform ongoing operations (e.g., total requests, total patients placed, origin hospital, receiving hospital, bed type requested)?**
 - Daily data may differ from incident data, and at certain times the capacity situation may dictate the need for further information. The MOCC should have clearly outlined expectations for the type and frequency of information exchanged and how those expectations may change based on available resources. Further, the MOCC should commit to sharing information about its functions (number of placements, type of placement, type of originating facility, type of receiving facility, time to placement, mode of transport, or other data) during an ongoing incident so that MOCC operations can be improved and trends monitored over time that may drive additional policy development
- **Will the MOCC manage resources aside from beds?**
 - Most MOCCs during COVID-19 have been state-level and focused on coordination of patient transfers. However, during a mass casualty incident, HCC/sub-state RMOCCs may play a critical role redistributing patients in their area, and may also be called upon to broker staff, medication, and other requests. If the RMOCC is not designed to assist with these requests there should be another mechanism (e.g., emergency management structures with healthcare liaison) to refer them to.

MOCC 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 next) 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. Funding sources may become available or expire, so a careful search for options should be undertaken.

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., HCCs) 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.

An [HHS press release](#) includes additional information about the cooperative agreements 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 Crisis Response Cooperative Agreement

If activated, the Centers for Disease Control and Prevention (CDC) Cooperative Agreement for Emergency Response recipients may utilize funding to support MOCC operations. 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 ensure 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.

[Emergency Response Funding](#) includes additional information; stakeholders can also contact their 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. 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 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.

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.

Additional information on the FEMA Public Assistance Program is available at <https://www.fema.gov/public-assistance-policy-and-guidance>. Stakeholders may also contact their regional FEMA representatives for assistance.

FEMA Mission Assignment Program – Direct Federal Assistance

Regional FMOCCs may be established and operated within FEMA Regional Response Coordination Centers (R RCCs). 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.

Additional information on the FEMA Mission Assignment Policy FP-104-010-2 is available at: www.fema.gov/media-library/assets/documents/112564. Stakeholders may also contact their regional FEMA representative. [Appendix E: MOCC Mission Assignment Template](#) contains an example MA statement of work.

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 (RMOCC)

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, capacity may be available 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) or other designated location 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 may direct the movement of patients (and potentially other 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 or a designated operations center (for example a healthcare system call center, hospital association call center, etc) if not co-located in the EOC.

- **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
- **Establishing policies** that describe the authorities and operating procedures for the MOCC including how the MOCC receives information, connects patients to beds (including any ‘forcing function’ that may be needed when all hospitals are at capacity for ICU beds), and load-balances hospitals when needed. Other functions may also be included as described in the main document.

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 or healthcare coalition 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 including the authorities of the RMOCC to place patients via rotation or other means when no ICU beds are available but a patient is in need of critical care in a facility that does not offer the relevant services.
- 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 other patients per RMOCC policy 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 (LTC) facilities, including nursing homes, skilled nursing facilities, and assisted living facilities to maximize use of LTC beds.

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 should 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. For additional guidance, see the [EMS Supplement for the MOCC Tool Kit](#).

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, healthcare coalitions, 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. RMOCC Managers may work rotating call schedules to assure leadership presence.
Experience: Healthcare operations and emergency management, particularly healthcare system response.
2. **Medical Director** – Oversees the medical team, support personnel, and clinical resource allocation. Responsibilities include, but are not limited to, the following activities which may be delegated to Medical Officers working rotating call schedules:
 - 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 Manager, Medical Officer, Call Taker(s), and Transfer Coordinator. Depending on the call volumes some of these staff may be virtual, particularly off-hours.

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 including agreeing on the policies for patient transfers and load-balancing.
- 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). The RMOCC must have certain information to operate, including knowledge of the services provided at each hospital in the region served as well as the availability of beds and resources. Web-based information systems are critical to that effort. Currently, no state has integration of all information directly from the electronic health record (EHR), this is a goal that needs to be actively pursued so that the information system reflects:

Baseline facility information:

- Demographics – name of facility, location, phone number, total operating beds
- Point of contact for facility – ideally a nurse manager / patient placement as well as a medical director

- Referral center phone number (if applicable)
- Beds by type and number (assure that common definitions are used) – floor, monitored, intermediate/step-down, ICU
- Do the ICU services include the following? Mechanical ventilation, dialysis, ECMO, other specialty services
- Surge beds for each bed type that can be made available in addition to usual beds if staffed
- For community hospitals, do you have in-house physician/hospitalist coverage 24/7?
- For community hospitals that do not provide comprehensive critical care, are you comfortable managing the following at your facility? (sepsis requiring pressors, respiratory distress requiring non-invasive respiratory support, mild DKA, CHF exacerbation)

Once activated, the RMOCC must determine the **essential elements of information (EIs)** for the incident, the method for sharing EIs, and the reporting time intervals. All member healthcare facilities (acute, non-acute, and alternate care sites) within the RMOCC boundary will report their EIs 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 EIs that may be reported to the RMOCC:

Essential elements of information – current situation information (as real-time as possible)

- Available beds by category
- Occupied beds by category (ideally by % of usual maximum capacity – e.g., 90% vs. 125% so that direct comparisons between facilities can be made)
- Staffing contingencies used? (e.g., adjusted staffing ratios, use of non-traditional staff in units)
- Number of admits boarding in the ED awaiting inpatient bed/transfer
- Non-emergency procedure status – unrestricted, case-by-case, no procedures that will generate inpatient bed need, no non-emergency procedures (or other similar stratification that use common language)
- Critical care contingencies in use (e.g., boarding ICU patients in step-down or other units)
- Surge beds in use

Definitions are important. Available beds may not mean the same thing (staffed vs. potential to be staffed, staff not available) between facilities. EHRs may have difficulty distinguishing surge beds vs. usually operated beds or may not be able to register them on the system at all. Data validation is critical, particularly if new systems of data submission are being used. Having baseline capacity data collected over time helps greatly to understand how far about baseline the facility and region is and also helps demonstrate capacity that exists when a no-notice incident begins (i.e., a system that is two standard deviations above usual capacity when a mass casualty event occurs is much more likely to require inter-regional assistance than one that is much lower than average).

EMS Agency Reporting of EIs

All member EMS agencies within the RMOCC boundary will report their EIs 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 EIs 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, and advanced directives 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 and may be implemented based on regional/state needs.

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 (SMOCC)

Sample Standard Operating Procedure

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

Overview

While some hospitals are overwhelmed with COVID-19 patients, capacity may be present in other nearby hospitals, creating a need and an opportunity to transfer patients to provide consistent levels of care.

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. Many states have used a statewide MOCC model during COVID-19 but sub-state regional MOCC may have more utility during local disasters, or during more widespread emergencies depending on the geographic and healthcare demographics of a given state or sub-state region.

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).

4. **State EOC integration of the healthcare response:** The SMOCC provides a direct integration of patient care operations and information to the State EOC and can leverage State assets and engage policymakers and emergency management directly.

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 or by the state government

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]).**

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 SMOCC 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 Director** – 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 Director, 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 (EIs)** for the incident, the method for sharing EIs, and the reporting time intervals.

RMOCC Reporting of Healthcare Facility EEs

All RMOCCs will report their healthcare facility EEs 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 EEs 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 EEs

All RMOCCs will report their EMS EEs 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. For additional guidance, see the [EMS Supplement for the MOCC Tool Kit](#).

The following are sample EMS agency EEs 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 (if established)

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.

Federal Region Medical Operations Coordination Cell (FMOCC)

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, capacity may be available in other 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.

An **FMOCC** has not been formally operationalized as of October, 2021 but should continue to be a focus for planning efforts. FMOCC 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. However, in states where referrals routinely occur across multiple borders, an FMOCC may contribute significantly to state-state coordination and allow more informed engagement of federal resources based on local needs or interstate transportation needs.

Objectives and Priorities of FMOCC

Objective: The FMOCC coordinates with SMOCCs within state EOCs and/or 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.

3. Integrate patient transfer operations and healthcare system monitoring / information management as a function of the federal regional response

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 triggers 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 (note that the FMOCC, unlike the RMOCCs may not be staffed 24/7):

1. **FMOCC Director** – 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 Director, 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.
- Determine thresholds to load-balance saturated facilities across state lines as possible
- Determine the role of the FMOCC in managing single patient transfers across state lines (under what conditions, what types of illness/need)
- 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 <i>(sourced from RMOCCs and/or SMOCCs)</i> | <ul style="list-style-type: none"> • 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 in use | <ul style="list-style-type: none"> • General status of the EMS agency/agencies • Total number of Federal Ambulance Contract ambulances • Availability of ground transport units for interstate transfers (e.g. ambulance strike teams, individual units by region) • Total number of staffed air medical transport assets |

| | | |
|--|---|---|
| | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 should use currently available systems supplemented by incident-specific calls and tracking boards, while documenting elements for a future information technology platform to enhance the ease of coordination.

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. When transfers are occurring across state lines providers should be familiar with limitations on their scope of practice and other regulatory considerations.

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:

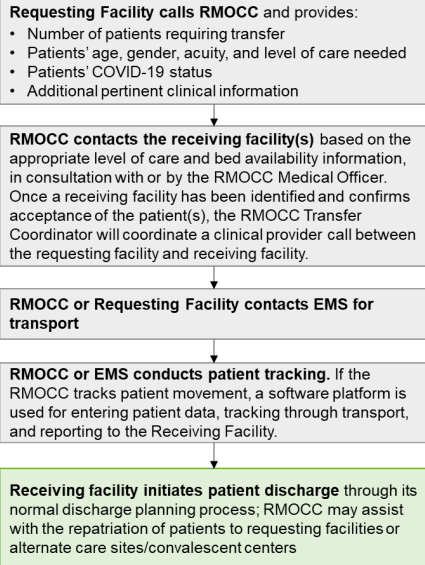
- Capacity, supplies, and capability of receiving sites
 - High intensity/complexity care is only provided at certain centers (e.g., Extracorporeal membrane oxygenation (ECMO), burn care, trauma care, cardiac care).
- Condition of patient (stable for transport or not, anticipated risk for decompensation 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

Sub-State Regional Medical Operations Coordination Cell (RMOCC) Workflow

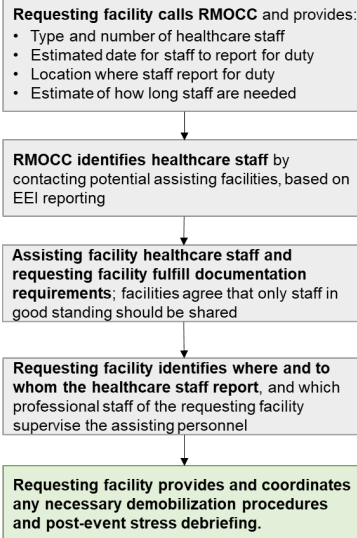
PATIENT MOVEMENT



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

MEDICAL RESOURCE SHARING

Healthcare Staffing Request

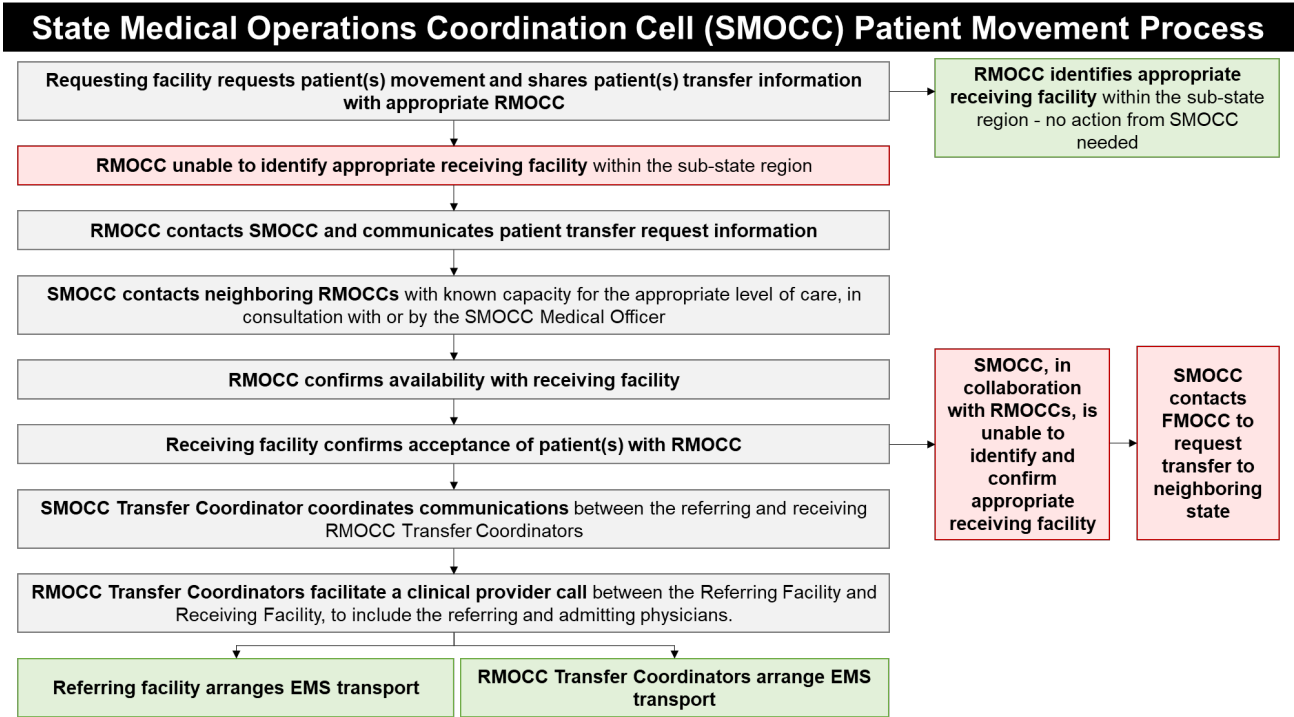


*Resource coordination within the RMOCC does not replace normal ESF-8 ICS213 resource request. The RMOCC simply expedites local sharing of medical resources to save lives

Pharmaceuticals, Supplies, or Equipment Request

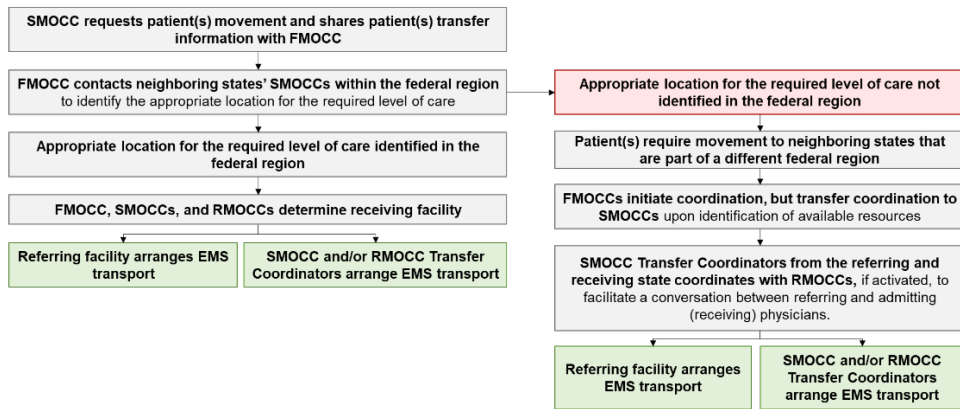


APPENDIX B: SMOCC PATIENT WORKFLOW

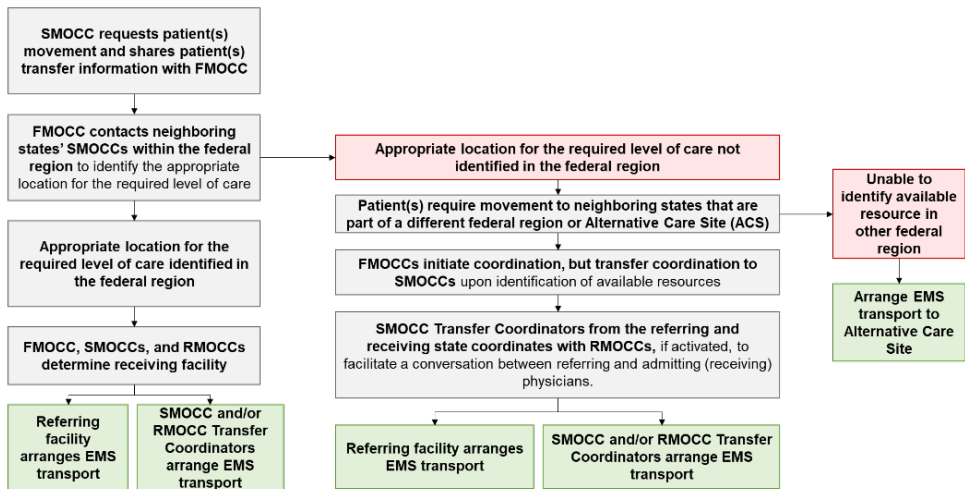


APPENDIX C: FMOCC PATIENT WORKFLOW AND DATA REPORTING PROCESS

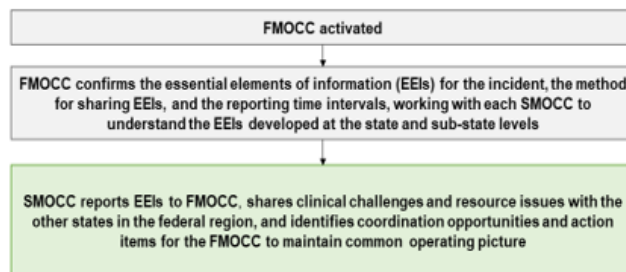
Federal Medical Operations Coordination Cell (FMOCC) Patient Movement Process



Federal Medical Operations Coordination Cell (FMOCC) Patient Movement Process



Federal (FMOCC) 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: _____

Current Treatment Provider: (Name) _____

Phone: _____

Admitting Diagnosis: _____

Allergies: _____

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

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

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: 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 F: SITUATION REPORT TEMPLATE

Regional Medical Operations and Coordination Center (RMOCC)

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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 (EIs) 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 |
|--|--|---|
| <ul style="list-style-type: none"> Hospitals or healthcare professionals in contact with or treating confirmed COVID-19 patients with potential for high loss of life. <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Transmission within vulnerable/elderly/ disabled populations High potential for multiple deaths | <ul style="list-style-type: none"> Facilities and EMS personnel that may encounter a suspected case and interface with a vulnerable population. <ul style="list-style-type: none"> Healthcare – hospitals Long-term care facilities, supportive housing and group homes with history of COVID-19 Isolated patient step-down locations | <ul style="list-style-type: none"> 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 | <i>Activated</i> |
| EMS Desk | <i>Activated (Virtual)</i> |
| Hospital Desk | <i>Activated (Virtual)</i> |
| Public Health Desk | <i>Activated (Virtual)</i> |

Operational Priorities:

Suggested operational priorities include:

- 1. Maintain the integrity of the regional healthcare system and its 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*