ASPR TRACIE Technical Assistance

On April 24, 2020 ASPR TRACIE hosted the webinar *Establishing Medical Operations Coordination Cells (MOCCs) for COVID-19*. During this webinar, speakers discussed how to establish MOCCs, available guidance to assist, and lessons learned from states that have used this concept in previous emergencies and currently with COVID-19. Access the PowerPoint presentation and recording of the webinar.

Due to the large number of questions received during the Question and Answer session, speakers were not able to respond to all of the questions during the webinar. These questions were sent to panelists and their answers are provided in this document.

Question 1: If our healthcare coalitions within the state and our partnering states in the region planning group already operate and coordinate similar to the MOCC, are states being required to set up an official MOCC?

Answer:

The MOCC concept is one that can be adapted at any level to meet the needs of the jurisdiction, so if what you are already operating provides clinical coordination and support for transport coordination between low census and high census facilities, with the mission of load balancing patients in your community, then there is no need to alter your structure to fit these template. These templates are being provided as a guide for jurisdictions to set up a MOCC concept where one has not previously existed and to provide resource information on funding, staffing, etc.

Question 2: How much visibility has local emergency medical services (EMS) had on the location of COVID-positive patients in congregate care facilities?

Answer:

(Note: This question is very jurisdiction specific and speakers' experiences/responses do not necessarily represent those of other jurisdictions.)

Minnesota:

- Our governor issued an executive order that makes long-term care facilities (LTCs) with positive cases information available to public safety.

Seattle/King County:

- Seattle/King County has used a combination of public health and EMS data to determine the location and degree of outbreaks in congregant settings. We are provided with two daily reports:

  - Public health provides the locations of all congregant settings with known positive cases. They also provide a summary of the known numbers of affected residents and staff. This is summarized manually and based upon their follow up work with the individual locations. This process is limited as our major health systems are also working with individual congregant care sites to provide on-site support and testing. Their efforts are not necessarily reflected consistently in our daily report.
  - EMS provides a daily report of the number of 911 responses to each congregant care site with known positives. It is broken down by suspected COVID symptoms/patient vs. those thought to be non-COVID. We use this data as a surrogate for disease spread at the specific site. It there have been > 3 COVID EMS responses in the past 48 hours, we reach out to the facility to check on them, establish a point of contact and make sure they are connected to public health or a health system than provide education/training/testing etc. There are currently 250 locations on the list.
- This solution is not sustainable as the pandemic continues. As I spoke about on the webinar, the new platform we have developed with Microsoft (Emergency Response) will hopefully address this in their 2nd release.
- The LTC associations have had a mixed reaction to this as their reporting requirements from various agencies have increased. Thus, we are trying to work with state level agencies to allow a single data entry feed to populate multiple agency requirements.
- It is our hope this will be the long-term solution for this problem in our state. If any jurisdiction is interested in the Microsoft platform they can contact: Gary Bird at garybird@microsoft.com. They have offered this (thus far) as a community service to the public free of charge.

Question 3: Does your local 911 dispatch (under disaster protocol) distribute patients to more than one local hospital?

Answer:

911 dispatchers and local emergency operations centers have varying engagement in load balancing patient distribution, but only within the confines of their respective jurisdictions. MOCCs are available to facilitate inter-facility transfers of patients rather than coordinating the 9-1-1 emergency services. The RMOCC concept is to coordinate agencies within a sub-state region, presumably one that covers several EMS systems with different dispatch organizations, therefore a regional coordination center with clinical direction would step in to coordinate between and among them.

Seattle/ King County:

- When our MOCC (disaster control) has been activated, the MOCC distributes patients to hospitals throughout our region. The challenge with the LTC facility I described (in Kirkland, WA) was that it was a relatively slow-moving disaster scenario that unfolded over 10 days.

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- The facility used both 911 dispatch (fire department) and private ambulance (non- 911) to send their patients. Because it occurred over 10 days it occurred over a variety of shifts - so any one person would not be as aware of the cumulative issue.
- Also, most (not all) surveillance systems are designed with emergency department (ED) capacity in mind. The ED at this hospital was busy, but never overwhelmed. It was merely the cumulative burden of these highly intensive patients and their long hospital length of stays (in the intensive care unit) which were the issue.
- In short, it caused a crisis with critical care access and equipment and not the ED. Our MOCC was not activated until the 10th day. We then distributed to roughly 14 hospitals across the region - including sending 16 patients to 11 hospitals across 3 counties at the beginning of the activation - which finally stabilized the situation.

Question 4: For Los Angeles, what sort of agreements do you exercise between resources?

Answer:

- Established 15-years ago, the Hospital Preparedness Program (HPP) contract with hospitals, clinics, dialysis centers, surgery centers, and LTC facilities has been the single greatest contractual contribution between the county and healthcare entities to coordinate, plan and exercise to prepare LA County for the current COVID-19 response.
- An example of a new contract established in response to the COVID-19 was the Los Angeles Surge Hospital (LASH) contract. It was established with the state, county, Kaiser Permanente, and Dignity Health to treat COVID-19 positive patients and decompress acute care hospitals. Under this contract, we established an Alternate Care Site at a recently closed acute care hospital.
- We have all the expected mutual aid and subcontractor agreements with surrounding counties, the region, local EMS and hospital providers.