December 10, 2021

Dawn O'Connell
Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Assistant Secretary O'Connell:

On behalf of the American College of Surgeons (ACS) and the American College of Emergency Physicians (ACEP), thank you for the opportunity to provide feedback on the *Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems.* We believe this is a critical time to incorporate the lessons learned from the response of our U.S. healthcare system to the pandemic into planning for a robust, national infrastructure to support our preparedness for future events. We thank ASPR for the thoughtful approach in reviewing the existing programs and systems of care and establishing a framework for the future.

In addition to submitting detailed comments on the existing document, our organizations respectfully request that ASPR consider these overarching issues as the guidelines are further developed.

Working Towards a National Trauma and Preparedness System

In order to mount an effective response to any future pandemic or mass casualty event, our organizations envision a National Trauma and Emergency Preparedness System (NTEPS) that provides situational awareness of the resources and surge capacity of the entire healthcare system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. The draft *Guidelines* document implies that a National Trauma System already exists. Unfortunately, no such coordinated national system is currently in place to take on these vital responsibilities. Instead, there is a variable collection of state and regional trauma systems that have developed to meet the needs of acutely injured patients, without federal legislation or funding to support these systems or to ensure systems meet specific metrics or collaborate to support a regional response. We believe the NTEPS should be built on the framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) which operate on a daily basis to support the movement of patients for routine time-sensitive emergencies and can rapidly scale up to serve as the coordinating entity for the healthcare sector during a major response. This framework, which was outlined in the Medical Operations Coordination Cells (MOCC toolkit) and developed by the Federal Emergency Management Agency (FEMA) Healthcare Resilience Taskforce during the pandemic, should be the cornerstone of the medical response executed through the Hospital Preparedness Program (HPP) and the Regional Disaster Health Response System (RDHRS) programs.

Furthermore, we agree with the premise that healthcare referral patterns do not always adhere to state or FEMA regional boundaries and thus suggest that regional MOCCs be established at the local level, with the support of the Health Care Coalitions, based on current referral patterns for time sensitive emergency conditions such as traumatic injury. These regional MOCCs would then be linked by a uniform data collection infrastructure to allow situational awareness at the state and FEMA region Emergency Operations Center (EOC) levels for major events. RMOCC Standards should be developed that are tied to HPP funding and Centers for Medicare & Medicaid Services

(CMS) requirements for disaster preparedness to facilitate participation of all healthcare entities in sharing relevant data and accepting load balancing decisions in times of a declared disaster or heath care crisis. As these standards and requirements are developed, it is important to understand that during disasters, there is a threshold at which everyone is "at risk," and that the challenges our healthcare system faces during these events are compounded by the underlying issues we experience on a daily basis.

Defining the Role of the RMOCC

The goal of the RMOCC is to strengthen regional care delivery through enhanced coordination, and the purpose of this model is to define and advocate for the structural and functional capabilities which should exist within the system. The RMOCC model is designed to facilitate the most appropriate level of care based on each individual patient's acuity, while simultaneously maintaining patient safety and keeping as many patients as possible within local facilities capable of providing high quality care. A key tenet of the RMOCC model is the philosophy that no facility will ever be left behind or forced to stand on its own in a time of healthcare crisis when healthcare resources could be in place within reasonable time and/or distance. The RMOCC enables the entirety of a region's healthcare system to load balance patient care needs and resources across healthcare facilities and healthcare systems prior to any individual facility transitioning to a crisis standard of care. To meet the goal, RMOCCs should have the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

While some of these concepts are included in Objectives 3 and 4 of the *Guidelines*, our organizations encourage ASPR to make MOCCs the centerpiece of the regionalized approach. There are several models of MOCCs that have developed in the absence of guidance, and this experience can be leveraged to develop standard requirements and operating procedures. As outlined in the *Guidelines,* the HPP cooperative agreement supports partnerships across the entire spectrum of healthcare

delivery. By integrating the Health Care Coalitions and RDHRS together in a MOCC structure, a unified system could be established and funded.

Concluding Comments

As noted above, we currently lack a National Trauma System capable of mounting an effective, coordinated response to any future pandemic or mass casualty event. This should be considered as part of the *Guidelines.* Establishing MOCC infrastructure is an all-hazards approach that can rapidly mobilize emergency operations for any healthcare surge response regardless of the etiology, regionalize responses for special populations, such as pediatrics and burns, and support the vision of a National Trauma and Emergency Preparedness System and a National Special Pathogens System. Investment will be required to support existing state and regional emergency care systems to achieve this comprehensive system.

Additionally, our organizations encourage ASPR to work with Agency partners, state and local agencies, and relevant stakeholders to establish a regulatory mechanism to allow physicians to respond to mass events across state lines by simplifying the process for state licensure when responding to a regional trauma disaster. Such flexibility is critical to support a medical surge response.

A recent study suggested that one in four of the deaths related to COVID-19 in the U.S. was potentially preventable and attributable to the stress of medical surge (Kadri et al, Annals of Internal Medicine 2021). We believe that by realizing the vision of an interconnected network of RMOCCs, the system could be effectively load balanced with a reduction in deaths and disability. Our organizations have extensive experience in the medical response to mass casualty events and stand ready to assist ASPR in the development of standards for the MOCC infrastructure as outlined above. We have established a joint task force of experts and would be happy to meet with you to discuss further. Thank you for your consideration and we look forward to working with you to improve our nations medical preparedness and response systems. If you have any questions, please contact Amelia Suermann with the American College of Surgeons, asuermann@facs.org, or Jeffrey Davis with the American College of Emergency Physicians, jdavis@acep.org.

Sincerely,

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