RDSTF-5 Trauma Advisory Board

Region 5 Mass Casualty Incident (MCI) Trauma Coordination Plan

Draft

Approved by RDSTF5 Trauma Advisory Board Executive Committee June 8, 2021

Approved by CFDMC Board on XX

Overview

Central Florida is uniquely vulnerable to large scale disasters. The July 2019 US Census estimates 4.5 million people reside in the nine counties representing Central Florida (Central Florida Regional Domestic Security Task Force, Region 5 or RDSTF-5). Winter residents dramatically increase this population. In addition, domestic and international tourists flock to Central Florida for golf, shopping, water sports, theme parks and conventions. Orlando is the number one most visited destination in the world. Orlando International Airport was the 10th busiest airport in the nation before the pandemic with approximately 50 million passengers each year and rebounded at twice the average rate of travelers in December 2020. Visitors also arrive in Central Florida via cruises at Cape Canaveral, Florida's fastest growing port and the second busiest port in the world, with more than 5 million travelers annually. There are three large chemical manufacturing plants within the region. There are multiple international and commercial airports, as well as both freight and passenger railroad service across the region. All of these factors increase the potential for a large scale trauma event in Central Florida.

The Region has a robust trauma system, including a Level I trauma center and a Level 1 pediatric trauma center in the metro Orlando area, and six Level 2 trauma centers across the region. However, in an event that produces a large number of trauma patients, an individual trauma center's capabilities and capacities would soon be overwhelmed and may even overwhelm the region's capabilities and capacities.

Goal

The goal of the Region 5 Trauma MCI Coordination Plan 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. The plan is based on the concepts outlined in the ASPR Medical Operations Coordination Cells (MOCCs) initiative. The plan focuses on the delivery of healthcare services and operates as a component of the Emergency Support Function #8, Public Health and Medical Services (ESF#8) activities, bringing the medical aspect of ESF#8 into emergency operations centers (EOCs) to guide the appropriate movement of patients along the care continuum.

Objectives and Priorities for the Region 5 MCI Trauma Coordination Plan:

Objective: The Region 5 MCI Trauma Coordination Plan (the plan) provides organization and foundational process information and data-available to stakeholder-informed decision-makers to balance patient load and ensure high-quality care. The plan ensures that clinical decision-making directs the movement of patients and resources from one facility to another, or re-direct referrals that would usually go to an overwhelmed facility or system to one with capacity.

The **priorities** of the Region 5 MCI Trauma Coordination Plan include the following activities:

1. **Collecting, analyzing, and disseminating hospital-capacity information**: One of the primary roles of the plan is to collect and analyze the information provided by each stakeholder (e.g., EMS, healthcare facilities). The staff identified in the Region 5 Trauma Coordination Center (Trauma Coordination Center) within the plan analyze and disseminate 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 staff identified within the plan in the Trauma Coordination Center facilitate the collection and reporting of healthcare-specific data elements; inform operational planning and stakeholder communications; and a clinician initiates regional and inter-regional transfer decision-making.

3. **Acting as a single point of contact (POC) for referral requests and life-saving resources:** The plan provides a single POC in a Trauma Coordination Center, as part of the impacted 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 plan **achieves its objectives and priorities** primarily by the following activities:

- **Integrating with the Florida public health and healthcare response system** to assure coordination of response actions. The plan is activated by the local EOC in response to an event that will overwhelm the county's trauma system and the trauma coordination center is under the local jurisdiction's Operations/ESF8 section (see Figure 1).
- **Adding clinical staff** to existing EOCs
- **Establishing stakeholder agreements** that allow for collecting data regarding the current capacity of the region's health system, synthesizing the data to understand the needs of the system, and determining areas of the system that may be overwhelmed

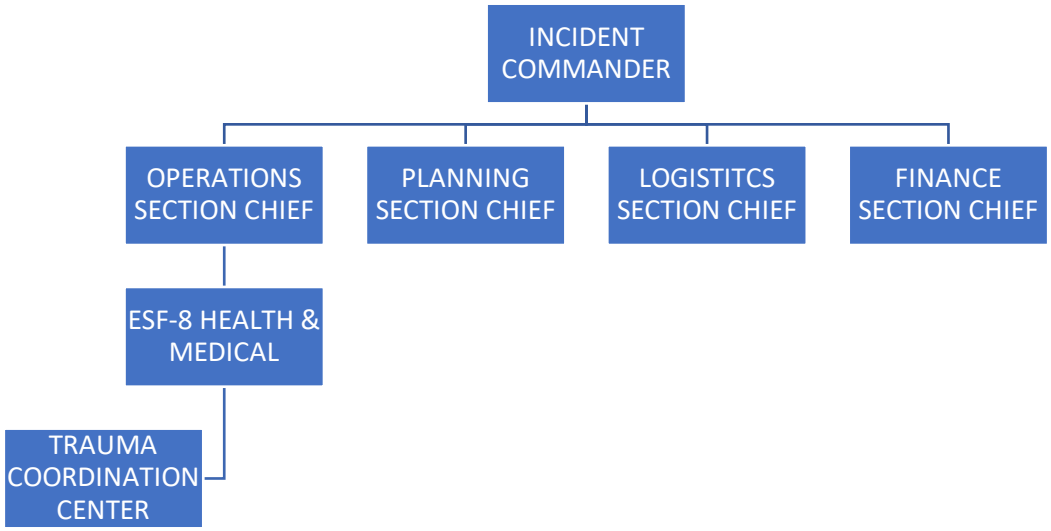

Figure 1

REGION 5 Trauma Coordination Center Staffing

Region 5 Trauma Coordination Center staff and experts are critical to its operations. The Trauma Coordination Center staffing should come from the local healthcare delivery system, as the load-balancing responsibilities of the Trauma Coordination Center require a high degree of medical and hospital operational expertise and familiarity.

The plan identified the following five key types of staff for the Trauma Coordination Center (see Figure 2) and role/required experience below:

1. **REGION 5 Trauma Coordination Center Director** – Serves as the unit manager and oversees REGION 5 MCI TRAUMA COORDINATION PLAN operations. **Experience**: Healthcare operations and emergency management, particularly healthcare system response. This role will be filled by a Region 5 Incident Management Team (IMT) member or the Regional Medical Assistance Team (RMAT) Commander. A liaison will be assigned to the director to coordinate with state and local ESF8s.

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

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

Experience: Physician with experience in emergency care, critical care, trauma, and/or mass causality. This role will be filled by the County EMS Medical Director in the impacted county or their designee.

3. **Call Takers** – Manage incoming calls to the Trauma Coordination Center ensures requests are entered in the appropriate platform by the requestor. **Experience**: Administrative staff, ideally with a background in EMS or public safety. These roles will be filled by 311 staff in the impacted county. Scripting will be provided.

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. This role will be filled by hospital staff experienced in transfer coordinator in a non-impacted county within the region.

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. There will be at least two transport coordinators, including one from the impacted county and one from a non-impacted county. In addition, a QA staff member may be identified to track assets and resources.

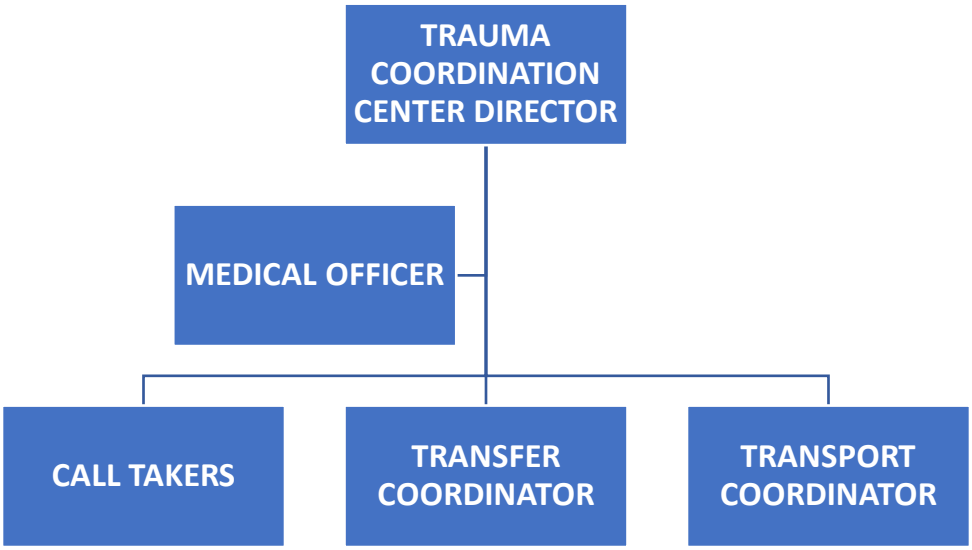

Figure 2

Region 5 Trauma Coordination Center Operations

Once the Trauma Coordination Center is activated, it will be staffed at a minimum by the Director, Medical Officer, Call Takers and Transfer Coordinator as described above. Additional positions will be added at the discretion of the Director.

The Trauma Coordination Center director will perform the following activities:

- Determine the location of the Trauma Coordination Center and if staff will report on-site or virtually.
- Decide when additional staff are needed.
- Distribute the Trauma Coordination Center 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 Trauma Coordination Center, and the EOC.

Once operational, all plan 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 Trauma Coordination Center to effectively respond to the disaster.
- Provide (virtual) POCs who can communicate with the Trauma Coordination Center and with their organizations on a continuous basis, if required.

Information Sharing / Situational Awareness

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

The Trauma Coordination Center **receives and shares** real-time emergency response information on the current status of the healthcare delivery system. The Trauma Coordination Center 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 Region has established **essential elements of information (EEIs).** Once activated, the Trauma Coordination Center must validate these **EEIs** for the incident, add additional EEIs as needed based on the incident, the method for sharing EEIs, and the reporting time intervals.

Facility Reporting of EEIs

All member healthcare facilities (acute, non-acute, and alternate care sites) within Region 5 will report their EEIs at the request of the Trauma Coordination Center through the designated platform. The region is currently piloting CORVENA as its primary event communication platform. The information will be updated twice daily, or at an interval defined by the Trauma Coordination Center for the duration of the incident. The following are the healthcare facility EEIs that may be reported to the Trauma Coordination Center.

- Reporting date
- Hospital name
- County name
- Structural damage
- Evacuation type
- Evacuation status
- Reentry status
- Power status
- Generator fuel status
- Generator fuel type
- HVAC generator status
- Normal water supply
- Dialysis reliable water supply
- Sewer status
- immediate needs
- Total number of non-ICU inpatient beds, including surge beds
- Total number of staffed available non-ICU beds
- Total number of ICU beds, including surge beds
- Total number of staffed available ICU beds
- Total number of ventilators, including converted machines
- Total number of ventilators available
- Staffing status
- Personal Protective Equipment status
- Additional resource availability, as applicable

Note: Additional EEIs may be identified based on the specific event

EMS Agency Reporting of EEIs

All member EMS agencies within the Region 5 boundary will report their EEIs at the request of the Trauma Coordination Center using the identified platform. The information will be updated twice daily, or at an interval defined by the Trauma Coordination Center for the duration of the incident.

The following are the EMS agency EEIs that may be reported to the Trauma Coordination Center:

- 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
- Additional EEIs may be identified based on the specific event

REGION 5 Trauma Coordination Center Reporting of EEIs to State ESF8:

The State ESF8 will establish the method and frequency for the Trauma Coordination Center to report EEIs. These communications will optimally occur twice daily, or as otherwise specified by the State ESF8

Patient Movement Request

The primary purpose of patient movement and tracking within the plan is to decompress overwhelmed healthcare facilities through an equitable distribution of patients. The Trauma Coordination Center 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 State ESF8 is unable to find conventional care resources in neighboring regions.

The plan **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: Region 5 MCI Trauma Coordination Plan Patient Workflow and Data Reporting Process.

1. Requesting Facility/EMS Transport Unit Communicates Request

The request for patient movement can be made by the requesting facility or EMS transport unit by calling the Trauma Coordination Center. The Coalition will distribute the phone number to all health care facilities, EMS agencies and emergency management/ESF8 when the Trauma Coordination Center begins operation.

The requestor 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 transport or transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information as applicable)

2. The Trauma Coordination Center Facilitates Patient Placement

The Trauma Coordination Center will contact the requestor based on the appropriate level of care and bed availability information, in consultation with or by the Trauma Coordination Center medical officer.

Once a receiving facility has been identified and confirms acceptance of the patient(s), the Trauma Coordination Center transfer coordinator will coordinate a clinical provider call between the requesting facility and receiving facility.

3. The Trauma Coordination Center Facilitates Patient Transport

The Trauma Coordination Center transport coordinator will coordinate with EMS for patient transport. The appropriate EMS asset will be assigned based on the level of care required during the transfer, the acuity of the patient, and the destination. EMS regulations differ widely by jurisdictions. See Appendix H: Patient Workflow and Data Reporting Process for the patient transportation plan and Appendix D: Patient Transfer Checklist.

4. The Trauma Coordination Center and/or EMS Conducts Patient Tracking

The Trauma Coordination Center has responsibility for patient tracking, with assistance from the EMS agencies conducting the patient transport, using the CORVENA platform. The Trauma Coordination Center 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; Trauma Coordination Center May Support Repatriation

The Receiving Facility will use its normal discharge planning process once a patient is able to be discharged. The Trauma Coordination Center 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

The plan 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 Trauma Coordination Center does not replace normal supply chain processes nor the normal ESF8 resource request process. The plan simply expedites local sharing of medical resources to save lives.

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

Healthcare Staffing Request

Initiation of healthcare staffing includes the following steps:

1. Requesting Facility Communicates Request

The request for healthcare staffing can be made by calling the Trauma Coordination Center number.

A verbal request must be followed by written documentation through the CORVENA platform, as soon as reasonably possible and include the following information:

- The type and number of healthcare staff
- An estimated time 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. The Trauma Coordination Center Identifies Staff

The Trauma Coordination Center 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 REGION 5 MCI TRAUMA COORDINATION PLAN at [*insert REGION 5 MCI TRAUMA COORDINATION PLAN 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 Trauma Coordination Center. This can be accomplished and tracked via the electronic resource request process in CORVENA

2. The Trauma Coordination Center Identifies Resources

The Trauma Coordination Center 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 the Trauma Coordination Center Coordinates the Transport of Pharmaceuticals, Supplies, or Equipment

The Requesting Facility, in coordination with the REGION 5 MCI TRAUMA COORDINATION PLAN, 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.

Integration with Local ESF#8

For most jurisdictions within Region 5, the local public health department serves as the ESF#8 lead for coordinating the response to public health and medical emergencies. In Orange County, the Orange County Office of the Medical Director serves as the ESF8 lead, supported by the health department. Given the considerable efforts required of both ESF8 and the medical/healthcare system in a large scale ESF8, the plan focuses on support ESF8 through coordination of trauma casualties, allowing ESF8 to focus on other response needs.

The integration of the plan with the local ESF#8 lead will be accomplished through a liaison from the Trauma Coordination Center to local and state ESF8s.

Roles and Responsibilities

The plan 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 plan 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.

Regional stakeholders include trauma centers, acute care hospitals, emergency management, EMS, county health departments, and other healthcare and response organizations.

The following agreements are necessary to successfully implement the plan:

- 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 Trauma Coordination Center to effectively respond to the disaster or public health emergency.

- All stakeholders must agree to provide (virtual) POCs who can communicate with the Trauma Coordination Center, and with their organizations on a continuous basis, if required.

- Relevant stakeholders must agree to review and process Trauma Coordination Center 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 Trauma Coordination Center 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.

The Trauma Coordination Center 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, the Trauma Coordination Center staff may engage and collaborate with standalone 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 Trauma Coordination Center.
- Define protocols and channels for communication with hospital leadership; identify POCs with Trauma Coordination Center.
- Agree to accept patients from a mass casualty incident and maximize any additional surge capacity.

Long-term Care Facilities

In coordination with the jurisdictional ESF#8 Lead Agency, Trauma Coordination Center staff may engage and collaborate with long-term care facilities, including nursing homes, skilled nursing facilities, and assisted living facilities to maximize surge capacity for low-acuity patients.

Emergency Management

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

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

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

Emergency Medical Services (EMS)

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

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

- Fulfill data requests from the Trauma Coordination Center.
- 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 Trauma Coordination Center may honor in-system transfer requests when possible based on availability.

Governmental Partners

In coordination with the jurisdictional ESF#8 Lead Agency, Trauma Coordination Center staff may engage and collaborate with other federal, state, and local governments. Federal, state, and local departments and programs that may support the plan include the following examples:

- State Department or Division of Public Safety
- State Department or Division of Emergency Management

- State Department of Health (State ESF8)
- National Guard
- Medical Reserve Corps
- Governmental Mutual Aid or Emergency Management Assistance Compact (EMAC) Partners

Other Coordinating Partners

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

References: State Patient Movement Plan