REGIONAL
Committees on Trauma

RCOT Field Program
RMOCC Webinar Series

Webinar 5 – 8/27/2025

Discussion Summary – Lessons learned from the Washington Medical Coordination Center

Session Overview

This session, part of the continuing national dialogue on Regional Medical Operations Coordination Centers (RMOCCs), highlighted the critical importance of coordinated hospital and system-level responses to surges in patient volume. Led by Dr. Warren Dorlac, the discussion featured Dr. Steve Mitchell, a key architect of the Washington Medical Coordination Center (WMCC), who shared the history, operations, and lessons learned from their pandemic-driven implementation. Attendees included trauma and emergency physicians, health system leaders, and state-level stakeholders seeking to build or improve similar capabilities in their own regions.

Opening Remarks

Facilitator: Dr. Warren Dorlac

Guest Speaker: Dr. Steve Mitchell, Emergency Medicine Physician, Interim Chair-University of Washington Department of Emergency Medicine and former Medical Director, Harborview Medical Center Emergency Department & founder of the Washington Medical Coordination Center (WMCC).

Focus: Lessons learned from the Washington Medical Coordination Center's (WMCC) creation, operations, and future directions — especially for developing and sustaining Regional Medical Operations Coordination Centers (RMOCCs) at local/state levels.

Key Presentation Highlights: Dr. Steve Mitchell

Origin of the WMCC

- Sparked by the 2020 COVID-19 outbreak at Life Care Center in Kirkland, WA. All patients were transferred to Evergreen Regional Hospital which quickly became overwhelmed.
- Demonstrated lack of coordination in timely patient transfers.
- Highlighted the need for regional patient flow management.

Initial Setup of the WMCC

- Started with just a cell phone and Excel sheet.
- Operated by two volunteers and repurposed staff from Harborview.
- Received funding 6–12 months later.

Organizational Model

- Began from Harborview's disaster coordination role.
- Evolved into WMCC after proving effective during COVID, most especially for rural and independent hospitals (not associated with a major health care system).

- Included agreements like a Unified Participation Agreement and Guaranteed Acceptance Policy.

Operational Insights

Load Balancing & Patient Outcomes

- High surge levels led to worse patient outcomes.
- WMCC provided 10,000-ft view for system-wide coordination.

Scope and Impact

- Handled 11,709 transfer requests by June 2025.
- 81–82% of requests came from rural or unaffiliated hospitals. (71% critical access facilities) [WMCC 2023 and 2024 data]
- Even small surges caused major system stress. As an example, Washington State has 14,000 acute care beds. A surge of only 200-300 patients (1-2%) can lead to an exponential increase in transfer requests.

Equity and Vulnerability

- High need correlated with those counties with high Social Vulnerability Index (SVI).
- Rural, unaffiliated hospitals lacked system support. After COVID we had other crises to include the triple threat RSV/Flu/COVID and pediatric specialty care.

Key Lessons & Strategic Recommendations

Start Small, Think Big

- Early success came from minimal resources.

Build Trust

- Act as a neutral, transparent, and clinically guided entity. (Trusted partners include academic centers, trauma centers, healthcare coalitions, and some governmental agencies. Invite all parties to the table. Must be transparent as people are concerned about ‘dumping’ of patients, “cherry picking”, influencing patient movement for financial gain, et,

Establish Executive Buy-in

- Engage CEOs with data and anecdotes about unmet needs. “Leverage a crisis” to get buy in and to build. Find out what is important to them or what problems do they need help solving.

Diversify Funding

- Avoid sole reliance on state or federal funding. Use philanthropy, subscriptions, grants.

Focus on Day-to-Day Use

- Daily operation prepares systems for large-scale emergencies. Focus is to keep patients close to home but to be a backstop if the normal transfer patterns cannot work in a timely manner.

Challenges with Bed Visibility

- Oregon's model is seen as more effective than self-report systems.

Audience Q&A Highlights

Funding & Volunteerism

- Initial work was unfunded and volunteer based. (Past three years had a 1.3 million budget).
- Supported by borrowed (non-utilized during COVID- elective surgery) staff.

Managing Health System Politics

- Less resistance from corporate hospital system CEOs, but more from individual hospital leaders.
- Emphasis should be on engaging executive leadership first.

Data & Coordination

- Bed data should be used contextually, not rigidly when determining transfers.
- Relied heavily on knowledge from nurses and on-the-ground staff.

Final Thoughts from Dr. Mitchell

- Success requires trust, purpose, and diversified support.
- WMCC aims to relaunch a 2.0 version.
- Small teams can achieve statewide impact.

Next Steps

The next session will build upon Dr. Mitchell's presentation by shifting focus to the Oregon model. David Lehrfeld from the Oregon Health Authority and Emergency Medical Services will present on their statewide hospital capacity tracking and coordination system, including tools, best practices, and governance structures.

Attendees are encouraged to:

- Review their state's current transfer and coordination protocols.
- Identify key stakeholders who could participate in a future RMOCC initiative.
- Begin informal data-gathering on current unmet transfer and surge coordination needs.

Next Meeting:

- Presenter: David Lehrfeld, Medical Director, Oregon Health Authority
- Topic: Statewide Hospital Capacity Tracking System
- Date: September 17, 2025
- Time: 1700 hrs
- Format: Virtual session (link to be provided)