REGIONAL
Committees on Trauma

RCOT Field Program
RMOCC Webinar Series

Webinar 3 – 4/17/2025

Discussion Summary – Broad overview of National Trauma and Emergency Preparedness System (NTEPS) and RMOCC importance

Session Overview

This first session will set the stage for the entire Field Program series by highlighting the historical development of NTEPS efforts in the U.S., review of NTEPS 2.0, and the idea that a day-to-day fully functional RMOCC can be the cornerstone of a national system. Discuss the roles of NTEPS in national security to include disaster response and during a potential Large Scale Combat Operation (LSCO). We will examine how evidence of mortality and morbidity benefit identified during mass casualty events or regional COVID-19 response. This session will also introduce participants to the RCOT RMOCC Field Program as a tool to support the COTs largest strategic objective of NTEPS development.

Opening Remarks

Facilitator: Dr. Warren Dorlac

Guest Speaker: Kristan Staudenmayer, COT Trauma Systems Pillar Chair

Focus: Present the framework for the development of RMOCC standards

Key Presentation Highlights

Introduction:

- There are no RMOCC standards (**YET!)**
- There is no verification program (**YET!)**

Why generate Standards:

- Standards provide a clear framework for delivering ***high-quality***, ***consistent care*** across diverse settings.
- They serve as a foundation for evaluation, improvement, and accountability, ensuring patients receive safe, effective, and coordinated treatment.

Principals behind RMOCC:

- **Structured Cooperation**
  Cultivate inter-organizational relationships before an event to ensure coordination among entities that typically compete in daily operations.
- **Maximal Inclusiveness**
  Engage *all* relevant stakeholders — trauma and non-trauma hospitals, EMS, public health, and emergency management — in planning and response.

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- **Timely Scalability**
  Enable rapid activation and expansion from daily coordination to full-scale disaster response using pre-established systems and processes.
- **Decisions by Consensus**
  Use shared, actionable information and a common operational language to promote agile, unified decision-making.
- **Bias for Action**
  Prioritize proactive engagement over passive monitoring — anticipating needs and acting early during uncertain conditions.

Goals of RMOCC Standards:

- **Ensure Consistency Across Regions**
  Define a common framework so RMOCCs function reliably regardless of geography or organizational structure.
- **Support Scalable Disaster Response**
  Enable rapid expansion from daily coordination to mass casualty incident management without building from scratch.
- **Facilitate Interoperability and Cross-State Coordination**
  Align protocols and data systems to support coordination across jurisdictions, especially during large-scale events.
- **Guide Implementation and Maturity**
  Provide a roadmap for developing and evolving RMOCC capabilities, from basic coordination to fully integrated operations.
- **Build Trust Through Transparency and Governance**
  Set clear expectations around authority, data use, and decision-making to encourage hospital participation and collaboration.
- **Enable Data-Driven Performance Improvement**
  Standardize what data is collected and how it's used to improve transfer efficiency, patient outcomes, and system learning.
- **Justify and Align Funding**
  Allow state, federal, and local funders to allocate resources based on demonstrable capacity, performance, and need.
- **Protect Legal and Ethical Integrity**
  Ensure triage and transfer decisions made during crisis conditions are supported by clear, defensible, and ethical guidelines.
- **Institutionalize the RMOCC Function**
  Shift coordination from a temporary workaround to a permanent system function that strengthens routine and emergency care alike.

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Basic Structural Components to be Addressed by RMOCC Standards:

Category	Key Needs
Authority	Legal/contractual authority to access data, compel transfers
Trust	Transparent governance, equitable policies
Infrastructure	Data platform, comms systems, call center setup
Staffing	Medical director, transfer coordinators, specialty consultants
Funding	Sustainable model
Integration	Ties with EMS, public health, trauma, and emergency management, others
Capabilities	Attributes outlined by ASPR (see next slide)

Basic Attributes/Capabilities to be Addressed by RMOCC Standards:

Attribute	Description
Centralized 24/7 Operations	Centralized, always-on coordination hub
Access to Real-Time Data	Bed capacity, strain indicators, specialty services, EMS availability
Prehospital Coordination	The ability to communicate and coordinate pre-hospital care with EMS
Transfer Coordination	Clinical prioritization and referral management
Legal Authority	Agreements that provide the authorization to compel acceptance of a transfer
Cross-Jurisdictional Function	Formal ability to work across counties/states
Compliance	Policies in compliance with EMTALA, disability rights, and other laws
EMS & Emergency Management Links	Integration with dispatch, EOCs, and regional incident command
Performance Improvement	Continuous monitoring and adaptation

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Ranges of RMOCC Development (Tiered Levels):

Tier 1: RN with a Phone ….all the way to…. Tier 4: STRAC capabilities and resources

Rational in Favor of Tiering:

- **Scalability**
  Allows smaller regions or states to establish basic coordination capacity
- **Funding Alignment**
  Enables resource allocation (e.g., HPP, ASPR, state funding) based on tier-specific goals and metrics.
- **Buy-In**
- Enables different points of entry based on local needs

What Standards WILL NOT be:

- **Not Prescriptive About Specific Technology Platforms**
  Standards should define *capabilities* (e.g., real-time data, dashboards, interoperability), but **not require a specific vendor, software, or data architecture**.
- **Not Mandate Geographic Boundaries or Catchment Areas**
  They should allow **flexibility for local/regional adaptation**, considering natural referral patterns, trauma regions, or EMS zones — rather than imposing rigid maps.
- **Not Supersede or Interfere with Existing Health System Operations**
  Standards should **complement**, not replace, internal transfer systems — especially during non-crisis periods.
- **Not Require Uniform Staffing Models**
  Standards can describe roles but **should not dictate exact FTEs, credentials, or staffing structures**, recognizing regional variation in workforce.
- **Not Assume Authority Without Local Agreement or Legal Backing**
  They should not imply that an RMOCC can compel actions (e.g., transfers, data sharing) without **statutory authority, MOUs, or executive orders**.
- **Not Be Static or One-Size-Fits-All**
  Standards should **evolve with practice, policy, and evidence**, and offer **tiered pathways** rather than rigid checklists.
- **Not Prioritize Bureaucracy Over Function**
  Avoid emphasizing reporting, documentation, or procedural compliance **at the expense of responsiveness, clinical insight, and adaptability**.
- **Not Focus Solely on Crisis or Disaster Use**
  While disaster scalability is essential, standards should **not ignore daily operations**, which build the infrastructure and "muscle memory" needed for surge.

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- **Not Redefine Trauma Systems or Healthcare Coalitions**
  Standards should **integrate with**, not **duplicate or compete with**, trauma systems, HCCs, EMS agencies, and public health roles.

NEXT Steps:

- Project underway
- Will draft standards for review
- Will start with standards *without* verification program

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