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Military Response to Medical Crises—Consensus Recommendations for Military–Civilian Transitions of Care

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Original Research

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Abstract

Objective: The threat that New York faced in 2020, as the COVID-19 pandemic unfolded, prompted an unprecedented response. The US military deployed active-duty medical professionals and equipment to NYC in a first of its kind response to a "medical" domestic disaster. Transitions of care for patients surfaced as a key challenge. Uniformed Services University and the Icahn School of Medicine at Mount Sinai hosted a consensus conference of civilian and military healthcare professionals to identify care transition best practices for future military-civilian responses.

Methods: We performed individual interviews followed by a modified Delphi technique during a two-day virtual conference. Patient transitions of care emerged as a key theme from pre-conference interviews. Twelve participants attended the two-day virtual conference and generated best practice recommendations from an iterative process.

Results: Participants identified 19 recommendations in 10 "sub-themes" related to patient transitions of care: needs assessment and capability analysis; unified command; equipment; patient handoffs; role of in-person facilitation; dynamic updates; patient selection; patient tracking; daily operations; and resource typing.

Conclusions: The COVID-19 pandemic resulted in an unprecedented military response. This study created 19 consensus recommendations for care transitions between military and civilian healthcare assets that may be useful in future military-civilian medical engagements.

Introduction

New York City (NYC) faced a dire threat in March 2020 as the coronavirus disease (COVID-19) pandemic unfolded.[1] The overwhelming number of patients, uncertainty of transmissibility, shortages of protective equipment, and lack of evidence-based treatment options created a tremendous health care challenge that prompted an unprecedented response. Within weeks of the first US case, upon the request of the New York State governor, the Department of Defense (DoD) deployed active-duty medical professionals and equipment to NYC in a first of its kind response to a "medical" domestic disaster.[2] Civilian and military medical professionals faced a number of challenges as they attempted to integrate disparate health care delivery systems rapidly. The challenges touched on many important aspects of the four "S" considerations of disaster response: staff, stuff, space (structures), and systems.[3] Transitions of care for patients between civilian and military-staffed facilities surfaced as one of the key challenges requiring alterations in typical practice.[4,5]

In this study, we hosted a consensus conference of civilian and military health care professionals, who responded to the initial NYC COVID-19 surge, to identify lessons learned and recommendations for patient care transitions between military and civilian systems. The recommendations are intended to optimize future military response to domestic medical crises.

Methods

We utilized a modified Delphi technique during a 2-day virtual conference on April 4–5, 2022, to build consensus recommendations among civilian and military health care professionals who responded to the March 2020 NYC COVID-19 surge. The Uniformed Services University of the

Health Sciences (USUHS) and Icahn School of Medicine at Mount Sinai (ISMMS) Institutional Review Boards approved the study protocol (DBS.2020.078 and STUDY-21-01565).

Interviews

To identify key topic area(s) for the consensus conference, we conducted a series of semi-structured interviews between May 2021 and February 2022. We used snowball sampling to recruit military and civilian health care professionals who had responded to the NYC surge. Then, research teams at USUHS and ISMMS interviewed military and civilian responders, respectively. A total of 16 military and 11 civilian health care responders completed interviews. A research team member interviewed each participant for about an hour. A panel of military medicine experts developed a 45-question interview framework, and these questions were used as a guide for military interviews and later adapted for civilian interviews. The interview questions addressed the "4-S" disaster framework of staff, stuff, space, and systems.[3] The USUHS interviewers did not record interviews but rather prepared a detailed script after each interview. Detailed scripts have been found to be equally effective and accurate in capturing the essence of the participants' meaning and experiences.[6] Study team members then used "member checking." The team emailed the detailed script to each participant to confirm its accuracy, add missing information, and make any corrections.[7] After member checking, research team members independently coded each interview script. Civilian interviews were conducted via Zoom, recorded, and transcribed using a third-party transcription service. After confirming accuracy, recordings were destroyed and transcriptions were coded independently by 2 research team members with a third team member used to ensure consistency and resolve conflicts between coders.

USUHS and ISMMS research team members met, reviewed the code books, and identified recurring themes. "Patient handoff and transfer" was commonly identified as a key challenge by both military and civilian participants. The study team then selected transitions of care as the focus of the consensus conference. Detailed findings of the semi-structured interviews will be published separately.

Prior to the conference, the study team created a list of 10 subthemes for the transitions of care focus area. The subthemes covered staff, stuff, space, and systems issues that interviewees raised in the semi-structured interviews. The study team invited all the health care professionals who completed interviews to participate in the consensus conference. Twelve participants attended the 2-day conference, 10 of whom were civilians and 2 were military. Participants were offered a $500 honorarium for their participation in the study.

Conference and Delphi Method

The median number of Delphi panels typically includes 17 members.[8] Twelve panelists attended the conference falling within the target range. Individuals were contacted approximately 2 months prior to the conference. The email invitation included a brief description of the purpose, process, timing, and expected commitment, and individuals were asked to confirm their participation.

On the first day of the conference, participants were asked to review the 10 pre-selected subthemes, identify and add missing subthemes, and select the final 10 subthemes that would be used for group discussions (Figure 1). Selection was completed via electronic votes with the top 5 subthemes selected first and the next 5 subthemes selected from the remaining list.

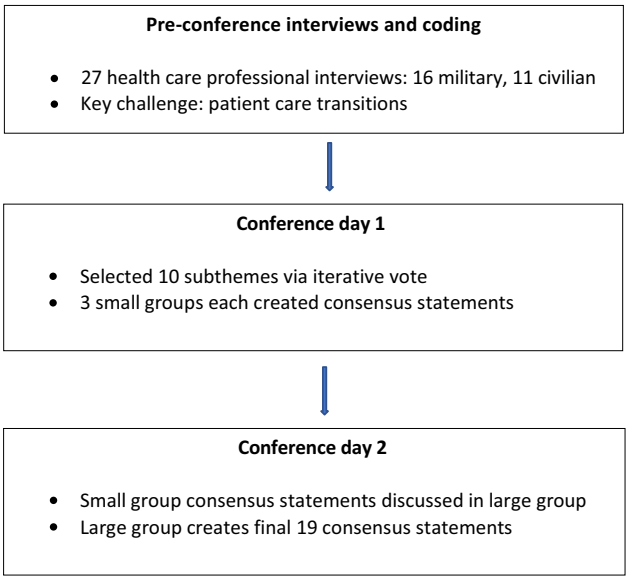

Figure 1. Study flow.

Once the group selected the 10 subthemes, the participants were divided into 3 groups. A study team member facilitated each group discussion. In each group, participants spent up to 25 minutes discussing each subtheme. Each group generated and voted on a consensus recommendation or recommendations for each subtheme in the allotted time. If needed, iterative votes were performed to reach 75% of the group members' approval.

On the second day of the conference, the study team presented the consensus statements generated by each of the 3 subgroups to the entire group of participants. All participants reviewed and discussed the statement(s) for each subtheme as a large group. The large group used the small groups' statements to generate composite consensus statements and then voted on each of the new statements. These final recommendations had to achieve a 75% majority vote to be considered a consensus recommendation. The conducting and reporting of this research complied with recommendations for the conduct of online surveys and the Conducting and Reporting of Delphi Studies (CREDES) criteria to enhance rigor.[9,10]

Results

The participants chose the following 10 subthemes of transitions of care to discuss needs assessment and capability analysis; unified command; equipment; patient handoffs; role of in-person facilitation; dynamic updates; patient selection; patient tracking; daily operations; and resource typing. The participants then generated a total of 19 consensus recommendations, 1 to 3 for each subtheme, using the iterative small and large group process described above (Table 1).

Discussion

The deployment of active-duty military medical troops and equipment to the 2020 COVID-19 surge in NYC represented an unprecedented response to a domestic medical disaster.[11] Reflecting on

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Table 1. Consensus recommendations

Subtheme	Large group consolidated recommendations
Needs assessment and capability analysis	The US Military should develop "packages" of medical personnel, equipment, and support that could be deployed for different medical needs. These packages could be tailored to provide combat casualty care needs, respiratory pandemic care, treatment teams for embedment into local facilities, among other medical response capabilities. The packages should be deployable to both combat/international (priority) and domestic situations.
	Each civilian regional system needs to establish a process for rapid, just-in-time needs assessment. Each regional system should use this needs assessment to make a clear request of the military for the right resources for the mission. A requesting civilian regional system could request a specific package or modular subcomponent of a package based on need (Mission Generation: matching resources and needs).
	Perform periodic updates to the needs assessment as operational situation changes.
Unified command	Utilize best incident command practices to establish rapidly a small group of military and civilian decision-makers who are empowered to integrate, coordinate, and direct the regional medical response on behalf of all stakeholders. This group would be nested within the overall disaster response command structure and should meet frequently and regularly. Group members should be posted publicly and an organizational chart developed to establish a chain of command for decision-making visibility. Roles, responsibilities, and authorities should be defined and appropriate expertise represented, including clinical and medical operational expertise.
Equipment	Perform an immediate interoperability analysis of communications equipment to recommend preferred practice and fill any gaps.
	Ensure military responding units have modern civilian communications equipment to reach people both internally to military units and externally to civilian partners (eg, Vocera).
Patient handoffs	Establish a tiered, direct medical handoff system that allows each facility or system to aggregate information about patients requiring transfer with a civilian physician medical director/transfer officer. This civilian medical director should then communicate with a reciprocal embedded military physician position (transfer officer or liaison) who accepts patients and communicates with treating physicians at the military facility.
	Integrate key patient information (records) into the transfer process. Create an adapted 9 line (key information used by US Military to facilitate transfer of patients), potentially using essential elements of information to be used as a universal handoff tool. Consider using existing Regional Health Information Organization data as standard. This information would allow the receiving triage officer to make an informed decision about acceptable transfers.
	Integrate patient information (records) into the transfer process. Establish required structured transfer information (digital records, printouts), such as discharge sheets, home meds. Develop a simple structured checklist for patient handoffs.
Role of in-person facilitation	Ideally, embed a forward military medical officer inside civilian hospitals to establish a "pull" system of patients for transfer from civilian to military treatment facilities. It is optimal to have liaisons at the sites, both civilians at military sites, and vice versa. However, the deployment of military medical liaisons/triage officers to health system transfer centers may not be necessary to facilitate transfer if the primary, if an alternative transfer process is able to keep up with patient load.
Dynamic updates	Establish a Joint Information Center (JIC) specifically related to strategy for clinical and policy updates. JIC outputs should include common operating picture, including situational awareness with data and dashboards, key information and updates related to medical response. Updates should be widely shared via standard, official channels of health care systems/HCCs/Hospital associations/MOCC, as well as a process for a digital dashboard, shared drives for wide access.
	The JIC should have regularly scheduled, frequent information. Information should be prioritizied and disseminated in categories (immediate/urgent vs routine).
Patient selection	Define the military medical mission, and then use the mission to determine appropriate patients for transfer to military facilities, or to select military members as augmentees for civilian hospital staffs. Establish a tiered system to evaluate acuity of care and recommend patients for alternative care sites. This tiered system should consider constraints in staffing, resources, space and expertise for both general and specific conditions. Patient selection should be based on this determination.
	Establish threshold markers so that patients and/or their families are not able to refuse transfer. Governor's order back it up. Responding to patient transfers based on objectives and needs assessment.
Patient tracking	Create and implement a universal patient tracking system that can track a patient from point of entry into the health care system, through all transfers until discharge. It should be digital, and able to generate reports. The system should work across all EMRs, prehospital systems, and so forth, and provide FedEx-like tracking fidelity of where a patient is in the system. Enhance training opportunities to ensure knowledge base.
	It also needs to be PHI compliant universal electronic registration/health information exchange system that could allow sharing of patient location and encounters. In addition to hospitals, allow family members/loved ones to locate patients using this system to facilitate family reunification. The system should provide information about which bed a patient occupies, record the move, upgraded, downgraded, and length of stay, and additional pertinent information.
Daily operations	Establish an operations center with a clear operations lead, as a subgroup of the unified command group, for all response partners participating in the regional medical response. This ops center coordinates logistics and planning issue to: streamline processes, recommend deviations for crisis standards of care as needed, and solve bottlenecks and other operational problems as they arise.
Resource typing	Ideally, a predetermined list of medical equipment terminology and definitions that could be used in medical disasters should be developed and distributed.
	All response systems should have advanced lists of resources, as well as rules and financial implications for resource use. All groups should crosswalk these lists with all response partners to ensure standardized terminology/ understanding of available resources, as well as rules and financial requirements for resource use.

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this response offers an opportunity to consider how our nation can use its resources most effectively to respond to future crises.[12] This study identified 19 consensus recommendations for care transitions between military and civilian health care assets during a medical crisis. These recommendations may be useful to optimize care transitions during any future episodes of military support to civilian health care.

There are 12 000 military physicians working as part of the Military Health System (MHS)—a large, global organization that cares for 9.5 million beneficiaries.[13] While active-duty military medical professionals must maintain an ability to deploy rapidly to support national contingency operations, they do not typically respond directly to civilian medical crises. The NYC COVID-19 military medical response surge is unprecedented in 2 key ways. First, the active-duty military response mission was patient care. This differs from more typical military responses to natural disasters, like hurricanes, that often involve national guard units rebuilding infrastructure and performing search and rescue activities. In NYC, the infrastructure remained undamaged during the COVID-19 surge. As of May 2020, more than 540 physicians, nurses, and other medical personnel had deployed for COVID-19 response across the country, and the 1200 person crew of the USNS Comfort had arrived and begun treating patients.[14,15] A second key difference is that military-civilian disaster partnerships generally address singular, regionalized events. COVID-19, however, is a sustained, prolonged global disaster.

The 19 practice recommendations identified in this study touched on a variety of considerations across the 4-S framework and ranged from broad to specific. During the discussions, participants recognized the importance of not identifying recommendations that were too specific to their previous experience, but rather consider how what they learned could be applied to a future situation. The conference discussions and recommendations addressed considerations from preparedness through recovery. Brief descriptions of the recommendations and their context are listed in the following paragraphs.

Needs Assessment and Capability Analysis

The participants generated 3 recommendations for this subtheme. One of the key concerns about the initial DoD response in NYC was a mismatch in deployed assets and the civilian health care systems' needs. Early in the response, the DoD deployed trauma teams designed primarily to treat wartime combat casualties. While trauma team members had important critical care expertise, their mission, primary skillset, and equipment were designed more for performing surgery and treating injury, rather than for respiratory infection management. Likewise, the design of major equipment, such as the USNS Comfort, was better suited to transporting injured patients who can be co-located in tight quarters rather than maintaining negative pressure isolation required of patients with airborne infectious disease. The participants recommended the development of "packages" of people and equipment that the DoD could deploy to meet different and tailored needs (eg, packages for respiratory infection, those designed to embed military medical personnel in civilian facilities, and other considerations beyond typical DoD response assets designed for trauma or weapons of mass destruction response). Furthermore, the group recommended each regional civilian system establish a process for a rapid, just-in-time needs assessment that an affected region, rather than an individual hospital, could perform and communicate to the DoD. This might allow the requesting civilian system and responding DoD to efficiently match available, predetermined packages with the defined need.

Unified Command

The study participants stressed the importance of using best incident command practices, as well as a long-standing military doctrine, to establish rapidly a small group of military and civilian decision-makers who are empowered to integrate, coordinate, and direct the regional medical response on behalf of all stakeholders. During the early phases of the integrated military-civilian response, participants noted some challenges identifying clear command and communicating updates and policy changes efficiently to all involved organizations.

Equipment

The conference yielded 2 recommendations regarding communications equipment. The first recommendation is agnostic to any specific technology and recommends performing an immediate interoperability analysis of equipment to ensure smooth communication between civilians and military and fill any gaps as needed. The second recommendation addresses a specific need for the military to have access to modern communication equipment that would allow them to reach both internal and external partners. Specifically, military members had to rely extensively on personal cell phones during the NYC response, as their equipment did not allow for seamless integration with non-military assets.

Patient Handoffs

While the entire conference focused on transitions of care, the participants focused on the specific act of "handing off" a patient from 1 care team to another as an important subtheme and made 3 recommendations. The first recommendation stressed the need for a tiered handoff structure that could allow for an effective information transfer about batches of patients at once. The participants described the extreme busyness of the direct patient care teams and the impracticality of expecting treating teams to perform physician-to-physician communications as they would during normal operations. Instead, it became efficient and effective to establish a funnel of transfer information to a single physician "transfer officer" at the outgoing facility who could then communicate with an equivalent position at the receiving facility. This made the treatment team's work more efficient and allowed for higher yield communications between facilities to manage the large volume of patients. The next 2 recommendations focused on the need to integrate patient information (records) into the transfer process. Specifically, brief, high yield information should be collected and transferred as a universal handoff tool. While there are existing handoff tools available, the participants did not feel that they had a standardized approach that worked effectively. There was discussion about adapting the military's 9-line transfer process, which communicates brief, key information about casualty evacuation, to transportation personnel, leadership, and medical teams. The participants also recognized the need for standardized discharge information when patients leave military treatment entities and are sent back for follow-up in their civilian systems. They again recommended developing standardized processes for this information.

Role of In-Person Facilitation

The participants had strong agreement that embedding a military medical officer inside the civilian facilities to establish a "pull"

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system to transfer patients from overwhelmed civilian to military facilities is an effective practice. In the early phases of the military response, civilian treatment teams were so busy providing patient care that they had very limited bandwidth to identify and communicate about appropriate patients for transfer. The process of transferring patients accelerated greatly when military medical officers, also known as *liaisons* by the military, embedded in the civilian facilities to proactively identify patients, thus removing this burden from the civilian treatment teams. The group recognized that this may not be necessary in circumstances in which existing transfer processes are able to keep up. However, it proved essential in the NYC response and may be highly beneficial for overwhelmed facilities in the future.

Dynamic Updates

Study participants recommended establishing a Joint Information Center (JIC), as rapidly as possible, specifically designed to strategize and promulgate clinical practice and medical policy updates. The participants experienced challenges and confusion related to disseminating consistent, clear messaging to all of the various civilian and military medical professionals involved in the NYC response. They recommended that the JIC have regular, frequently scheduled meetings and updates.

Patient Selection

Participants generated 2 consensus recommendations regarding patient selection for transfer. First, responders should define the military medical mission and then use the defined mission parameters to identify appropriate patients to transfer from civilian to military medical treatment areas. This recommendation stemmed from frustration that the participants experienced during the early stages of the response. Initially, military treatment areas, such as the USNS Comfort, were unable to treat the COVID-19 patients for whom the civilian NYC system most desperately needed help.[16] If all parties clearly understand the mission and capabilities, then appropriate patients can be selected more efficiently. Second, the group recommended establishing "threshold conditions" that, once met, could require a patient to be transferred, even against a patient's preference. Study participants noted that patients frequently refused to be transferred to the Javits Center. During a state of emergency, an order from an appropriate authority, such as the state Governor, could allow treatment teams to transfer appropriate patients when needed to create capacity for others needing help.

Patient Tracking

Study participants emphasized the need for a universal patient tracking system that can track patients from point of entry into the health care system until discharge. The tracking would need to work across various electronic medical records, prehospital systems, and other entities while providing highly reliable information. Participants noted difficulties in knowing where patients were located throughout the military-civilian system at any given time. This became especially difficult when trying to relay information to worried family members. In addition to tracking, study participants identified that the system should protect health information while allowing for sharing of patient encounter information. The group stopped short of recommending a universal health record but thought that robust tracking information could be essential for future crises involving large numbers of care transitions.

Daily Operations

The participants recommended establishing an operations center as a subgroup of the unified command structure (see above). This operations center should have a clear lead and bear responsibility for logistics and planning issues. The participants noted numerous system bottlenecks, for example, during the COVID-19 response in NYC. For example, there were sometimes large numbers of ambulances, and therefore long waits, to drop off patients being transferred from civilian hospitals to the Javits Center. These ambulances were then out of circulation and unable to respond to other needs. An operations center with visibility and authority could provide real-time solutions to these problems that are difficult for a single entity to address adequately.

Resource Typing

Types of resources available and the rules for using them were issues the group considered important. They suggested creating predetermined lists of medical equipment that responding entities would use during disasters, and then distribute these lists for situational awareness. Participants noted that sometimes details, like referring to a piece of medical equipment with different terminology, created challenges in understanding what the entire system possessed and how to optimize its use. In addition, the participants recommended that all responding groups should understand the financial rules for use of any shared equipment and resources. These rules can be complicated, and obtaining a rapid understanding is important for an effective response.

Limitations

This study has limitations. The results represent the consensus of 12 health care professionals who responded to the NYC COVID-19 surge. Their recommendations may not necessarily be applicable to future medical disasters. Due to ongoing challenges of the COVID-19 pandemic, the study team elected to hold this conference virtually. It is possible that an in-person conference may have fostered a more robust discussion that could have shaped different outcomes. Due to the 2-day time constraint of the conference, the study team chose to limit the discussion to focus on transitions of care. While this topic is important, there are many other considerations for a future military response to civilian medical crises.

Conclusion

This study identified 19 consensus recommendations for care transitions between military and civilian health care assets during a medical crisis. These recommendations may be useful to optimize care transitions during any future episodes of military support to civilian health care.

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