NEW YORK CITY HEALTH CARE COALITION (NYCHCC) LEADERSHIP COUNCIL MEETING

September 28, 2017

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WELCOME!

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Morning Agenda

9:00 - 9:15a	Welcome - Bill Lang, MS
9:15 - 10:15a	Health & Medical Executive Committee (HMExec) Presentation
10:15 - 10:30a	Opening Remarks - Celia Quinn, MD, MPH
10:30 - 10:50a	ASPR 5 Year Contract (2017-2022) - Darrin Pruitt, PhD, MPH
10:50 - 11:00a	NETWORKING BREAK
11:00 - 11:20a	ASPR Funding - Budgetary Period 1 (BP1) - Robert Moore, MSPPM
11:20 - 11:40a	BP5 (2016/17) Coalition Output – Jannae Parrot, MPH
11:40 – 12:00p	Health System Playbook: Update, Q&A – Darrin Pruitt, PhD, MPH

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Afternoon Agenda

12:00 - 12:30p	LUNCH
12:30 - 1:30p	NYCHCC Charter Development: Workshop Sessions
1:30 - 1:45p	NYCHCC Charter Development: Workshop Report Out
1:45 - 2:45p	Hazard Vulnerability Analysis - Shahrzad Kardooni, MD, MPH
2:45 - 2:55p	NETWORKING BREAK
2:55 - 3:10p	Health System Infection Control Program: Briefing - Mary Foote, MD, MPH
3:10 - 3:30p	Citywide Surge Exercise: Update, Q&A – Marie Irvine
3:30 - 3:45p	Community Resilience Planning Committee: Overview Hannah Arnett, Jacqlene Moran
3:45 - 3:55p	Member Announcements & Invitations to Upcoming Events - All
3:55 - 4:00p	Concluding Remarks – Bill Lang

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HEALTH & MEDICAL EXECUTIVE COMMITTEE

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NYC Health and Medical Executive Advisory Group (HMExec)

FIRE DEPARTMENT CITY OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION GNYHA

NYC Health

NYC Emergency Management

NYC HEALTH+ HOSPITALS | EMERGENCY MANAGEMENT

NEW YORK STATE Department of Health

NYC Health

Overview

- Establishment of the HMExec group
  - Purpose
  - Rationale
  - Process
- 2016 Priorities and Accomplishments
- 2017 Priorities and Status
- Questions and Discussion

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HMExec

NYC Health and Medical Executive Advisory Group (HMExec)

- Membership
  - NYC Emergency Management (NYCEM)
  - Fire Department of NY (FDNY)
  - NYC Health + Hospital (NYC H+H)
  - Greater NY Hospital Association (GNYHA)
  - NYC Department of Health and Mental Hygiene (NYCDOHMH)
  - NY State Department of Health (NYSDOH)
- Meeting monthly since November 2015
- Bring in additional ESF-8 partners for specific issues/priorities

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Mission

- **Working in coordination with other ESF-8 agencies and NYC health system partners, the mission of HMExec is to:**
  - Advise and inform agency and incident response leadership on health and medical response objectives
  - Ensure that agencies are aligned in setting planning and response goals and meeting response needs appropriately
  - Provide strategic direction to Health/Medical agencies and health system partners in support of ESF-8
  - Identify and prioritize policy issues requiring HMExec agency input and coordinate timely resolution of these issues

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HMExec: Improving ***Preparedness***

Preparedness

- ❑ Increase information sharing among health and medical agencies
- ❑ Ensure that health and medical agencies are aligned in setting preparedness priorities, and carrying out preparedness activities
- ❑ Establish 3-5 shared, system-level preparedness planning priorities annually
- ❑ Achieve and report progress on planning priorities to organizational leadership and stakeholders

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HMExec Improving ***Response***

Response

- ❑ Advise leadership from HMExec members on emerging issues with potential system impact
- ❑ Develop shared incident objectives for Health and Medical Sector
- ❑ Streamline interagency communications and response-based policy development
- ❑ Provide strategic direction to Health/Medical agencies and health system partners in support of ESF-8

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2016 Priorities and Accomplishments

2016 Priorities & Accomplishments

Priority 1: Establish HMExec Framework/Guiding Principles and Gain Executive Approval of Group

Priority 2: Improve Health System Situational Awareness and Engagement in NYC Response

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2016 Priorities & Accomplishments

Priority 3: Formalize Exemptions for Healthcare Workers in New York City Travel Bans

Priority 4: Sustain Gains in Infectious Disease Readiness and Control

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Notable Accomplishments

- Developed a planning framework and guiding principles during planning and response (2016 P1)
- Developed and disseminated hospital guidance to improve coordination with law enforcement and investigative agencies (2016 P2)
- Created a process to develop incident-specific response guides for the healthcare community; completed and disseminated a coastal storm guide (2016 P2)
- Formalized strategies with the Mayor's Office, NYPD, and NYCEM with regard to the implementation of travel ban exemptions for health workers under the Credential Verification/Access Coordination Plan (2016 P3)

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Notable Accomplishments

- Seven hospital systems, including NYC Health + Hospitals, completed Ebola response plans, trained staff, and conducted exercises testing the ability to identify/manage Ebola patients, all of which would be highly beneficial in response to any emerging infectious disease (2016 P4)

- Coordinated with relevant partners in New York and New Jersey to develop a regional transport plan addressing the movement of patients with confirmed Ebola or other special pathogen between treatment hospitals in the region and the Regional Ebola and Special Pathogens Treatment Center at Health + Hospitals / Bellevue Hospital Center (2016 P4)

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2016 Emergency Responses

- **2016 Zika virus:** provided input into NYC response via monthly calls

- **2016 Winter and Coastal storms:** facilitated timely development of operational objectives and communication of planning timeframes

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2017 Priorities

2017 Priorities

- **Priority Area 1:** Articulate a Vision for New York City's Healthcare System Preparedness, Response, and Recovery Through Development and Implementation of the "New York City Healthcare System Playbook"

- **Priority Area 2:** Improve NYC/Regional Response to a Coastal Storm by Identifying Mechanisms to Increase NYC Health System Receiving Capacity and Addressing Needs of Homebound Individuals Who Use Durable Medical Equipment

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2017 Priorities (cont'd)

- **Priority Area 3:** Improve NYC Health System Readiness to Respond to Mass Casualty Incidents (MCI) Through Enhanced Coordination Between Hospitals and NYC Agencies

- **Priority Area 4:** Integrate HMExec Into NYC Response Processes and Within the ESF-8 Response Framework

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2017 Status

- **Priority Area 1:** HMExec reviewed Healthcare System Playbook framework (based on stakeholder input from Budget Period 4). Executive summary expected Nov 2017.

- **Priority Area 2:**
  - Surveyed nursing homes and conducted key informant interviews to develop recommendations related to reimbursement policy
  - Developed protocols for use of emPOWER dataset in coastal storm scenario

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2017 Status

- **Priority Area 3:**
  - CIMS/HICS exercise January 2017
  - Pediatric Disaster Coalition exercise April 2017
  - Emergency Department Staff Training on MCI response May 2017
  - Continuous monitoring of EMS-to-hospital MCI notification protocols

- **Priority Area 4:**
  - Introduced HMExec to ESF 8 agencies in January 2017
  - Discussed role of HMExec in ESF-8 and NYC Healthcare Coalition and reviewed draft NYC Healthcare Coalition Charter

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NEXT STEPS

Next Steps

- Complete and document 2017 accomplishments
- Formalize HMExec Role within NYC Healthcare Coalition Charter
- Jointly set priorities for 2018

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QUESTIONS?

OPENING REMARKS

Celia Quinn, MD, MPH

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ASPR 5 YEAR CONTRACT (2017-2022)

Darrin Pruitt, PhD, MPH

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New Project Period, New Requirements

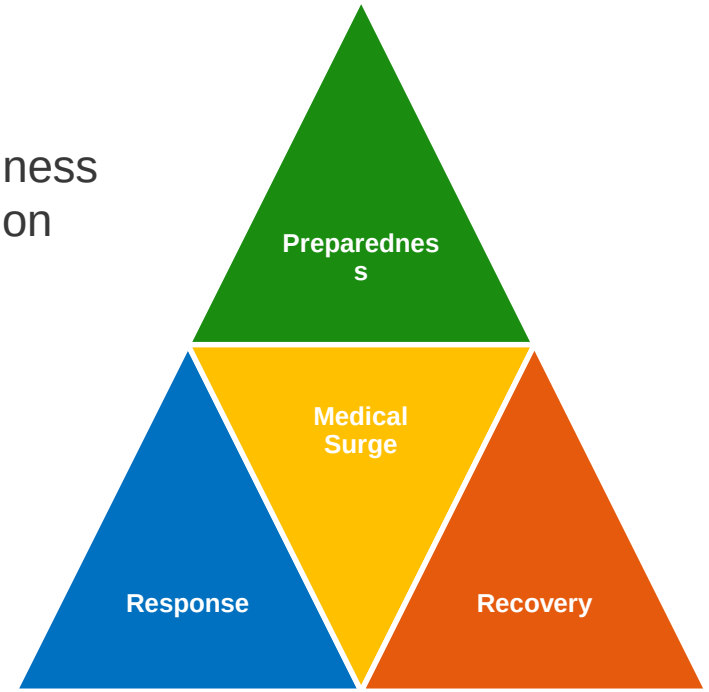
No longer only preparedness

4 capabilities

1. Foundation for Health Care and Medical Readiness
2. Health Care and Medical Response Coordination
3. Continuity of Health Care Service Delivery
4. Medical Surge

Coalition focus

1. Annual HVA
2. Preparedness, Response and COOP Plans
3. Annual Surge Exercise



Getting there: contract deliverables, work groups, HMExec

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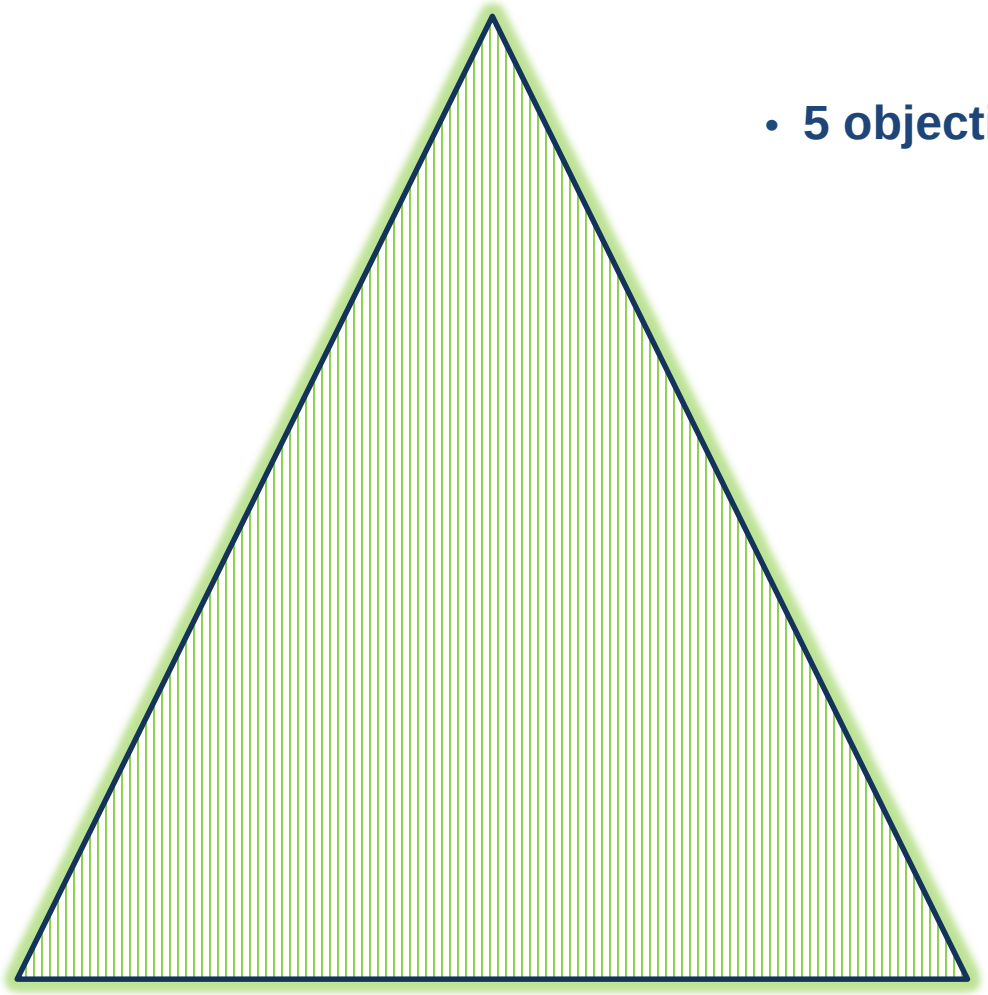
Preparedness

Foundation for Health Care and Medical Readiness



- **5 objectives focused on building the healthcare coalition (HCC)**

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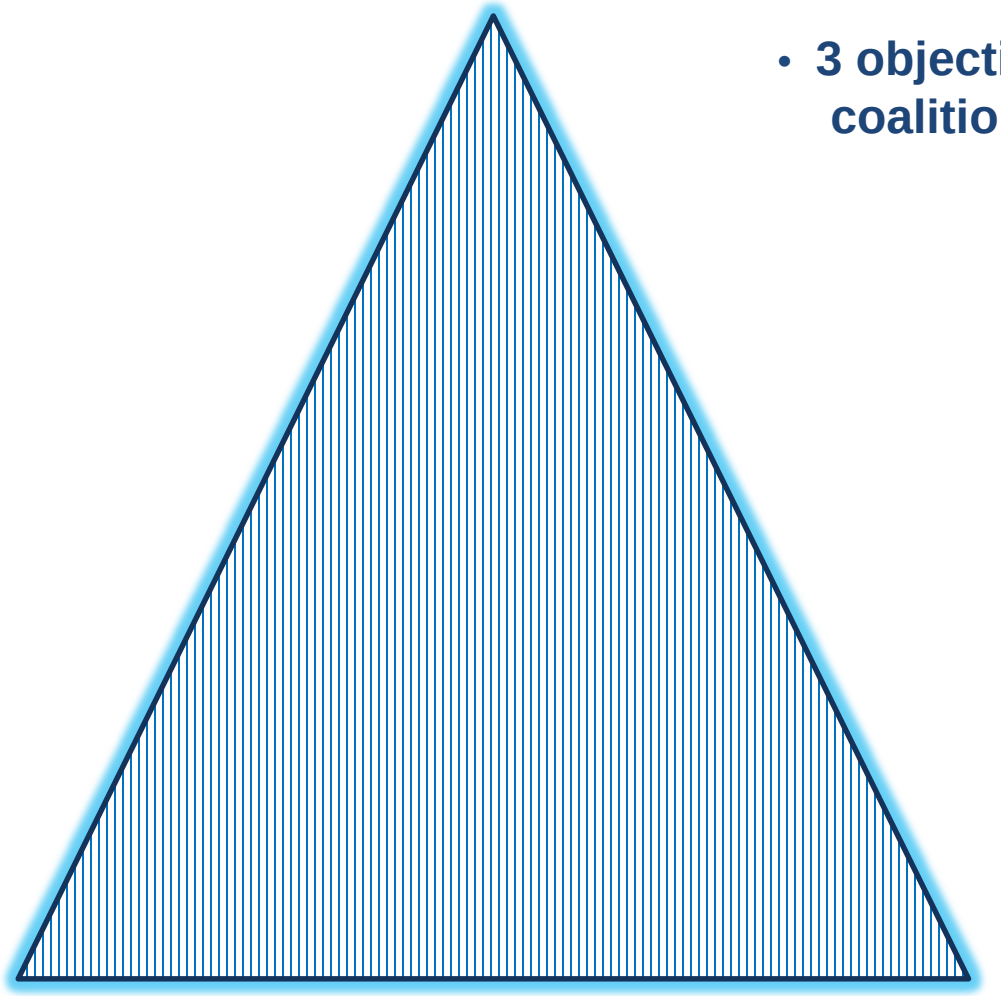
Response

Health Care and Medical Response Coordination



- **3 objectives focused on coordinating facility + coalition response plans, information sharing and resources**

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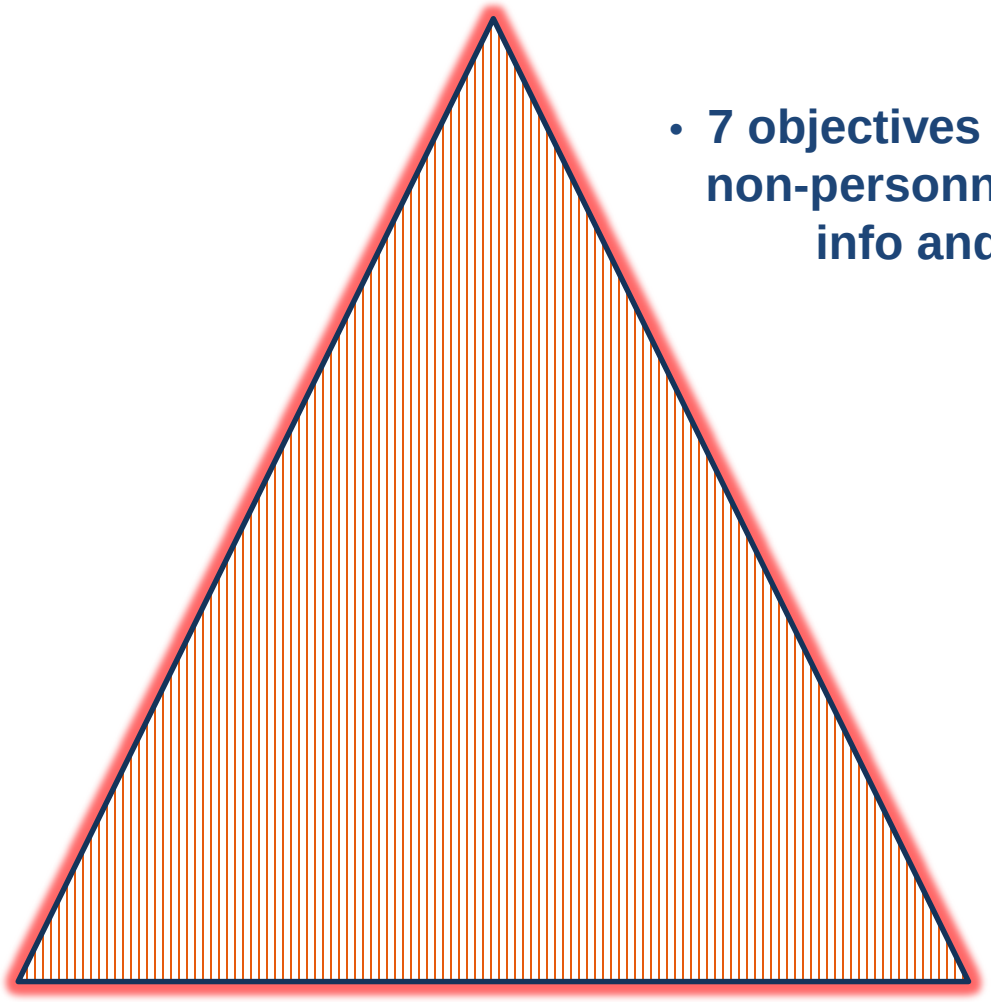
Recovery

Continuity of Health Care Service Delivery



- **7 objectives focused on essential functions, coop, non-personnel resources, protection of healthcare info and responders, coordinated evacuation, system recovery**

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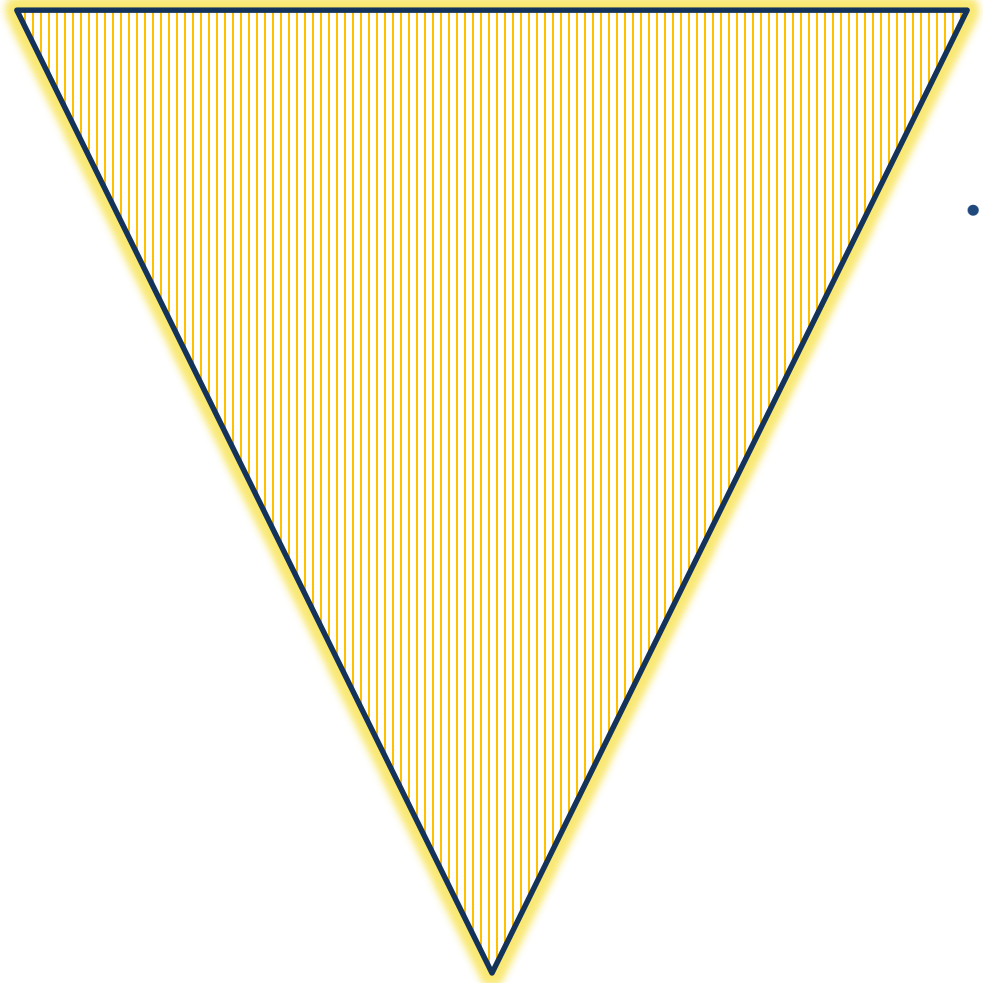
Medical Surge



- **2 objectives focused on medical surge planning and response**

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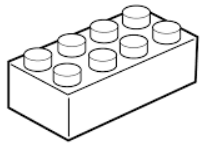
Year 1 (2017-18) Requirements

Capability	What's due	NYC HCC role
Healthcare and Medical Readiness	• Coalition Governance (Charter) • Coalition Preparedness Plan • Coalition HVA • NIMS	• Provide input via LCM • Provide input via LCM, review annually • Provide data, review HVA, share with all members • Complete deliverable for CIMS
Healthcare and Medical Response Coordination	• Coalition Surge Test Exercise	• Design, participate, provide data



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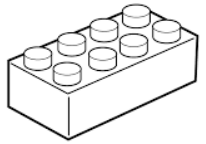
Year 2 (2018-19) Requirements

Capability	What's due	NYC HCC role
Healthcare and Medical Readiness	• Regional Healthcare Resource Assessment • Coalition HVA • NIMS	• Track and share information with all HCC members • Provide data, review HVA, share with all members • Continue NIMS education
Healthcare and Medical Response Coordination	• Coalition Response Plan • Coalition Surge Test Exercise	• Provide input, review annually • Design, participate, provide data



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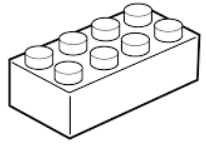
Year 3 (2019-20) Requirements

Capability	What's due	NYC HCC role
Healthcare and Medical Readiness	• Coalition HVA • NIMS	• Review HVA, share with all members, provide data • Complete deliverable for CIMS
Healthcare and Medical Response Coordination	• Coalition COOP • Coalition Surge Test Exercise	• Provide input, review annually • Design, participate, provide data



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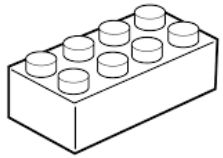
Due Every Year (2017-22)

Capability	What's due	NYC HCC role
Healthcare and Medical Readiness	• Coalition HVA • NIMS	• Review HVA, share with all members, provide data • Complete deliverable for CIMS
Healthcare and Medical Response Coordination	• Coalition Surge Test Exercise	



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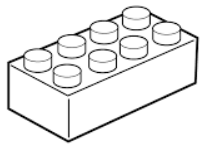
Due by the end of year 5 (2022)

Capability	What's due	NYC HCC role
Healthcare and Medical Readiness	• Jurisdictional Risk Assessment	• Provide input via LCM
Healthcare and Medical Response Coordination	• Statewide Exercise	• Similar process as Surge Exercise, TBA
Continuity of Healthcare Service Delivery	• Supply Chain Assessment	• Input via deliverables and LCM
Medical Surge	• Crisis Standards of Care Documentation	• Provide input, coordinate with community for input



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NETWORKING BREAK

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2017-2022 HOSPITAL PREPAREDNESS PROGRAM (HPP)

NYC Dept. of Health & Mental Hygiene
Office of Emergency Preparedness & Response (OEPR)
Bureau of Grants Management & Administration (GMA)

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BP1 HPP Overview

- New 5-year HPP-PHEP project period: July 1, 2017 – June 30, 2022
- Budget Period 1 (BP1) – July 1, 2017 – June 30, 2018
- Purpose
  - To strengthen and enhance the capabilities of the public health and health care systems to respond to evolving threats and other emergencies.
  - To prevent or reduce morbidity and mortality from public health incidents whose scale, rapid onset, or unpredictability stresses the public health and health care systems
  - To ensure the earliest possible recovery and return of the public health and health care systems to pre-incident levels or improved functioning.
  - HPP: To document progress in establishing or maintaining ready health care systems through strong health care coalitions.

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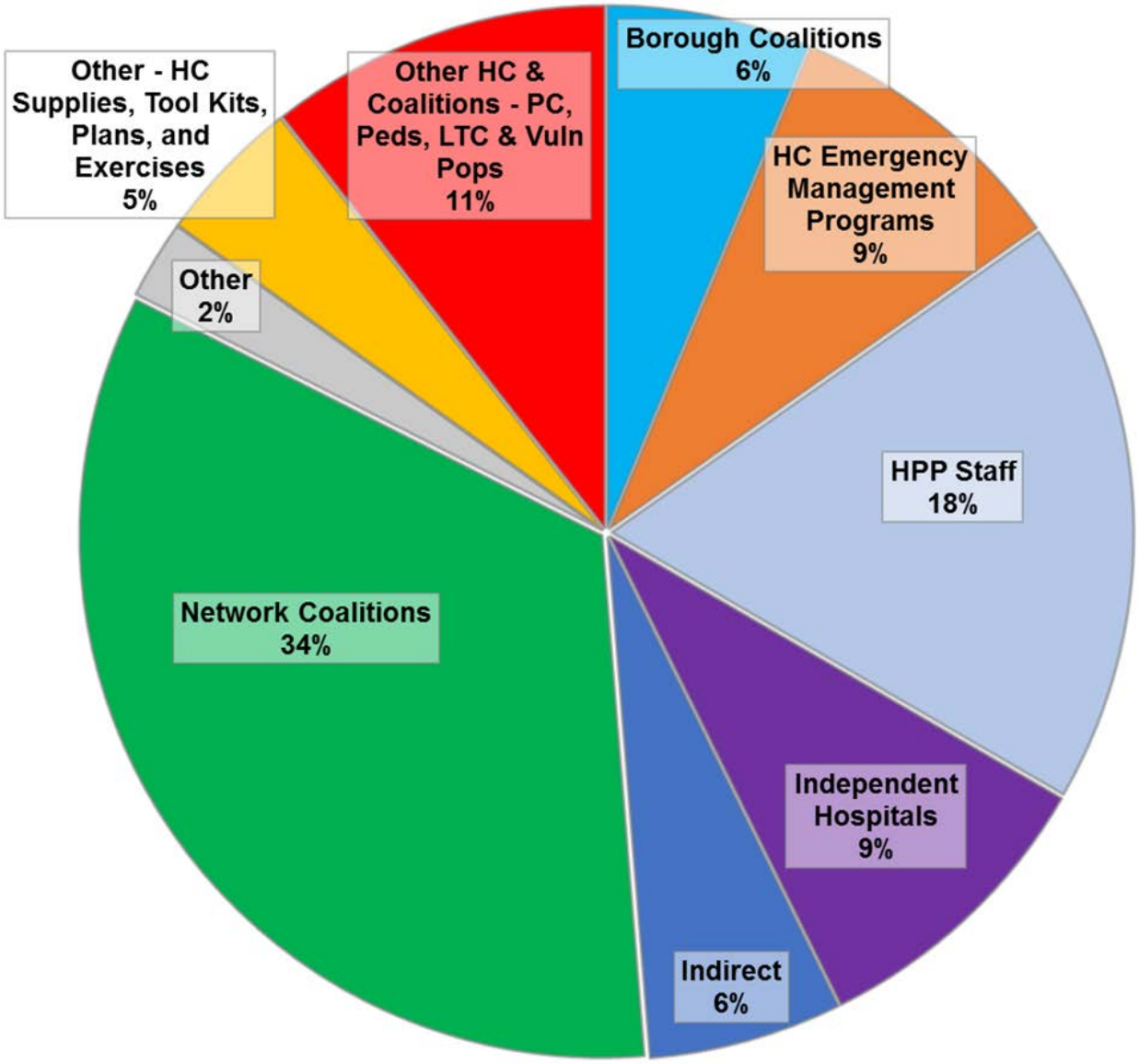
BP1 Hospital Preparedness Program (HPP)



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Public Health Solutions (PHS)

- PHS will continue to serve as designated recipient and fiscal/administrative agent for HPP-PHEP
- PHS role (on behalf of DOHMH):
  - Receive/expend grants (i.e. remit payments to vendors)
  - Procure goods/services, including contracts
  - Ensure compliance with uniform administrative requirements, cost principles, and audit requirements for federal awards
- DOHMH role:
  - Sole programmatic decision making
  - Review/approve budget submissions
  - Review/approve procurement for goods/services, including contracts
  - Ensure work plan activities are carried out

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Contract & Voucher Process

Contract Process

- ❑ PHS sends contract to HC facility for signature
- ❑ HC facility returns signed contract & required documentation to PHS
- ❑ PHS sends copy of executed contract to HC facility

Voucher Process

- ❑ Upon deliverable completion by specified due date, HC facility submits voucher/deliverable documentation to DOHMH Project Manager
- ❑ Project Manager reviews deliverable, notifies HC facility of approval and signs voucher
  - If deliverable not approved, Project Manager communicates to HC facility what modifications are needed
  - HC facility resubmits deliverable for approval
- ❑ Project Manager submits voucher to OEPR Grants Management & Administration (GMA)
- ❑ OEPR GMA reviews/approves and submits voucher to PHS for payment
- ❑ PHS reviews/approves and remits payment to HC facility

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Deliverable Documentation

- Deliverable documentation **must** match documentation outlined in Scope of Work
- If DOHMH Project Manager/Contractor mutually agree upon changes, contract amendment and/or note to file may be required

- **Contracts, payments and deliverable documentation are subject to multiple audits, including federal audits**

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Contract Execution Deliverable

- **Reminder:** Independent Hospitals, Network Coalitions, and Borough Coalitions must sign and return to Public Health Solutions (PHS) a partially executed contract within 45 calendar days of contract receipt via email from PHS

- Boroughs: sent 9/12; due 10/27 by 5pm

- Networks: sent 9/13; due 10/28 by 5pm

- Independents: TBD

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BP5 COALITION OUTPUT

Jannae Parrott, MPH

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Overview

- Purpose
- Coalition Development Overview, BP1-BP5
- Methods
- Big 5 Capabilities
- Results
- Next Steps

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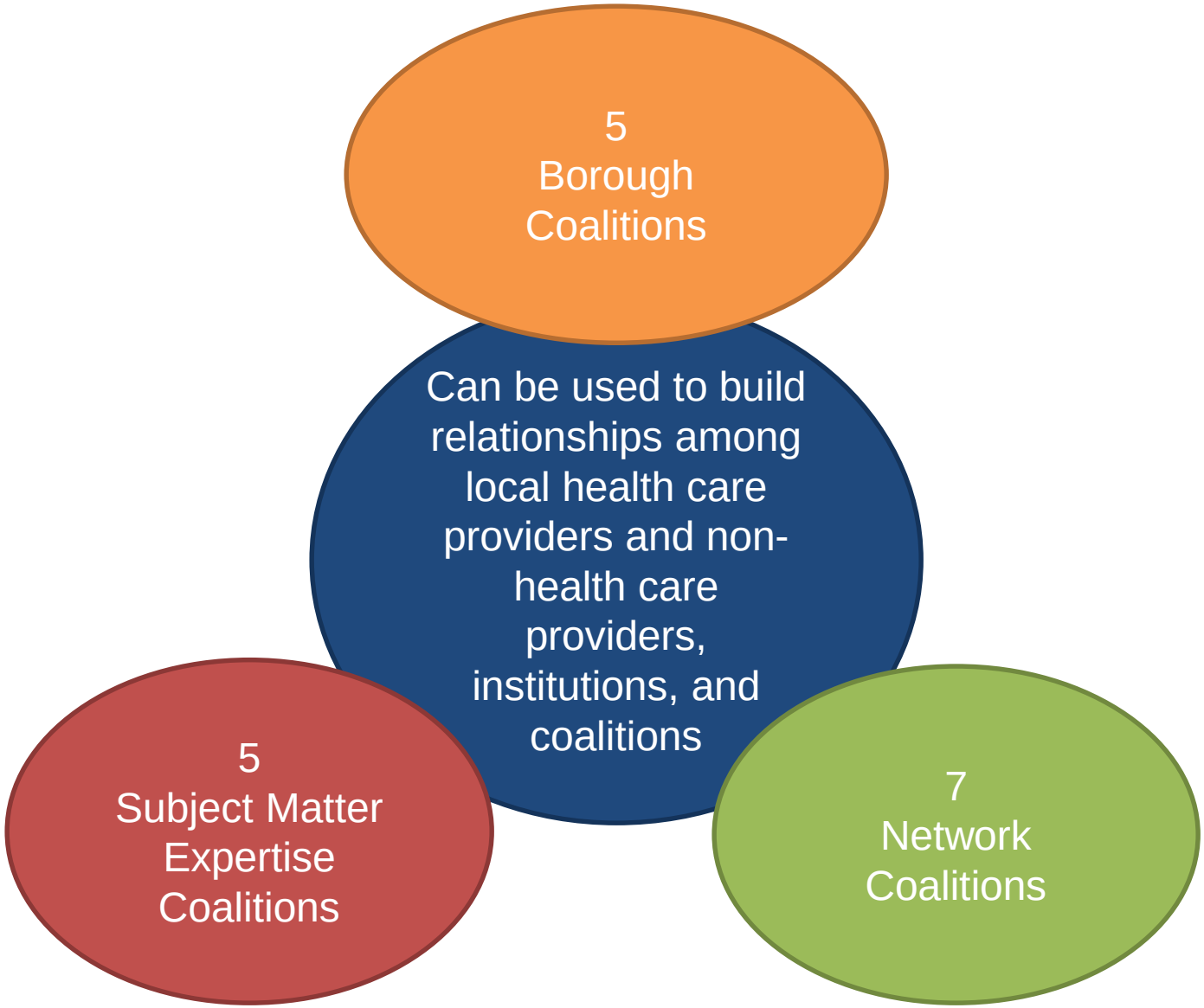

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Purpose

- Conduct a review of all NYCHCC outputs during BP5
- Trend our progress since BP3
- Discover trends and note our progress
- Provide snap-shot for how emergency management has progressed in relation to core capabilities
- Guide the direction of coalition work as we transition into a new budget cycle
- Suggest areas of improvement

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Coalition development: BP1-BP3

- Developed a roadmap
  - Concept of operations
  - Organizational chart of NYCHCC

BP1

2012 - 2013

- Established coalition types
  - Defined individual coalition charters
  - Began strategic planning with shared focus

BP2

2013 - 2014

- Expanded on prior work
  - Incorporated situational awareness tools
  - Conducted risk assessments (HVAs)
  - Established a baseline for the first time

BP3

2014 - 2015

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Coalition Development: BP4-BP5

- Standardization
  - Strengthening of capabilities
  - Making sure coalitions are on the same page

BP4

2015 - 2016

- Organization and Expansion
  - Inclusion of multidisciplinary health care and non-health care organizations
  - Promotion and sharing of promising and best practices

BP5

2016 - 2017

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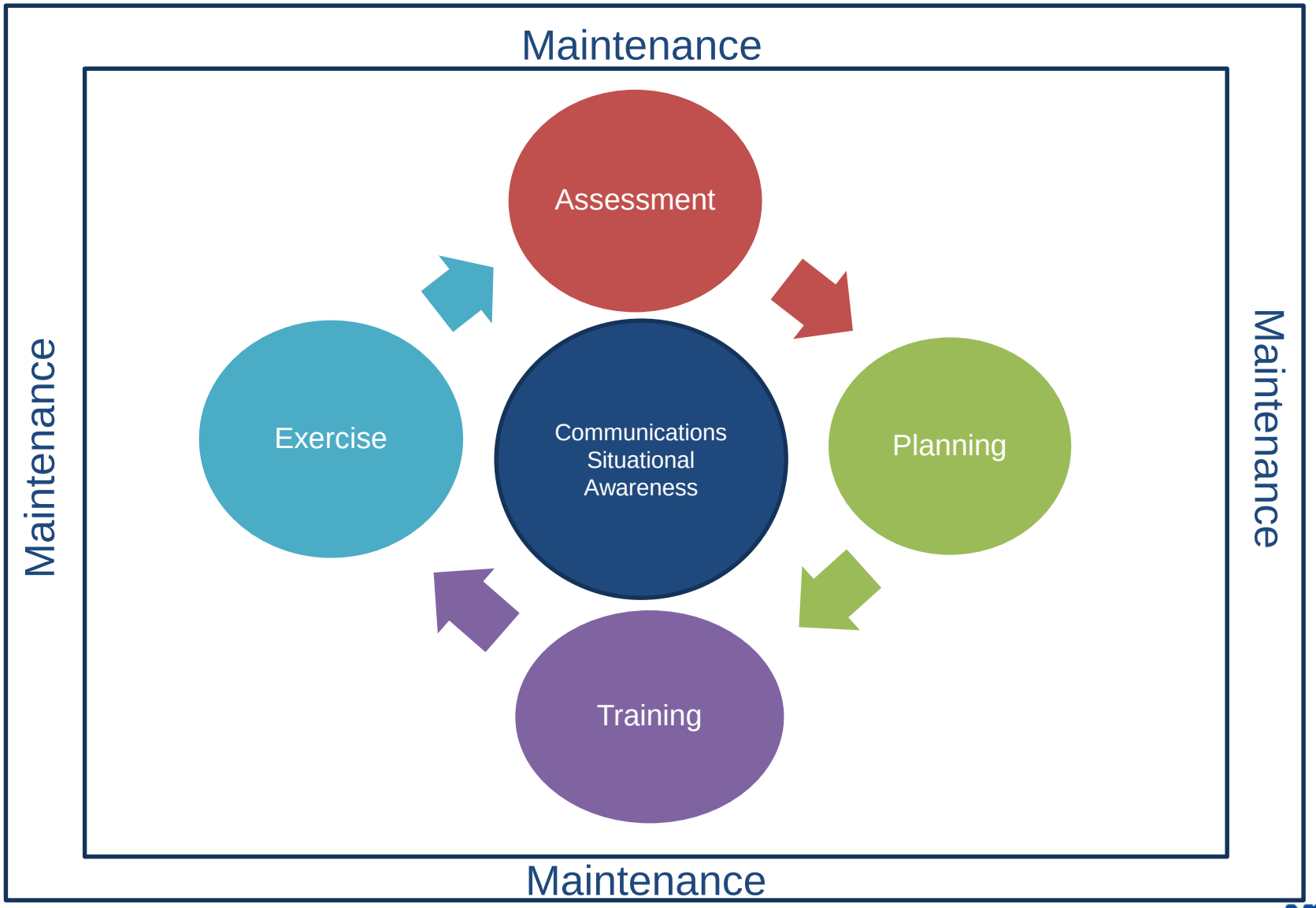
“Big 5” Capabilities



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Big 5 Capabilities

Capability	Definitions
Assessment/HVA	The process of discovery of hazards and the evaluation of risk and impact of these hazards that can confront the healthcare coalition.
Planning	The process of matching activities, staff and other assets to risks from hazards discovered and evaluated by the healthcare coalition.
Training	The presentation of knowledge to, practice of skills and furthering of abilities in staff related to plans meant to prepare for, mitigate, respond to and recover from hazards.
Exercise	Planned events meant to provide experience to staff to test the utility, strengths and weaknesses of plans.
Communications/ Situational Awareness	Activities undertaken to gather and share information to facilitate planning and response.

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Methods

Review
- Collected 58 scopes of work
- Reviewed 98 deliverables

Code
- Summarized deliverables
- Tagged each deliverable by most relevant “big five” capability

Analyze
- Quantitative trend of capabilities progress
- Qualitative review of best practice

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Sample Scope of Work and Deliverables

DELIVERABLE	ACTIVITIES	REQUIRED DOCUMENTATION	MAXIMUM REIMBURSABLE AMOUNT	DUE DATE
ED4 - Training – Hospital Staff	Complete one (1) of the following training activities: • Based on identified gaps or vulnerabilities, develop and deliver a training for at least twenty (20) staff. Topics could include: active shooter, evacuation, eFINDs, or others. OR • Hospitals may send at least two (2) staff to FEMA/ HHS approved training (e.g., Hospital Emergency Response Training (HERT) in Anniston, Alabama) OR • Register/renew memberships for emergency management or business continuity associations/organizations (e.g., International Association of Emergency Managers (IAEM), Disaster Recovery Institute (DRI)). OR • Register for and receive an emergency management credential (e.g., Associate Emergency Manager (AEM), Certified Emergency Manager (CEM), Certified Business Continuity Professional (CBCP), Member Business Continuity Institute (MBCI), etc.)	• Brief proposal of desired training topic and how this supports preparedness of the facility (e.g., indicated in facility's Hazard Vulnerability Analysis (HVA), a visit from The Joint Commission, an exercise AAR, etc.). AND • Proof of attendance (e.g. certificates of completion, sign-in sheet or EPC attestation). OR • Proof of credential/membership.	$7,500.00	April 03, 2017
Output: Up to 55 hospitals will have newly developed or reinforcement of existing staff knowledge and skills for healthcare emergency response.				

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Sample Activities

Capability	Coalition Activities
Assessment	• *Northwell Health*: Establish six standardized Hazard Vulnerability Analyses for the entire network coalition
Planning	• *Queens Coalition*: Develop a two to three year strategic plan based on the mission and goals set forth by the QCEPHC charter
Training	• *NY Presbyterian Healthcare System*: Provide training on a topic from the Network Coalition's Hazard Vulnerability Analysis (HVA) including participants from all sectors and facilities
Exercise	• *NYU*: Conduct a cyber security tabletop exercise (ttx) including all Network Coalition hospitals and mission areas
Communications/ Situational Awareness	• *Network and Borough Coalitions*: Attend and participate in two NYCHCC Leadership Council meetings and present an overview of the coalition's emergency preparedness work • *Montefiore*: Host a MRC Volunteer Recruitment Campaign at appropriate MEPC facilities

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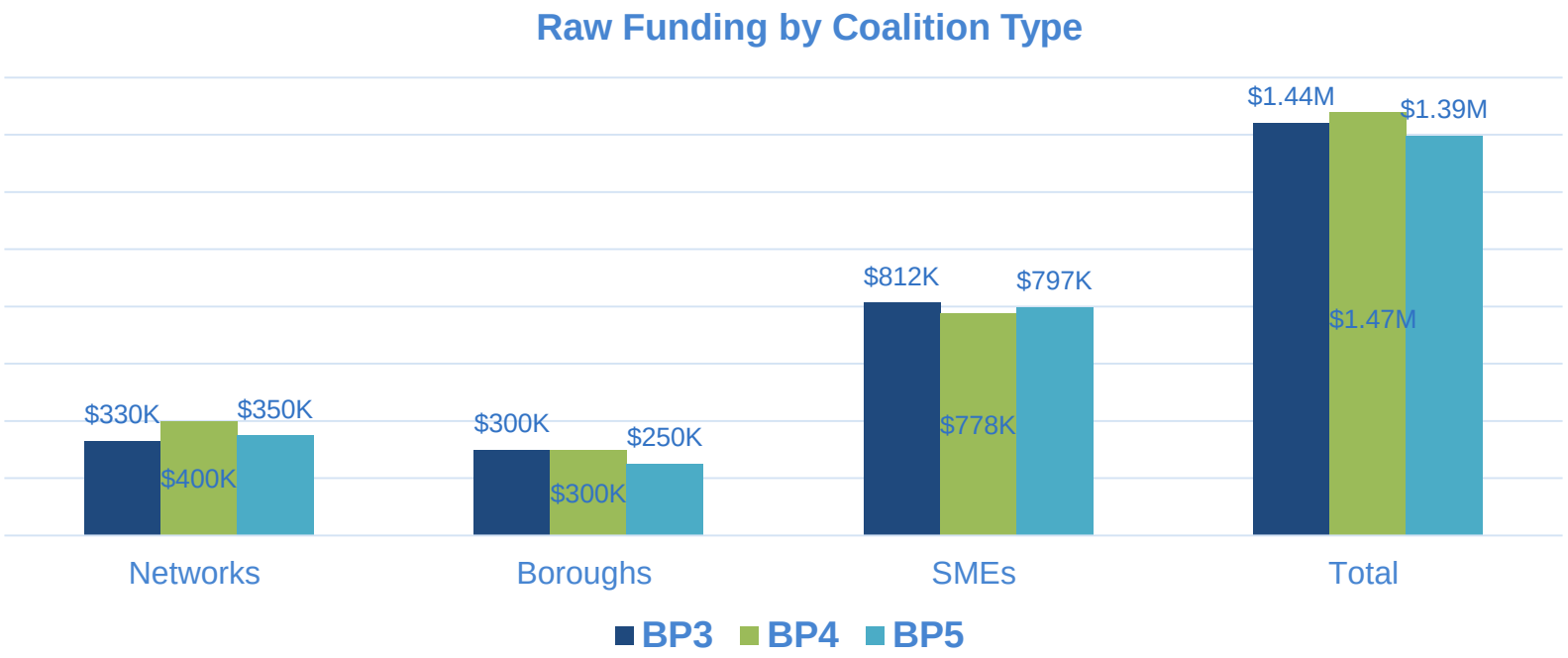
Aggregate Coalition Dollars Reimbursed

Coalition	# Deliverables	Funds Reimbursed	% Change Funding between BP4-BP5
Networks	42	$350,000	-12.5%
Boroughs	17	$250,000	-16.7%
SMEs	39	$797,000	+2.4%
Total	98	$1,397,000	-3.5%



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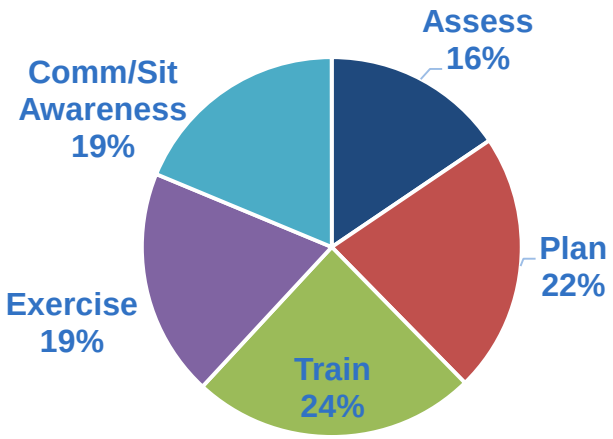
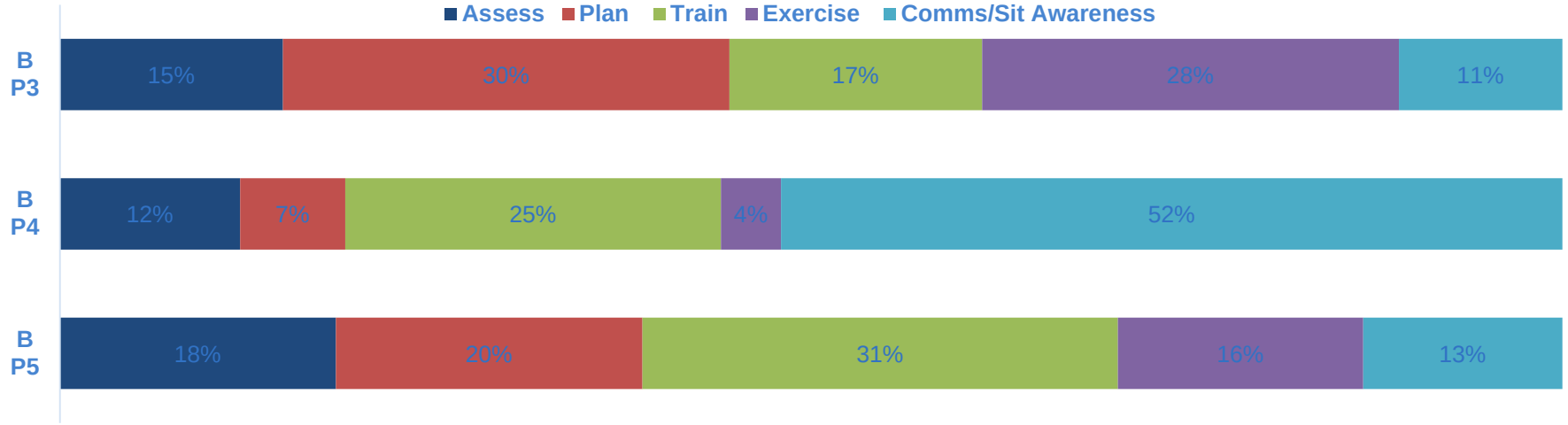
Aggregate Coalition Capabilities, BP3-BP5



Capability	% Change from BP3 to BP5
Assessment	+ 20%
Planning	- 33%
Training	+ 82%
Exercising	- 42%
Comm. / Sit Awareness	+ 18%



Percent (%) Distribution of Funds to Capabilities

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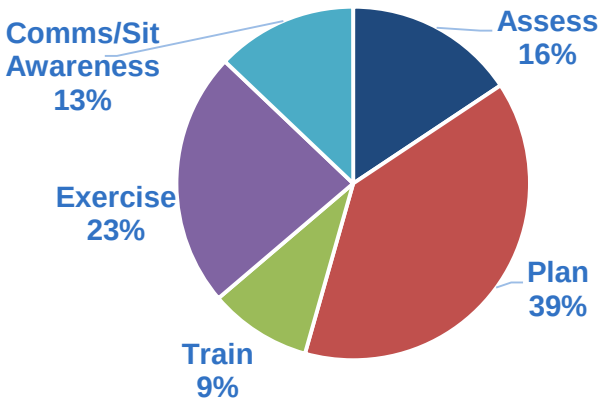
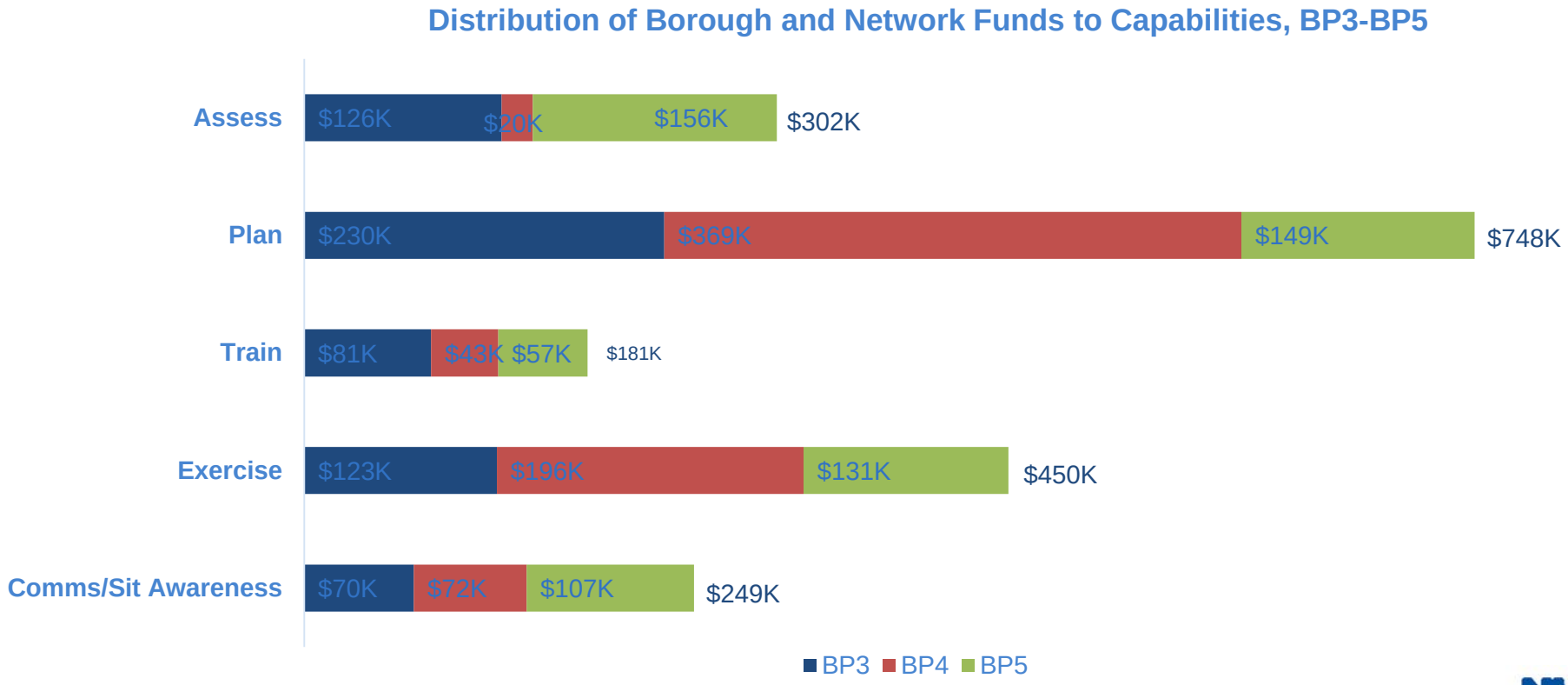
Borough and Network Coalition Capabilities, BP3-BP5





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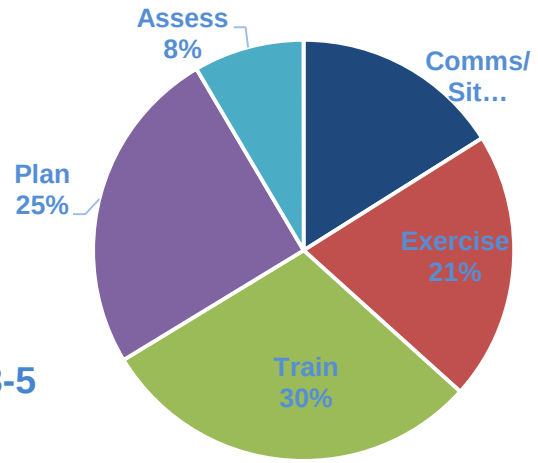
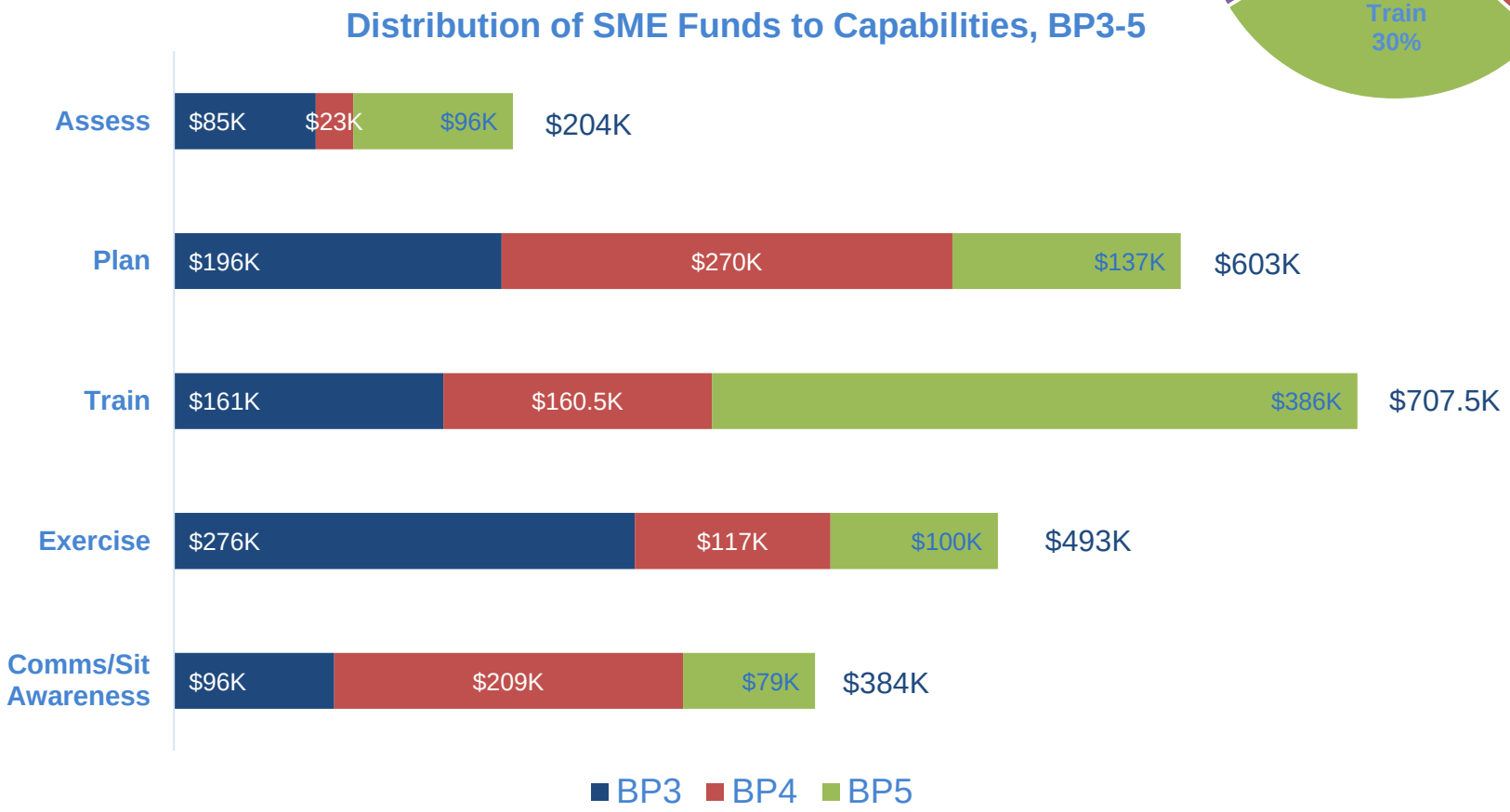
Subject Matter Expertise (SME) Coalitions





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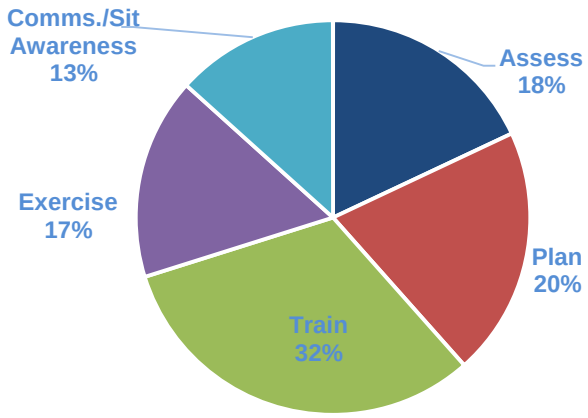
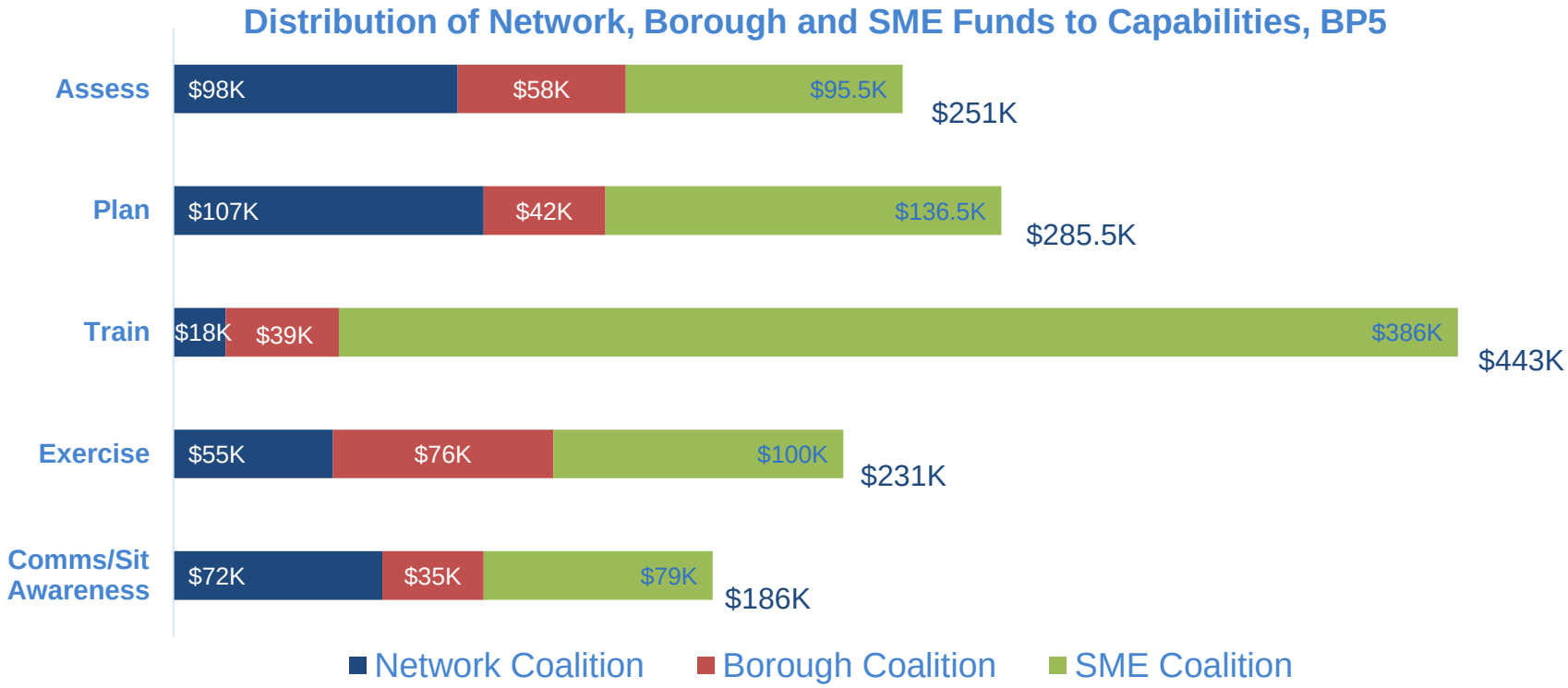
Aggregate Capabilities, BP5





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QUESTIONS?

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HEALTH SYSTEM PLAYBOOK

Darrin Pruitt, PhD, MPH

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Big Thanks!

3 Meetings

Thoughtful input, even with an impending snow storm!

Hundreds of data points!

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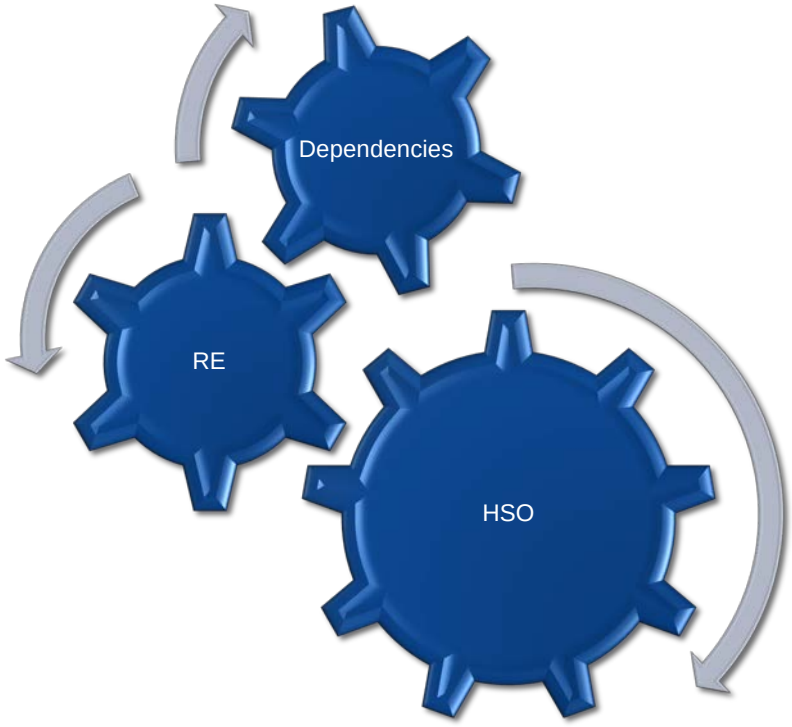
Big Picture, Big Thinking

11 Healthcare **System** Objectives

14 Resource Elements

Many, many dependencies.



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Healthcare System Objectives (HSO)
What the system and its partners must achieve during emergencies.

- **Coordinate Healthcare System Response**
- **Establish Alternate Care Sites**
- **Evacuate Healthcare Facilities**
- **Align with Citywide Infrastructure**
- **Provide Adequate Staffing**
- **Provide Clear, Timely Communications**
- **Provide Mental Health Response**
- **Provide Mutual Aid**
- **Provide Patient Care**
- **Respond to Medical Surge**
- **Support Family Reunification**

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Resource Elements (RE)
Materiel and plans/protocols necessary to achieve objectives.

These support one or more HSO.

- Citywide Coordination
- Communication and Information Sharing
- Data Tracking and Reporting
- Uniform Situational Awareness Tool
- Supplies, Mutual Aid
- Surge Space
- Transportation Resources
- Financial Plans
- Patient Tracking
- Regulatory Plans
- Staff Credentialing
- Emergency Mental Health Services
- Psychological First Aid

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Example of HSO supported by REs

The System aims to… (HSO)	This requires… (RE)	An RE depends upon…
Respond to Medical Surge	**Supplies**	Appropriate supplies (e.g., special populations)
		Knowledge of how to use specialized supplies
	Surge Space	Sufficient storage space
		Pre-positioning supplies
	Uniform Situational Awareness Tool	Supply logistics
		Availability of vendors
		Manufacturing capacity
	Data Tracking and Reporting	Maintenance of city/state issued equipment and supplies
		Knowledge of available resources (outside facility or network)
		Resource tracking
		Managing limited resources

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How will the HSP help the NYC HCC?

- Products and Tools
  - NYC Coastal Storm Operations Overview for Healthcare Facilities
  - NYC HCC Charter

- Goal Setting
  - DOHMH will use the HSP to guide developing annual priorities for HPP by focusing on developing REs.

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LUNCH!

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NYCHCC CHARTER DEVELOPMENT WORKSHOPS

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NYCHCC CHARTER DEVELOPMENT REPORT-OUT

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HAZARD VULNERABILITY ANALYSIS (HVA)

Sheri Kardooni, MD, MPH

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NETWORKING BREAK

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HEALTH SYSTEM INFECTION CONTROL PROGRAM

Mary Foote, MD, MPH

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Ebola was a story about Infection Prevention and Control

Strong healthcare systems are still vulnerable

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Elevating everyday infection control practices

- ✓ Reduce risk of outbreaks
- ✓ Protect patients and staff
- ✓ Decrease spread of infections between healthcare settings and community
- ✓ Support ‘all infectious hazard’ preparedness
  - Pandemic-flu vs. seasonal flu→ *tools are the same!*

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INFECTION CONTROL ASSESSMENT AND RESPONSE PROGRAM

ELC-Ebola (CDC)

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- National Initiative
  - CDC + State and local health Departments

- Goal→ Enhance infection control capacity of
  - Individual health care facilities
  - Health care sectors
  - Healthcare systems

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- Voluntary participation
- Utilize assessment tools developed by CDC
  - Nursing homes
  - Outpatient clinics / Urgent Care
  - Hospitals
- On site visits → "Guided Self-Assessments"
  - Roundtable discussion based on survey responses
- Post visit→ Report with recommendations and follow-up resources

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Infection Control Domains Assessed

- Infection control program and infrastructure
- Healthcare personnel and resident safety
- Surveillance and disease reporting
- Hand and respiratory hygiene
- Personal protective equipment
- Antibiotic stewardship
- Injection and device safety
- Environmental cleaning

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March 2016-Sept 2017

Facility Type	2016	2017	Total
Hospitals	6	1	7
Nursing Homes	33	40	73
Primary Care	9	10	19
Urgent Care	0	12	12
Dental	1	0	1
Total	49	63	**112**

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Key Hospital Gaps

Hospitals (N=7)

- 5 networks and 2 independent

Topic	% no response
Personnel demonstrate hand hygiene (HH) competency following training	57%
Personal demonstrate PPE competency after training (selection and use)	57%
Interfacility communication when culture results are available after transfer	29%

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Key Long-Term Care Gaps

Long-Term Care (N=73)

Topic	% no response
The person coordinating the infection prevention program has received training in infection control	74%
Antibiotic stewardship - Policies on antibiotic prescribing - Prescriber audits and feedback - Training for nurses and prescribers	 63% 64% 71% and 64%
Annual training on Personal protective equipment - Auditing staff PPE adherence	34% 53%

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Key Primary Care Gaps

Primary Care (N=19)

Topic	% no response
Providers demonstrate competency with PPE - Facility audits staff PPE adherence	39% 72%
Providers demonstrate hand hygiene (HH) competency - Facility audits staff HH adherence	61% 56%
At least one individual trained in infection prevention is available to manage the infection control program	56%
HCP are required to demonstrate competency with environmental cleaning procedures	39%
An updated list of diseases reportable to the public health authority is readily available to all personnel.	28%

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MYSTERY PATIENT DRILLS

Lessons Learned

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Key Infection Control Findings

Infection Control Measure Achieved	Total
If the patient reported a fever, **were they asked if they or someone close to them had traveled outside the US**?	**85%**
Was a screened positive **patient given a mask**?	**86%**
Was **hand hygiene performed by staff**?	**36%**
Was **Infection Control signage posted for the isolation room**?	**70%**
All staff entering the isolation room had properly donned PPE?	**77%**

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Additional Findings

- ~ 40% of hospitals failed at least one drill
- Masking and isolation achieved more often when travel history was obtained
  - **88% vs. 21% when travel history not obtained**
- Staff more likely to enter the isolation room with recommended PPE when isolation precaution signage was posted
  - **85% vs. 63% when signage not posted**

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HPP-EBOLA EXERCISES

Lessons Learned

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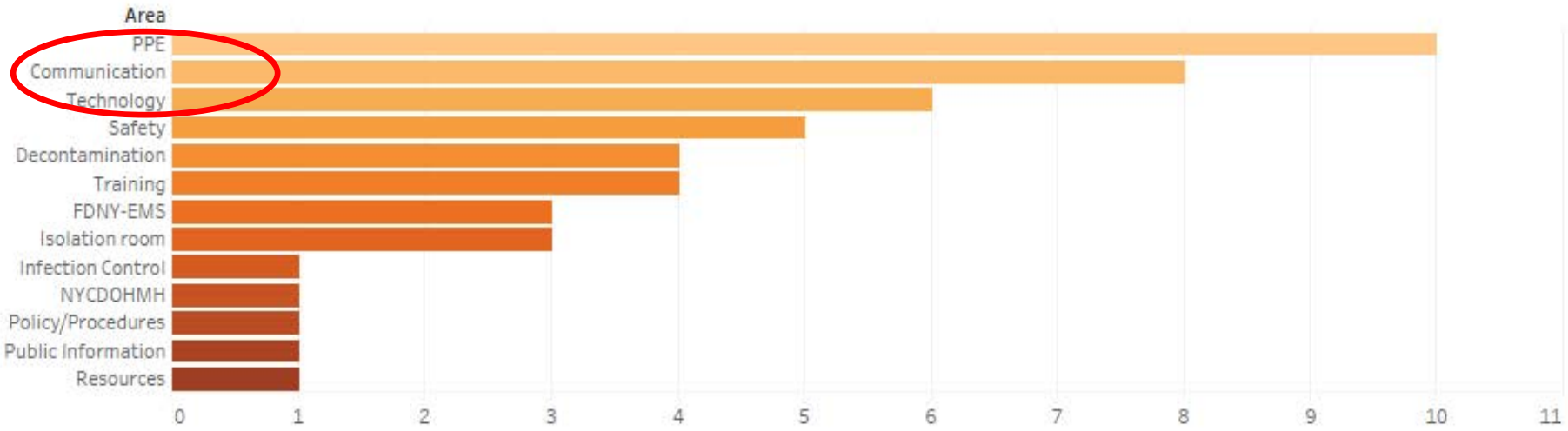
HPP Ebola:

Hospital network (coalition) exercises top areas for improvement identified by AAR/IP (N=7)



Areas for Improvement	Total (times mentioned)
PPE	10
Isolation room	4
Infection control	3

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Improvement Plan Examples

- "EMS staff (private) improperly donning/doffing PPE"
- "Staff donning and doffing took too long. Lack of familiarity with equipment…"
- "Security officers currently do not carry minimum PPE (gloves, mask)"
- "Donning and doffing checklist not followed step by step… staff did not don outside gloves"
- "No signage outside room that identifies a Person Under Investigation (PUI) inside"
- "Reinforce hand hygiene protocols"

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NYC Hospital Survey

May 2017

Rates of hospital training offerings by topic and modality (n=40 hospitals)

	Classroom or online training with posttest	Hands-on skills training with demonstration of competencies
Environmental services, disinfection and waste management	45%	17.5%
Hand hygiene	45%	25%
Injection Safety	50%	17.5%
Routes of transmission and infection control precautions	60%	2.5%
Personal Protective Equipment (PPE)	32.5%	50%

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Takeaway Recommendations

- Focus on implementing competency-based infection control training
  - Demonstrate hand hygiene and PPE
- Ensure ‘fever + travel’ screening in acute care setting
- Use simple algorithms to guide masking and isolation when screen is positive
  - Can be used by non-clinical staff (e.g. greeters, security)
- Perform regular audits with feedback
- Support staff training in infection control
- Build infrastructure for antibiotic stewardship

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Key Points

Infection Control is an integral part of health system preparedness for communicable disease

- Prepare to prevent infections
- Prepare to detect
- Prepare to protect
- Prepare to respond to an outbreak

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THANK YOU!

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CITYWIDE SURGE EXERCISE

Marie Irvine, MSc, MIM

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Why a Surge Exercise?

St John's Med. Ctr. May 2011

- 6 deaths in hospital
- 183 patients evacuated in 90 minutes
- 161 deaths in overall event

Superstorm Sandy October, 2012

- 6,300 patients from 37 healthcare facilities evacuated
- 43 deaths, tens of thousands injured

Boston Marathon April, 2013

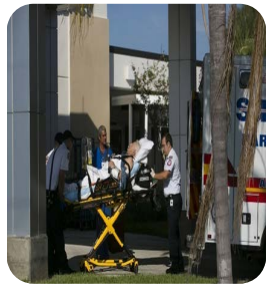
- 101 injuries
- 13 serious
- 17 critical

Pulse Nightclub June 2016

- 50 fatalities
- 44 injured

Hurricane Harvey August, 2017

- 82 dead, to date (9/21/17)
- Closed and/or evacuated
- 20 hospitals
- 45 nursing homes
- 51 adult care facilities



Hurricane Irma August, 2017

- 42 dead, to date (9/21/17)
- Evacuated 29 hospitals
- 239 assisted-living centers
- 56 other health care facilities
- 60 shelters opened for those with special needs

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What is SurgeEx?

- ASPR Annual Federal Requirement (Coalition Surge Test, "CST")
  - First year will be baseline
  - Linked to jurisdictional program performance measures for DOHMH
- Testing New York City's Acute Care Sector ability to surge 20%+ in response to a Coastal Storm Incident
  - ExPlay will focus on **pre-HEC activities**
  - Evacuation of ~12 hospitals, ~Zone 1-4
  - Ability of receiving hospitals to respond to surge
- Low/No-notice Exercise
- Work in progress through planning team and feedback sessions

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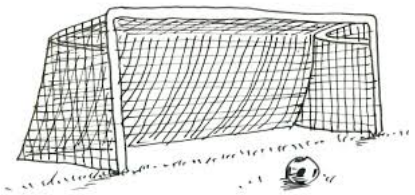
SurgeEx Goals

- The CST is intended to improve health care system response readiness.
  - Tests functional surge capacity and identifies gaps in surge planning
  - Tests ability to perform the tasks with existing on-site staff without excessive guidance or prompting
  - Tests if evacuating facility knows who to contact in evacuation scenario, and ability to reach partners on a moment's notice

- The CST tests the overall health care system response.
  - Simulates an evacuation, but can demonstrate:
    - ✓ Emergency Operations Coordination
    - ✓ Information Sharing
    - ✓ Medical Surge Capacity



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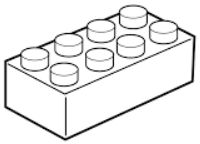
SurgeEx Elements

	Element	Participants	Time	Outcome
1	Functional Exercise (FE)	• 55 hospitals (incl. independents) • 7 Networks • City/State Agencies	• First Two Weeks of April 2018 • 150 min. (2.5 h) • At facilities/network locations	• Sending, receiving and bed matching data (quantitative)
2	Table-Top ("TTX") and Hotwash	• 55 hospitals (incl. independents) • 7 Networks • City/State Agencies	• Early May 2018 • 90-min. (1.5h) + 30-minute Hotwash • At combined EPS/LCM	• Identify gaps/issues in surge capacity (qualitative)
3	After-Action Discussion	• Health and Medical Executive Committee (HM Exec)	• Early June 2018	• Address citywide surge capacity gaps and concerns



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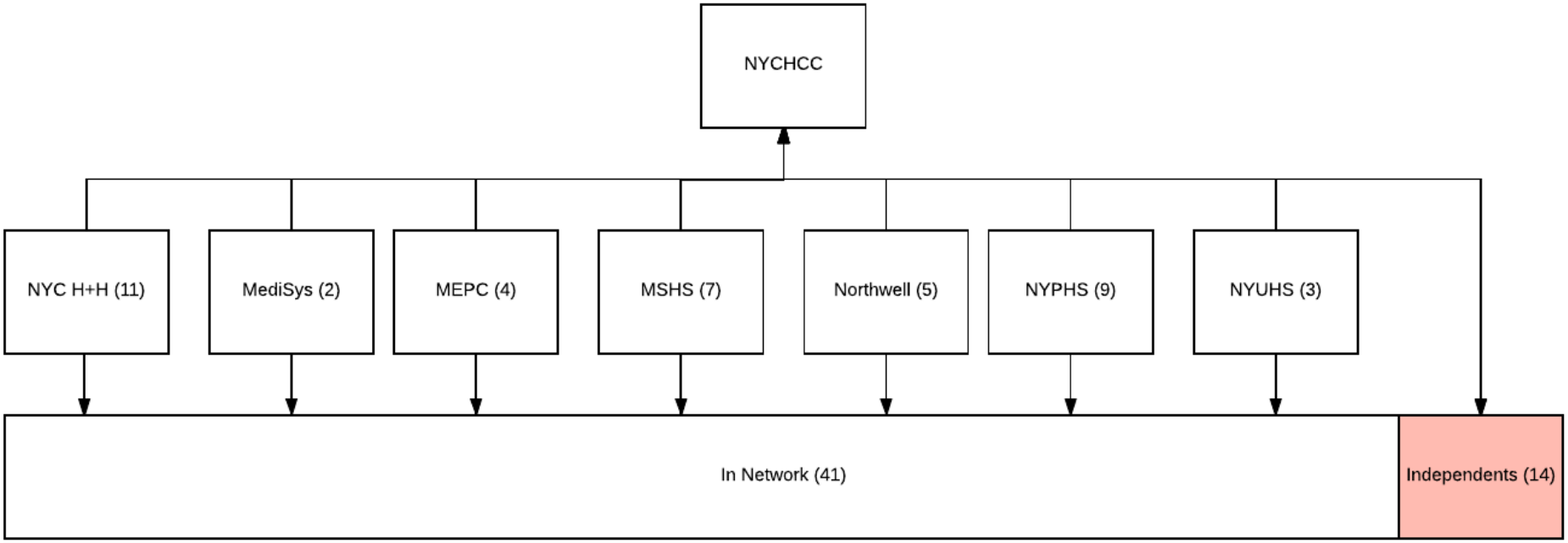
SurgeEx Staffing



Network-Level:
- 1 trusted insider
- 1 evaluator
- players

Facility-Level:
- 1 trusted insider
- 1 evaluator*
- players

*Differing tasks EVAC vs. RECEIVING

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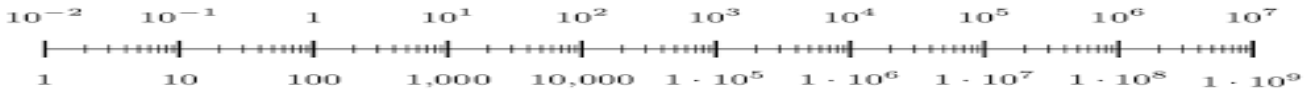
Surge Ex Planning Timeline

- IPM (Oct. 4th, 2017)
  - Input Planning Meeting I (October 18th, 2017 – EPS 1)
- MPM (January 2018 – TBD)
  - Input Planning Meeting II (February 27th, 2018 – EPS 2)
- FPM (March 2018 – TBD)
  - Input Planning Meeting III (TBD)



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QUESTIONS?

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COMMUNITY RESILIENCE PLANNING COMMITTEE

Hannah Arnett

Jacqlene Moran

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Connecting to the Whole Community

New York City Health Care Coalition

September 28, 2017

New York City Department of Health and Mental Hygiene
Office of Emergency Preparedness and Response

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What is a COAD?

- **Community Organizations Active in Disaster (COAD)**
  - A COAD (Community Organizations Active in Disaster) is a geographically based association of community and faith based organizations, civic groups, businesses and local leaders who work together to address all four phases of emergency management: mitigation, preparedness, response and recovery.

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COAD Neighborhoods

Why does this matter to NYCHCC?

Deliverable	Required Activities	Required Documentation
3. Increase Coalition Membership	1. Using BP5 membership rosters as a baseline measure, increase Borough Coalition membership by a minimum of 25% by the end of BP1. Non-acute healthcare providers and community-based organizations should represent 20% of the total membership increase. • Draft and submit a list of providers and organizations that were members of the Borough Coalition in BP5 (including healthcare facilities and representatives from all sectors, planning partners, response agencies, and community-based agencies and organizations). *Due by November 24, 2017.* • Draft and submit a list of all new BP1 Borough Coalition members by affiliation demonstrating a minimum increase of 25% in membership; include a brief summary of strategies used for recruitment of new members. *Template to be provided by DOHMH.*	1a. List of BP5 Borough Coalition members in BP5 (including healthcare facilities and representatives from all sectors, planning partners, response agencies, and community-based agencies and organizations). 1b. Final BP1 list of all members by affiliation reflecting a minimum increase of 25%; include a brief summary of strategies used for recruitment of new members. *Template to be provided by DOHMH.*

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Community Resiliency Planning Committee

- **Goal:** The mission of the CRPC is to increase the capacity of New York City communities to prepare for, mitigate, respond to, and recover from public health emergencies. The CRPC collaborates and partners with DOHMH, community and faith-based organizations to improve communication, planning, and coordination of shared resources.
- **Next Meeting:** Thursday, October 12, 2017 10am-12pm

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Thank You!

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MEMBER ANNOUNCEMENTS/UPDATES

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CONCLUDING REMARKS

Our next NYCHCC Leadership Council Meeting is scheduled for:

December 13th

Formal Outlook Invitation to Follow

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