How the BEPC Supports Healthcare Facilities in Preparedness and Response

A review of the Bronx Emergency Preparedness Coalition’s strategies for Mutual Aid and Communication Plans

Presented by Ryan Fraleigh
CHALLENGES OF WORKING TOGETHER
ADDRESSING THE CHALLENGES
Success is in the Follow Up!
DISASTER RESOURCE DIRECTORY (DRD)
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### Additional Resources

- **Example**: Hospital with an issue is in red

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**Note**: The table above represents the bed capacity data for various facilities, including adult beds, adult ICU beds, pediatric beds, and total ICU beds. The data is organized by facility and includes columns for adult bed availability, adult ICU bed availability, pediatric bed availability, and total ICU bed availability. Any facilities with issues are marked in red.
CALL DOWN DRILL
***This is just an Exercise!!!!!!****

Early this morning, Lincoln Hospital experienced an explosion in its 3rd floor mechanical floor. 4 Staff were injured. All generators, and various equipment and medical devices have been damaged. Furthermore due to a reoccurrence of the flu affecting the other 4 boroughs the H+H System will not be able to accommodate all the patients or provide sufficient resources to address the event.

@ 09:47 time Ryan Fraleigh Emergency Management Director of Lincoln Hospital sent an SOS via GroupMe.

*(GroupMe) Communication 1*

This is just an Exercise!!!!!

*Major Explosion at Lincoln Hospital need resources, immediately, total evacuation possible!!*

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**SIGNIFICANT EVENTS LOG:** Please provide information on any significant events.

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<tr>
<td>09:56</td>
<td>Everbridge Message sent</td>
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<tr>
<td>~10:15</td>
<td>2nd Everbridge message sent</td>
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### Incident Report for Montefiore

**B,E,P,C, Notification**

**ID:** 8101205968485951

**CLOSED**

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**Message** (Customized Email below)

This is an Exercise! Lincoln hospital has had a catastrophic event! Please check your email for further information. Authority of the Bronx Emergency Preparedness Coalition. This is an Exercise!

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Creating the Appropriate ICS Structure for Your Healthcare Coalition

Willie K. Carley, NY/NJ Veterans Integrated Service Network 2 (VISN 2), Network Emergency Manager
Introduction

Incident Management is the capability to effectively direct and manage incident activities by using the Incident Command System (ICS) consistent with the National Incident Management System (NIMS).

This case study introduced a real-world methodology developed for the Bronx Emergency Preparedness Coalition (BEPC). Table Top Exercise (TTX) to systematically develop an Incident Command System for their healthcare coalition to guide their future practice.

Problem Statement

The potential participants for this study are (N=492) healthcare coalitions registered with the U.S. Department of Health and Human Services.

Purpose of the Study

There is little theoretical research on how to systematically develop an Incident Command System for a healthcare coalition.

Research Questions

1. What are the required constructs of an Incident Command System for a healthcare coalition?
2. How are Healthcare Coalitions Incident Command Systems Developed?

Method

A Case Study was the overarching methodology selected to identify a process for the Bronx Emergency Preparedness Coalition to develop their Incident Command System. The goal of the exercise was not to determine if the BEPC needed an Incident Command System; but to identify and examine the process required to systematically develop their Incident Command System to guide their future practice.

Data Analysis

The initial steps for this qualitative case study consisted of the researcher developing a list of codes from the literature review. Once data from the (a) semi structured interviews, (b) secondary data, such as documents, after action reports, and literature provided by the participant (c) self-developed interview questionnaire, and (d) field notes are collected, the initial codes were compared and revised against the actual data (Cortin & Strauss, 2008).

Conclusion

1. The Lead Facility will be the coordinating facility for the BEPC.
2. It was determined by the BEPC that the BEPC members identified as the primary role of the BEPC was to provide logistical (Human & Materiel) support.
3. The BEPC members identified as the primary role of the BEPC was to provide logistical (Human & Materiel) support.
4. The BEPC were not able to come to an agreement on the role of the BEPC as a collective unit serving “operations and planning”.
5. To be further discussed. The BEPC TTX successfully provided participants with an opportunity to explore their current plans, roles and responsibilities in the event the BEPC was needed within their community.
6. While several areas for improvement were identified, the overall play demonstrated that the basic plan is viable and the BEPC is prepared to support one another as needed.
Breakout Session: What is a Borough Coalition’s Role in Response?
Networking Break
ASPR & National Healthcare Coalition Preparedness Conference Updates

Celia Quinn, Executive Director, Bureau of Healthcare System Readiness, NYC DOHMH
GNYHA Update - MCI Naming Conventions

Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs, GNYHA
Regional Guidance: Naming Conventions and Associated Protocols for Unidentified Patients during a MCI Response

December 20, 2018
Project Genesis: Fact-Finding Delegation Visit to Las Vegas, February 1-2, 2018

- **Purpose:** Learn about Las Vegas’ response to the October 1st mass shooting
  - Organized in collaboration with the Nevada Hospital Association

- **Who participated:**
  - Nine NYS health systems
  - Government response agencies including: FDNY, NYPD, OCME, DOHMH, NYCEM, NTSB, Department of State Diplomatic Services
  - Three Las Vegas hospitals, Las Vegas police and fire agencies, community ambulance companies, Public Health District, Nevada Hospital Association
Sunrise Hospital and Medical Center, the Las Vegas–area hospital that received the largest number of patients, treated 92 individuals who arrived with no identification.

The volume of unidentified patients quickly overwhelmed their existing naming convention procedures.

At a jurisdictional level, it was difficult for the public health authority to compile and track unidentified patients hampering family reunification.

In follow up call after the delegation visit, the group identified this area as one of concern.
Facility Level: Improve/enhance existing disaster registration protocols to support both clinical care and family reunification.

Jurisdiction Level: For events that may result in many unidentified patients across multiple hospitals, facilitate the creation of a jurisdiction-wide manifest.
Disseminated to all GNYHA members on November 6th

Includes guidance + accompanying tool with suggested first and last names for every GNYHA member

Members asked to voluntarily implement guidance by March 31, 2019
Regional Guidance for Registration of Unidentified Patients

This tool provides a regional naming convention and associated protocols for identifying, tracking, and caring for unidentified patients during a mass casualty incident (MCI) response. The table contains naming convention guidance, including for first and last names and estimated age. There is also information for incorporation of identifying features into the patient record, and a tag to associate victims of the same incident. In addition, the guidance offers a target time period for patient registration.

<table>
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<th>TARGET TIME PERIOD FOR ELECTRONIC REGISTRATION</th>
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<td>While patient care takes precedent, hospitals should develop and exercise disaster registration protocols so that patients, including unidentified patients, can be quickly registered. Registering patients within this timeframe directly supports broader patient tracking and family reunification efforts.</td>
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Suggested First and Last Name for All GNYHA Member Hospitals

<table>
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<tr>
<th>HOSPITAL NAME</th>
<th>HOSPITAL ABBREVIATION FOR LAST NAME</th>
<th>ASSIGNED HOSPITAL ITEM FOR FIRST NAME</th>
<th>EXAMPLE FIRST NAMES</th>
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<tbody>
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<td>AlbMed1</td>
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<td>albatross, blackbird, bluebird, booby, crane, crow, cuckoo, dove, duck, eagle, emu, falcon, finch, flamingo, goose, guan, gull, hawk, heron, hornbill, hummingbird, ibis, jay, kingfisher, lark, mockingbird, motmot, oriole, osprey, ostrich, owl, parrot, pelican, penguin, petrel, pigeon, quail, robin, sparrow, starling, stork, swallow, swan, thrush, tinamou, toucan, turkey, warbler, woodpecker, wren</td>
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</table>

Principles underlying suggested first and last names:

- All unidentified patients will be associated via the last name with the originating hospital, even if transferred.
- All hospitals have been provided with a suggested item for first name and 50 “names” within that item.
- While first names items are repeated, each hospital within a health system has a unique first name item; geographically close hospitals also have been assigned distinct first name items.
Questions? Suggestions?

Jenna Mandel-Ricci
Vice President, Regulatory and Professional Affairs
Greater New York Hospital Association
Phone: 212.258-5314
Email: jmandel-ricci@gnyha.org
What is Pandemic Influenza?

- A pandemic is a global disease outbreak
- An influenza pandemic occurs when a new influenza A virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads easily person-to-person worldwide
Seasonal vs Pandemic Impacts

Seasonal:
- Impacts can vary year to year
- Annual strain-specific vaccines available
- Generally the ‘very young and the very old’ most at risk
  - Highest rates of hospitalization among young children and persons ≥65 years of age
  - 90% of deaths among persons ≥65yrs
- 3,300 to 49,000 deaths per year across the country
- > 225,000 excess hospitalizations nationwide

Pandemic:
- Unknown who the most at risk will be
- NO vaccine for first few months!
- Mild/ Moderate
  - Attack rate between 5-20%; 0.4 - 1.6 million estimated to be infected
  - Case fatality rate (CFR) < 0.1%
  - Impact can be similar to seasonal flu, but may be ‘worse’
- Severe
  - Attack rate between 20-25%
  - CFR approximately 2%+
  - 50% of infected require outpatient care and 11% of those require hospitalization
Pandemics Have Different Characteristics

- Occurs in waves (approximately 3, 8-12 weeks each)
- Attack rate of up to 40% in school-aged children and 20% in working adults
- Fatality rate of up to 2% in infected
- Impact can be similar to seasonal flu, but may be ‘worse’
- No all locations will experience the same effects at the same time
Pandemic Intervals

- Based on WHO/ CDC guidance
- Phased event (per wave):
  - Recognition
    - We are always at this level
  - Initiation
  - Acceleration
  - Peak Transmission
  - Deceleration
Clinical severity – how serious is illness associated with infection?

Transmissibility – how easily does virus spread from person to person?

Conceptual framework for assessment of the effects of an influenza pandemic
  - Clinical severity X-axis
  - Transmissibility Y-axis
  - A is milder, D is more severe
Initial assessment
- Limited activity in pockets or specific communities
- Potential impact: How severe so far? How transmissible so far?

Refined assessment
- Later in the pandemic, more info available
- Severity and transmissibility, including by age group
- Compare with previous pandemics, or even seasonal epidemics
CDC Pandemic Severity Assessment Framework (PSAF)

- Example of a refined assessment, with examples of past pandemics and past influenza seasons
  - The x-axis is clinical severity, and the y-axis is transmissibility. Examples:
    - 2006-07 was a mild influenza season, lower far left
    - 1918 was a severe pandemic, upper far right
Potential NYC Pandemic Influenza Impact (Worst-case Scenario)

**Assumptions:**
- Based on an attack rate of 33% (similar to the 1918 pandemic rate)
- Case fatality rate 2.5% (equal to 1918)
- NYC population currently estimated at 8.4 million
- Case fatality rate range US *seasonal* influenza 1.4-16.7/100,000 population

**Possible worst case for NYC:**
- Cases: > 2.5 million
- Hospitalizations: *hundreds of thousands*
- Deaths:
  - Seasonal influenza range: 120-1400 deaths/year in NYC
  - Potential pandemic influenza NYC deaths: > 70,000
  - For perspective, only about 50,000 *all-cause* deaths typically occur in NYC annually
What Does DOHMH Hope to Do?

- Help support all New Yorkers during a pandemic in order to limit the spread of transmission, minimize negative outcomes, and lessen healthcare impacts.
In a public health emergency like a pandemic, DOHMH is part of the ‘Unified Command’ (under CIMS), along with FDNY and NYPD.

While the impact will be global, ultimately DOHMH will need to plan and respond with local partners to implement relevant public health core competencies with the assistance of citywide partners.

Response Partners:
- **Command Element** – Agencies with “Incident Command” responsibilities (lead decision-makers)
- **Supporting Agency** – Agencies that support incident operations (provision of personnel / equipment / support)
- **Coordinating Agency** – NYC Office of Emergency Management
DOHMH Core Competencies During a Pandemic

- Any action asked and performed by the agency will fall under the following:
- Primary competencies:
  - Disease Surveillance and Epidemiology
  - Public Health Orders, Clinical Guidance and Risk Communication
  - Mass Prophylaxis/Vaccination
  - Laboratory Testing (Biological and Radiological)
  - Public Health Assessment
  - Mental Health Needs Assessment and Service Coordination
- While important to our larger response role, these will likely to not be fully utilized:
  - Environmental Mitigation (Radiological and Biological)
    - Exception: assisting with guidance on cleaning, especially school and public areas
  - Animal-Related Surveillance and Vector Control
    - Exception: concerns in the public regarding ‘wet- markets’ being sites of transmission
Goals of Health Care System Response

- Provide quality care to affected patients
- Protect patients and healthcare personnel from health care-associated infections
- Maintain continuity of essential services
- Communication and collaboration with diverse partners for a coordinated response
Supporting the Healthcare System

- Support NYC hospitals and other medical service providers during an outbreak
- Assist with surge planning and response
  - Coordinate with other agencies/organizations involved in healthcare system response (ESF-8, HMExec, NYSDOH, etc)
  - “Nurse Triage Line”
- Messaging and coordination
  - Disseminate guidance on testing, infection control, etc.
  - Healthcare facility workgroups, provider calls, Health Alerts
- Support countermeasure distribution to facilities
Challenges to Health Care Delivery

- Pandemic flu would strain already limited resources
  - Space + Staff + Stuff
  - Particular impact on “safety net” systems

- Factors impacting surge capabilities
  - Variations in planning and staff experience
  - Competition for resources
  - Duration of surge
  - Geographic breadth
Day to day ED patient **volume** increasing → number of EDs decreasing

- Limited amount of
  - ICU beds
  - Emergency Department beds
  - Airborne isolation rooms

- Need for hospital surge space and alternative sites of care

- Support services to decrease hospital demand
  - Home care services, outpatient clinics, nurse triage lines, telemedicine
Staff

- Shortages of nurses, physicians and other healthcare workers
  - Limited specialists: ED, critical care, pediatric

- Internal resources can strain quickly
  - HCW illness/absenteeism, burnout

- Difficult to mobilize more staff quickly for prolonged surge
  - Competing with other institutions
  - Travelers
  - Credentialing

- Barriers to utilizing volunteer resources
- Supply shortages expected
  - Gloves, respirators, mechanical ventilators, pharmaceuticals

- Just in time supply chain
  - Real time inventory/burn rate
  - Possibility of regional/national shortages

- Limited information sharing
  - Match supplies to need

- Ventilators and advanced therapies (e.g. ECMO, dialysis)
  - Limited amount of equipment and trained staff
  - Staff familiarity of stockpile equipment
Legal Preparedness and Crisis Standards of Care:
Jurisdictional role

- Develop with healthcare and community partner input
- Provide clear and accepted guidance that is fair and clinically sound *to ensure consistent and equitable triaging*
- Maximize appropriate care for the largest number of patients
- Minimize morbidity and death
  - Allocate resources to those most likely to benefit
- Maximize self-triage and self-care by the general public
- Provide a legal/regulatory framework
  - Triggers to activate protocols
  - Developing triage decisions
  - Utilizing nonstandard health care facilities in an emergency

Thank you!

Jessica Cole, MA
joneill@health.nyc.gov
(347) 396-2717
Networking Lunch
Meeting Adjourned