The New York City Health Care Coalition (NYCHCC) Leadership Council Meeting (LCM)

NYC Department of Health and Mental Hygiene
Office of Emergency Preparedness and Response
Bureau of Healthcare System readiness

Thursday, February 14, 2019

NYC Health


Welcome!

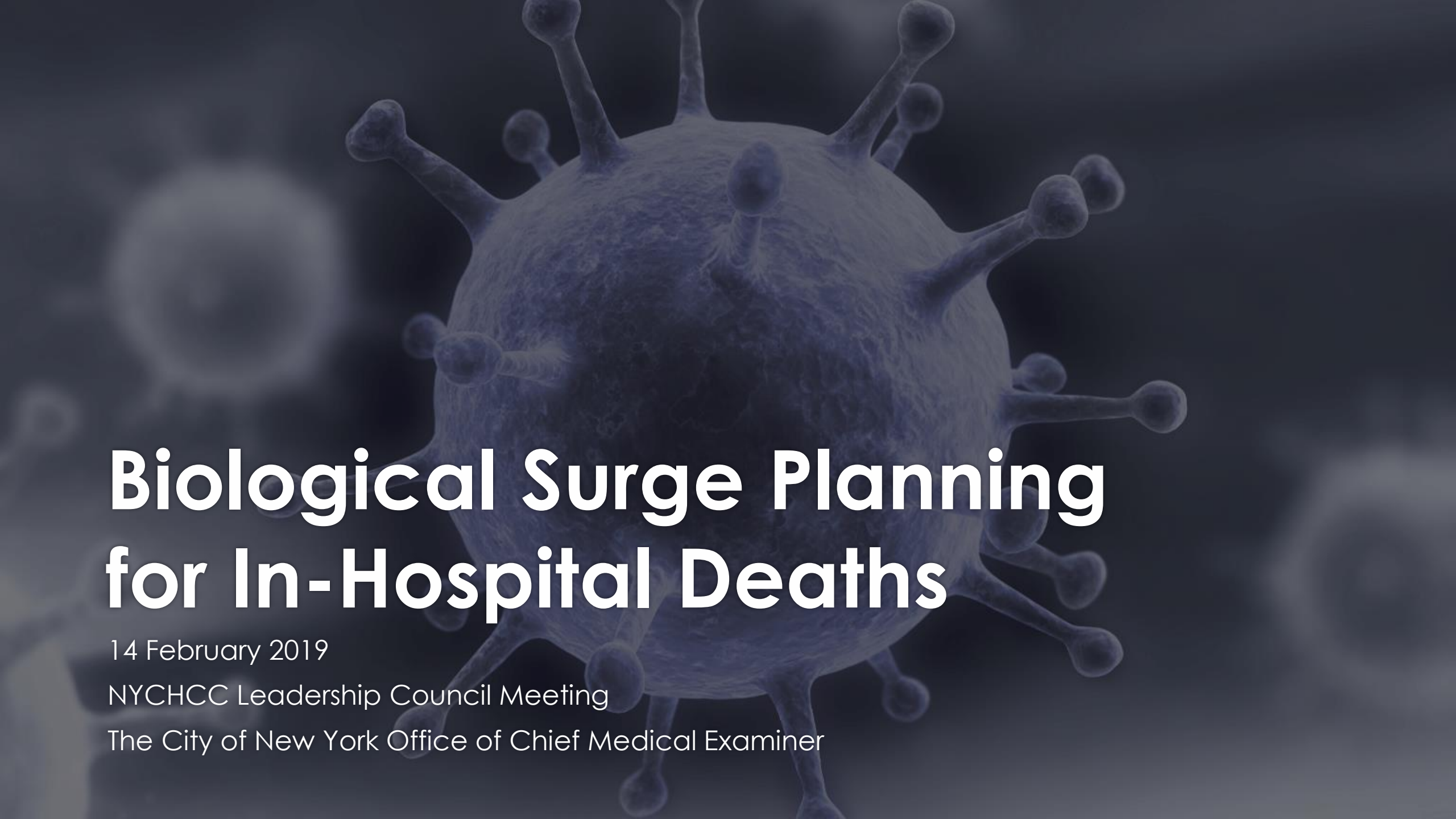
Agenda

PM	
1:00 – 1:15	Welcome & Introduction
1:15 – 2:45	Borough Coalition Report - QCEPHC
2:45 – 3:15	Mass Fatality Planning
3:15 – 3:30	Networking Break
3:30 – 3:35	Evacuation and Surge Planning, Tools and Operations, Continued
3:35 – 4:00	Patient Movement Workgroup Bed Types Overview
4:00 – 4:15	Q/A and Summary of Evacuation and Surge Planning, Tools and Operations
4:15 – 4:30	Closing Remarks
4:30	Meeting Adjourned

Borough Coalition Report– QCEPHC

Mass Fatality Planning

Helen S. Alesbury, Assistant Director, Emergency Management/Forensic Operations, Office of Chief Medical Examiner, (OCME)



Biological Surge Planning for In-Hospital Deaths

14 February 2019

NYCHCC Leadership Council Meeting

The City of New York Office of Chief Medical Examiner

Introduction

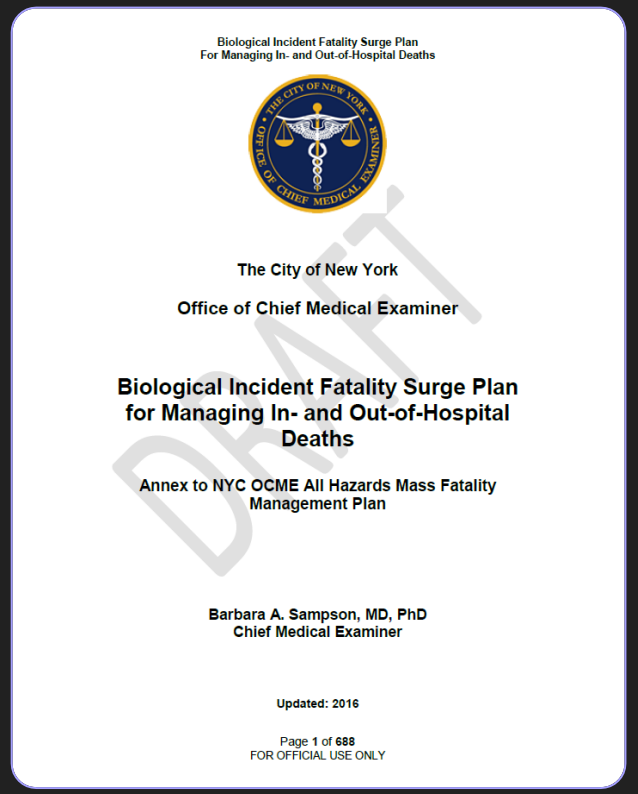
- Helen Alesbury, Assistant Director of Emergency Management
- Emily Carroll, Deputy Director of Emergency Management
- Elissia Conlon, Deputy Director of Forensic Operations

Introduction

- Objectives
  - Overview and Plan Background
  - Response Triggers
  - Facilities and Systems Specific MFM Plans
  - Special Considerations
  - What We Need From You
  - Q & A

Background

Background



Biological Incident Fatality Surge Plan
For Managing In- and Out-of-Hospital Deaths

The City of New York

Office of Chief Medical Examiner

Biological Incident Fatality Surge Plan for Managing In- and Out-of-Hospital Deaths

Annex to NYC OCME All Hazards Mass Fatality Management Plan

Barbara A. Sampson, MD, PhD
Chief Medical Examiner

Updated: 2016

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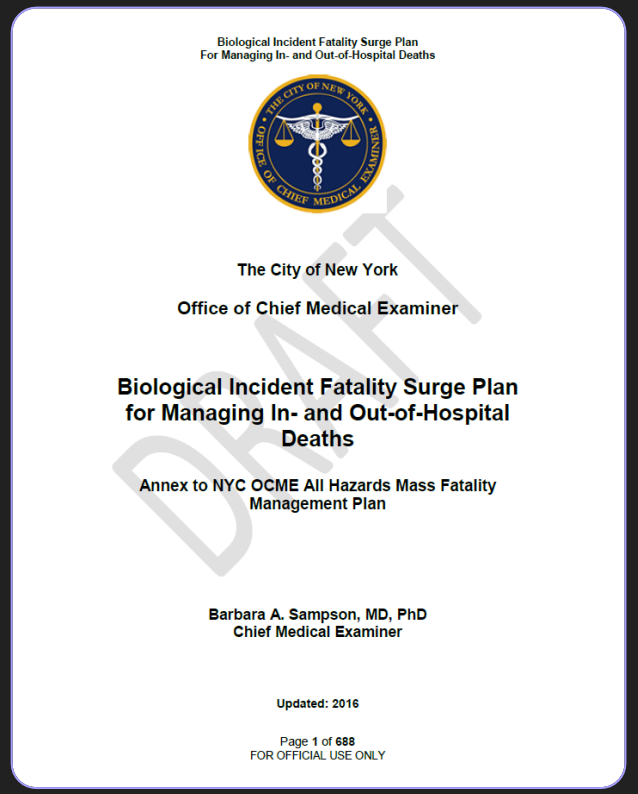
- Originally derived from Pandemic Influenza Plan written in 2008
- Updated to all Biological Hazards Plan in 2016

Purpose



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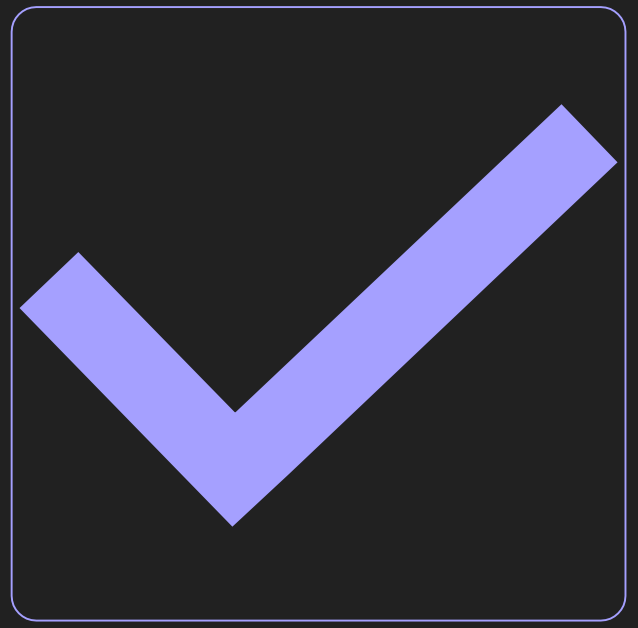
- Operational response strategies to arrange for the recovery, transport, storage, tracking and processing of disaster and non-disaster decedents.
- Expansion of the OCME's capability when mortuary affairs resources will likely be limited.
- Increasing the capacity for fatality management allows healthcare facilities to continue to care for the living.

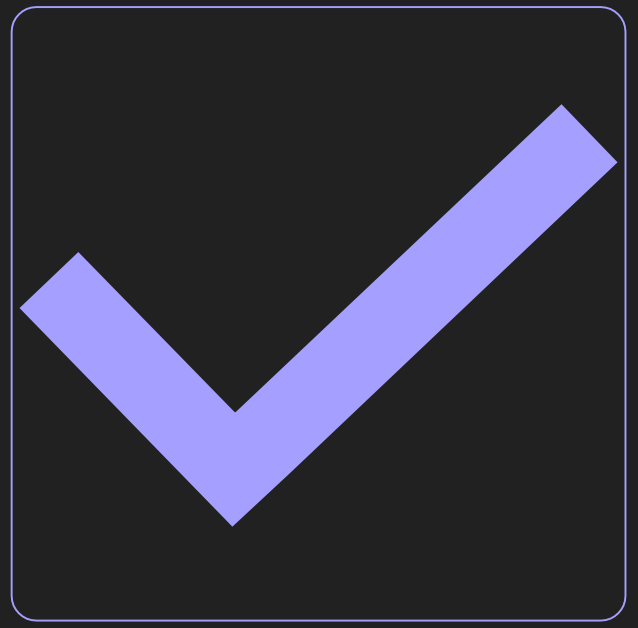
Biological Incident Surge Response Triggers

Biological Incident Surge Response Triggers



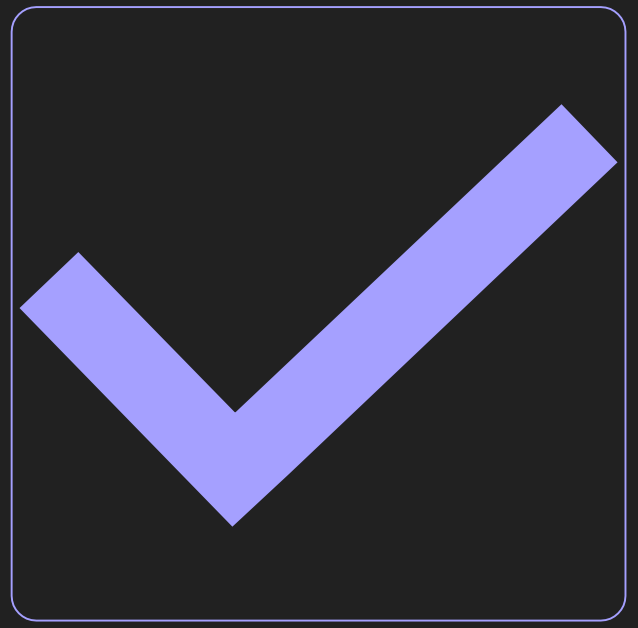
- Majority of biological outbreaks will not cause significant strain or fatalities to activate this plan
- Decision to activate will be made by OCME leadership, HCFs and other city agencies and officials
- OCME has established daily caseload hazard trigger points to help signal an incident is underway

Biological Incident Surge Response Triggers



- Early increased numbers of daily fatalities will manifest at all stages of decedent processing:
  - An increase in the number of requests by health care facilities for OCME to hold decedents
  - An increase in funeral directors being unable to pick up decedents from HCFs or OCME in a timely manner
  - An increase in cases that exceeds OCME's standard storage capacity
  - Inability of cemeteries and City Burial to keep up the number of requested burials

Assignment of Responsibilities



- A majority of the Body Collection Point (BCP) operations will fall on the HCF
  - Assistance provided by NYCEM and OCME
  - HCF staff should be prepared to magnify daily operations including, but not limited to:
    - Family notification
    - Remains storage
    - Decedent tracking
    - Personal effects management
    - Issuance of death certificates (when appropriate)
    - Release of remains

Jurisdictional Authority

The origin of the biological incident will affect how fatality management operations are handled:

Criminal Act / Homicide / Risk to Public Health	ME Case
Naturally Occurring Outbreak of Disease	Claim Case

Separation of Cases

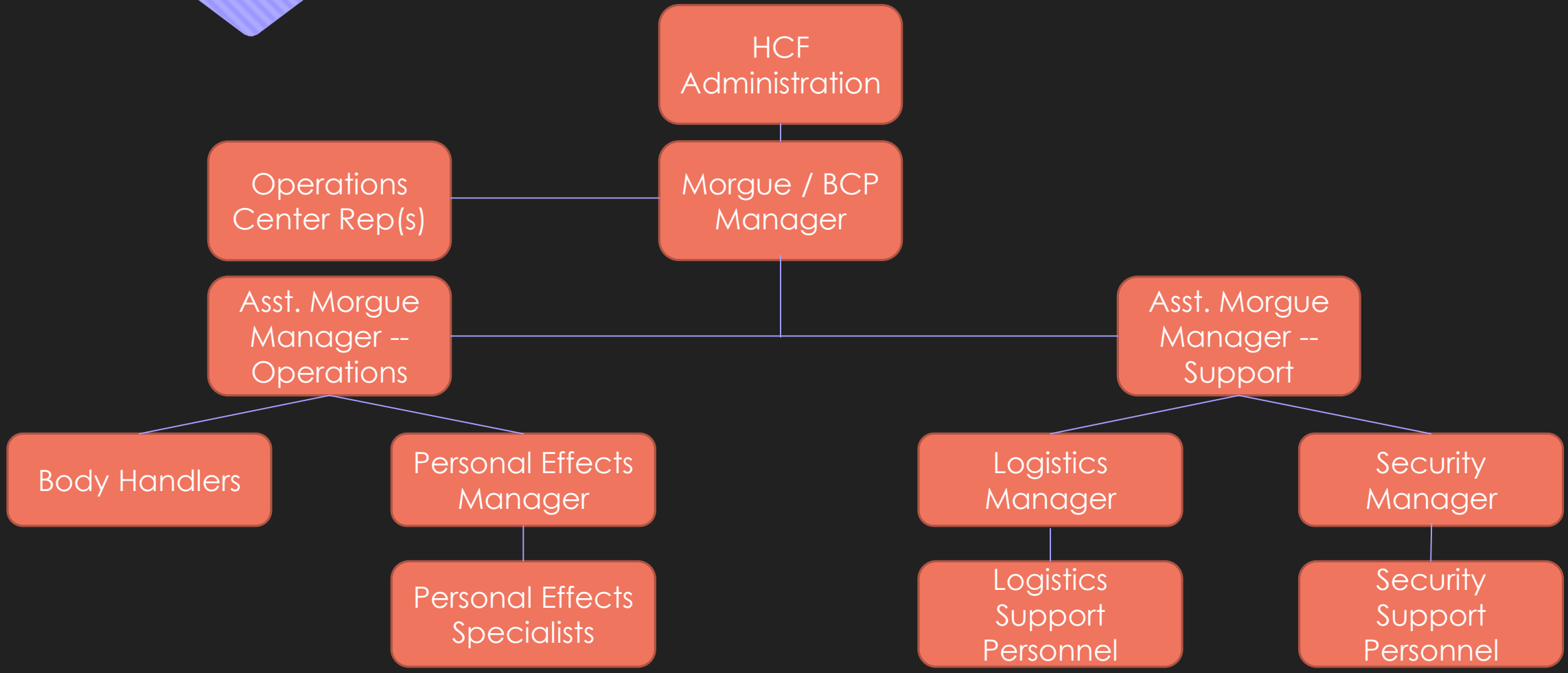
	Natural Occurrence	Criminal Act
Incident-Related Cases	***Claim Cases*** Stored in BCP	***ME Cases*** Stored in BCP
Non-Incident Claim Cases	Can be stored in BCP with incident-related claim cases	Must be stored separately
Non-Incident ME Cases	Must be reported to OCME, in accordance with day-to-day protocol, and stored separately	

Facility & System Specific MFM Plans

Facility & System Specific MFM Plans: First Steps

- Upon recognition or anticipation of a fatality surge:
  - Continue normal death reporting of ME Cases to OCME
  - Initiate internal HCF Fatality Management Plan, including the activation of staff
  - Communicate remains storage concerns to OCME Operations Center
  - Report to EOC Representative / ESF-8 regarding storage capacity issues and make a resource request

Facility & System Specific MFM Plans: Body Collection Point Staffing



Facility & System Specific MFM Plans: Body Collection Point Staffing

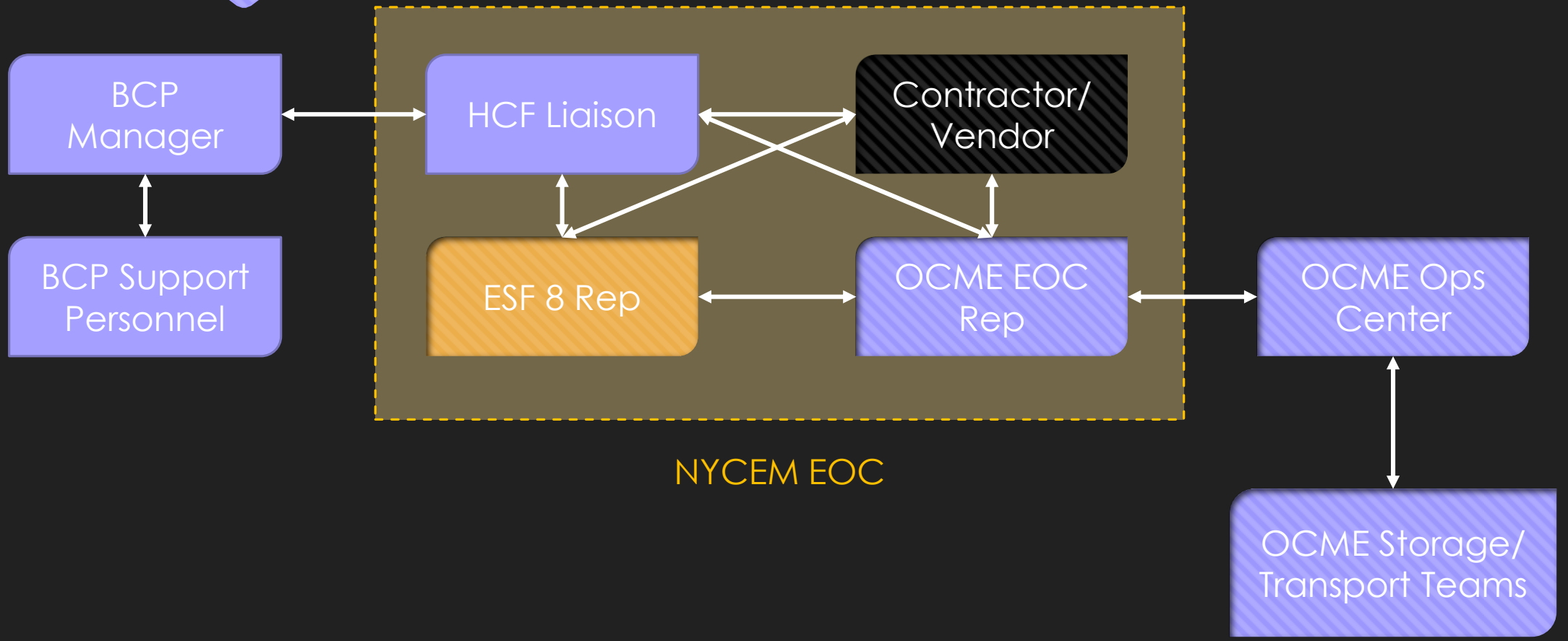
HCFS SHOULD IDENTIFY INDIVIDUALS TO FILL ANCILLARY ROLES RELATED TO BCP OPERATIONS DURING A SURGE

KEEP IN MIND THAT BCP OPERATIONS WILL NEED TO RUN 24 HOURS A DAY FOR AN EXTENDED PERIOD OF TIME AND APPROPRIATELY TRAIN AN ADEQUATE NUMBER OF PERSONNEL TO FILL EACH POSITION

Staff Limitations

Consider the impact a biological incident will have on your own staff due to absenteeism, increased patient care needs and potentially public fear

Facility & System Specific MFM Plans : Interagency Communication



Facility & System Specific MFM Plans: Logistics Requirements

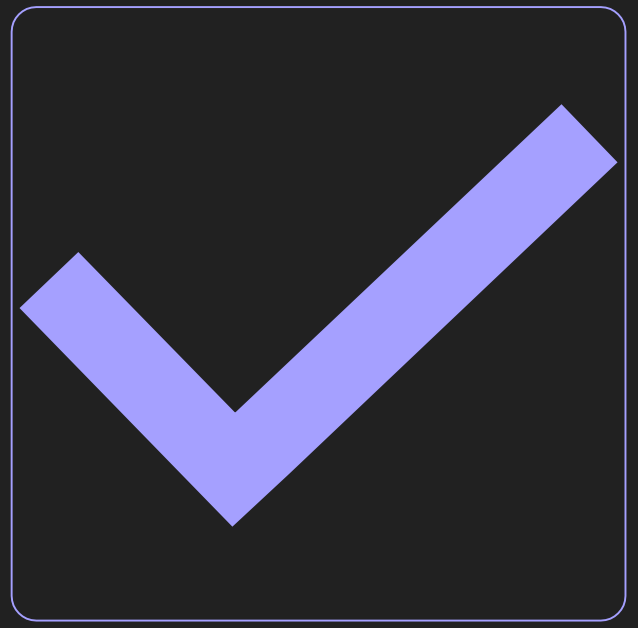
Planning efforts should identify appropriate facility infrastructure and predetermined locations for accommodating a Body Collection Point:

Area	Accessibility	Utilities / Fueling	Security
Large enough to accommodate two identical units	Route must be accessible by tractor trailer Availability of loading dock	Electric and fuel requirements must be met	Area should be private & secure

Refrigerated Trailer

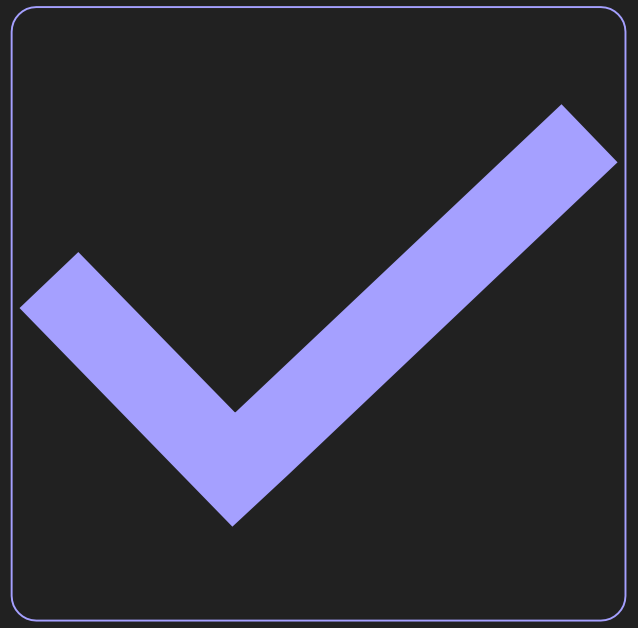
CONEX Unit

Facility & System Specific MFM Plans: Supplies



- Supply inventories will need to be monitored and increased as the incident progresses
- Human Remains Pouches (HRPs) made from thicker material designed to hold up against repeated transfers and natural decomposition should be used
- Supplies for documentation of decedent and PE tracking
- PPE and disinfection supplies dependent on pathogen

Facility & System Specific MFM Plans: Decedent Tracking



- Decedent tracking is paramount during all phases
- Must ensure 100% accuracy
- Chain of custody shall be enforced
- Consider designating a QA/QC officer
- OCME will reconcile the BCP against the manifest documentation prior to accepting custody

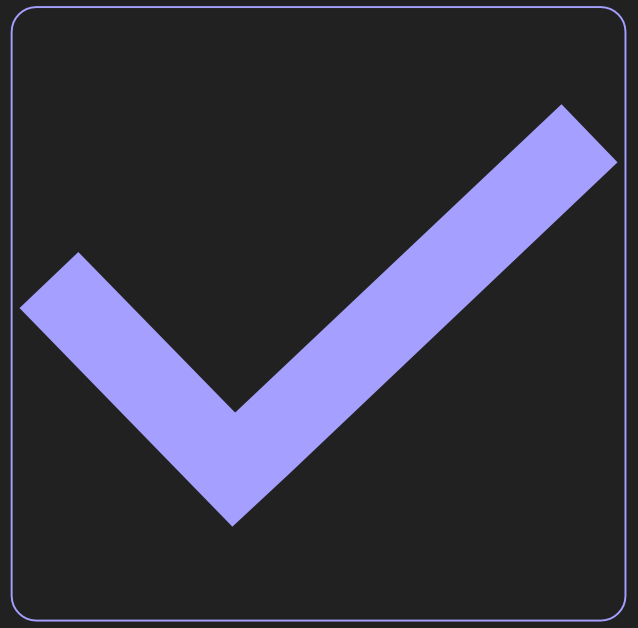
Facility & System Specific MFM Plans: Decedent Tracking

HCF's should record all pertinent information relating to a decedent:

- Full name
- DOB
- DOD
- Sex
- Age
- BCP intake date
- HCF admission date
- Case Hx
- BCP/HCF ID number
- Presence of personal effects*
- OCME case number*
- OCME case type*
- Contact information for NOK*
- Contact information for funeral home*
- Religious affiliation*

*if applicable

Facility & System Specific MFM Plans: Personal Effects Management



- Will need increased capacity for Personal Effects (PE)
- Prepare to store PE for an extended period of time until released to the family
- 100% accuracy and chain of custody
- Unlikely PE will have evidentiary value

Facility & System Specific MFM Plans : Security

Limit Public View

Access Control & Credentialing

Consistent Protocols & Documentation

Special Considerations

Special Considerations: Limited Resources

- Fatality Management will potentially be in competition for resources with other incident-related operations.
  - Consider time required for sourcing and potential delays when making requests
- HCFs not electing to receive a BCP must develop an alternative fatality surge capability
  - If utilizing an alternate or individual route, be aware of competition for limited resources

Special Considerations: Direct Drop-Off

During large scale biological incident, it is possible decedents will be dropped off directly to HCFs

Special Considerations: Direct Drop-Off

In these cases, HCFs should:

1. Treat the decedent as a patient and pronounce death according to protocol.
2. Obtain information about the decedent
3. Obtain basic information about the individual who is dropping off decedent, including contact information for next of kin
4. Notify NYPD, as necessary, to determine is an investigation is warranted
5. Move decedent to the appropriate remains storage location

Special Considerations: Funeral Directors

- HCFs should release claim cases on demand to licensed funeral directors
- Public fear during an incident may result in funeral directors refusing responsibility; it is the family's responsibility to select a funeral home which is willing to take custody of decedents
- During biological incidents of criminal or intentional nature, no decedents should be released from HCF BCPs, as they are considered homicides (and therefore ME cases)

Special Considerations : Sensitivity Guidance

- Decedents should always be handled in a manner denoting respect
- Personnel assigned to BCP operations should be briefed about their job tasks and what to expect
- Decedents should always be placed face up and never stacked
- Personnel should not smoke, eat, or drink near the BCP
- Personnel should refrain from joking and laughing when performing BCP operations to prevent the skewing of public perception
- Personnel should be aware of impact to self and coworkers. Take breaks and seek resources as needed.

Special Considerations: Religious Traditions

- All BCP operations should be conducted in a safe, respectful and error-free manner no matter the known religious or cultural beliefs of the decedent
- Delayed release of remains will be the primary conflict with most religious traditions
- Religious traditions surrounding death should be accommodated as much as feasibly possible without impacting BCP operations or risking public health
- Maintain open communication with religious leaders

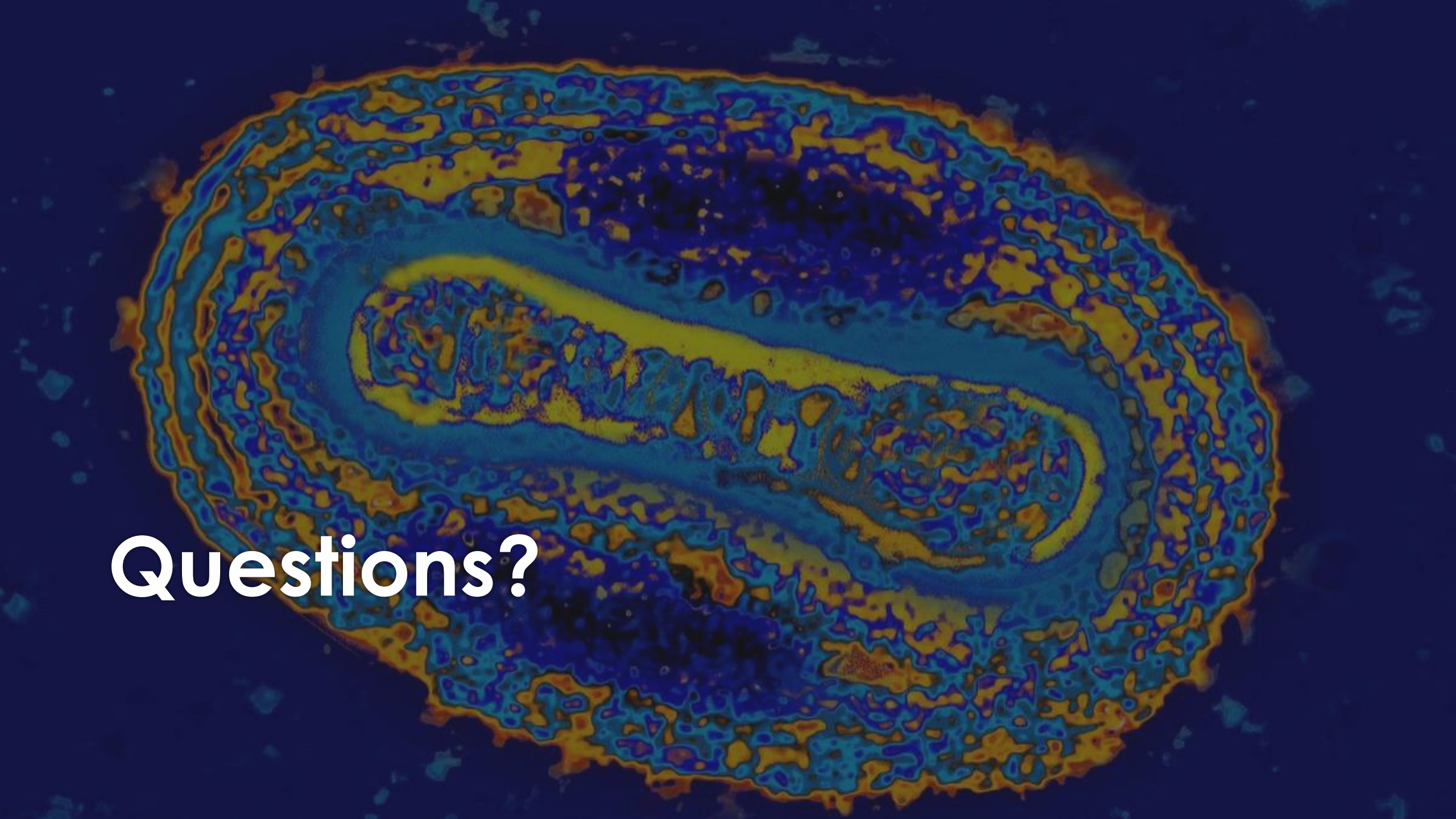
What Do We Need From You?

What Do We Need From You?

- Healthcare Facility Name / System or Network Affiliation (as recognized by E-Vital)
- Facility Morgue Address
- Facility Points of Contact:
  - Emergency Preparedness Coordinator (EPC) and alternate
  - Morgue Manager POC
  - Facilities Department POC
  - Security Department POC
- Capacity of on-site morgue (as it stands today)

What Do We Need From You?

- Pre-identify a staging location for the BCP:
  - Address or detailed description of staging location (GPS Coordinates)
  - Access route with a tractor trailer and/or fuel truck
  - Access to shore power? (if needed or as an option)
  - Are there security cameras?
  - Are there public view concerns?
  - Is this space adjacent to a loading dock?
  - Is this space in close proximity to air intake/HVAC systems?


Questions?

Contact Information

Emily Carroll, MSPH
Deputy Director, Emergency Management
NYC Office of Chief Medical Examiner
Telephone: (212) 323-1314
Cell: (646) 706-3850
Email: emcarroll@ocme.nyc.gov

Elissia Conlon
Deputy Director, Forensic Operations
NYC Office of Chief Medical Examiner
Telephone: (212) 323-1587
Cell: (347) 865-2187
Email: econlon@ocme.nyc.gov

Helen Alesbury, MA
Assistant Director, Emergency Management
NYC Office of Chief Medical Examiner
Telephone: (212) 323-1329
Cell: (646) 984-0420
Email: halesbury@ocme.nyc.gov

Networking Break

Evacuation and Surge Planning, Tools and Operations, Continued

Darrin Pruitt, Deputy Director, Bureau of Healthcare System Readiness, OEPR, NYC DOHMH

Patient Movement Workgroup Bed Types Overview

Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs, GNYHA

Preparation for the 2019 Surge Ex Drill: **Using Standardized Bed Definitions**

February 14, 2018

GREATER NEW YORK HOSPITAL ASSOCIATION

Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

Our Shared Objective

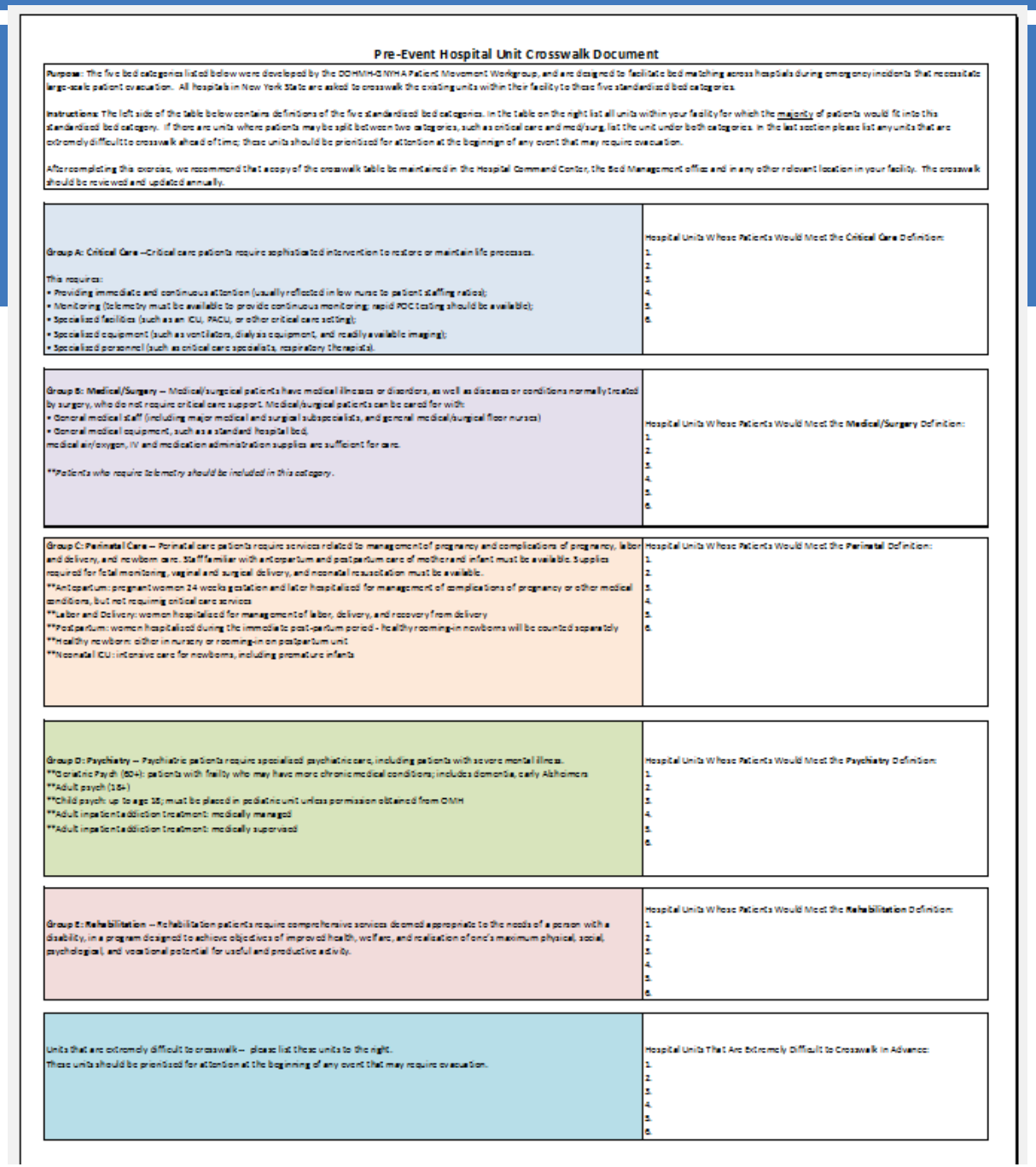
- Use **standardized bed definitions** *(developed through a collaborative workgroup process)* to facilitate bed matching during the 2019 DOHMH Surge Ex drill

Bed Types
Critical Care – Adult, Pediatric
Med/Surg – Adult, Adult Telemetry, Pediatric, Pediatric Telemetry
Perinatal (Mothers) – Antepartum, Labor & Delivery, Postpartum
Perinatal (Babies) – NICU Level 1, 2, 3, 4
Addiction - Adult
Psych – Geriatric, Adult, Pediatric
Rehab – Adult, Pediatric

Step 1: Pre-Event Hospital Unit Crosswalk

Each facility is asked to complete this Pre-Event Unit Crosswalk **between now and February 22nd**.

The purpose of the crosswalk is to associate each inpatient unit with the standardized bed definition(s) to which that unit is most likely to contribute patients.



Pre-Event Hospital Unit Crosswalk Document

Purpose: The five bed categories listed below were developed by the DOHMH-GNYHA Patient Movement Workgroup, and are designed to facilitate bed matching across hospitals during emergency incidents that necessitate large-scale patient evacuation. All hospitals in New York State are asked to crosswalk the existing units within their facility to these five standardized bed categories.

Instructions: The left side of the table below contains definitions of the five standardized bed categories. In the table on the right list all units within your facility for which the majority of patients would fit into this standardized bed category. If there are units where patients may be split between two categories, such as critical care and med/surg, list the unit under both categories. In the last section please list any units that are extremely difficult to crosswalk ahead of time; these units should be prioritized for attention at the beginning of any event that may require evacuation.

After completing this exercise, we recommend that a copy of the crosswalk table be maintained in the Hospital Command Center, the Bed Management office and in any other relevant location in your facility. The crosswalk should be reviewed and updated annually.

Group A: Critical Care –Critical care patients require sophisticated intervention to restore or maintain life processes. This requires: • Providing immediate and continuous attention (usually reflected in low nurse to patient staffing ratios); • Monitoring (telemetry must be available to provide continuous monitoring; rapid POC testing should be available); • Specialized facilities (such as an ICU, PACU, or other critical care setting); • Specialized equipment (such as ventilators, dialysis equipment, and readily available imaging); • Specialized personnel (such as critical care specialists, respiratory therapists).	**Hospital Units Whose Patients Would Meet the Critical Care Definition:** 1. 2. 3. 4. 5. 6.
Group B: Medical/Surgery – Medical/surgical patients have medical illnesses or disorders, as well as diseases or conditions normally treated by surgery, who do not require critical care support. Medical/surgical patients can be cared for with: • General medical staff (including major medical and surgical subspecialists, and general medical/surgical floor nurses) • General medical equipment, such as a standard hospital bed; medical air/oxygen, IV and medication administration supplies are sufficient for care. ***Patients who require telemetry should be included in this category.*	**Hospital Units Whose Patients Would Meet the Medical/Surgery Definition:** 1. 2. 3. 4. 5. 6.
Group C: Perinatal Care – Perinatal care patients require services related to management of pregnancy and complications of pregnancy, labor and delivery, and newborn care. Staff familiar with antepartum and postpartum care of mother and infant must be available. Supplies required for fetal monitoring, vaginal and surgical delivery, and neonatal resuscitation must be available. **Antepartum: pregnant women 24 weeks gestation and later hospitalized for management of complications of pregnancy or other medical conditions, but not requiring critical care services **Labor and Delivery: women hospitalized for management of labor, delivery, and recovery from delivery **Postpartum: women hospitalized during the immediate post-partum period - healthy rooming-in newborns will be counted separately **Healthy newborn: either in nursery or rooming-in on postpartum unit **Neonatal ICU: intensive care for newborns, including premature infants	**Hospital Units Whose Patients Would Meet the Perinatal Definition:** 1. 2. 3. 4. 5. 6.
Group D: Psychiatry – Psychiatric patients require specialized psychiatric care, including patients with severe mental illness. **Geriatric Psych (60+): patients with frailty who may have more chronic medical conditions; includes dementia, early Alzheimers **Adult psych (18+) **Child psych: up to age 18; must be placed in pediatric unit unless permission obtained from OMH **Adult inpatient addiction treatment: medically managed **Adult inpatient addiction treatment: medically supervised	**Hospital Units Whose Patients Would Meet the Psychiatry Definition:** 1. 2. 3. 4. 5. 6.
Group E: Rehabilitation – Rehabilitation patients require comprehensive services deemed appropriate to the needs of a person with a disability, in a program designed to achieve objectives of improved health, welfare, and realization of one's maximum physical, social, psychological, and vocational potential for useful and productive activity.	**Hospital Units Whose Patients Would Meet the Rehabilitation Definition:** 1. 2. 3. 4. 5. 6.
Units that are extremely difficult to crosswalk – please list these units to the right. These units should be prioritized for attention at the beginning of any event that may require evacuation.	**Hospital Units That Are Extremely Difficult to Crosswalk in Advance:** 1. 2. 3. 4. 5. 6.

Step 2: February 22nd Sit Stat 2.0 Bed Drill

- At 9:00am on Friday, February 22nd all NYC hospitals currently participating in Sit Stat 2.0 will be asked to complete a brief bed drill.
  - Evacuating hospitals will be asked to provide bed census numbers for standardized bed categories
  - Receiving hospitals will be asked to provide bed availability numbers for standardized bed categories
  - Opportunity to become familiar with the mechanics of providing hospital bed data using these standardized bed categories

Step 3: Wait for Surge Ex!

- Any questions regarding the Pre-Event Crosswalk or February 22nd Sit Stat 2.0 Bed Drill – please contact:
  - Jenna Mandel-Ricci jmandel-ricci@Gnyha.org or (212) 258-5314
  - Samia McEachin smceachin@Gnyha.org or (212) 258-5336

Q/A and Summary of Evacuation and Surge Planning, Tools and Operations


Meeting Adjourned