



**NYC Health Care Coalition (NYCHCC) Leadership Council
Meeting co-hosted with the Staten Island COAD
NYC DOHMH Office of Emergency Preparedness and Response
Bureau of Healthcare and Community Readiness**

Wednesday, June 2, 2021



Welcome!

Agenda

AM

10:00 – 10:03

Arrivals / Welcome

Taina Lopez, Sr. Manager Planning and Strategy, Healthcare System Readiness, OEPR, Bureau of Healthcare and Community Readiness, NYC DOHMH

David Miller Jr., Executive Director, Bureau of Healthcare and Community Readiness, OEPR, NYC DOHMH

10:03 – 11:00

Leveraging Healthcare & Community Partnerships to Increase COVID-19 Vaccination in Staten Island

SI Borough Coalition COVID-19 Response – Welcome & Introductions

- **Sharmila Rao Thakkar**, MPA, MPH, Executive Director, Staten Island Not For Profit Association/Staten Island Community Organizations Active in Disaster

Staten Island COVID-19 Vaccination – Setting the Stage & Early Efforts with Frontline Healthcare Providers

- **Trientina Campbell**, MES Co-chair and Director of Environmental Safety/EPC, Richmond University Medical Center

Broadening Vaccine Education and Access across the Borough

- **Ginny Mantello**, MD, MES Co-chair and Health & Wellness Director, SI Borough President

Engaging Skilled Nursing Facilities & PCPs in Local Vaccine Efforts

- **Donna Seminara**, MD – MES Lead Rep for Skilled Nursing Facilities (SNFs) and Director of Geriatrics at Staten Island University Hospital & Medical Director, Eger Healthcare & Rehab

A Community-Based Approach – Deepening COVID-19 Vaccine Outreach with Trusted Partners

- **Rev. Karen Jackson**, Administrator, SI Long Term Recovery Organization (LTRO) and Director of Recovery & Community Initiatives at Project Hospitality

The Value of a Borough Coalition in Bridging Gaps, Linking Programs & Serving the Community – the 4Cs: Communications, Coordination, Cooperation and Collaboration

- **Frank Blancero**, Program Manager, Staten Island Not For Profit Association/Staten Island Community Organizations Active in Disaster

Agenda

AM

11:00 – 11:05	<i>Introduction to Chief Medical Officer of the New York City Department of Health and Mental Hygiene</i> <ul style="list-style-type: none">• Taina Lopez, Sr. Manager Planning and Strategy, Healthcare System Readiness, OEPR, Bureau of Healthcare and Community Readiness, NYC DOHMH• Michelle Morse, MD, MPH, Chief Medical Officer, Deputy Commissioner, Center for Health Equity and Community Wellness, NYC DOHMH
11:05 – 11:40	<i>Network Coalition Presentations</i> <ul style="list-style-type: none">• MediSys Health Network• Montefiore Medical Center• NYU Langone Hospitals• Northwell Health• New York-Presbyterian Healthcare System• NYC Health + Hospitals• Mount Sinai Health System
11:40 – 11:50	<i>Open Forum / Q&A</i>
11:50 -12:15	<i>Subject Matter Expert (SME) Coalition Presentations</i> <ul style="list-style-type: none">• Pediatric Disaster Coalition (PDC)• NorthHelp• Long Term Care:<ul style="list-style-type: none">○ Greater New York Hospital Association - Continuing Care (GNYHA-CCLC)○ Greater New York Health Care Facilities Association (GNYHCFA)○ Southern New York Association (SNYA)
12:15 – 12:30	<i>Open Forum / Q&A</i>
12:30	<i>Adjournment</i>



Leveraging Healthcare & Community Partnerships to Increase COVID-19 Vaccination in Staten Island



Introduction to Chief Medical Officer of the New York City Department of Health and Mental Hygiene

Taina Lopez, Senior Manager Planning and Strategy, Bureau of Healthcare and Community Readiness, OEPR, NYC DOHMH

Michelle Morse, MD, MPH, Chief Medical Officer, Deputy Commissioner, Center for Health Equity and Community Wellness, NYC DOHMH



- ## Michelle Morse, MD, MPH
- Chief Medical Officer
 - Deputy Commissioner, Center for Health Equity and Community Wellness
 - New York City Department of Health and Mental Hygiene

Michelle Morse, MD, MPH

- Dr. Morse is an internal medicine and public health doctor who works to achieve health equity through global solidarity, social medicine and anti-racism education, and activism. She is an internal medicine hospitalist, Co-Founder of EqualHealth, and Assistant Professor at Harvard Medical School. EqualHealth is a non-profit organization that builds critical consciousness and collective action globally, in the pursuit of health equity for all. In 2015, Dr. Morse worked with several EqualHealth partners to found the Social Medicine Consortium (SMC), a global coalition of over 1200 people representing over 50 universities and organizations in twelve countries, which seeks to use activism and disruptive pedagogy rooted in the practice and teaching of social medicine to address the miseducation of health professionals on the root causes of illness. In 2018, Dr. Morse was named as a Soros Equality Fellow and worked on the SMC's global Campaign Against Racism during the fellowship. In September 2019 she began a Robert Wood Johnson Health Policy fellowship in Washington, DC and worked with the U.S. House of Representatives Ways and Means Committee, Majority Staff.
- Dr. Morse also has a history of global service. As a Howard Hiatt Global Health Equity resident in Internal Medicine at Brigham and Women's Hospital from 2008-2012, Dr. Morse worked in Haiti, Rwanda, and Botswana. She focused her international work in Haiti where she helped to coordinate Partners In Health's (PIH) earthquake relief efforts, was a first-responder for the cholera epidemic, and worked on women's health and quality improvement projects.
- Dr. Morse earned her B.S. in French in 2003 from the University of Virginia, her M.D. from the University of Pennsylvania School of Medicine in 2008, and her MPH from the Harvard School of Public Health in May 2012.



Network Coalitions Presentations

MediSys COVID-19 Task Force Overview

Presented by:

John Keogh

Emergency Management Planner

MediSys Health Network

MediSys COVID-19 Task Force

- In response to the COVID-19 pandemic MediSys Emergency Management established the MediSys COVID-19 Task Force.
- The COVID-19 Task Force consisted of an interdisciplinary team of senior clinical and administrative leadership from across the health network. charged with reviewing network-wide response protocols.
- This task force approach has proven to be successful in the network's response to Y2K (1999), nuclear, biological & chemical preparedness (2001), pandemic influenza (2009), and Ebola Virus Disease (2014).

Task Force Structure/Leads

- **Project Management**

- Mark Marino, Director, Emergency Management

- **Clinical Care**

- Sabiha Raoof, MD, Chief Medical Officer

- **Ancillary & Support Care**

- John Arline, Administrative Director, Operations

- **Staff Education and Training**

- Sharon Narducci, Chief Quality Officer

- **Human Resource Management & Workforce Safety**

- Trina Cornet, Vice President, Human Resources

- **Inventory Management Workgroup**

- Fred Beekman, Vice President, Ambulatory Care

Project Management

- Task Force Oversight, Structure and Tracking
- Regulatory Compliance and Data Reporting
- Situational Awareness (Facility, Network, Regional)
- Network Readiness
- Interagency Liaison

Clinical Care

- Screening and Treatment Protocols
- In-Patient and Critical Care
- Remote screening and evaluation
- Laboratory Processing
- Maintaining guidance on COVID-19 management protocols
- Pre-designated in-patient locations
- Pandemic Surge
- Long Term Care

Ancillary & Support Care

- Isolation Capability
- Environmental Controls
- Security and Access Control
- Space/Equipment Disinfection
- Visitation policies
- Environment of Care
- Informatics
- Load Balancing

Staff Education & Training

- Curriculum Development
- Instructor Training
- Just-In-Time Training
- Training Tracking
- MediSys COVID-19 Resource Center (Intranet)
- Standardized PPE Compliance

Inventory Management

- Inventory Controls & Tracking of all Critical Supplies
- PPE Procurement
- Training supplies
- Par Level Modifications
- Reordering Thresholds
- Distribution Controls
- PPE Security

Situational Awareness

A proven success of our task force structure is ability to provide continuous situational awareness to our leadership teams.

- Daily SitStat Calls
 - Network wide call daily 9:00 AM
 - SitStat report distributed daily by EOC staff
- Weekly Friday 8:00 AM taskforce call **biweekly as of 5.1.21
 - Workgroup lead report outs
 - Open Discussions
 - CEO/COO comments

Personal Protective Equipment

Through out the pandemic management of PPE was a significant challenge. Operating in a setting of extreme resource shortages due to the increased demand and supply chain disruption.

- DOHMH/GNYHA Support
- PPE Security/Controls
 - PPE Distribution Centers
 - Centralized 24/7 PPE Center
 - Floor-based 24/7 PPE Stations (staffed)

Thank you

Montefiore Emergency Preparedness Coalition

End of Year Briefing

to the

New York City Healthcare Coalition Leadership Council

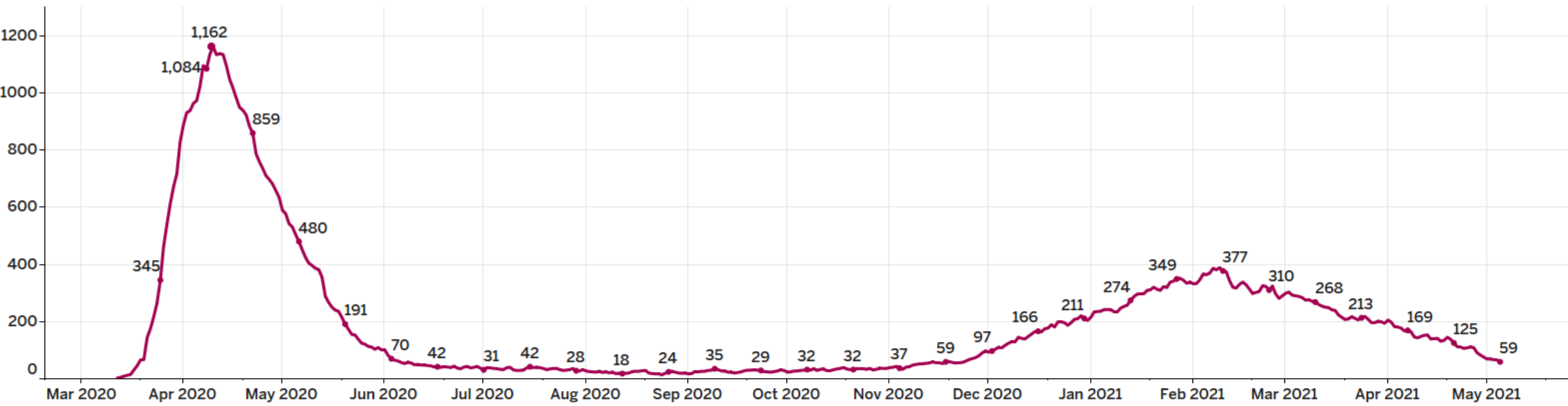


One Success: Surge Capacity

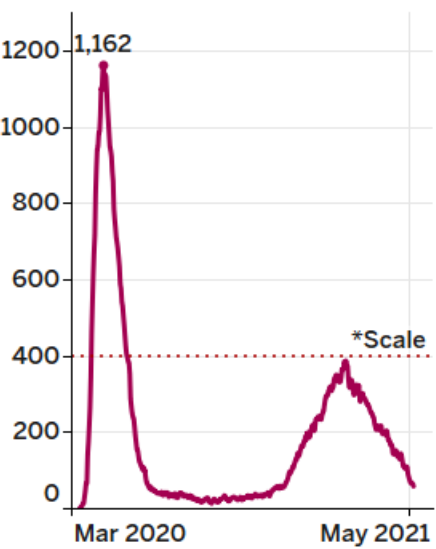
- Surge of patients exceeded all conventional spaces
- Traditional “non-traditional spaces” were used first
- Additional non-traditional surge spaces were identified and established across the Health System including Moses’ Grand Hall (23 beds), Weiler gym, Wakefield closed units
- Created headwalls and a clinical environment in the Learning Center (12 beds)
- More than doubled ICU capacity
- Policy challenges: there was no procedure or plan for this
- Logistics challenges
 - Beds
 - Oxygen
 - Information Technology (IT) support in making non-traditional surge space operational
 - IT leaders were identified for each site that coordinated all technological support
 - Implementation of EPIC reports specific for COVID
 - Procurement of equipment needed to support standing up of non-traditional surge space



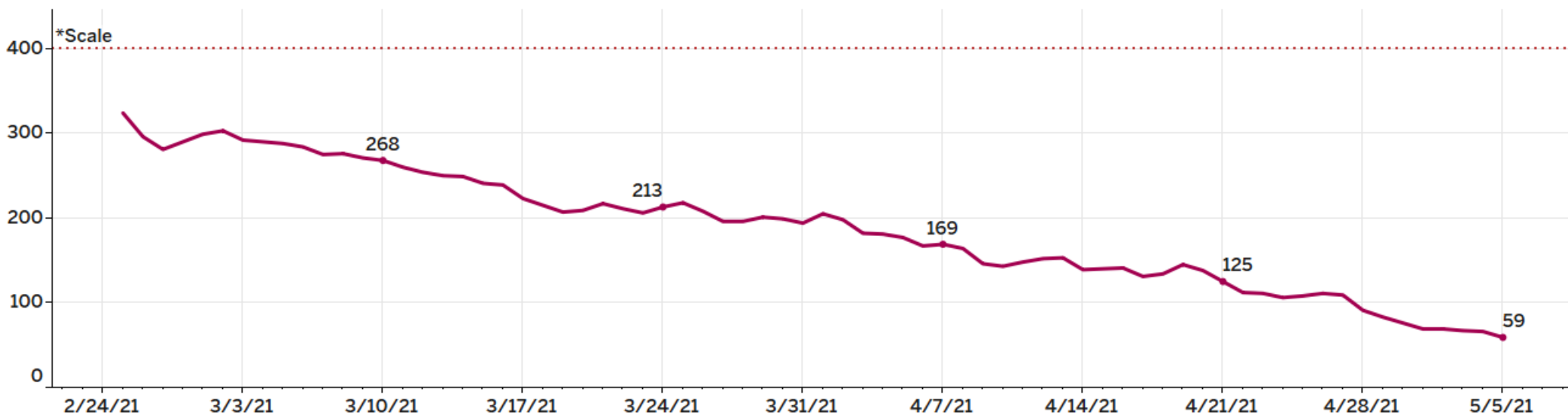
MMC Total COVID-19 Case Count



Peak

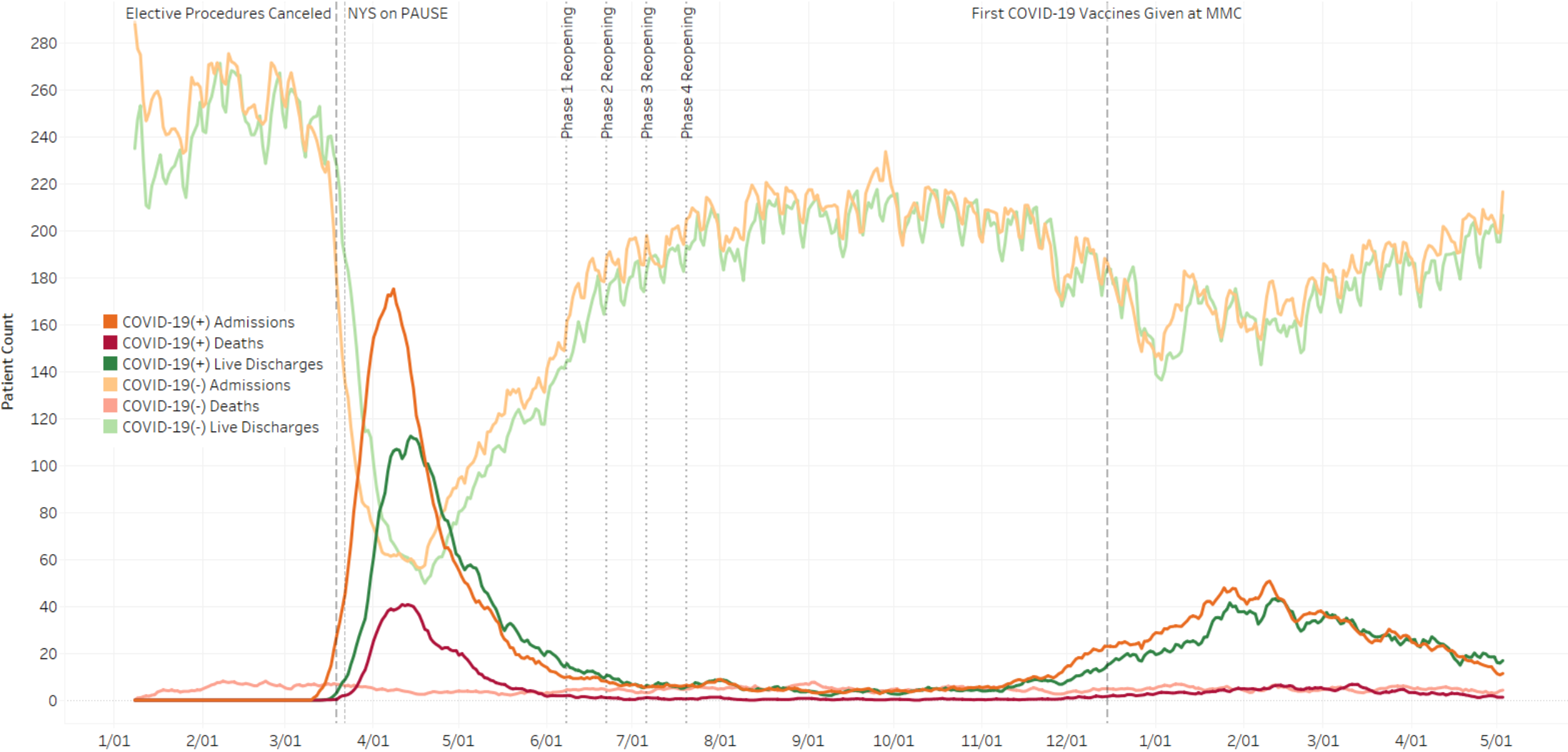


Last 60 Days



*Dashed reference lines on both graphs indicate the difference in scale from the peak to our current position.

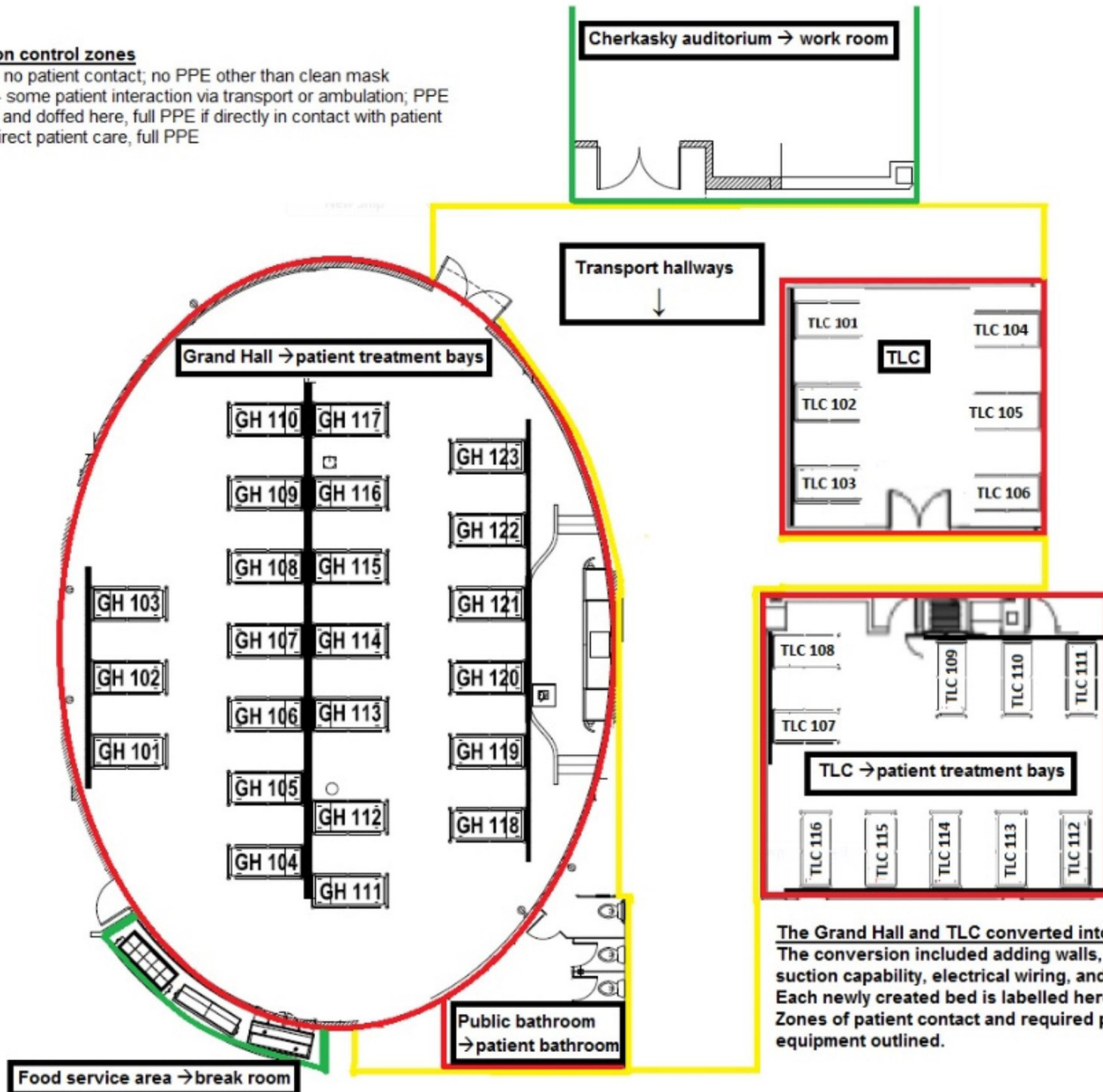
Montefiore Medical Center Admission, Discharges and Deaths by COVID-19 Status, 7 Day Moving Average



The Grand Hall and Tishman Learning Center converted into a Covid-19 medical unit

Infection control zones


- Green** - no patient contact; no PPE other than clean mask
- Yellow** - some patient interaction via transport or ambulation; PPE donned and doffed here, full PPE if directly in contact with patient
- Red** - direct patient care, full PPE



The Grand Hall and TLC converted into Covid-19 unit
 The conversion included adding walls, oxygen piping, suction capability, electrical wiring, and curtains. Each newly created bed is labelled here with a number. Zones of patient contact and required personal protective equipment outlined.



Creation of a medical ward from non-clinical space amidst the Covid-19 pandemic

Cameron J. Locke MD^{1,2} | Benjamin Koo MD^{1,2} | Sarah W. Baron MD, MS^{1,2} |
Jared Shapiro DrPH(c), PhD(c), MPH³ | Jessica Pacifico MD, MS^{1,2} 

¹Department of Medicine, Albert Einstein College of Medicine, Bronx, New York

²Division of Hospital Medicine, Montefiore Medical Center, New York, New York

³Department of Environmental Health and Safety, Montefiore Medical Center, New York, New York

Correspondence

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Email: jessica.pacifico@gmail.com, jpacifico@montefiore.org

Abstract

Introduction: Hospitals were mandated to dramatically increase capacity during the Covid-19 crisis in New York City. Conversion of non-clinical space into medical units designated for Covid-19 patients became necessary to accommodate this mandate.

Methods: Non-clinical space was converted into medical units at multiple campuses of a large academic hospital system over 1 week. The conversion required construction to deliver basic care including oxygen supplementation. Creation of provider workspaces, handwashing areas, and colour-coded infection control zones was prioritized. Selection criteria were created with a workflow to determine appropriate patients for transfer into converted space. Staffing of converted space shifted as hospitalizations surged.

Results: The unit was open for 18 days and accommodated 170 unique patients. Five patients (2.9%) required transfer to a higher level of care. There were no respiratory arrests, cardiac arrests, or deaths in the new unit.

Conclusion: Converting non-clinical space to a medical unit was accomplished quickly with staffing, workflow for appropriate patients, few patients who returned to a higher level of care, and no respiratory or cardiac arrests or deaths on the unit.

KEYWORDS

Covid-19, non-clinical space, SARS-CoV-2, space conversion, surge capacity

1 | INTRODUCTION

Montefiore Medical Center opened its Emergency Operations Center to prepare for the Covid-19 pandemic on February 11, 2020 and the first Covid-19 patient was admitted on March 11, 2020. On March 23, 2020, an emergency order from New York State Governor Andrew M. Cuomo mandated all hospitals in the state increase capacity by 50% to accommodate the expected surge in Covid-19 cases. At the time, state health officials estimated 55 000 new hospital beds would be needed.¹ Montefiore Health System is the largest hospital system in the Bronx, NY, the borough with both the highest per capita

hospitalizations and deaths from Covid-19 in New York City.² During the initial surge of patients with Covid-19 in March and April of 2020, Montefiore converted non-clinical hospital spaces into Covid-19 patient care areas to accommodate the growing inpatient census. Although the conversion of existing clinical space to Covid-19 medical wards has been described,³ there are limited reports available that describe the conversion of non-clinical space. Unfortunately, as the Covid-19 pandemic continues and with hospitalizations in the United States rising, the need for additional capacity is ongoing. As of the first week of March 2021, there are over 46 000 Covid-19 hospitalizations in the United States.⁴ We describe here the steps taken to convert non-clinical space into a functioning medical unit including the physical alterations of the space, methods by which we selected appropriate patients, the staffing model, and patient outcomes.

Recommendations to Improve Surge Capacity

- Issues related to management and operationalization of spaces that were not normally used for care
- Many of the sites employed different methodologies for converting surge spaces back to normal use
- Additional training is needed on alternate care site (ACS) operationalization
- Facilities should have comprehensive ACS plans that address personnel, resources, equipment, etc. that are needed to make a space functional
- Education/training is also needed for staff on how to operate effectively within spaces that they may not be familiar with
- Need for more predictive surge modeling that can help develop planning activities and assumptions more accurately
- Training on operationalizing ACS; develop/formalize plans

One Challenge: Fatality Management

- Over 28,598 individuals lost their lives in New York alone to COVID-19
- Hospital morgues in the area were not equipped to handle the number of decedents related to COVID-19
- Limited on-site capacity and staffing led to significant challenges with fatality management
- The Office of the Chief Medical Examiner deployed Body Collection Points (BCPs) to institutions around the City to help alleviate the hospital morgues
- Significant issues with the claims process, body handling, transport, and property management
- Many morgues do not have adequate staffing or around-the-clock staffing trained and ready to handle the number of casualties produced



Recommendations to Improve Fatality Management

- Revise mass fatality management plans to better optimize operations across the system
- Convene a system-level workgroup to best address issues related to capacity, transport, and staffing
- Consider implementing mortuary technician jobs in the beginning stages of an outbreak based on the anticipated needs of these individuals



Thank you



Thank You



Montefiore



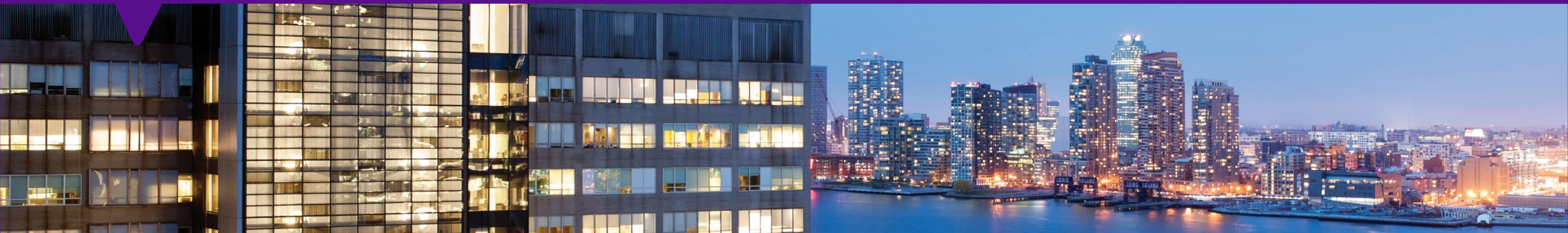
Albert Einstein College of Medicine



Emergency Management + Enterprise Resilience

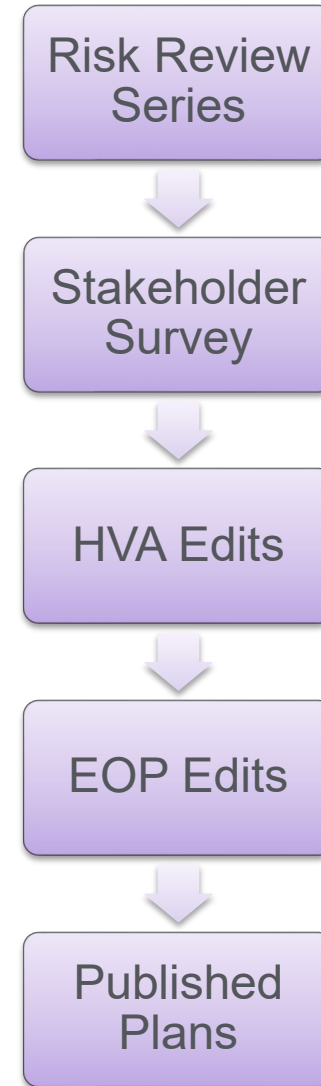
RETHINKING HAZARD VULNERABILITY ANALYSIS

Stephanie Hagans, Senior Emergency Management Specialist



Current Process

Incident Type		Severity				Risk
		Probability	Human Impact	Property Impact	Business Impact	
Score		Likelihood this hazard will occur	Possibility of death or injury	Physical loss or damage	Disruption to critical services	* Relative threat
		0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 - 100%
Active Shooter		0	0	0	0	0%
Bomb Threat		0	0	0	0	0%
Chemical Exposure - Internal		0	0	0	0	0%
Chemical Exposure - External		0	0	0	0	0%
Chemical Spill - Large, Internal		0	0	0	0	0%
Child / Pediatric Abduction		0	0	0	0	0%
Civil Disturbance (e.g., Animal Activ		0	0	0	0	0%
Communication: Telephone Failure		0	0	0	0	0%
Communication: Email Failure		0	0	0	0	0%
Cyberattack		0	0	0	0	0%
Drought		0	0	0	0	0%
Earthquake		0	0	0	0	0%
Evacuation (to another floor, building		0	0	0	0	0%
Evacuation (to another hospital)		0	0	0	0	0%



New Design

Interactive

- Workflow designed so that next question, or series of questions, is based on previous answers

Individualized

- Tailored to department specific hazards and impacts
- Broad enough to be measurable across departments

Single Sign-on

- All NYULH employees should have access

NYU Langone Hazard Vulnerability Analysis

Home / NYU Langone / Stephanie Test Group / HVA Prototype

Members | New | Edit | Tools | View | Idle Refresh

Hazard Vulnerability Assessment Source Review

- National Protection Framework, US DHS, June 2016
- Hazard Mitigation Plan, NYS DHSES, June 2012
- Hazard Mitigation Plan, NYS DHSES, 2019
- Political Risk, Terrorism & Political Violence RMR, Ann PLC, 2020
- Critical Threat Outlook (CTO), allhazards.net, Aug 2017
- IT Threats Report, McAfee Labs, June 2020
- Global Risk Report, World Economic Forum, 14th Ed., 2020

Event Type by Number of Events

Severe Weather	1,069
Extreme Temperatures	511
Winter Storm	242
Flooding	147
Infrastructure Failure	95
Coastal Storm	43
Wildfires	19
Earthquake	13
CBRN	11
Disease Outbreaks	10
Drought	7
Cyber Threats	7
Aviation Incident	5
Campus Coordination Attack	2
Fire	1

Table 5 2021 Hazard Vulnerability Assessment Matrix

This table depicts the results of the 2020 Hazards and Vulnerability Stakeholder Survey. RED shading indicates the highest hazard, according to stakeholders while YELLOW shading indicates a lower risk.

Key Hazards ¹	Probability	Human Impact	Property Impact	Business Impact	Cumulative Total
Active Shooter	Red	Red	Red	Red	Red
Infectious Disease Outbreak	Red	Red	Red	Red	Red
Flood - Internal	Red	Red	Red	Red	Red
Bomb Threat	Red	Red	Red	Red	Red
Earthquake	Red	Red	Red	Red	Red
Fire - Internal	Red	Red	Red	Red	Red
Workplace Violence / Threat	Red	Red	Red	Red	Red
Explosion	Red	Red	Red	Red	Red
Power Outage	Red	Red	Red	Red	Red
Transportation Failure	Red	Red	Red	Red	Red
Tsunami	Red	Red	Red	Red	Red
Chemical Exposure - Internal	Red	Red	Red	Red	Red
Cyberattack	Red	Red	Red	Red	Red
Hazmat Incident with Mass Casualties	Red	Red	Red	Red	Red
Generator Failure	Red	Red	Red	Red	Red
Hurricane	Red	Red	Red	Red	Red
Influenza, Seasonal	Red	Red	Red	Red	Red
Child / Pediatric Abduction	Red	Red	Red	Red	Red
Hostage Situation	Red	Red	Red	Red	Red
IT System Outage	Red	Red	Red	Red	Red
Chemical Exposure - External	Red	Red	Red	Red	Red
Mass Casualty Incident (MCI)	Red	Red	Red	Red	Red
Radiation Exposure	Red	Red	Red	Red	Red
Flood - External	Red	Red	Red	Red	Red
Terrorist Attack	Red	Red	Red	Red	Red
Patient Surge	Red	Red	Red	Red	Red
Tornado	Red	Red	Red	Red	Red
Shooter in Place	Red	Red	Red	Red	Red
Chemical Spill - Large, Internal	Red	Red	Red	Red	Red
Civil Disturbance (e.g. Animal Activists)	Red	Red	Red	Red	Red
Strikes / Labor Action / Work Stoppage	Red	Red	Red	Red	Red
Heating, Ventilation, and Air Conditioning Failure	Red	Red	Red	Red	Red
Communication: Telephone Failure	Red	Red	Red	Red	Red
Utility Failure (Other than HVAC, Gas)	Red	Red	Red	Red	Red
Water Contamination	Red	Red	Red	Red	Red
Suspicious Package, Substance, or Order	Red	Red	Red	Red	Red
Fire - External	Red	Red	Red	Red	Red
Evacuation (to another hospital)	Red	Red	Red	Red	Red
Evacuation (to another floor, building)	Red	Red	Red	Red	Red
Hazmat Incident	Red	Red	Red	Red	Red
Water Disruption	Red	Red	Red	Red	Red
Supply Chain Shortage / Failure	Red	Red	Red	Red	Red
Suicide	Red	Red	Red	Red	Red
Gas / Emissions Leak	Red	Red	Red	Red	Red
Natural Gas Disruption	Red	Red	Red	Red	Red
Communication: Email Failure	Red	Red	Red	Red	Red
Temperature Extremes	Red	Red	Red	Red	Red
Sewer Failure	Red	Red	Red	Red	Red
Planned Power Outages	Red	Red	Red	Red	Red
Natural Gas Failure	Red	Red	Red	Red	Red
Drought	Red	Red	Red	Red	Red

¹Key Hazards are applicable to all NYU Langone Health facilities, although some may be more vulnerable than others. For instance, NYU Langone Health facilities in Florida are more vulnerable to Coastal Surges, while the Manhattan Campus is less vulnerable to Utility Disruption.

Coastal Storms

Emerging Diseases

CBRN

Winter Weather

Cyber Threats

Flooding

FULL REPORT

SUBMIT FORM

Click here to submit 2022 Hazard Vulnerability Survey

Concept

- Visual Display of Real-Time HVA, as opposed to an episodic analysis
- This is a window into our Watch & Size up Process

NYU Langone Hazard Vulnerability Analysis

Home / NYU Langone / Stephanie Test Group / HVA Prototype

Members | New | Edit | Tools | View | Idle Refresh

NYC Hurricane Evacuation Zone Finder

Search for an address...

Evacuation Centers Legend

Use the NYC Hurricane Evacuation Zone Finder to find out if your address is in a hurricane evacuation zone. The best way to be prepared for the possibility of a hurricane evacuation is to know your evacuation zone, and plan your destination and travel routes ahead of time. Zones are color-coded and labeled 1, 2, 3, 4, 5, and 6 when represented on a map. Information on evacuation centers is subject to change. Please revisit this site for updated reports on building status and wheelchair accessibility features.

- Accessible Evacuation Center
- Evacuation Center
- Zone 1
- Zone 2
- Zone 3
- Zone 4
- Zone 5
- Zone 6

Zone Transparency: 0%

Find out more about the zones and preparing for a coastal storm: NYC Hazards - Coastal Storms & Hurricanes



THANK YOU



Multi-Agency Cooperation - Old Westbury Mass Vaccination Site

Glenn Schaefering



June 2, 2021

SUNY Old Westbury Site Timeline

Early March 2021 – Initial Planning Meetings

March 18, 2021 – Soft Opening

March 19, 2021 – Full Opening

SUNY Old Westbury Agency Participants

- Governor's Office
- New York State DOT – Incident Command
- SUNY Old Westbury Police - Security
- Northwell Health – Clinical Leads / Vaccinators / Pharmacists
Command Staff / Safety Officers
- AECOM / Tishman – Flow Control / Scribes / Runners
- New York State DOH – Clinical Oversight
- New York State Police – Planning / Security
- New York State DEC – Operations / IT
- New York State DMNA – Staff and Patient Check-Ins
- Forestry Service - Logistics
- Ambulnz / Pt. Jefferson EMS – On Site EMS / Transport

SUNY Old Westbury MVS



Entrance to Registration Tent



POD Walkway to Registration



POD Layout



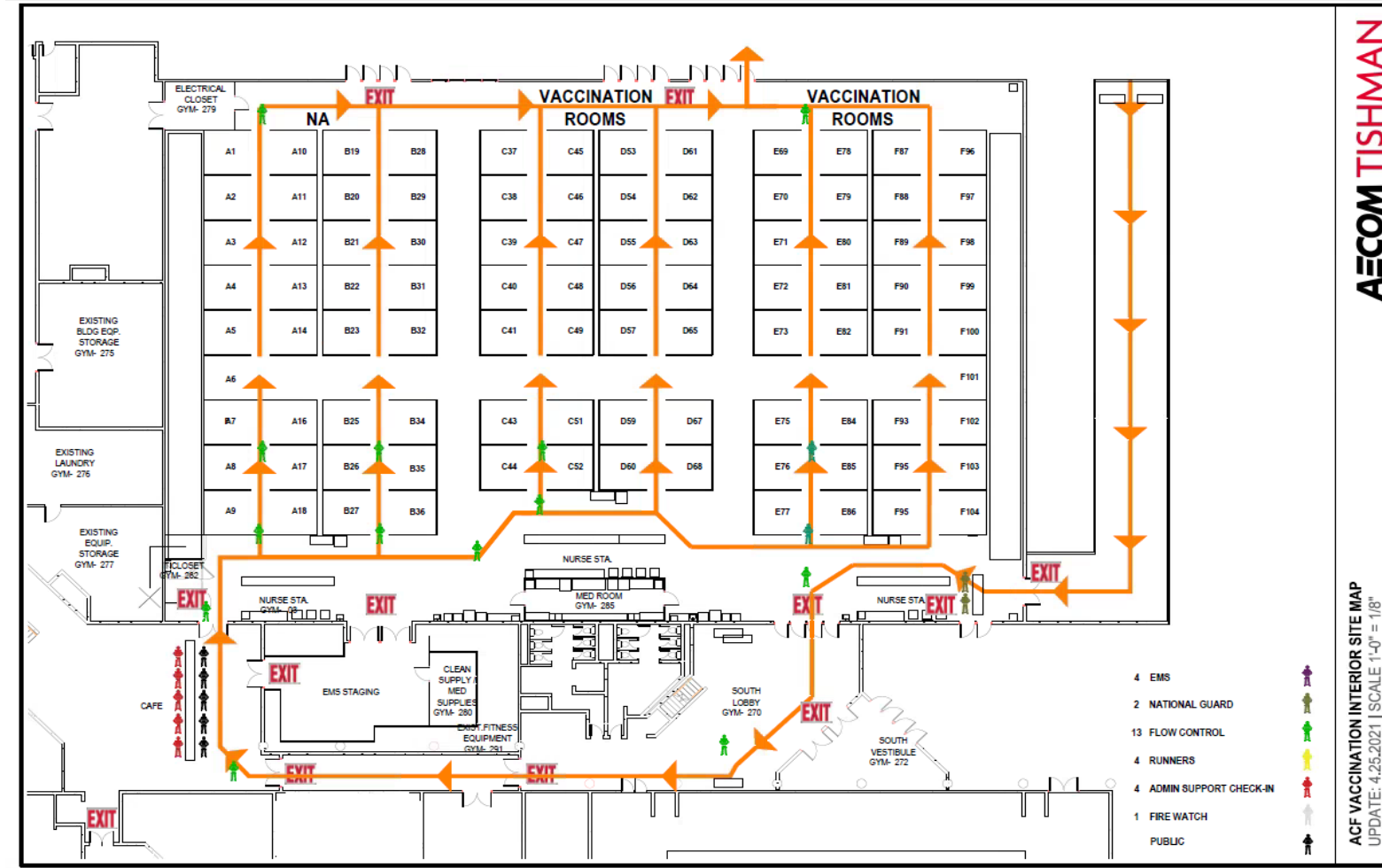
SUNY Old Westbury POD



SUNY Old Westbury POD Layout



Clark Gymnasium Layout



SUNY Old Westbury Challenges

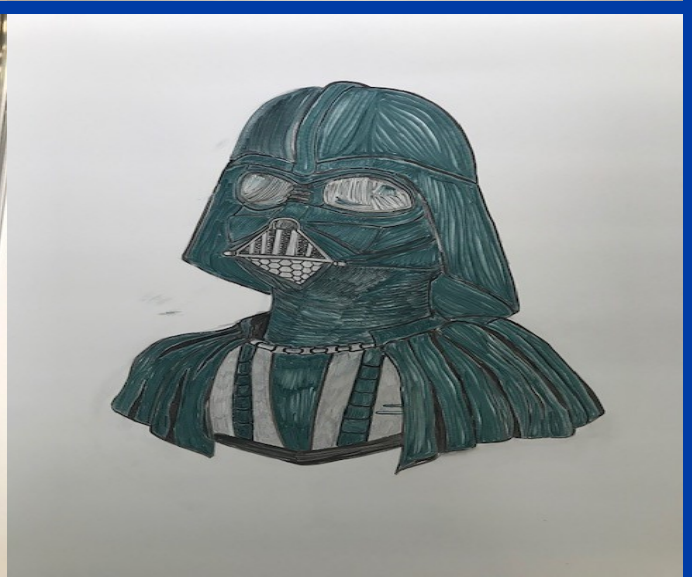
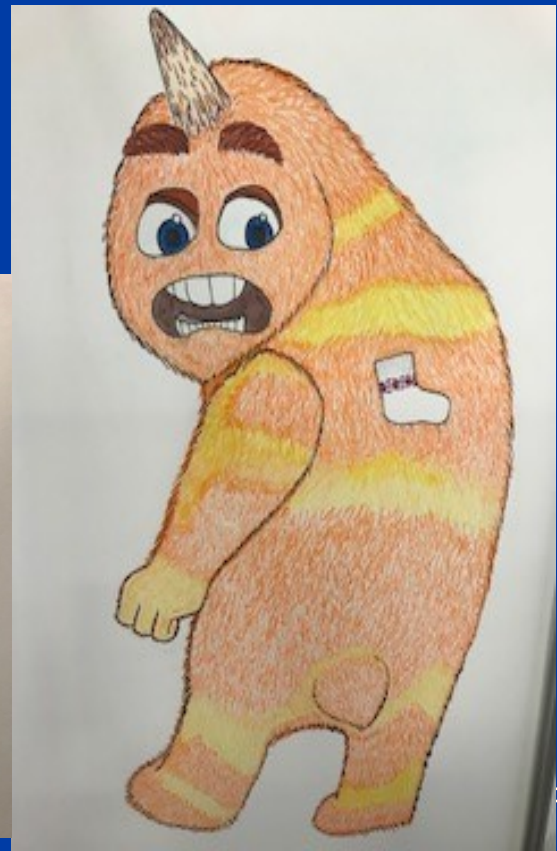
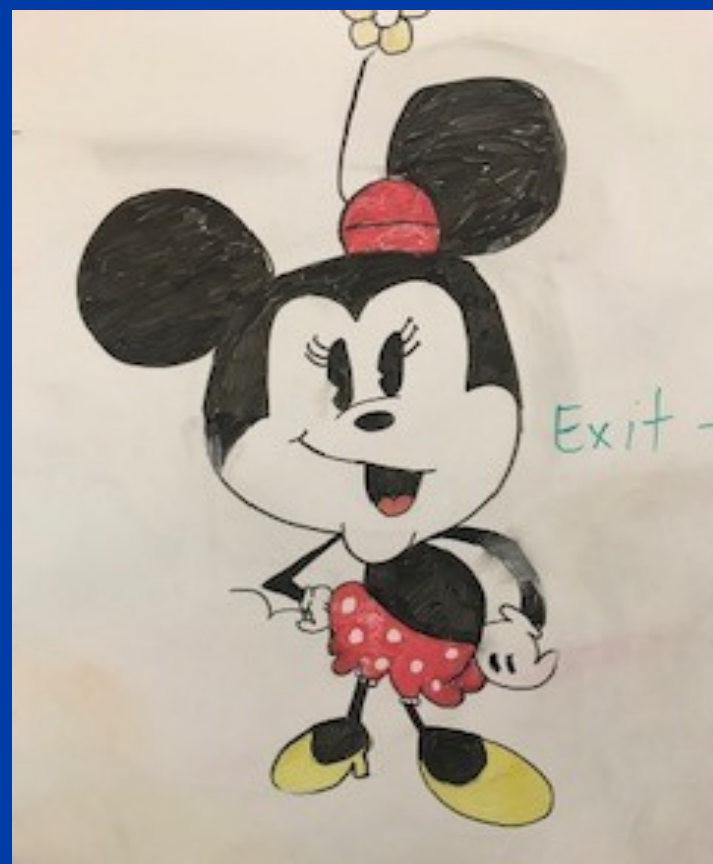
- CDC & State Guideline – Pfizer / J&J
- State CDMS System – Training / Daily Entries
- POD Layout – No observation area / HIPAA
- Initial Food Vendor - Morale
- Rotating Staff – Northwell & Leads
- POD Location – State appointment directions
- Policies, Procedures, and Plans
 - Active Shooter, Fire Safety, Service Animals, Lost/Found, Missing Children, Severe Weather, Lightning/Severe Winds, Traffic, Needle Sticks, EMS Transport

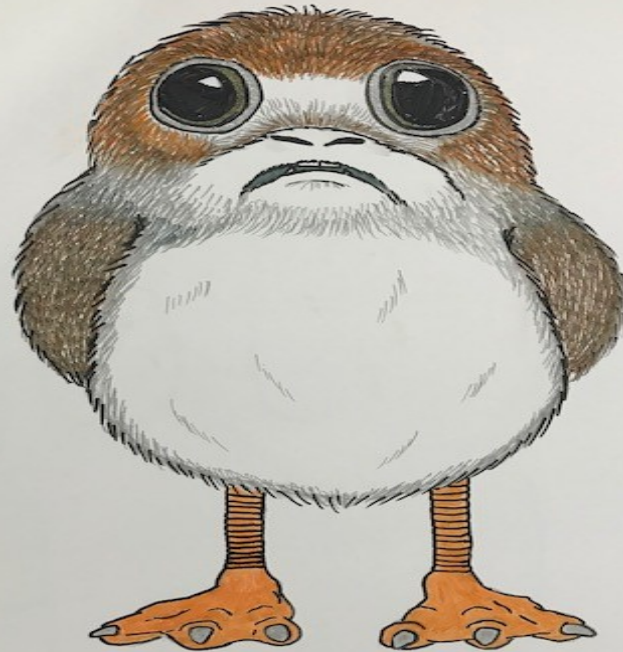
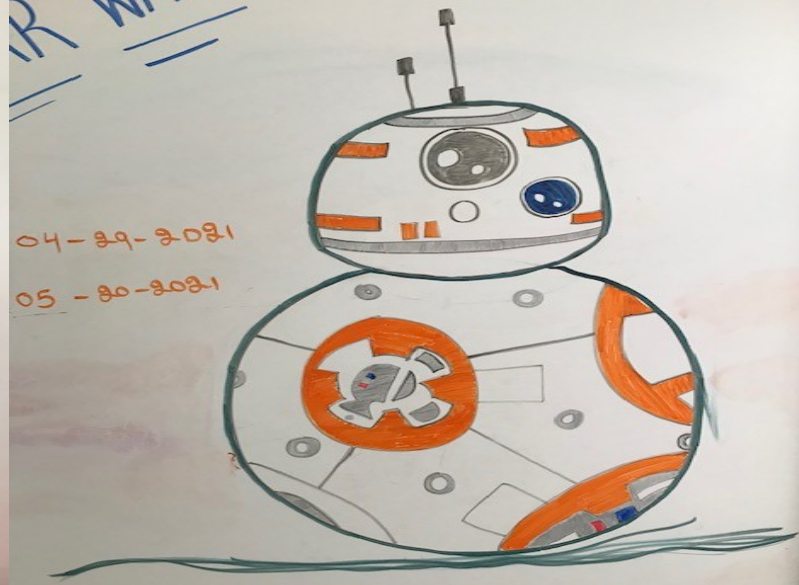
SUNY Old Westbury – What Worked

1. IAP were completed Saturday for the following week
2. Staff Check-In
3. Clinical and general briefings held each morning
4. Multiple Command Staff briefings each day
5. Good Communications among the leads
6. Colored Vests – Yellow, Green, Red, Blue
7. Language Line
8. Call buttons in pods
9. Radio communications for emergencies
10. Drawings on the pod walls

SUNY Old Westbury Lessons Learned

1. Use of the Incident Command System
2. Good communications between Section Chiefs was key to a smooth operation
3. Make sure all stakeholders have knowledge of changes at the site
4. Good food = good morale
5. Address any personnel issues immediately
6. Consistency among agency representatives cannot be stressed enough
7. Transmit all pertinent information during demob.







OUT



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VACCINATE



NEW

YORK

Thank You

