

# Emergency Preparedness Coordinating Council

October 27, 2021



**GREATER NEW YORK HOSPITAL ASSOCIATION**

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## Hospital Adaptation, Resilience and Regulatory Reporting Burden to the COVID-19 Pandemic: Progress to Date

- Dr. David Kaufman, Clinical Associate Professor of Medical Informatics at SUNY Downstate
- Dr. Yalini Senathirajah, Assistant Professor of Biomedical Informatics at the University of Pittsburgh

## The Upcoming Flu Season: What We Can Expect

- Dr. Mary Foote, Medical Director, NYC Department of Health and Mental Hygiene



# HOSPITAL ADAPTATION, RESILIENCE AND REGULATORY REPORTING BURDEN TO THE COVID-19 PANDEMIC: PROGRESS TO DATE

David Kaufman, PhD, Yalini Senathirajah, PhD

# COVID-19 Research Team

- Kenrick Cato, Ph.D., RN, CPHIMS, FAAN (Columbia University)
- Andre Kushniruk, PhD, FACMI(University of Victoria)
- Elizabeth Borycki, RN PhD FACMI, FCAHS, FIAHSI (University of Victoria)
- **Emergency Management Response Team**
- Bonnie Arquilla, DO, SUNY University Hospital Brooklyn, New York Institute All Hazard Preparedness
- Pia Daniel, MD, MPH, SUNY Downstate Medical Center
- Patricia Roblin, MS, SUNY Downstate Medical Center  
New York Institute for all Hazard Preparedness
- Claire Nurse, MPH, SUNY Downstate Medical Center
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BACKGROUND

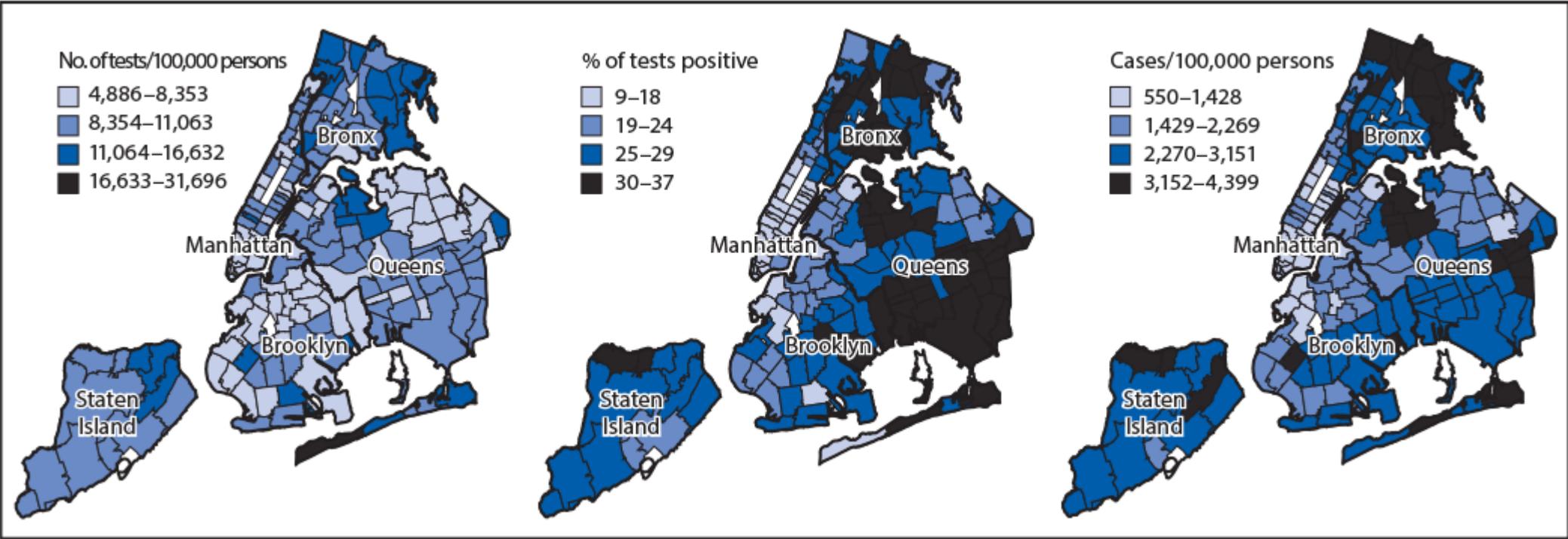


# The overall objective of this project is to examine hospital workflow during the COVID-19 pandemic response



- We use an evidence-based approach to support emergency management disaster response workflow, and more specifically, workflow around health information technology (HIT).
- We use a combination of theoretical frameworks grounded in literature associated with hospital resilience, human factors engineering, informatics, and decision-making science.

We are specifically focused on New York City, which was overwhelmed with an onslaught of patients who were severely ill from a poorly understood disease



Cumulative crude rates of COVID-19 testing per 100,000 population, percentage of tests positive for SARS-CoV-2, and cumulative crude rates of COVID-19 cases per 100,000 population,\* by modified ZIP code tabulation areas — New York City, February 29–June 1, 2020<sup>1</sup>

The University Hospital of Brooklyn (UHB) is a lower resourced safety-net hospital located in NYC and caters to a health disparities population



- Queens, Kings (Brooklyn), Bronx, and Suffolk Counties accounted for approximately 66% of NYS's total cases.
- Brooklyn has one of the highest rates of deaths, comorbidities (hypertension, diabetes, obesity), uninsured, and poverty in NYC exacerbating COVID-19's effect.

## Our project aims to answer the following questions:

How did hospital workflow change because of the pandemic? (Aim 1)

What are the applications, roles, tasks, information needs, communication modes, systems/tools, decisions, and the sequence of activities that characterize this change in workflow? (Aim 1)

How can we objectively model these changes to identify adaptations, challenges, barriers, and stress points? (Aim 2)

What HIT solutions (e.g., dashboards, visualizations, etc.) can address the experienced challenges and stress points and improve pandemic response and overall emergency management? (Aim 3)

While we are focused specifically on UHB, we also collected data from a larger network hospital, New York Presbyterian – Columbia University to serve as a comparison

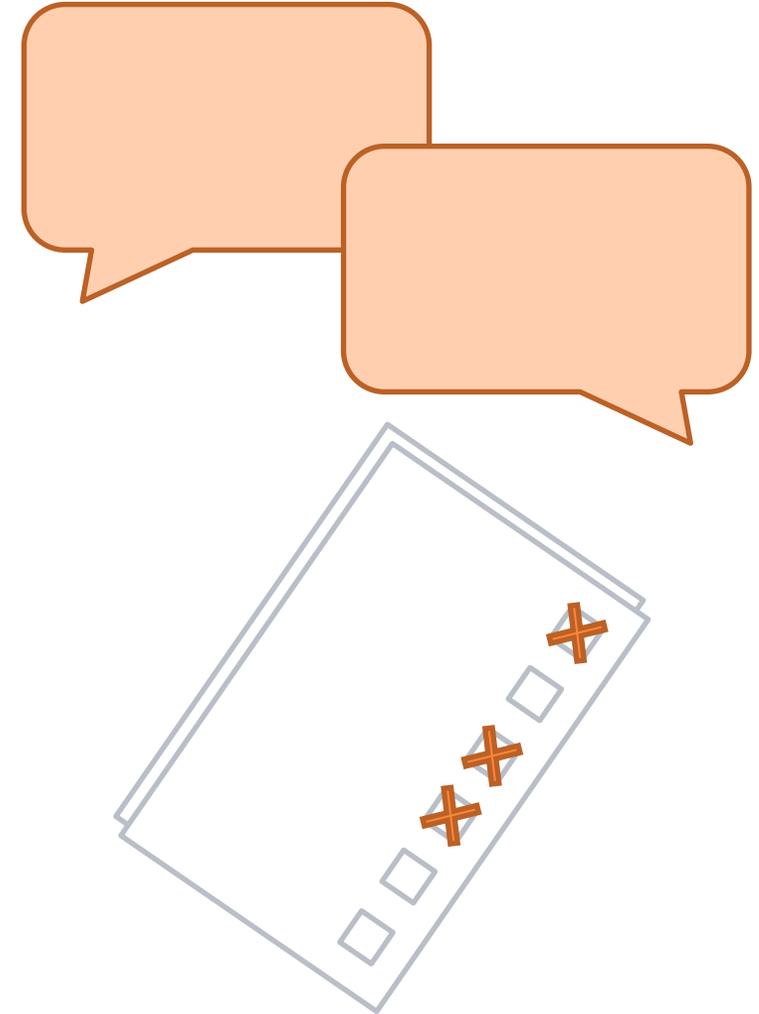


METHODS



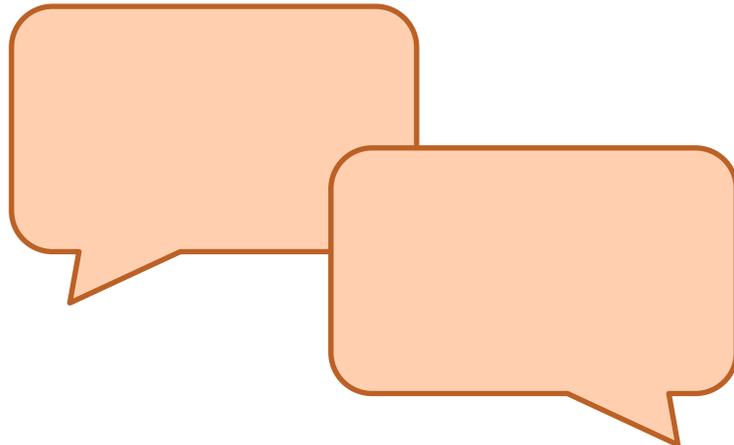
# Our methods involved a combination of interviews, observations, and a survey

- **Interviews (45–60 minutes)**
  - ▣ Emergency Management Response Team
  - ▣ Clinical and nursing leadership
  - ▣ Senior hospital administrators
  - ▣ Infectious disease and infection control staff
  - ▣ Pharmacy and lab/pathology staff
  - ▣ Supplies management
  - ▣ Respiratory therapy
  - ▣ Information technology team
- **Virtual Observations**
  - ▣ Staff performing related tasks
- **Survey**



Overall, we have conducted **47 interviews.**

- **30** with UHB
- **14** with NYP– Columbia
- **3** with external partners (e.g., Greater New York Hospital Association, NYC Department of Health and Mental Hygiene)

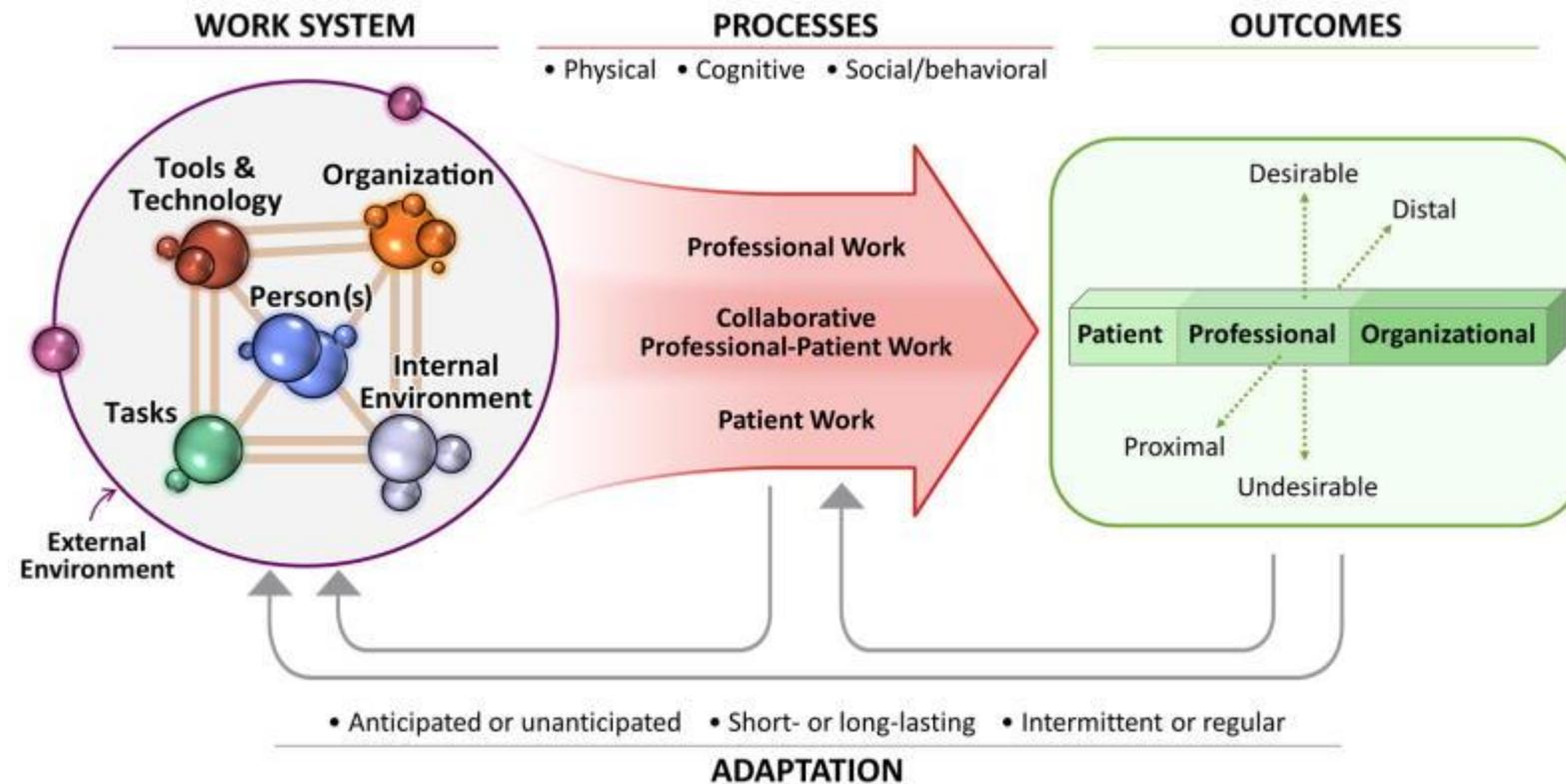


We interviewed and examined workflow changes across a range of domains and units, including but not limited to:



Lab Services and Information Systems	IT Reporting	Critical Care	Residency Training	Mental Health	Morgue
Supplies and PPE Management	Bed Management	Vaccination Workflow	Emergency Medicine	Emergency Response Team	Respiratory Therapy
Infectious Disease	Infection Control	Nursing	Telehealth	Contact Tracing	Surgical Care

The Systems Engineering Initiative for Patient Safety (SEIPS 2.0)<sup>2</sup> serves as a theoretical framework for our analysis and understanding of workflow.



Specifically, SEIPS served as a basis for **coding and gaining understanding of workflow from our interviews**, with the primary domains serving as our high-level codes (adapted slightly for our context)



**Person/Domain:** The unit of the hospital involved in the task (e.g., infection control) or an emergent process unit of focus (e.g., vaccine workflow).



**Tasks:** The actions taking place during the process of interest (e.g., data reporting) and characteristics of this task (e.g., data type).



**Tools and Technologies:** The digital and non-digital tools being used to during the workflow and tasks.

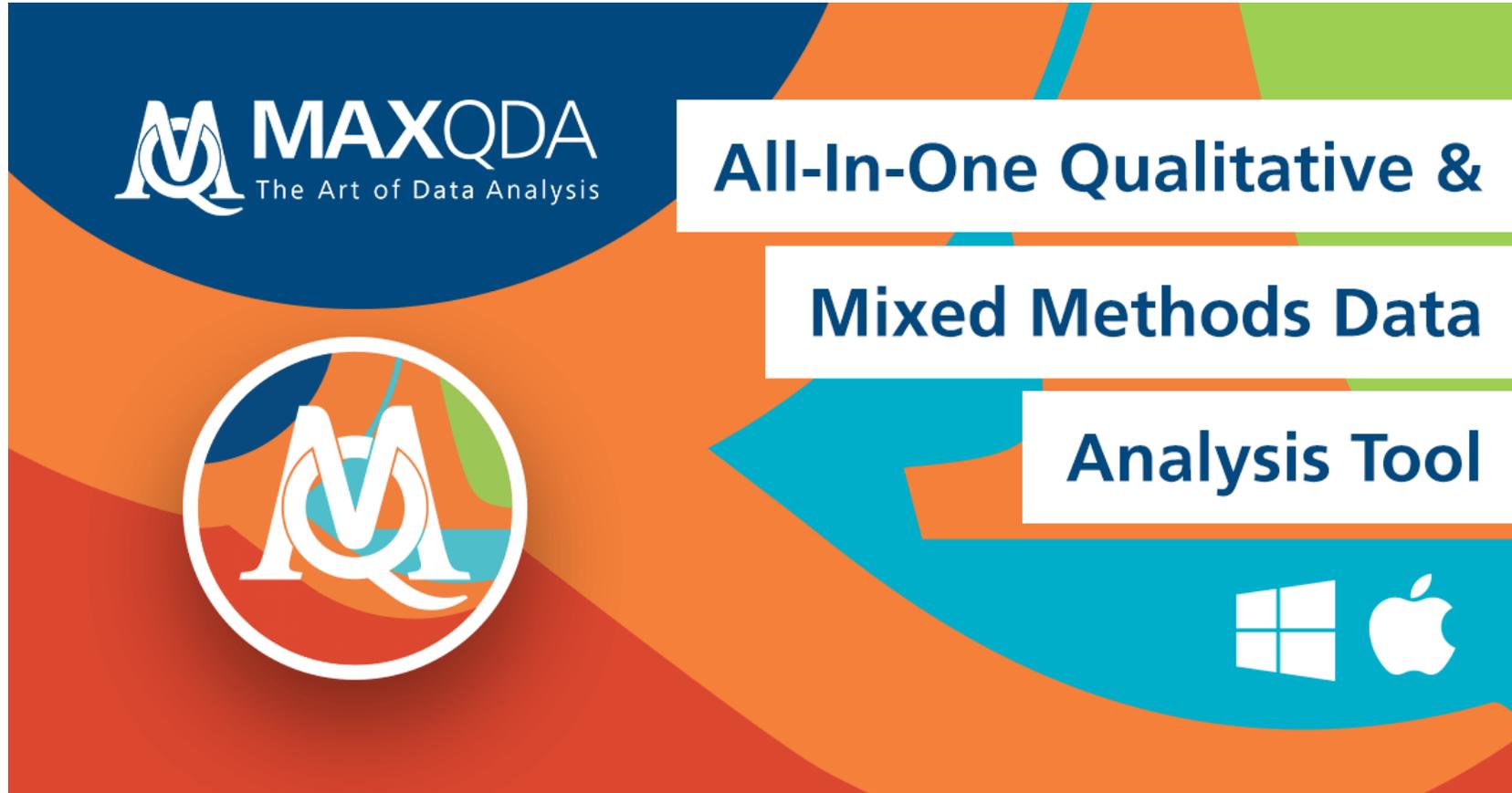


**Outcomes:** Impact of the task and workflow on patient, professional, and organizational outcomes (E.g., patient clinical status, staff burden, etc.)



**Internal/External Environment:** Physical characteristics of the internal space; external factors that influenced the workflow.

We analyzed our interview data using **MAXQDA** software, a powerful qualitative analysis tool with coding, text retrieval, and visualization capabilities. Specifically, we examined themes, frequencies, and code co-occurrences.



The graphic features a dark blue header with the MAXQDA logo and tagline. Below this, a large white arrow points from left to right, containing the text 'All-In-One Qualitative & Mixed Methods Data Analysis Tool'. At the bottom right, the Windows and Apple logos are displayed. The background is a colorful abstract design with orange, blue, and green shapes.

**MAXQDA**  
The Art of Data Analysis

**All-In-One Qualitative &  
Mixed Methods Data  
Analysis Tool**

Windows logo and Apple logo

# SUMMARY OF KEY FINDINGS



# We have identified some key themes and findings:

1. Hospitals were tremendously **burdened with data reporting requests** on COVID patients, supplies, staffing capacity, etc.
2. Hospitals did not always have access to the necessary data and information to promote **situational awareness**, a key component to effective emergency response and resilience
3. Hospitals underwent **reactive changes** to address challenges they could not prepare for or anticipate, including a massive redeployment of staff and resources
4. Not all hospitals have the **same HIT capacity, resources, and infrastructure** to meet the intense data and information demands necessary for effective pandemic response
  - ▣ Significant institutional inequity problem

# “One Rich NY Hospital Got Warren Buffett’s help. This One Got Duct Tape.”



The New York Times

PLAY THE CROSSWORD

Account

One Rich N.Y. Hospital Got Warren Buffett's Help. This One Got Duct Tape.

The inequities of New York City's health care system are clear at a public hospital in a section of Brooklyn hit hard by the coronavirus pandemic.

# KEY FINDINGS

REPORTING BURDEN

The hospitals were required to complete multiple extensive reports on a weekly, daily, or semi-daily basis.



CARES Report

HAN

HERDS Critical Assets Survey

HERDS FEPA

SitSat

FEMA COVID Testing

HERDS COVID Census

HERDS Influenza

HERDS PPE/Supplies

Tele-Tracking

VAERS COVID Vaccine

COVID Vaccine CIR Database

CARES COVID 7 Questions

Lab Capacity

OCME Morgue Census

HERDS Pediatrics

COVID Vaccine NYS

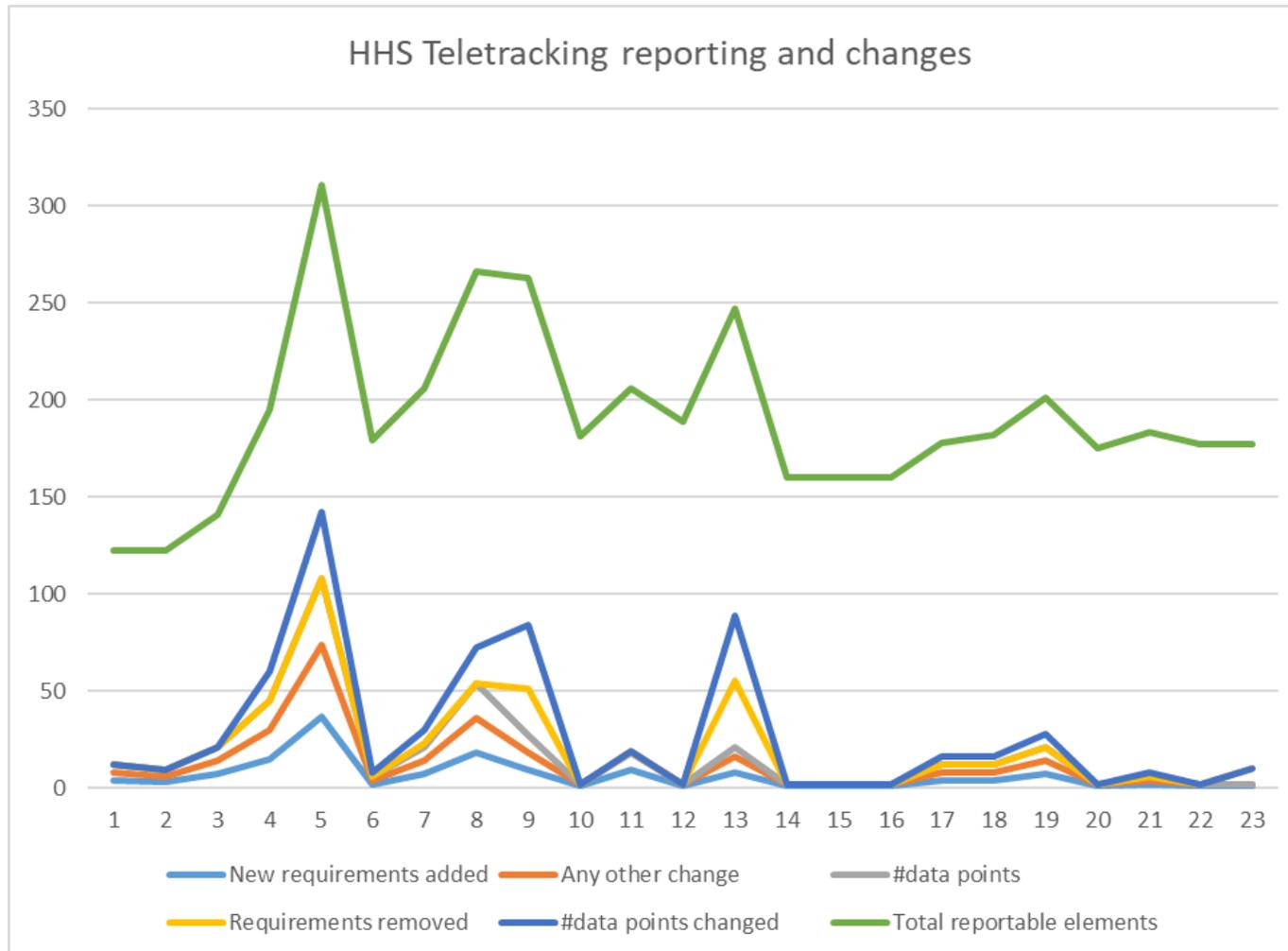
Remdesivir

And more...

Interviewees most often talked about the HERDS reporting required from New York State, indicating that reporting burden was mostly driven at the state level

Code System	ExternalEnv	OtherOrgs	Local	State	National	International	CityLocalGov	StateGov	FedGov
Tasks		1					1	4	2
Info_Need							1	2	3
InfoType									
PPEAmount							1	4	3
Deaths								2	1
PatientCensus					1			2	4
COVIDTests		7	2		2		3	14	6
Staffing									
Supplies		2							
Medication									
Exposure								1	
Vaccination									1
Predict			2						
InfoGather		3	2	1			6	11	8
InfoReport		6		1	1		11	70	31
SitAware		5	3	1			1	7	3
Easy									
Burden		6					3	20	6

We believe reporting was cited as being burdensome because of its frequent changing questions, non-standard definitions, and length.



Areas of the hospital most burdened by information reporting tasks were the **IT department, PPE and supplies management, vaccine management (Pharmacy/Nursing), and infection control** teams who often had to do this reporting on top of their normal responsibilities

*“For the Department of Health in New York State, they want the report at a set time. If you don't put it in at that time, you get penalized and it's a huge fine for the hospital. So now we have to meet all the mandates together with meeting your primary responsibilities before COVID, right?”*

*“When we got the vaccine, the governor threatened, I think it was a million-dollar fine if the vaccine went to a person who wasn't within the 1A category of essential healthcare workers. But at the same time, the Department of Health was saying, we gave you vaccine and if you don't use it within, I think it was five days, we're gonna punish you. They're heavy-handed.?”*

# And it Continues

*“Well, so since the vaccine mandate, September 27th, the questions began to involve how many of your staff are eligible, how many have declined, how many are medically eligible, how many have applied for other exemptions, how many of them are off service now, how many of them are furloughed as a result of a positive COVID test”*

Burden was amplified by the fact that data reporting was largely manual, especially for reporting COVID tests.

*“We have a number of machines that are not interfaced yet with our EMR for one technical reason or another, and so instead the technician is responsible for manually entering in each results”*

*“We have to extract it, so it's not a 100% full-proof process, sometimes you have to do manual extraction, which is very tedious, and that takes the whole time. So between nine to one-o-clock, that's what we're working on.”*

# Challenges to Public Health Reporting Experienced by Non-Federal Acute Care Hospitals, 2019 (ONC)

- Half of all hospitals reported a lack of capacity to electronically exchange information with public health agencies
- Small, rural, independent, and Critical Access hospitals more likely to experience public health reporting challenge
- Interface issues and different vocabulary standards presented significant problems
- Difficulty extracting relevant information from electronic health records
- Significant variation among states

# Lessons Learned: Hospital and Health System Data Collection & Data Use (GNYHA)

- Burden of data collection on hospitals and health systems should be balanced with need
  - ▣ Data to characterize impacts to the health system
  - ▣ Inform operational actions of key response partners
- Alignment (including standardized definitions) and reduction of redundancy among data collection systems should be a goal
  - ▣ Across local, State, Federal, and non-governmental systems
- Frequency of data collection should be reviewed regularly.
  - ▣ During crisis situations, daily data collection may be necessary.
  - ▣ As the situation stabilizes and potential risks reduced, data collection frequency should be reduced to decrease the burden



HOME

TECHNICAL RESOURCES ▾

ASSISTANCE CENTER ▾

INFORMATION EXCHANGE ▾

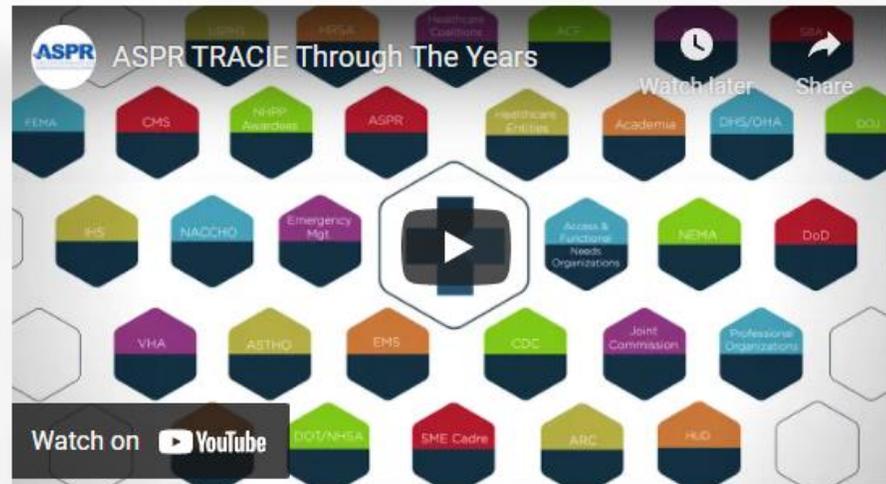


REGISTER

LOGIN

# WELCOME TO ASPR TRACIE

Brought to you by HHS ASPR, the Technical Resources, Assistance Center, and Information Exchange (TRACIE) was created to meet the information and technical assistance needs of regional ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness.



TIMELY. ACCURATE. ACCESSIBLE.

# THE NEW WORLD OF PUBLIC HEALTH DATA

CDC is building a digital public health superhighway to accelerate lifesaving prevention and response.

## THE REALITY



## THE OPPORTUNITY

**REACTING**  
Always behind when epidemics occur



**PREDICTING**  
Getting ahead of epidemics to stop them quickly

**COUNTING**  
Collecting data without the ability to rapidly analyze it



**UNDERSTANDING**  
Rapid data analysis to gain real-time insights

**STORING SEPARATELY**  
Siloed systems that restrict data sharing



**SHARING EFFECTIVELY**  
Interoperable, accessible data for action

**MOVING SLOWLY**  
Outdated, paper-based systems with multiple points of data transfer



**MOVING FAST**  
A true digital highway to automate transfer of critical data in real time

**USING RESOURCES INEFFICIENTLY**  
New resources always required to do new data collection



**CONNECTING RESOURCES**  
Leveraging existing resources and making common investments for the future

# KEY FINDINGS

ESTABLISHING SITUATIONAL AWARENESS

# Establishing Situational Awareness

- *“I mean, we looked at it every day, we had conference calls multiple times every day to see what the censuses were.”*
- *“Nobody's analyzing the cases as they come into the hospital, what's their O2 stat in an aggregated way? How sick are they? Are they having fevers? Are they getting discharged? How long has it taken for them to be discharged? I would be really interested in that sort of thing to understand the complexion of the epidemic.”*

Huddles and other forms of formal communication were essential to establishing situational awareness for the hospital

*“Besides going around to the units and doing just-in-time conversations with them, is that we had a weekly huddle with our nursing team, the leadership, so they know this is where we are based on the huddles.”*

*“So when I come in a morning and we have a 7:30 am huddle, all the managers, they call in by phone, I'm present in the office to take over from the outgoing person, and I would go over the census and what the staffing is.”*

*“I would say the huddle every week, keeping those lines of communication open has been incredibly valuable.”*

Dashboards and visualizations were cited as being both helpful in establishing awareness but could be improved upon

*“On that dashboard, I do have, what I look at historically was the burn rate, a low burn rate of what we had at one point and what was the highest burn rate, and on that dashboard I calculate our current inventory.”*

*“It'd be also nice to have longitudinal data, of course as well, so taking a look at how things have evolved over the past week over the past month, over the past two months, just to see how those things have changed over time, so I've heard mention of a dashboard, but I haven't seen it implemented yet.”*

# KEY FINDINGS

REDEPLOYMENT AND RESILIENCE

The biggest change in workflow/process was around redeployment of staff from typical responsibilities.

“We didn't even know what it meant to be anointed, a covid only hospital. ...Would we get bus loads of people? We immediately had to draft scenarios. We have our main hospital and a surgery center a couple of miles away; and we drafted two different models for each site, what if we were a covid only hospital at 50% critical care level, and then 80% critical care level; what would we need?”

PPE and supplies management most often cited making reactive changes to unanticipated challenges

*“I think I'm still suffering from post-traumatic stress disorder from trying to make sure that we had enough PPE. ... we were calling all over the country looking for proper PPE, talking to very shady people.”*

*“People thought we had an unlimited supply of PPE and saying that you have 30,000 isolation gowns. When you're burning through 3000 a day, thinking 30,000 is a lot, you tell them you burnt 3000 a day, was very useful information for the clinicians to understand that we need to conserve, 30,000 sounds like a big number.”*

# KEY FINDINGS

HEALTH INFORMATION TECHNOLOGY INEQUITY

# Larger network hospital had greater HIT capacity, infrastructure and resources which enabled their COVID response



1. The network hospital had a dedicated analytics team that could manage data aggregation and reporting, reducing burden on other staff.
2. The network hospital had a centralized data warehouse that automatically updated, reducing the need for manual searching and compiling of data for reports
3. The network hospital had an EMR that generated reports that anyone could access, not just the IT team or specific departments

# Safety net hospitals lack basic IT infrastructure and resources.

- UHB had to manually transport test results from the lab, leading up to almost 12-hour delays.
- In contrast, NYP has a 50-person analytics team and 6 AI faculty to advise predictive analytics. They have had automated aggregation and centralized data warehouses for >20 years.
- Pulling frontline clinicians from clinical duties to manage and extract data has consequences for patient care (e.g., infection control staff, nursing staff). Clinical **department leadership**, such as the Director of Infection Control, were often spending the time completing these manual and clerical tasks.

# HIT: Facilitators vs Challenges

## Columbia NYP

Code System	Resilience	Facilitator	Challenge
Resilience			
Facilitator			
Challenge			
TechTools		18	
Dashboard/Visualization			
Non-Digital			
Digital			
Automated		4	
Manual		1	
Tool			
Teams			
Pen/Paper			
Excel			
EHR		11	2
Website			
Theradoc			
PotentialSolution		1	1

## UH Brooklyn

Code System	Resilience	Facilitator	Challenge
Resilience			
Facilitator			4
Challenge		4	
TechTools			
Dashboard/Visualization			
Non-Digital			
Digital			
Automated			1
Manual			1
Tool			3
Teams			
Pen/Paper			
Excel			2
EHR			3
Website			
Theradoc			
PotentialSolution		1	6

# Facilitators vs Challenges

- *“I would say that if there's a system where I don't need to call IT to generate the report and there's a way that I can go in, click a few things and I get my report. It's an electronic system. Why do I need to wait to go to [redacted], do all the specs and so on to get what I need when I'm sure there's an access type database. I don't know, I'm not a computer person.” SUNY/UHB*
  - *“There was also ambitions early on to automate the transmission of information once a case was reported but due to a lack of, I would say technology, but also time and skill set of the people involved, it didn't happen.” SUNY/UHB*
- 
- *“So thankfully, most of that was done by our information technology and analytics group for the hospital. So they also had to sort of kick into high gear to fulfill all of those reporting requirements.” CUIMC*
  - *“So a specific dashboard...that helped us make some informed decisions about what was going on with respect to the volume of COVID patients, inpatients versus not. So that, we really relied on that information.” CUIMC*

# IMPORTANCE AND IMPACT OF HIT

Solution Strategies Moving Forward

# Technology tools for pandemic/ emergency response

- Based on our findings, there are needs for:
  - ▣ Dashboards based on real time data
  - ▣ Data extraction automation
  - ▣ Administration council early morning data counts
  - ▣ Clinical – tracking patient location and basic conditions (available to residents and all other clinical staff) → also dashboards

# Technology tools for pandemic/emergency response

- Based on our findings, there are needs for:
  - ▣ Regional data sharing including PPE, beds, patients, other resources
  - ▣ Connection of systems to reduce silos and streamline workflows
  - ▣ Education of staff about their existing data infrastructures, including resources they may not be aware of
  - ▣ Training of ordinary staff in informatics skills for use in emergencies
  - ▣ Incident command center with potential to act immediately
  - ▣ Formulation of an emergency informatics corps?

# Clinical Tracking

- Teams – ‘cards’ used to track patient progress in rounds, location-specific
- NORA – chatbot to retrieve patient data from Allscripts, via chat
- Post to White Board via text
- Needs:
  - ▣ Ideally, can be done from mobiles
  - ▣ Dissemination to specific groups and pan-hospital
  - ▣ Location, patient basic data, problems
  - ▣ Rapid counting for decisions

# Motivation

## Ensemble Forecasts

### National

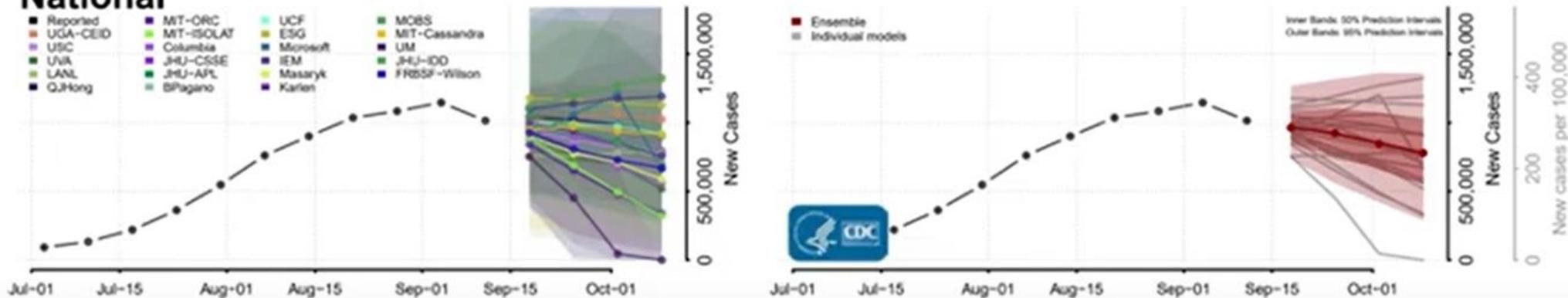


Image: CDC

- Ensemble prediction done on September 15, 2021
- On September 25, 2021, according to CDC, the new case rate per 100,000 is 241

# Future Directions

- We are at a planning stage
- **Health IT disparities as basis of and reflecting other disparities**
- High level conversations with administration
- Leapfrog – openEHR?
- Covid tracking systems
- Equity, equitable resources, what is the minimum?
  - ▣ Government mandates sometimes presume a level of technology existing without aid, e.g., the EHR API/FHIR mandate
- Need for an informatics emergency corps?
- Rating hospitals readiness a la HIMSS
  - ▣ Include scale examples
  - ▣ Philosophy – rerouting approaches
  - ▣ Are there ways to feed back to regulators/policy makers?

# To address institutional inequity, we first need to be able to measure it

- Institutional inequities are significant obstacles for emergency preparedness
- We need a measure of HIT emergency preparedness
- The analogy is HIMSS EMR Adoption Model Stages
- Understanding the dimensions of the problem in specific terms will enable government agencies to adjust their reporting demands
- It provides guideposts or targets for future initiatives

# Rubric for Pandemic Preparedness

- How automated is data extraction?
  - ▣ What data must be manually copied?
- How much clinical staff time is taken in extraction and reporting?
- How much time, staff is required for each typical new data request?
- Are all clinical systems networked with each other?
- In a federated system, is all information available for summarization in dashboards and/or clinical data warehouses for analysis?
- Does the institution have at least one dedicated analytics person who can be deployed full-time in an emergency?
- Is there redundancy in the system if part of it should fail?

# Rubric for Pandemic Preparedness

- ❑ Is the institution regionally networked in order to share experience and resources, and allow predictions? (in NYC GNYHA has a role)?
- ❑ Are there numerous people trained in analytics and generating reports?
  - ❑ so that there is analytics capacity even if staff are out?
- ❑ Are there alternate routes to acquire data if the usual ones are down?
  - ❑ systems of data capture and sharing via mobiles,
  - ❑ Teams lists, Whatsapp groups
- ❑ Are institutions able to view their own data and that of regional neighbors and participate in joint predictive modelling, resource sharing, tool sharing, and other desirable goals?

# Interoperability less an issue for well-resourced institutions. Safety-Net Hospitals don't have same capabilities

- Large networks may have decision making for larger group, but have better access to resources and capacity.
- Many hospitals simply don't have the resources to implement interoperability mandates, despite ONC policy.
- Across the US, we have 90% EHR penetration because it was paid for, but this same funding isn't being provided to improve interoperability.

# Suggested Design considerations.

- **Shift to nonprogrammer end users**
  - ▣ Allows broader range of staff to do things in an emergency (e.g., when people with high level skills are unavailable, unaffordable, or occupied)
  - ▣ In non-emergency times smoothens out information system functioning and ability to deliver care and make decisions [i.e. should be part of normal way it functions]
  - ▣ Analytics tools that are user-friendly such as Tableau, others, exist [include small training programs for broad staff]

# Survey

- The survey constitutes the next phase of our research and represents an attempt to test the generality of our findings and capture clinicians' and nonclinical staff's experience during the pandemic. The survey asks questions pertaining to a) the individual's role at their institution and how it may have changed, b) hospital pandemic response, c) IT needs during the pandemic, d) hospital adjustments made in response to COVID. The final phase of our research is to fashion digital health solutions with our collaborating partners to better meet information needs and guide decision-making. This survey will assist us in furthering those objectives. It is entirely anonymous and can be completed in about 15 minutes.

[https://downstate.columbia.edu/qualtrics.com/jfe/form/SV\\_3ZXGs7pAKCtGVRs](https://downstate.columbia.edu/qualtrics.com/jfe/form/SV_3ZXGs7pAKCtGVRs)

THANK YOU!

Questions or Comments?

# Flu Season Resources from CDC

Influenza (Flu)

Seasonal Influenza (Flu) > Health Professionals






🏠 Seasonal Influenza (Flu)

- About Flu +
- Who is at Higher Risk of Flu Complications +
- This Flu Season +
- Prevent Flu +
- Flu Vaccines Work +
- Symptoms & Diagnosis +
- Treatment +
- Schools, Businesses & Travelers +
- Flu Activity & Surveillance +
- Health Professionals -**
- 2021-22 ACIP Summary +
- Vaccination +
- Information for Clinicians on Influenza Virus Testing -**

## Information for Clinicians on Influenza Virus Testing

[Español](#) | [Other Languages](#)

Testing and treatment of influenza when SARS-CoV-2 and influenza viruses are co-circulating

- **New** [Consolidated Clinical Algorithm for Outpatient Clinic or Emergency Department Patients with Acute Respiratory Illness Symptoms \(With or Without Fever\)](#)
- **New** [Clinical Algorithm for Outpatient Clinic or Emergency Department Patients with Acute Respiratory Illness Symptoms \(With or Without Fever\) Not Requiring Hospital Admission](#)
- **New** [Clinical Algorithm for Patients with Acute Respiratory Illness Symptoms Requiring Hospital Admission \(With or Without Fever\)](#)
- **New** [Testing and Management Considerations for Nursing Home Residents](#)

What Influenza Virus Tests Are Available

- [Overview of influenza tests](#)
- [Influenza Virus Testing Methods](#)
- [Table 1: Influenza Virus Testing Methods](#)
- [Table 2: FDA-cleared and Available Rapid Influenza Diagnostic Tests](#)
- [Table 3: FDA-cleared Nucleic Acid Detection Based Tests for Influenza Viruses](#)
- [Table 4. Multiplex Assays Authorized for Simultaneous Detection of Influenza Viruses and SARS-CoV-2](#)
- [Information on Rapid Molecular Assays, RT-PCR, and other Molecular Assays for Diagnosis of Influenza Virus Infection](#)
- [Information about Rapid Influenza Diagnostic Tests](#)

<https://www.cdc.gov/flu/professionals/diagnosis/index.htm>

# Flu Surveillance Resources



WHO Weekly surveillance reports

- <https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring/influenza-updates/current-influenza-update>

CDC Fluvview

- <https://www.cdc.gov/flu/weekly/index.htm>

NYS Weekly flu reports (not activated yet)

- <https://www.health.ny.gov/diseases/communicable/influenza/surveillance/>

NYC Weekly flu reports (not activated yet)

- <https://www1.nyc.gov/site/doh/providers/health-topics/flu-alerts.page>

# GNYHA Updates

# Surge & Flex Comparison Chart



- Details NYS regulations related to Section 360.2 Surge and Flex Health Care Coordination System Requirements
  - Compares previous directive (8/6/20) with current directive (7/30/21)
  - <https://www.gnyha.org/wp-content/uploads/2021/09/Surge-Flex-comparison-chart-FINAL.xlsx>

TOPIC	PREVIOUS DIRECTIVE (8/6/2020)	CURRENT DIRECTIVE (7/30/2021) - Underscored matter is new, deleted matter appears with a strikethrough
<b>SECTION 360.2. SURGE AND FLEX HEALTH CARE COORDINATION SYSTEM REQUIREMENTS</b>		
In the event of a declared state disaster emergency, the Commissioner shall have all necessary authority to activate the Surge and Flex Health Care Coordination System (hereinafter "Surge and Flex System"), including the following:		
<b>INCREASE BED CAPACITY</b>	At the Commissioner's direction, health care facilities shall increase by at least 50% and up to 100% the number of acute care beds and/or change the service categories of beds certified or otherwise approved in any entity regulated by the Department	At the Commissioner's direction, <u>which shall be incremental and geographically targeted</u> health care facilities shall increase <u>by up to 50%</u> the number of acute care beds and/or change the service categories of beds certified or otherwise approved in any entity regulated by the Department
<b>ELECTIVE PROCEDURES</b>	At the Commissioner's direction, health care facilities shall postpone all non-essential elective procedures or allow such procedures only pursuant to such conditions as the Commissioner may determine	At the Commissioner's direction, health care facilities shall postpone <u>up to 100%</u> of non-essential elective procedures or allow such procedures only pursuant to such conditions as the Commissioner may determine
<b>ENHANCED STAFFING CAPACITY</b>	Health care facilities shall establish plans to meet enhanced staffing levels sufficient to ensure that the increased bed capacity has adequate staffing. The Commissioner may further expand or modify criteria for staffing. Health care facilities shall have access to a state run portal for staffing needs identifying both volunteers and available staff; whether licensed or registered in New York State, or authorized or licensed to practice in any other state or Canada.	No change

# Sit Stat In Use Over the Past 3 Months

*July 27<sup>th</sup> – October 26<sup>th</sup>*



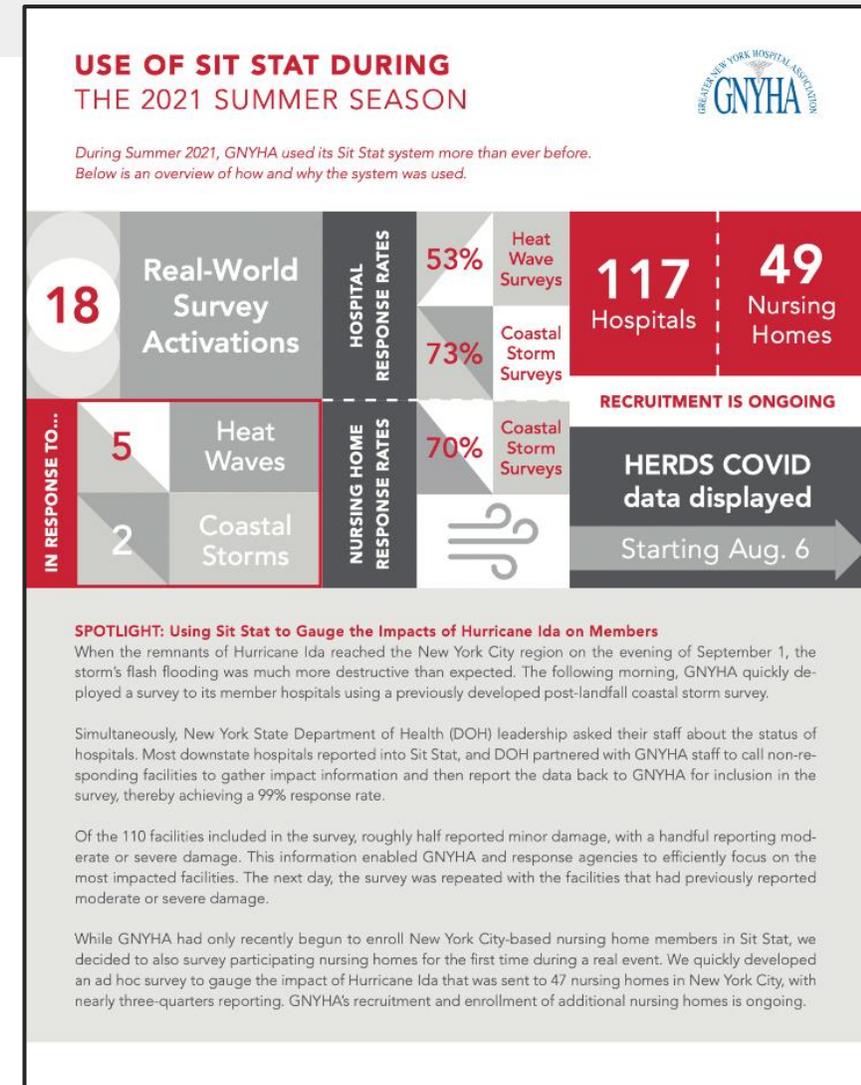
# Sit Stat Use in Response to 2021 Summer Hazards



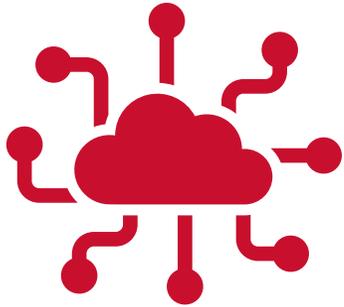
## Use of Sit Stat During Summer 2021

20 June 2021 – 22 September 2021

Real World Survey Activations *in response to 5 heat waves, 2 coastal storms	<b>18</b>
Hospital Response Rate Heat Wave	<b>53%</b>
Coastal Storms	<b>73%</b>
Nursing Response Rate Coastal Storms	<b>70%</b>
Summer Hazard Survey Drills	<b>4</b>



# Sit Stat Bed Data Automation Efforts



## Sit Stat 3.0 Rollout Status

- Bed management system integration project to facilitate collection of real-time bed data
- **19 hospitals** enrolled
  - All hospitals actively sending data
  - Ongoing quality assurance
- Visit GNYHA's [website](#) to learn more
- Submit an online enrollment [form](#)



## Collaboration with NYS DOH

- Hospital Capacity Direct Access (HCDA) Pilot
- Utilizing EMResource, the same underlying platform Sit Stat is built on
- DOH working on standardized bed definitions
- GNYHA working closely with DOH to coordinate efforts

# Other Data Automation Initiatives



## ED Capacity Metric

- Workgroup co-led by GNYHA and NYC FDNY
- Developing a regional ED capacity metric to be used as a comparison across facilities as well as a tool to track individual facility capacity over time
- Potential to inform daily and emergency event EMS transport decisions, EMS redirection, regional load balancing, and internal monitoring
- Workgroup reviewed existing metrics and assessed their applicability to NYC
- Drafted a tailored metric and beginning initial data analysis and testing phases

## NYC Burn Bed Availability

- GNYHA and FDNY met with burn centers September 15<sup>th</sup>
- FDNY to survey burn centers to better understand capacity, capabilities, and current reporting practices in order to standardize current reporting
- Plans to incorporate burn bed reporting into Sit Stat via manual data entry, then via automated bed management integrations
- Once Sit Stat-CAD integration is complete, burn bed data can be automatically pushed into CAD via Sit Stat

# Sit Stat Data Collaboration Efforts



## NYS DOH Critical Asset Survey (CAS)

- Incorporation of key CAS data elements into facility detail views in Sit Stat
- GNYHA requested facility permission to access and display facility data
- Currently working to upload data and will periodically obtain data from NYS DOH to make updates



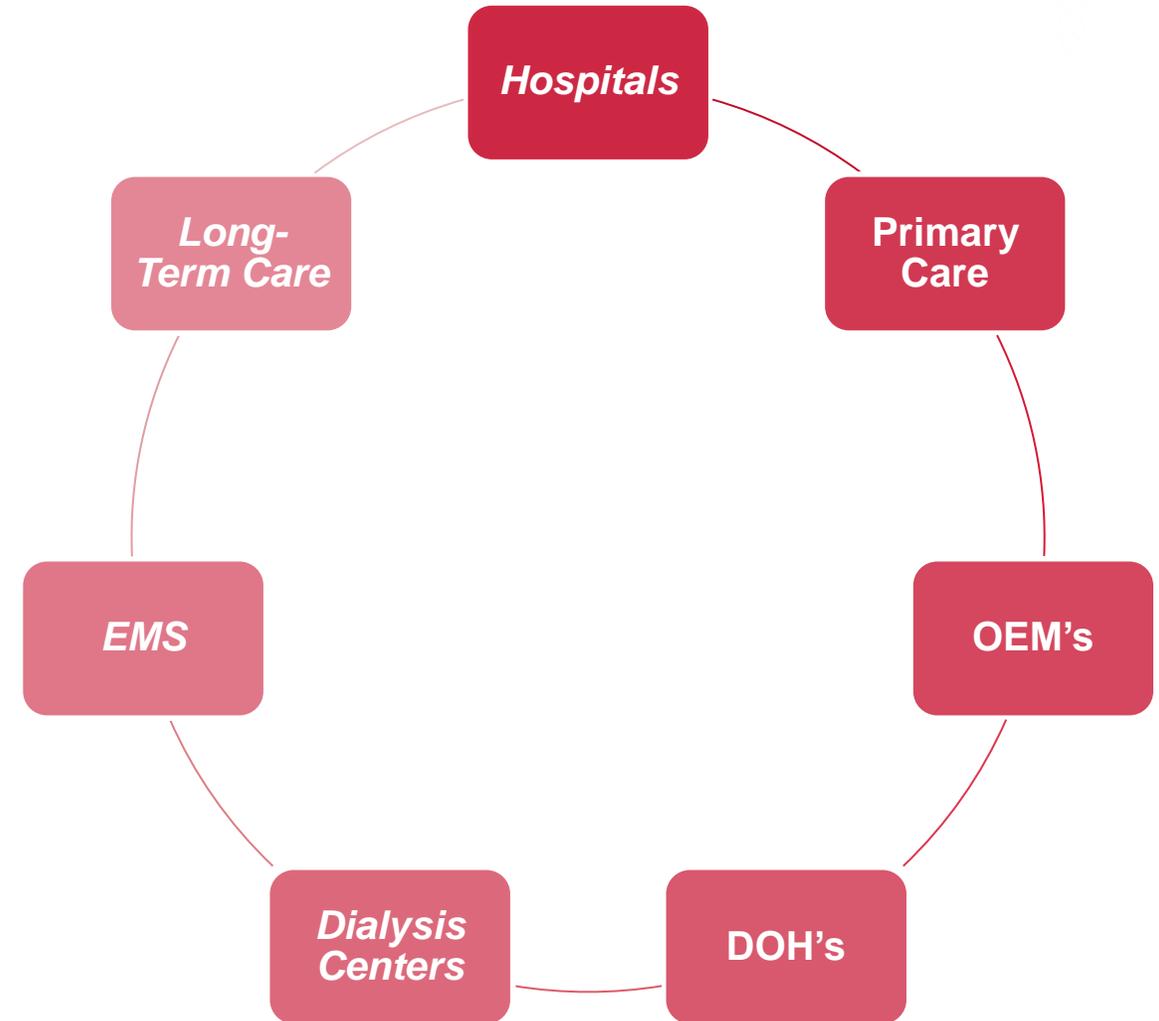
## NYC DOHMH Health Facility Directory (HFD)

- Integration of NYC DOHMH HFD into Sit Stat
- NYC facilities required to update/verify information as part of an HPP deliverable; deadline of October 29<sup>th</sup>
- Loading dock address and key contacts for departmental directors (Infection Control, Infectious Disease, OBGYN, Pediatrics, Neonatology, Medical Records, Pharmacy)

# Regional Situational Awareness Strategic Assessment Initiative



- Partnership with NYC DOHMH to enhance regional situational awareness and information sharing capabilities
  - Primary focus on downstate region, but including state-level partners
- **Areas of Focus**
  - Identify current data collection and information sharing capabilities and gaps
  - Identify opportunities to connect existing systems and processes, implement new ones where needed, and coordinate future efforts
  - Develop 5-year strategic plan to integrate key sectors and partnering agencies
- **Participating Entities**
  - **Hospitals** – HANYS, Suburban Hospital Association, health systems, independent hospitals
  - **Long-Term Care** – GNYHA CC, GNYHCFA, SNYA, NYSHFA
  - **Primary Care** – CHCANYS
  - **Dialysis** – North Help, NYS IPRO
  - **Regional DOHs, OEMs, and EMS Agencies** – NYC, Nassau, Suffolk, Westchester
  - **State Agencies** – DOH and DHSES



# Other Efforts & Initiatives



## GNYHA

- Pre-hospital to Hospital Workgroup
- Transport Group

### ***Future Areas of Interest***

- Implications of climate change on healthcare emergency preparedness
- Risk and Crisis Communication Training
- Resurrecting, Improving and Formally Adopting Regional Unidentified Patient Naming Convention and Processes
- *What else?*

## Complementary Activities

- NYC Pandemic Response Institute
- Mount Sinai Health System Regional Disaster Health Response System application
- NYC Healthcare Coalition activities

# In Case You Missed It...



## Symposium: How Healthcare Emergency Preparedness Has Changed Since the 9/11 Attacks

### The Evolution of Healthcare Emergency Management: Then, Now, and (Many) Future Threats

GNYHA 9/11 Twentieth Anniversary Program  
September 9, 2021

Dan Hanfling, MD  
Vice President, Technical Staff, In-Q-Tel  
Co-chair, National Academies Forum on Medical and Public Health  
Preparedness for Large Scale Emergencies



[Symposium: How Health Care Emergency Preparedness Has Changed Since the September 11 Attacks – GNYHA](#)

## Podcast: Evolution of Healthcare Emergency Preparedness

<https://lnkd.in/dX5F7tgN>

### PERSPECTIVES

Ep. 7: Evolution of Health Care  
Emergency Preparedness  
with Dr. Meghan McGinty  
and Scott Heller





## Updates

- NYS DOH
- NYC DOHMH
- NYCEM
- FDNY
- Others

# Thank you for your extraordinary work.



## Jenna Mandel-Ricci

Vice President, Regulatory and Professional Affairs

Phone: 212-258-5314

E-mail: [jmandel-ricci@gnyha.org](mailto:jmandel-ricci@gnyha.org)

## Samia McEachin

Senior Project Manager, Emergency Preparedness & Employee Wellness

Phone: 212-258-5336

E-mail: [smceachin@gnyha.org](mailto:smceachin@gnyha.org)

## Upcoming EPCC Meetings

- November 18<sup>th</sup>
- December 16<sup>th</sup>
- ***Will set and send out 2022 dates soon***

*Seeking presentation ideas and topics of interest for these meetings!*