Disclosure

I have no financial interests or relationships to disclose.
Who we are – NYC Health + Hospitals

- Largest public healthcare system in United States
- 11 acute hospitals, 5 skilled nursing facilities, 70+ ambulatory clinics, insurance plan, correctional health services, home health agency
- 1.1 million patients
- NYC Care – guaranteed healthcare to all New Yorkers
Epicenter of the epicenter

- New York City: over 118,000 cases and 10,800 deaths
- Our patients are disproportionately affected by COVID-19 pandemic and social distancing measures
- Elmhurst, Lincoln, Queens, Woodhull, Coney Island, Kings County
ED COVID Action Team

- Small, nimble team with wide representation and expertise
- Formal representation in HICS and Central Office structures
- Twice daily calls
- 1-2 times weekly ED Council Updates
- Weekly e-mail updates
- Bilateral communication to identify key issues that informed goals
H+H ED COVID Action Team

- Dave Silvestri, MD – Sr Director, NYC Health + Hospitals
- Shaw Natsui, MD – Director, NYC Health + Hospitals
- James Salway, MD – Director, NYC Health + Hospitals
- Stu Kessler, MD – Chief, NYC Health + Hospitals/Elmhurst
- Laura Iavicoli, MD – Associate Chief, NYC Health + Hospitals/Elmhurst
- Raj Gulati, MD – Chief, NYC Health + Hospitals/Bellevue
- Mike Bouton, MD – Chief Medical Informatics Officer, NYC Health + Hospitals
- Gus Agoritsas, MD – Associate CMO, NYC Health + Hospitals/Kings County
- Anjali Hulbanni, MD – Patient Safety Officer, NYC Health + Hospitals/Harlem
- Marc Kanter, MD – Associate Chief, NYC Health + Hospitals/Lincoln
- Karin Rhodes, MD – Professor of EM, Zucker School of Medicine Hofstra Northwell
Goals

1. Decant volume from within EDs
2. Prevent and minimize quarantine on existing ED staff
3. Expand staffing model outside existing staffing model to meet surge demand
4. Free up new and existing ED space to care for patients
5. Protect supply of vital equipment
6. Minimize burden surrounding reporting and communication
Red Surge

** PRIMARY CHANGE FROM ORANGE TO RED IS REMOVAL OF LABS FOR ED EVALUATION AND DISPOSITION **

- Patient is sent into ED by provider up-front

  ** Is the patient hypoxic? (SaO2 < 94%)**
  - Yes -> Start work-up (CXR, labs**, EKG) with plans to admit
  - No OR

  ** Age > 50 OR Comorbidities**
  - No infiltrate -> Discharge (Not hypoxic, not tachypneic)
  - Yes -> Obtain CXR

  ** + Fever, cough, Tachycardia**
  - No infiltrate -> Obtain CXR
  - Yes -> Consider Extensive COVID Obs for serial exams

  ** Place in COVID Obs for serial exams**
  - Stable on reassessment -> Discharge (Not hypoxic, not tachypneic)
  - Worsening resp status or hypoxia
    - Discharge (Not hypoxic, not tachypneic)
    - Escalate care and expand work-up accordingly

** = Comorbidities = Cardiovascular disease, DM, COPD, structural lung disease, CHF, HTN, immunocompromised (disease or meds), pregnancy
** = Labs = CBC, CRP, d-dimer, ferritin, CRP, LFTs, procalcitonin, legionella (stool panel)
** = COVID-19 testing for admitted patients ONLY. No testing for influenza/RVP.
Black Surge

Diagram:

1. Provider(s)-up-front sends patient into ED if hypoxic or looks sick.
2. Critically ill to resuscitation area.
5. Serial reassessments and SpO2 checks in ED or in COVID Obs based on clinical judgment.
6. Worsening status but not critical.
7. Admit.

Status:
- Stable

NYC Health + Hospitals
Planning versus adapting

Everyone has a plan, until they get punched in the mouth.
Flattening the COVID-19 Surge

- Streamlined transfer process to allow for high volume, batch transfers
- Data driven
  - # of boarding admissions
  - Med/surg occupancy %
  - ICU surge level
  - # of vented patients in hospital
- 700+ patients moved across the system
  - 500+ med/surg
  - 150+ ICU
Thank you for what you do