COVID-19 Decedent Management: Experiences from New York City

During the COVID-19 pandemic, New York City (NYC) was often the harbinger for the rest of the country and managing large numbers of fatalities presented a significant challenge to hospitals across the city. ASPR TRACIE met with the following subject matter experts (listed alphabetically) who shared how their individual hospitals, systems, and enterprises handled decedent management during the first surge in 2020:

- **Andrew Dahl**, Vice President for Emergency Preparedness and Response at the Greater New York Hospital Association (GNYHA)
- **Jory Guttsman**, Director of Emergency Management at NYC Health + Hospitals/Bellevue
- **Johanna Miele**, Manager, Emergency Management + Enterprise Resilience, NYU Langone Health

John Hick (JH)

Tell us what hospital preparedness for mass fatality incidents was like in New York City before COVID-19.

Johanna Miele (JM)

In the years leading up to COVID-19, New York City Emergency Management was developing a biological incident plan, which has a fatality management operational strategy. NYC's Office of Chief Medical Examiner (OCME) also updated their plans during that process and developed a guide of in-hospital surge that was shared with hospitals. I started working at OCME in 2017, while they were in the process of updating the document. Just before COVID-19 struck, we were submitting data points about our Body Collection Point (BCP) locations as part of a larger conversation on logistics.

Jory Guttsman (JG)

In 2019, mass fatality planning was a grant deliverable for all hospitals in NYC. At NYC Health + Hospitals, we spent at least one year prior to the pandemic contemplating several planning questions: Where can you put a BCP? Do you have the logistics to support it? Do you have power? Which loading dock can you use? One of the biggest lessons learned was that our planning was based on a shorter-term incident with

***Access this report* for more information on how New York City Health + Hospitals managed fatalities during the COVID-19 pandemic.**

The GNYHA created a Body Collection Point Operation Guide to help staff understand responsibilities and regulations specific to using these structures to manage decedents.

a sudden influx of fatalities, for example an event like 9/11. We weren't expecting a situation so long and protracted. For instance, having a BCP in place on the loading dock for months on end would make it difficult to receive packages and continue other normal operations.

JH

Johanna, can you tell our readers more about the BCP locations?

JM

BCPs are temporary refrigeration units used to store decedents until transport can be arranged. Morgue capacity across hospitals in our state is very limited. Some have capacity for ten decedents or less, some might have the capacity for 80. Each facility was dependent on surge capacity, especially earlier in the pandemic. During the planning phase, as Jory mentioned, hospitals were asked to provide an approximate location of where the BCP would be located which was frustrating and confusing at the time, but ensured privacy and made delivery easier. The BCPs were purchased by NYC Emergency Management through the logistics team and OCME supported decedent collection. Another lesson we learned was that we had to address wraparound requirements and provide an ADA compliant ramp to facilitate moving stretchers in and out of the structure as well as access to the entrance. No matter where the BCP was located, privacy was an issue. Since not all areas were good candidates for privacy coverings, we had to create wooden privacy structures next to some entrances to ensure privacy while decedents were being loaded in. We also needed electricity pulled from the hospital into the trailers to provide light inside the BCP for nighttime operations, even though the trailers were primarily dependent on diesel fuel.

JH

How many BCP trailers did NYC emergency management have?

AD

There were 135 BCPs deployed at the height of the first surge. NYU Langone - Brooklyn Hospital, for example, had three.

JG

Most hospitals ended up with two, three, or four BCPs which presented a variety of logistics challenges. We had to decide if we were using part or all of the hospital's loading dock for the BCP, and for how long? Our solution was to build a temporary loading dock with a ramp that was secure and private. There were other concerns, like how to move a decedent across the street when it's raining or across uneven ground while protecting employee safety. We were already dealing with staff absences from injuries, illness, and COVID isolations, so injury prevention was a significant consideration.

JM

Not all hospitals received BCPs as part of the response. NYU Langone on Long Island contracted with an agency who provided different types of containers that resembled shipping containers. The Nassau County medical examiner and emergency management groups did not have the same capacity for BCP management and recovery as others in the city.

Those containers needed to be modified to store bodies safely. We also were lucky enough to have staff trained in body mechanics and body handling. We redirected physical therapists—who were not working their traditional outpatient jobs at the time due to the pandemic—as body handlers in the morgues and BCPs. Our physical therapists created procedures that taught staff how to appropriately leverage body mechanics; there were no related injuries to staff involved in moving bodies across our enterprise.

JH

What other considerations went in to taking care of your staff during COVID-19?

JG

The impact on our employees' mental health was not expected. One of our staff called us in the Incident Command Center and asked for help, saying "I can't keep seeing body bags be wheeled past me." We needed to think not just about the mental health of doctors and nurses but also those we redeployed as morgue staff, handlers, and in other support roles. Morgue staff were used to seeing one or two decedents in a day, and at the peak they were seeing 10-20.

JH

Did you have issues with many unidentified decedents?

JG

We didn't deal too much with unidentified decedents, mostly unclaimed decedents. In New York City, we have a clear process for what happens in that scenario. Custody of the remains would be turned over from the hospital to the medical examiner's office who would either locate next of kin (with the help of the police department) or coordinate a city burial. That process didn't change with COVID-19, but the number of decedents who needed city burial did change. Our facility is in a neighborhood on the lower end of the socioeconomic scale, and some family members did not have resources for their loved ones' final disposition, especially after the economic impacts of COVID. The challenges we were really faced with were how to get decedents to the medical examiner's office and how would the medical examiner intake such a high number of decedents.

JM

In the case of COVID-19, for the most part we knew who they were, we knew their names and next of kin, so there was no issue with identifying them. The challenge was having them claimed in the system. And so many people were unprepared for the death of their loved ones.

One day, I was working in the morgue, and I saw that one of the decedents had the same birth-year as me. I am 32; that early in the pandemic, we weren't expecting a 32-year-old to die. We thought we'd primarily be seeing older people. That person was in the morgue for a very long time because the family was completely unprepared to lose such a young family member. There were so many unexpected deaths, and the funeral home industry became completely backlogged.

We also had backlog because of issues with the hazardous material body containment pouches we used. The heavy plastics were designed to keep fluids in, but not for cremation; they created an untenable amount of black smoke in crematories, so we had to switch bags. All these factors combined led to an increase in unclaimed remains, even when families wanted to do more. They simply couldn't.

JG

Yes, all those challenges created the perfect storm. We needed the disaster pouches, but supply chain issues meant we couldn't source them at rates we needed.

Funeral home backlogs meant loved ones couldn't get decedents to the funeral home, so they were held at the hospital. Impacts to OCME and the funeral homes meant decedents had to be held at the hospital until the funeral home could come pick them up. That process and the nimbleness of the city overall eventually helped relieve hospital backlogs.

> ***The issues continued to compound while we were faced with unexpected deaths and sustained surge. It was less of one tidal wave, and more of a constant tsunami, with pressure that did not ease.***
>
> ***--Jory Guttsman***

In my facility, getting paperwork completed was another challenge. On a normal day we can make our way through it without much issue, but during the COVID-19 pandemic it really stressed the system.

AD

During March and April 2020, the city deployed upward of 50 trailers across the city. Two weeks later, we had 800 deaths per day across the city, nearly doubling in a short time. The peak of COVID-19 deaths happened quickly, so it got very tight very quickly in the trailers. Thinking about the worst case earlier on would have improved the response and provided more space for decedents.

JH

What helped you get on top of the backlog? Was it the decline of the surge, an increase in capacity, or something else?

JM

In NYU Langone, ultimately what helped the most is when OCME took those unclaimed decedents, some of whom had been there for two months. OCME usually takes unclaimed remains for city burial, but they were operating on a much

higher scale to help relieve pressure on hospitals and in home deaths. OCME had a disaster portable morgue in Brooklyn. That was a magnificent operation, and really brought some relief. Honestly, some funeral directors did not catch up until 2021, since they and their staff were also getting sick and/or in isolation. So OCME portable morgues really relieved pressure on individual hospitals until the surge declined.

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JH

Were there any challenges associated with processing the bodies? Did you make any changes to meet the delays in final disposition?

JM

We did implement some storage processes that allowed us to effectively store decedents longer than usual. There were media stories that were slanted against city burial, which made some perceive this long-time practice in a negative light. That also contributed to longer times in reaching final decedent disposition.

JG

Processing the paperwork was one of the biggest challenges we faced. Decedent management in general is a very complex, legal-heavy process. There are steps related to chains of custody; ensuring appropriate identification of remains; preparing and signing the death certificate; and ensuring decedents were not released to the wrong family. With the volume of decedents in the early phase of the pandemic, this was very challenging to ensure that nothing slipped through the cracks.

Paperwork was another major issue. We redeployed a quality management team to work solely on the paperwork, making sure death certificates and claim forms were completed properly. Without paperwork, we couldn't get decedents picked up by funeral homes, medical examiners, or families, so it truly became one of the limiting factors to having decedents reach their final disposition.

JH

From a resource standpoint, what went into paperwork and liaising with families?

JG

The team we used was a trusted group who could identify breakdowns in the process. That team was sent in to ensure the paperwork aligned when the OCME arrived. This allowed us to clearly communicate with families and describe next steps, letting them know where their loved one would be throughout the process. We also instructed them to tell the funeral homes to retrieve the bodies from the OCME location, and not the hospital, to avoid confusion and additional backlog. All these logistics were part of this team's work.

Preparing for the day-to-day operations more succinctly prepares you to make those operations work well during mass fatality scenarios.

--Johanna Miele

The city also held daily calls on fatality management with representatives from NYCEM, OCME, and the Department of Health and Mental Hygiene (DOHMH) Bureau of Vital Statistics so every hospital knew what was happening.

AD

My colleagues from GNYHA worked with the city and tried to keep a pulse on what was happening in hospitals. To build on what Jory said, paperwork was a significant issue. There were staff having to sign death certificates who typically didn't have to. The OCME formed strike teams to help decant those BCPs at hospitals because they were getting very full, partly because of lags in paperwork.

JH

Would you like to share any specific lessons you learned about existing fatality management plans or things our stakeholders should consider for the future?

JM

Mass fatality often gets overlooked in emergency management. From a healthcare perspective, it is also not a priority. Across enterprise locations, we had to go through all processes for regular non-COVID-19 deaths and enhance and expedite them. As Andrew mentioned, having an alternate death certificate signer was an important part of the expediting process. Including non-acute facility providers as part of the death process was also a requirement. For example, during COVID the DOHMH changed their policy for recording residential deaths from paper death certificates to electronic death certificates. This now includes managing workflow for deaths at home. We had to train outpatient providers on how to use the associated system to support this change. As for advice for other locations, preparing for the day-to-day operations more succinctly prepares you to make those operations work well during mass fatality scenarios. You can't expedite the practices; you have to streamline them.

Most hospitals manage decedents on a case-by-case basis and a paper-only plan with low morgue visibility. This is an opportunity for enhancing your mass fatality response plan both in the short and long term. We examined the processes for day-to-day deaths and ensured they were clear and aligned and had alternate processes and backups.

JG

As Johanna said, we need to integrate emergency management into regular operations. Since the initial surge, we have been using a matrix based on our surge plan to examine our emergency department and inpatient numbers to help us determine whether we needed to escalate our decedent management response.

Using that model and coming out of spring 2020 into the rest of the pandemic, including ebbs and flows of pandemic cases, we saw the effectiveness of that surge tool. Every day at our huddle we added data points on fatality management and morgue capacity, to include number of unsigned death certificates and morgue capacity. We monitored when the morgue was filling up and adjusted our response and tempo. By leaning into the operational side and incorporating that into normal operations, we got ahead of those issues before capacity became a problem again.

JH

Is GNYHA augmenting any plans going forward?

AD

OCME began surveying their hospitals to better understand their needs and gaps associated with capacity. The state is developing a real-time system for monitoring the number of inpatient beds occupied. The same thing is needed for fatality management. We would love a real time status of how full hospital morgues are.

JH

Are there any gaps in your plans that you'd like to address in future?

JM

Streamlining processes for an enterprise while acknowledging jurisdictional differences is important. OCME trailers are provided and serviced by New York City emergency management. That was not the case for our location in Long Island, where capacity differed and they ended up incurring costs to have the same capabilities as other counties. It's important to streamline processes to facilitate workflows and plans that are flexible enough to allow for the different set ups in counties and states. In New York, each county has different processes for their coroners and medical examiners especially outside of NYC boundaries. Understanding these jurisdictional differences is a top priority; when I create guidance, I make a note of what jurisdiction the decedents are in, as decedent management differs depending on the location.

JG

My big takeaway for fatality management planning is to look at the system supporting the whole operation. It's one of those things we don't focus on, and little steps make a big difference. For example, in New York, physicians must sign death certificates in an on-line system. This was a significant bottleneck during COVID, because some physicians didn't use the system on a regular basis and were not able to operate it efficiently.

In other cases, the admitting team and the morgue team had never met each other in person. There were a lot of assumptions, such as that funeral directors would make their way around the hospitals and morgues, which was often

not the case. Looking at the process at a granular level and creating partnerships in non-emergency times offers the opportunity to streamline and facilitate the process before a mass fatality incident happens.

JM

The GNYHA acted as an advocate for our health system. Processes were often opaque, so we were lucky to have GNYHA to advocate for changes at my hospital system and other hospitals. Regional support is one of the best practices. We needed someone from a provider's perspective to understand what was needed. I'd like to thank GNYHA for what they did to help us.

AD

And GNYHA is grateful for you sharing your experiences.