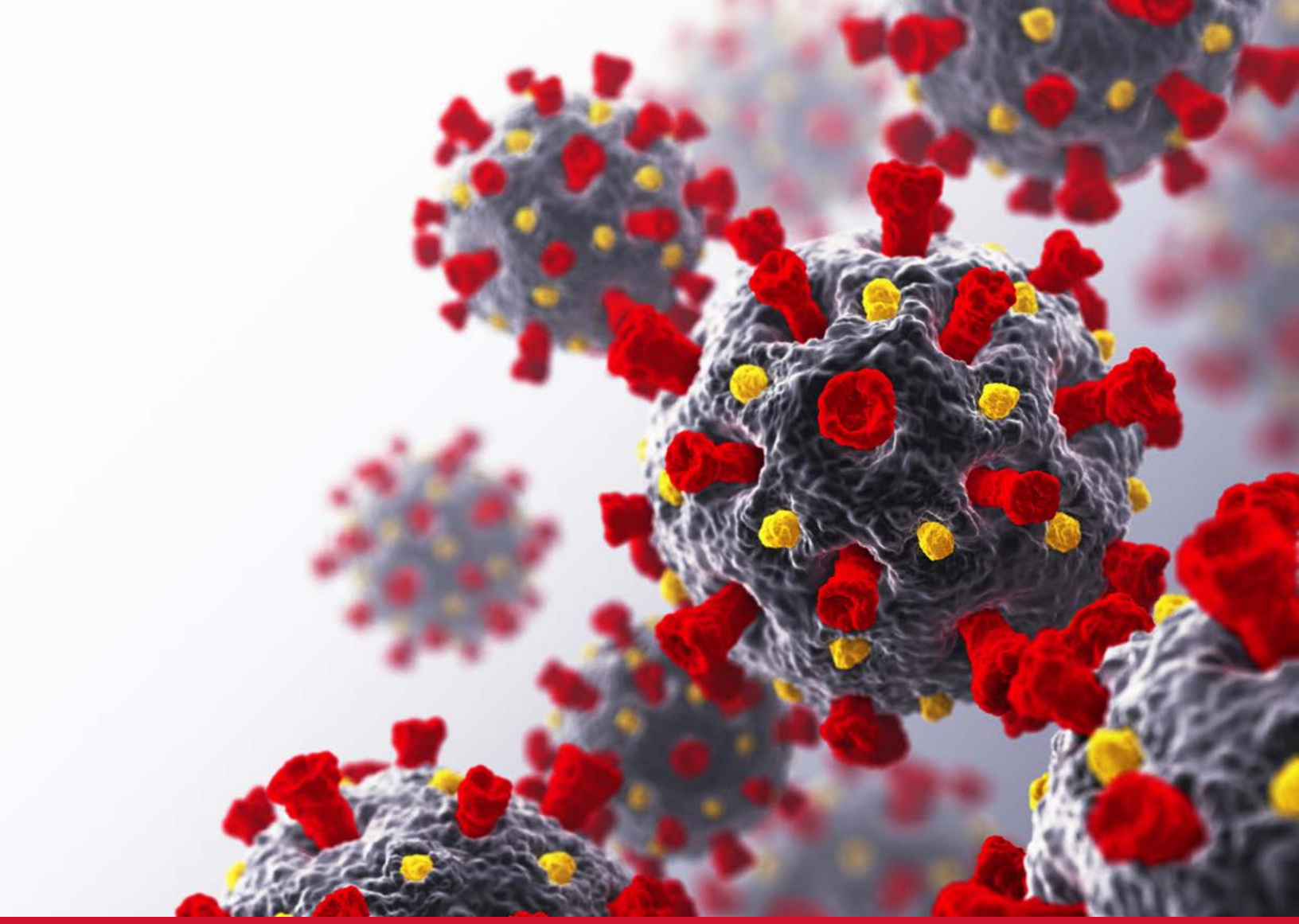


GNYHA LESSONS LEARNED/PREPARATION FOR FUTURE COVID-19 WAVES

Topic: Fatality Management in New York City Hospitals

For limited distribution

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

INTRODUCTION

This document outlines the fatality management operations related to the COVID-19 patient surge that occurred in New York City beginning in March 2020. It outlines what happened, including challenges, innovations, and lessons learned in preparation for future COVID-19 waves. This document also includes a timeline of events (Appendix A) and short-term and long-term recommendations.

BACKGROUND

Prior to the COVID-19 pandemic, the New York City Office of Chief Medical Examiner (OCME) had developed a "Planning Tool for Health Care Facilities" within their "Biological Incident Surge Plan for Managing In-Hospital Deaths." Each hospital also had a mass fatality plan in place. These plans involved the use of body collection points (BCPs), or refrigerated trailers, to expand morgue capacity. While these citywide and hospital-specific plans served as the foundation for fatality management strategies during the pandemic, many necessary adjustments were made.

Under normal circumstances, hospitals only interact with OCME about medical examiner (ME) cases and cases with no known next-of-kin (unclaimed cases). For all other cases, hospitals typically deal directly with funeral homes. This was not the case during the pandemic due to the high volume of fatalities that occurred over a relatively short period of time, and the difficulties experienced by the funeral home industry in managing the volume of decedents.

Many stakeholders were involved in fatality management operations, including but not limited to:

- New York City Office of Chief Medical Examiner (OCME)
- New York City Office of Emergency Management (NYCEM)
- New York City Department of Health and Mental Hygiene (DOHMH) Bureau of Vital Statistics (BVS)
- NYC Health + Hospitals (H+H)
- Greater New York Hospital Association (GNYHA)
- New York City Hospitals
- New York City Funeral Homes and Funeral Directors
- New York City Cemeteries and Crematoriums

COVID-19 FATALITIES

COVID-19 led to an unprecedented number of deaths in New York City—both in-hospital and at-home deaths—taxing every aspect of the fatality management continuum. In total, 17,507 confirmed COVID-19-related deaths occurred in New York City between March 14 and June 18, with the peak on April 7 of approximately 800 COVID-19-related fatalities. The charts on page 3 provide key fatality-related data for this time period.

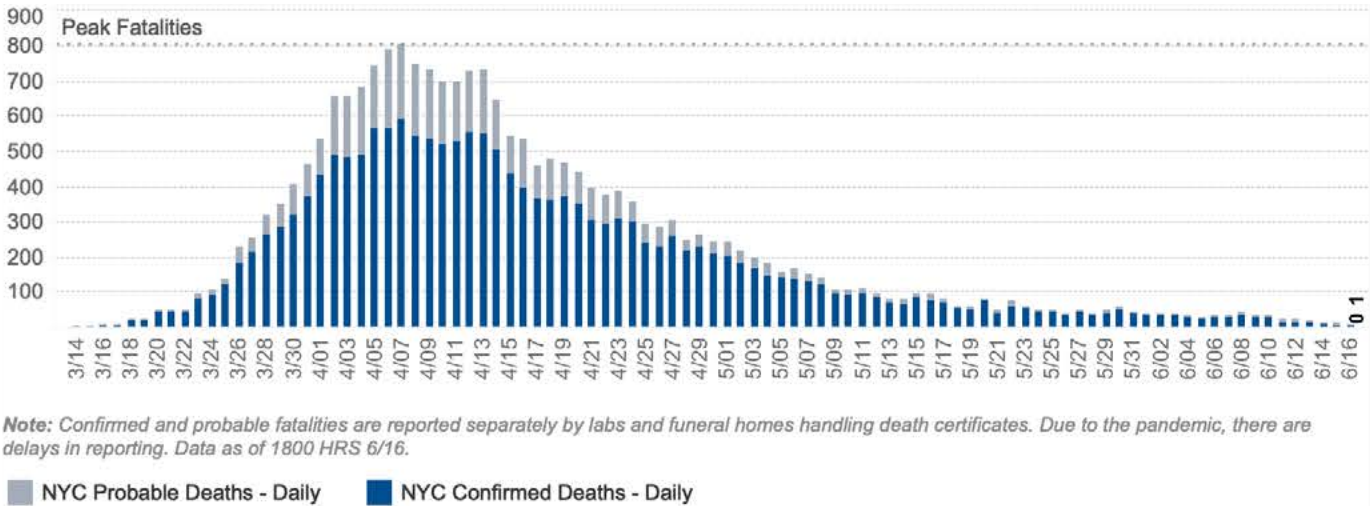
STRUCTURES AND RESOURCES TO SUPPORT FATALITY MANAGEMENT IN HOSPITALS

Multiple resources were made available to hospitals during the pandemic to assist with fatality management efforts.

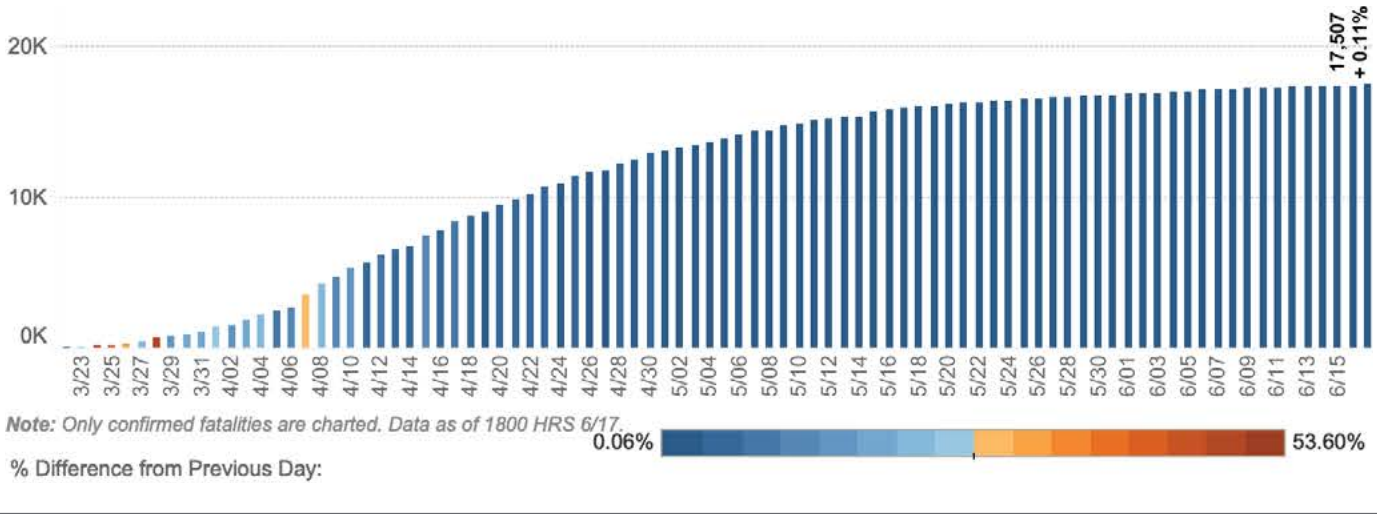
OCME Staff

OCME staff were vital to fatality management operations, specifically the Executive Deputy Commissioner for Administration and Chief of Staff, the Deputy Commissioner for Forensic Operations, and the Forensic Operations and Emergency Management teams. These staff led fatality management discussions and coordinated various calls with hospitals and other stakeholders.

Daily New York City Fatalities Per Day (March 14–June 16)



Cumulative New York City Fatalities (March 22–June 17)



Daily Fatality Management Taskforce Call

OCME began holding daily fatality management taskforce calls on March 25 to discuss current and upcoming operations and strategies. All City hospitals, NYCEM, DOHMH BVS, GNYHA, and H+H were invited to the calls, which were a means to communicate directly with hospitals about fatality management operations and changes to existing processes.

Daily Morgue Census Survey

OCME requested on March 25 that all hospitals complete a daily survey with information about their decedent counts and resources. The daily survey asked hospitals to indicate the total number of decedents in their custody—both within their fixed morgues and Body Collection Points (BCPs) or refrigerated trailers. This data was used to determine where additional

resources were needed and also to monitor the in-hospital decedent situation overall. The survey questions were adjusted as needed throughout the patient surge. See Appendix B for a data dictionary outlining all survey elements, including when items were added or removed from the survey.

Guidance Documents

Multiple resource documents were made available to hospitals during the pandemic. These included BCP guides, workflows, and OCME memos. Guidance and processes changed frequently throughout the pandemic (See Appendix A for more detail).

NYCEM Logistics Team

The NYCEM Logistics Team coordinated the deployment of BCPs to hospitals. Hospitals were asked to submit a resource request for a BCP through their GNYHA or H+H liaison, who then communicated with NYCEM. BCPs were typically deployed within 24 hours of receiving a request. The Logistics Team also addressed maintenance questions and provided specifications for the two types of BCPs available—diesel and electric—though most of the deployed units were diesel.

GNYHA and H+H Support

OCME relied on GNYHA and H+H to facilitate communication about various tasks among their respective membership and hospital system. At the onset of the BCP operations, GNYHA's representative was the liaison for all hospitals who had reached capacity within their BCP. Before sending information to OCME, the hospital and GNYHA followed a pre-screening checklist to ensure the BCP was ready for retrieval and that the decedents were stored properly. GNYHA and H+H also assisted with vetting documents created by OCME—and other agencies—prior to distribution to hospitals.

NYCEM, OCME, H+H, and GNYHA met on April 10 to discuss fatality management operations in what became a routine call for the agencies to review the long-term storage freezer facility plan (see below for additional information) and hospitals' status with decedents and BCP operations.

Federal Resources

New York City requested Federal resources such as Disaster Mortuary Operational Response Teams (DMORTs) to assist with managing the high volume of fatalities. These operations are detailed below.

EFFORTS TO INCREASE HOSPITAL STAFFING

Hospitals required additional resources to manage the high volume of fatalities. OCME advised all New York City hospitals on April 3 to increase their mortuary staff by three to four times, given the volume of decedents and number of BCPs deployed to hospitals. The expanded staff members were needed to perform various functions, including completing and maintaining all documentation; communicating with families, funeral directors, and OCME staff; handling decedents; and providing security for the BCPs. These surge staffing needs occurred at the same time many staff were out sick themselves or caring for sick family members, and while hospital operations were mostly focused on managing the enormous patient surge—which peaked at more than 12,000 hospitalizations on April 12. While hospitals initially were asked to bring on these staff through the normal recruiting channels, this proved difficult—and hospitals requested external assistance.

Medical Reserve Corps

Hospitals were advised on April 9 to submit a request for mortuary staff through the Medical Reserve Corps (MRC) survey. "Mortuary staff" was added to the available jobs listed on the MRC website where volunteers could sign up. A total of 115

mortuary staff volunteers were matched to 27 New York City hospitals through this process. After MRC's initial referral, the hospitals were responsible for connecting with their volunteers for orientation, onboarding, and scheduling.

Outreach to Funeral Director and Veterinary Associations

To identify surge staff, GNYHA also contacted various associations (funeral director and veterinary), as it was believed that their members may be willing to volunteer in this field due to their background working with the deceased and grieving families.

BCP USE AND MANAGEMENT BY HOSPITALS

Due to the surge in fatalities in the City during the COVID-19 pandemic, BCPs were used to accommodate the high volume of decedents. New York City hospitals typically have small fixed morgues, with an average capacity of about 15 decedents. In total, City hospitals can accommodate approximately 800 decedents total across their fixed morgues. At the pandemic's peak, New York City experienced approximately 800 deaths/day, a volume that would be impossible to accommodate within hospital's fixed morgues. The BCPs served as extensions to hospitals' fixed morgues and allowed families and funeral homes additional time to retrieve decedents and/or make final arrangements for loved ones.

Supply

NYCEM acquired BCPs to provide hospitals with the additional space needed to hold an excess number of decedents. At the surge's apex, NYCEM deployed 230 53-foot BCPs—145 locally sourced and 85 federally sourced—which hospitals used to increase their morgue capacities. The locally sourced BCPs are leased until December 31, 2020, should there be future waves.

Deployment

Hospitals were advised to request a BCP if their fixed morgue was near or at capacity. The first BCP request was received on March 19, and the first BCPs were deployed to hospitals on March 21. Within two weeks, 83 BCPs were deployed (including to alternative care sites), with some hospitals holding three BCPs. By April 17, the maximum number of BCPs were deployed to hospitals (for a total of 135), with some hospitals holding as many as five BCPs.

Shelving

The first NYCEM-deployed BCPs did not contain any shelving. A BCP without shelving can hold approximately 40-45 decedents when the decedents are placed appropriately within the trailer. As BCPs quickly filled up, OCME asked all hospitals to add two levels of shelving into their BCPs to increase the capacity to 80 to 100 decedents. This was a challenge for some hospitals, which had already placed decedents into their trailers and could not add shelving without removing the bodies. To assist hospitals, NYCEM began adding shelving to trailers prior to deploying them to hospitals. NYCEM deployed the first BCPs with preinstalled shelving to hospitals on April 8. While shelving successfully increased BCP capacity, it created unintended transport difficulties when BCPs were retrieved (see section below).

Privacy and Security

Some hospitals required tenting and/or other structures to surround the BCPs to ensure privacy from the public. The need for hospital security to perform routine checks of the area placed an additional requirement on hospitals.

Maintenance and Service

NYCEM provided several contact numbers should hospitals experience any issues with the BCPs such as temperature monitoring or locks. No issues were reported with connecting with the appropriate vendors.

BCP AND DECEDENT RETRIEVAL

Decedent Storage

Upon initial deployment of the BCPs, OCME did not provide hospitals with a timeline for how long decedents could be stored in the trailers. However, OCME advised on April 13 that decedents should only be stored in the BCPs for a maximum of 30 days, and that hospitals should request pickup of decedents who had been in their custody for two weeks or more.

Delay in BCP Retrievals

OCME had reported that it would retrieve BCPs from hospitals when they reached capacity; however, there were significant delays in OCME's ability to begin BCP retrieval. The main reason for this was the lag in the arrival of requested Federal resources that were needed to create Disaster Portable Morgue Units (DPMUs) and Strike Teams. OCME's BCP retrieval process was not implemented until April 28. Due to this delay, hospitals were asked to maintain their BCPs onsite until OCME could retrieve decedents, and hospitals were asked to request additional BCPs when their initial unit reached capacity. One challenge with this was space. The New York City Police Department (NYPD) and Department of Transportation (DOT) had to assist in necessary road closures to accommodate multiple 53-foot trailers at some facilities.

OCME Decedent Retrieval

Under normal circumstances, OCME takes custody of ME and unclaimed cases from hospitals. In line with this, OCME initially stated it would not pick up claimed cases from hospital fixed morgues or BCPs, with the understanding that funeral directors would continue to retrieve claimed decedents directly from hospitals. Hospitals were advised on April 12 to separate decedents based on type by holding unclaimed cases in one BCP and claimed cases in another BCP, and to inform OCME when a BCP of unclaimed decedents had reached capacity. Additionally, ME cases were only to be stored in fixed morgues (as per guidance provided at the beginning of the surge).

It was soon realized that most cases at hospitals were claimed, meaning they had funeral home and/or family involvement, and most hospitals were unable to fill a BCP of only unclaimed decedents. Unfortunately, many claimed cases resided at hospitals for extended periods of time, as funeral homes were overwhelmed and unable to retrieve decedents in a timely fashion. Families also faced difficulties making final arrangements quickly due to strict visitor policies and ongoing in-hospital surges. Funeral homes experienced a significant backlog during the pandemic due to delays at cemeteries and crematoriums, leaving hospitals to hold decedents for extended periods of time with no pickup date identified.

Given these circumstances, only a few BCPs filled with unclaimed cases were retrieved by OCME, with significant effort required of the hospital to ready the BCP. OCME launched a small pilot to try to relieve burden on hospitals. OCME transferred an entire BCP—with both claimed and unclaimed cases—to Disaster Portable Morgue Unit #4 (DPMU) (see below for additional information), transferred the unclaimed cases to OCME custody, and then returned the BCP with the remaining cases back to the hospital. The pilot proved unworkable for both the hospital and OCME.

OCME informed hospitals on April 18 that it would begin picking up both claimed and unclaimed cases. This was decided because the funeral home industry continued to experience severe delays with the pickup of decedents from hospitals. Many hospitals were initially reluctant to transfer custody of claimed decedents to OCME due to fears—their own and the families—around temporary burials at City Cemetery (which is the burial location for long-term unclaimed decedents).

Disaster Portable Morgue Unit #4 Established

During the pandemic, OCME established four DPMUs across New York City to provide increased storage capacity for decedents and enable funeral directors to collect decedents for final disposition. DPMU #1, #2, and #3 (in Manhattan, Queens, and Brooklyn) were for in-home fatalities. DPMU #4 (located at the South Brooklyn Marine Terminal)—which opened on April 14, with the help of Federal DMORT resources—exclusively stored decedents and BCPs from hospitals.

ESTABLISHMENT OF AND CHALLENGES WITH LONG-TERM STORAGE FACILITY

Even after DPMU #4 was established, for the reasons noted above, the BCP retrieval process was slow. There was growing concern about the volume of BCPs still at hospitals and the length of time some decedents had been held in BCPs. Some decedents had been in hospital-maintained BCPs for more than a month, and there was concern about decomposition. Most decedents being held in BCPs were claimed—meaning there was some level of funeral home and/or family involvement—but had not yet been removed from the hospital.

Creation of Long-Term Storage Facility

OCME, NYCEM, H+H, and GNYHA convened on April 16 to discuss creating a long-term storage option for hospitals to decant their morgues and BCPs. A long-term—or freezer storage—option would allow decedents to be held indefinitely rather than just 30 days in a BCP. The hospitals' need for relief for their claimed decedents and for the City to devise a plan to provide this support was also discussed. A long-term storage facility would provide this support and allow time for the funeral home industry to catch up and families to make arrangements. Furthermore, the long-term storage facility would elude any concerns around temporary burial at City Cemetery. The long-term storage facility was established on April 28 and held more than 1,300 decedents at one point.

Challenges with Death Certificates

One challenge throughout the BCP and decedent pickup process was related to death certificates. OCME can only pick up decedents that have a registered death certificate completed in the eVital System. The death certificate must include a method and place of disposition. In many instances, there were pending or incomplete death certificates in eVital as funeral homes had claimed the case but had not yet entered a final disposition. As a result, OCME could not retrieve these cases. The DOHMH BVS helped with outreach to funeral homes, or in some cases, relinquished custody of the case back to the hospital to complete the death certificate and enter a final disposition.

Communication with Families

Communicating with families during the patient and fatality surge was another challenge for hospitals. While many hospitals activated their family management programs, the volume of fatalities caused delays in communication. Many families could not retrieve their loved ones in a timely fashion for various reasons, including travel restrictions and financial concerns, causing further backlogs in hospitals and BCPs. Family members that wanted their loved one released to a funeral home urged hospitals to not transfer their decedent to OCME's custody due to concerns about temporary internment at City Cemetery—which OCME initially said was a possibility, but later retracted—and lack of knowledge about the long-term storage option. OCME, GNYHA, and other agencies provided detailed communications to help hospitals understand the DPMU pickup process and long-term storage option.

STRIKE TEAMS CREATION TO EXPEDITE RETRIEVAL AND REDUCE PAPERWORK

By April's end, with long-term storage available and growing concerns about how long many decedents had been held in hospital BCPs—with many decedents nearing the one-month mark—OCME and several agencies formed Strike Teams, or

interagency taskforces, to expedite BCP and decedent retrieval from hospitals. These Strike Teams consisted of staff from OCME, NYPD, NYCEM, and the US Armed Forces.

Benefits and Timeline of Strike Teams

Strike Teams helped hospitals to complete decedent paperwork—including the manifest, which provided details on each decedent within the BCP—and readying BCPs for removal—including ensuring all decedents were placed in disaster body bags (see below for additional information). This aggressive approach allowed for the retrieval of many decedents in a short period of time, marking a significant milestone in fatality management operations.

The first Strike Team visit occurred on April 28. At the onset of this operation, OCME completed approximately three Strike Team visits per day, increasing to six visits per day by May 11. Each visit lasted anywhere from one to 10 hours based on the number of decedents being retrieved and how prepared the hospital was prior to the Strike Team's arrival. Over time, OCME provided hospitals more notice and had them work with BCP coordinators to streamline the process.

OCME demobilized the Strike Team operations on May 21. At the conclusion of the operation, more than 100 Strike Team visits had occurred, with 47 hospitals receiving at least one visit and 16 hospitals receiving three or more visits. Almost 2,000 decedents were recovered during the Strike Team process (between April 28 and May 21). In total, OCME recovered more than 2,350 decedents from New York City hospitals between April 15 and June 5, with more than 150 total hospital visits.

Reduction in Paperwork Requirements

To further expedite the pace of retrievals, OCME reduced paperwork requirements. At the onset, hospitals were required to gather five items to facilitate the removal of decedents from their facility: manifest, face sheet, clinical summary worksheet, death certificate, and burial permit. With the Strike Teams, OCME reduced the requirement to just the face sheet and death certificate, eliminating the need for hospitals to prepare manifests—which would be created in real time during the retrieval—burial permits, and clinical summary worksheets. Additionally, the death certificates could be pulled directly from eVital, if filed correctly, so facilities were only required to print the face sheets for OCME.

Strike Team Launch Preparation

Given the significant resources being deployed via the Strike Teams and the importance of their success to the overall fatality management operation, participating stakeholders worked diligently to develop clear guidance and to share information about Strike Team operations directly with hospital leadership. The Strike Team model was first piloted at a handful of sites, with H+H and GNYHA holding preliminary calls with hospital Chief Operating Officers and other key staff involved in mortuary operations.

As the Strike Team model reached its full capacity with six teams going out each day, H+H and GNYHA staff worked closely with OCME and NYCEM staff to select hospitals for Strike Team visits based on data from the daily morgue survey and to communicate with and prepare each facility for the Strike Team's arrival. GNYHA held numerous coordination calls and shared several bulletins to highlight this effort and provide detailed instruction.

Body Bags

By the time DPMU #4 was established and OCME could retrieve BCPs, many decedents had been in hospitals' custody for two weeks or more. It was quickly noticed that decedents that had aged and were stored in regular human remains pouches, or body bags, were starting to decompose. To avoid leakage and other issues, OCME advised hospitals to store all dece-

dents requiring OCME pickup in ruggedized, heavy-duty disaster bags. Transferring decedents to these disaster body bags was difficult work—physically and emotionally—for hospital staff. Shortages of disaster body bags throughout the spring plagued the overall operation. Strike Teams helped with transferring decedents from regular to disaster body bags (assuming bags were available) to expedite this process.

RECOMMENDATIONS

GNYHA shares the recommendations below to inform planning for future waves, and emergencies that include a mass fatality component.

Fatality Management Operations

- Maintain long-term storage capability. Clear triggers should be established for activating this capability, and availability should be communicated to hospitals and other key stakeholders.
- Codify the abridged paperwork process and elements, including when this differential standard will begin.
- Establish a body handler labor pool function that hospitals can access. Establish clear triggers for the activation of this labor pool and a clear request process.
- Update and consolidate all guidance for hospitals and make it available on a centralized website portal. When updates are made, have a consistent way to describe and date changes so hospital personnel can easily find and follow current versions.
    - Guidance should include specifications for all potential BCPs and for acceptable human remains pouches.

Stakeholder Coordination

- Formalize an interagency coordination call for strategy development and forward planning, including establishing a trigger for the activation of the call. Begin by holding calls twice weekly, increasing frequency as warranted by the situation. Involved stakeholders should include: NYCEM, OCME, City Hall, GNYHA, H+H, and other agencies as needed.
- Formalize and communicate coordination structures between City agencies/organizations and hospitals, including information calls and the web portal mentioned above.
- Explore leveraging electronic medical record systems to manage and track decedent information and automate reporting.

Hospital-Level Planning and Operations

- Hospitals should update fatality management plans with lessons learned from COVID-19. Suggested components include:
    - Ability to surge internal morgue space to accommodate additional decedents.
    - Develop detailed plans for all types of BCPs that may be received, and identify numerous potential locations to store BCPs.
    - Update morgue surge staffing plans. Update existing job action sheets and develop new job action sheets for roles established during the COVID-19 patient surge.
    - Based on proportions of patients and fatalities during the COVID-19 patient surge, establish internal triggers for requesting BCPs and surging mortuary staff.
    - Form or expand an interdepartmental fatality management team, including admitting, security, emergency

management, morgue operations, and hospital operations. This team should review and discuss all plans and establish triggers for operational response meetings.

- Source and store disaster body bags to build an internal stockpile.
- Modify family management programs based upon lessons learned from the initial COVID-19 patient surge.

APPENDIX A: TIMELINE OF MAJOR FATALITY MANAGEMENT ACTIVITIES IN NEW YORK CITY DURING COVID-19 PATIENT SURGE

Date	Major Fatality Management Activities
March 13	First COVID-19 fatality in New York City
March 19	First hospital Body Collection Point (BCP) trailer request received
March 21	First BCPs deployed to hospitals
March 24	Initial New York City Office of Chief Medical Examiner (OCME) BCP retrieval guide released
March 25	Daily fatality management taskforce calls initiated
	Daily morgue census survey initiated
March 27	All but five New York City hospitals have at least one BCP onsite
March 30	Hospitals advised to prepare to hold multiple BCPs onsite and to contact the New York City Police Department/Department of Transportation for help shutting down streets to create space
March 31	OCME requests that all hospitals add shelving to BCPs to increase capacity from 45 to approximately 100 decedents per BCP
April 3	OCME recommends that all New York City hospitals increase mortuary staff by three to four times
April 4	83 BCPs staged at New York City hospitals
	OCME releases guidance about six-day waiting period for unclaimed decedents who then will be sent to City Cemetery for temporary internment
April 7	Peak of COVID-19-related fatalities in New York City (approximately 800)
April 8	First BCPs with preinstalled shelving deployed to hospitals
April 9	Mortuary staff added to New York City Medical Reserve Corps (MRC) job listings; hospitals advised to request mortuary staff through MRC survey
	OCME reverts to 14-day waiting period before sending unclaimed decedents to City Cemetery
April 10	OCME, New York City Emergency Management Department, NYC Health + Hospitals (H+H), and GNYHA hold first interagency call
April 11	OCME updates guidance stating no temporary burials will occur
April 12	Hospitals advised to separate and store decedents by type (claimed vs. unclaimed) in separate BCPs
	Peak of New York City hospitalizations (over 12,000)
April 13	OCME advises hospitals to hold decedents in BCPs for a maximum of 30 days
April 14	Disaster Portable Morgue Unit (DPMU) #4 becomes operational
April 15	According to daily morgue census survey, 4,551 decedents held in New York City hospitals (fixed morgues and BCPs)
April 16	Interagency call held to discuss long-term storage option
April 17	Maximum number of BCPs deployed to hospitals (135 total)
April 18	OCME reports decision to retrieve claimed cases (in addition to unclaimed cases) from hospitals

Date	Major Fatality Management Activities
April 21	OCME advises hospitals to contact H+H and/or GNYHA for decedents in their custody for over three weeks to initiate retrieval
April 23	Funeral director portal allowing funeral directors to identify location of decedent goes live
April 24	OCME releases updated BCP retrieval guide
	The New York City Department of Health and Mental Hygiene Bureau of Vital Statistics releases guidance on running reports in eVital to identify incomplete death certificates
April 28	OCME BCP/decedent retrieval process initiated; First Strike Team visit completed (average of three visits/day)
	Long-term storage at DPMU #4 opens
May 4	OCME retrieves over 900 decedents and 17 BCPs to date
May 5	OCME retrieves over 1,000 decedents and 18 BCPs to date
	New York City has 31,000 fatalities since March 11 (COVID-19 and non-COVID-19)
May 11	Strike Team visits increased to six per day
May 19	OCME retrieves 2,041 decedents to date (1,743 via Strike Teams alone)
May 21	Strike Teams demobilized; almost 2,000 decedents recovered via Strike Team visits
	Per daily morgue census survey, 409 decedents in New York City hospitals
	39 BCPs remain deployed at hospitals
May 29	24 BCPs remain deployed at hospitals
June 2	14 BCPS remain deployed at hospitals
June 5	OCME recovers over 2,350 decedents from New York City hospitals
June 16	Two BCPs remain deployed at hospitals
June 22	All BCPs demobilized and held at staging area
July 16	OCME announces daily morgue census survey is required only on weekdays moving forward

APPENDIX B: OCME DATA DICTIONARY

Survey Questions			Data Collection		
Status Name	**Description**	**Response Options**	**Start Date**	**End Date**	**Frequency**
Fixed Facility Morgue Capacity	Full capacity of fixed facility morgue	Quantitative, whole numbers	3/25/20	April	Daily
Fixed Facility Morgue Cases	Number of cases held in fixed facility	Quantitative, whole numbers	3/25/20	Ongoing	Daily
Number of BCPs	Number of BCPs currently on site at facility	Quantitative, whole numbers	3/25/20	End of May	Daily
Number of Cases in BCPs	Number of cases held in BCP	Quantitative, whole numbers	3/25/20	End of May	Daily
Surge Space Capacity	Capacity of any surge space (this does not include BCPs, but additional building or rooms that can be used to properly store decedents	Quantitative, whole numbers	3/25/20	April	Daily
Number of Claimed Cases	Number of cases that a funeral homes have claimed	Quantitative, whole numbers	April	Ongoing	Daily
Number of Unclaimed Cases	Number of cases that have NO funeral home involvement	Quantitative, whole numbers	April	Ongoing	Daily
Cases Released	Number of cases released to Funeral Homes in last 24 hours	Quantitative, whole numbers	April	Ongoing	Daily
Age of Oldest Case	Time since date of death (DOD)	Quantitative, whole number of days. In first iteration was a count of how many cases were 0-10 days, 11-20, 21-30, 30+ days, then in late May it was changed to giving the number of days of the oldest case in custody	April	Ongoing	Daily
Type of Body Bag Decedents Storted In	Percentage of decedents stored in regular body bags vs more heavy duty disaster bags	**Sliding Percentage Bar:** % of cases in disaster bags	April	May	Daily
Number of Body Bags On Hand	Number of body bags each facility has	Quantitative, whole numbers	April	Ongoing	Daily
Shelving/Privacy of BCP	If shelving is present in their BCP, and if there is a privacy concern	For each BCP, facility identifies if there is shelving or racking (a previous iteration of the question just asked if they had them in general, then it was modified to indicate which BCPs had modificiations)	April	May	Daily

Survey Questions			Data Collection		
Status Name	**Description**	**Response Options**	**Start Date**	**End Date**	**Frequency**
Paperwork Status	How much of the necessary paperwork for case removal has been submitted	Yes, we have submitted all paperwork for unclamed cases in our BCP (whether or not it is full/ready for pick up) No, we have not submitted all paperwork for unclaimed cases in our BCP, and it is NOT full No, we have not submitted all paperwork for unclaimed cases in our BCP, and it is full Our facility does not have a BCP	April	May	Daily
Comments and Concerns	Space to ask questions or provide comments	Qualitative	March	Late May	Daily