



Greater New York Hospital Association

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TESTIMONY

OF THE

GREATER NEW YORK HOSPITAL ASSOCIATION

ON

HEALTH CARE RESPONSE AND EMERGENCY COORDINATION

IN THE EVENT OF

NUCLEAR, BIOLOGICAL OR CHEMICAL ATTACK

AT A

PUBLIC HEARING HELD BEFORE THE

NEW YORK CITY COUNCIL

COMMITTEE ON HEALTH

AND

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Good afternoon. I am Susan C. Waltman, Senior Vice President and General Counsel of the Greater New York Hospital Association, which represents the interests of 220 hospitals and continuing care facilities in New York City and surrounding areas. All of GNYHA's members are either not-for-profit, charitable organizations or publicly-sponsored institutions. Together, they provide services that range from state-of-the art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities they serve.

GNYHA members also serve an additional role, one that has become much more important and much more demanding since September 11, 2001: they are the front line of the region's public health defense and disaster response systems. Unquestionably, GNYHA members performed admirably on September 11 and during the subsequent anthrax attacks, a reflection of their years of preparedness planning. But those events and the subsequent and growing number of terrorist alerts have demonstrated how vulnerable we are as a society and how much more we need to do to be fully prepared.

As a result, GNYHA members have been working intensively, on their own and in close coordination with each other as well as with area emergency managers and public health officials, to enhance their preparedness. Through this process, GNYHA and its members have forged strong working relationships with key New York City agencies such as the Office of Emergency Management, the Department of Health and Mental Hygiene, and the Fire Department's Emergency Medical Service system. But, preparedness is a continual process that must be constantly reviewed, enhanced, and practiced. It is also an extraordinarily expensive

process, one that is causing GNYHA members to expend scarce resources during a time of severe financial pressures without any significant reimbursement in sight.

We therefore commend you for holding today's hearing and are hopeful that you will be able to assist GNYHA members in obtaining what they need most to fulfill their role of protecting the public's health: the financial resources to maintain and continue enhancing their preparedness. To demonstrate the resources that GNYHA members require to fulfill this role, I will outline their efforts before September 11, how valuable those efforts were in responding on September 11, and what the health care system has been doing to enhance preparedness since then.

I. Emergency Preparedness Activities Before September 1, 2001

GNYHA and its members have long been committed to ensuring that the health care system is prepared to respond to a broad range of emergencies, disasters, and attacks that might occur in the New York City region. For years, area hospitals have worked on preparing and improving detailed disaster plans, engaged in regular drills, and constantly reviewed their readiness for many events. Indeed, it is the mission of hospitals to respond to the needs of their communities, and, in a "community" such as New York, we recognize that any number of disasters and emergencies could occur. GNYHA has in turn supported its members' activities by providing training programs, educational materials, and workgroups for improving preparedness.

GNYHA and its members have also worked closely with area emergency management and public health officials over the years and are considered an integral part of the region's emergency/disaster response system. In recognition of this role, GNYHA has a desk at the New York City Office of Emergency Management's (OEM's) Emergency Operations Center (EOC), which GNYHA staffs during disasters, major area events, and anticipated possible emergencies, e.g., heat emergencies. Grouped with local, State, and Federal health and environmental agencies at the EOC, GNYHA is able to address members' needs quickly as well as facilitate the region's medical response to disasters.

II. The Health Care System's Response to the World Trade Center

The Hospitals' Response—On September 11, GNYHA's members demonstrated that they were prepared for the particular disaster that we all faced that day. Area hospitals instantly activated their disaster plans, cancelled all elective procedures, freed up thousands of beds in anticipation of large numbers of admissions, reconfigured areas internally to make room for additional patients, and established triage centers on their streets. At the same time, many hospitals found themselves without functioning communications systems, while some also found themselves without electricity and were forced to rely upon emergency generators. Some also experienced significant drops in their water pressure and were forced to seek alternative means to sterilize their equipment.

As the day wore on, hospitals were faced with another, more devastating phenomenon—thousands of family members were walking from hospital to hospital looking for their loved ones. Hospitals therefore established family centers to care for and counsel those individuals and ultimately requested that a patient locator hotline be established. And, throughout the ordeal, hospitals also acted as safe havens for individuals fleeing from the World Trade Center and even sent employees into neighboring buildings to make sure the elderly were safe. In short, the area's hospitals rose to all of the challenges they faced as a result of the events of September 11.

GNYHA's Response and Coordination on Behalf of Its Members—GNYHA, on behalf of its members, also played a key role on September 11. On the morning of the disaster, GNYHA was called by OEM within minutes of the initial plane crash and was requested to report to New York City's EOC. GNYHA was also in immediate contact with the New York State Department of Health, which directed hospitals to activate their disaster plans and expect mass casualties, a directive that GNYHA immediately communicated to its members by both e-mail and facsimile. Within moments of OEM's call to GNYHA, however, New York City's EOC, which had been located at 7 World Trade Center, was evacuated. Given this situation and the scope of the disaster, GNYHA established a command center at its offices to assist members and to act as a liaison to emergency managers, public health officials, and the public. Within hours, OEM established a replacement EOC, and GNYHA was able to assume its role of facilitating its

members' response efforts from there as well. For many weeks thereafter, GNYHA staffed both its desk at OEM and its command center at GNYHA's offices round the clock as the area undertook its recovery from the attacks.

Anticipating possible additional attacks, GNYHA also began to provide members with briefings on identifying and responding to biological and chemical events and to expand GNYHA's e-mail lists. Thus, by the time the first case of anthrax was reported in Florida, GNYHA was able to transmit immediately to members health alerts prepared by the New York City Department of Health and Mental Hygiene (NYC DOHMH) that contained key information needed to diagnose and treat anthrax.

The Cost of Responding to the World Trade Center—The cost of responding to the World Trade Center was significant for hospitals. GNYHA collected cost information from area hospitals and calculated that their total initial costs of responding (or preparing to respond) reached \$140 million, a figure that includes lost vehicles, such as ambulances; increased overtime, supplies, and staffing; damage to facilities; and stand-by costs associated with creating surge capacity. In addition, hospitals suffered additional lost revenues in excess of \$100 million in the long term as a result of the events of September 11, due in part to the fact that many patients did not want to venture into the city for care. *Thus, the total cost of responding—or standing ready to respond—to the events of September 11 was in excess of \$240 million for New York City area hospitals alone.*

The Need for Every Hospital to Be Prepared—I point out one fact about what happened on September 11 that has materially affected how GNYHA and its members have been preparing for future emergencies. Individuals caught in the disaster ran, they jumped on boats, and they jumped on trains and subways to escape the horror. As a result, over 100 hospitals in the region saw more than 7,300 patients in their emergency departments for World Trade Center disaster injuries. Although there was no evidence of a release of biological, chemical, or radiological agents in connection with the plane crashes, many hospitals chose to decontaminate or wash down patients to protect both the patients as well as health care workers.

What is the lesson to be learned from this? *Every single hospital must have some degree of capability to respond to disasters of all types.* We cannot, as a system, depend on an orderly distribution of patients to one or two regional disaster centers. It is essential that every hospital have the ability to identify and respond to biological, chemical, and radiological events to some extent, which in turn means that significant resources must be devoted to ensuring wide-spread readiness.

III. Establishment of GNYHA Emergency Preparedness Coordinating Council

In recognition of this need for broad-based preparedness, GNYHA created an emergency preparedness coordinating council in November 2001. The coordinating council brings together representatives of GNYHA members, other provider groups, and local, State, and Federal public health, emergency management, and law enforcement agencies for the purpose of promoting collaboration and communication across the region and providing a more integrated response to any future attacks or events. Through this collaborative planning process, the coordinating council is also facilitating readiness through the sharing of expertise, experiences, templates, and other information.

Since the coordinating council began its activities in early November 2001, it has met almost weekly through either full council meetings, workgroup meetings, or membership briefings on topics identified through the coordinating council. The following summarizes the activities and work plan of the coordinating council.

Improving the Ability to Communicate and Respond—The coordinating council has devoted considerable efforts to improving the ability to communicate and respond during disasters, which often relies on having key data available before, during, and after an emergency. Thus, the council has focused heavily on identifying the information that might be needed as well as developing efficient and effective systems for collecting and making the information available.

- **Emergency Contact Directory**—To improve communications in response to an emergency, GNYHA has developed a directory of key contact information regarding local, State, and Federal agencies, private agencies, and key vendors and other

services. GNYHA has also created a directory of its member hospitals and many of its largest long term care members that contains extensive contact information about members' emergency operations centers, chairs of disaster committees, and other key contacts in the event of emergencies. The directory also contains information about each members' facility response capabilities—for example, trauma center designation, decontamination capabilities, and the number of negative pressure isolation rooms.

- **Hospital Emergency Response Data System**—The coordinating council, working collaboratively with the New York State Department of Health (NYSDOH) and NYC DOHMH, has developed an emergency data collection system called the Hospital Emergency Response Data System or HERDS. The system, which is an internet-based system located on a secure area of NYSDOH's Health Provider Network, is designed to be activated during an emergency and to collect information from hospitals that may be needed to assess and respond to the emergency. Although the system is located on the NYSDOH Health Provider Network, New York City agencies have immediate access to all data collected so that they can better respond to any emergencies affecting the region. The categories of data that can be collected include the following:
 - Bed, staffing, and supply needs and availability;
 - Event-related data, including the number of patients seen and waiting to be seen, admissions, unidentified patients, and mortalities; and
 - Information required to establish a patient locator system, if needed.

GNYHA has held a region-wide drill of the system and is planning additional drills in the near future. GNYHA is also working with its members to facilitate incorporation of the system in their disaster plans and incident command structures.

- **Syndromic Surveillance Systems**—GNYHA has supported the efforts of the NYC DOHMH as it has undertaken its extensive syndromic surveillance system, which is designed to identify clusters of suspicious symptoms as quickly as possible. Currently, approximately 40 hospitals in New York City submit daily emergency department information to NYC DOHMH for this purpose. GNYHA has held

briefings to familiarize its members with the system and its value for both combating terrorism and responding quickly to emerging public health issues.

Minimizing the Impact of Disruptions in Communications—Many GNYHA members experienced significant disruptions in communication services as a result of the World Trade Center disaster. GNYHA has thus worked with members both to minimize future disruptions as well as to build in redundant means of communication.

- **Communications Options**—GNYHA has prepared a matrix of communications options, both systems and options, that describes each option’s functionality and limitations.
- **Undertaking Risk Assessments**—The coordinating council has discussed undertaking risk assessments designed to identify vulnerabilities and solutions for avoiding disruptions and GNYHA has presented briefings on the subject.
- **Group Purchasing of Phones and Two-way Radios**—GNYHA Services, Inc., has negotiated group purchasing arrangements for several communication options and services on behalf of its members and has developed special health care emergency channels on members’ Nextel two-way radios that enable participating providers to communicate with each other during an emergency.
- **800 Megahertz Radios**—GNYHA has worked with OEM to facilitate the purchase of radios and the reinstatement of a special health care talk channel so that New York City area health care facilities can communicate among each other and with OEM. GNYHA is exploring options for members outside of New York City as well.

Detecting and Responding to Radiological, Biological and Chemical Events—The coordinating council has devoted significant efforts to enhancing the ability of providers to detect and respond to radiological, biological, and chemical events.

- **Training and Education Programs**—Training and education are key to the ability of the health care system to identify the presence of a radiological, biological, or chemical agent and to then provide appropriate treatment and institute containment measures. GNYHA has therefore provided numerous briefings aimed at facilitating knowledge in these areas as well as at improving the basic infrastructure for

responding to emergencies through the development and implementation of effective incident command systems.

- **Development of Training and Education Materials**—The council has helped develop or identify training materials on many types of events that can be used to educate the community at large, the general employee population within health care institutions, and physicians and other practitioners who must be able to identify and respond to such events. The challenge is to take the extensive training and education materials that already exist and to distill them into useful, practical, and accessible formats to ensure broad-based education and distribution to the targeted audiences.
- **E-Mail Alert Service**—GNYHA provides extensive information to its members through immediate distribution via e-mail of health and security-related alerts, advisories, and directives. To ensure broad distribution of the alerts, GNYHA sends the materials to many different lists of individuals in each member institution such as chairs of disaster committees, infection control directors, directors of the emergency departments, and directors of security.
- **GNYHA Web Site**—GNYHA provides extensive information on the issue of emergency preparedness through its Emergency Preparedness Resource Center located on its Web site at www.gnyha.org/eprc. This information is updated continuously and is made available on the public area of GNYHA's Web site so that the public and providers can have access to needed information day or night. In addition, in order to address the concerns of the community, GNYHA has added a special section of its Web site that brings together extensive materials on preparing for and responding to disasters from a community perspective.

Development of Protocols and Policies—Finally, the coordinating council has assisted members develop guidelines to address a number of key issues related to emergency preparedness. Topics include: responding to radiological and chemical events, biological event preparedness guidelines, personal protective equipment and decontamination capacity, internal security and lockdown procedures, threat alert guidelines, supplies and stockpiles, employee communications, and managing volunteers.

IV. The High Price of Preparedness

The activities of GNYHA’s emergency preparedness coordinating council are intended to enhance preparedness in the most efficient, efficacious, and cost-effective ways. However, the price of preparedness is still high. GNYHA recently undertook a survey of its members’ actual and proposed expenditures associated with their preparedness activities. The survey requested information about their incremental expenditures over and above what they would have spent on their preparedness and planning activities but for the World Trade Center attacks, and excluding any costs incurred in the immediate response to the September 11 attacks. The survey requested cost information broken down into three categories:

- Expenditures undertaken during the period September 11, 2001, through December 31, 2002;
- Expenditures planned for the year 2003; and
- Expenditures that would be undertaken in 2003 if additional funds were available.

Fifty-four out of 106 hospitals responded, representing 51% of the institutions and 61% of the total operating expenses of the potential sample. The following chart presents the expenditures by time period and further separated by total expenditures, average expenditures by hospital, and expenditures by staffed bed.

Figure 1. Expenditures by Time Period

	Total Expenditures	Average Expenditure/ Hospital	Expenditure/ Staffed Bed
Spent (9/11/01-12/31/02)	90,223,959	1,670,814	3,998
Planned Expenditures (1/1/03-12/31/03)	110,475,640	2,045,845	4,895
Needed but Unbudgeted Projects (1/1/03-12/31/03)	468,609,786	8,677,959	20,765

The survey indicated that teaching hospitals had invested more heavily in preparedness than non-teaching institutions, a finding that is not surprising given that teaching hospitals are more likely to serve as regional trauma centers and burn centers, possess advanced disease surveillance and

analytical laboratory capabilities, and tend to have a broader scope of services than community hospitals in general. The following chart indicates the differences in expenditures per staffed bed by teaching status.

Figure 2. Expenditures per Staffed Bed by Teaching Status

Teaching Status	Expenditure/Staffed Bed (\$)	
	Spent (9/11/01-12/31/02)	Planned Expenditures (1/1/03-12/31/03)
Teaching (N=41)	4,350	5,309
Non-teaching (N=13)	1,526	1,992

In order to predict regional and Statewide expenditures for preparedness and based upon the observation that teaching hospitals have made greater investments in these activities, GNYHA extrapolated the survey findings using average expenditures per staffed bed according to hospitals’ teaching status to all hospitals in the New York City metropolitan region as well as to all hospitals Statewide. Figure 3 below indicates the results of that extrapolation process.

Figure 3. Expenditures by Time Period Extrapolated to New York City Region and New York State According to Teaching Hospital Status and Expenditures per Staffed Bed

	Total Respondents (\$ in millions)	GNYHA Downstate Hospitals (\$ in millions)	New York State Hospitals (\$ in millions)
Spent (9/11/01-12/31/02)	90.2	149.7	218.3
Planned Expenditures (1/1/03-12/31/03)	110.5	183.6	269.3
Needed but Unbudgeted Projects (1/1/03-12/31/03)	468.6	788.6	1,215.4

Not surprisingly, hospitals in New York City spent more on average than did hospitals outside of the City, presumably because New York City hospitals place a higher priority on preparedness and have imposed a more aggressive timetable for implementation due to the higher risk of an attack in New York City. The following two figures depict the increased expenditures in New York City versus the rest of the State both in total dollars per hospital and per staffed bed.

Figure 4. Average Expenditures Per Hospital by Region

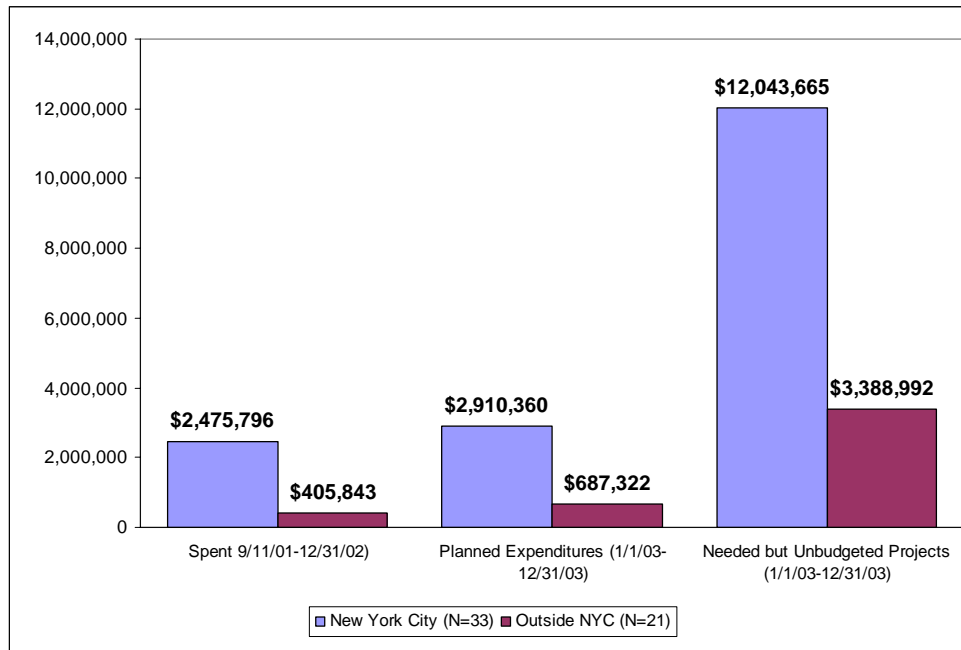


Figure 5. Average Expenditures per Staffed Bed by Region

Region	Expenditure/Staffed Bed (\$)		
	Spent (9/11/01-12/31/02)	Planned Expenditures (1/1/03-12/31/03)	Needed but Unbudgeted Projects (1/1/03-12/31/03)
New York City (N=33)	5,087	5,980	24,748
Outside NYC (N=21)	1,310	2,218	10,936

The types of costs covered by the survey included an array of expenditures for decontamination facilities; medical/surgical supplies such as antidotes and antibiotics; staff resources for training, drills, and developing protocols; personal protective equipment for employees; enhanced security; information systems for syndromic surveillance, reporting, and other purposes; and communication system improvements. Figure 6 demonstrates the proportion of total emergency preparedness expenditures by category.

Figure 6. Proportion of Total Emergency Preparedness Expenditures by Category

Expenditure Categories	Expenditures	Planned Expenditures	Needed but Unbudgeted Projects
	9/11/01-12/31/02	1/1/03-12/31/03	1/1/03-12/31/03
Security	4.6%	3.3%	5.4%
Facility (Including Dedicated Decontamination Facilities)	20.4%	25.5%	41.0%
Medical/Surgical and pharmaceutical supplies - Treatment	6.1%	4.2%	2.0%
Other Equipment and Supplies (Including Personal Protective Equipment)	8.7%	14.0%	6.3%
Information Systems (Including Disease Surveillance, Reporting and Laboratory Identification)	31.9%	32.1%	32.2%
Communication	2.4%	3.0%	1.8%
Staff Resources (Including Training & Drills and Consultants)	25.8%	17.7%	10.9%
Other	0.2%	0.2%	0.5%
Total	100.0%	100.0%	100.0%

Although the costs identified through GNYHA’s survey are significant, they do not begin to capture the actual cost to our members in terms of the hours upon hours of administrative, clinical, and other personnel time that have been devoted to and will continue to be devoted to the continual training, development of protocols, and reviews that will be undertaken each time a new threat alert or piece of intelligence is transmitted. They also do not include the costs of offering the current pre-event smallpox vaccination initiative that is viewed as an important

aspect of public health preparedness. In short, the price of preparedness is great and on-going, and there is no indication that providers in New York City will be able to stand down in terms of their level of preparedness.

The Poor Financial Condition of Area Hospitals—The need to increase preparedness and in turn expenditures for this purpose could not come at a worse time for hospitals. Hospitals in New York State suffer from the worst financial conditions of hospitals anywhere in the country. This situation is rooted in New York’s previously regulated all-payer rate-setting system, which squeezed any surpluses out of hospitals, declining revenues resulting from private payer negotiations and practices, the mission of caring for the State’s three million uninsured residents, and the imposition of unprecedented Medicare cuts in the Federal Balanced Budget Act of 1997. In addition, in October 2002, Medicare made further payment cuts to teaching hospitals such that teaching hospital revenues in New York State will be reduced by \$140 million a year, with \$100 million of the loss coming from hospitals in New York City.

More recently, New York State’s Executive Budget has proposed a series of new taxes and Medicaid payment cuts that GNYHA estimates will further reduce hospital revenues by \$850 million per year. More than \$650 million of that amount would come from New York City hospitals alone. Given that hospitals Statewide lost more than \$300 million in 2001, these cuts would result in losses of close to \$1.2 billion Statewide and \$850 million in New York City. Clearly, these cuts will greatly impede the ability of area hospitals to undertake the activities that are essential to enhancing and maintaining preparedness.

Securing the Necessary Resources to Ensure Public Health and Health System Preparedness—It is essential that New York City’s hospitals obtain the resources they need to continue to enhance and maintain their preparedness for the protection of all of us. To date, the only payments available for this purpose have been \$40,000 per hospital for bioterrorism preparedness through Federal grants under the Health Services and Resource Administration (HRSA). Recently, the U.S. Congress approved additional funding for this same purpose for the current Federal fiscal year. While the amount approved for hospital bioterrorism preparedness in the most recent round is approximately four times greater than last year’s amount, it is unclear

that the entire amount will be shared with hospitals, there is a considerable time-lag in distributing the funds to hospitals, and the amount, although appreciated, barely begins to scratch the surface in terms of need.

We must therefore work together to ensure that the need for continual preparedness can be met. Providers must continue to be well-trained to identify and respond to possible radiological, chemical, and nuclear events. They must have the resources, equipment, and facilities that permit them to implement what they might be called upon to do—to decontaminate patients, to isolate patients, and to care for patients with appropriate antibiotics and antidotes. They must be able to protect their employees with proper protective equipment. They must be able to communicate through myriad means in the event one method of communication is disrupted. And, they must be able to receive and transmit alerts and data quickly, preferably electronically, in order to support the area's public health surveillance and response systems.

We are hopeful that the New York City Council can assist us in obtaining funding to cover the costs of these critically-essential activities. We appreciate the opportunity to appear before you today and welcome the opportunity to work with you to identify the resources needed to ensure the protection of all of our citizens against potential terrorist attacks.