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TESTIMONY OF

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BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

HEARING ON

PREPARING EARLY, ACTING QUICKLY: MEETING THE NEEDS OF OLDER AMERICANS DURING A DISASTER

OCTOBER 5, 2005

Testimony of
Susan C. Waltman
Senior Vice President and General Counsel
Greater New York Hospital Association
Before the
Special Committee on Aging
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Mr. Chairman and Members of the Committee:

Good morning, and thank you for the opportunity to appear before you today. I am Susan C. Waltman, Senior Vice President and General Counsel of the Greater New York Hospital Association, which represents more than 250 hospitals and continuing care facilities in the New York metropolitan area, as well as throughout New York State, New Jersey, Connecticut, and Rhode Island. 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 in light of the events of September 11, 2001, and the emergencies that have occurred since then: they are the front line of the public health defense and disaster response systems for one of the highest risk areas in the United States. Unquestionably, GNYHA members performed admirably on September 11 as well as during the subsequent anthrax attacks and the Blackout of 2003, a reflection of their years of preparedness planning. But those events, together with the growing number of terrorist alerts, natural disasters such as Hurricanes Katrina and Rita, and the threat of a possible pandemic influenza have demonstrated how vulnerable we are as a society and how much more we need to do to be fully prepared.

Meeting the Needs of Older Americans During Disasters—The issues raised by today's hearing are of critical importance to all of us. While many sectors and regions of our country have devoted significant resources to emergency preparedness, the effects of Hurricane Katrina have demonstrated quite vividly the disparate abilities of different populations to participate in an emergency response plan, particularly evacuations. The Committee is, of course, focused on issues facing older Americans during disasters. The same issues arise however for all populations whose circumstances create barriers for them to gain the benefits of even the best of emergency plans: the poor, the medically fragile, and other special needs populations. We applaud you therefore for focusing on these issues, and I assure you that the relevant providers, agencies, and authorities in the New York area take these matters very seriously and have already begun to review their own plans in light of what the aftermath of Hurricane Katrina revealed about emergency planning in general.

Applying a Strong Regional Framework to Protect Older Americans—Since September 11, GNYHA and its members have devoted significant efforts to enhancing what was already a strong regional framework for responding to disasters of all kinds. While GNYHA's principal focus has been on preparing its hospital members as the entities most likely to be called upon during an emergency, its activities have nevertheless built a framework that can be used in other regions of the country in general, as well as to address the needs of special populations, including older Americans, in particular. GNYHA's framework is premised on the idea that preparedness is an on-going process, one that requires us to learn from every event, alert, and emergency, and one that requires us to work closely every day with our partners in preparedness: other providers of every kind as well as local, state, and Federal agencies. Our guiding principles are the following, the application of which I discuss in more detail later in my testimony:

- **High-Risk Area**—The New York City region is a high-risk area for emergencies in general and terrorist attacks in particular. Therefore, providers must anticipate the possibility that an event could occur at any time.

- **Strong Three-Way Partnership**—Preparedness in the health care sector requires a strong, continuous three-way partnership among providers, health/public health agencies, and emergency management agencies.

- **All-Hazards Approach**—Provider preparedness should be undertaken using an all-hazards approach.

- **Incident Command Systems**—Providers should implement an incident command system in order to have a common framework for communicating internally and externally during disasters.

- **Enhancing Communications**—Providers must develop effective mechanisms for communicating. This involves knowing *in advance* of a disaster with whom, how, and for what purposes to communicate during disasters. It also means developing effective and redundant means of communicating during disasters.

- **Understanding Each Other's Systems**—We must ensure that we understand each other's systems, roles, and responsibilities.

- **Planning and Drilling Together Regularly**—In order to further the foregoing goals, it is essential that we plan and drill together regularly.

- **Training and Education**—Knowledge is the key to ensuring the rapid identification, treatment, and containment of all types of terrorist agents and naturally-occurring events.

We believe that the relationships that have been built based on the foregoing principles are mutually beneficial and invaluable to our ability to protect our country, its communities, and particularly our most vulnerable members of society.

Overview of Testimony—To assist you in understanding the approach that we take, I will review the New York City region's preparedness from a health care provider perspective before September 11, how that level of preparedness was demonstrated on September 11, and how preparedness has been enhanced significantly since then. I will then provide information on how the New York region is building upon those efforts to improve its ability to care for special needs populations during future emergencies.

I. Emergency Preparedness Activities Before September 11, 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 and improved upon their disaster plans and programs, 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 have recognized that any number of disasters and emergencies can occur. GNYHA has in turn supported its members' activities by providing training programs, educational materials, and workgroups for improving preparedness.

Hospitals as an Integral Part of the Region's Response System—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 had a desk at the New York City Office of Emergency Management's (OEM's) Emergency Operations Center (EOC) for many years,* which GNYHA staffs during major area events, actual emergencies, or anticipated possible emergencies, e.g., impending hurricanes, snow storms or 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 to facilitate the region's health care response to disasters.

The health care sector's preparations for the Y2K transition also helped foster regional collaboration that was helpful to the health care system's response on September 11. During the year 1999, GNYHA brought together its members and area agencies literally every other week for the purpose of developing communication mechanisms, contingency plans, and a framework for inter-hospital/inter-agency coordination. That process proved invaluable on September 11.

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

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 casualties, 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 communication systems, while some also found themselves without electricity and were forced to rely upon emergency generators. Some also experienced drops in water pressure and steam and were forced to seek alternative means to sterilize equipment.

As the day wore on, hospitals were faced with another, perhaps 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 system 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 was 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 at the New York City Police Academy, and GNYHA was able to continue its role of facilitating its members' response efforts from there as well.* For weeks thereafter, GNYHA staffed both its desk at OEM and its command center at GNYHA's offices around 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 immediately transmit to members health alerts prepared by the New York City Department of Health and Mental Hygiene that contained key information needed to diagnose and treat anthrax.

The Cost of Responding to the World Trade Center Disaster—The cost of responding to the World Trade Center disaster was significant for hospitals. GNYHA collected cost information from area hospitals and calculated that their total initial costs of responding reached $140 million, a figure that included lost vehicles, such as ambulances; increased overtime, supplies, and staffing; damage to facilities; and stand-by costs associated with creating surge capacity. Hospitals also suffered additional lost revenues in excess of $100 million in the long term as a result of the events of September 11. Thus, the total cost of responding to the events of September 11 was in excess of $240 million for New York City area hospitals alone. We are very appreciative that the Federal government, with the strong support of Senators Clinton and Schumer, subsequently provided hospitals in all responding areas with $175 million to reimburse them for a significant portion of their costs; however, it is important to underscore the high costs associated with responding to such events from a provider perspective.

The Biggest Lesson Learned: The Need for Every Hospital to Be Prepared—I point out one fact about the events of 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 attacks, many hospitals chose to decontaminate or wash down patients to protect both patients as well as health care workers. But if there had been a contemporaneous release of some agent, every one of those over 100 hospitals would have received potentially exposed or contaminated patients.

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 more regional disaster centers. It is essential that every hospital have the ability to identify and respond, at least initially, to a variety of events, which in turn means that significant resources must be devoted to ensuring widespread readiness.

III. Post-September 11 Preparedness—Focus on Intensive Regional Collaboration

Establishment of Emergency Preparedness Coordinating Council—In recognition of the need for broad-based preparedness, GNYHA and its members have focused intensively on regional collaboration and planning since September 11. To this end, GNYHA created its Emergency Preparedness Coordinating Council in November 2001. The 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 purposes 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 Council is also facilitating readiness through the sharing of expertise, experiences, templates, and other information.

Guiding Principles of Preparedness—As the Council has moved forward, it has subscribed to a number of key principles that were outlined briefly earlier in my testimony and that are summarized in more detail below:

- **Operating Within a High-Risk Area**—In recognition of the high-risk area in which we are located, GNYHA and its members appreciate that an event could occur at any time and at any place and that we must enhance our preparedness with all due speed and deliberation. As a result, since the Council was established in November 2001, *it has met almost weekly through either full Council meetings, workgroup meetings, or membership briefings on topics identified through the Council.* The Council has also become the framework for communicating rapidly and effectively regarding emergencies, alerts, and protocols.

- **Development of Strong Three-Way Partnership Among Providers, Public Health Agencies, and Emergency Managers**—We have undertaken extraordinary efforts to work collaboratively with a variety of types of providers as well as with the public health and emergency management/public security agencies who will need our services and whose services we will need. Our preparedness and any future responses will be superior for that effort.

From a provider standpoint, we have made efforts to include providers of all types including nursing homes, home care agencies, community health centers, primary care centers, and physician organizations.

From a local government standpoint, we work closely with New York City's Office of Emergency Management, Department of Health and Mental Hygiene (NYCDOHMH), Fire Department, and Police Department. Because we prepare as a region, we have established similar working relationships with the public health and emergency management agencies in the counties surrounding New York City.

On the state level, we have excellent relationships with the New York State Department of Health (NYSDOH), Office of Public Security, and Emergency Management Office, and have incorporated New Jersey's Department of Health and Senior Services and emergency management agencies in our process as well.

On the Federal level, we work closely with both the Department of Health and Human Services and the Department of Homeland Security, through its Federal Emergency Management Agency (FEMA), both of which support and enhance our activities on a regular basis. Indeed, our communications with and support from both agencies are models for public-private partnerships.

- **Developing an All-Hazards Framework and Implementing Incident Command Systems**—GNYHA and its members have placed a strong emphasis on developing and implementing an all-hazards response framework on the theory that one can never anticipate precisely how or when an event might occur and indeed an event might present with multiple features. We therefore believe that planning under an all-hazards approach will make us better able to respond to multiple variations of possible attacks and natural events.

  As a result, GNYHA and its members have devoted extensive efforts toward implementing strong incident command systems, which can be activated in response to a variety of emergencies. Using the incident command approach also permits hospitals to employ a common response framework with similar roles and responsibilities across organizations. Most hospital incident command systems are modeled after the Hospital Emergency Incident Command System or HEICS, and thus, GNYHA has offered numerous training sessions on implementing HEICS. Special sessions have been offered for individuals working on the evening, night, and weekend shifts in order to ensure the availability of staff familiar with incident command principles during all hours of operation. Many of these training modules are available in GNYHA's Emergency Preparedness Resource Center located on GNYHA's Web site at **www.gnyha.org/eprc** so that members can download and use them in their own institutions.

- **Enhancing and Ensuring Effective Communications**—We have placed an extraordinary emphasis on communications because the ability to communicate with one's partners during an emergency is key to an effective and rapid response. We have tackled this issue from two perspectives. First, we have focused on the issue of ensuring that we know with whom, how, and for what purposes to communicate during a disaster. Second, we have focused on

ensuring that we have rapid, effective, and redundant means to communicate during a disaster. The following outlines some of the specific systems and mechanisms put in place to address this critical component of preparedness:

- **GNYHA Emergency Contact Directory**—To improve communications during an emergency, GNYHA has developed a directory of key contact information regarding local, state, and Federal agencies. GNYHA has also created a member directory 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 basic information about each members' capabilities—for example, trauma center designation, decontamination capabilities, and the number of negative pressure isolation rooms. Members are encouraged to update their information regularly, and revised directories are made available quarterly or as needed. The directory proved to be invaluable during the August 2003 Blackout when communication systems were disrupted throughout the region.

- **Health Emergency Response Data System**—NYSDOH, working collaboratively with the Council, has developed an emergency data collection system called the Health 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 to collect information that may be needed to assess and respond to the emergency and to enhance and protect surge capacity. Although the system is located on NYSDOH's Health Provider Network, local public health and emergency management agencies also have access to the system so that they can better respond to any emergencies affecting their 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.

  NYSDOH also uses the system to collect weekly bed availability data from hospitals, to survey them on such information as facility capabilities, vaccine supplies, and other health initiatives, and to communicate regarding preparations for events such as possible weather emergencies. We have also held a number of drills designed to test both the system itself and the ability of hospitals to use it successfully. Work-arounds in anticipation of possible disruptions in the system have also been established. NYSDOH is currently expanding HERDS for use by other types of providers.

- **Ensuring Rapid Communications**—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 types of individuals in each member institution

such as chairs of disaster committees, infection control directors, directors of emergency departments, and directors of security.

- **Assessing Communications Risks and Minimizing Disruptions**—GNYHA has prepared a matrix of communication options that describes each option's functionality and limitations. In addition, GNYHA has prepared a checklist of considerations regarding possible disruptions to communication systems in order to assist members plan for and thus avoid or work around possible disruptions to their systems. Finally, the Council has discussed how to undertake effective risk assessments to identify vulnerabilities and solutions for avoiding disruptions.

- **Building in Redundancies**—Although a vulnerability assessment might minimize disruptions in communication systems, GNYHA and its members have sought to build in as many redundancies in communication systems as possible. This is evidenced by the multiple ways that members can be reached as set forth in GNYHA's emergency contact directory mentioned above. In addition, GNYHA members have established and rely on the following systems:
  - ✓ **800 Megahertz Radios**—GNYHA worked with New York City OEM to establish a health care channel on the City's 800 Megahertz radio system. This channel permits New York City health care facilities to communicate among each other and with OEM during emergencies. The City conducts roll calls on this system on a daily basis. This system was used extensively during the 2003 Blackout to communicate member needs for generators, fuel, and other supplies.

  - ✓ **Two-way Emergency Response Radios**—GNYHA has also developed a two-way radio emergency response network to enable GNYHA to communicate with its members both inside and outside of New York City.

- **GNYHA Web Site**—GNYHA provides extensive information on the issue of preparedness through its Emergency Preparedness Resource Center located on its Web site at **www.gnyha.org/eprc**. This information is updated regularly and is made available on the public area of GNYHA's Web site so that the public and providers can have access to the information day and night. In order to address the concerns of the community, the Web site includes a section with materials on preparing for and responding to disasters from a community perspective.

- **Syndromic Surveillance**—GNYHA has supported the efforts of NYCDOHMH as it has built its impressive syndromic surveillance system, which is designed to identify clusters of suspicious symptoms, such as gastrointestinal or respiratory problems, that might signal a bioterrorism event or other serious public health problem. Currently, NYCDOHMH collects daily emergency department logs from area hospitals, emergency medical services call data, certain employee absenteeism rates, and local pharmacy purchases, all toward the goal of identifying and containing possible infectious disease outbreaks or other events as quickly as possible. Should a cluster be identified, NYCDOHMH would investigate and notify area emergency departments and infection control directors accordingly.

- **Understanding Each Other's Roles, Resources, and Responsibilities: Planning and Drilling Together Regularly**—Understanding each other's roles, resources, and responsibilities is essential to a well-coordinated response to an emergency, and thus, GNYHA and its members have worked hard to understand precisely what each hospital's and agency's capabilities, planned responses, and resources might be under a variety of scenarios. This is accomplished in great part through our collaborative planning process and the undertaking of many drills and exercises, all designed to assess the strengths and weaknesses of the response system and then to address any identified gaps. Some of the more notable examples of these efforts are the following:

    - **Development of Threat Alert Guidelines**—To assist members work within and to respond to changes in the Federal color-coded threat alert levels, GNYHA worked with its Council, NYSDOH, and NYCDOHMH to develop Threat Alert Guidelines for health care providers. The Guidelines provide a checklist of measures providers should take by alert level. Each level is divided into a number of categories of measures, which include such issues as overall emergency planning, communications, security, staffing, and supplies. While designed to respond to terrorist threat levels, the Guidelines can be used to prepare for any type of emergency. Thus, the Guidelines are distributed each time a planned event or possible anticipated emergency arises.

    - **2003 Blackout Response**—The 2003 Blackout tested us all and demonstrated the gaps that we still needed to address. But it also highlighted what worked well: our emphasis on redundant communications paid off; our collection of emergency contact information regarding members helped us reach every member; our 800 Megahertz radio system helped address emergency generator and fuel requirements; the HERDS system collected information about available beds in anticipation of the possible evacuation of a facility; and most importantly, our strong three-way partnership with the health and emergency management agencies proved invaluable. In order to enhance preparedness based on experiences during the Blackout, GNYHA prepared checklists outlining considerations for preparing for future disruptions in power and communications and held a debriefing session attended by members as well as local, state, and Federal agencies.

    - **Preparing for Bioterrorism**—Since its inception, the Council has focused its discussions on a number of bioterrorism agents, spending a significant amount of time initially on identifying, treating, and containing smallpox in particular. In August 2002, however, a small hospital in Brooklyn experienced a "smallpox scare," which raised useful questions regarding various elements of responding to such a situation. As a result, NYCDOHMH and NYSDOH, working collaboratively with the Council, developed extensive guidelines for managing a suspect smallpox case. While the guidelines focus on smallpox, many aspects of the guidelines apply equally to managing other infectious diseases as well. The guidelines are available on GNYHA's Web site at **www.gnyha.org/eprc**.

- **SARS Planning and Response**—The work that has been done to prepare for a possible bioterrorism attack proved to be helpful to the health care system's ability to respond quickly to the threat of Severe Acute Respiratory Syndrome or SARS in 2003. The Centers for Disease Control and Prevention (CDC) immediately transmitted health alerts to state and local health departments, which in turn immediately distributed the alerts to providers. In order to ensure broad distribution of the alerts within its members, GNYHA distributed them to its many e-mail lists. GNYHA also held briefings on SARS, which were given by NYSDOH and NYCDOHMH; held meetings of its Council to discuss the development of SARS guidelines and surge capacity plans; and created a SARS page on its Web site.
- **Planning for a Pandemic Influenza**—The New York region, like the rest of the world, is preparing for the possibility of a potential pandemic influenza, whether from Avian flu or some other source. Again, using its Council as the convening body, GNYHA has provided programs attended by the CDC, NYSDOH, and NYCDOHMH, all aimed at collaborative planning for such an event. We anticipate that the process will continue for some time.

- **Undertaking Drills and Exercises**—Although we meet and work together regularly, we find that drills and exercises are an excellent way to test our systems and to identify gaps. We thus have placed a heavy emphasis on conducting table-top exercises, communication drills, and other exercises. We have picked up the pace of these drills and exercises as we unroll more components of our systems and have more to test.

- **Training and Education**—The Council has placed heavy emphasis on training and education. Thus, GNYHA has offered over 75 briefings and training sessions to its members and key agencies since September 11. The topics have included programs on various biological, chemical, and radiological events; preparing for and responding to power outages and other disruptions; undertaking evacuations; implementing incident command systems; communication systems; and facility security. Recognizing that training is a continual process, we often revisit issues already presented. Upcoming programs include:

  - A briefing on *blast injuries and mass casualty events* that will be given by the U.S. Public Health Service on October 17;

  - A workgroup meeting on *functionality and improvements to the Health Emergency Response Data System* in light of the issues raised by Hurricane Katrina that will be held on October 18; and

  - A meeting on *Learning from Hurricane Katrina,* which will include representatives of GNYHA members, emergency management agencies, and the Joint Commission on Healthcare Organizations who visited the Gulf Region following Hurricane Katrina and that will be held on October 31.

IV. Addressing Special Needs Populations

Application to Emergency Planning for Special Needs Populations—We believe that the strong framework that is in place in the New York region can be applied in almost any area of the country for preparedness purposes in general as well as for addressing emergency planning and response on behalf of special needs populations in particular. Wherever the framework is applied, however, some party or entity must be the champion for the process. It does not matter who drives the process, whether it is someone from the provider or the human services communities, the public health agencies, or the emergency management agencies. But some player in the community or region must step forward and take ownership of the process. And that lead entity cannot lose sight of the fact that preparedness is continual, and it must be collaborative. That sounds simple, but it so easy for the importance of preparedness planning to get lost in the course of the demands of any one day. And it is so easy to fall into the more typical "silo" or "stove pipe" approach to planning. Without a continual, collaborative approach to preparedness however, it is also far too easy to repeat what occurred in the aftermath of Hurricane Katrina, without in any sense making judgments as to the causes.

New York City Planning for Special Needs Populations—The New York region has long been sensitive to the barriers that face special needs populations when it comes to emergency preparedness and response. As a result, New York City and New York State have focused heavily on addressing those barriers through emergency plans that take into account those with special needs as well as through materials aimed at helping them prepare for emergencies individually, if possible. Indeed, last week, Joseph Bruno, Commissioner of the New York City Office of Emergency Management (OEM), testified before the New York City Council's Committee on Public Safety and outlined New York City's plans for responding to natural disasters, including its evacuation and sheltering plans. For this purpose, New York City has identified 700 public schools, with a capacity to house over 800,000 individuals, that are not in storm surge zones. In order to ensure no one shelter is overwhelmed, the public will be directed to reception centers where workers will then arrange for transportation to an appropriate shelter. Information about the process is available on New York City's Web site and in brochures that have been developed for this purpose and would additionally be available through media announcements as the need arises.

With respect to special need populations in particular, Commissioner Bruno outlined in his testimony how the City's plan contemplates making sure that their needs are met during emergencies. Commissioner Bruno testified that more than 50 agencies have responsibility for identifying individuals among their clientele and patients who have special needs, including the New York City Department for the Aging, the New York City Human Resources Administration, and many private agencies. In addition, local utilities, such as Con Edison and KeySpan, maintain lists of customers who are dependent on electricity for their care, e.g., those who are ventilator dependent, and will share this information with the City, as appropriate. During an emergency, the respective agencies have responsibility for contacting their clients and patients and for making arrangements for their care and evacuation if needed. If the individual cannot be contacted or there is a problem with his or her ability to evacuate, the appropriate City agency will make contact with the individual and the person will be evacuated. The City's 311 call system and Web site will also play a role in identifying and assisting at-risk individuals. The

City recognizes that some individuals will not want to leave their homes and thus advises them to have on hand what they will need for up to 72 hours after a storm.

To help prepare special needs populations and older Americans in particular for emergencies, New York City has published a brochure entitled *Ready New York.* The brochure provides information on developing a disaster plan, being prepared to evacuate, and what might be needed to shelter in place. And of course, the brochure provides information on resources that might be available to assist seniors and individuals with disabilities in this regard. New York City also recognizes that it is a city of many languages, and thus makes its readiness guide for household preparedness available in nine languages.

New York State Planning for Special Needs Populations—On a statewide level, the New York State Department of Health has also undertaken efforts to ensure preparedness for special needs populations by bringing together representatives of key agencies and associations representing hospitals, nursing homes, and other services to prepare for emergencies in a collaborative manner. In addition, New York State also recently requested all home care and related agencies to undertake certain activities as part of their emergency preparedness plans, including:

- Identification of a 24/7 emergency contact telephone number and e-mail address for the agency's emergency contact person and alternate;

- Development of a call down list of agency staff and a procedure that addresses how the information will be kept current;

- Development of a contact list of community partners, including the local health department, local emergency management agencies, emergency medical services, and law enforcement, and a policy that addresses how this information will be kept current;

- Collaboration with the local emergency manager, local health department, and other community partners in planning efforts;

- Development of policies that require the provider to maintain a current New York State Health Provider Network (HPN) account with a designated HPN coordinator responsible for securing staff HPN accounts and completing the HPN Communications Directory;

- Maintenance of a current patient roster that is capable of facilitating the rapid identification and location of patients at risk and that should contain, at a minimum:

    - Patient name, address, and telephone number
    - Patient classification level (high, moderate, or low priority)
    - Identification of patients dependent on electricity to sustain life
    - Emergency contact telephone numbers of family/caregivers
    - Other specific information that may be critical to first responders;

- Development of procedures to respond to requests for information by the local health department, emergency management agency, and other emergency responders in emergency situations; and

- Development of policies addressing the annual review and update of the emergency plan and the orientation of staff to the plan.

Emphasis on Collaborative Planning and Response—I emphasize that New York City's and New York State's overall approach to preparedness and response permits all interested agencies and parties, whether public or private, to prepare and respond in a collaborative way, thus better ensuring the successful implementation of their plans. For example, New York City's emergency operations center (EOC) brings together up to 150 different agencies and organizations as needed during emergencies. GNYHA in particular sits with the relevant health and medical agencies and thus can provide and/or obtain assistance on behalf of its members as needed. It can just as easily walk over to the utility section and request assistance from ConEdison if needed to follow up on a call for help on behalf of one of its members or another health care provider. Or it could walk over to the human services area to seek assistance from the American Red Cross or one of the other agencies that staff the EOC.

I also emphasize two other points. First, it is not the building known as the "EOC" that makes the difference, but rather the collaborative planning that takes place. As noted, New York City lost its "EOC" within minutes of the World Trade Center attack. But it was able to bring everyone together in another location within a matter of hours so that the relevant agencies could begin working together as they do so very well every day. Second, health care providers, particularly GNYHA members, know that they can call GNYHA at the EOC to obtain help for them and their patients. Both elements are important to New York's ability to provide care on behalf of special need populations.

Learning from Hurricane Katrina—Although New York City's and New York State's plans already contemplate caring for and protecting special needs populations during emergencies, New York City and New York State are nevertheless embarking on extensive efforts to enhance preparedness for these populations as a result of what occurred during the aftermath of Hurricane Katrina. First, New York City and New York State officials, together with provider groups, have already begun meeting to ensure that health care facilities have effective and realistic evacuation plans. They are also reviewing their existing plans to ensure that special needs populations are effectively considered and cared for as part of them. For this purpose, it is clear that many more agencies and organizations will be involved in planning efforts moving forward as well as in certain EOC activations in the future. We at GNYHA are similarly examining what occurred during the aftermath of Hurricane Katrina to enhance our collaboration, communications, and partnerships with many different types of providers and agencies. As noted, GNYHA has planned two meetings to begin addressing these issues during the month of October alone.

V. The Price of Preparedness

Quite clearly, extensive efforts are in place to be prepared for a vast array of events, both planned and unplanned, in the New York region. The collaborative efforts that have taken place through GNYHA's Emergency Preparedness Coordinating Council are intended to enhance preparedness in the most efficient, efficacious, and expeditious way.

The Cost of Preparedness—However, the price of preparedness remains high. While today's hearing is meant to focus on meeting the needs of older Americans during emergencies, GNYHA believes it is important for the Committee and others to understand the cost of preparedness for that part of the health care system on which aging Americans might be most dependent during an emergency, specifically, the hospitals.

In late 2002, GNYHA undertook a survey of its members' actual and anticipated expenditures associated with their preparedness activities. Although GNYHA has not updated the information collected through the 2002 survey, the findings are nevertheless useful to inform the Committee on the cost of preparedness. The survey requested information about hospitals' incremental expenditures over and above what they would have spent on preparedness if the World Trade Center attack had not occurred, and excluding any costs incurred in the immediate response to the September 11 attacks.

Fifty-four hospitals responded representing 51% of the institutions and 61% of the total operating expenses of the potential sample. 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. In addition, hospitals in New York City not surprisingly 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.

Average Expenditures For Preparedness Per NYC Hospital—With respect to individual hospital expenditures for preparedness, hospitals in New York City:

- Spent on average nearly $2.5 million per hospital during the period from 9/11/01 to 12/31/02;
- Planned to spend on average an additional $2.9 million per hospital during 2003; and
- Identified additional needed but unbudgeted projects with projected costs totaling on average $12 million per hospital.

Although the costs identified through GNYHA's survey are significant, they do not 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 training, the development of protocols, and the reviews that will be undertaken each time a new alert or emergency arises. In short, the price of preparedness is great and on-going, and there is no

indication that providers in the New York City region will be able to stand down in terms of their level of preparedness.

Funding for Preparedness—New York State hospitals have received only relatively small amounts of funding toward their preparedness activities. While GNYHA and its members are appreciative of the bioterrorism funding that has been made available and continues to be made available through the Health Resources and Services Administration (HRSA), the amounts that filter down to individual hospitals do not begin to address the expenditures that are being made by the New York City region's hospitals.

The Poor Financial Condition of New York State Hospitals—The need to increase and maintain preparedness and in turn to increase expenditures for this purpose could not come at a worse time. *Hospitals in New York State suffer from the worst financial conditions of hospitals anywhere in the country and have experienced years of bottom-line losses.* This situation is rooted in the following factors:

- 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 their practices of delaying and denying payments;
- The mission of caring for the State's three million uninsured residents; and
- The imposition of unprecedented Medicare cuts, beginning with the Federal Balanced Budget Act of 1997, continuing with reductions in payments to teaching hospitals, and most recently, the arbitrary dilution of the New York City area wage index, which alone has reduced Medicare payments to area hospitals by over $100 million annually.

Clearly, the financial condition facing New York's hospitals impedes their ability to undertake the activities that are essential to both fulfilling their basic mission of providing health care and their new role as the front line of the public health defense and emergency response systems for their communities.

Securing the Necessary Resources to Ensure Public Health and Health System Preparedness—Based on our experience, creating and maintaining comprehensive emergency preparedness plans is costly and time consuming, but it is also critical for the communities that our health care providers serve. Hospitals in New York have made this tremendous commitment to emergency planning, despite the dire lack of resources available. It is vital for this Committee to consider the costs of emergency preparedness when making any recommendations or creating any preparedness requirements for providers in at-risk areas, such as the New York region, or anywhere else in the nation. For America's hospitals to be sufficiently prepared for any disasters, whether terrorist or weather related, Congress should also consider making funding available based on the threats and emergencies that a region's health care providers face.

I thank you for the opportunity to appear before you today and am of course available to answer any questions you may have.