Testimony

Of

Dr. Thomas A. Farley
Commissioner
New York City Department of Health and Mental Hygiene

before the

New York City Council
Committees on Health, Government Operations, and Public Safety

On

New York City's Response to H1N1

June 11, 2009

Council Chambers
City Hall
New York City

Good afternoon Chairpersons Rivera, Sears, Vallone and members of the Committees. I am Dr. Tom Farley, New York City Health Commissioner. Thank you for the opportunity to testify regarding the City's response to H1N1 influenza and overall influenza preparedness.

Influenza is a serious viral disease. There is seasonal flu every year in the United States, and an average of five to 20 percent of the population gets the flu, more than 200,000 people are hospitalized from its complications, and about 36,000 people die. On average 1,000 New Yorkers die from influenza each year, the vast majority of whom are over the age of 65.

The new strain of the influenza virus, H1N1, was first recognized in Mexico in April and has since caused outbreaks of illness in the United States and in many other countries around the world. The Health Department first detected the virus in New York when a large number of students from St. Francis Preparatory School in Queens presented to a school nurse office over a 2-day period with symptoms of influenza-like-illness (ILI). At that time we knew little about how easily the virus would be transmitted, the severity of the illness it might cause, and who amongst the New York City population was most at risk for infection or for severe illness.

Under the Citywide Incident Management System, the Department of Health and Mental Hygiene (DOHMH) is the lead agency in responding to public health emergencies, including pandemics. In preparation for such an event, the Department developed a *Pandemic Influenza Preparedness and Response Plan.* The plan is grounded in the reality that we will not be able to prevent pandemic flu from entering New York City once it emerges anywhere in the world, and that once it arrives we can try to slow its transmission, but will not be able to halt it. A key priority in our plan, which is very relevant in our current response, is minimizing severe illness and death by identifying and treating those New Yorkers who are most at risk as early as possible in the pandemic.

In response to the initial H1N1 outbreak at St. Francis, the Department activated its Incident Command System (ICS), a set of agency-wide on-call teams established to draw on all needed agency resources and provide the highest level of coordinated response. Since then, the ICS leadership has been meeting several times daily to execute our plan. During the height of the outbreak more than 200 Health Department staff worked 12 to 18 hour days and I'd like to acknowledge and thank them for their hard work and dedication.

The Health Department constantly monitors ILI activity in community and health care settings using a variety of surveillance methods, and we immediately scaled up our efforts in response to the St. Francis outbreak. We track hospital emergency department visits, pharmacy sales of antiviral and other medications, school absenteeism and primary care visits, among other indicators, to monitor trends and identify clusters of influenza-like illness.

From the start, because H1N1 was a new virus and little information on its clinical and epidemiologic characteristics were initially known, our priority for surveillance was monitoring for more severe illness and death. In partnership with the healthcare community and the Office of the Chief Medical Examiner, we established enhanced surveillance in order to track the number of persons who were hospitalized or had died with influenza-like symptoms. We actively worked with the healthcare providers reporting suspect cases to arrange testing for H1N1 in our laboratory.

The Department's Public Health Laboratory provides a wide range of clinical and environmental laboratory testing services. During the early period of the outbreak, the Lab was able to determine that the ILI at St. Francis was probable H1N1, and we recently acquired the technology necessary to perform confirmatory tests for the new H1N1 influenza. Our Lab was one of the first nationally to receive this test and having this capacity locally improved our ability to obtain timely information about the virus. The development and distribution of such a test in such a short period of time is a remarkable feat, and we appreciate the support we've received from our partners at the CDC.

We observed some important patterns about this new H1N1 influenza virus from our early investigations. First, the virus appeared to spread easily in particular settings, most notably schools. Second, in spite of this, the elderly were generally spared, in contrast to seasonal flu. Third, nearly all of the younger people who did become ill had mild symptoms, with most recovering completely in 2-5 days.

The Health Department continues to survey New Yorkers to determine what proportion of the city's population has experienced flu-like illness since late April, and what types of symptoms people have experienced. We surveyed students, teachers and parents at St. Francis to learn more about the particular circumstances surrounding the outbreak at that school and to understand the patterns of transmission of the new virus.

In late May we conducted a random-digit-dial telephone survey of 1,000 New York City residents. Of those surveyed, 6.9 percent reported having fever accompanied by sore throat or cough in the previous three weeks. We are still refining our estimates, but the survey suggests that many thousands – perhaps hundreds of thousands - of New Yorkers have had influenza-like illness.

DOHMH recently released an analysis of H1N1 hospitalization data, which found that the most common risk factor for complications due to H1N1 in NYC thus far has been asthma. We also observed that individuals who are younger than 2, over 65, pregnant or have a weakened immune system, diabetes or cardiovascular disease are at elevated risk during the current outbreak.

As with seasonal flu, the H1N1 flu has claimed lives, 15 so far in New York City since the outbreak began. While most of these deaths have involved people with risk factors for flu complications, influenza is sometimes fatal in otherwise-healthy people. These deaths are tragic, but not unexpected. This is why it is important for anyone who has the risk factors mentioned previously or chronic underlying health problems to

consult a health care provider when experiencing flu-like illness. It is important for all New Yorkers to take measures to protect themselves from flu, including avoiding close contact with people who have influenza-like illness, and washing hands often with soap and water.

Armed with a basic understanding of the virus, a recognition that novel H1N1 transmission and symptoms were similar to seasonal flu, and the capacity to test locally for H1N1, the Department's main objective has been to minimize the impact on high risk individuals. The community control and response portion of our *Pandemic Influenza Preparedness and Response Plan* calls for the Department to assess epidemiologic, clinical, and behavioral characteristics of the pandemic strain and make recommendations for containment measures to limit spread, morbidity, and mortality, while minimizing social disruption and cost. School closures and the distribution of public health messages such as "cover your cough" are examples of measures that the plan suggests could be taken, if indicated.

To date, more than 59 schools have been recommended for closure due to the new H1N1 influenza—all of which have already reopened without incident. In the case of the H1N1 virus, the main goal of school closures is to protect those at highest risk of complications from flu by slowing transmission in that particular school community and reducing exposures among those with underlying conditions. School closure is not done with the expectation that it will interrupt the spread of flu in the city as a whole.

The Health Department and the Department of Education (DOE) are working together to monitor influenza-like illness in New York City schools in response to this outbreak. Information is collected daily from school nurses and school administrators and evaluated by the City's Office of School Health. School nurses notify the principal and contact the City's Office of School Health if there are five or more children who come to the medical room with ILI. The Health Department reviews this data along with absenteeism over the past week, looking for a sudden or a sustained increase in flu-like illness.

To be clear, high absenteeism, by itself, is not a basis for closure; there is no single number upon which school closures decisions are made. In deciding whether to close a school, the Departments of Health and Education seek to balance definite harm– lost education, parental wages, school nutrition programs and possible unsupervised children – with a possible benefit. The Health Department carefully evaluates the circumstances occurring at each school and pays closest attention to schools in which a certain percentage of the student body comes to the medical room on a given day with fever and cough or sore throat. This indicates that a significant number of students are ill while at school and may be spreading infection to those at risk.

One of the greatest challenges facing the Department during a pandemic is to provide quick, clear, consistent, and frequent emergency information to the public. Central to our communications strategy is the use of the news media to keep New Yorkers well informed about the progress of the outbreak and about what measures they

can take to protect themselves. The Department's recommendations to New Yorkers remained consistent since we first detected the virus:

- stay home from work or school if you are sick;
- cover your mouth when you cough;
- avoid close contact with people who have influenza-like illness;
- wash your hands often with soap and water or alcohol-based cleansers;
- seek health care and treatment for severe symptoms; and
- for individuals at high risk of complications from influenza, seek preventive treatment from a health care provider and contact your provider immediately if you develop flu symptoms.

The Health Department issued 23 press releases and held eleven press conferences and briefings, generating thousands of media stories. This method of communication is effective and efficient, and allows us to reach the maximum number of people with the latest and most up to date information.

The Department also issued a wide variety of fact sheets, brochures, posters and pamphlets targeting various populations, including the school community, employers, and faith and community leaders. We translated these documents into up to 12 languages, and developed low literacy materials. All of these materials are available on a dedicated H1N1 page on the DOHMH website.

To assist us with our outreach to the public we partnered with elected officials at the city, state and federal levels. We held briefings for the City Council, State Assembly and Senate, the city's Congressional delegation and all five Borough Service Cabinets. We made an effort to personally notify every elected official in advance of any school being closed in his or her district, and provided the information necessary to respond to questions from his or her constituents. We thank the City Council for your assistance and appreciate your feedback on our messaging and outreach plan.

In addition to proactively distributing information, the City was well prepared to handle the unprecedented volume of incoming requests for information. Since the outbreak began, we responded to more than 54,000 calls to 311 and our DOHMH call center regarding H1N1. Customized scripts were developed to assist call-takers respond to inquiries. As of June 10th, we distributed more than 21,000 educational posters and brochures on H1N1 and general prevention measures, including respiratory and hand hygiene, to callers upon request.

Equally important to our ability to communicate with the public is our ability to distribute important clinical information to health care providers. With more than 30,000 subscribers, our Health Alert Network provides an opportunity to get clinical recommendations and treatment guidance directly into the hands of providers with the click of a button; we sent out eleven health alerts, as well as multiple clinical guidance documents and treatment recommendations during the past six weeks providing physicians with the latest information on novel H1N1 activity in New York City. Our Provider Access Line (PAL), staffed by Health Department and Medical Reserve Corp

personnel, fielded nearly 5,000 requests for assistance since the beginning of the outbreak.

Before closing, I would like to recognize two challenges. The first is funding. Our estimate is that the DOHMH response to the H1N1 outbreak will cost approximately $4 million dollars this fiscal year. Be assured the Department is capable of sustaining our response and we are very well prepared. However as we continue to prepare for flu season and the possibility that a more severe H1N1 virus will return, it is critical that the Federal government sufficiently support our activities. Our federal Public Health Emergency Preparedness grants decreased by more than $6 million over the past 4 years, and we are expecting another $1.5 million cut in the upcoming federal fiscal year. President Obama and Congress have both indicated they intend to make supplementary funds available to address the H1N1 outbreak and prepare for the upcoming flu season, and we are hopeful that New York City will receive its share of this funding.

Perhaps the greatest challenge we face—one that is common to pandemic planning and response—is the need to respond and make policy decisions in the face of medical and scientific uncertainty. Influenza can evolve in unpredictable ways; it is impossible to know whether the novel H1N1 influenza virus will dwindle, remain the same, or surge in coming weeks; whether the illness caused by this virus will remain mostly mild; and whether the virus will return in the fall or the expected winter flu season. The Health Department will continue to monitor this situation closely and make policy decisions based on the best information available to us at that time.

Thank you again for the opportunity to testify. I'm happy to answer your questions.

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NEW YORK CITY OFFICE OF EMERGENCY MANAGEMENT

TESTIMONY OF JOSEPH F. BRUNO

COMMISSIONER OF THE NEW YORK CITY

OFFICE OF EMERGENCY MANAGEMENT

Before the New York City Council Committees on Governmental Operations; Health; Public Safety

Thursday, June 11 2009

Hello. I am Joe Bruno, Commissioner of the Office of the Emergency Management (OEM). Today I will be discussing OEM's role in the recent H1N1 incident in New York City, including the steps we took to support the Department of Health and Mental Hygiene's response, the steps we are taking now to prepare the city for the future, and how we are communicating with the public and with the private sector so that they can prepare themselves as well.

Virtually all aspects of OEM's mission came into play when the H1N1 virus was first detected in New York City. Under CIMS (the Citywide Incident Management System) DOHMH is the Incident Commander for public health incidents in New York City, along with NYPD and FDNY. Based on the nature of this incident DOHMH took the lead and handled the majority of the issues. OEM supported the DOHMH response alongside representatives from many other city agencies and coordinated information with other state and federal agencies, as well as non-profit organizations and the private sector.

PRE-INCIDENT PREPAREDNESS

Before I get into the specifics of this incident, I want to provide you with some background on the work we have done to support DOHMH in planning for a pandemic flu event. The Citywide Pandemic Flu Plan was created by DOHMH. As a member of the DOHMH Pandemic Flu Planning Task Force, OEM has worked to formulate policy, strategy and tactics related to this type of event. We have supported DOHMH planning with specific non-medical preparedness projects including the following:

- Working with DOHMH and DOE we researched issues surrounding school closures.
- Working with DOHMH, MTA, Amtrak, Port Authority and NJT, we identified a range of social distancing strategies for public transit in New York City that could be implemented during an influenza pandemic.
- Working with COSH (Citywide Office of Occupational Health and Safety) and others we formulated strategies to identify and mitigate the risks to NYC employees from pandemic influenza.
- Working with DOHMH we conducted pan flu-specific preparedness outreach to the public and private sector.

INCIDENT

We became aware of the H1N1 virus a few days before it was detected in New York City. We were then notified by DOHMH of its investigation at St. Francis Prep in Fresh Meadows, Queens. By the next day DOHMH had activated its Department Emergency Operations Center (DEOC) and we sent a representative there in support of its operations. We have stood beside DOHMH throughout this response and that support continues today. Within just a few days of the DEOC activating, we understood that the situation in Queens was growing and we subsequently made the decision to activate our Situation Room at OEM headquarters; representatives from NYPD, FDNY, DOHMH, and DOE joined us in the Situation Room.

During our Situation Room activation we increased our support to the DOHMH response with focused planning and interagency coordination. This work centered on a few main areas including logistics, school closures, workplace sick and leave policies, legal issues, regional

coordination, worker health and safety and continuity of New York City agency operations, or COOP. I will describe these in more detail now:

- Targeted Outreach to Special Needs Population: We reached out to our special needs population with targeted messaging through our Advance Warning System Conference Calls with key agencies including all these who serve special needs clients: American Red Cross, Departments for the Aging, Homeless Services, Education, DOHMH, HHC, the Home Based Care Task Force, HRA, MOPD, MTA Paratransit, the ESRD Network (End-Stage Renal Disease) and the Salvation Army. These calls focused on situational awareness and developing long-term objectives to ensure continuity of services to our most vulnerable residents and visitors.

- Workplace Sick and Leave Policies: As we faced a situation where city workers may be unable to come to work due to their own or a family member's health, we met several times with OLR, DCAS (Department of Citywide Administrative Services), the NYC Law Department, DOHMH, DOE and the Comptroller's office to identify changes to labor agreements and workplace policies that would be required by this event. The group agreed that existing agreements and policies were sufficient for the incident at that time. Our considerations covered the following areas: potential suspension of the illness documentation requirement, compressed work schedules, supervisor direction to identify and address sick employees, and telecommuting. As a result of these discussions, DCAS drafted a directive to City agencies reiterating the standard time and leave policies, including DOHMH FAQs on H1N1 and the workplace.

- Legal Issues: We convened legal experts and agency counsels from the NYC Law Dept, DOHMH, OEM, NYS Health Department, SEMO, Nassau, Westchester and Suffolk counties to identify any changes to local laws, regulations or licensing as well as any executive orders that would need to be created to assist in the response. This group met several times to discuss these issues as well as general legal issues surrounding public health emergencies. The group concluded that existing agreements and policies were sufficient for the incident at that time.

- Worker Health and Safety: We worked closely with a number of City agencies, including DCAS/COSH (Citywide Office of Occupational Safety and Health) and DOHMH to review Worker Health and Safety policies and provide guidance to City agencies about how to identify at-risk employees.

It should be noted that we believe it is our job to convene the stakeholders and experts to take a hard look at these key issues in order to solicit advice about the actions that should or could be taken.

- COOP (Continuity of Operations Planning): OEM COOP staff met daily throughout the event and communicated regularly with all agency COOP representatives. On May 7th, I sent a memo to all agency heads in regards to the key objectives related to their in-progress continuity plans and integrating the H1N1 challenges and assumptions into their current methodology. These key objectives are protection of employees, maintenance of essential services, and communication with employees and critical agency stakeholders.

On Monday, May 18th, we hosted a 'Special Session on Pandemic Planning' at OEM headquarters with agency COOP representatives to go over continuity planning and the recent event. The session provided a forum for agencies to speak about events from the past month and OEM provided guidance related to continuing the development of their COOP planning while incorporating elements specific to pandemic influenza. OEM, DOHMH, and DOE all gave comprehensive presentations. All agencies were asked to deepen their planning assumptions related to staffing and other issues that may arise during a pandemic.

- Logistics: Our logistics team was highly engaged during this incident, and continues to work on resource management issues, including prioritizing and fulfilling resource requests. We modified a security plan for the Strategic National Stockpile and, working with NYPD and our regional partners, coordinated security for the SNS storage facility. Logistics also identified scarce resources related to the incident and is planning for possible future resource needs. As you are well aware, resources and supplies are a critical piece of pandemic flu planning and response, and we are working to ensure that we have the right resources in the City when we need them. We canvassed vendors and distributors for availability of key resources and identified an emerging scarcity of N95 respirators. We drafted a Resource Request and the Mayor authorized the purchase of an additional 1.2 million N95 respirators to ensure a continued supply in the event they would be needed.

- School Closures: With DOE personnel we identified coordination and resource requirements necessary to maintain the primary mission of the agency, including continuity of education.

- Regional Coordination: We also used this incident as an opportunity to activate our RELT, or Regional Emergency Liaison Team calls. This group includes me and the Emergency Management Commissioners from our surrounding counties of Nassau, Suffolk, Westchester, and the State of New York, as well as FEMA. The RELT provides an important forum for sharing situational awareness and resolution of critical issues. These daily discussions allowed us to discuss emerging experiences and resolve some key policy issues including resource distribution and use of respirators by workers.

As the incident continued, we supported DOHMH through interagency coordination. As more cases emerged, we worked with City Hall to convene, and continue to hold, daily conference calls with senior staff at DOHMH, DOE, DOC and HHC to assess the situation and discuss next steps. Our staff meets regularly to implement next steps and discuss possible future scenarios. We are working with OMB to calculate the cost of this incident to New York City and seek potential reimbursement from funding that has been identified by the federal government.

Another major focus was the impact of the incident on hospitals and EMS. At the request of DOHMH, we convened a task force of key healthcare agencies, including FDNY EMS, HHC, GNYHA, and NYSDOH to identify a range of strategies to address the surge at hospital emergency departments and for FDNY/EMS ambulance service. These strategies included revised and expanded public information and working with the NYS Department of Health to

suspend some of its hospital data reporting requirements to alleviate this added burden on already overworked hospital staff.

COMMUNITY OUTREACH

I want to take a moment to talk about another important piece of this incident, which has been community outreach. While all of the planning and response work was taking place, OEM was working closely with DOHMH to provide the public with much-needed information. OEM and DOHMH had been working on a Pandemic Flu Ready New York guide which was fortuitously approved for production two days before H1N1 was detected in New York City. As a response to this incident we immediately posted the guide on NYC.gov the morning of Sunday, April 26th and expedited printing to receive the physical guides in early May.

As you know, we print our preparedness guides in many languages, and we were originally planning to print this pandemic flu guide in 14 languages. In addition to expediting the translation of those languages, we translated the guide into nine additional languages. As such, the guide is now available in print in 14 languages and available to download online in 9 languages. They are: English, Spanish, French, Chinese, Italian, Russian, Polish, Greek, Korean, Urdu, Haitian Creole, Portuguese, Japanese, Yiddish, Bengali, Arabic, Tagalog, Hebrew, Hindi, Albanian, Romanian, Czech and Vietnamese[1]. As of June 9th the guide has been distributed widely at all of OEM Ready New York events and has been downloaded 14, 862 times in 23 languages.

Our first guide printing consisted of 200,000 English, 30,000 each of Chinese, Russian and Spanish and 5,000 each of ten additional languages. We have since identified additional funding to print 100,000 more English guides and are working with DOHMH to identify funding to print the guide in more languages.

In order to ensure that residents were getting the preparedness message, OEM and DOHMH mailed to each of the City's elected officials (City, State and Federal) and all 110 consulates a package in which we included 50 English guides and a fax-back form to order additional guides. Many of your colleagues have requested additional guides, and we are happy to make them available upon request. For those of you who have not yet seen the guide, I have brought some extra copies with me today.

We have also mailed 37,500 guides and the fax-back form to senior centers, medical centers, Citizen Corps Council member agencies, CERT teams, the City's human services agencies, and others. As a result of these mailings, organizations across the City have requested more than 76,000 additional guides. We have also given several thousand guides to the Red Cross for it to distribute and we are distributing them at the Ready New York events we hold each week.

As hospital communication to the public is clearly a vital piece of the outreach program, OEM is also working with DOHMH, HHC and the Greater New York Hospital Association to schedule pandemic flu presentations in each of the City's hospitals. We are also working with the private sector and in addition to holding conference calls with our industry partners on a regular basis to

[1] Listed in order of frequency of downloads

provide updates, we are scheduling presentations for them. On June 5th, OEM, SBS and DOHMH held a briefing with the Downtown Alliance for Lower Manhattan businesses on this topic and will be scheduling more such events across the City.

We are also in the process of creating advertisements to publicize the pandemic flu guide, which will run over the summer, as well as posters for agencies and businesses to post in their places of business.

Finally, as you may have heard, we launched the citywide pilot of Notify NYC on May 28th. One of the options for people to select is school notifications, and we have already used this service to let people know of school closings related to H1N1. These Notify NYC messages refer subscribers to the DOE website or to 311 for specific details on school closures in their area.

LESSONS LEARNED

The presence of H1N1 in New York City served to highlight some of our critical planning assumptions related to pandemic preparedness. Public outreach, access to information, and frequent communication is an essential part of every emergency plan. Agencies working together to provide the shared expertise and resources of the City of New York inform this process. New York City does not stand alone during an event of this kind. This particular event occurred simultaneously throughout much of the US, and the world, and a perception of need for the same resources at the same time emerged almost immediately. We saw this in the first days of the event when N95 respirators were not available at any price. We were reminded that the sharing of critical assets between surrounding counties and states that usually occurs in response to other disasters might be scarce or unavailable.

I can tell you that we are working hard to be prepared for the future and bringing to bear the best thinking and resources that we have available. A pandemic event of any severity affects everyone. There are 8.2 million people who live in New York City. There are more than 200,000 businesses in this City and 800,000 people who travel into the city every working day. I cannot stress strongly enough how important it is that individuals, families, businesses and organizations understand the issues and prepare for the event:

- Every business needs to consider the impact of potential high absentee rates on their critical operations and how to identify and protect at-risk workers.
- Families need to be prepared and educated about disasters and emergencies of all kinds in the event that services they rely upon -- such as transportation or schools – are disrupted. Our suite of Ready NY guides addresses many of these issues.

Minimizing the disruption in day-to-day business, services and activities, and working toward protecting the health and safety of all New Yorkers is our top priority. We had been working on these issues before the H1N1 occurrence, and will continue to work on them throughout the coming weeks and months.

Thank you for your time today.

FOR THE RECORD

TESTIMONY BY
NYC COMPTROLLER WILLIAM C. THOMPSON, JR.

AT A JOINT HEARING OF THE GOVERNMENTAL OPERATIONS, HEALTH, AND PUBLIC SAFETY COMMITTEES OF THE NEW YORK CITY COUNCIL

RE: NEW YORK CITY'S RESPONSE TO H1N1 AND ASSESSING INFLUENZA PREPAREDNESS

I would like to thank Chairman Rivera, Chairwoman Sears, Chairman Vallone and members of the Governmental Operations, Health, and Public Safety Committees for holding this timely hearing regarding the City's H1N1 flu preparedness.

The City's response to this event revealed a number of troubling weaknesses in the City's capabilities and should serve as a clear warning to both the City and New York State that action must be taken to avert potentially life-threatening consequences in the future.

As many of you know, no less than 15 New York City emergency rooms have been shuttered since 2002.

Incredibly, these closures were made without addressing the inevitable impact on surrounding hospitals and without regard to each community's input.

On June 1, 2009, Queens Borough President Helen Marshall joined me in front of Jamaica Hospital, where I released a Policy Alert regarding the closures of St. John's and Mary Immaculate Hospitals in Queens and the fact that neighboring hospitals have been overwhelmed with demands for care. Indeed, many of you may recall the media's recent depictions of patients being housed in a tent outside of one hospital awaiting treatment.

Since the February 2009 bankruptcy and the subsequent closure of Mary Immaculate and St. John's Hospitals, my Office has been monitoring the impact on the emergency rooms of the remaining nearby hospitals and found that emergency rooms are straining to meet demand. These trends started with the closures of the two hospitals and were magnified by the onset of the H1N1 flu virus.

A Queens Hospital Center emergency room doctor with more than two decades of experience told our Office that conditions at the hospital have become a "living nightmare," and that the state of emergency medicine in Queens was the worst he's seen in his career. His observations echoed other physicians, some of whom spoke of an overwhelming added patient load.

Many of these problems were predicted in the letter I sent to the New York State Health Commissioner in February of this year. I noted that there had been no public or inclusive discussion concerning transition plans or how hospital closures would affect the health and safety of our city's residents.

On February 20, 2009, I also wrote to Fire Department Commissioner Scoppetta urging EMS to evaluate the impact of the Queens hospital closures and to publicly outline the steps necessary to minimize adverse impacts upon surrounding neighborhoods. In addition, I urged that the Department publish data regarding ambulance response and turnaround times for the Queens communities affected by these hospital closures.

My Office's December 2006 report, *Emergency Room Care: Will It Be There?,* raised similar concerns about the impact of the five New York City emergency room closures proposed by the Berger Commission.

What we are seeing now is a crisis in the hospital and healthcare system in much of Queens, particularly for safety net hospitals that tend to treat a higher proportion of uninsured or under-insured patients.

A similar scenario may repeat itself, however, if the H1N1 virus outbreaks appear in other boroughs, now or in the future. If this does occur, it will be due, in part, to the repeated failure by both the City and the State to take steps to adequately address the impact of the 15 hospital closures.

New York City is losing its primary care capabilities at an alarming rate, forcing many individuals to rely on the emergency room instead. Hospital outpatient departments represent a significant portion of the City's primary care capacity and the recent closures have markedly reduced capacity. Many remaining hospitals have cut back their outpatient care services thereby adding to this problem.

While the timing of the H1N1 virus itself was not foreseeable, the likelihood of some event of a similar nature causing a sudden surge in demand was both foreseeable and inevitable. In fact, it is one of the core missions of the City and State Departments of Health, as well as other State and municipal agencies, to prepare for and respond to this type of healthcare emergency.

So what can we do?

First and foremost, what is needed most is leadership. The Administration's ill-considered initial approach to the appearance of H1N1 in City schools was to keep schools open despite dozens of children contracting the virus. By failing to share this information, the City denied parents an ability to make informed decisions.

The City and State need to pull together key healthcare providers and other stakeholders immediately to share information, identify problems, and develop solutions to address the current surge in demand stemming from the H1N1 virus and to prepare for a possible return of the virus later this year.

For the remainder of the H1N1 flu virus cycle, we need to:

- **Triage individuals with flu symptoms at ambulatory care facilities.** Many of the people currently seeking care in the emergency room either do not actually have the H1N1 virus or have a mild form and do not have other risk factors. By

seeking out an initial diagnosis at a community health center, they can be evaluated by doctors and directed to the emergency room if necessary.

- **Activate any necessary additional resources to deal with the current situation and be ready to provide more resources in other communities as needed.** Hospitals in much of Queens needed immediate help to cope with the heightened challenges presented by the two closures and now the H1N1 virus. At these times, State Department of Health and the City should post staff at the affected hospitals, especially at peak hours, to ensure smooth operations, rather than relying on telephone calls between the Department and hospital administrators.

- **Provide loans and working capital to cover surge-related costs.** Because many hospitals are in weak financial positions, it is difficult for them to borrow money. Indeed, many hospitals are now relying heavily on the use of unbudgeted overtime to maintain staffing levels during the H1N1 surge. By asking hospitals that are financially challenged to spend money they do not have, the very survival of these hospitals is threatened.

- **Provide data on emergency room utilization to the public.** In a recent letter to schools Chancellor Joel Klein, I urged him to publish daily school attendance data. DOE adopted this practice and it should be continued. Similarly, the State Department of Health needs to restore public confidence by publishing key daily statistics about emergency room utilization and staffing.

  EMS should publish data regarding ambulance response and turnaround times for the Queens communities affected by the two recent hospital closures and on a community basis citywide. This data should be updated and issued regularly. This is especially important if budget cuts to EMS proposed by the State and the City are adopted.

In the longer term, the answer is planning. Money alone will not solve this problem.

The State Department of Health should create a master plan, in consultation with communities, to restructure the healthcare delivery system in New York City. A new approach is needed if we are to ensure that the Queens hospitals and all of our remaining hospitals and their emergency rooms are able to provide the public with quality care, even during surges in demand. The State Department of Health has taken some promising steps in this direction already, especially in its focus on primary care.

I appreciate this opportunity to provide testimony on this important issue and I want to thank the members of the committees assembled today for their hard work.

FOR THE RECORD

American Red Cross in Greater New York

Testimony from the American Red Cross in Greater New York before the City Council Committees on Health, Governmental Operations and Public Safety

Thursday, June 11, 2009
City Hall, New York, NY 10007

The mission of the American Red Cross is helping people prevent, prepare for, and respond to emergencies. The National Red Cross not only responds to tens of thousands of disasters each year, but also has responded to many public health emergencies in the past, such as the influenza pandemic of 1918.

That year, responding to a call for help from the Surgeon General of the United States Public Health Service 15,000 Red Cross nurses, dietitians, and personnel were recruited to work in military camps, hospitals, coal fields, munitions plants and shipyards where they remained until the epidemic finally subsided in the spring of 1919.

Today, the National Red Cross headquartered in Washington, DC is monitoring the developing situation regarding the H1N1 or swine flu outbreak and is in close contact with federal and state officials, including the Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security. In response to this and any further flu outbreaks our organization and our chapter will follow the guidance of these agencies.

The National Red Cross has spent the past few years working with federal agencies to plan for a pandemic and participated in numerous exercises and work groups on the subject. In preparation for a pandemic, the National Red Cross formed a corporate

pandemic task force in 2006 to plan with government for such an event and to develop education materials for the general public. Since that time, we have offered a video, a pandemic workshop, brochures, and other items to educate the public on coping with a pandemic and caring for sick loved ones.

Our chapter the American Red Cross in Greater New York has been involved in the city's response to the H1N1 outbreak since the first cases were confirmed. Our chapter liaisons participated in daily conference calls with the New York City Department of Health & Mental Hygiene and New York City Office of Emergency Management. During this outbreak, our chapter will continue to respond to local and large-scale disasters, will work with our National headquarters to ensure a safe and adequate blood supply, will provide logistical support for distribution of vaccines if requested and will share informational materials.

Our chapter has also gone to great lengths to ensure that our personnel have the latest information about the outbreak and how to prevent infection. Our personnel have been provided with written guidance on ways to avoid contamination when out in the field, and about additional preventive measures that can be taken to protect themselves and their families. In response to the outbreak our chapter installed hand sanitizers near all elevators and public spaces. The chapter is committed to the health and safety of its personnel whose mission is to assist the city in time of need.

To help educate and inform the public our chapter has posted information on how to prevent and prepare for H1N1 outbreaks on our website with links to relevant local and

national agencies for more details. We have also used social media outlets such as Facebook and Twitter to help inform the public.

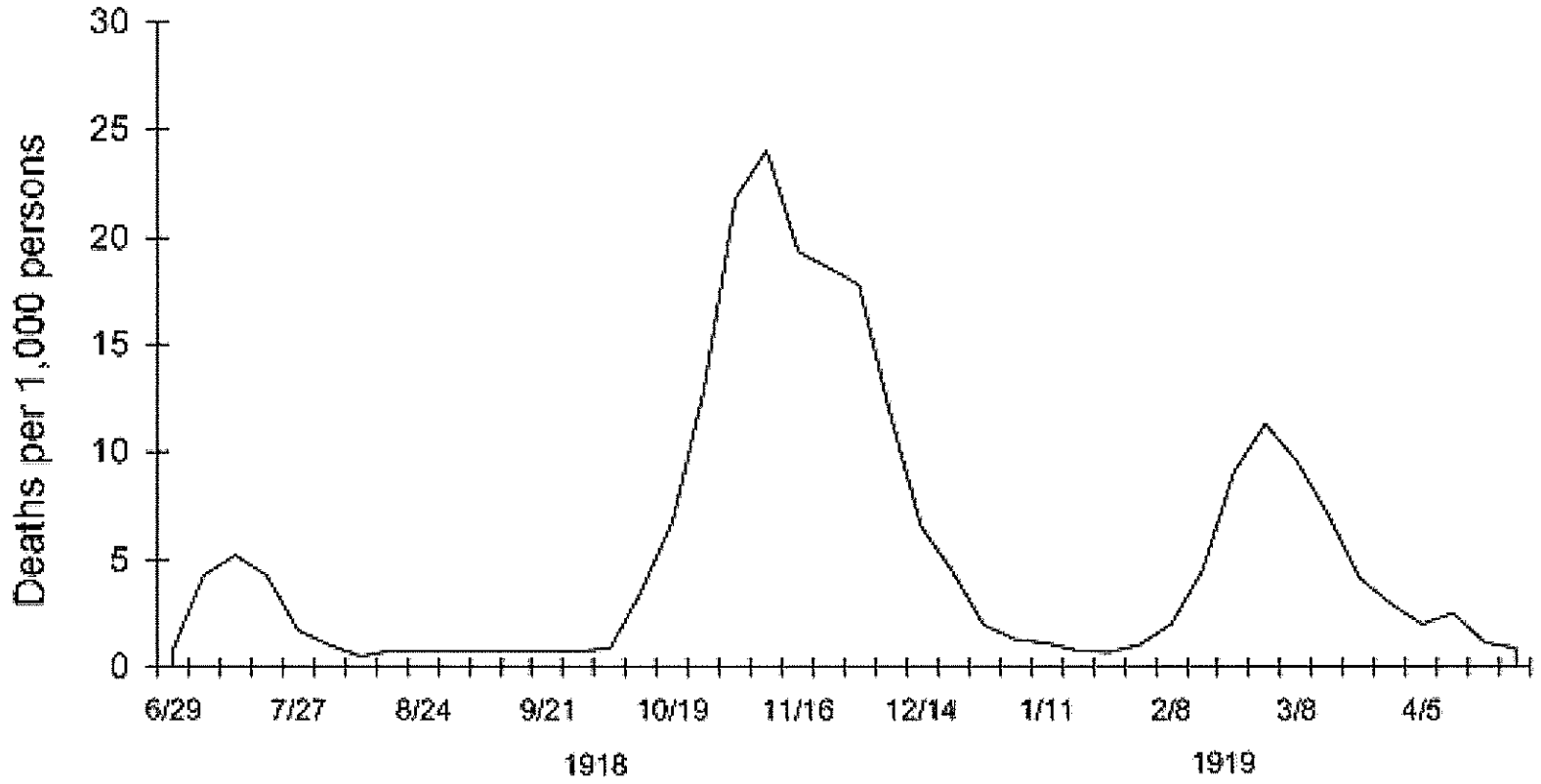
Our chapter has also developed a one-hour flu preparedness training program for our business and corporate partners that covers topics such as what to expect during a pandemic, the difference between seasonal flu and pandemic flu, how the virus is spread, how to prepare for business continuity during a flu pandemic and steps to prevent spread of the flu.

Our chapter and our National Headquarters stand ready to assist the city during this outbreak and should there be an increase in cases during the fall and winter which has occurred in past pandemic flu outbreaks. Our personnel continue to train and conduct exercises using an all-hazards approach that includes pandemic flu and we continue to stockpile flu kits and personal hygiene kits which are available to the public through our website and the Red Cross Store, located in our headquarters at 520 West 49th Street.

In closing we would like to thank the City Council for the opportunity to testify and for the Council's continued support.

American Red Cross

Pandemic Waves - U.S. 1918/1919



Are You Prepared?

Pandemic Flu

FOR THE RECORD

National Center for
Disaster Preparedness
Mailman School of Public Health
Columbia University

Responding to Novel H1N1 Outbreak: Are Children at Greater Risk? & What Are Lessons for the Next Pandemic?

Testimony before

New York City Council
11 June, 2009

Irwin Redlener, MD
Professor of Clinical Population and Family Health
Director, National Center for Disaster Preparedness
Columbia University Mailman School of Public Health
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Irwin Redlener, MD
NYC Council
11 June, 2009

Good Afternoon. I am Dr. Irwin Redlener, a pediatrician and Director of the national Center for Disaster Preparedness at Columbia University Mailman School of Public Health. I am also president of Children's Health Fund and a Commissioner on the federally designated National Commission on Children and Disasters.

My principle conclusion will be, and I want to note this right now, is that what we have been experiencing from April through this moment should be considered a remarkable learning opportunity. We have been fortunate that the outbreak thus far has been relatively mild. Yet we have seen evidence of potential system breakdown that can only be considered serious warning signs; a significant "wake-up call" that should be analyzed carefully and responded to appropriately. Unfortunately, on many levels, previous "wake-up calls" from the 1993 World Trade Center bombings, to 9/11, to the Anthrax attacks to Hurricane Katrina have seemed less like wake-up calls, and more like "snooze alarms" where we get aroused, we respond – but fail to make all of the fundamental adjustments in policy and resource designation mandated by our experiences.

But let me turn my attention to the current H1N1 situation as it has been affecting our own City, I would like to point out some key issues that have come to our collective attention.

- Novel H1N1 comes after a national and international focus on preparedness for pandemic influenza that peaked around 2007. Although this outbreak has been mild by pandemic standards, this has been an opportunity to test drive many of the policies and systems that were developed in the past decade.
- Despite the low pathogenicity of H1N1, certain key systems did not function as intended or were overwhelmed. These shortfalls would have had absolutely critical implications if H1N1 had been moderate or severe.
- Children were major factors in this outbreak, even beyond what would normally be expected for an influenza outbreak or pandemic. In NYC there have been relatively few cases of H1N1 in those over 65, and half of those hospitalized have been <18 years old. The mean age for hospitalized cases is low at 19.

There have been a number of key successes in the past few weeks, particularly relative to the City's public health response to the emergency. These include the following:

- The City responded early and effectively with political and public health messages that were deliberative and consistent with rapidly changing circumstances. In essence the *content* of the messages was appropriate, though the *context* and *impact* of the messages on a number of intended audiences was les effective than desired. Clearly, one could argue that the *content* of the messages were too reassuring and too slow to act in terms of, for instance, school closures. One could also argue that the actions and recommendations were too intense, too unclear and too aggressive. Proponents for both extremes were vocal, but under the circumstances my judgment is that the

messages generally struck a reasonable balance.
- DOHMH's continually updated website – virtually seven days a week - has been a model of public health excellence; highly useful to health care providers in New York City.

In general, my colleagues and I were very impressed with the dedication and skill of our City's public health officials, often having to operate in an environment far less than ideal.

While these successes were highly notable, there were and are critical areas where concerns have been raised and where we need to look carefully at ways of mitigating shortfalls and prepare most effectively for future public health crises.

- **Communicating with the public**
  - While the public message from DOHMH and CDC was clear (stay home if sick, go to doctor for ILI in those <2, with preexisting illness, pregnancy, etc.) the information seems to have had insufficient penetration among many of the City's communities. This resulted in severe overloading of many hospitals, particularly in a number of emergency departments. The National Center for Disaster Preparedness at Columbia University Mailman School of Public Health will be working with DOHMH to help determine what factors were most important in driving the emergency department (ED) overload.
  - The ability of the public to get real-time advice from a public flu call center was not fully evaluated. While time intensive, one-on-one advice is a challenge to provide in large numbers during a surge, there may be ways that this process could be automated and overseen to ensure that the public is confident with the process. It is important to explore how this variable contributed to those decided to report to the local EDs.
- **Conflicting information**
  - There were some instances where the recommendations from the DOHMH did not sync perfectly with those from the federal agencies due to the need to customize recommendations to fit the situation in NYC, especially around personal protective equipment use. There was also some degree of confusion over the information that was coming out from both CDC and the DOHMH. Were recommendations from major public health agencies *suggested guidance* or *enforceable regulations?*
  - Some of the same issues were also apparent from time to time in recommendations for health care workers. In at least one reported instance, OSHA representatives were distributing information to hospital employees that seemed to conflict with personal protective recommendations published by DOHMH.

- **The health care delivery system was challenged in some unique and unexpected ways**
  - Emergency Departments were faced with an "ambulatory surge" of patients who were seeking reassurance, testing, treatment with antiviral medications, and even notes to go back to school or work (which should not be required or requested). Some systems were seeing more than double their daily average volume or more.

  - There was a relative pediatric surge of patients in this group, which placed extreme challenges on both the dedicated pediatric hospitals with EDs and upon the general emergency departments as well.
  - Hospital diagnostic labs were challenged. Some of the smaller labs reported that they were not staffed to provide ongoing support to the surge in patient care occurring in the EDs. While the testing for H1N1 itself was sent out (which also can be time intensive), there was an overall increase in the number of lab requests due to the higher volume. This requires further study.

- **Potentially insufficient consideration around use of auxiliary personnel resources, such as:**
  - The Medical Reserve Corps (MRC)
  - Community Emergency Response Teams (CERT) Federal Disaster Medical Assistance Teams (DMAT)
- **A need to better engage and educate the media**

In conclusion, the jury is out as to whether we are experiencing a wake-up call or snooze alarm. We will move on to a new "issue du jour" or seek to understand and address the clear shortfalls in our pandemic response system?

It is clear at this point that the World Health Organization's categorization of "pandemic phasing" is flawed, since it does not incorporate fatality rates or any other disease severity index in the assessment of staging. That said, the current outbreak is serving as an instructive test of our capacity to manage a severe and lethal pandemic. Whether this occurs in a relatively short time frame with a more virulent form of the H1N1 returning to the Northern Hemisphere this Fall and Winter – or whether we don't see a sever pandemic for years to come, it is essential that we understand the lessons that have been unfolding over the past two months.

In addition to the obvious need to develop methodologies to rapidly manufacture and distribute effective vaccine and expand anti-viral medication stockpiles, these are the principle challenges that must be faced:

1. We need to much more about the content, crafting and delivery of essential public health messages to assure maximum penetration among the public.
2. We need a far more robust and distributed laboratory system for specific diagnosis of pandemic-potential viruses.
3. There needs to be a far better system of coordinating the public, public health and medical responses to any significant outbreak scenario. In other words, there is a role for (a) early institution of public health methods to reduce spread; (b) public access to usable information without necessitating direct contact with the health care system (expansion and enhancement of the 311 system would be highly useful.); (c) enhanced guidance to avoid diversion of patients from primary care sites to EDs and other hospital facilities; and, (d) prospective planning for operational alternate care sites, as needed.
4. As has been the case since the heightened concern around Avian H5N1 pandemic potential, there has been a dangerous imbalance between focusing on public health measures and health system response capacity. Billions are being invested in the former –

and that's a good thing, but only a fraction of the hospital surge capacity goals are even close to being met. This is the time to focus on bolstering hospital response capacity. If we fail to this now, we could face an unthinkable calamity if our already fragile and overly stressed medical care system ever faces a 1918 Spanish Flu-like pandemic.

5. Children remain both at high risk for contracting illness in a H1N1 environment and vulnerable to severe complications and potentially high fatality rates in a significant pandemic. Compared to adult care capacity, pediatric resources in terms of trained personnel, materials, equipment and intensive care beds are limited, including in New York. The possibility of needing to confront what would potentially amount to a "children's pandemic" is certainly conceivable, at least enough to pay special attention to the special needs of our youngest citizens.

Thank you.

POLICY ALERT

Office of the New York City Comptroller
Office of Policy Management
William C. Thompson, Jr., Comptroller

Closures of St. John's and Mary Immaculate Hospitals Are Overwhelming Remaining Emergency Rooms

Emergence of H1N1 Virus Causing ER Crisis in Queens

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June 2009

Executive Summary

Hospital emergency departments in much of the Borough of Queens are in crisis, experiencing many of the problems predicted in a letter by the Comptroller to the New York State Health Commissioner on February 12, 2009. The letter warned that closure of St. John's and Mary Immaculate Hospitals would lead to overcrowded emergency rooms, longer wait times for patients, and longer ambulance turnaround times. Since the two hospitals closed their emergency rooms on February 14th, all of this has come to pass.

The letter also noted that there had been no public or inclusive discussion concerning transition plans or how these closures would affect the health and safety of area residents. The report issued by the Comptroller in December 2006, *Emergency Room Care: Will It Be There?,* raised similar concerns about the impact of the five New York City emergency room closures proposed by the Berger Commission.

The New York State Department of Health (SDOH) and the New York City Department of Health and Mental Hygiene (DOHMH) failed to acknowledge and act in response to the deteriorating financial condition of Mary Immaculate and St. John's Hospitals in a timely fashion. As a result, a critical opportunity to engage in a transparent, inclusive planning process prior to the closures was lost.

Hospitals that intend to cease operations are required to file a closure plan with SDOH. A hospital's closure plan is intended to be the culminating product of a thoughtful planning process. Yet, according to individuals directly involved in the process, SDOH allowed St. John's and Mary Immaculate Hospitals to close without finalizing and approving a closure plan, in violation of the Department's own requirement. Yet the "Final Draft" closure plan prepared by Caritas Health Care Incorporated, the two hospitals' owner, dated February 5, 2009, stated:[1]

> "There is significant proposed impact on the Health and Hospitals Corporation Elmhurst and Queens Hospital Center facilities, projecting an additional 30,000 emergency department visits and 8,000 inpatient admissions. Based on our Monday January 26 meeting with HHC, these *hospitals may not be in a position to absorb this projected demand in the timeframe contemplated herein. Our meeting with senior staff of Medisys [owner of Jamaica Hospital] on Wednesday January 28 provided similar serious reservations with respect to ability of Jamaica Hospital to absorb emergency room volume and inpatient psychiatry admissions.* "[emphasis added]

And:

> "There have been multiple communications with City and State EMS authorities with respect to termination of Caritas ambulance service and emergency rooms.

[1] Caritas Health Care Closure Plan, *Draft Final*, February 5, 2009.

We have yet to determine that alternate resources will be in place upon the closure of Caritas..."

An effective planning process would have been grounded in the realities of healthcare delivery and taken into account the lead time needed to add space and staff at nearby hospitals, to put replacement primary care services into place and to help patients make a successful transition to a new medical provider. With these elements in place, it is likely that fewer people would now be crowding the emergency rooms, and conditions in the emergency rooms would be significantly better for both patients and staff.

What we are seeing now is a crisis in the hospital and healthcare system in much of Queens, particularly for safety net hospitals which tend to treat a higher proportion of uninsured or under-insured patients. A similar scenario may repeat itself if H1N1 virus outbreaks appear in other boroughs. To be sure, while the timing of the H1N1 virus itself was not foreseeable, the likelihood of some event of a similar nature causing a sudden surge in demand was both foreseeable and inevitable. In fact, it is one of the core missions of the City and State Departments of Health, as well as other State and municipal agencies, to prepare for and respond to this type of healthcare emergency.

Yet, as the hospitals and patients struggle in the face of this crisis, they do so alone. Comptroller staff has been told by hospital administrators that no senior State Department of Health officials have come from Albany to see with their own eyes what is happening. They claim that no assistance of any kind has been offered. The same is true of the City Department of Health and Mental Hygiene.

The missteps surrounding the closures of Mary Immaculate and St. John's Hospitals can, to some extent, be redeemed if the State and the City learn from this experience. Effectively meeting the healthcare needs of New Yorkers is a fundamental responsibility of government and it is one that can and must be met.

Recommendations

New York City has a proud history of pulling together in a crisis. It is time for officials to publicly acknowledge that many hospitals in Queens, especially those serving the most disadvantaged populations, are in crisis primarily as a result of the closures of Mary Immaculate and St. John's Hospitals and exacerbated by the rapid spread of the H1N1 virus. But money alone will not solve this problem.

First and foremost, what is needed is leadership. Patients and hospitals cannot resolve these problems alone. The City and State need to pull key healthcare providers and other stakeholders together immediately to share information, identify problems and develop solutions to address the current surge in demand stemming from the H1N1 virus. As the flu spreads and possibly returns in the fall, other hospitals throughout the city could be pulled into the same downward spiral that Queens is experiencing. It is critical that the lines of communication between government and healthcare providers be open and responsive.

Short term

- **Triage individuals with flu symptoms at ambulatory care facilities.** Many of the people currently seeking care in the emergency room either do not actually have the H1N1 virus or have a mild form and do not have other risk factors. By seeking out an initial diagnosis at a community health center, they can be evaluated by doctors and directed to the emergency room if indicated. Reducing the crowding at emergency rooms will allow patients with serious flu-related conditions and others with true medical emergencies to receive better and faster attention.

  For this approach to be successful, two actions are critical. The City must encourage the use of these health centers and widely advertise their locations. In addition, the City must work with the centers to temporarily expand their hours and be open seven days a week. Local medical practices should also be approached.

  Although there are not many in Queens, Federally Qualified Health Centers, known as FQHCs, are located throughout the city. These centers will see all patients regardless of their insurance status and, with expanded hours, could become the backbone of an effective triage system if emergency rooms in other boroughs experience the same surge. Because of the FQHC funding mechanisms, they are in a better position to manage the marginal costs associated with expanded hours. Other clinics may require a small subsidy to cover the extra staff costs.

- **Activate necessary additional resources to deal with the current situation and be ready to provide more resources in other communities as needed.** Hospitals in much of Queens need immediate help to cope with the heightened challenges presented by the two closures and now the H1N1 virus. Just as the City and State sends personnel, equipment and supplies to emergencies throughout the State, such as floods or fires, it may be necessary to ask other New York locales to provide similar assistance in Queens or in other boroughs if similar emergency room overcrowding becomes a concern. With Jamaica Hospital, for example, now handling well over 500 emergency room visits daily, up from 300 to 350 a day before H1N1 and the two hospital closures, this is indeed a crisis.

  SDOH and the City should post staff at the affected hospitals, especially at peak hours, to ensure smooth operations, rather than relying on telephone calls between the Department and hospital administrators.

- **Provide loans and working capital to cover expansion costs.** Because many hospitals are in weak financial positions, it is difficult for them to borrow money. If they hire staff, treat uninsured patients, modify their facility or incur any other expenses associated with expanding capacity to meet a significantly increased patient load, they must wait anywhere from months to a year to recoup that expenditure in form of insurance or government reimbursement and frequently no reimbursement is provided. By asking those hospitals that are financially challenged and that are near the two that closed to spend money they do not have, SDOH is threatening the very

survival of those hospitals. For example, many hospitals are relying heavily on the use of overtime during the H1N1 surge.

- **Provide data on emergency room utilization to the public.** In conjunction with the hospital closures, SDOH agreed to disclose emergency room data like those cited throughout this report. After an initial release in early April, no additional data has been made available, according to press accounts.[2] SDOH has cited the need to focus its staff on managing the H1N1 virus as the reason it has not followed through on the commitment. While it is certainly true that the spike in emergency room utilization caused by H1N1 may make analysis of the impact of the closures alone more difficult, SDOH is undoubtedly still collecting emergency room data as part of its H1N1 monitoring.

  SDOH needs to restore public confidence by publishing key daily statistics about emergency room utilization and staffing. These should include the total number of adult and pediatric emergency room visits, the number of hours patients are waiting before actual care begins (not to be triaged), the number of hours admitted patients are waiting to be moved from the emergency room to Intensive Care Units and to a bed on an inpatient floor as well as daily staffing levels and overtime hours worked at affected hospitals.

- **Help hospitals staff-up to meet the increased demand.** SDOH should issue an update on the number and type of additional staff hired at these hospitals, while doing whatever is necessary to expedite hospitals' ability to hire staff, especially in medically-underserved areas where it is difficult to attract physicians and other medical personnel. For example, the federal stimulus package contains funding for a medical school loan-forgiveness program for doctors who work in high need areas.

- **Identify gaps in services created by the closures.** As soon as possible, SDOH should publish an inventory of the quantity and type of all services provided by the two closed hospitals, where those services are now being provided and which services have not been continued by any provider in the area. The lapsed services, if deemed essential, should be the basis for a community healthcare plan.

Longer term

In the longer term, the answer is planning, as the Office of the Comptroller has recommended previously. SDOH should be proactive and create a master plan, in dialogue with the community, to begin to restructure the health care delivery system in New York City. SDOH has taken some promising steps in this direction already, especially in its focus on primary care.

At the moment, however, it seems that New York City is losing primary care at an alarming rate. Since hospital outpatient departments represent a significant portion of the

[2] John Lauinger, "Study on impact of closing hosps sidetracked by epidemic scare," *New York Daily News,* May 3, 2009.

City's primary care capacity, the closures of 15 New York City emergency rooms since 2002 has markedly reduced capacity. In addition, outpatient departments can be a drain on hospital finances and some have cut back these services to improve their financial picture.

New York State needs to develop integrated systems that accurately reflect primary care service levels and can be used to assess where shortfalls exist. The Department needs to return to community-based comprehensive health care needs assessments and use the results as the basis for allocating resources in the most efficient, cost-effective manner. If SDOH had undertaken this process beginning in December 2006, as the Office of the Comptroller recommended, it is likely that much of the current impacts in Queens could have been minimized.

The need for such an assessment and allocation process is especially acute in Queens. A 2006 report by the Office of the Queens Borough President found that the borough had only 1.4 hospital beds per 1,000 residents, compared to 7.1 per 1,000 residents in Manhattan, and projected a 1.4 percent increase in Emergency Department visits and 11.1 percent increase in hospital admissions and discharges, from 2004 to 2016.[3]

[3] Office of the Queens Borough President, *Borough President Helen Marshall's Vision for a Comprehensive and Sustainable Healthcare Delivery System in Queens,* November 2006.

Introduction

On Saturday, February 14, 2009, St. John's Hospital and Mary Immaculate Hospitals' emergency rooms closed their doors for the last time.[4] According to the Doctor's Council, which represents New York City Health and Hospital Corporation (HHC) physicians, and the Council of Interns and Residents (CIR), which represents doctors in training, at least two nearby hospitals, Elmhurst Hospital and Queens Hospital Center already were operating at full capacity and, at times, even turning ambulances away in the weeks leading up to the closure.

Hospitals that intend to cease operations are required to file a closure plan with the New York State Department of Health (SDOH). Among other requirements, closure plans must demonstrate how continuity of care will be ensured for the institution's patients. In its closure plan of February 5, 2009, Caritas Health Care Incorporated, the operator of the two now-closed hospitals, raised concerns that nearby hospitals would not be able to absorb their emergency room visits: "[T]hese hospitals may not be in a position to absorb this projected demand in the timeframe contemplated herein."[5]

Based on analysis of emergency room data, and interviews with community leaders, CIR and Doctor's Council officials, and hospital executives and emergency room physicians at several of the remaining hospitals in Queens, the Office of the Comptroller has found that the concerns raised in the closure plan were well-founded. The specific findings are described below.

The closures occurred only two weeks after the hospitals' financial difficulties were made public, affording nearby hospitals little time and no additional funding to prepare for the flood of additional patients that ambulances were now bringing to their doors. While the rapidity with which the decision was made to close the hospitals was unexpected, the possibility of closures should not have been a surprise to the State; the State had spent over $61 million subsidizing the two hospitals' operations in the years leading up to Caritas's bankruptcy.

In December 2006, the Office of the Comptroller released a report, *Emergency Care: Will It Be There?*, raising concerns that New York City hospital emergency rooms were already overcrowded and that the closure of several hospitals as recommended by the Berger Commission would overload the hospitals nearest to those scheduled to close. Among other recommendations, the report urged SDOH to lead an inclusive, transparent community-based planning process to ensure that adequate resources were in place before any closures occurred.

Since that time, the Office of the Comptroller has continued to monitor the situation in New York City's emergency rooms. The severe impact of the closures on the

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[4] The two hospitals also ceased accepting elective admissions on February 14th. They closed their doors on February 28th.

[5] Caritas Health Care Closure Plan, *Draft Final*, February 5, 2009, p. 6.

emergency rooms surrounding Mary Immaculate and St. John's Hospitals -- made even worse by the recent appearance of the H1N1 virus -- offers a timely lesson in the consequences of failing to plan ahead. What has happened to the hospitals in Queens in the wake of these two closures could happen to other hospitals in other neighborhoods throughout the city.

This Policy Alert seeks to raise awareness of the crisis in Queens and to highlight the urgent need for leadership at the highest levels of City and State government. A new approach is needed if we are to ensure that the Queens hospitals and all our remaining hospitals and their emergency rooms are able to provide the public with quality care.

A. The immediate impact of the closures on nearby hospital emergency rooms

While every hospital in Queens is experiencing increased demand as a result of the two closures, we focused primarily on Queens Hospital Center, Jamaica Hospital, North Shore University Hospital-Forest Hills and Elmhurst Hospital, which are closest. The Office of the Comptroller obtained emergency room utilization data for these hospitals compiled by the State Department of Health.[6] The following data provide a sense of the daunting challenges faced by emergency room staff in the remaining hospitals in the six weeks after the two closures but *before* the appearance of the H1N1 virus:

- *Emergency room registrations soared.* Between the mid-February closures of the St. John's and Mary Immaculate emergency rooms through the end of March, Emergency Department patient registrations at the HHC Queens Hospital Center consistently exceeded those of the comparable period one year before. On at least a dozen days, the number of emergency room patient registrations reached 300 or more whereas this occurred on only one day in the same period a year prior. At Jamaica Hospital Center, from mid-February through the end of March there were 20 days on which there were at least 350 registrations, compared to only two such days in 2008.

- *Numbers of patients waiting to be admitted from the Emergency Department also soared.* Between mid-February and the end of March 2009:

    - At Jamaica Hospital, there were nine days where at least 20 or more patients were waiting to be admitted from the emergency department and 25 days when at least 10 patients were waiting. For the comparable period in 2008, there were no days when 20 patients were waiting and only eight days when 10 patients were waiting.

    - At Queens Hospital Center, there were 24 days when at least 10 patients waited for admission compared to eight days in 2008.

    - At Long Island Jewish Hospital, there were seven days when at least 20 patients were waiting for admission compared to no days in 2008 and there were 35 days when at least 10 patients were waiting compared to 19 days in 2008.

[6] The data was self-reported by the hospitals and was, in some cases, incomplete.

Since the appearance of H1N1, the number of persons who present at emergency rooms has only increased.

B. The immediate impact of the closures on EMS activity

The closures of Mary Immaculate and St. John's Hospitals eliminated a total of 28 daily ambulance tours that were operated by the two hospitals. St. John's former territory attracted interest from local voluntary hospitals, and New York Hospital of Queens, Wyckoff Heights Medical Center and North Shore picked up a total of 11 tours. However, an official of one hospital told Comptroller staff that no hospitals were interested in assuming Mary Immaculate's runs, and the New York City Fire Department EMS, as the provider of last resort, took them over. The long-term sustainability of the 28 tours is not assured, however. The Mayor's Executive Budget cuts the FDNY EMS budget by $3 million, which would result in the elimination of 30 ambulance tours citywide. This is in addition to the substantially greater number of tours that are expected to be eliminated because of an anticipated $60 million Medicaid reimbursement reduction. In 2007, there was an average of slightly more than 900 New York City EMS tours a day.

According to EMS data reported to the New York State Department of Health and obtained by the Office of the Comptroller, the number of transports to the affected hospitals has risen dramatically. In the first week following the closures, the number of EMS transports to Jamaica Hospital increased by 197 compared to the same period a year earlier, an increase of 39 percent, and transports to North Shore University Hospital-Forest Hills almost doubled to 203 from 111 during same week in the prior year.

A PowerPoint presentation by New York City EMS to the Office of the Queens Borough President on the impact of the two closures focused on four hospitals -- Jamaica Hospital Medical Center, Queens Hospital Center, Elmhurst Hospital Center and North Shore University Hospital-Forest Hills. According to the presentation,[7] which the Borough President's office provided the Office of the Comptroller:

- *Ambulance transports went up.* Comparing January 2009 to March 2009, the number of patients brought by ambulance to Queens Hospital Center increased by 51 percent, North Shore-Forest Hills had a 40 percent increase, and Jamaica Hospital and Elmhurst Hospitals saw transports rise by 24 percent and 13 percent respectively.

- *Ambulance turnaround times increased.* Turnaround time -- the amount of time from EMS's arrival at the emergency room until the ambulance is free to take the next call -- can be a proxy for overcrowding. The more crowded the emergency room, the longer EMS must wait until medical personnel are available for a safe hand-off. Turnaround time at Jamaica Hospital grew from 27:51 minutes prior to the February

[7] FDNY EMS - Division 4 Hospital Closure Presentation, Chief Robert P. Browne, EMS Division 4 Commander.

14th emergency room closures to 30:36 minutes during March 2009; at Queens Hospital Center turnaround time increased from 22:49 minutes to 24:39 minutes; and at North Shore University-Forest Hills Hospital turnaround rose from 27:16 minutes to 28:21 minutes.

A letter from a Queens mother to her local newspaper suggests that too few ambulances have been left in some locations. She wrote that after her son had a seizure, a first responder from the Fire Department arrived in four minutes but that the ambulance took another 21 minutes to reach her home. She subsequently learned that there was a nine-minute delay in assigning the first ambulance. A second ambulance was dispatched 16 minutes after the first call. The medics told her they had come from Erskine Street and the Belt Parkway near Spring Creek in Brooklyn to her home in Ridgewood, Queens -- a distance of nearly six miles.[8]

C. The impact of increased patient loads, according to healthcare workers

Doctors, nurses, paraprofessionals and other staff at the hospitals most directly affected by the St. John's and Mary Immaculate closures are now facing extraordinary challenges in delivering healthcare to their patients. A number of them told Comptroller staff that overcrowded emergency rooms conditions were already negatively affecting the quality of patient care before the H1N1 virus appeared and that the situation has markedly deteriorated since then.

With Queens as the epicenter of the illness, hospital emergency rooms in the vicinity of the closures are seeing unprecedented numbers of patients. According to one recent newspaper article, "The emergency room at Jamaica Hospital Medical Center hit a record high of 478 patients [on April 27, 2009.] At least an extra 100 patients a day poured into ERs at Elmhurst Hospital, Queens Hospital Center and New York Hospital Queens."[9] The increased patient load continued to grow through the Memorial Day weekend. Jamaica Hospital was up to 663 emergency room visits on May 27th, more than double the average daily volume in 2008. As discussed above, these sharp flu-related increases come on top of the additional patients due to the closures.

It is well documented that lack of access to primary care often leads to overuse of the emergency room, further contributing to overcrowding. In 2008, Mary Immaculate and St. John's Hospital together had 119,883 outpatient department visits. With the exception of Mary Immaculate's family health center that was transferred to a new operator, little of the two hospitals' primary care capacity remains. Comptroller staff was told by hospital personnel that this has led to overcrowding in outpatient clinics at the nearby hospitals due to the closures, and increased reliance on the local emergency rooms as an alternative place to seek care.

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[8] Letter to the Editor, *Ridgewood Times*, April 16, 2009.

[9] Ginger Adams Otis and Melissa Klein, "'Room' Emergency at Bursting Qns. Hosps," *New York Post,* May 3, 2009.

In some cases, patients are actually "bouncing" from one local hospital to another, making multiple visits over a short period of time, according to a Queens Hospital Center emergency room physician. For example, after finding the outpatient clinic at Jamaica Hospital too crowded, patients left without being seen by a doctor and sought care in its emergency room instead. When the emergency room at Jamaica Hospital grew too crowded, patients then presented at Queens Hospital Center's emergency room.

Some patients reported being seen in several emergency rooms because they had been discharged without understanding how to follow-up on their condition. In the rush to see the next patient, some doctors and nurses may not have the time or the resources -- such as translation services--to properly explain what the patient needs to do upon discharge, and the medical condition worsens as a result. Other patients, unable or unwilling to cope with the long waits to be seen are leaving the emergency room without getting care at all. As Dr. Toni Lewis, President of CIR, stated, "Because the ERs are full, everyone is waiting longer and coming in sicker. This is only going to snowball."

Doctors, nurses and other healthcare professionals told Comptroller staff that they are reluctant to make public their concerns about delivering quality care in overcrowded emergency rooms because they do not want to frighten patients. Instead, many stated that they just work harder and longer. But the consequences could be serious. As one doctor stated, "Patients feel like they're not getting good care and the doctors feel like they're not giving it." In the wake of the closures, doctors working in the emergency rooms at Queens Hospital Center, Elmhurst, and Flushing Hospitals have stated that they feel overwhelmed.

It is clear that their all-out effort cannot be sustained indefinitely. For example, to accommodate the extra patients from the closures and now from H1N1, hospitals have been forced to quickly make additional space available in their emergency rooms. Medical professionals are providing care in temporary converted spaces such as former offices or waiting areas that lack essential supplies, provide little or no privacy for patients, and make merely moving around difficult.

Doctors working at Flushing Hospital and Queens Hospital Center told Comptroller staff that administrators have given temporary permission for patients to be admitted to the hospital but remain in the hallways or in the emergency room. Patients have remained in corridors for 24 to 48 hours at times of peak overcrowding, and a resident said that procedures such as blood transfusions are administered in the halls, without proper privacy, infection control or access to oxygen in case of an adverse reaction. The resident added that the situation was "dangerous" and [s]he worried about the welfare of the patients.

A Queens Hospital Center emergency room doctor with over two decades of experience described conditions at the hospital to Comptroller staff as a "living nightmare," and added that "the state of emergency medicine in the borough of Queens is the worst I've seen it in my career." He expressed a deep concern that the level of care has deteriorated because there is pressure to "move the patients" -- either admit them or

get them out of the emergency room. He noted that he leaves his shift worried that he has "missed something" in treating a patient because of the volume and time pressure. He estimated that he now sees 35 patients per shift compared to 20 before the closures. To meet the increased demand, he works at least two hours extra for every eight hour shift plus 10 hours a week of mandatory overtime.

With only a few weeks' notice before the closures and the onset of the H1N1 virus soon after, many of the affected hospitals did not have time or, as discussed below, the financial resources to hire additional staff to meet the demands of an increased patient load. Consequently, in order to keep the emergency room at appropriate staffing levels, administrators are forced to rely on having their personnel work overtime and/or shifts other than those for which they are regularly scheduled. Both approaches are costly, both financially and in terms of staff morale and performance. All of the staff and administrators interviewed by Comptroller staff noted that staffing levels are wholly inadequate, not just in the emergency room, but also in laboratories, x-ray areas and other ancillary service areas needed to diagnose emergency room patients.

D. Lack of additional funding combined with recent budget cuts are impeding some hospitals' ability to respond.

The affected hospitals have received a total of $14.5 million from the State to expand capacity needed to absorb the additional patients they are seeing as a result of the closures. The availability of this money was announced by the Department of Health on February 17, 2009, two days after the emergency rooms at the two Caritas hospitals closed.

One hospital official told Comptroller staff that "the funds are too little, too late." Some hospitals have yet to receive their full allotment, and, according to hospital administrators, the funds will not fully cover construction costs. Some hospitals cannot afford to start construction of new emergency room and inpatient space until the monies are in hand, which means that space to relieve overcrowding may not be completed for at least another year or more. More significantly, the State has not announced any program to provide the hospitals with additional loans or grants to cover the costs of their expanded operations. Without this assistance, some hospitals are finding it difficult to afford more staff or to purchase new equipment. Instead, as discussed previously, they are relying on current staff working overtime to meet the demand. Unbudgeted overtime costs, however, will not be financially sustainable over the long term if there is no prospect of recouping the expenditure.

Hospitals also report that no funding has been advanced to the affected hospitals to cover the increase in patients who are unable to pay for their care. St. John's Hospital and Mary Immaculate Hospital both served a mostly low-income population, many of whom were uninsured or underinsured and unable to pay some or all of their medical bills. This reimbursement shortfall was a significant contributing factor to Caritas' bankruptcy. With these patients now receiving care at nearby hospitals, some of which were already in a financially precarious position, the long term financial viability of some of the remaining hospitals may be in question.

As if the impact from the closures and the upsurge in patients from the H1N1 virus were not enough, hospitals are now facing lowered Medicaid reimbursement and increased assessments under New York State's FY 2009-2010 budget. For HHC hospitals, in particular, which serve as a safety net, the loss of Medicaid revenue combined with the increase in uninsured and underinsured patients is likely to result in a financial "perfect storm."

E. Recommendations

New York City has a proud history of pulling together in a crisis. It is time for officials to publicly acknowledge that many hospitals in Queens, especially those serving the most disadvantaged populations, are in crisis primarily as a result of the closures of Mary Immaculate and St. John's Hospitals and exacerbated by the rapid spread of the H1N1 virus.

Money alone will not solve this problem. First and foremost, what is needed is leadership. Patients and hospitals cannot resolve these problems alone. The City and State need to pull key healthcare providers and other stakeholders together immediately to share information, identify problems and develop solutions to address the current surge in demand stemming from the H1N1 virus. As the flu spreads and possibly returns in the fall, other hospitals throughout the city could be pulled into the same downward spiral that Queens is experiencing. It is critical that the lines of communication between government and healthcare providers be open and responsive.

Short term

- **Activate the necessary resources to deal with emergencies.** Hospitals in much of Queens need immediate help to cope with the heightened challenges presented by the two closures and now the H1N1 virus. Just as the City and State sends personnel, equipment and supplies to emergencies throughout the State, such as floods or fires, it may be necessary to ask other New York locales to provide similar assistance in Queens. With Jamaica Hospital, for example, now handling well over 500 emergency room visits daily, up from 300 to 350 a day before H1N1 and the two hospital closures, this is indeed a crisis.

  SDOH and the City should post staff at the affected hospitals, especially at peak hours, to ensure smooth operations, rather than relying on telephone calls between the Department and hospital administrators.

- **Triage individuals with flu symptoms at ambulatory care facilities**. Many of the people currently seeking care in the emergency room either do not actually have the H1N1 virus, have a mild form, and do not have other risk factors. By seeking out an initial diagnosis at a community health center, they can be evaluated by doctors and directed to the emergency room if indicated. Reducing the crowding at emergency rooms will allow patients with serious flu-related conditions and others with true medical emergencies to receive better and faster attention.

For this approach to be successful, two actions are critical. The City must encourage the use of these health centers and widely advertise their locations. In addition, the City must work with the centers to temporarily expand their hours and be open seven days a week. Local medical practices should also be approached.

Although there are not many in Queens, Federally Qualified Health Centers, known as FQHCs, are located throughout the city. These centers will see all patients regardless of their insurance status and, with expanded hours, could become the backbone of an effective triage system if emergency rooms in other boroughs experience the same surge. Because of the FQHC funding mechanisms, they are in a better position to manage the marginal costs associated with expanded hours. Other clinics may require a small subsidy to cover staff costs associated with expanded hours.

- **Provide loans and working capital to cover expansion costs.** Because many hospitals are in weak financial positions, it is difficult for them to borrow money. If they hire staff, treat uninsured patients, modify their facility or incur any other expenses associated with expanding capacity to meet a significantly increased patient load, they must wait anywhere from months to a year to recoup that expenditure in form of insurance or government reimbursement and frequently no reimbursement is provided. By asking hospitals near the two that closed to spend money they do not have, SDOH is threatening the very survival of those hospitals. For example, many hospitals are relying heavily on the use of overtime during the H1N1 surge.

- **Provide data on emergency room utilization to the public.** In conjunction with the hospital closures, SDOH agreed to disclose emergency room data like those cited throughout this report. After an initial release in early April, no additional data has been made available, according to press accounts. SDOH has cited the need to focus its staff on managing the H1N1 virus as the reason it has not followed through on the commitment. While it is certainly true that the spike in emergency room utilization caused by H1N1 may make analysis of the impact of the closures alone more difficult, SDOH is undoubtedly still collecting emergency room data as part of its H1N1 monitoring.

  SDOH needs to restore public confidence by publishing key daily statistics about emergency room utilization and staffing. These should include the total number of adult and pediatric emergency room visits, the number of hours patients are waiting before actual care begins (not to be triaged), the number of hours admitted patients are waiting to be moved from the emergency room to Intensive Care Units and to a bed on an inpatient floor as well as daily staffing levels and overtime hours worked at affected hospitals.

- **Help hospitals staff-up to meet the increased demand.** SDOH should issue an update on the number and type of additional staff hired at these hospitals, while doing whatever is necessary to expedite hospitals' ability to hire staff, especially in

medically-underserved areas where it is difficult to attract physicians and other medical personnel. For example, the federal stimulus package contains funding for a medical school loan-forgiveness program for doctors who work in high need areas.

- **Identify gaps in services created by the closures.** As soon as possible, SDOH should publish an inventory of the quantity and type of all services provided by the two closed hospitals, where those services are now being provided and which services have not been continued by any provider in the area. The lapsed services, if deemed essential, should be the basis for a community healthcare plan.

Longer term

In the longer term, the answer is planning, as the Office of the Comptroller has recommended previously. SDOH should be proactive and create a master plan, in dialogue with the community, to begin to restructure the health care delivery system in New York City. SDOH has taken some promising steps in this direction already, especially in its focus on primary care.

At the moment, however, it seems that New York City is losing primary care at an alarming rate. Since hospital outpatient department represent a significant portion of the City's primary care capacity, the closures of 15 New York City emergency rooms since 2002 has markedly reduced capacity. In addition, outpatient departments can be a drain on hospital finances and some have cut back these services to improve their financial picture.

The State needs to develop integrated systems that accurately reflect primary care service levels and can be used to assess where shortfalls exist. With a comparatively high ratio of 592 residents per hospital bed in Queens, the Department needs to return to community-based comprehensive health care needs assessments and use the results as the basis for allocating resources in the most efficient, cost-effective manner.

If SDOH had undertaken this process in December 2006, as the Office of the Comptroller recommended, it is likely that much of the current impacts in Queens could have been minimized or avoided entirely.

Gayle M. Horwitz, First Deputy Comptroller
Glenn von Nostitz, Director, Office of Policy Management

Staff: Susan Scheer, Assistant Director, Office of Policy Management and Senior Health Policy Analyst

New York State Nurses Association
Testimony before the New York City Council Health Committee
On NYC preparedness for the A H1N1 Influenza
FOR THE RECORD June 11, 2009
City Hall

Chairs Rivera, Sears, Vallone and members of the committees:

The New York State Nurses Association represents more than 34, 000 nurses state wide and of that number, approximately 26,000 work in hospitals, clinics and long-term care facilities in the five boroughs. This includes the 7,800 RNs of the NYC Health and Hospitals Corporation and the Mayoral Agencies. Thank you for this opportunity to present testimony on the issue of preparedness for a Pandemic Flu.

The current outbreak of A H1N1 has not reached the severity of previous epidemics and the numbers appear to be declining. This does not mean, however, that our focus on preparedness can be minimized. There is much to do in order to be prepared for what some scientists are predicting to be a re-emergence of a more tenacious flu come this fall. Guidance from agencies telling healthcare workers that the use of a surgical mask is okay when taking care of suspected or confirmed cases, as long as there are no high risk activities involved, needs to be corrected. This guidance is in conflict with the provisions of law found in the respiratory protection standard, (29 CFR 1910.134) and contrary to recent research regarding the spread of the virus from aerosolized particles (Measurement of Airborne Influenza Virus in a Hospital Emergency Department, Blachere, F. et al, CID, 2009:48, 15 February, 2009 pp 438-440) and against the decision to use N-95 or better respiratory protection by personnel exposed to recognized respiratory hazards found on a respiratory hazard risk assessment. Some hospitals are sending home perfectly well nurses simply because their son or daughter (also asymptomatic) attends one of the schools that have been closed by the flu. This irrational knee-jerk reaction only serves to worsen an already understaffed facility. Nurses are being asked to wear respirators without being given proper medical clearance, fit tests or training. This practice must also be corrected if we are to protect the health and safety of our nurses.

The "risk messaging" to the general public and the healthcare community concerning the A H1N1 flu virus must convey an accurate assessment of the current status, coupled with a clear and concise direction for the targeted audience. To achieve this, the city must develop a better system to more accurately and consistently account for the numbers of confirmed and probable cases. Criteria for public health strategies for containment, such as closing schools, staggering business start times and use of work-at-home options must be clearly defined and applied in a consistent manner.

New York State NURSES ASSOCIATION
120 Wall St. 23rd Floor, New York, NY 10005 ■ 212-785-0157 ■ www.nysna.org

NYSNA believes that the preparedness response to a Pandemic Flu must proactively prepare and protect our nurses and other frontline personnel. Central to this concept of preparedness is an evidence- based, well coordinated written practical plan that addresses early detection, effective prevention and containment strategies. The plan needs to address sound resource management of both personnel and physical facilities to meet the surge demand. A preparedness opportunity also demands a plan for recovery from both the emotional and economic impact left by a pandemic flu.

We urge the city to expand its understanding and preparation for the impact of the patient surge a pandemic will undoubtedly bring. Now is the time to involve our nurses and other frontline personnel with the planning process to build a comprehensive and robust response.

The lessons learned from previous pandemics must be heeded. Knowing that a pandemic can span the course of several months, 24 hours a day, seven days a week, and come in several waves, we need to verify that every hospital has the capability to appropriately staff the expected increase that capacity demands. Every hospital and healthcare facility must have an adequate supply of appropriate respirators, in house or accessibly warehoused, for the protection of the staff. Use of surgical masks to protect against aerosolized flu particles is not appropriate. N-95 respirators or better must be provided. Nurses and other frontline personnel need to be taught the proper use, be medically cleared and fit tested to use the appropriate respirators.

Those facilities that do not have respiratory isolation rooms attached to their emergency department should consider use of temporary or portable negative pressure rooms and equipment that are far less expensive than the traditional bricks and mortar solutions. Each community hospital and major teaching institution needs to take an active part in educating the public on proper respiratory etiquette. Yes, we need to teach the public how to sneeze, cough and blow their noses in a responsible fashion!

All city healthcare agencies, public and private, need to coordinate resources, readiness and response not just within the city, but within the region, state and federal arena. When a pandemic hits, New York City will not be an Island unto its own and our nurses should not be left to fend for themselves in an already understaffed healthcare environment.

Safe staffing levels must immediately be implemented in all facilities so that nurses and other personnel can provide appropriate and safe care for patients already in our hospitals. Basic nurse staffing needs must be addressed immediately in order for more long-term solutions for surge demands to become viable. Then, built on a firm foundation of routine safe staffing, surge capacity

plans have to be developed and tested to ensure continued safe staffing levels during a pandemic.

When a pandemic flu vaccine becomes available, our nurses should have that vaccine offered as a priority and not a condition of employment. Seasonal vaccine levels among healthcare providers are historically low, but there have been some innovative and effective programs to increase the numbers who voluntarily take the vaccine. NYSNA encourages the development of these non mandatory programs. The time to start those programs is now.

In summary:

Resources are key to being prepared. First and foremost are the personnel resources which will be needed to sustain our current healthcare delivery system and be able to expand to meet the demands of an impending pandemic; this means adequate RN staffing NOW. Resourcing preparedness efforts is also critical. Using pandemic impact prediction models, facilities should already be assessing inventory levels of PPE, ventilators and hospital beds, establishing par levels and setting re-supply triggers.

Our nurses and allied healthcare professionals need to be involved in the process of planning, we need the resources that will enable us to perform our responsibilities, we need the training to know not only what to do, but how to do it, and perhaps most importantly we need the opportunity to practice what we have been trained to do. Pandemic Flu preparedness and response has to be facility-specific, community-based and regionally compatible.

The New York State Nurses Association has a proud history of service to the public in both times of calm and disaster. NYSNA stands ready to again respond and now offers any assistance it can to this committee as it supports the efforts being made toward preparedness for a Pandemic flu.

Thank you again for the opportunity to testify.

Thomas J. Lowe, RN, MPH, COHN-S, COHST
Health and Safety Representative, NYSNA

Testimony of

Randi Weingarten,
President

United Federation of Teachers

Before the
City Council Committee on Health and the Committee on Public Safety

Re

Oversight: New York City's Response to H1N1 and Assessing Influenza Preparedness

June 11, 2009
2:00 PM

Good afternoon, and thank you for this opportunity to testify today on New York City's response to the H1N1 flu virus and assessing our influenza preparedness. My name is Randi Weingarten, and I am president of the United Federation of Teachers (UFT), which represents approximately 110,000 employees in New York City's public schools as well as several thousand hospital and visiting nurses.

I'd like to begin by again offering our condolences to the family, friends and colleagues of Mitchell Weiner, the assistant principal at IS 238 in Queens, who died on May 17th from complications of the H1N1 flu that he likely contracted in an outbreak at his school.

We also want to offer our condolences to the family of a more recent H1N1 flu victim, a student at IS 609 in Brooklyn who died on Sunday. We are still gathering information about this and we are reaching out to the staff and the school community to offer guidance, counseling and any other support they might need.

At this point we'd also like to thank all of our educators, nurses and the school communities who have been incredibly heroic in the face of the flu epidemic.

Because this flu spread quickly through the school system beginning first in Queens and now in all boroughs, I'd like to give you some background on our experience.

As soon as the union became aware on Saturday, April 25, that flu cases at St. Francis Preparatory High School were probably of swine origin, we began putting a plan into action. By the time the federal government declared swine flu a public health emergency on April 26, the UFT had consulted with the Commissioner of the Office of Emergency Management as well as representatives from the New York City Department of Health and Mental Hygiene and the Department of Education. We also issued a fact sheet on the swine flu virus for distribution to UFT district representatives and school reps – we call them chapter leaders – throughout the city.

The UFT fact sheet provided an overview of swine flu, including symptoms, transmission routes and preventive measures as well as joint UFT/DOE/DOH health and safety protocols. These protocols included increased cleaning and disinfecting of restrooms, cafeterias and doorknobs in common areas, making sure that all restrooms are stocked with soap and paper towels, opening windows to ensure the building is properly ventilated, running ventilation systems with maximum outside air and providing disposable respirators to the school medical offices. In addition, ill students with fever and flu-like symptoms were to be isolated in the medical room and not returned to the classroom or general office.

Although the UFT is not a designated emergency first responder, our preparedness was critical to assisting schools in dealing with the potential flu epidemic.

Let me describe the scene at PS 177 in Queens on Monday, April 27, and the reports we received that afternoon. Here is how one report read: "PS 177 has had one

child hospitalized over the weekend with flu and an assistant principal was taken by ambulance to the hospital today. Additionally 10 students have been sent home today with symptoms and two other staff members, a para and a teacher, are ill. This is a total of 14 people from the school with flu or flu-like symptoms. There are approximately 480 students and 200 staff in the school. It is located about 5 blocks from St. Francis Prep. Several staff members have spouses or children who work at or attend St. Francis."

When UFT staff arrived at PS 177Q early the next morning on April 28th they found confusion about how to proceed. There was no doctor on site, no respirators and no plan in place. The UFT quickly put together a set of protocols for how to proceed during a flu outbreak and these protocols have served as guidance for schools citywide.

UFT representatives and safety and health staffers spent the day at PS 177 assisting the school in dealing with this situation, interviewing school staff and providing the school with disposable respirators, gloves and alcohol-based sanitizers. The union recommended that the school close, which it did on April 29 for a week. There were five confirmed cases of swine flu at PS 177, which reopened on May 6.

Flu outbreaks began to occur in many other Queens public schools and have now spread citywide with schools in each borough reporting flu outbreaks. Regardless of the school or borough, the outbreaks are similar, and the following story from IS 227 in Queens could have just as easily come from a school in any of the other boroughs.

IS 227 Chapter Leader Tom O'Brien described what the school had been like during one week in May: "In my 30 years of teaching, I've never seen so many kids fall sick so quickly. Everyone feels under siege. One-third of our school population has been out sick this week, and we had 20 out of 98 teachers out today.

"Our medical staff is overwhelmed. We ended up having to use the science room across the hall from the medical suite when that was overflowing with students; 81 students were sent home on Tuesday."

What has made it all work has been the tremendous cooperation by everyone involved, from teachers to administrators, the union, parents and students, O'Brien said. "Colleagues are taking kids from other classes, changing schedules and working in concert with administration and medical personnel to get through the day in these very unusual circumstances," he said.

The UFT monitored each school by sending union staff there, maintaining contact with each chapter leader and, in turn, maintaining constant contact with the Department of Education and the Department of Health and Mental Hygiene. We collected information about each school with flu outbreaks, including the number of absent students and staff and how many students and staff with fever or flu-like symptoms were sent home each day. Over 900 schools have been providing this information to the union, and we in turn provide all this information to the DOE and DOH.

The UFT also set up a special Web page containing a set of recommendations for schools, plus additional useful links to health information sources, available on our website at www.uft.org.

The DOH and DOE were assessing the situation in the schools daily. Decisions regarding school closings and other measures were being made on a case-by-case basis. Although information about H1N1 was provided (including guidance that sick students and staff should stay home), no one knew what to do in the midst of a spreading contagion. No one knew the criteria for assessing when to close a school. Information was not being provided to the school communities and the UFT about why one school was being closed and another wasn't when both seemed to have similar flu outbreaks. As a result, concern and panic were spreading throughout the school system. For example, on May 16, parents were protesting outside a Brooklyn school to have it closed based on a single case of flu while parents at other schools with 15, 20 or 25 students being sent home sick with fever or flu-like symptoms had no idea what was going on.

So on May 21, the UFT held a press conference outside IS 227 in East Elmhurst. To help prevent the spread of influenza-like illness and reduce panic, we urged the DOH and the DOE to provide parent and the public with accurate information in a timely manner, including the rationale and criteria for closing a school. Subsequently the DOE began posting school attendance rates on their website and the DOH has been posting rates of influenza-like illness in schools on their website along with their rationale and criteria for closing a school. This has gone a long way to reassure our school communities.

In light of our experience, including this recent passing of the student at IS 609 in Brooklyn, we are calling on the Department of Education and the Department of Health to take two key steps:

First, immediately begin notifying school communities, including parents, of any confirmed cases of influenza in public schools. Specifically, we are asking that in any school where a case of the flu – swine or other strains – has been confirmed that letters be sent to notify staff and parents so that those with underlying medical conditions can take appropriate precautions. Some might say this is an overreaction, but if this step can help prevent another student death, then it needs to be implemented so that parents can know the system is doing everything it can to keep children safe.

Secondly, because we know that influenza will likely resurge in the fall as it typically does, we call on the Department of Education and the Department of Health to begin strategic planning now, including a review of existing health protocols, and have in place by September a comprehensive system for addressing the flu.

In addition to these steps, the following are our recommendations for an **Influenza Preparedness - Action Plan for Schools (and other workplaces):**

Emergency Preparedness Plans – Prepare and provide to schools a written flu epidemic plan that includes outlining local, state and federal contacts and resources, protocols and preventive measures to reduce the spread of flu, purchasing of the necessary personal protective equipment and supplies including thermometers, isolation policies and guidance for people at risk of complications from the flu.

Transparency and Disclosure of Information – The city should quickly get information out to the public and workers that includes not only the health hazards of the flu virus and steps to take to reduce the chance of spreading it, but also guidance and directives on how the DOH is assessing and monitoring schools, worksites, shelters, etc. and on what basis decisions are made to close these sites. Not sharing this information can lead to widespread panic. There also needs to be a road map or set of protocols outlining what to do when influenza begins showing up in the school building and spreading through a school or other building. Be transparent with information and outline the rationale and criteria for monitoring and closing a school due to influenza-like illness.

School Nurse in Every School – The school nurse is the key person for assessing and determining the level of influenza-like illness in the school, so there should be a nurse in every school.

Consider impact of closing community hospitals and other healthcare facilities – We know this is an extraordinary time of economic crisis, but it is precisely at such times that we need a comprehensive vision in order to plan ahead. As we noted earlier, this flu or some other strain will likely resurface in the fall. Closing community hospitals in Queens just as a potential flu epidemic was unfolding further victimized the community and overburdened existing healthcare facilities and doctors' offices.

Specifically, St. John's Queens Hospital in Elmhurst and Mary Immaculate Hospital in Jamaica closed in March after filing for bankruptcy protection. Even though they closed before the flu outbreak, their absence during the epidemic caused chaos and overburdened all the remaining hospital emergency rooms in the borough, resulting in very long waits and tents being erected at one Jamaica hospital. Our communities need adequate healthcare staffing citywide, and any change in the availability of medical resources can have a significant impact on the community and its public health. City health officials should keep this in mind when they consider closing or cutting back city healthcare facilities because of budget cuts.

COBA PRESIDENT NORMAN SEABROOK'S TESTIMONY

BEFORE THE NEW YORK CITY COUNCIL COMMITTEES ON

GOVERNMENT OPERATIONS, HEALTH, AND PUBLIC SAFETY

REGARDING NEW YORK CITY'S RESPONSE TO H1N1 AND

ASSESSING INFLUENZA PREPAREDNESS

JUNE 11, 2009

Good afternoon Chairman Vallone and Members of the Council. First and foremost, I would like to take this opportunity to thank you for inviting me to testify at today's hearing. My name is Norman Seabrook. I am the President of the Correction Officers' Benevolent Association, the second largest uniformed force in the City of the New York.

Let me first begin by saying that the Swine Flu, now known as H1N1 Virus, is a problem that is going to reach epidemic levels, not only in New York, but in the entire country before long. The H1N1 Virus is our Hurricane Katrina. I am pleased to see that the President of the United States is dealing with this issue and making the resources of the Federal Government available to us. The H1N1 Virus has no readily available vaccination at this time. It has taken the life of approximately nine individuals in New York City thus far.

It has also been suggested that all of these individual who passed away, had an "underlying health issue." Everyone in this room

has some type of "underlying health issue" and we should not dismiss the cause of their deaths
for any other reason, than for what it was, the H1N1 VIRUS.

I have had the opportunity to address this issue with the City of New York. When the City began to look at the H1N1 Virus, some dismissed it as a mild case of the flu. This is **NOT FLU SEASON**! I became so alarmed by this H1N1 Virus that I requested that the New York City Department of Correction implement policies and procedures on how to immediately combat this deadly, unknown virus.

Specifically, our request to staff members at City Hall was to establish a "contingency plan" to address what the Department of Correction had failed to do. The Department of Correction failed to act and that forced this organization to seek injunctive relief from the courts. After threats of pursuing a lawsuit, the City of New York finally intervened along with the help of Commissioner James Hanley, to satisfy our concerns and to ensure that the Department of Correction and the City of New

York are implementing a plan to address the health concerns of the members of this organization and their families, the detainees in our system and the non-uniformed members that include teachers, doctors, chaplains, and maintenance workers.

The Department has not been able to provide real solutions to the real problems facing our Department and our City. While the Commissioner of the Department of Correction is not responsible for running the entire city, he is responsible for the well-being of all the members of this Department.

As we all know, it is the Mayor, who is ultimately responsible for effectively and responsibly responding to this city-wide crisis. I am not suggesting that we should all live in a bubble nor am I suggesting that we turn a blind eye to this problem like others have. However, I am suggesting that as responsible leaders in this City, it is incumbent upon us, as both union leaders and elected officials, to immediately establish a task force that strictly deals with this crisis.

FIRST: To establish a task force to implement policies and procedures to combat this virus immediately.

SECONDLY: That the City of New York ascertain an accurate number of exactly how many people have been affected H1N1 symptoms, by using the 311 system.

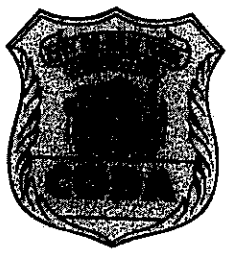
I know that Tamiflu is just a "band aid" in treating this virus, but it has been suggested by experts that it can slow the spread of the H1N1 virus. When we first brought this situation to light on May 19, 2009, we had nine cases of H1N1 on Rikers Island. Now, a month later, this has multiplied by ten, and continues to grow.

In closing, I thank you for the opportunity to address these concerns at this hearing. I look forward to having further dialogue with you and your designees and answering any questions you may have. In addition, I have provided each of

you with copies of a letter from DOC Senior Deputy Commissioner, John Antontelli, regarding the DOC's additional measures to the H1N1 Response Plan, which the COBA demanded, as well as, a letter I sent to my members, briefing them on the steps that we requested the DOC to take to fully address this crisis.

Finally, please note for the record that I have designated Joseph Bracco and Elizabeth Castro, Vice-Presidents of the Correction Officers' Benevolent Association, who are seated here next to me, as the liaisons from my office to assist you in any way possible.

Thank you again.



May 20, 2009

Dear Brother and Sister Officers:

Yesterday, the COBA Executive Board and I attended a meeting at 60 Hudson Street and requested the Department of Correction brief us on the steps that they have taken to protect your health and safety.

I'll begin by informing you that the Chief of Department, Carolyn Thomas and Commissioner Martin Horn, have NO PLANS. A legitimate course of action was not put forth until we requested the immediate attention of emergency medical experts to deal with this virus, which has the potential of being deadly and spreading rapidly.

During this meeting we presented our concerns and proposed the following courses of action:

1. How does the Department determine whether or not a person is infected with the virus? Their response: "we check for fever." That is not acceptable. We suggested that the physical examination consist of nasal swabbing and these results should be sent to the DOHMH for analysis.
2. We recommended that half of AMKC be closed temporarily for the purpose of decontamination of the Facility. Also, we recommended closing half of AMKC and that Department should re-open the Brooklyn House of Detention, which holds approximately 800 inmates as well as reopen the Queens House of Detention, which holds approximately the same number of inmates. We also recommended that JATC, formerly known as HDM, be reopened so that every inmate moved from that half of the facility can be housed appropriately.
3. Our next recommendation was to have detainees and/or sentenced inmates clean, scrub, and decontaminate AMKC and that the Department should immediately stop transporting inmates to the courts in order to prevent further exposure of this virus.
4. We then proposed that the visitation rights of inmates in the affected areas be postponed until it has been determined that the inmates are not infected with this virus.
5. We further proposed that the Department of Correction implement a written policy on how to deal with this strain of virus.

Let me state clearly, if you are sick, you have the right to stay home. Whether you're on probation or not! The Mayor and the Commissioner have asserted this previously. We will continue to do all that we can to ensure your rights are protected. I want to also emphasize the fact that if the City of New York can close and decontaminate schools, then certainly Correction Officers, civilians, and detainees can be treated with the same level of significance.

If the City of New York and the Department do not assist you and your families by establishing and implementing an effective policy and procedure that protects you, we will seek all necessary legal action on your behalf and take this fight to the steps of City Hall, if necessary.

In the meantime, while we fight this battle, here are just a few things you can do to protect yourself.

1. Don't wear your uniforms home.
2. Don't allow inmates in your space.
3. Wear the masks and the gloves provided to you.
4. Use the hand sanitizer.
5. Wash your hands frequently.
6. Have the HOUSE DETAIL clean housing areas more frequently.

If you have any further questions or concerns, please contact your Delegate or the Executive Board member assigned to your facility.

Sincerely,
Norman Seabrook
President

The City of New York

NEW YORK CITY DEPARTMENT OF CORRECTION
Martin F. Horn, Commissioner
John J. Antonelli, Senior Deputy Commissioner
Management Services
60 Hudson St.
New York, N.Y. 10013
212 • 266 •1271
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May 21, 2009

Norman Seabrook
President
Correction Officers' Benevolent Association
75 Broad Street – Suite 810
New York, New York 10004

Dear Mr. Seabrook:

This is to confirm that the Department of Correction will take the following additional measures with respect to the H1N1 response plan:

1. DOC will assign HMD medical staff to jails to provide consultation to staff, screen for symptoms, etc. beginning with staff with underlying conditions.

2. DOC will establish a labor management task force with an infection control doctor assigned from DOH/MH to monitor implementation and recommend adjustments to the plan. SDC Antonelli to Chair; Chief Oliver and Deputy Chief of Staff Cranston to participate.

3. DOC will screen all inmates going to Court in all jails (currently being done only in AMKC) to prevent transmission and as an indicator of infection in all jails.

4. DOC will continue to offer use of mask and latex gloves to all staff on request and continue to require masks for staff on medical response teams.

5. The Criminal Justice Coordinator and the DOC Commissioner will work with the Office of Court Administration and the legal community to maximize efficiency and reduce unnecessary court appearances.

6. DOC will use available Sprungs and JATC, as best meets the need, to place only screened healthy inmates who have been symptom-free for 72 hours (as soon as practicable).

7. As housing units are freed up in AMKC, DOC will thoroughly sanitize areas. These areas will be used for inmates meeting criteria of being symptom-free for 72 hours. Sanitation will continue on a rolling basis.

In the event of any emergent developments, the DOC will convene a labor management meeting with the COBA and the Mayor's Office of Labor Relations as soon as practicable.

Very truly yours,

John J. Antonelli
Acting Commissioner

Cc James F. Hanley, Commissioner, OLR
Richard Yates, Assistant Commissioner, OLR

CHCANYS | *Defining New Directions*

Community Health Care Association of New York State

City Council
Hearing on New York City's Response to H1N1 and Assessing Influenza Preparedness.

Good afternoon, my name is Darryl Ng and I am the Director of Government Affairs for the Community Health Care Association of New York State (CHCANYS). CHCANYS is New York's primary care association and the statewide association of community health centers. I'd like to thank the City Council for the opportunity to testify at its Hearing on New York City's Response to H1N1 and Assessing Influenza Preparedness. CHCANYS is here today to voice our strong support for the New York City Department of Health and Mental Hygiene's (DOHMH) past and ongoing efforts related to H1N1 and to encourage a continuation and expansion of its focus on linking community health centers to city emergency planners.

Community Health Centers (CHCs) are nonprofit health care practices that provide high quality and cost-effective primary care to anyone seeking care regardless of ability to pay. They operate in underserved communities in all five boroughs and also bring health care services wherever needy patients, including homeless persons and migrant workers, need them. In New York City, 35 federally qualified community health centers provide care to over 700,000 individuals in approximately 200 sites. Together, New York City's community health centers comprise one of the most comprehensive primary care networks in the five boroughs. These centers provide high quality, comprehensive, community-based primary care to New Yorkers living in some of the poorest communities in New York City. Community health centers provide a "one-stop" approach to care that has produced outstanding health outcomes for their patients, especially those with chronic diseases.

Because they are run by and serve their communities, community health centers play an important role in emergency preparedness and response. In recognition of their critical role, DOHMH has developed a strong and effective partnership with CHCANYS to reach out to our member centers and other primary care centers to respond to the recent H1N1 outbreak.

The Community Health Care Association of New York State (CHCANYS) has represented the community health centers of New York for nearly 40 years. CHCANYS works to increase access for those who would otherwise go without care through

advocacy and education and also creates major new programs and initiatives that showcase community health centers as centers of excellence. CHCANYS works to ensure that all New Yorkers have medical homes.

Primary care is and should be at the forefront of a public health response to pandemics, with CHCs caring for people who would not go to a hospital ER for treatment for a flu-like illness. Community health centers also alleviate the burden a pandemic places on hospital emergency rooms by treating other patients who are not seriously ill enough to require acute care. Add to this the ability of community health centers to reach medically underserved communities and it becomes clear that these centers are an integral part of a public health response to pandemic.

When H1N1 was discovered to be affecting local communities, DOHMH recognized the importance of primary care and community health centers. DOHMH reached out to CHCANYS to relay important information in email alerts, conduct outreach to gain participation for primary care-specific conference calls, and learn from the centers what issues they faced and what assistance might be needed. When DOHMH needed data on changes in patient volume the health centers were experiencing, they turned to CHCANYS to reach out to the centers to collect it. CHCANYS worked closely with our partners at the Primary Care Development Corporation (PCDC) to collect, analyze and report on the responses.

Prior to the outbreak of H1N1, CHCANYS' Emergency Preparedness Program was working with the DOHMH on community health centers' inclusion in the City's Pandemic Antiviral Allocation Plan. CHCANYS worked with DOHMH to identify and assess the capabilities and needs of community health centers to receive antiviral supplies from the City in the event that the Strategic National Stockpile would be released.

With the onset of H1N1 in New York City, however, the Antiviral Allocation Plan immediately became an urgent priority. The DOHMH led a speedy and thoughtful response to this potential crisis. Our original goal of distributing a cooperative agreement for health centers to review by the end of June became a distribution of the agreement for immediate signature. Community health centers responded positively and so far, twenty-six will participate in the City's Pandemic Antiviral Allocation Plan.

As we continue to address H1N1 issues on a daily basis, we are planning for the fall flu season, which some fear may bring a return of more virulent strain of H1N1. While we have come a long way in a short time due to the strong and steady leadership of the DOHMH, additional and critical planning must occur as the clock is ticking toward the fall. We look forward to our continuing close partnership with the DOHMH in this process.

Thank you.

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

TESTIMONY OF

GREATER NEW YORK HOSPITAL ASSOCIATION

BEFORE THE

COMMITTEE ON HEALTH,

COMMITTEE ON GOVERNMENTAL OPERATIONS, AND

COMMITTEE ON PUBLIC SAFETY

AT A HEARING ON

NEW YORK CITY'S RESPONSE TO H1N1 AND

ASSESSING INFLUENZA PREPAREDNESS

JUNE 11, 2009

Testimony of
Greater New York Hospital Association
Before the
Committee on Health,
Committee on Governmental Operations, and
Committee on Public Safety
At a Hearing on
New York City's Response to H1N1 and
Assessing Influenza Preparedness

June 11, 2009

Good afternoon, and thank you for the opportunity to appear before you today. I am Susan C. Waltman, Executive Vice President and General Counsel for the Greater New York Hospital Association, which represents the interests of approximately 250 hospitals and continuing care facilities in the New York City region 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 that they serve.

GNYHA members also serve an additional role, one that has become more important and more demanding in light of the terrorist attacks 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, among other events, the subsequent anthrax attacks, the blackout of 2003, and the threat of SARS, a reflection of their years of preparedness planning. But those events, together with a number of terrorist alerts as well as natural disasters, have demonstrated how vulnerable we are as a society and how essential constant preparedness planning truly is.

The issues raised by today's hearing are of critical importance to all of us. While the H1N1 influenza is presenting much like seasonal flu at the moment, the possibility of a more virulent and deadly strain of influenza in the future, whether because of the evolution of H1N1 or from another strain, is both real and significant. It is therefore important to assess the region's current

level of preparedness as well as to improve upon our response system based on what that assessment yields. We therefore appreciate that you have called today's hearing in order to ensure and foster preparedness on behalf of the citizens of New York.

Overview of Testimony—For the purposes of today's hearing, I will review briefly: 1) the New York region's approach to preparedness, including its focus on preparedness for a pandemic influenza; 2) how that approach has served New York well in terms of the current H1N1 influenza outbreak; and 3) what the current outbreak has taught us and what we are doing to incorporate those lessons in our preparedness plans.

I. Health Care Preparedness Framework

New York City has worked long and hard at developing an effective framework for responding to emergencies and disasters of all kinds, concentrating heavily on all-hazards planning as well as developing more tailored plans for specific incidents, such as coastal storms, specific types of terrorist attacks, and, for the purposes of today's hearing, infectious disease outbreaks. This has been done by necessity, of course, due to the high profile of New York City, its large number of planned events, and the complexities of protecting a metropolitan area of its size from both man-made and natural disasters.

As a result, New York City has in place a strong infrastructure for responding to emergencies, particularly in the health care area. For the purposes of discussing the region's preparedness for emergencies affecting the health care system, GNYHA will understandably focus on preparedness from the perspective of hospitals, but will comment, as it does so, upon the strong partnership that GNYHA and its members have forged with key New York City agencies, particularly the Department of Health and Mental Hygiene (DOHMH), the Office of Emergency Management (OEM), and the Fire Department of the City of New York (FDNY). Indeed, as GNYHA and its members have approached preparedness, they have premised their approach on the idea that preparedness requires continuous regional collaboration with those entities to which we refer as our "partners in preparedness:" other providers of every kind as well as local, state,

and federal agencies. The following outlines the preparedness infrastructure already in existence.

A. Vehicles for Regional Collaboration

The Health Care Sector's Participation at OEM's Emergency Operations Center—First, GNYHA and its members have 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 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. 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 health care response to disasters.

Creation of Emergency Preparedness Coordinating Council—Second, in recognition of the need for broad-based preparedness, GNYHA and its members have focused intensively on regional collaboration and planning since the September 11 terrorist attacks. To this end, GNYHA created its Emergency Preparedness Coordinating Council, which 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 Coordinating Council also facilitates readiness through the sharing of expertise, experiences, and templates. More recently, GNYHA has created a steering group of hospital emergency managers to help guide GNYHA in its preparedness activities and ensure effective planning and response efforts.

Leadership by City and State Departments of Health—Third, both DOHMH and the New York State Department of Health (NYSDOH) have devoted considerable and meaningful resources and efforts to supporting the health care system's level of preparedness since the September 11 attacks. This has been done in part through their distribution of federal funds

made available for hospital and other provider preparedness activities. However, each of these agencies has also provided significant leadership in working with providers, helping them to develop strong preparedness plans, and generally facilitating their preparedness activities. To help accomplish this, DOHMH has worked closely with both hospitals and GNYHA over the years and similarly supported GNYHA's work with its members and development of systems designed to support the region's health care response to emergencies.

B. Overarching Guiding Principles—As GNYHA and its members have moved forward with their preparedness efforts, they have subscribed to a number of key principles that we believe strongly support our planning for and response to emergencies in general and in response to an infectious disease outbreak.

- **Operating Within a High-Risk Area**—In recognition of the high-risk area in which we are located, GNYHA, its members, and the key preparedness and response agencies appreciate that an event, whether naturally occurring or man-made, could occur at any time and at any place and that we must enhance our preparedness continuously, learning from every event, alert, and situation.

- **Development of 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 that an event might present with multiple features. Members have also devoted extensive efforts toward implementing strong incident command systems, which can be used to manage a variety of emergencies, including infectious disease outbreaks, and that allow agencies and hospitals to employ a common response framework across organizations.

- **Ensuring and Enhancing Effective Communications**—We have placed extraordinary emphasis on communications because the ability to communicate with one's partners during an emergency is key to an effective and rapid response. Indeed, the ability to communicate effectively before and during an emergency, particularly an infectious disease outbreak, is

essential. 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 emergency management committees, and other key contacts. The directory also contains basic information about each hospital's capabilities, such as trauma center designation. GNYHA makes these directories available to key government agencies and of course its members.

- **Health Emergency Response Data System**—In 2002, NYSDOH, working collaboratively with GNYHA's Coordinating Council, developed an emergency data collection system called the Health Emergency Response Data System or HERDS, which is able to collect from hospitals information about a wide variety of health care related matters including a facility's critical assets; staffing, supply, and bed availability and needs; and patients being seen in hospitals (both on an ongoing basis and during emergencies). The system is internet-based, located on the State's Health Provider Network, and allows for local public health and emergency management agencies to access the system so that they can better respond to and manage emergencies affecting their regions.

- **Ensuring Rapid Communications**—GNYHA provides extensive information to its members on a regular basis but particularly during emergency situations. Most often, this is accomplished through the distribution of alerts, advisories, and directives via email. To ensure broad distribution of such information, GNYHA has developed extensive lists of

members' key contacts such as chairs of emergency management committees, emergency department personnel, infection control directors, and ICU medical directors. New York City and New York State have similarly developed extensive lists of providers for the purposes of distributing health alerts, updates regarding health issues, and notifications regarding surveys and other requests for information via the City's Health Alert Network and the State's HERDS, respectively.

- **Building in Redundancies**—In anticipation of the possibility of disruptions in communication systems, GNYHA and its members have built numerous redundancies into their communication systems, which is evidenced by the multiple ways that members can be reached as set forth in GNYHA's emergency contact directory, e.g., via mobile phones, pagers, satellite phones, and 800 Megahertz radios connected to OEM.

- **GNYHA Web Site**—GNYHA also provides extensive information on the issue of preparedness on its Emergency Preparedness Resource Center located on GNYHA's Web site at www.gnyha.org/eprc. GNYHA is able to add specific Web pages on various emergencies as they arise, such as specific disease outbreaks, in order to bring together information from multiple agencies such as DOHMH, NYSDOH, and the Centers for Disease Control and Prevention.

- **Understanding Each Other's Roles, Resources, and Responsibilities: Planning Collaboratively**—Understanding each other's roles, resources, and responsibilities is essential to a well-coordinated response to any emergency, and thus GNYHA and its members have worked hard to understand what each hospital's and agency's capabilities, planned responses, and resources might be under a variety of scenarios. This has been accomplished in great part through the collaborative planning process described above and by undertaking drills and exercises designed to assess the strengths and weaknesses of the response system and then to address any identified gaps. Among the more notable efforts have been planning for a number of bioterrorism events, including anthrax and smallpox; SARS planning and response; development of threat alert guidelines that include checklists

regarding overall emergency planning, communications, security, staffing, and supplies; and planning for a number of natural events such as coastal flooding and hurricanes.

- **Training and Education**—Both GNYHA and DOHMH have placed significant emphasis on training and education on all aspects of the preparedness and response systems. Topics have included preparing and responding to various terrorism events; power disruptions; evacuations and sheltering in place; and infectious disease outbreaks.

II. Specific Planning for Influenza Outbreaks

The framework outlined above is intended to support emergencies of all types and indeed has served New York City well during many events and disasters. However, as noted, New York City agencies and GNYHA also concentrate on specific types of emergencies, particularly infectious disease outbreaks, and develop more tailored plans and response systems for addressing such events.

Extensive Planning for Pandemic Influenza—With respect to pandemic influenza planning in particular, there has been an exceptional amount of planning that has been undertaken at all levels of government as well as within the private sector. Although planning for major disease outbreaks has gone on for many, many years, in 2005, the U.S. government released a broad-based plan for responding to a pandemic influenza premised, at that time, on a number of assumptions, e.g., that the attack rate would be 30% in the overall population and that illness rates would be highest among school aged children; that, at the peak of the outbreak, about 10% of the workforce in general would be absent because they are ill or taking care of ill family members; at least 50% of those infected would seek outpatient care; and that demand for hospital beds and intensive care would increase by more than 25% even during a moderate pandemic.

Included in the health care preparedness section of the federal plan are guidelines on a number of topics including surveillance; communications; education and training; triage, evaluation and admissions; controlling access; occupational health; vaccines and antivirals; surge capacity; security; and mortuary capacity. In addition, the plan contains extensive information on

infection control and emphasizes regional planning. In turn, NYSDOH and DOHMH have developed more tailored state and local pandemic plans as well.

Separately, DOHMH, NYSDOH, GNYHA, and area providers have held a number of briefings and meetings over the years, at which they have discussed potential pandemic influenza disease and response assumptions based on prior pandemics as well as related recommendations for provider preparedness, focusing on infection control and patient management: enhancing surge capacity; and staff education and training. In addition, New York City has also conducted a tabletop exercise that used a pandemic influenza scenario in which more than 300 representatives of GNYHA members, other providers, and relevant agencies participated. Appropriately so, New York City used the after action report from the exercise as well as the results of a survey of participants to guide the City's planning moving forward.

CDC Pandemic Planning Grant—In addition, over the last year, DOHMH has been working with GNYHA and its members to develop a plan that addresses a number of key areas of concern during a possible pandemic influenza or other major communicable disease outbreak. Those areas include: 1) how to provide services to both influenza patients as well as those patients who will have essential medical needs during the waves of a pandemic (which might be expected to last from 6-8 weeks); 2) how to develop public messages that explain modified or diminished health care services necessitated by a pandemic; and 3) how to address the legal and ethical issues that might arise when health care delivery systems must be modified or care must be allocated due to a pandemic. The initiative has been funded by the Centers for Disease Control and Prevention and will result in the development of a plan that will itemize the resource needs required; define strategies to maintain essential medical services; define regulatory modifications that will be required; and outline potential ethical ramifications.

III. Evaluating New York City's Response to the H1N1 Outbreak

The current H1N1 influenza outbreak in New York City fortunately has been, in influenza parlance, "mild," presenting itself much like seasonal influenza in terms of transmission and illness. Although there have been deaths, each one of which is of course unfortunate and tragic,

a normal influenza season also unfortunately results in deaths, most of which are related to age or underlying medical conditions. The morbidity and mortality associated with regular seasonal flu for certain populations is of course one of the reasons why public health authorities strongly recommend that all individuals, but particularly more vulnerable populations, be vaccinated each year.

While the current outbreak is not over by any means, and there is understandably concern about its possible evolution to a more virulent and deadly strain by the fall, our experiences since the end of April have proven useful in terms of testing our current plans, appreciating what has worked well, and concentrating on what needs improvement. The following outlines what has worked well, what needs improvement, and how we are moving to make those improvements.

A. What Has Been Working Well

Communications—Almost immediately upon the initial announcements about possible cases of H1N1 influenza, first in Mexico and then in the U.S., public health officials at all levels of government moved quickly to understand the disease, how to minimize its transmission, and how to care for patients affected by it. For this purpose, the CDC, NYSDOH, and particularly DOHMH developed extensive guidance about the symptoms of H1N1 influenza infection, screening and management of patients with influenza-like illness, infection control, testing, reporting, and treatment. The distribution of this information was exceptionally speedy, and almost on a real-time basis, particularly at the front-end of the outbreak, when less was known and information was essential.

Focusing on the local level for the purposes of this testimony, GNYHA believes that DOHMH has been doing a masterful and exceptional job of ensuring that providers have the best information available to guide them in their response to the outbreak. GNYHA outlines below the main features of DOHMH's efforts in this regard.

- **Regular Conference Calls With Providers**—Beginning on the first day that information about the possibility of an outbreak in New York City became available, DOHMH began to

hold daily conference calls with providers to brief them on how the disease was presenting, how to screen and care for patients, and how to avoid transmission. The calls were announced by means of New York City's Health Alert Network, for which providers register, and which alerts registered providers via emails and phone calls that there is important information available on DOHMH's Web site and/or that a conference call will be held. GNYHA in turn transmits these notices to its members at many levels of their organizations to ensure that they are aware of the calls and will be participating. At one point, DOHMH indicated that they were using 1,000 lines for the purposes of the calls, even though people working within providers were urged to take the calls in groups to ensure that enough lines were available across the system. Without question, the calls and the content provided have been invaluable and certainly timely.

- **Health Alerts**—In addition to the conference calls, DOHMH has also been preparing and distributing widely a number of Health Alerts that provide extensive written information about the outbreak, including, as noted above, screening and management of patients, infection control, reporting, and testing of specimens. Again, GNYHA also transmits the Health Alerts broadly within its members to ensure that all levels of staff are aware of the document, from emergency department to ICU to infection control personnel. To ensure that guidance from DOHMH as well as NYSDOH, CDC, and the World Health Organization is made available to all providers, GNYHA also created a special Web page on which it posts all alerts, recommendations, and advisories on H1N1 influenza. The Web page is available on GNYHA's Web site at www.gnyha.org/eprc.

- **Communications with Individual Hospitals**—DOHMH has also communicated regularly with individual hospitals about the cases being seen at the hospital, particularly when there are clusters of cases and when there are patients with more serious illnesses. This has been done in part to help support the hospitals with respect to their management and care of patients and in part to understand the course of the disease for epidemiological purposes.

- **Press Conferences**—Finally, in the early days of the outbreak, New York City officials, especially Mayor Michael Bloomberg and DOHMH Commissioner Tom Frieden, held

regular press conferences to provide information about what was known about the outbreak, what was perhaps not yet known, and what New York City and other government authorities were doing to determine additional key information.

Collaboration and Coordination—While DOHMH has been acting as the lead agency with respect to the outbreak in New York City, the New York City Office of Emergency Management has organized several meetings and calls with interested agencies and parties in order to coordinate the region's response, key services, and needs. New York State, through NYSDOH and the State Emergency Management Office, have been participating in the various conference calls and meetings that have been held in order to ensure coordination of information, recommendations, and advisories across the State. GNYHA assumes, but does not know first hand, that DOHMH has been separately coordinating regularly with both NYSDOH and the CDC with respect to the response.

GNYHA of course has undertaken its role of acting as a liaison among member hospitals and agencies in order to provide assistance and support to members when needed and to provide information and support to key agencies involved in the response. In particular, as hospitals have faced problems with emergency department overcrowding, questions about infection control, and concerns about shortages of supplies, beds, and staff, GNYHA has been coordinating with DOHMH, OEM, NYSDOH, and the Centers for Medicare & Medicare Services to help resolve some of the issues being presented.

Data Collection—The availability of data regarding the number and nature of cases of H1N1 influenza being seen as well as the resources required to respond to the situation is of course critical to the ability of the health care system to respond to an outbreak. DOHMH and NYSDOH therefore have worked together to make use of the State's Health Emergency Response Data System in order to collect information from hospitals about the number of cases being seen as well as the availability of key supplies potentially needed, such as antivirals and personal protective equipment. Recognizing that data collection can be resource-intensive, the two health agencies have discussed how to try to minimize the burdens on providers to the extent possible.

Hospital Response—By all accounts, hospitals have performed admirably and risen to the challenges of responding to the outbreak. Many hospitals have chosen to activate parts of their emergency management plans as well as to activate their emergency operations centers for periods of time to facilitate the coordination of their responses, both internally and with outside agencies. Many hospitals have faced significant overcrowding in their emergency departments (EDs) as large numbers of individuals with only mild influenza-like symptoms as well as the worried well (i.e., individuals who have no symptoms but who are just worried about H1N1 infection) have presented to area EDs. In response and after coordination with health authorities, many hospitals have established separate areas of the hospital where patients presenting with influenza-like symptoms or even just expressing worries about the flu can be directed for screening, treatment, or education, as appropriate. In doing this, hospitals have relied and built upon their existing emergency management plans as well as specific plans or components of plans focusing on infectious disease outbreaks, SARS, and pandemic influenza.

Hospitals have also had some difficulties with shortages of specific supplies, generally N95 masks, concerns about staff shortages due to staff illnesses or fatigue, and questions about converting beds to accommodate patients who require hospitalization. However, in general, most of these issues are being resolved using existing supplies, workforce, and bed complements, although DOHMH has made some allocations of supplies from its stockpile to address shortages, particularly in the area of personal protective equipment. In addition, GNYHA has also attempted to locate supplies of N95 masks and antivirals through its relationships with suppliers and distributers.

B. Where We Need to Focus Moving Forward

GNYHA believes that New York City agencies and providers have responded quite well to the current H1N1 outbreak. However, as always, GNYHA and its members strive to learn from those aspects of a response that might be problematic or unexpected in order to improve preparedness plans for future purposes. The following outlines those aspects of the response that GNYHA believes deserve attention moving forward.

Emergency Department Overcrowding—As noted, many New York City hospitals have found that their emergency departments have been exceptionally overcrowded due to the large numbers of individuals presenting to EDs. While some of the individuals have presented with severe influenza-like illness and therefore should appropriately go to EDs, the majority of individuals have been those with only mild symptoms or completely asymptomatic, but just worried. GNYHA notes that the overcrowding due to the H1N1 outbreak continues today in some hospitals and is often triggered by the closure of surrounding schools. For some hospitals, this has meant almost a doubling of the number of patients being seen in their EDs, with the vast majority of the increase being attributable to individuals not requiring ED treatment at all. As noted above, hospitals, in coordination with relevant health authorities, have responded to this situation in part by creating separate flu clinics or areas in which the hospital can screen, treat, and/or counsel the flu-related patients. GNYHA emphasizes that, for this purpose, GNYHA and members have sought guidance from federal and state officials to ensure that the resulting triaging and treatment protocols were acceptable.

The High Cost of Responding—Although the cases presenting to hospitals have, overall, been similar to seasonal flu, the overcrowding that has occurred has carried a very significant cost for hospitals. They have had to request extra duty by both clinicians and administrative staff; they have had to pay considerable overtime compensation; they have had to use extra supplies and equipment to protect both patients and staff; and they have had to adapt existing space to accommodate the surge of patients they have experienced. They have also had to devote considerable time and resources to responding to the surveys that have been required to be completed, all admittedly for good purposes, but sometimes not requesting data in the manner maintained by the hospitals. Therefore, hospitals have had to devote a number of staff members, sometimes on weekends, to collect, extract, and submit the data requested.

As is well known, many New York State hospitals are in poor financial condition, often much worse than that of hospitals in other states. As a result, bearing the cost of even a mild outbreak can be damaging and further undermine the financial viability of already precariously positioned hospitals. Therefore, as GNYHA has urged in the past, it is critically important that the 24/7 availability of hospitals to respond to all types of community emergencies be recognized and

compensated, whether on an on-going basis in terms of reimbursement rates or for special circumstances such as the current H1N1 outbreak.

Importance of Public Messaging—As stated, DOHMH has done an outstanding job of communicating with providers regarding the screening and management of patients, infection control recommendations, and other clinically related issues. However, the current outbreak has underscored how important it is to communicate effectively with the public regarding an outbreak as well as regarding how, when, and where the public should seek needed care. It is hard to imagine more credible spokespersons than New York City has. But, for whatever reason, the press conferences and information available on New York City Web sites did not initially curb the flood of people presenting to hospitals EDs, many unnecessarily so and all at a considerable expense to hospitals.

To address this, GNYHA has recommended that New York City request that all print and broadcast media put forward simple and concise messages regarding the situation and what people should do if they have questions or concerns. The goal of course is to try to reduce the unnecessary use of ED care but at the same time ensure that the public's questions and concerns are being addressed. In part to address this problem in the future, DOHMH is currently undertaking a survey of patients in EDs to inquire why they are presenting to EDs so that public messaging can be better targeted to ensuring appropriate use of health care resources in the future.

Use of Alternate Care Sites—To address the ED overcrowding situation, GNYHA has also recommended the establishment of alternate care sites where people who have certain symptoms (or no symptoms) can go to alleviate the burden on hospital EDs. Staffing could be provided in part by New York City's Medical Reserve Corps or other providers available for this purpose. GNYHA appreciates the difficulties of establishing and managing such sites but hopes that such sites will be considered for future purposes.

Difficulties With the Supply Chain—The current outbreak also underscores the difficulties that can occur with respect to the availability of supplies, in part dependent on what the public health

authorities recommend for treatment and infection control purposes. GNYHA believes that DOHMH has given expert advice on the issues of treatment and infection control and therefore the quality of the advice is not the question. However, GNYHA members have experienced difficulties obtaining some of the supplies recommended, both due to shortages in the availability of these supplies across the country as well as the establishment of limits on purchasing imposed by manufacturers and distributers to avoid hoarding of supplies by providers. GNYHA will be working with New York City agencies, members, vendors, and distributers to try to identify improved systems for ensuring the availability of key supplies in the future.

IV. Summary

GNYHA recognizes that the current H1N1 outbreak is not yet behind us. However, GNYHA believes that New York City's level of preparedness, both at the agency level and at the individual hospital level, has served the region well in terms of responding to the current outbreak to date. Moreover, DOHMH has done an exceptional job of ensuring that providers have the information that they need to screen and treat patients as well as to protect patients, the workforce, and the community at large. GNYHA will most definitely be working with its members, DOHMH, and other key agencies to ensure that we put to use the lessons that we are learning in responding to the situation as it has presented thus far. We thank you for the opportunity to appear before you today and are available to answer any questions that you may have.

PRIMARY CARE DEVELOPMENT CORPORATION

Excellent Healthcare in Every Neighborhood

Testimony of Melissa Corrado, Director of Emergency Preparedness
to the New York City Council Committees on Health, Public Safety, and Government Operations:
Evaluating New York City's Influenza Preparedness

June 11, 2009

I am Melissa Corrado, Director of Emergency Preparedness at Primary Care Development Corporation (PCDC). I am testifying today on the state of primary care preparedness for H1N1 and other emergencies and its impact on New York City residents. Founded in 1993 as a city initiative, PCDC has maintained a close partnership with the Mayor's office and City Council to expand access to quality primary care in communities throughout New York City. The City Council has been a valuable partner with PCDC, investing $4.1 million over the last four years to support our Emergency Preparedness program, which has trained and prepared almost 70 primary care sites serving more than 500,000 New Yorkers to respond effectively and immediately in the event of an emergency.

CONSEQUENCES OF THE H1N1 OUTBREAK IN NYC

The H1N1 virus continues to overwhelm emergency rooms. Patients experiencing mild flu-like symptoms or who are merely concerned about the flu are seeking treatment in the emergency room rather than with their primary care provider, especially communities that lack access to primary care. Nowhere is this more evident than in Queens, where already strained emergency rooms have become more overcrowded.

A surge in H1N1 cases could occur in the fall. Some health experts believe that we may be in the "calm before the storm," and that when flu season arrives in the fall, we could see a major increase H1N1 cases, further challenging already strained emergency rooms. In fact, some experts at the Center for Disease Control (CDC) are concerned that the current H1N1 strain may morph over the next few months and affect more healthy young adults, much like the Spanish influenza pandemic of 1918, which was most severe in its second wave.

New York must have the primary care capacity to respond to a major flu outbreak. Primary care providers, such as community health centers, ambulatory clinics, and private physicians are equipped to handle non-emergency flu cases, but it is questionable whether we have enough, and whether existing providers have the capacity or training to respond to a major outbreak.

As the City Council's Primary Care Initiative study revealed last year, 62% of New York City zip codes have an inadequate number of primary care physicians, and nearly half of residents in the 11 highest need communities have trouble finding a primary care provider. If the flu situation worsens, New York's primary care *and* ERs may find themselves overwhelmed and unable to treat a greatly increased patient load. This will be further exacerbated when staff at health care centers also inevitably becomes ill with the flu, thereby reducing the number of providers available to treat the public.

THE ROLE OF PCDC AND PRIMARY CARE PROVIDERS DURING THE H1N1 OUTBREAK

Since 2005, the New York City Council has provided crucial support for PCDC's Primary Care Emergency Preparedness Program. As a result, nearly 70 primary care sites increased their emergency readiness by 42 percentage points, in accordance with Primary Care Emergency Preparedness standards. Now these providers are among the most prepared in the country to respond to H1N1, with the ability to:

- Accommodate a surge in patient volume
- Quickly and efficiently diagnose and triage this dramatic influx of patients
- Survey, track, and report patient data, such as increase in number of patients, severity of symptoms, underlying risk factors, and patient demographics (elderly, pediatrics, etc.)
- Provide culturally relevant information for the diverse communities they serve

These health centers, which serve more than 500,000 mostly low-income New Yorkers, are treating increasing numbers of patients with flu symptoms, and are **prepared to treat even larger numbers of patients should the outbreak worsen**. Patients with mild symptoms can visit these health centers, where under normal circumstances they generally can get ***same-day appointments and wait less than an hour***, instead of ***more than four hours*** in an emergency room.

Coordinating closely with the NYC Department of Health and Mental Hygiene and the Community Health Care Association of New York State (CHCANYS), PCDC and providers help assess and report outpatient volume through an electronic survey system. This information is provided daily to the New York City Department of Health and Mental Hygiene to assist in meeting the needs of health centers and their patients as the situation progresses. And NYCDOHMH, PCDC, and CHCANYS are proposing that a seat for Primary Care/Community Health Centers be created at the Health and Medical Desk of the NYC Emergency Operations Center (EOC) in order to provide a formalized and efficient communications link between the City and its health centers to be used in times of public health emergencies. This would create standardized protocols for activation and would enable the City to receive information from health centers as well as disseminate information among them in an efficient and organized manner.

RECOMMENDATIONS FOR CONTINUED PREPAREDNESS

The role of primary care providers in a flu emergency, and New York City's proven track record as a leader in comprehensive emergency planning are clear. However, we must expand the capacity of existing primary care providers to respond to a major flu outbreak, and steer New Yorkers toward primary care providers unless they have a true emergency. To bolster capacity, and change patient behavior, PCDC is making the following recommendations:

1. Vastly expand primary care emergency preparedness programs throughout New York City

The emergency preparedness program that PCDC is executing with key support from the City Council has prepared about 70 health centers and with continued support, can prepare additional sites and monitor and coordinate the H1N1 response of the sites that have already undergone training. But this still leaves many sites– in whole neighborhoods in all five boroughs - without this kind of training. PCDC recommends the City undertake a major expansion of the emergency

preparedness program to ensure that every community has sufficient primary care capacity in an emergency.

2. Fully fund the Primary Care Initiative to expand access to primary care

The Primary Care Initiative, spearheaded by the City Council, will expand primary care capacity in the 11 highest need areas in all five boroughs. It was anticipated that $3.8 million would be available in FY10 and $6.4 million over four years, in expense funds to expand access to primary care. The Mayor's executive budget completely eliminates this funding. We strongly urge full funding for this initiative. If effectively targeted, this funding can help primary care providers in New York's most underserved communities dramatically expand access to patients at very low cost to the city. This is important any time, but particularly during a health emergency like we are seeing

3. Utilize the Power of Mass Media to Educate Primary Care Providers and the Public

Mass communication is critical to keeping the public informed. The city must continue to communicate the need for residents to seek treatment from a primary care provider, rather than an emergency room. It is imperative that primary care providers and the public have access to vital information regarding H1N1 and seasonal influenza, specifically messages that

- Encourage patients with mild flu-like symptoms to seek treatment from their primary care doctor or community health center, and
- Heavily promote the use of **Notify NYC** to keep the public informed, and reduce flu panic.

CONCLUSION

Primary care is pivotal in flu emergencies, and should be at the forefront of New York City's H1N1 preparedness and emergency planning agenda. We have a small and shrinking window in which to prepare the public and health centers for the potential of a full-scale health emergency with the start of the fall flu season. New York City must continue to act as an exemplary leader in emergency planning and response, and must use the next few months wisely to implement intelligent planning and allocate resources effectively.

About Primary Care Development Corporation (PCDC): The first and largest nonprofit in the United States specializing in primary care financing for low-income communities, PCDC's total investment of more than $240 million has funded 80 primary care projects that have a direct impact on the health and economy of communities across New York State. This investment has generated more than 2,200 permanent jobs; built or renovated 630,000 square feet of space; and created the capacity to serve approximately 550,000 New Yorkers and provide 1.7 million medical visits annually. PCDC has also helped hundreds of primary care teams increase productivity, effectively implement electronic medical records, and prepare for health emergencies.

Antimicrobial Invented At Emory University

Goldshield 5
Aqueous Based Antimicrobial Sanitizer

Making Everyday Safer

Distributor:

BRIAN WHITNEY Inc.
Arthur J. Russell, Owner
130-13 227th Street
Laurelton, N.Y. 11413
Ph: 917-674-6054
E/M: brianwhitney@earthlink.net
www.brianandwhitney.com

Presented by: Tom Higgins,
For: BRIAN WHITNEY, Inc.
June 3, 2009

New York City Presentation:

INTRODUCTION: "Good morning, my name is Tom Higgins I am CEO of AP Goldshield LLC, a biotechnology company, and I am a native New Yorker. I was asked by my distributor, Art Russell, to put together a brief outline of why our antimicrobial technology would add both safety and an economic value to the challenges you face with harmful diseases in all public venues. From Public schools, council meeting rooms, etc., wherever a flat surface, curtain or door-knob can be found.

First, here is the Abstract: Are the existing cleaning protocols sufficient to contain the spread of diseases such as the recent [present] outbreak of H1N1? To answer that you have to understand the products that are presently being used to clean and how they function:

BACKGROUND: Disinfectants whether bleach or quaternary compounds, generally are only effective for an hour and ½. Their killing functionality is a chemical encapsulation, which destroys the organism within 10 minutes, but requires generally 3-10 minutes to kill, so you just can't spray and wipe, you must leave on the surfaces for them to function.

This means, if you clean twice a day, as most hospital protocols call for, 21 of the 24 hours of each day the facility remains susceptible to contamination and, in fact probably is, as organism are ubiquitous. The surface is contaminated, 90% of the time. If you clean a school at night, by early morning it is re-contaminated by airborne organisms. And if a child with H1N1 sneezes, and releases approximately 40,000 of those organisms, those surfaces have no protective shield and will become a reservoir of contagion.

SOLUTION: Although these agents are necessary, they fail to provide long term protection. Our patented technology, invented by the Head of Chemistry at Emory University in Atlanta, Dr. Lanny Liebeskind, who is also a native New Yorker, did his post-graduate work at MIT and Stanford. What he has developed is a water stabilized-organsilane formulation, which bond to surfaces and cross link to textiles, providing a long term prophylactic protection when applied to any surface or textile material, destroying the existing organism and not permitting any airborne organism from attaching through a unique killing functionality which is described as acting like a sword piercing a balloon.

Unlike disinfectants, which the science has shown leave trace amounts of organics on the surfaces, Goldshield is permanently bound. And unlike disinfectants, it is a mechanical, as well as a chemical kill. It leaves neither organics on the surface nor will it leach off.

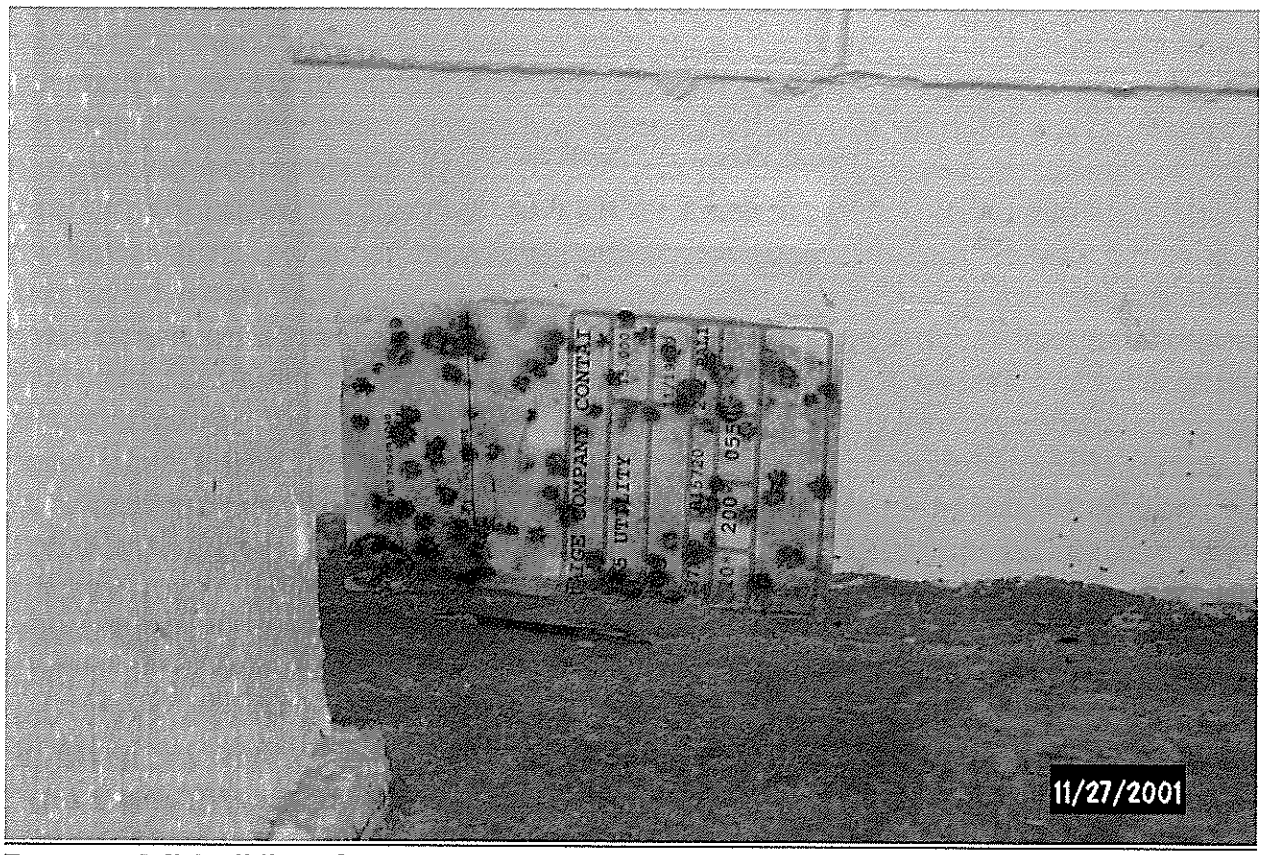
ECONOMICS: Our product in a usable diluted gallon is $33.00. If you power spray with fine micron dispensers you get approximately 800 sq ft per gallon, if you hand spray, you yield 400 sq. ft per gal. So let's take a power sprayer: $33.00 ÷ 800 sq ft- $0.04 per sq ft, and if you leave it on for 14 days it will cost $0.003 per sq. ft., excepting labor. If you compare that to a $0.19 per gal. quaternary compound, $0.19 x 2 times a day= $0.38 ÷ 800 sq ft =$0.006 or twice what Goldshield costs for raw materials.

Will GS Kill Viruses Such as Swine Flu?

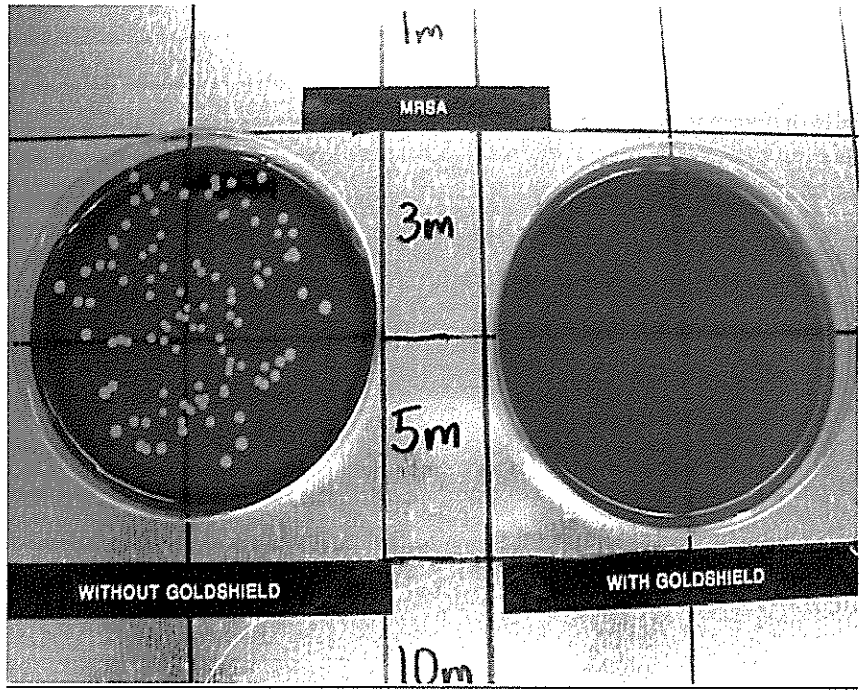
Yes

- RE: the mechanism of the quaternary compounds [QAC;s] in GS formulation,
- Animal viruses often contain lipids similar to their hosts. This helps them penetrate into the host cells in order to release their DNA or RNA and infect the host cells.
- Our agent disrupts the membranes in such virus, which releases the DNA or RNA, which are then denatured and become inactive.
- Thus viruses such as Influenza A, HIV B Swine Flu would be killed by this functionality

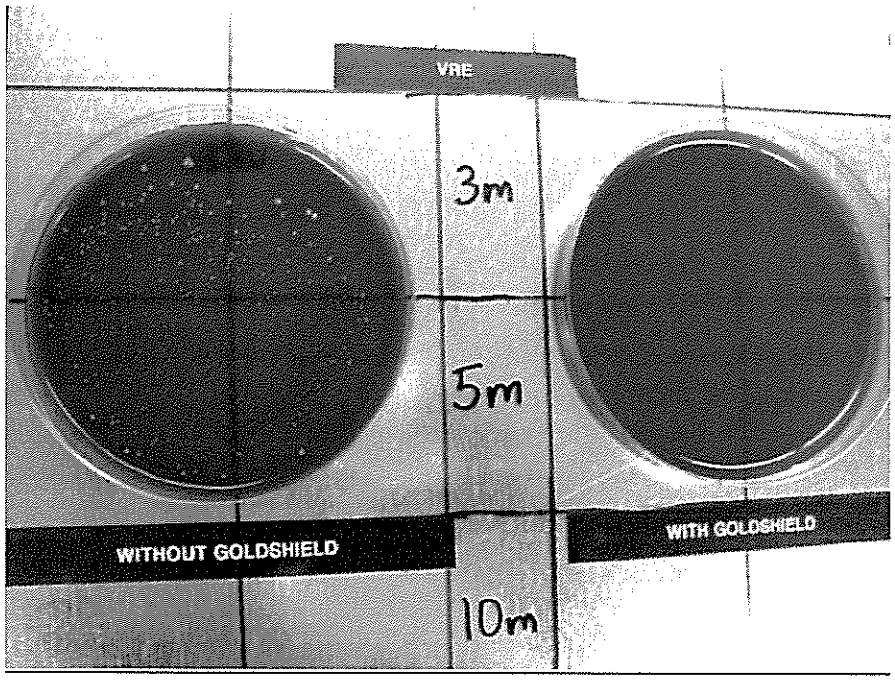
More importantly, Goldshieldt provides the protection other products do not. Thank you for your time if you have any questions I would happy to answer them, I have included a list of testimony and visuals of efficacy data for your review.



Basement ML Building after 9-11; 45 days of residual protection



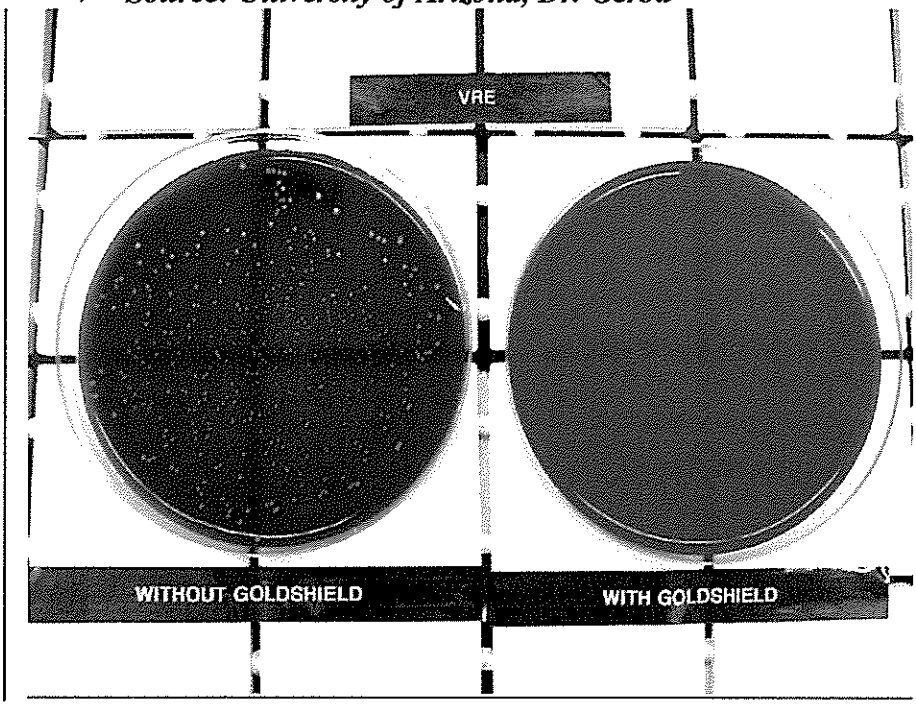
- Shows the residual action of Goldshield on stainless steel with MRSA over a 14 day period. MRSA was reduced by greater than 99% in one minute after three, five, ten and fourteen days post application of Goldshield.
- ***Source: University of Arizona, Dr. Gerba***



Residual action of Goldshield against VRE on stainless steel is shown in Table 10. VRE was reduced by greater than 99.99% after 3 days post application after five minutes. After 5 days post application the bacteria were reduced by 99% in 1 and 3 minutes and greater than 99.9%

reduction was seen at the 5 and 10 minute points. VRE continued to be reduced after 10 and 14 days of Goldshield application by greater than 99% in 3 minutes.

- ***Source: University of Arizona, Dr. Gerba***



- After 3 days post application of Goldshield, VRE was reduced by 99.9% after one minute and by 99.99% after 10 minutes. Five days after application reduction of VRE was still reduced by 99.97% after ten minutes, after 10 and 14 days this was reduced to approximately 99%.
- ***Source: University of Arizona, Dr. Gerba***

TESTIMONY:

- Dr. Dwayne Baxa Henry Ford Hospital System: concluded*: " Goldshield® 5 completely prevented growth of MRSA and VRE patient isolates……we have demonstrated that Goldshield® 5 has the potential to become an important component in infection control practices as an addition to current cleaning protocols."*
- **The bacterial surveys on textiles were conducted over a 14 day period. In the fabric test Henry Ford determined***: "the product (Goldshield 5) prevented the growth of Staph. aureus immediately on contact and prevented growth for 14 days."*

Goldshield 5™ Antimicrobial Distributor
130-13 227 Street
Laurelton, New York 11413
917-674-6054
Brianwhitney@earthlink.net

Brian Whitney Inc.

New York City Council Hearing
H1N1 City Preparedness (Infectious Diseases)

This is a quick reference Product comparison. Please note all the leading products listed here are Cleaners / disinfectants, however **not one of those products or any other on the market** can substantiate a claim of **providing a durable residual disinfection action.** So what that means to you is... **During the cleaning process each one of the chemicals will kill a limited but selected variety of pathogenic (disease-causing) microbes but once that cleaning cycle is completed those chemicals will deactivate anywhere from 10 minutes to 2 hours.**

With (1) application Goldshield 5 Water-based antimicrobial Sanitizer has proven to remain active 24 hours a day / 7 days a week for up 4 weeks.

Antibacterial vs. Antimicrobial Solutions

GOLDSHIELD gives 24/7 residual protection and existing cleaners protect for only minutes.

Basically the **main differences** lie within **and "what kind of pathogenic (disease-causing) microbes an antimicrobial or antibacterial product kills.**
Antibacterial formulas - kill limited quantities and types of bacteria. Please Note- they are formulated to meet the minimum cleanliness requirements of laboratories and Hospital environments.
Antimicrobial sanitizers – Far surpass antibacterial solutions – They kill a significantly higher percentage and a much broader spectrum of germs including fungi, yeast, mold, Hardy Gram (+) & Gram(-) bacteria(s) Staph Infections and virus(s)

Continued

With Respect,

Arthur Russell

Manufacturer / Product	Cleaner Disinfectant	Deodorizer	Sanitizer	Long Term Protection No YES
Envirox H20 * Orange	✓	✓	✓	No
Johnson Wax Oxivir TB	✓			No
Sensible Life Prods Botanical Disinfectant	✓			No
ZEP Manufacture Lemonex	✓	✓		No
Johnson Wax Virex II 256 Hospital Grade	✓	✓		No
Johnson Wax Crew Restroom	✓			No
NCL -Quats Disinfectant	✓	✓		No
Grand Technology Turbanex	Disinfectant			No
Rochester midland Envirocare	✓	✓		No
Goldshield 5 Antimicrobial Sanitizer			✓	YES
Spray 9 *	✓		✓	**No**
TOTALS	**9**	**5**	**3**	**1**

GOLDSHIELD 5? ANTIMICROBIAL SANITIZER

Effectively tested Against
BRIAN WHITNEY Inc.
Data release date 04/27/07

Bacteria	**Fungi**	**1. Clinical isolates**
	Aspergillus niger	
Micrococcus sp.	Aspergillus fumigatus	Stapylococcus epidermidis1
Stapylococcus epidermidis1	Aspergillus versicolor	Enterobacter agglomerans1
Enterobacter agglomerans1	Aspergillus flavus	Acinetobacter calcoaceticus1
Acinetobacter calcoaceticus1	Aspergillus terreus	Stapylococcus aureus(pigmented)1
Stapylococcus aureus(pigmented)1	Penicillium chrysogenum	Stapylococcus aureus (non-pigmented)1
Stapylococcus aureus (non-pigmented)1	Penicillium albicans	Klebsiella pneumoniae ATCC 4352
methicillin resistant Staphylococcus aureus(MRSA),	Penicillium citrinum	Pseudomonas aeruginosa
Clostridium difficile	Penicillium elegans	Pseudomonas aeruginosa PRD-10
Burkholderia cepacia,	Penicillium funiculosum	Strepticoccus faecalis
Klebsiella pneumoniae ATCC 4352	Penicillium humicola	Pseudomonas aeruginosa1
Pseudomonas aeruginosa	Penicillium notatum	Escherichia coli ATCC 23266
Pseudomonas aeruginosa PRD-10	Penicillium variabile	Escherichia coli1
Strepticoccus faecalis	Mucor sp.	Proteus mirabilis
Pseudomonas aeruginosa1	**Tricophyton mentagrophytes**	Citrobacter diversus1
Escherichia coli ATCC 23266	Tricophyton interdigitalie	Salmonella typhosa
Escherichia coli1	Trichoderma flavus	Proteus mirabilis1
Enterococcus faecalis (ATCC 51299)	Chaetomium globusum	Salmonella choleraesuis
Proteus mirabilis	Rhizopus nigricans	Corynebacterium bovis
Citrobacter diversus1	Cladosporium herbarum	Mycobacterium smegmatis
Salmonella typhosa	Aureobasidium pullulans	Mycobacterium tuberculosis
Proteus mirabilis1	Fusarium nigrum	Bruncella cania
Salmonella choleraesuis	Fusarium solani	Brucella abortus
Corynebacterium bovis	Gliocladium roseum	Brucella suis
Mycobacterium smegmatis	Oosopa lactis	Streptococcus mutans
Mycobacterium tuberculosis	**Stachybotrys chartarum**	Bacillus subtilis
Bruncella cania		Bacillus cereus
Brucella abortus	**Algae**	Clostridium perfringens
Brucella suis	Oscillatoria borneti LB143	Haemopilus influenzae
Streptococcus mutans	Anabaena cylindrica B-1446-1C	Haemophilus suis
Bacillus subtilis	Selenastrum gracile B-325	Lactobacillus casei

Bacillus cereus
Clostridium perfringens
Haemopilus influenzae
Haemophilus suis
Lactobacillus casei
Leuconostoc lactis
Listeria monocytogenes
Propionbacterium acnes
Proteus vulgaris
Pseudomonas cepacia
Pseudomonas filluorescens
Xanthomonas campestris

Pleurococcus sp. LB11
Schenedesmus quadricauda
Gonium sp. LB 9c
Volvox sp. LB 9
Chlorella vulgarus

Yeast
Saccharomyces cerevisiae
Candida albicans

Leuconostoc lactis
Listeria monocytogenes
Propionbacterium acnes
Proteus vulgaris
Pseudomonas cepacia
Pseudomonas filluorescens
Xanthomonas campestris

Virus
Influenza A
Avian Flu*
HIV B
SARS
HAV
HBV
HCV
The less virulent strains
Not H5N1
Goldshield 100 is effective against this strain.

United Federation of Nurses and Epidemiologists
Local 436, District Council 37, AFSCME, AFL-CIO
125 Barclay Street, 4th floor Professional Division
New York, New York 10007
212-815-1436 ***fax:*** **212-341-4793** **L436@verizon.net**

Testimony before New York City Council Oversight Hearing by the Committee on Health, Committee on Public Safety, and Committee on Government Operations on the City's Response to H1N1 and Assessing Influenza Preparedness

June 11, 2009-Thursday

Good afternoon Chairman Joel Rivera, Chairwoman Sears, Chairman Vallone, honorable members of the Committees, and distinguished guests. I am Judith Arroyo, President of Local 436 DC 37, United Federation of Nurses and Epidemiologists. I represented the almost 1,000 public health nurses and epidemiologists employed by the Department of Health and Mental Hygiene and the City of New York.

Of those approximately 1,000 public health nurses and epidemiologists, almost 800 of them are public health nurses working in the City school system. We are in the public school system and we are the only group of nurses in the non-public schools. This is the group of health professionals that have been on the front lines of dealing with the H1NI outbreak which has swept our schools both public and non-public. While I and my colleagues will speak to the public health nurses' experience during this time, please note we were one member of a team of health professionals addressing H1N1. We worked with epidemiologists, public health assistants, public health advisors, doctors, and the school nurses of our sister union the UFT. They too have experiences to share which will assist you in assessing the City's Influenza Preparedness.

I have spoken with our members, the public health nurses involved in H1NI, both those on the Swine Flu Team and the ones in the school.

I spent time speaking, specifically, with the Queens nurses of the affected/closed schools. There are a number of things which stood out in all of their stories.

1. ***Soap is no longer provided to the school nurse.*** Nurses either buy their own soap or are instructed to obtain soap from the school custodian. There are concerns about the effectiveness of the soap given to the nurses by the school. In addition many school bathrooms do not have soap for students to use. (See attached poster.) What was issued to the nurses was a travel size bottle of sanitizer.

(Labor Donated). The statistics presented by the City of the number of influenza cases related to H1N1 are low. The numbers of students sent home ill was collected from the nurses on a

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daily basis. However, the only students the City was interested were those who met the protocols. You have copies attached. City officials were only counting students who had "… a fever of 100.4 or greater with respiratory symptoms…" such as cough, sore throat, difficulty breathing. However, more than one of the nurses told me they had students with temperatures of 100 F with respiratory symptoms whom were sent home. When these students returned to school, many of them returned with notes from their pediatricians stating the child had had influence and tests were sent to confirm if H1N1 was involved. One nurse told me, "I sent home a sick child with only a temperature of 99 F and he turned out positive. When I tried to tell Central Office about this but they told me they weren't interested."

3. Even though they are the front line of the H1N1 outbreak, the only group of employees the City is not paying upon the closing of a school is the nurse in the school. In addition, it wasn't until well into the outbreak that a memo went out stating that nurses unable to take their lunch hour because of the overwhelming number of sick students would be paid for the missed lunch hour. However, the nurses had all ready turned in their time cards by the time the memo came out. We are waiting for this pay period, Friday, May 12 to see if they have been paid for the missed lunch hours.

4. At first when schools were closed, the nurses were told to stay home. Then there was a sudden policy change and these nurses were reassigned to other schools if their school remained closed. The nurses expressed concerned that this may spread the virus.

5. All of the nurses needed additional support of public health assistants or public health advisors. These trained professionals are able to hand out band aids, place ice packs on childhood bumps in addition to looking up health records, record names, information and enter all the information into A.S.H.R. –the Automated School Health Record.

"You're taking temperatures and then running outside to calm crying parents."
"It really felt like a war zone."
" There were just so many, so sick, so fast. You had to hydrate them, cool them off…"
(Labor Donated) " And there was no space…"

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212-815-1436 ***fax:*** **212-341-4793** **L436@verizon.net**

6. That last statement refers to the fact sick children had to wait ***somewhere*** before their parents could pick them up. I was informed by the Office of School Health that principals were instructed to put clusters of waiting children in a separate room-with the children wearing masks, and an adult, also wearing a mask, supervising them. While the nurses confirmed this was done in many cases, they felt, in their professional opinion, sick children should be under their constant observation. This was a problem all the nurses feel really needs to be looked at closely. They understand sick children need to be separated so other children do not fall ill but removing them from the observation of the nurse made them uneasy.

7. The non-public schools are a gap in the public health safety net in responding to such outbreaks as H1N1. As it was pointed out by the Councilmember Simcha Felder during the May 27th budget hearings, the non-public schools do not have a central authority to issue instructions and make decisions about closing a school. For the most part each administrator, director or principal of these schools is his/her own authority. The result is schools are closed which do not need to close and schools which should be closed, and the teachers, staff, and students followed up, remain open. Such open schools could pose a risk of spreading not just the flu but any other communicable disease into the City at large. Indeed that is exactly what happened in this instance with H1N1. The first identified cases were in a non-public school. An issue of public health cannot be left to waiting on a school to ask for assistance.

There are other issues which came out of our conversations. Issues about the type of mask used, sudden changes in protocols from day to day or week to week, lack of cooperation from principals, etc. but what I've outlined above are the main points that stand out across the board.

The members of Local 436 stand ready to assist the Council and the City in formulating solutions to these issues. As one nurse put it, "I figured we're all in this together."

Thank you for allowing me to present to you the words and experiences of the public health nurses on the front lines of any public health emergency. I look forward to answering any questions you may have.

(Labor Donated)

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas R. Frieden, MD, MPH
Commissioner

NEW YORK CITY DEPARTMENT
EDUCATION
Joel I. Klein
Chancellor

OFFICE OF
SCHOOL HEALTH

Protocol for assessing students suspected of having the flu

Any student with the following should be considered at risk for the flu:

- Fever > 100.5 and any of the following
  - Cough
  - Sore throat
  - Shortness of breath

These students should have a surgical mask applied immediately. Once the mask has been placed on the student, the following questions should be asked of either the student or their parent:

- Has the student traveled to Mexico within seven days of onset of symptoms?
- Does the student have a sibling or close contact that attends St. Francis High School in Queens?
- Is the student a contact of a known case of swine flu?

Students with a positive response to any of these questions should remain with the mask on. Their parents or guardians should be contacted and the child sent home. The student should remain in the medical room or in the medical room waiting area apart from the general population until he or she is picked up by an authorized individual. Students should not be kept in the general office or classroom while waiting to be picked up.

These students should remain out of school until they are no longer febrile and have no respiratory symptoms.

Students with a negative response to **all** of the above questions may have their masks removed. These students should be assessed as per the nurse's clinical judgment.

General Considerations:

- Children with respiratory symptoms, but no fever may be sent back to class, if in the nurse's clinical judgment the child is well enough to return to class.
- Children with a fever are to be sent home whether or not they have respiratory symptoms.
- Children with fever and respiratory symptoms should be sent home. They should remain in the medical room or waiting area that is not heavily trafficked. They should not go back to class or the general office.
- In schools where there were medically fragile children who need procedures done, nurse should work with principals to find suitable alternate rooms where ill students can remain until parents came to pick them up.
- Nurses should follow standard protocols in requiring a student have medical clearance before returning to school.

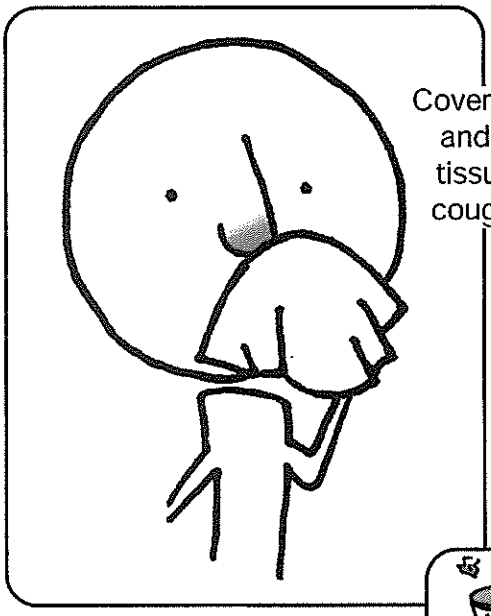
Infection control precautions

As with all potentially communicable illnesses, staff should wash hands frequently and wipe flat surfaces in the medical room on a frequent basis with caviwipes.

OSH Guidance 4/26/09. Guidance to be updated as CDC guidance is updated.

Stop the spread of germs that make you and others sick!

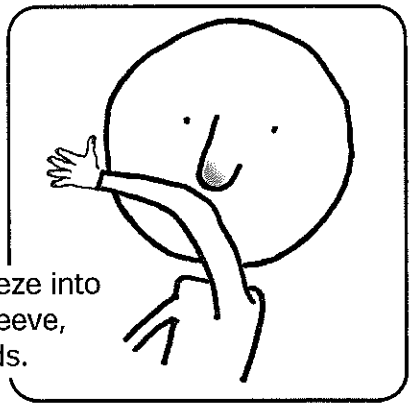
Cover your Cough

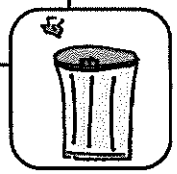


Cover your mouth and nose with a tissue when you cough or sneeze

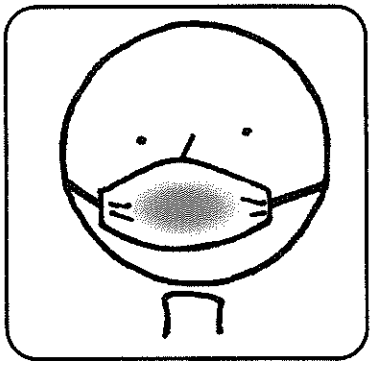
or

cough or sneeze into your upper sleeve, not your hands.





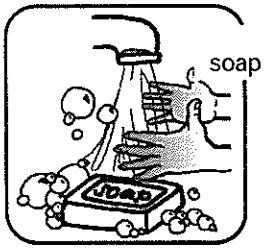
Put your used tissue in a waste basket.



You may be asked to wear a surgical mask in public. Don't worry if you see staff and others wearing masks. They are preventing the spread of germs.

Wash your Hands

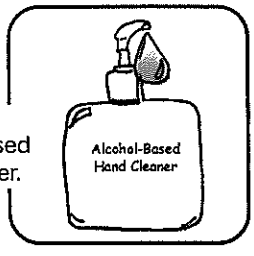
after coughing or sneezing.



Wash with soap and water

or

clean with alcohol-based hand cleaner.



Special thanks to the Minnesota Department of Health and the Minnesota Antibiotic Resistance Collaborative.

NYC Health

THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE
Michael R. Bloomberg, Mayor
Thomas R. Frieden, M.D., M.P.H., Commissioner
nyc.gov/health/flu

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District Council 37

New York City Council Committees on
Health, Governmental Operations and
Public Safety

New York City's Response to the H1N1 Virus and Assessing Influenza Preparedness

Testimony of Lisa Baum
Safety and Health Department
District Council 37, AFSCME, AFL-CIO

June 11, 2009

My name is Lisa Baum and I am a Principal Program Coordinator with the AFSCME District Council 37 Safety and Health Department. I am here to call your attention to an aspect of the H1N1 virus that has received little attention – occupational exposure to the H1N1 virus.

Every day thousands of New York City employees, many of them of District Council 37 members, are at increased risk for H1N1 exposure because of the work they do – hospital aides, emergency room workers, school nurses, school aides, corrections facility and homeless shelter staff, ACS childcare providers and recreation specialists who work closely with medically fragile youth – all face increased risk of exposure to the H1N1 virus.

School nurses have faced some of the highest exposure to the H1N1 virus. Students who are experiencing flu-like symptoms are told to report to the school nurse. In some schools nurses are exposed to hundreds of children with these symptoms. A number of school nurses have become ill with swine flu because of this exposure. Yet the employers of these nurses, the NYC Department of Health and Mental Hygiene (DOHMH) and the NYC Department of Education (DOE), have left these workers unprotected.

Just last week a school aide in Staten Island was forced, against her will, to accompany a child with a high fever and flu-like symptoms in an ambulance to the hospital. Although in an enclosed space with a child who, in all likelihood, had swine flu, she was not provided with adequate respiratory protection.

Other high risk environments have done little to provide proper protection and training other than hand out NYC DOHMH flyers encouraging workers to wash their hands and follow proper coughing and sneezing "etiquette." In some schools and Department of Juvenile Justice facilities, surgical masks are being distributed to workers indiscriminately. This provides a false sense of security to workers and does nothing to assess who is actually at increased risk of exposure.

The NYC Department of Health and Mental Hygiene and other city agencies have responded to the recent Swine Flu outbreak as a public health issue. But there has been little, or in most cases, no response to this highly contagious disease in terms of occupational exposure.

According to the NYS Department of Labor (NYSDOL) and the federal Occupational Safety and Health Administration (OSHA), employers whose employees are at risk of exposure to the H1N1 virus in the workplace must perform a risk assessment and take steps to eliminate or decrease the employees' risk of exposure. In most city agencies this requirement has been willfully ignored. According to DCAS General Counsel Ilene Lees, who oversees the Citywide Office of Occupational Safety and Health, there is no pandemic and, therefore, no special measures are required. It is "business as usual" she stated. The director of the Department of Education's Occupational Safety and Health's response to a request for a risk assessment? "I'm not even sure how to conduct a risk assessment for Swine Flu."

Because the NYC DOHMH has chosen to test very few of those suspected of having Swine Flu, the actual numbers of affected individuals has been significantly undercounted. Newspapers and official documents only quote "confirmed" cases. It has also meant that accurate tracking of contagion patterns is limited. There has been no effort to track occupational exposure.

In addition in contradiction to CDC, OSHA and NYSDOL guidelines, the NYC DOHMH recommends a form of respiratory protection for workers who come in close contact with individuals with known or suspected swine flu that is inadequate.

Scientific studies published by the Centers for Disease Control, Journal of Clinical Infectious Diseases and others confirm that the influenza virus can be spread through airborne transmission. The NYC DOHMH continues to ignore this data and has concluded that droplet protection is adequate. Protection from airborne transmission requires respiratory protection in the form of, at a minimum, an N95 respirator. A surgical mask can be considered adequate protection from droplet transmission only. City agencies including HHC are following NYC DOHMH's insufficient guidelines. Even workers who enter the isolation room of a patient with a confirmed case of swine flu are given nothing more than a surgical mask to wear.

District Council 37 in no way wishes to create a panic or unnecessary fear over an illness that for most people is not life threatening. However, the list of underlying health conditions that can cause the disease to take a more serious, and sometimes fatal, turn are extraordinarily common. Obesity, asthma, diabetes, immune suppression – how many New Yorkers suffer from one or more of these conditions? Employers are required by law to protect workers from occupational exposure to illnesses. Proper protections in this case are in no way onerous or extreme.

Specifically we demand that city agencies:

- Conduct job hazard assessments and institute adequate measures to protect workers based on these assessments.
- Provide proper respiratory protection, including training and fit testing.
- Assure workers ill with Swine Flu adequate time off from work without penalty.

Please note that the World Health Organization has declared Swine Flu a pandemic. The federal government and the city have supposedly spent years and enormous amounts of money preparing for an influenza pandemic. Yet when it comes to city workers, there has been an unconscionable lack of action to protect its employees. Should Swine Flu return more virulently in the Fall as is anticipated by many infectious disease specialists, it is imperative that city workers remain well and feel safe enough on the job to keep New York City functioning.

FOR THE RECORD

New York State Nurses Association
Testimony before the New York City Council Health Committee
On NYC preparedness for the A H1N1 Influenza
June 11, 2009
City Hall

Chairs Rivera, Sears, Vallone and members of the committees:

The New York State Nurses Association represents more than 34, 000 nurses state wide and of that number, approximately 26,000 work in hospitals, clinics and long-term care facilities in the five boroughs. This includes the 7,800 RNs of the NYC Health and Hospitals Corporation and the Mayoral Agencies. Thank you for this opportunity to present testimony on the issue of preparedness for a Pandemic Flu.

The current outbreak of A H1N1 has not reached the severity of previous epidemics and the numbers appear to be declining. This does not mean, however, that our focus on preparedness can be minimized. There is much to do in order to be prepared for what some scientists are predicting to be a re-emergence of a more tenacious flu come this fall. Guidance from agencies telling healthcare workers that the use of a surgical mask is okay when taking care of suspected or confirmed cases, as long as there are no high risk activities involved, needs to be corrected. This guidance is in conflict with the provisions of law found in the respiratory protection standard, (29 CFR 1910.134) and contrary to recent research regarding the spread of the virus from aerosolized particles (Measurement of Airborne Influenza Virus in a Hospital Emergency Department, Blachere, F. et al, CID, 2009:48, 15 February, 2009 pp 438-440) and against the decision to use N-95 or better respiratory protection by personnel exposed to recognized respiratory hazards found on a respiratory hazard risk assessment. Some hospitals are sending home perfectly well nurses simply because their son or daughter (also asymptomatic) attends one of the schools that have been closed by the flu. This irrational knee-jerk reaction only serves to worsen an already understaffed facility. Nurses are being asked to wear respirators without being given proper medical clearance, fit tests or training. This practice must also be corrected if we are to protect the health and safety of our nurses.

The "risk messaging" to the general public and the healthcare community concerning the A H1N1 flu virus must convey an accurate assessment of the current status, coupled with a clear and concise direction for the targeted audience. To achieve this, the city must develop a better system to more accurately and consistently account for the numbers of confirmed and probable cases. Criteria for public health strategies for containment, such as closing schools, staggering business start times and use of work-at-home options must be clearly defined and applied in a consistent manner.

New York State NURSES ASSOCIATION
120 Wall St. 23rd Floor, New York, NY 10005 ■ 212-785-0157 ■ www.nysna.org

NYSNA believes that the preparedness response to a Pandemic Flu must proactively prepare and protect our nurses and other frontline personnel. Central to this concept of preparedness is an evidence- based, well coordinated written practical plan that addresses early detection, effective prevention and containment strategies. The plan needs to address sound resource management of both personnel and physical facilities to meet the surge demand. A preparedness opportunity also demands a plan for recovery from both the emotional and economic impact left by a pandemic flu.

We urge the city to expand its understanding and preparation for the impact of the patient surge a pandemic will undoubtedly bring. Now is the time to involve our nurses and other frontline personnel with the planning process to build a comprehensive and robust response.

The lessons learned from previous pandemics must be heeded. Knowing that a pandemic can span the course of several months, 24 hours a day, seven days a week, and come in several waves, we need to verify that every hospital has the capability to appropriately staff the expected increase that capacity demands. Every hospital and healthcare facility must have an adequate supply of appropriate respirators, in house or accessibly warehoused, for the protection of the staff. Use of surgical masks to protect against aerosolized flu particles is not appropriate. N-95 respirators or better must be provided. Nurses and other frontline personnel need to be taught the proper use, be medically cleared and fit tested to use the appropriate respirators.

Those facilities that do not have respiratory isolation rooms attached to their emergency department should consider use of temporary or portable negative pressure rooms and equipment that are far less expensive than the traditional bricks and mortar solutions. Each community hospital and major teaching institution needs to take an active part in educating the public on proper respiratory etiquette. Yes, we need to teach the public how to sneeze, cough and blow their noses in a responsible fashion!

All city healthcare agencies, public and private, need to coordinate resources, readiness and response not just within the city, but within the region, state and federal arena. When a pandemic hits, New York City will not be an Island unto its own and our nurses should not be left to fend for themselves in an already understaffed healthcare environment.

Safe staffing levels must immediately be implemented in all facilities so that nurses and other personnel can provide appropriate and safe care for patients already in our hospitals. Basic nurse staffing needs must be addressed immediately in order for more long-term solutions for surge demands to become viable. Then, built on a firm foundation of routine safe staffing, surge capacity

plans have to be developed and tested to ensure continued safe staffing levels during a pandemic.

When a pandemic flu vaccine becomes available, our nurses should have that vaccine offered as a priority and not a condition of employment. Seasonal vaccine levels among healthcare providers are historically low, but there have been some innovative and effective programs to increase the numbers who voluntarily take the vaccine. NYSNA encourages the development of these non mandatory programs. The time to start those programs is now.

In summary:

Resources are key to being prepared. First and foremost are the personnel resources which will be needed to sustain our current healthcare delivery system and be able to expand to meet the demands of an impending pandemic; this means adequate RN staffing NOW. Resourcing preparedness efforts is also critical. Using pandemic impact prediction models, facilities should already be assessing inventory levels of PPE, ventilators and hospital beds, establishing par levels and setting re-supply triggers.

Our nurses and allied healthcare professionals need to be involved in the process of planning, we need the resources that will enable us to perform our responsibilities, we need the training to know not only what to do, but how to do it, and perhaps most importantly we need the opportunity to practice what we have been trained to do. Pandemic Flu preparedness and response has to be facility-specific, community-based and regionally compatible.

The New York State Nurses Association has a proud history of service to the public in both times of calm and disaster. NYSNA stands ready to again respond and now offers any assistance it can to this committee as it supports the efforts being made toward preparedness for a Pandemic flu.

Thank you again for the opportunity to testify.

Thomas J. Lowe, RN, MPH, COHN-S, COHST
Health and Safety Representative, NYSNA

Testimony of Dr. Danielle Ompad and Ms. Keosha Bond, Associate Director and Project Manager of the Center for Urban Epidemiologic Studies of The New York Academy of Medicine

New York City Council Committee on Health
Oversight Hearing Regarding
New York City's Response to H1N1 & Influenza Preparedness

June 11, 2009
New York City

Thank you for the opportunity to discuss New York City's response to H1N1 & influenza preparedness. On behalf of The New York Academy of Medicine (NYAM) we appreciate the City Council's interest in this issue which has been the subject of important research at NYAM and has led NYAM to directly engage our local community to increase immunization rates.

The New York Academy of Medicine, founded in 1847, is an independent non-profit which uses research, education, community engagement and evidence-based advocacy to improve the health of people living in cities, especially disadvantaged and vulnerable populations. The impact of these initiatives reaches into neighborhoods in New York City, across the nation, and around the world. We look forward to working with the City Council on this and many other issues of mutual importance.

Every year, 5% to 20% of the American population falls ill with influenza and on average 36,000 persons die from influenza-related complications. Immunization reduces the illness and death that results from influenza and respiratory tract infections that result from the underlying influenza. Seasonal influenza immunization rates among the elderly, the population that accounts for 90% of influenza-related deaths, rose

steadily for a number of years, but have now leveled off at between 50% and 70%. In New York City, the Department of Health and Mental Hygiene reported a 2007 city-wide immunization rate of 54.7% for adults aged 65 and over.

Efforts to increase vaccination rates have historically targeted individuals at high-risk for complications due to influenza, including the elderly and those with certain chronic health conditions. Despite recommendations from the Advisory Committee on Immunization Practices (ACIP), vaccination coverage among populations at high-risk for complications from influenza like older people and those with heart and lung conditions has been generally low. We systematically reviewed 56 studies, published between 1990 and 2006, evaluating programs in different settings, from within medical settings to venue-based and community-based approaches, in an effort to identify programs that successfully increased immunization rates. In the US, the Healthy People 2010 (HP2010) goals included 90 percent vaccination coverage for adults aged ≥65 years and 60 percent for high-risk adults aged 18-64 years. Only a handful of the studies we reviewed managed to meet those goals. Interventions that increased vaccination coverage to HP2010 goals included advertising, provider and patient mailings, registry-based telephone calls, patient and staff education, standing orders coupled with standardized forms, targeting syringe exchange customers, visiting nurses, and pharmacists as immunizers.

Of the 56 studies we examined, more than half of the studies occurred in primary care settings, one in four were large-scale regional programs (i.e., Medicaid, etc.), 7% were in tertiary care facilities or hospitals, 3% were targeted to nursing homes or long term care facilities, and 3% included active community engagement. Thus, most studies examined vaccination within the context of primary care settings or large-scale regional programs. In short, these programs targeted people already connected to the health

care system. An important limitation of these types of approaches is their inability to reach those people who are not engaged in the health care system.

Data from several sources, including the National Health Interview Study, suggest that immunization rates are lower in racial/ethnic minority groups than Whites, a disparity that exists for all age groups, including elderly persons covered by Medicare and populations specifically targeted by public health interventions. Of particular concern is what is known as "hard-to-reach" (HTR) populations. While no uniform definition of HTR population exists, HTR populations have typically been defined from the perspective of the absence of regular linkage with the health care system. Although data are limited, hard-to-reach (HTR) groups such as the housebound elderly, disenfranchised groups, people living in disadvantaged urban communities, undocumented immigrants, and substance users may be less likely than individuals receiving routine health care services to receive influenza immunization.

While failure to be immunized is related to lack of health insurance and to having a regular provider, other barriers to accessing care may include: culturally derived attitudes and belief systems; negative experiences with past treatment; language and other barriers in patient-provider relationships; and, legal status (e.g., undocumented immigrants). Some groups harbor substantial myths about and distrust of the medical system; previous research has shown that their attitudes appear to be strong predictors of being immunized.

Members of HTR groups may be at increased risk of morbidity and mortality secondary to influenza because of increased incidence and prevalence of medical conditions for which influenza vaccine is recommended (e.g., asthma, diabetes), and reduced immune system activity.

As noted above, a number of interventions have been shown to be effective for increasing vaccination coverage among the general population, including provider-based

interventions, and interventions aimed at increasing community demand and enhancing access to immunization services. Studies on how best to immunize HTR populations are sparse, however. Existing research suggests, however, that most interventions are strengthened by multiple approaches, particularly those that are community-based.

In light of the limited data available addressing vaccine access among HTR populations, we at NYAM sought to fill this gap. The Harlem Community and Academic Partnership, a network of community-based organizations and health leaders affiliated with NYAM, carried out Project VIVA (Venue Intensive Vaccines for Adults). Project VIVA was a set of intervention activities aimed at increasing acceptance of influenza vaccination among HTR populations in East Harlem and the Bronx. Activities targeted the individual, community organization, and neighborhood-levels and included disseminating project information, presentations at community meetings, and providing street-based and door-to-door vaccination during two influenza vaccine seasons. Essentially, we hired outreach workers from the community and trained them to deliver information about flu vaccine to the community. A key aspect of the intervention was our uniforms: bright yellow jackets with our logo. The more time we spent in the community talking to people about influenza vaccination, the more recognizable we became. We also attended community meetings and distributed more than 100,000 promotional flyers, vaccination myths cartoons, vaccine/influenza information sheets and 2,200 vaccine doses.

Project VIVA increased interest in receiving influenza vaccine post-intervention and distributed vaccine in the community. At one point we had a line around the block at the Pathmark at 125th Street and Lexinton Avenue. Individuals living in intervention neighborhoods were more interested in receiving influenza vaccine compared to their interest before the intervention. Specifically, members of HRT populations, persons

reporting a prior influenza vaccine, and persons medically indicated to receive vaccine were more likely to be interested in receiving vaccine.

Community participation and leadership was critical to the success of Project VIVA. The Community Based Participatory Research (CBPR) methods used here, including community members leading the planning and implementation of the intervention, helped to ensure that community priorities were incorporated and contributed to our ability to gain access to members of HTR populations to deliver immunization. Specific factors contributed to the success of the rapid vaccination intervention: extensive outreach activities, the selection of staff with personal knowledge of the project neighborhoods, and the readily recognizable project staff wearing highly visible, and consistent, attire. These factors allowed us to gain access to populations unlikely to report to a private or government-sponsored health clinic to receive immunization. Our findings demonstrate the feasibility of delivering vaccine to members of HTR populations in non-traditional urban settings through the use of a CBPR framework. We also learned that our target population was not "hard-to-reach," but rather "easy-to-miss" if we don't walk outside our institutions and into the community.

These findings were consistent with what we'd previously learned in our research of nontraditional vaccination points, following NYAM's support of New City Council Resolution 1231, and New York State legislation permitting pharmacists to administer vaccine. Indeed, an eight state study, documenting the differences between vaccination coverage for an area when pharmacists administered vaccine as compared to when there was no legislation permitting such action, demonstrated that vaccination coverage was increased by 10.7% where pharmacists were permitted to vaccinate as compared to an increase of only 3.5% where there was no such option.

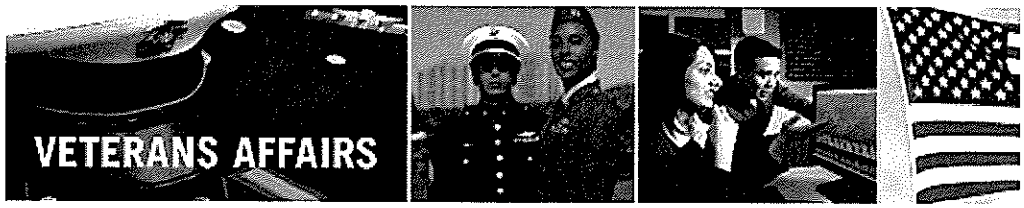
Targeting underserved neighborhoods through a multilevel community intervention increased interest in influenza vaccination, particularly among the HTR.

Given the research and community work we've done, NYAM recommends the City Council consider providing grants to community-based organizations and health providers to run targeted, culturally sensitive outreach programs with "easy-to-miss" populations. In addition, the City Council and City Health Department should consider providing support to allow existing health outreach programs to expand their services to provide vaccinations.

Our experience also told us that involving the community in the planning and execution of vaccine distribution is key. This was also a main theme we discussed at an external partners meeting on Pandemic Influenza Preparedness & Response in Selected Vulnerable Populations at the CDC in 2008. The community can provide important information about barriers and facilitators to compliance with pandemic influenza recommendations in a crisis.

New York City has taken important steps to increase vaccination rates and to prepare the City for a pandemic. The current H1N1 situation is testing these efforts and we applaud the New York City Department of Health and Mental Hygiene's efforts to keep the public informed and calm, while monitoring cases and contributing to our knowledge of the epidemiology of H1N1. Efforts to expand immunizations amongst the easy-to-miss populations will require creative and intensive efforts and must involve community organizations who can prepare for and promote vaccination in non-traditional settings and at times convenient to HTR populations.

Current strategies for vaccination all-too-often employ methods most comfortable for those providing the vaccine, giving little attention to the sensitivities of those needing vaccinations miss the hard-to-reach population. This population cannot be ignored and the strategies we implement today, and the lessons we learn, will be vital as this pandemic of influenza unfolds. Thank you for the opportunity to testify and I look forward to any questions you might have.



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This website is a virtual one-stop source of information regarding services for veterans, reservists and survivors. In addition, it is a valuable resource for faculty and staff who, in the course of their duties, m information. It is a guide to educational benefits, entitlements, counseling and advocacy resources, wh in pursuing their academic and civilian careers.

The CUNY Office of Veterans Affairs team is happy to assist you with any questions. Plea

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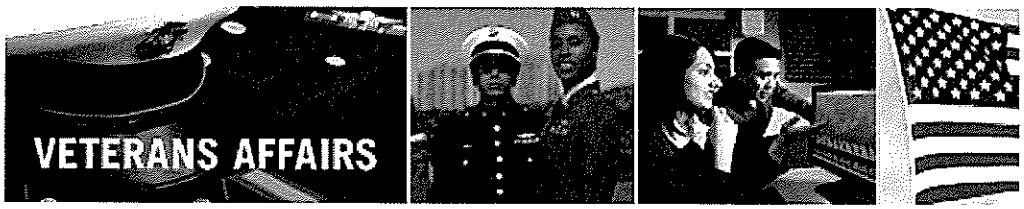
SEE WHAT OUR OFFICE IS UP TO...

On Tuesday, November 11th, 2008 CUNY had a 75+ student and staff contingent at the Veterans D. some pictures of our student veterans and float...



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The major educational assistance pro

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- Veterans Tuition Awards (Starts 7/1/08)
- Tuition Benefit for Active New York State National Guard Members
- New York Army National Guard Federal Tuition Assistance Program (ARNG FTA)
- New York State Veterans Tuition Award
- Regents Award for Children Of Deceased or Disabled Veterans
- Military Service Recognition Scholarship (formerly War on Terrorism Scholarship)
- New York State 4/03 Support For Military Families

More on State Aid >>

Merit-Based Aid

A variety of merit-based aid exists thr grants, and fellowships. Some of this or dependent status. Veteran's organi merit-based aid.

Students are encouraged to research his/her campus Financial Aid Office a

For more information visit:

- CUNY's Financial Aid website >>
- Scholarships at the CUNY Colle

CUNY The City University of New York

Friday, April 24, 2009

Leading the Way

2nd Annual CUNY Student Veteran Conference

Medgar Evers College

1665 Bedford Avenue, Brooklyn, NY 11225

By Subway to Carroll St. Building: IRT 7th Ave., Express No. 2 or No. 5 to President St., No. 3 to Nostrand Ave.
By Subway to Bedford Ave. Building: No. 2, 3, 4 or 5 to Franklyn Ave.

Location: Campus Auditorium

Registration/breakfast: from 8:00 a.m. to 8:45 a.m.

Conference Program: from 9:00 a.m. to 4:00 p.m.

Lunch will be served

Register online at:
http://www.cuny.edu/veterans

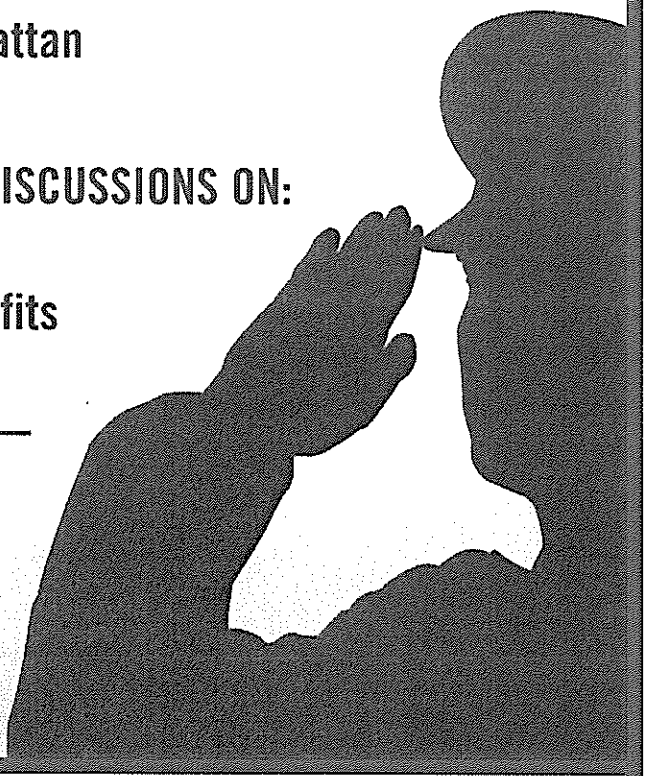
For more info contact
the CUNY Office of Veteran Affairs at:

(212) 652-2002 or (212) 652-2011

CUNY COLLEGE FAIR FOR VETERANS

ALL ACTIVE DUTY, RESERVISTS, VETERANS, DEPENDENTS, AND SURVIVORS ARE WELCOME.

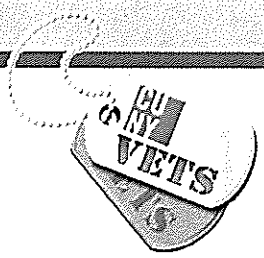
Thursday, October 16, 2008
4:00 PM - 7:00 PM
Borough of Manhattan Community College
Richard Harris Terrace
199 Chambers Street, Manhattan



WORKSHOPS, PANELS, AND DISCUSSIONS ON:

- The Admission Process
- Financial Aid & VA Benefits
- Student Life

To RSVP, please visit
www.cuny.edu/veterans
or call 212-290-5674.



LEADING THE WAY

WWW.CUNY.EDU/VETERANS

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Susan Meehan (Q+A)

Address: Assistant Vice President for Emergency Management

I represent: Health & Hospitals Corporation

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kathleen Grimm (Q+A)

Address: Deputy Chancellor

I represent: Department of Education

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Adam Karpati (Q+A)

Address: Executive Deputy Commissioner

I represent: Department of Health - Mental Hygiene

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: William C. Thompson, Comptroller

Address: 1 Centre Street

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Joe Bruno

Address: Commissioners

I represent: Office of Emergency Management

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Tom Farley

Address: Commissioners

I represent: Department of Health + Mental Hygiene

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Lisa Baum

Address: 430 E. 20 St., NY, NY

I represent: District Council 37 AFSCME

Address: 125 Barclay St, NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Scott Graham & Jim Parker

Address: 520 W. 49th Street

I represent: American Red Cross

Address: 520 W. 49th Street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Melissa Corrado

Address: 15 Hawthorne Ave

I represent: Primary Care Development Corporation

Address: 22 Cortlandt St. NY NY 10007

Please complete this card and return to the Sergeant-at-Arms

H1N1 Hearing

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Randi Weingarten, President

Address: UFT

I represent: UFT

Address: 52 Broadway

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Judith Arroyo

Address: 125 Barclay Street NY 10007

I represent: President, L. 436

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Lisa Baum

Address: 125 Barclay Street NY 10007

I represent: DC37 Health + Safety Dept.

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 06/11/09

(PLEASE PRINT)

Name: C. PITTMAN

Address: _____

I represent: New York State Nurses Assoc

Address: 120 Wall, 11Y NY 10005

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

H1N1 oversight *Date:* 6/11/09

(PLEASE PRINT)

Name: New York Civil Liberties Union Seth Hawkes

Address: 125 Broad Street 19th Flr 10004

I represent: NYCLU

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. H1N1 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: PRESIDENT JUDITH ARROYO

Address: ~~DC 37~~ 125 Barclay Street 10007

I represent: Local 436 DC37

Address: 125 Barclay Street 10007

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Norman Seabrook

Address: _____

I represent: NYC Correction Officers' Benevolent Association

Address: 75 Broad Street Suite 810

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. H1N1 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ARTHUR RUSSELL CEO OF BRIAN WHITNEY INC.

Address: _____

I represent: BRIAN WHITNEY INC

Address: 130-13 22 AVE/ST CAARLETON N.Y

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. H1N1 Res. No. _____

☑ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: Dr. Daniella Ouimet

Address: Ms. Keosha Bond

I represent: The New York Academy of Medicine

Address: 1216 Fifth Avenue, NYC 10029

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: SCOTT GRAHAM

Address: _____

I represent: American Red Cross of Greater New York

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JIM PARKER

Address: _____

I represent: American Red Cross of Greater New York

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DARRYL NG

Address: _____

I represent: Community Health Care of New York STATE

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: IRWIN Redlener M.D Director

Address: _____

I represent: Center for Disaster Preparedness at Columbia

Address: University Mailman School of public Health

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/11/09

(PLEASE PRINT)

Name: RONDA KOTELCHUCK

Address: _____

I represent: PRIMARY CARE DEVELOPMENT CORP

Address: 82 Cortlandt St, 10007

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Susan Waltman

Address: _____

I represent: Greater N.Y. Hospital Assn

Address: _____

Please complete this card and return to the Sergeant-at-Arms