



Testimony

of

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regarding

Strategic Perspectives on the Bioterrorism Threat

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Good morning Chairwoman McSally, Ranking Member Payne, and Members of the Subcommittee. I am Marisa Raphael, Deputy Commissioner for the Office of Emergency Preparedness and Response at the New York City Department of Health and Mental Hygiene. Our mission is to promote New York City's ability to prevent, prepare for, respond to, and recover from public health emergencies. I have been privileged to serve in a leadership role in this field for more than a decade. On behalf of Mayor Bill de Blasio and Health Commissioner Mary Bassett, thank you for the opportunity to testify on New York City's efforts to prepare for and respond to emergencies with public health and medical consequences.

Public Health and Emergency Preparedness

I am here today to discuss the vital role that public health plays in detecting and responding to emergencies, the importance of federal public health and healthcare preparedness funding, and examples of how these investments have increased preparedness. I will focus on our most recent and ongoing Ebola response and the Rapid Activation and Mobilization Point of Dispensing Exercise, called RAMPEX, which the Health Department conducted in August 2014.

Our nation's public health and healthcare infrastructure play a critical role in protecting our citizens by quickly detecting acts of bioterrorism or naturally occurring outbreaks, containing the spread of disease, and otherwise mitigating the public health impacts of emergencies. State and local health departments along with their local healthcare systems play equally vital roles as that of first responder agencies – we prevent illness and save lives. The Department currently receives federal emergency preparedness funding from the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness program (PHEP), the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) cooperative agreements, and the Department of Homeland Security Urban Area Security Initiative (UASI) grant awards. As a result, the Department's public health and healthcare emergency response capabilities have been expanded, and we have made vital investments in plan development, training and exercises, supplies and equipment, and skilled and experienced personnel to respond to a broad range of emergencies. In New York City, a perpetual target for terrorism, focal point for disease outbreaks, and victim of natural disasters, these investments have been critical to shoring up our public health and healthcare system. I want to thank the Committee and Subcommittee for their continued interest and recognition of the need for these critical federal programs.

Ebola in New York City

As the largest point of entry in the United States, we recognize the increased likelihood that a naturally occurring disease in any area of the world can quickly spread to New York City. This was demonstrated during our recent and ongoing response to Ebola. Beginning in July 2014, when it became apparent that cases of Ebola were increasing in West Africa and that an individual with Ebola would likely reach New York City, the City activated a highly detailed, coordinated and expensive multiagency and multijurisdictional effort. The Mayor convened interagency preparedness meetings to discuss various scenarios and ensure our healthcare system and first-responders were aware of their roles and familiar with protocols. I would be remiss to not mention the over twenty agencies, including the NYC Health and Hospitals Corporation (HHC), FDNY, NYPD and NYC Office of Emergency Management that worked hand in hand with our team at Health and City Hall to ensure a coordinated response. Each city agency dispensed invaluable expertise and leadership and I cannot emphasize enough how critical coordination is in the face of threats like this.

To give you a sense of our preparation at the Health Department, we addressed hospital readiness, risk communication and emergency transport, increased lab capacity, and community engagement. The Health Department began developing detailed plans for disease surveillance, emphasizing early detection, isolation and rapid notification, as well as plans to manage a person under investigation. Our public health surveillance and epidemiology staff investigated hundreds of suspect cases; the Public Health Laboratory

quickly became proficient in testing for Ebola to facilitate rapid diagnosis and delivered test results in record time. We also prioritized community engagement, distributing over 100,000 “Am I at Risk?” palm cards and speaking at over 115 public events to address the public health concerns of New York City’s diverse communities. For example, our Commissioner personally went out into West African immigrant communities and other vulnerable areas of the City to begin a dialogue about, not only of the risks of infection, but also discussing issues of tolerance to ensure immigrants were being treated fairly.

Most notably, HHC proactively conducted extensive staff training at each of its eleven hospitals, to be prepared to receive and screen individuals potentially exposed to the disease. Additionally, the City chose to focus on readying Bellevue Hospital as the primary NYC Ebola treatment center. Bellevue was selected because its “quarantine and isolation” unit has been supported over the past decade through HPP funding and we could focus on enhancing existing capabilities by further training staff and hiring additional personnel, as well as outfitting of isolation rooms to properly handle additional electrical and laboratory capacity. The fact that Bellevue was the sole facility ready to receive and treat an Ebola patient when that capacity was actually needed – and that it did so with successful outcome for the patient and all the personnel who care for and supported the patient – is merely part of the remarkable preparedness and response work overseen by Dr. Raju, HHC’s President.

Years of planning made possible through the previously mentioned funding gave the City the capacity to quickly prepare and respond to the Ebola threat. On October 23, 2014, when the first confirmed case in New York City was identified the City was in a strong position to respond because of these federal dollars. Nonetheless, funding is still needed to reimburse the City for the costs incurred in transporting, screening, treating and monitoring persons with or potentially exposed to Ebola.

Mass Prophylaxis Capability and RAMPEX

One of the biggest challenges we currently face is maintaining a permanent state of readiness among city agencies and the healthcare system. This brings us back to the original impetus for the federal preparedness funds – the September 11th attacks and the subsequent anthrax attacks.

The receipt of letters tainted with anthrax in multiple cities in 2001 led to a state and local requirement to develop mass prophylaxis capabilities. PHEP funds support state and local health departments to develop and execute plans for the mass dispensing of medication in response to a biological attack. In the case of a widespread, aerosolized attack, all potentially exposed people must begin taking antibiotics within 48 hours to prevent illness and death. While 48 hours is the target, modeling has shown that the more rapidly medication is provided to the public, the more lives will be saved. The primary method of rapidly dispensing medication is through Points of Dispensing, or PODs, which are temporary emergency sites established to provide free medication to large numbers of people to prevent them from becoming sick. Years of planning, training and exercises as well as our investment in a team of experienced, highly skilled Health Department emergency managers culminated on August 1, 2014, when the Health Department conducted the largest no-notice emergency response exercise on record: the Rapid Activation for Mass Prophylaxis Exercise, or RAMPEX. This exercise involved notifying and mobilizing over 1,500 city employees and setting up and opening 30 PODs simultaneously, and was funded by UASI.

RAMPEX tested all components of our mass prophylaxis response to an aerosolized anthrax attack from the mobilization of our Receipt, Stage and Store (RSS) warehouse, to the coordination of our command and control center and mobilization of PODs. RAMPEX definitively demonstrated our ability to rapidly open 30 PODs citywide in less than 8 hours, with some fully set up, staffed, and ready to open within 6 hours.

RAMPEX helped identify critical planning gaps and solutions. First, all PODs were ready to open up to 4 hours before medications from CDC's Strategic National Stockpile (SNS) would arrive at New York City warehouses. In an effort to close this gap, the Health Department has requested that SNS assets be forward deployed in reasonable and useful quantities to NYC and other high-threat, high-density urban areas that have demonstrated an ability to stand up PODs faster than SNS medications can be delivered. The consequence of the failure to forward-deploy SNS assets may ultimately be measured in the numbers of lives lost because of delayed access to medication.

Second, we have not met our POD staffing goals for both leadership and general staff. In NYC alone, citywide prophylaxis distribution will require 33,000 POD staff to support 48 hours of dispensing operations. In anticipation of "role abandonment" or failure to report, NYC has made great efforts to recruit, pre-train, and assign staff to a POD site close to home. We are advocating for non-mission critical federal staff, who live locally, to be similarly pre-identified and pre-trained to support POD operations. There are many areas in which federal staff could be utilized to augment local response efforts during a large-scale emergency, PODs being one such opportunity.

RAMPEX demonstrated New York City's extensive medical countermeasure capabilities and high level of readiness for this type of scenario, and the importance of federal preparedness funding to sustain such efforts.

Importance of Federal Emergency Preparedness Funding

Our successful Ebola response and medical countermeasure exercise are a direct result of a decade of federal investments in local preparedness. However, the greatest danger to our progress is the decline in federal emergency preparedness funding. Preparedness is an on-going effort that must be sustained over time. While the overall emergency preparedness and response funding should be increased, funding allocations should also be based on risk to reflect the scale of threat, impact to high-density urban areas, and complexity of response. These funds support the development, maintenance, testing and continued improvement of these public health and healthcare capabilities and without these funds, lives would be lost.

Federal funds have allowed us to build critical capabilities so that when faced with public health emergencies, we have the tools necessary to protect the public. The Department relies on the dedicated emergency preparedness federal funding streams of PHEP, HPP, and UASI to build and maintain these critical public health and healthcare capabilities. Significant cuts to the PHEP award, combined with similar cuts to the HPP award jeopardize NYC's, and other state and local jurisdictions' existing capabilities and impede planning to address known gaps. I will speak to the cuts New York City has endured specifically.

PHEP funding for New York City has decreased 35% from its peak in FY2005, which has led to a 47% reduction in our public health preparedness and response workforce. The erosion of a skilled, dedicated workforce including epidemiologists, laboratory technicians, and preparedness planners threatens to compromise our ability to detect and respond to disease outbreaks. In New York City, for example, the cuts have reduced the ability of the Public Health Lab to respond to after-hours lab testing needs, which is critical to the 24/7 response needed for bioterrorism incidents and public health emergencies such as pandemic influenza and Ebola.

Similarly, drastic cuts of nearly 40% to HPP have impeded preparedness and response efforts necessary to shore up our nation's health care sector. Healthcare system preparedness is essential to responding to all types of public health emergencies. During the recent Ebola response, every hospital had to be ready to identify, isolate and stabilize any patient with potential Ebola disease and a handful of hospitals had to be ready to provide intensive treatment for a confirmed Ebola patient. There are 55

hospitals, 259 long-term care facilities, 303 primary care centers, 50 urgent care centers, and 101 dialysis centers in New York City. Preparing a healthcare system of this size and complexity requires significant resources, and as the funding has declined, NYC's ability to fully prepare its healthcare system has been compromised.

In the immediate months following a particular emergency, jurisdictions have occasionally received one-time funding to supplement the PHEP and HPP grants. New York City is thankful to have received such an allocation for our Ebola response. However, these singular funding allocations are not an adequate substitute for sufficient and sustained base funding. There is also a critical need for a real time funding mechanism to support public health emergency response. Currently, we must use federal preparedness funds to cover response costs, however with decreasing budgets that are already allotted to preparedness projects, this is unrealistic. Generally speaking, federal budgets designed to support public health and health care system preparedness and response capabilities must be increased and sustained, this is as true for New York City as it is for localities nationwide, particularly dense urban centers.

Chairwoman McSally and Ranking Member Payne, thank you once again for inviting me to testify today. We are grateful for your and your colleagues' work to protect our citizens. I look forward to your questions.