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EMERGENCY PREPAREDNESS FOR THE ELDERLY AND DISABLED

FIELD HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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CONTENTS

	Page
Opening Statement of Senator Larry E. Craig	1

PANEL I

Hon. Benjamin A. Gilman, A Representative in Congress from the State of New York	3
Josefina G. Carbonell, Assistant Secretary for Aging, U.S. Department of Health and Human Services	6
R. David Paulison, U.S. Fire Administrator, Federal Emergency Management Agency	20
Stephen Ostroff, M.D., Associate Director for Epidemiologic Science, National Center for Infectious Diseases, Centers for Disease Control and Prevention, Department of Health and Human Services	22
Alexander Parzych, Assistant Chief of Fire Prevention	35
Richard Sheirer, Director New York City Office of Emergency Management	36
Wayne Osten, Director, Office of Health Systems Management	38
Igal Jellinek, Executive Director, Council on Senior Centers and Services of New York	41
Michael Benfante, Employee of Network Plus	44
Andrea Dale, Visiting Nurse Service of New York	49

APPENDIX

Information on Emergency Evacuation Devices	83

EMERGENCY PREPAREDNESS FOR THE ELDERLY AND DISABLED

MONDAY, FEBRUARY 11, 2002

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
New York, NY.

The committee met, pursuant to notice, at 2 p.m., at 5 Penn Plaza, Room 302, New York, NY, Senator Larry Craig, presiding.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG

Senator CRAIG. Ladies and gentlemen, if I could have your attention. We will start this hearing on the Special Committee on Aging of the U.S. Senate. First and foremost, let me thank all of you so very much for being with us today. We view this as a very special hearing to hear from New York City, and to have you share with us some of the things that you have learned in the last several months.

Five months ago today attacks on America began right here in this city: First at the World Trade Center as, of course, you all know. Many of you who are New Yorkers may well have experienced it visually and in reality firsthand. Then, of course, down in a city where I spend a fair amount of my time, Washington DC., and the Pentagon. These attacks on America I think changed all of our lives in some way and many lives and many institutions in major ways. I suspect none of us will ever forget that tragic day.

I came here shortly after the attacks with my friends and colleagues from the U.S. Senate. We stood in shock and in awe at Ground Zero and what we saw with the devastation that was clearly evident there. I chose to come back here today so that we could look at some of the expertise and some of the finest emergency response that clearly went on during that time that the world is now well aware of. I think New Yorkers learned much about the tragedy of September 11, and I want to hear what you have learned as it relates to the seniors, the elderly, and the some of the infirm of America and what we might learn better so that the Special Committee on Aging can turn to people like Governor Ridge, who is now heading up homeland security, and we might offer suggestions and even propose regulation changes or law changes to some of our agencies as it relates to all of that.

Well, there are all heroes, but there are some heroes here today, Michael Benfante—there are many more just like him, people who help strangers in a time of need, and I could go on and on as it relates to some of the wonderful things that occurred in this city.

Abe Zelmanowitz, we want to recognize him, the work he did on behalf of a friend, a paraplegic in a wheelchair, and all that is now part of the history of September 11. These were heroes: The firemen who arrived at the scene, many who gave their lives; we all know about that now, and we will never forget it, and we will continue to honor it. They were and are brave men and women who responded in the line of duty.

According to a poll commissioned by the National Organization On Disability last November, 58 percent of people with disabilities say they do not know who to contact about emergency plans for a community in event of a terrorist attack or other crises. In other words, we are just beginning to learn that there is a whole community of people out there who find themselves or feel increasingly vulnerable as a result of September 11. Sixty-one percent say that they have not made plans to safely or quickly evacuate their own homes, and it goes on and on. Well, those are some of the issues that we will talk about today with the panels that we have assembled, and I want to thank you all so very, very much for coming.

The first person who is with us today, I am very proud that he had the time to join us because he is a gentleman I got to know a long while ago. I served in the House for 10 years, and during that period of time I got to know and appreciate Congressman Ben Gilman from here in your area.

Ben has been one of those great public servants who constantly gives of his time and his talent to all of his great State and now to the Nation, and I was extremely pleased that Ben would join us today and to become a part of a panel not only to give testimony, but to sit here at the dais with me and, Ben, I will tell you that you can question and participate just like this was a joint House and Senate hearing because that is what we are going to make it with Ben's presence here.

Let me also thank my chairman, John Breaux of Louisiana, for allowing me to bring the committee up here today for what I think is an extremely valuable hearing. Then what we are going to do because of the character of the way we set this room up so that you are all a part of it in a somewhat roundtable discussion, I am going to work my way around the room and introduce you and receive your testimony and then, as I ask questions this afternoon, while some of them might be specific to you as an individual in your expertise, please feel free to add to or join in as questions are asked and you feel you have additional information to offer.

I would also tell you that all of your written testimony is a part of the record and will be reviewed by the committee and can be reviewed by all Senators because it is a part of our committee record. So, we again thank you all so very much for being with us this afternoon. We will keep our hearings on schedule and on time; we will make every effort to do that.

Now let me turn to a good friend over the years and I know one of your very best in Washington and here in New York, Congressman Ben Gilman. Ben, thanks so much for being with us.

[The prepared statement of Senator Larry Craig follows:]

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Good afternoon. Thank you for attending today's hearing of the Senate Special Committee on Aging. I would like to thank the witnesses for agreeing to testify on the critical issue of emergency preparedness for the elderly and disabled. I know that some of you have stories of personal experiences that may be difficult to tell, and I especially thank you for being here.

Five months ago today attacks on America began right here in New York City—first at the World Trade Center and then at the Pentagon. These attacks on America changed our lives forever. No one will ever forget that terrible day.

I came here shortly after the attacks with my friends and colleagues from the U.S. Senate. We stood in shocked awe at the scope of the devastation at the site of the World Trade Center.

I chose to come back here today so that we can call upon the expertise of the finest emergency responders in the nation. New Yorkers learned much from the tragedy of September 11 and I look forward to hearing your testimony, ideas and suggestions about how we can address the needs of seniors and disabled people in future times of crisis.

We will also hear from at least one hero today, Michael Benfante—and there are many more just like him—people who helped strangers in a time of need. There are other heroes we will never hear from—people who laid down their lives for others.

One of those heroes we will not hear from—but one we should recognize—is Abe Zelmanowitz. He stayed by the side of his friend, Ed Beyea, a quadriplegic who used a wheelchair. When it came time to evacuate the World Trade Center, Abe stayed with Ed and waited with him to be rescued. Abe lost his life waiting with his friend Ed—Abe Zelmanowitz was a hero.

There were other heroes too—the firemen who arrived on the scene, many of whom also gave their lives for others. These brave men and women have always put their lives on the line. It is critical to their safety, as well as for the safety of the rest of us, that our nation's firefighters have access to the equipment, training, and personnel they need—and I am working hard in Washington, DC, to make that happen.

According to a poll commissioned by the National Organization on Disability last November, 58 percent of people with disabilities say they do not know who to contact about emergency plans for their community in the event of a terrorist attack or other crisis. Sixty-one percent say that they have not made plans to quickly and safely evacuate their home.

Clearly we must highlight the need for greater preparation in meeting these needs.

I'd like to thank each of the witnesses for being here today and for sharing their insights into his complex problem. I look forward to hearing your testimony.

STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Rep. GILMAN. Thank you, Senator Craig, for your kind invitation to join the Senate Special Committee on Aging. It has done so much good for so many of us and keeps us all apprised of the needs of our aging in both the Senate and the House. I want to thank our participating panelists who are here from the Federal Government, and the State Government and the City Government, as well as visiting nurses and some of the other important dignitaries who we look forward to hearing from today.

I represent a little, small part of New York State a little bit north of New York City in Westchester, Rockland, Orange, and Sullivan Counties. Regrettably we had over 90 families that lost their next of kin in the World Trade Center tragedy. And that is why this hearing is so important as we try to learn from the lessons of what occurred at that time. As New York continues to recover from the tragic events of 9/11, our Nation continues to go through the process of discerning what best we can learn from all of that experience. It is important we discuss the issue of emergency responses for our elderly and our disabled. I commend this Special Committee

on Aging, for moving forward so that we can put together some better thoughts for the future. Hopefully we won't have to need those preparations, but better to be prepared than not prepared.

Mr. Chairman, obviously emergency evacuation procedures need to be reconsidered. While no one before September 11 could have envisioned the massive brutal destruction or the speed in which it occurred, we have to recognize the special and unique challenges which exist for our elderly and our disabled. The World Trade Center Tower Number One and Number Two burned for 102 minutes and 56 minutes, respectively, before the top floors of each tower collapsed onto the lower floors. Even more incredible is the fact that 8 seconds later, the entire second tower collapsed, and in 10 seconds Tower One followed suit. That means that more than 50,000 individuals employed or visiting the towers had about an hour to walk down 104 smoke and debris-filled floors and hallways—no small task for any young person, relatively healthy individual, let alone someone either elderly or disabled.

All of us from the New York metropolitan area and across the nation are grateful for the heroism displayed by our firefighters, our police, our rescue people and emergency personnel. Those services were taxed to the maximum, the maximum extent possible, more than anyone could have ever imagined prior to 9/11. And while we need to proceed forward and determine our best to reconfigure current emergency preparedness plans, we should make certain that we pay careful attention to addressing this specific and different needs which exist for the elderly and disabled, and that is why I am so pleased to join Senator Craig today as we address this problem.

However, it is also important that we realize that 9/11, while unique in its once unthinkable occurrence, may not be the last of such events as our nation engages in our war on terrorism; and, as the President reminds us, this may not be the last event. Accordingly, at today's hearing we need to hear from the top City, State, and Federal officials on what we have learned from September 11 and what is being done to correct any lapses or inconsistencies which it may be found to exist with regard to emergency preparedness and evacuation.

In an emergency situation advanced planning, of course, is the key to safety and to piece of mind. This also rings true for those elderly and our disabled. Without the assistance of coworkers those individuals most often could be left behind. Decisions and now what must be done during such an event must be thoroughly reviewed to determine how best to meet those kind of emergencies prior to any event happening. This includes the obvious concerns that have come about in my own region recently, when it comes to nearby nuclear power plants. I am specifically referring to Indian Point, which is just up the river within a 30-mile range from here, Senator Craig.

Let me read you two brief quotes with regard to that problem. State and local governments are the first line of defense in the event of a serious nuclear power plant accident, and their ability to respond depends to some extent on the adequacy of guidance and training provided by FEMA—and I am pleased FEMA is here today—and other Federal agencies. Further, more can be done to

help state and local governments to respond effectively to a radiological emergency.

Now, those quotes were taken from a 1984 U.S. Controller General GAO report entitled Further Actions Needed to Improve Emergency Preparedness Around Nuclear Power Plants. Proper improvements to the emergency preparedness plan for any event can be made when those responsible for public safety at all levels of government effectively communicate with each other. And that is why it is so good, Senator Craig, to have all of these agencies represented here today. Hopefully this process will enhance our preparedness to these kind of emergencies.

So, in closing, permit me to again stress my sincere appreciation for all of the incredible heroism, the dedication displayed by all of those that were involved in this tragic event: Our firefighters, our police, our agency personnel, emergency personnel, rescue personnel, and our good Samaritans. And many of these true national heroes reside in my congressional district. I have a number of our police and firemen residing in my area, and many lost their lives regrettably on that faithful day. So I look forward along with Senator Craig to hear your testimony today and your good thoughts of what we can do to prepare for any future event. God willing, we will not have any such occurrence again. Thank you, Senator Craig.

[The prepared statement of Rep. Gilman follows:]

PREPARED STATEMENT OF REP. BENJAMIN A. GILMAN

I want to thank Senator Craig for the invitation to participate at today's hearing. As New York continues to recover from the tragic events of September 11, and our Nation continues to go through the process of discerning what can be learned from the experience, it is important that we discuss the issue of emergency responses for the elderly and disabled. I commend the Special Committee on Aging for proceeding forward today.

Mr. Chairman and Ranking Member, clearly emergency evacuation procedures need to be reconsidered. While, no one before September 11, could have envisioned such destruction or the speed in which it occurred; we must recognize the special and unique challenges which exist for those elderly and/or disabled.

World Trade Center tower number one and two burned for 102 minutes and 56 minutes respectively, before the top floors of each tower collapsed onto lower floors. Even more incredible, is the fact that eight seconds later the entire second tower collapsed and in ten seconds tower one followed suit. This means that more than 50,000 individuals employed or visiting the towers had approximately an hour to walk down 104 smoke and debris filled floors and hallways. No small task for a young, relatively healthy individual, let alone someone either elderly or disabled.

All of us from New York and across the Nation are grateful for the heroism displayed by our firefighters, police, rescue and emergency personnel. These services were taxed to the maximum extent possible—more than anyone could have ever imagined prior to September 11.

While we need to proceed forward and determine how best to reconfigure current emergency preparedness plans, we must be sure to pay careful attention to addressing the specific and differing needs which exist for the elderly and disabled.

However, it is also important that we realize that September 11, while unique in its once unthinkable occurrence, may not be the last such event, as our Nation engages in the war on terror.

Accordingly, at today's hearing we need to hear from top City and State officials on what has been learned since September 11 and what is being done to correct any lapses or inconsistencies, which may be found to exist with regard to emergency preparedness and evacuation.

In an emergency situation, advance planning is the key to safety and peace of mind. This statement also rings true for those elderly and/or disabled. Without the assistance of co-workers these individuals most often would be left behind. Decisions on how and what must be done during such an event must be planned and determine now prior to its happening.

In closing, I want to again stress my sincere appreciation for all of the incredible heroism displayed by our firefighters, police, emergency and rescue personnel. Many of these true national heroes reside in my congressional district and many lost there lives on that fateful day.

Thank you.

Senator CRAIG. Ben, thank you very much. Ms. Gilman, thank you for joining us today.

As far away as Idaho is, you would think that we were relatively untouched by it. It is simply not the case. Certainly we were touched emotionally, and Idahoans have responded in a variety of ways. But uniquely enough, we have a company that is homed in Idaho that was started in Idaho a long while ago who had a division that was housed in the World Trade Center and lost 13 employees, four of them native Idahoans. That is something that oftentimes we don't realize, but I think when we examine the magnitude of the loss of the Trade Center that occurred here, that it truly was a national situation, an incident, and I think the Congressman, as you know, and certainly with your efforts has tried to respond in that context.

Now, let us move around the table and hear from all of you. As you know, the Special Committee On Aging in the Senate is not an authorizing committee. In other words, we don't write legislation. We hold hearings and oversight on those issues that are of concern to the seniors and the elderly of our country, and then we make recommendations to other committees. Oftentimes Chairman Breaux or myself or members of our committee will actually testify before other committees about our findings. There are several committees in the Senate and the House that are unique in this way. We are largely an investigative oversight body. That is an uniqueness of the Special Committee.

So, with that, let me introduce our first person to testify with us today, Josefina Carbonell, the Assistant Secretary of Aging at HHS. Again, thank you so very much for being with us. We would like to ask all of you to stay within the 5 minute rule if you could, please.

STATEMENT OF JOSEFINA G. CARBONELL, ASSISTANT SECRETARY FOR AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. CARBONELL. Thank you, Mr. Chairman, and members of the committee. It is indeed a pleasure and an honor to discuss the Administration on Aging's perspective on emergency preparedness for the elderly and those within disabilities. We appreciate your leadership in convening this very important hearing.

Working in partnership with our national aging network, all the service providers that form part of this aging network, AOA is charged with providing essential home community-based care services to those elderly in most need, some of whom are frail and disabled. The Administration on Aging was at the forefront to serve this population on September 11 in New York City. We were joined by the Centers for Medicare and Medicaid Services and the New York Aging provider network to deliver critical services during this crisis. The emergency help line put into place by CMS and the Administration on Aging received thousands of calls from all over the country, many of which were from older persons and their care-

givers. I have submitted written testimony for the record, but I will confine my oral presentation again to the lessons we learned from September 11.

Mr. Chairman, I am committed to ensuring that the aging network and all of our providers through state, units on aging and the local area agencies on aging and aging providers are ready and better prepared for any future disaster. There are five needs to be addressed that I would like to address in this brief presentation. First, one of my priorities is to ensure that our states, our area agencies and tribal organizations have emergency and backup plans in place for natural or manmade disasters; that they have timetables for updating and revising these plans and that there also would be ongoing training programs to ensure the timeliness of the training and the implementation stages. The administration is currently updating our disaster assistance materials and plans to conduct training for all levels of the network at the state and local levels.

Second, there is the need for alternative and backup communications systems and that is paramount at all levels of government. Battery powered radios and other such devices need to be made available in the even of land line and cell phone failure, which was the case right here in New York. Third, up-to-date emergency contact information needs to be available on key aging officials with emergency protocols to follow.

Fourth, we must collect and maintain a special needs roster. This information should be shared with all partners in the different locations across the country and with our local emergency preparedness network.

Fifth, the aging network resources need to be coordinated and integrated with larger Federal, state, and local emergency management operations not only to avoid duplication, but most importantly, to ensure that the special needs of elders are incorporated into the overall community preparedness response action plans.

Every one who is involved in an emergency has to be sensitive to the fact that some older persons, especially those with disabilities, may become disoriented, may take longer to evacuate, may need special equipment or may depend on others to help them.

I want to also call to your attention the need for mental health counseling. These services provide individuals impacted by disasters with an opportunity to react to and talk about what they have experienced. For older persons their day-to-day existence is often fragile, meaning that even the most modest changes may trigger a series of events that threaten or even destroy their ability to continue independently. For example, this happened right here in Chinatown at the City Hall Senior Center.

We have learned much from the September 11 event, especially that we cannot predict the future. We can, however, be better prepared. The commitment of Secretary Thompson to help our seniors and their families was put to the test of September 11. HHS is one department that exemplifies the capacity of all agencies to provide critical assistance during crisis. I applaud the dedication of so many of our Federal partners, such as the CDC, FEMA, CMS and others who have answered the call that day and in the weeks and months that followed. We are particularly humbled by the heroic

work of the New York Aging Service Provider Network including Igal Jellinek, who you will hear from later. I want to thank you for calling today's hearing. As responsible public officials we must do everything in our power to help our communities be better prepared.

Most areas around the country have emergency plans in place, and it is critical that these plans cover the needs of the elderly. Mr. Chairman, I salute your commitment to our nation's older Americans and their characters and I would be happy to respond to any questions.

[The prepared statement of Ms. Carbonell follows:]

Statement of

Josefina G. Carbonell

Assistant Secretary for Aging

U.S. Department of Health and Human Services

Before the

Special Committee on Aging

United States Senate

Field Hearing

New York City, New York

February 11, 2002

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to discuss the Administration on Aging's (AoA) perspectives on emergency preparedness for the elderly and those with disabilities. We appreciate your leadership in convening this hearing on responding to the needs of at-risk populations during and following a local or national state of emergency.

Mr. Chairman, the past six months have been emotional ones for all of us. Being in New York City today -- so close to one of the worst human tragedies in American history -- brings once again into focus all the vivid pictures that many Americans only watched in horror from their living room televisions.

We have learned many lessons from September 11. First and foremost, we have proven again that Americans are the most patriotic and resilient people in the world. Second, we have learned that we are not immune to terrorist attacks, and we must do all we can to support the President's efforts to protect the freedom we enjoy as Americans. Third, we have learned that we must be better prepared to deal with the possibility of future attacks on our way of life or other such disasters that impact our citizens and our families.

The Administration on Aging is charged with providing essential home and community-based services to those most in need – older persons, those who are frail and who have disabilities, as well as their caregivers. Through the Older Americans Act, the AoA works in partnership with

our national aging network of State and area agencies on aging, tribal organizations, service providers and hundreds of thousands of family caregivers and volunteers. AoA's programs touch people's lives where they live – in their homes and communities. We provide meals in senior centers, and to those who are homebound. We also provide transportation to and from medical appointments or perhaps shopping or pharmacies as well as preventive health services, such as screening for diabetes, and many other important supportive services that enable older citizens to remain at home. Thanks to your leadership, we are also able to provide assistance for the first time to family caregivers who struggle on a daily basis to care for their older loved ones.

Today, there are approximately 45.7 million people 60 years of age or older. Many of these individuals have chronic health problems, and many are homebound. These individuals are dependent upon community service systems for their day-to-day existence. And that number is growing. Estimates show that by 2003, there will be 4.7 million frail, elderly persons – 85 and older – which indicates that the need for services for the aging population will only increase with time. In an emergency, these individuals represent the most vulnerable sector of our population.

Perspectives on What We Have Learned from September 11.

The events in New York, Pennsylvania and at the Pentagon on September 11 heightened our awareness of the importance of good communication. As we all now know, communication was one of the most critical challenges experienced in the hours and days following the attacks. It was difficult assessing what areas were safe and how to communicate with others to plan the next steps to protect ourselves or those we are entrusted to serve. Telephone service, something

we all take for granted, was not available. You will remember that in Washington, D.C. communication was impaired due to system overloads. Here in New York this was further compounded by power outages, especially in the areas surrounding the World Trade Center. The fact that we did not have an alternative communication system made it very difficult for us to determine the immediate needs of our seniors.

Immediately after the attacks, I was in touch with the New York State Office on Aging to assess the situation. Because the New York City Department for the Aging had lost phone service, this was a challenge. As was the case with many of my colleagues, staff were impacted due to the proximity of our offices to the World Trade Center. Upon evacuation of 26 Federal Plaza in the hours after the attack, our Regional Administrator first ensured that all staff were evacuated safely. Later, offices were reopened in temporary quarters in New York City in order to continue to serve our customers. Then, only by using a handheld personal pager system with satellite linkages was he able to communicate with us in Washington during the first few hours and days following the attacks. This connection was incredibly valuable until emergency phone systems and other communications could be arranged. Portable cell phones, battery radios, and laptop computers were essential in the early days following the attacks.

Our heavy reliance on computer data systems, which hold client data about hard-to-reach older persons who rely on our services, was also at risk. Some of the material could not be retrieved and concerns were raised about confidentiality and information security. Just as we did after Hurricane Andrew in South Florida, our network had to find out who needed help the old-

fashioned way – through neighborhood teams who went door to door identifying the needs of those who were homebound. Sometimes extraordinary events call for extraordinary measures.

Many elderly people were stranded in their apartments. Others were either physically unable or afraid to leave their own residences. For example, the work of the Visiting Nurse Service of New York (VNS) was invaluable, as we will hear later in today's hearing. Following September 11, VNS was tasked with locating and assisting their frail and isolated homebound clients confined in the areas around the World Trade Center. Individuals were cut off from their doctors, grocers, and pharmacies. AoA was proud to work in partnership with the Centers for Medicare and Medicaid Services (CMS) to assist the VNS in their efforts to reach those in need of food and water. AoA worked with the New York State Office on Aging and the New York City Department for the Aging to help facilitate access for the VNS.

AoA also joined with the Centers for Medicare and Medicaid Services in the establishment of a 24-hour, rapid response, multilingual hotline for older New Yorkers living in lower Manhattan. This allowed seniors to quickly access help in filling prescriptions, receiving personal services, therapies, transportation to health care professionals, or other important dailyliving needs. In addition, the New York aging network was able to establish a telephone system staffed by older, visually impaired adults who provided information and assistance to other visually impaired, older New Yorkers. In response to the need for continued, seamless availability of Medicare and Medicaid services, CMS ensured that medical and benefit payments flowed despite dislocation of

staff and/or the destruction of offices and systems and coordinated certain emergency help for New York City below the 14th Street disaster area.

For some, reliable caregiving systems completely disintegrated as a result of family and friends who were affected by the event. In Washington, D, C, a caregiver dropped his mother off at an adult day care center on his way to work at the Pentagon and never returned. I am deeply grateful that funds from our National Family Caregiver Support Program were able to provide the family with one week of respite for the mother at a group home so they could attend to the funeral of her son. We know that there must be many similar stories here in New York.

Mr. Chairman, the importance of providing funding as quickly as possible to aid in recovery and relief efforts for older persons is paramount during these types of situations. The Administration on Aging was able to immediately provide almost $1.8 million in emergency funding to the State of New York following the September 11 attacks. These funds were provided to ensure that services would continue to be provided to those who needed them the most. Additionally, we were able to provide $25,000 to Virginia to assist seniors and caregivers who were impacted by the Pentagon attack.

Recommendations for Emergency Preparedness Plans - Where Do We Go From Here?

In the mid-1990's, AoA developed detailed technical assistance materials and provided training to key persons in the aging network in the event of a disaster. As a result of the events of September 11, we are currently in the process of updating these materials and plan to conduct

more intensive training. One of my priorities is to ensure that our State and area agencies and tribal organizations have emergency and back-up plans for natural or man-made disasters in place, timetables for updating and revising plans, and training programs on an ongoing and regular basis. It is important too for plans at all levels to be available for use on short notice when the unexpected occurs. In addition to these plans, I recommend the following:

- First, as I have stated, the need for alternative and back up communication systems is paramount at all levels of government. Battery-powered radios and other such devices need to be made available in the event of land line and cell phone failure;
- Second, up-to-date information needs to be available about who and how to contact key aging officials when a disaster occurs and how to reach these individuals after hours and on weekends. State agencies need to have contacts for all of the area agencies which, in turn, need contacts for each service provider. Consistent emergency protocols must be available;
- Third, up-to-date knowledge about who needs special assistance should be readily available. For example, information about clients is currently kept almost entirely at the community level and is likely to be inaccessible in or immediately following a disaster, which hampers the network and others' ability to locate seniors who may need immediate assistance or have special needs. We should develop a special needs client data base accessible to States, area agencies on aging and network providers. The aging network must develop a strong working partnership with State and local emergency management agencies to make sure that the names of frail and at-risk older persons are on their list of individuals with special needs. In times of disasters, elders with special needs, such as

those who have disabilities, those who are electricity-dependent – on ventilators or oxygen, those with limited ability to speak English, and those who are afraid must have their needs immediately addressed.

- Fourth, aging network resources need to be coordinated and integrated with and among larger Federal, State, and local emergency management operations so as to avoid duplication of efforts, and most importantly, to ensure that the special needs of elders are incorporated into overall community preparedness response action plans. We will be working with the State and area agencies on aging to determine how the current program can be shape to respond to these new challenges.

Additionally, it is important for everyone who is involved in an emergency to be sensitive to the fact that some older persons and individuals with disabilities may become disoriented, may take longer to evacuate, may need special equipment or may depend on others to help them evacuate.

Mr. Chairman, I also want to call to your attention the need for mental health counseling to provide individuals impacted by disasters an opportunity to react to and talk about what they have experienced. Shortly following September 11, the Department of Health and Human Services held a Mental Health and Substance Abuse Summit here in New York City. While it did not address concerns specific to the elderly, it did raise some key points that warrant attention. We know the elderly experience the same grief, anger, fear and sense of loss as others, but the disruption to their daily routine can be overwhelming. For younger persons, the possibility of recovering to a point they experienced before the disaster has greater probability.

For older persons, their losses are more likely to be permanent losses, be it their home, possessions, their caregivers, or other important aspects of their daily life.

The most important item to note in terms of post-traumatic recovery is that for older persons, their day-to-day existence is often more fragile; meaning that even the most modest changes such as a neighbor moving or a meal site closing, such as was experienced in Chinatown at the City Hall Senior Center, may trigger a series of events that threaten or even destroy their ability to continue independent living. The need to make new living arrangements is much more complicated, and the ability to recover from various losses can be very difficult. We cannot let these frail individuals live in isolation or in fear. We must do our best to provide continuity and normalcy to their already fragile existence.

Preparing our workforce to respond

If we have learned anything from September 11, it is that we cannot predict the future. We can, however, be better prepared. As an agency, and certainly within the Department, we are now taking action to update our own disaster assistance and training efforts rather than talking about it as a "future" event.

One of the first steps we took was to update our employee roster for both central and regional office staff with more detailed information about ways to contact staff and their families. We implemented some back-up communication arrangements with hand-held communication and other portable devices.

A second step was to greatly tighten up our in-house emergency plans. These events have heightened our awareness for the need to educate our staff and to improve employee evacuation and safety concerns. We have had training sessions on fire safety and CPR. More training is planned.

Finally, in order to better prepare our own network to address unexpected disasters, such as bio-terrorism, the Administration on Aging is revising our Disaster Preparedness Training Manual utilizing the experience gained from this incident and other disasters. We are working with States, area agencies on aging and local communities to use this material to train staff at all levels for the development of preparedness plans. In these uncertain times, everyone should know what to do if a disaster occurs.

In closing, we are very proud of the continued commitment of Secretary Thompson to help our seniors and their families. His philosophy that the Department of Health and Human Services is "one department" increased the capacity of all agencies to provide much needed assistance during this crisis. We applaud the dedication of so many of our Federal partners, such as the Centers for Disease Control and Prevention, the Federal Emergency Management Agency and others who answered the call that day and in the weeks and months to follow. And again, we are very proud of the heroic work of the New York aging network. I would like to give special acknowledgment to Igal Jellinek, the Executive Director of the Council on Senior Centers and Services of New York, which has focused much of its energy on emergency preparedness at the local level.

I want to again commend you for calling today's hearing. As responsible public officials, we must do everything in our power to help our communities to be prepared. Most areas around the country have emergency plans in place. However, I cannot speak with confidence that these plans cover all the needs of the elderly. Today's hearing is a very important step. Mr. Chairman, thank you for this opportunity and for your continued concern for our nation's older Americans and their caregivers. I would be happy to respond to any questions.

Senator CRAIG. Thank you very much, Josefina. In a little while you are going to be hearing from Marion Anello.

Ms. CARBONELL. Yes.

Senator CRAIG. Marion is one of those seniors who found herself evacuated into an area that was somewhat ill prepared to respond to her needs. So, following her testimony I want to come back to you and get not only your reaction, but some of the thoughts that you may have about those kinds of circumstances.

Now let me turn to David Paulison, U.S. Fire Administrator FEMA—that's the Federal Emergency Management Agency. FEMA is well-known around the country and has developed really a first class reputation in the last good number of years for its ability to respond quickly and with a level of preparedness that is a product of many years of refinement. I am not going to suggest you do it perfectly yet, David. It means that you are supposed to, though. With that, let us turn to your testimony and thanks for being here.

STATEMENT OF R. DAVID PAULISON, U.S. FIRE ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY

Mr. PAULISON. Thank you, Senator Craig, and I appreciate the fact you recognize that we are still working on making it better. Also, Representative Gilman, I appreciate having both sides of the Congress here.

I am also pleased to be here representing Joe Allbaugh, the FEMA Director. He had previous commitments and could not be here, but he reminds us on a regular basis that FEMA should be about people helping people, and as a U.S. Fire Administrator, I share the Director's commitment to the well-being of disabled and our senior citizens.

Just a little background, I had 30 years of fire service experience. I was also in my early years as a firefighter and a paramedic.

Senator CRAIG. We need to have you pull it a little closer and speak into it so our court reporter can hear you.

Mr. PAULISON. As a young firefighter and paramedic, I worked mainly in an area with many elderly. I learned some of the needs that are there and to love the people that I worked with during that time. I have also handled several major incidents, particularly Hurricane Andrew, the Valujet crash several large evacuations of elderly people during hurricanes, and I will talk about those a little bit later.

The United States Fire Administration worked closely with other branches of FEMA to understand, prepare for, respond to and recover from all hazards with an eye toward loss of property and loss of life. We lose 4,000 people a year to fire in this country and 1,200 of those people are over 65, so the United States Fire Administration has set a goal to reduce that by 25 percent over the next few years. Just as a side note, we also lose one firefighter every third day in this country, which is totally unacceptable.

My testimony will focus mainly on what FEMA has achieved, what actions we are currently undertaking, and what FEMA intends to do in the future. The efforts by FEMA in this area was originally spearheaded by FEMA's national community relations cadres. The cadres were assigned the responsibility to locate and assist special needs population in disaster areas. Over the years,

FEMA has taken a number of steps in this area, and let me briefly cover a couple of those.

Since 1997 the disaster, field offices have included a special needs section to provide further aid. FEMA's national community relations operation in the New York disaster area made an intense effort to locate and assist special need populations. It is essential to provide this function. The agency hired a local person knowledgeable not only about emergency management and the disabled community. FEMA, in concert with New York City, ensured that the Disaster Assistance Service Center would be accessible to seniors and the disabled.

We also prepared a special brochure for all service center employees informing them of their responsibility to assist those with special needs. It is important to remember that part of dealing with this issue is education internally so that people who are handling the disaster understand the needs of the elderly and the disabled.

Right now we are developing another manual to aid first responders in dealing with disabled persons. In Miami Dade County, we put together a group called Elder Links, where we train firefighters and paramedics and EMTs to recognize when they go on calls of elderly people who are either abused or neglected, and we have 24-hour call-in line. As soon as they got back in the station, they called in the names and addresses of those people. The next day, the next day we got those people help and got the right agencies there. I think that is a model program that should spread across this country, and it is easy to put together through the local fire departments.

There is an emergency management education network; FEMA has sponsored several video conferences on this subject over the years to get the word out that the local emergency managers and local fire departments have to be very responsive in recognizing the needs of the elderly in their communities.

FEMA has also developed an innovative course that introduces service providers to emergency management and emergency management to the special needs population. Protecting the disabled and elderly persons from disaster is a major responsibility of the emergency management community, and that includes FEMA; but that responsibility is shared with others, with relief organizations like the American Red Cross, with fire and EMS services, with state and local governments, and with the media. We found a long time ago that we used the media as the main form of communications during our hurricane disasters. We hold four or five press conferences a day, and we tell the public exactly what we expect of them and what they need to do to prepare for these emergencies.

Warning systems need to include provisions for people who are deaf and hard of hearing. Televisions stations must live up to the FCC mandate to provide emergency information in caption form and first responders they must become familiar with how to deal with the special needs of this population, and that involves training and education for our first responders.

Building evacuation plans must include provisions for warning to deaf persons and special evacuation devices to assist mobilely impaired persons, You can't simply tell people that shelters are open.

You have to provide services for them. In Miami Dade County we do a bus transit system—and not just regular buses, buses that can handle people with disabilities and handle people in wheelchairs and often sometimes people who are bedridden. That is what every community must prepare for.

One final point every member of the adult community or disabled community must learn as much as possible what is required of them to survive in a disaster. The disability rights movement has stressed the dignity and independence of the individual as its goal. It is consistent with that philosophy that each disabled person, to the extent possible, assures responsibility for his or her own safety. So, together in a partnership with the local fire department, the state agencies and other local communities and the individuals themselves we can develop a plan to help elderly survive these disasters. Thank you, Commissioner.

Senator CRAIG. David, thank you very much. You have someone with you?

Mr. PAULISON. Yes. This is Marko Bourne from the Fire Administration also.

Senator CRAIG. Thank you. Thanks for joining us.

Mr. PAULISON. Thank you for your time.

Senator CRAIG. Now, let me turn to Dr. Stephen Ostroff, Center for Disease Control and Prevention, better known as CDC to most of us at least. Doctor, we thank you very much for being here. Please proceed.

STATEMENT OF STEPHEN OSTROFF, M.D., ASSOCIATE DIRECTOR FOR EPIDEMIOLOGIC SCIENCE, NATIONAL CENTER FOR INFECTIOUS DISEASES, CENTERS FOR DISEASE CONTROL AND PREVENTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. OSTROFF. Thank you, Mr. Chairman, and Representative Gilman. Like all other Americans, we at CDC were horrified and saddened by the events which took place in New York last fall. As the Nation's disease control and prevention agency, however, we were also immediately galvanized to action to provide assistance to our partners in the City and State of New York and in D.C.

During the bioterrorism-associated anthrax attacks last fall, I was the lead field investigator of the CDC team sent to New York City to assist the public health in emergency response, so I had firsthand knowledge of the tremendous effort which took place then and continues to take place to recover from the events of last fall. In my oral comments I will provide a brief overview of CDC's activities related to September 11, but focus more on the subsequent anthrax attacks and how we worked to better prepare our Nation's states and cities for the threat of terrorism from biological agents while assuring that we meet the needs of particularly vulnerable populations such as the elderly and disabled.

Within hours of the September 11 attacks, CDC deployed teams of responders to New York City to assist in monitoring the impact of the event and deployed assets of the national pharmaceutical stockpile to assure essential medical supplies and drugs would be available. By the end of that first week we had more than 70 personnel engaged in a range of activities including monitoring and

documenting the patterns of illness and injuries in victims and relief workers measuring hazardous exposures at the World Trade Center site and recommending ways to protect rescue and cleanup workers.

We also assisted the City Health Department in maintaining their high state of alert for other types of events. These activities were ongoing when anthrax was first recognized in Florida on October 4th and then here in New York City the following week. In response we augmented our onsite presence to assist in investigating the sources of infection and populations at risk and in providing antibiotic prophylaxis to thousands of affected persons at the various media outlets and postal facilities. Accomplishing these tasks against the backdrop of September 11 was an example of Federal-state-local corporation at its best and a credit to the diligence of our colleagues here in New York City.

Overall there were a total of 22 cases of anthrax with 11 being the cutaneous or skin variety and 11 being the inhalational form. In New York City there were seven cutaneous cases and one inhalation case, with the latter being the only fatality. It is worth noting that the inhalation cases were on average significantly older than the cutaneous cases. This finding was noted even before the last case was detected in a 94-year-old resident of Connecticut. Since we have little historical data on which to base our epidemiologic information, we don't know if this difference really has a biological basis or is simply a reflection of age difference in work forces in the various locations.

At the peak of the anthrax response we had more than 200 personnel in the field assisting state and local partners and hundreds more personnel at headquarters assisting the effort. While we deeply regret each illness that occurred, we are very encouraged by the fact that none of the approximately 10,000 persons who were given antibiotic prophylaxis developed anthrax, despite significant exposure to spores in many locations.

Last fall's events revealed serious gaps in our nation's public health defenses against biological and chemical threats. These include inadequate epidemiologic and laboratory search capability and insufficient knowledge base concerning sampling and remediation and lack of information concerning infectious dose and post susceptibility.

In addition, the public health system needs to improve its ability to convey information and provide treatment and preventive measures to large numbers of persons and a way of assuring compliance. This will require extensive preparedness planning, cooperation across agencies, and between Federal, state and local counterparts.

All states and localities must be prepared to address these threats and mount an effective response. This is as true for New York City as it is for rural Idaho, although clearly the needs and solutions will be different.

In late January Secretary Thompson announced that a total of $1.1 billion in funding would be provided to states and large cities to assist them in their bioterrorism preparedness efforts. Here in New York the state will receive $29.4 million in funds and the city $22.8 million in funds from CDC.

Agents such as anthrax, smallpox, and botulism are prime bioterrorism threats because of their extreme virulence and ease of dissemination. If used, they would likely affect all segments of the population. However, there are certain special challenges for the elderly and disabled. One relates to the drugs and vaccines used to treat and prevent these diseases. Many have side effects such as dizziness and nausea which make them particularly difficult to use for prolonged periods in older persons. In addition, these persons are more likely to be taking drugs which have known or unrecognized interactions with our recommended therapies. These factors must be taken into consideration as our state and local partners move forward with their preparedness planning so that we can assure that we can properly care for and protect our most vulnerable populations.

Additional research is also necessary to understand infectious dose of agents such as anthrax and whether it is lower in older individuals than in other age groups.

In conclusion, CDC is committed to working with other Federal agencies and partners, state and local health departments, and the health care community to ensure the health and medical care of all of our citizens from terrorist threats. Although we have made substantial progress in enhancing the nation's ability to prepare for and respond to a bioterrorist attack, the events of last fall demonstrate that we must accelerate the pace of our efforts. Thank you very much.

[The prepared statement of Dr. Ostroff follows:]

Testimony
Before the Special Committee on Aging
United States Senate

The CDC and Emergency Preparedness for the Elderly and Disabled

Statement of
Stephen Ostroff, M.D.
Associate Director for Epidemiologic Science
National Center for Infectious Diseases
Centers for Disease Control and Prevention
Department of Health and Human Services

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Good afternoon, Mr. Chairman and Members of the Committee. I am Dr. Stephen Ostroff, Associate Director for Epidemiologic Science in the National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC). During the bioterrorism-associated anthrax attacks last fall, I was the lead investigator of the CDC team sent to New York City to assist the City's public health and emergency response officials. I have also worked closely with New York City officials over the years to address other emerging infectious disease threats, particularly West Nile virus which made its first North American appearance here in 1999. Let me thank you for the invitation to participate in today's hearing on emergency preparedness for the elderly and disabled and for the ongoing interest of the Committee in this issue. Today I will be discussing CDC's public health response to the threat of terrorism, particularly that associated with biological agents, and how we are working with our state and local partners to strengthen the nation's capacity to address these threats and improve our response in the future.

Let me begin by providing a brief overview of CDC's activities related to September 11th and the subsequent anthrax attacks. Within hours of the September 11th attacks, CDC deployed teams of responders to New York City to assist in monitoring the impact of the event and deployed assets of the National Pharmaceutical Stockpile to assure availability of essential medical supplies and drugs. Within 4 hours of the first plane attack, CDC sent a Health Alert Network message to all 50 states, 4 cities and 1 territory advising the nation's public health system to heighten surveillance. By the end of that week, CDC had on-site more than 70 personnel engaged in a range of activities, in particular, monitoring the patterns of injury and illness in victims and relief workers; measuring hazardous exposures at the WTC site and recommending strategies to protect rescue and cleanup workers; and maintaining a heightened state of alert for other events, particularly of a biological or chemical nature. These activities were still ongoing when anthrax was recognized in New York City on October 12th, and CDC augmented its onsite presence to assist in investigating the sources of infection, assessing workplace contamination, enhancing

laboratory diagnostic capability, and providing antibiotic chemoprophylaxis to thousands of affected individuals at the various media outlets and postal facilities.

The episode of bioterrorism-related anthrax was the first instance of the intentional use of this agent in U.S. history. Overall, there were a total of 22 cases of anthrax in Florida, Washington DC, New Jersey, New York, and Connecticut, with five fatalities. Eleven of the cases were the cutaneous (or skin) form of anthrax, while the remaining eleven were the inhalational form of the disease, which has traditionally been associated with mortality rates in excess of 80%. In New York City, there was a total of eight anthrax cases, seven cutaneous and one inhalational, with one fatality. Among all 22 cases, the mean age of patients was 46.6 years, with a range of 7 months to 94 years. However, it was observed that persons with inhalational disease were significantly older (mean age 60.3 years) than persons with cutaneous disease (mean age 32.9 years). Since there is little previous experience with the intentional use of anthrax, we do not know if this age differential is a usual feature of anthrax. For some diseases such as West Nile virus, older individuals are at higher risk of developing severe disease if infected. However, in the recent anthrax events, it may simply reflect the fact that the workers who handled the letters in New York City were somewhat younger than the postal workers who processed them in other locations. Of note, two of the five fatalities occurred in persons over the age of 70 years.

The response to the anthrax episodes was rapid, intense, and comprehensive. During the peak phase of the investigation, CDC had more than 200 persons in the field in the various locations, with hundreds of additional personnel in our home offices supporting the field effort, handling thousands of public and media inquiries, disseminating information, and processing many thousands of clinical and environmental specimens. Over 1.4 million individual participants were recipients of distance learning broadcasts originating from CDC via satellite broadcasts and web streamed video. The Epidemic Information Exchange (*Epi-X*)—public health's established,

secure communications network—provided local CDC investigative teams, state epidemiologists and other public health officials a forum for posting and discussing new and evolving information, as well as for receiving information from CDC. The urgent notification feature was used to alert state epidemiologists by pager and phone of the report of the first anthrax case in New York City, and over 90 other reports were posted and local response plans were distributed. It has been estimated that approximately 25% of CDC's workforce was involved in some aspect of the anthrax response. Similar efforts occurred on the part of public health agencies in the directly involved states, and in the less involved regions as well. All states and localities were called upon to respond to public concerns about the events, and state public health laboratories throughout the country were overwhelmed with samples for anthrax testing, all requiring rapid turnaround and handling as part of a potential criminal investigation.

In all sites combined, approximately 10,000 persons were recommended by public health authorities to receive 60 days of antibiotic prophylaxis as a result of their exposure to anthrax spores. The incidence of adverse reactions among these persons was similar to those previously reported for the antibiotics which were offered. Among those persons offered prophylaxis, none developed either inhalational or cutaneous anthrax once the antibiotics were started.

The events of September 11th and the anthrax episodes demonstrate the critical need for a strong and flexible public health system which can effectively respond to bioterrorism as well as to the numerous naturally-occurring public health threats that affect U.S. citizens every day. This system needs to be able to smoothly integrate its activities with a variety of emergency response and law enforcement partners and the health care community, and it needs to seamlessly operate at the federal, state, and local levels.

Congress first allocated funds to CDC to begin to address the need to build state and local

capacity to address the threat of bioterrorism in 1999. CDC's program for bioterrorism preparedness and response has focused on the following areas:

- Planning for emergency preparedness
- Development of epidemiologic capacity and monitoring systems
- Development of capacity to rapidly and accurately identify biological agents
- Development of capacity to rapidly and accurately identify chemical agents
- Development of standards for respiratory protection for responders to biological, chemical, and radiation hazards resulting from acts of terrorism
- Development and enhancement of communications systems to allow public health officials to share critical and timely information through the Health Alert Network, distance learning, and *Epi-X*
- Development of the National Pharmaceutical Stockpile
- Regulation of the shipment of selected biological agents and toxins

Even before the events of last fall, CDC had in place cooperative agreements with all state health departments, as well as many large local health departments, to build capacity in some or all of the program areas just mentioned.

Some of CDC's accomplishments during this period include the development and deployment throughout the country of 12-hour push packs of essential medical supplies and drugs to be used in the immediate aftermath of an event; development of the Laboratory Response Network that includes approximately 90 state and local public health laboratory facilities around the country which use standardized testing procedures and reagents to identify threat agents such as anthrax, plague, tularemia, and botulism; and deployment of syndromic surveillance systems at high profile events to assure rapid recognition of biological or chemical terrorism; and release of the

first standard for first responders' respiratory protection against weapons of terrorism.

However, the events of last fall demonstrate that we must move much more rapidly to expand our capacity in all of these areas. We must assure that all states and localities are adequately prepared to address biological threats to their populations and can mount an effective response. In late January, HHS announced that a total of $1.1 billion in funding would be provided to states to assist them in their bioterrorism preparedness efforts. On January 31st, Secretary Thompson sent a letter to the governor in each state detailing how much of the $1.1 billion his or her state would receive to allow them to initiate and expand planning and building of the public health systems necessary to respond. The funds will be made available through cooperative agreements with State health departments, to be awarded by CDC and the Health Resources and Services Administration, and through contracts awarded by the Office of Emergency Preparedness with cities for the Metropolitan Medical Response System Initiative.

The funds are to be used for development of comprehensive bioterrorism preparedness and public health emergency response capabilities; upgrading infectious disease surveillance and investigation; enhancing the readiness of hospital systems to deal with large numbers of casualties; expanding public health laboratory and communications capacities; education and training for public health personnel, including clinicians, hospitals, and other critical public health responders; and improving connectivity between hospitals and local, city, and state health departments to enhance disease reporting. The State of New York will receive $29.4 million in funds and the City of New York $22.8 million in funds from CDC.

Biological agents such as anthrax, smallpox, and botulism are considered bioterrorism threats because of their extreme virulence and relative ease of dissemination. Should they be used, they would likely affect all segments of the population, including children, healthy young adults, and

older people, with substantial morbidity and mortality in all groups. However, there are certain challenges for older Americans related to bioterrorism. One relates to the drugs and vaccines used to treat and prevent these diseases. Many have side effects, such as dizziness or nausea, which make them particularly difficult to use for prolonged periods in older persons. In addition, older people are more likely than other groups to be taking other medications, some of which might have known or unrecognized drug interactions with recommended antibiotics. The FDA approved "Indication and Usage" of the licensed Anthrax Vaccine Adsorbed is for use in persons between 18 and 65 years of age.

Additional research is necessary to better understand the infectious dose of agents such as anthrax and whether the amount of exposure necessary for development of disease could be lower in older individuals than other age groups. This issue arose with respect to the potential risk posed by low numbers of spores which could be present in cross-contaminated mail. Even recognizing that any such risk was small given the large volume of mail in this country, CDC issued prudent guidelines for persons who wished to further reduce their risk of exposure to contaminated mail.

At the NIH, the National Institute of Allergy and Infectious Diseases (NIAID) leads the effort to develop new and improved vaccines. As part of its smallpox dilution study, the NIAID will soon undertake a study to examine the effect of re-vaccinating individuals who were previously vaccines 30-plus years ago to determine the spectrum of reactions and safety. This study will be open to anyone over age 35 who has evidence of prior vaccination. The NIAID also plans to engage in studies of "next generation" smallpox vaccines that can be used in all segments of the population, including the elderly.

In addition to older people, another group of citizens should be given consideration in developing

bioterrorism and emergency preparedness plans. This group are our citizens with disabilities and functional limitations. As with older people, some will have increased susceptibility due to compromised immune systems or poor health status. Many will also be on medications and thus drug interactions could be an issue.

In developing emergency preparedness plans, it is just as important to remember to address some general issues that impact older Americans and those with disabilities regardless of the type of emergency: natural, bioterrorism, chemical, nuclear, etc. These issues include but are not limited to:

- Older people and people with disabilities often need more time than others to make necessary preparations in an emergency.
- Emergency and disaster warning must be given in a variety of formats to reach people with vision and hearing impairments, including closed captioning, audio alerts, and additional visual cues. These warning mechanisms assist everyone in an evacuation, not just people with disabilities.
- People who are blind or visually-impaired, especially older people, may be extremely reluctant to leave familiar surroundings when the request for evacuation comes from a stranger.
- Although a well trained, guide dog and other assistance animals can become confused or disoriented in a disaster, people who are blind or partially sighted may have to depend on others to lead them, as well as their dog, to safety during a disaster.
- People with impaired mobility are often concerned about being dropped when being lifted or carried. Preparedness must include learning proper techniques to transfer or move someone in a wheelchair and what exit routes from buildings are best. If a person is separated from his or her mobility device during the

evacuation, plans for recovering the mobility device or moving that person once outside the danger area must be considered.

- Some people with mental retardation, or people who are cognitively impaired, may be unable to understand the emergency and could become disoriented or confused about the proper way to react. Emergency warnings may need to be modified to permit the individual with cognitive impairments to better understand and respond to the warning
- Many respiratory illnesses can be aggravated by stress. In an emergency, oxygen and respiratory equipment may not be readily available.
- People with epilepsy, paralysis, Parkinson's disease, end stage renal disease and other conditions and impairments often have very individualized medication or treatment regimes that cannot be interrupted without serious consequences. Some may be unable to communicate this information in an emergency.
- Care should be taken to ensure that temporary shelters are accessible and have alternate communication services available for people with visual and hearing impairments.

In conclusion, CDC is committed to working with other federal agencies and partners, state and local health departments, and the health care community, to ensure the health and medical care of our citizens. Although we have made substantial progress in enhancing the nation's capability to prepare for and respond to a bioterrorist episode, the events of last fall demonstrate that we must accelerate the pace of our efforts to assure an adequate response capacity. The best public health strategy to protect the health of civilians against biological terrorism is the development, organization, and enhancement of public health prevention systems and tools. Priorities include a strengthened public health laboratory capacity, increased surveillance and outbreak investigation capacity, and better health communications, education, and training at local, state,

and federal levels. Not only will this approach ensure that we are prepared for deliberate bioterrorist threats, it will also ensure that we will be able to recognize and control naturally occurring new and re-emerging infectious disease threats. A strong and flexible public health system is the best defense against any disease outbreak or public health emergency.

Once again, let me thank you for the opportunity to be here today and to assist the citizens of New York City last fall and in the future. We look forward to working with you to address the health and security threats of the 21st century.

At this time, I will be happy to answer any questions you may have.

Senator CRAIG. Doctor, thank you very much for that testimony.

Now, let me move to Assistant Chief of Fire Prevention. Alexander, I work really hard at damaging names. Pronounce your last name for me.

Mr. PARZYCH. Parzych.

Senator CRAIG. Parzych. Fine enough. Thank you for joining us.

Mr. PARZYCH. Thank you for having me.

Senator CRAIG. Please proceed.

You will hold for just a moment.

Please proceed.

STATEMENT OF ALEXANDER PARZYCH, ASSISTANT CHIEF OF FIRE PREVENTION

Mr. PARZYCH. I would like to thank the committee to have the fire department to have a chance to say something at it. I am reading a statement from our Fire Department New York City.

Although disabled rights, laws and increased community awareness have removed some barriers to everyday life for senior citizens and people with disabilities, barriers still exist. They present an even more significant challenge during emergency conditions. September 11, once again, raises our awareness of the challenges presented to both the disabled and those challenges to assist them in an emergency. In addition to these physical barriers such as flights of stairs, change of level, no use of elevators, barriers to the acquisition of information also exist. Communication that is audible, such as TV and radio is not available to people who are deaf or hard of hearing, people who have low vision or all blind cannot get information from print media or the web site. People who have learning disabilities or developmental disability often cannot understand information when it is presented rapidly.

As we review our emergency plans, we must ensure that to the fullest extent possible the needs of the disabled are considered. This includes but is not limited to: One, we must do our best to remove physical barriers. Future designs should be universal, including everything from web sites to transportation systems to escape routes. Two, do not separate the disabled from the plans, but determine how they can be included in the planning process, assuring that different disabilities are included in all emergency plans and that these plans are practiced, practiced, and practiced again. Public education can raise awareness. An example of an improved procedure would have the building fire safety warden and floor searches coordinate with a designated point of contact for each organization located in a building such as the personnel department to develop a plan along with the Fire Department to both locate and evacuate people with disabilities in emergencies.

This plan may be tailored to the person's disability and effectively communicated to them. Such a plan would have to be updated on a regular basis to keep up with the changes in personnel, work status awareness, and new rescue technology. The New York City Fire Department is working with the public-private sectors to enhance its ability to serve all members of society. We must be responsible to our ever changing world and the new threats that the world may bring.

Senator CRAIG. Thank you so much for that testimony. You are one now of several panelists who we are especially wanting to hear from because you were all here and had to deal with the circumstances of September 11 on a daily basis, Alexander, as you know and as you are obviously telling us with some of your experiences.

Now, let me turn to the Director of the Office of Emergency Management, Richard Sheirer. Richard. Thank you.

STATEMENT OF RICHARD SHEIRER, DIRECTOR NEW YORK CITY OFFICE OF EMERGENCY MANAGEMENT

Mr. SHEIRER. Thank you, Senator, Representative Gilman. I am Richard Sheirer. I am the Commissioner of the New York City Office of Emergency Management, and I am pleased to appear before you today at the request of Mayor Bloomberg. OEM's role in New York City is to coordinate and oversee the preparedness for response to and recovery from all emergencies and disasters. Our mission includes the protection of proper and the continuance of government in the face of disaster; but our most important goal is the safety and preservation of lives.

OEM accomplishes its mission through the collaboration with all city, state, and Federal agencies through the use of the resources of the Mayor's Office of People with Disabilities, the mayor's Office of Aging, the Department of the Buildings, Housing Authority, Transit Authority to name a few. We work very closely with the American Red Cross, the Salvation Army, and are partnered with many advocacy service groups in the special needs community.

New York City appreciates the opportunity to present information during this hearing about the unique planning and response needs of the special needs community which includes persons with disabilities and seniors and, as these populations might be impacted, language issues as well. My comments will focus on pre-September 11 issues, what happened during September 11, and where we are going after September 11.

Prior to September 11 OEM employed a full-time special needs advisor since 1997 who was responsible for the development and execution of preparedness initiatives, response actions, and recovery efforts working with both the emergency management and respondent community as well as with representatives from the special needs community itself. We developed and coordinated a 4-day conference on emergency preparedness for seniors and people with disabilities held at Lighthouse International. It was attended by 500 members of the community, 25 city response and service agencies, various advocacy groups. In addition, attendance was mandated by the New York State Department of Health for all home-based agencies and residential care facilities licensed within the city.

We developed and implemented the communications picture board program. This is a low tech solution which fills the immediate communication gap in emergencies between response personnel and persons with disabilities and/or non-English speaking persons. It was originally designed with special needs community in mind, but the tool has served to have broader applications and used for members of the general public. They have been placed in

every New York City ambulance, in every police precinct, in every FDNY certified first responder engine company, every hospital emergency department, and with the Red Cross and Salvation Army.

We convene special needs advisory panels for emergencies to advise and assist the city in emergency planning for the special needs community with representatives from all relevant agencies advocacy groups, service organizations participating. We have convened task forces in the past and we will continue to do so in the future.

We have ensured that all emergency information materials produced and distributed presented or posted on the OEM web site contain specific special needs messages which would also be available in alternate formats such as braille, large type, and audio when requested and translated. We do it in multiple languages which 13 review so far.

During September 11, in addition to the door-to-door searches conducted by the fire department, police department and rescue workers, an additional search was held, a follow-up search, with members of the Steel and Ironworkers, with American Red Cross and medic representatives. These teams were directed back to buildings known to have large numbers of seniors or people with special needs residing in them. We confirmed that 50 percent of all the emergency shelters that we opened were accessible to people with special needs. We confirmed that the dialysis network of which there are 90 locations was fully functional. We confirmed that the residential health care facilities, all 185 of them, were fully functional and executed all necessary parts of their internal emergency plans. We confirmed that most of the home-based care industry had initiated their internal disaster planning.

Once communication was reestablished it was learned that of the city contracted agencies below 14th Street, seven operated in the evacuation zone and moved their administration functions out of the zone. These agencies continued to serve as clients with a team of staff, and every last client was accounted for. We ensured that access restriction policies in the frozen zone exempted all Access-A-Ride, Paratransit, Meals on Wheels deliveries and private ambulances. We also ensured that properly identified health care workers were allowed reentry to assist their clients and directly to provide medication.

We confirmed that pharmacies honored appropriate refills from bottles without written scripts and/or insurance cards. We oversaw the mental health and crisis response activities initiated by various agencies and groups for the response personnel to direct victims and the city at large, and we worked with those groups involved to be certain that the experiences of the special needs community are accounted for in services.

Post-September 11. The horrific events of September 11 tested all New Yorkers. Not only New Yorkers, people from throughout our region as Congressman Gilman has said, and people throughout the country who came here to help. There are a lot of lessons we learned from our individual experiences and from those of others. We are in the process of drafting a proposal for a comprehensive special needs emergency plan and mitigation that incorporates everything we learned.

We have begun additional research into how additional notifications, communications, evacuation technologies and policies can be implemented. We will continue to convene the various task forces for the special needs community that we started long before this incident. And We are committed to reviewing existing emergency plans to incorporate the special needs community at every level. We will continue to incorporate the special needs community in each and every one of our disaster drills and our planning for coastal storms which incorporates the relocation of anywhere from 250 to 900,000 people has always included a special needs community and dogs for that community.

Finally, there are a number of issues that can be looked at right now by other emergency managers and ourselves. The Federal mitigation funding available after a disaster that formally was directed only to infrastructure initiative, we are very hopeful that it is going be expanded to include more human service measures. In my conversations with Joe Allbaugh, FEMA appreciates all the problem that we have experienced and while this has been an absolute horrible event, it has given us a lot of insight into things that we can do, how we can do things better, how we can help people better and, more importantly, how we can better prepare our country working with the Governor Ridge, Joe Allbaugh, and the other agencies. Emergency managers in the public and private sector, whether they be the fire safety director at a business or a person in a high-rise office or residential building, all need to be very cognizant of the special needs community, and we will continue to work with that community to make sure that we get all relevant information out and improve our processes based on our experience as much as possible. Thank you.

Senator CRAIG. Richard, thank you. I will come back to you. You mentioned in your testimony that you are in the process of drafting a special needs proposal or proposals with special needs elements in it. The question I will be asking you is what would be your four top four or five recommendations within that proposal. What do you see coming out of your experience that you would elevate to a level of priority that either need to be done or refined and improved. OK, Thank you.

Now, let me go to Wayne Osten, Director, Office of Health Systems Management. Wayne, thank you for being with us.

STATEMENT OF WAYNE OSTEN, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT

Mr. OSTEN. Thank you, Senator, and thank you, Congressman Gilman, for giving me the opportunity to speak with you today on the subject of New York State's emergency preparedness for elderly and disabled. The Department of Health's Office of Health Systems Management is responsible for overseeing quality of care in New York's hospitals, nursing homes, home care agencies and clinics. We have been working to ensure that all health care providers in New York State have emergency response plans in place; and, since September 11, we have been in close communication with the New York City Department of Health, County Health Departments, the state and local emergency management organizations, and the

health care providers to ensure our readiness in emergency situations.

Preparing our health care facilities to be able to respond to a disaster is not a new activity. We took many steps in New York State to develop strong disaster preparedness plans in preparation for Y2K. We worked with health care providers, including nursing homes and home care agencies, to ensure that they all had up-to-date disaster plans in place. We made sure they had adequate staffing, supplies, medication, and food, as well as backup emergency generators. We saw clear evidence of the success of these efforts in response to the events of September 11 and in the days and weeks that followed. Hospitals in Manhattan and throughout New York City immediately implemented their disaster plans bringing in additional staff and making beds available. Nursing home and home care agencies in New York City also took immediate steps to ensure that those in their care were getting the services they needed.

While we recognized that there were cases of individual hardship, home care agencies did an outstanding job of providing food, medication, and care to the home bound in lower Manhattan in the days and weeks following the World Trade Center disaster.

Since September 11 the Department of Health has been working to update its emergency response plan, particularly as they relate to nuclear, biological, and chemical events. We have focused these activities on four functional areas: First, surveillance and detection. How our health care providers can quickly identify and report a potential event. Two, response. How our health care providers should respond to an event both individually and in partnership. Three, communication. How our health care providers can maintain communications both during and after a disaster; and finally, internal security what steps our providers can take to improve their own organizational security.

The model we are working on relies heavily on creating and strengthening partnerships between state and local governmental agencies and health care providers so that we can provide a community-based response in emergency situations. The scope and magnitude of September 11 terrorist attack has firmly established the critical need for strong local public health infrastructure to serve as the first line of defense in responding to disasters whether they stem from natural or manmade causes. We plan to use this model as a prototype. We are meeting with county health departments, health care providers, EMS representatives across New York State to assure that they have emergency plans that meet the specific needs of the communities. Nursing homes and home care agencies need to be key components in this process.

We recognize that the elderly and disabled are particularly vulnerable to the effects of a terrorist attack, and New York will continue to work to provide for the needs of both of these groups. New York State's current nursing home regulations require that nursing homes have written disaster and emergency preparedness response plans updated at least twice a year with procedures to be followed for the proper care of residents and staff. Nursing homes also must have plans in place for receiving and treating victims of mass casualty. All nursing homes must have plans in place for evacuating

residents if it becomes necessary. This plan must include plans to transport residents to another facility or location. The plan must also include preplanning for an evacuation with the local 911 system.

It should be noted that nursing homes, because they are equipped with independent generators and supplies of food and water, may be determined to be places to bring victims in the event that area hospitals reach capacity. We were in a media contact with nursing homes near the World Trade Center following the September 11 attacks to determine their capacity to handle overflow from area hospitals should that become necessary. While this was not required, we did receive a very positive and cooperative response from our nursing homes.

The anthrax threat that followed the World Trade Center attacks, including the deaths of two older women in New York and Connecticut who had no affiliation with the media or the Postal Service seemed to indicate a greater vulnerability of our elderly to agents used in bioterrorist attacks. The state department of health has been in contact with nursing homes about how to handle bioterrorist incidents so that they will be prepared to protect the health of their residents and to alert public health authorities should any suspicious incidents occur within their facilities.

In conclusion, the New York State's disaster response plan for the aging and the disabled will be part of our ongoing collaborative effort between Federal, state, and local agencies and health care providers to safeguard the health and well-being of all New Yorkers. Our efforts emphasize the need for a community-wide response beginning at the local levels and involving partners in neighboring communities. Several weeks ago we had the opportunity to meet with President Bush's homeland security director, Governor Ridge to discuss our emergency response plan. He was both encouraging and encouraged by the cooperative efforts that we have embraced in New York State. Governor Pataki and the Department of Health are extremely proud of the way the city of New York and New York State responded to the World Trade Center attack and the ensuing bioterrorism incidents. Our response would not have nearly been so effective without the strong leadership and coordination among many agencies at the city, state, and Federal levels. Thank you very much.

Senator CRAIG. Wayne, thank you very much. We will be back to visit about some of those connective things that you see as necessary between that local, state, and Federal partnership that we are working on building at this moment.

Now, let me go to Igal Jellinek, Executive Director, Counsel on Senior Centers and Services of New York. Igal, welcome to the committee.

STATEMENT OF IGAL JELLINEK, EXECUTIVE DIRECTOR, COUNCIL ON SENIOR CENTERS AND SERVICES OF NEW YORK

Mr. JELLINEK. Thank you, Mr. Chairman and Representative Gilman and members of the committee. I welcome the privilege of appearing before you.

By way of background, the Council of Senior Centers and Services is the premier professional nonprofit organization for the city's senior service providers representing 265 senior service organizations ranging from individual committee-based senior centers to large, multipurpose city-wide organizations.

New York City's five boroughs are home to some 1.3 million seniors. Regarding the problems our members and their seniors face as a result of the most recent and horrific emergency situation on September 11 of last year, I think the good news is that we have all learned a great deal from how they coped with these problems. As you will hear, their solutions are both innovative and compassionate.

But you will also hear what we feel is the most important solution of all; that is, that we as aging services providers need to join with members of the communities, members of social service agencies, with city, state, and Federal Government in the private sector to pool our resources to truly prepare for a unified integrated and effective response to emergencies. That said, there are five overarching categories of need. Getting services to the homebound person and people with disabilities, ensuring that our clients have adequate food, water and shelter, transportation of people, services, medications and food. Three-hundred sixty degree communications with staff, seniors, their families, and emergency organization and addressing the mental health issues that arise for everyone.

Let me give you some examples beginning with the homebound and disabled population. At Sunnyside Community Center in Queens serving 1,500 seniors, they have an emergency planning system in place that includes setting up a triage of client needs from those who cannot function alone to those who can function independently within their home. Part of the emergency plan includes updating this information monthly and ensuring that the client's levels of need has not changed.

In addition, Sunnyside keeps both a hard copy and a computer file of their clients and shares both with the Fire Department and Police Bureau Commander. Thus, in an emergency, they immediately know which of their clients need help first. When the problems arose on September 11 and in the following days, that many of the home care workers could not get to their clients because they didn't have official identification badges to get through the blockades. These are the small but critical issues that our members have alerted us to and that together we can remedy.

At the Stanley Isaacs Neighborhood Center on the upper east side of Manhattan, which also provides Meals on Wheels they were serving congregate meals in their senior center on September 11 when tragedy hit, and they continued to serve their seniors that day making sure they were given their lunch. But they could not carry out their Meals on Wheels program because the trucks that brought in the food were stuck out in Queens with the bridges and tunnels shut down. These are the problems that occurred across

areas of transportation issues, communications issues and mental health needs arising from the emergency. If a homebound person does not get his or her meal, it is first a physical issue but quickly becomes an emotional one as well as isolation, fear and panic set in, all with terrible consequences for the homebound person. The solution in this case a brace of some 24 corporate volunteers from Bloomberg Communications delivered Meals on Wheels by going door to door on foot, and two restaurants in the area; namely, the world famous Le Bernardin and Daniel donated food to feed the center's clients.

Transportation problems became the central issue preventing people from receiving needed supplies of food and medications, keeping people away from their homes and families, given the city's need to close down all bridges and tunnels. It increased safety for the island of Manhattan and the outer boroughs but sent providers without local emergency backup scrambling to cover the necessities that we took for granted before the attack of 9/11.

On the issue of 360 degree communication, that means communicating with staff, with clients, with emergency service operations, with anyone else you need to reach or who needs to reach you. Our members have asked us for help in creating a redundant communications plan; that is, multiple ways of communicating in an emergency that includes backup if one method doesn't work. This is something we need to address going forward, including the use of cell phones, backup land lines, two-way radios, a special radio band for emergency communications and broadcasting, and, of course, ensuring that every person has a portable radio with fresh batteries.

Some of our members have created call down systems where people can call in to them and they can try to contact emergency services. But when the phone lines were down and cell phones not working, this fell apart. Many are worried about both what role they need to play in the event of a bioterrorist attack and how to protect their seniors. Then there are the mental health services which need to be offered in a 360 degree manner as well. All our members told us that participation in congregate facilities increased, sometimes double what it was before 9/11. Senior centers became safe havens for our city's older adults, as our members told us of the clear need seniors had to be in touch with someone and not be isolated.

Each of the coping mechanisms our members designed to meet the issue raised by the terror attack is ingenious, but therein lies a larger problem. They should not have had to work on their own to solve the problems they all shared. We need a community-level preparedness plan where all stakeholders work together. I would like to make some recommendations.

One develop a network of emergency pharmaceutical services that includes the means both to fill medications and get them to those who need them. Credit cards did not work for prescriptions. We need to find a way to get prescriptions to our community-based seniors as well.

Two, increase in-home services for the homebound including in-home psychiatric mental health services and home health aide providers.

Three, ensure that there is a team of restaurants identified in the neighborhood as willing and able to provide emergency food to a pooled resource.

Four, develop an emergency support system for the in-home services including emergency respite care and communications abilities for in-home caregivers.

Five, create a secure system of photo identification for professional health care and senior service workers, even for the Meals on Wheels providers and the drivers, that will enable them to get through to their homebound clients in an emergency. Ensure that each facility has done a risk assessment, audit of its hardware, software, insurance coverage, and physical plant. Develop a citywide, statewide and national emergency transportation plan. Each community needs a contingency plan for moving people, including those in wheelchairs, emergency supplies, and medication. Upgrade communications systems including trunks of telephone lines and emergency response systems and develop redundancy communication plans including instructions on use of emergency communications products and tools of backups. For Meals on Wheels programs, offer a sixth meal or a shelf stable emergency pack in case of interruption of service. Ensure that on an organizational level each organization develops an emergency plan and that it is kept updated, and teach them to remain flexible depending on the nature and site of the emergency. Communicate with your clients and staff immediately and continuously as possible. Ensure that people do not feel isolated or abandoned. Understand that your staff may feel a need to offer help and to be helped. Offer group discussion sessions and if possible allow staff release time for volunteer efforts.

One of the things that we found during this process is that the seniors acted as a resource because they have gone through this in World War II and other experiences, and they were sometimes a resource to the staff who have never gone through this before. In short, our message is that we never know what natural or unnatural disaster will strike, but it is never too soon to be prepared, especially for our nation's seniors. Thank you.

Senator CRAIG. Mr. Jellinek, thank you very much.

Now I am going to turn to Mr. Michael Benfante. Michael is unique in the sense that he was there, an employee of the Network Plus Company, he worked on the 81st floor of Tower One at the World Trade Center, and on September 11 Mr. Benfante helped evacuate a woman with rheumatoid arthritis with the help of an evacuation chair. So, we really do appreciate your being here today. We look forward to your testimony.

STATEMENT OF MICHAEL BENFANTE, EMPLOYEE OF NETWORK PLUS

Mr. BENFANTE. Thank you, Senator. First I would like to thank you Senator Craig and the other committee members for inviting me to participate in this U.S. Senate Special committee hearing regarding emergency preparedness for the elderly and disabled. On the day of September 11 I consider myself to be one of the fortunate ones, fortunate in many regards which I am going to relay to you and to this committee.

First after the impact of the first airplane hitting the north side of Tower One above my office, I was fortunate to have the ability to stay calm to direct 28 of my sales reps out of the office and into the stairwell, fortunate to be in the highest office of the 81st floor of Tower One, to come away from that day without a casualty, fortunate to have the strength and composure to carry down Tina Hansen 68 flights, fortunate to have that emergency evacuation wheelchair there to assist me in doing so, fortunate to have my coworker John Cerqueira along with me to help me carry her down 68 flights.

It was also very fortunate encounter firemen on the fifth floor where we were stuck for a while who eventually directed me out of Tower One and through the destruction and onto the West Side Highway where they further directed me to an awaiting ambulance where I was able to put Tina Hansen into, where she eventually made it to safety. I was fortunate to have about 95 of those 102 minutes that Congressman Gilman mentioned earlier, the time from the initial impact to the time of the eventual collapse of the second tower. What I will do now is try to explain to you what occurred in those 95 minutes from start to end to see if it can assist you in this hearing, if that is what you would care to listen to.

Like Senator Craig said, I was located on the 81st floor of Tower One. The first plane hit above my office on the north side of the tower. I was fortunate to be in the southeastern corner of the tower, 7,000 square feet, where I had 28 of my reps there. I don't know if you are aware that the actual floors of the World Trade are about a acre large, so I actually heard my reps screaming before I actually felt the impact because I was on the south side of the floor. My office actually overlooked the Statue of Liberty. So, I heard one of my reps screaming from the impact before I actually felt the impact, and I immediately rose from my desk and ran out to the office and screamed for everybody to remain calm. I looked out my window behind me and I saw debris and fire falling from the building. And then I immediately ran out into the main office through my reps and out into the hallway to see what the destruction was like out there, and I saw that the stairwell was clear. I did not know what was occurring at that time. I thought it was a gas explosion or something, so I told everyone to get to the center of the floor where, believe it or not, they listened to me and came together and eventually made it to the stairwell and began their descent down the stairs.

While I was directing them out, someone said that someone was stuck in the bathroom, so I ran back into my office, grabbed my cell phone and grabbed my bag, ran down to the men's room in the main hallway, ran over some debris, did the combination on the

men's room door, opened it where there was a lot of destruction in there, but there was nobody in there, fortunately, ran back into my office and made sure everybody had already left the office, so it was just myself and an assistant branch manager. Everybody had already left and I began my descent down the stairs.

I made it down about one flight and tried to assist two men that were stuck in an elevator halfway between the landing. Me and another gentleman, I don't recall who it was, we ran into an office and tried to grab something to wedge the doors open of that elevator. It was a bathroom key with a long stick at the end of it. It was one of the devices we used—I think it was a leg from a chair, and we tried to wedge the doors open, but they were buckling front to back instead of opening horizontally, so I felt that we were going to do more harm than good, so I left those devices with those gentlemen and wished them good luck. I don't know what actually eventually happened to them, and I continued on down the stairs.

On my way down I passed many fire extinguishers in the stairwell. People were screaming that there was fire on the 77th floor. People still—we did not know what was going on. I grabbed the fire extinguisher on the 72nd floor and started heading back up, but I was getting nowhere fast because of the people coming down the stairs. So, I put down the fire extinguisher and continued on down the stairs. On the 68th floor I stopped out onto a floor and where there were people and I was trying to direct them out into the stairwell. As I looked down the hallway, there were large glass doors, and there were these women just standing there behind the glass doors. And it seemed to me kind of odd with all this hysteria that they were just standing there, so I ran down the hallway. I banged on the door where they eventually pressed the button to open the doors. And as I was walking in to scream at them to evacuate, one woman stepped aside and there was Tina Hansen in her motorized wheelchair. I asked her if she needed help, and I also noticed an emergency evacuation wheelchair still strapped together on the floor besides the women. Nobody was doing anything, and pretty much everybody had already evacuated except for these women, and Tina was trying to calmly tell me to use this chair, so I was frantically trying to open the chair where I eventually saw a lever toward the back, flicked the lever, the chair opened up, and I took, grabbed Tina from her wheelchair and strapped her into this wheelchair where I initially had her carrying her on the back and I had my assistant manager carrying on the front and another gentleman, and then I saw my coworker John Cerqueira and asked for his help. He took one side of the front, I took one side of the back and different gentlemen switched on and off on the back, and we proceeded to carry her down 68 flights.

On the way down it was relative calm. Everybody was helpful. For the most part it was clear. It did get backed up from people evacuating the different floors and the flow of traffic coming into the stairwell. We did switch stairwells a couple of times to try and make better time.

There was a, I think, an emergency. We encountered the firemen I guess around the forties full gear, tools and on their way up trying to assist people in evacuation, exhausted from climbing 40 flights with all that gear. There were people trying to help them.

They did not know what was wrong with Tina. They thought maybe she was ill. They did indicate that on the 21st floor there was a medic station set up where we could set her down; maybe they could assist her.

As we got closer to the 21st floor, I asked her if she would like me to put her down she was relatively calm and I asked her again I will take you all the way out, and she said OK, so we never let go, and I believe it was when we got down to the tenth floor, around the tenth floor was maybe when Tower Two was starting because we felt the rumble and some smoke started to filter into the building.

Then we went into a floor landing. I believe—I don't know if it was a Port Authority or some type of maintenance floor because it was very dark. It was very narrow. There were lockers and there were no lights, but the firemen were there to assist us. They had lights and were trying to direct us. We were going a couple of different ways, but I think because of the collapse of the tower they could not find a safe way for us to get out, so it started filling up with smoke, and there was some panic there. Meanwhile we are lifting Tina and carrying her over debris or trying to move the debris and carrying her through and eventually a fireman tapped me on the shoulder and said let's try this way again, and we were like, "We already went that way." We followed him and took us to a stairwell where I barely remember going down the last four flights. At that point it was myself and John Cerqueira and a firemen carrying Tina from the back, and we made it down to the lobby of Tower One on the West Side Highway side of the tower. So, if you look to your right, it is where the turnstiles are to go up the tower and the security desk to the left and massive destruction where firemen directed us through the broken glass of the tower out into the West Side Highway, where I put Tina into the ambulance.

I as I was looking up trying to take in the enormity not even realizing the enormity of the situation, I still did not realize that Tower Two was down, I started to walk away and heard an explosion and Tower One was collapsing behind me, so I just ran for my life and dove under a truck. As the debris and the smoke eventually subsided, I got up and walked away. I will answer any questions that you may have regarding the hearing.

Senator CRAIG. Michael, you have answered all the questions. You are obviously a very brave young man. We will come back to you. There are a couple questions I would like to ask you. I would like to hear from both Andrea and Marion here, who are with us.

I understand, Josefina, you have to leave us to catch an airplane in the somewhat immediate future. Is that right? Let me come back then and ask you a question before we get final testimony. I had hoped we could get to Marion before you left, but I do want to ask you the question as it relates to preparing the aging network and nursing homes for disasters and the kind of coordination that is necessary.

You have had past experience in dealing with seniors in emergencies. I guess my question really is what is the kind of interagency coordination that you are participating in now that is in part a direct response to the September 11 experience?

Ms. CARBONELL. Thank you, Senator Craig. I think my experience again goes back to, just like Mr. Paulison, Hurricane Andrew in Florida, particularly working over 29 years with the elderly community and disabled community in Miami. I think many things changed after 1992, and we are working to expand and to upgrade the material in our disaster preparedness plan based on the recent experience.

But the most important thing is No. 1, that we need to do a better job of ensuring that there is a special needs roster. We developed the kinds of data that identify people that have special needs and that in case of emergency that data base is available in one location and could be spread into other areas. So, it means that we work with 56 state units on aging. We also work with 660 area agencies on aging. We have over 29,000 community providers throughout the country that work day in and day out with individuals both in the congregate senior center settings but also that serve homebound clients. So, we make need to make sure that in the process of revising our disaster preparedness manual, we take in recommendations from experts, such as many around this table today, to incorporate those recommendations into our technical assistance manual. We can never be too prepared. We don't know where and when our next emergency will hit, whether it is manmade or whether it is natural disaster. So, definitely being able to have protection in place and surveillance like we heard from Mr. Osten and being able to have a response plan and a backup system, better communications and ensuring that we work collaboratively like we are doing at the department level right now with CDC, with HRSA and CMS and other partners with FEMA and the local emergency preparedness folks to integrate all of those plans together. It starts at the Federal level, Senator Craig, and that is what we are beginning to do right now, and we hope to have a more up-to-date plan in place hopefully by the end of this year that will address not only a manual on how to, but will also increase the training of the individuals on the field to the 660 AAAs throughout this country.

Senator CRAIG. Thank you very much. Let me turn to Congressman Gilman. The Congressman is going to have to leave us in a few moments, so I want him to ask any questions he might want to and any comments he would want to make, and then we will come back to you ladies for final testimony and the balance of the questions I have to ask. Ben.

Rep. GILMAN. Again thank you, Senator Craig, for conducting this hearing on behalf of the Special Committee on Aging. I think the recommendations coming out of this will be helpful to every agency throughout our nation who is trying to prepare properly for emergencies of this nature. I want to congratulate Michael Benfante for his dedication and his heroism and what he described to us of the method of saving one of the disabled. I think that will stand out in our memory as we recall this hearing, what we have to do to try to perfect our systems. Please excuse me, our good nursing folks, Andrea and Marion. But I have your testimony and I will look at it very carefully. I have to go to another meeting very quickly, but I want to ask just two quick questions, Senator, if I might.

Dr. Ostroff, you talked about all your recent initiatives on behalf of the center, but I heard a report recently that there was a toxicity found in the air following the 9/11 tragedy, and it had not been publicly released nor disseminated to those who were in need, particularly our rescue workers. Is there some substance to that.

Dr. OSTROFF. I don't know all of the details of that, Congressman. I work in the infectious part/disease part of the agency. I know that there was an a hearing that took place this morning that discussed many of those issues, and I know that there are ongoing concerns about some of the air quality issues around the World Trade Center.

Rep. GILMAN. Well, then, let me ask Wayne Nelson from our New York State Health Department. Wayne, can you tell us anything about that toxicity and why the information was disseminated to the rescue workers?

Mr. NELSON. No. Unfortunately, Congressman, I don't know the details of that.

Rep. GILMAN. I hope that maybe you can provide it to both of us, Senator Craig and myself, and we would welcome knowing more about it.

Mr. Sheirer, on behalf of the—with regard to the FEMA——

Senator CRAIG. Richard just stepped out.

Rep. GILMAN. Oh, Richard stepped out? Well, I am sorry. I would like to know just more about, and I will ask our FEMA fire coordinator, what about the joint meetings of all of the interested parties? How often do you get together to review what our good Deputy Secretary was saying about coming together to make plans? How often do you bring your agencies together?

Mr. PAULISON. I don't know the answer to that. I have been in FEMA a few months. But I can tell you that what I testified before is absolutely accurate. It starts at the top with the Federal Government. We have to get our act together first if we are going to expect the local responders to act. That is the message that we are taking back to the FEMA Director. FEMA should take the lead in gathering some of these agencies together to come up with some definitive plans.

Rep. GILMAN. I hope you follow up on that.

Mr. PAULISON. Absolutely.

Rep. GILMAN. I think interagency communications and planning is so important in what we are doing.

Mr. PAULISON. It has to be. Everybody has to take ownership in this. Everybody has to take ownership from the individual all the way up to the top. If we do that—the ideas are out there. Everybody around the table has the same message. We listened very carefully. Laid out the same steps, the five or six steps of what had to be done. We know what the issues are, and I am sure we are going to have another testimony to tell us very clearly what the issues are, what they see from their end of it, and we just have to get together and resolve it. That is a message that I am going to take back to the FEMA Director.

Rep. GILMAN. Hopefully they will listen. I want to thank you all for your recommendations, for being here today, Senator Craig for conducting this hearing. Mr. Jellinek, you had good recommendations. I hope there will be other good recommendations of that na-

ture passed on to us from both the Senate and the House. Thank you very much. Please forgive me for having to go to another meeting. Senator Craig, thanks again for inviting me to participate. Thank you.

Senator CRAIG. Congressman, thank you very much. We are pleased you could join with us today.

Let us now complete the testimony before I follow up with some questions. I would like to ask Andrea Dale, a nurse with the Visiting Nurse Service of New York to offer her testimony at this moment. If you could pull that mike as close as is comfortable. There you go.

Ms. DALE. Mr. Chairman and members of this committee, I am Andrea Dale. I am a registered nurse.

Senator CRAIG. Andrea, we are going to ask you to hold until the tape gets changed.

All right. Thank you.

STATEMENT OF ANDREA DALE, VISITING NURSE SERVICE OF NEW YORK

Ms. DALE. Mr. Chairman and members of this committee, I am Andrea Dale. I am a registered nurse appearing before this committee for myself and on behalf of the Visiting Nurse Service of New York. I am joined today by Marion Anello, a resident of lower Manhattan. I welcome the opportunity to join you today along with the other witnesses in your efforts to learn firsthand experience of the September 11 disaster and the days that followed. I hope my experiences during those days as a field nurse working in lower Manhattan will help the committee better understand the environment and the challenges at that time.

There are many things to be learned from September 11 terrorist attacks, too many to list here. I would like to take a few minutes to highlight what to me are important lessons to learn. First is that emergency preparedness planning must recognize that homebound patients are spread throughout our neighborhoods. As an example, VNSNY provides home care services to over 24,000 patients each week throughout the five boroughs of Manhattan, of New York City, and in Nassau County. Many of our patients are homebound, chronically ill and elderly. Many live alone. They are dependent on receiving services such as wound care and medication administration on a daily basis. This required home health aides to help them perform the activities of daily living. Particular concern must be given to those who are wheelchair bound and unable to leave home without assistance.

Before September 11 I was one of 20 visiting New York nurses assigned to see active home care cases in lower Manhattan. My area extended from Canal Street to Battery Park, from Church Street to the Hudson River. I care principally for elderly patients and I recognize my responsibility to care for them. Many of my elderly patients have few surviving family members and small circles of friends. I must go to them. They do not and cannot come to me.

VNSNY realized early on September 11 the challenges we faced given our patient population and the fact that 1,600 of our patients lived in the restricted area below 14th Street. I was responsible for 30 of these patients. No public or private transportation was avail-

able in this area for many weeks. Phone lines, land and mobile, did not work or they were unreliable. Stores, including grocery stores and pharmacies were closed. Resident and emergency workers wore masks. People were instructed to keep their windows closed due to the heavy smoke.

In the area below Canal Streets there was a lot of physical damage and access was very limited. Essentially it was a war zone. On September 11 many of my patients saw from their windows the collapse of the World Trade Center buildings and the devastation and chaos that enveloped the area. For many it provoked memories of World War II and other traumatic events they had experienced over the course of their lives. As my colleagues and I continued to provide nursing therapy and other home care services, we were struggling to meet the mental health needs of our patients.

Second, emergency preparedness must include the resources to transport care givers to their patients as well as being able to transport patients to the medical care facilities. On the morning of September 11 I was a few blocks north of the WTC en route to my patients when the second airplane crashed into the tower. I immediately contacted my team manager who advised me to return home, and I was able to get home quickly, as my home was a little more than a mile north, and I watched from my balcony as the towers collapsed.

I contacted some of my patients living in Tribeca, and hearing the distress in their voices as we talked, I decided I needed to get back downtown I packed a backpack with some supplies and I headed back downtown on foot to them as all transportation had already stopped below 14th Street. After my checking my patients door to door and caring for those who were scheduled to be seen that day, I began to follow up on those who had been evacuated. By the end of that first week a pattern was established—miles of daily walking to care for the sick and help provide for their basic needs such as food. Where possible we contacted patients' relatives, passed along news of their family members or arranged for patients who had been staying in shelters to be brought to their family members' home.

The point is that I was only able to get to my patients because I could walk the distances that separated us and I knew where they had been evacuated to or where they lived. Emergency preparedness cannot always assume this will be the situation.

Three, emergency preparedness will depend on reliable and predictable communications. My cell phone worked for a few hours immediately following the attack and then became useless. Our residential phone service lasted a little bit longer and then became less and less reliable. Using these phones for a while I was able to remain in contact with my team manager in the hours following the attack. During these critical hours immediately after the attack I was essentially operating without depending on means of communicating with our central office. This indicates I believe that it is such service be made dependable and reliable in a time of crisis with a wider use of radio communication be adopted for care givers.

A corporate lesson is to be prepared. VNSNY learned many lessons from this tragedy. We are working with government agencies to address public health issues that might arise in the immediate

future. For fine-tuning our disaster planning, we have developed our comprehensive bioterrorism readiness plan. Most important, out of our disaster recovery plan was done as soon as the first plane hit, all our field staff knew their first priority was to their patients. Management did turn to the jobs to help the field staff do this. Senior management communicated with the city, state, and Federal agencies to request permission to enter the frozen area. New York City Office of Emergency Management, Police Department Centers for Medicare and Medicaid Services all offered greatly appreciated assistance and support.

In the days after the attack it was essential to communicate with field staff to make sure they had all the necessary information on their patients, especially new ones. Masks were obtained to wear in the "frozen" zone. Our information technology unit had a backup system in place so that no data were lost in communication. Patient information was maintained with the staff through portable computers.

As noted, there were problems with communicating with staffs since our phone lines broke down. In response VNSNY is in the process of formalizing a business continuity plan. We are developing policies procedures to ensure that business operations can continue in the face of outside forces affecting our buildings, our systems, our communications with staff. It must include the assessment of the current environment, development of business and technology requirements, strategy and planned development and planned validation through mock exercises. A dedicated VNSNY project team was formed in November 2001. This practice was to provide project oversight to represent all corporate entities. Contingency plans need to be developed which show redundancy based on a variety of scenarios: fires, floods, bomb scares, and bioterrorist attacks.

Bioterrorism readiness—Home Care and VNAs must play a role. As our nation begins a major readiness initiative in anticipation of an unimaginable attack, it is important to recognize the vital role to be played by home health agencies. VNS and VNAs across the country have more than 100 years of public health and immunization experience that should be brought to bear on the local bioterrorism, readiness and immunization planning process.

Home health care is not just an alternative to inpatient care. It is a front line defense to any biological or chemical threat this country may face and a key component to the public health system. For over 100 years VNAs have immunized and vaccinated hundreds of thousands of people in their homes and at community sites. VNSNY under contract with the CDC screened and immunized postal workers against anthrax in New York City. In the event of a widespread epidemic VNAs and other health agencies in each city can provide the experience and the infrastructure to deliver care to every community.

During the days and hours following September 11 VNSNY staff——

Senator CRAIG. Andrea, could you sum it as quickly as possible. Thank you.

Ms. Dale: We have developed a bioterrorism readiness plan as part of our overall disaster planning and will be doing drills and

regular correspondence as it will be periodically updated. We thank you.

[The prepared statement of Andrea Dale follows:]

Testimony
of
Andrea Dale, R.N.
Visiting Nurse Service of New York
before the
United States Senate
Special Committee on Aging
on
Emergency Preparedness for the Elderly and Disabled
February 11, 2002

Mr. Chairman and members of this committee, I am Andrea Dale. I am a registered nurse appearing before this committee for myself and on behalf of the Visiting Nurse Service of New York (VNSNY). I am joined today by Marion Anello, a resident of lower Manhattan.

I welcome the opportunity to join you today, along with the other witnesses, in your ongoing efforts to learn from first hand experiences of the September 11 disaster and the days that followed. I hope my experiences during those days as a field nurse working in lower Manhattan will help the Committee better understand the environment and its challenges at that dreadful time.

Obviously there are many things to be learned from the September 11 terrorists' attacks – too many to fully list here. I would like, however, to take a few minutes to highlight what to me are important lessons to learn from this tragedy.

1. **Emergency preparedness planning must recognize that homebound patients are spread throughout our neighborhoods.**

   As an example, VNSNY provides home care services to over 24,000 patients every week throughout the five boroughs of New York City and in Nassau County. Many of our patients are homebound, chronically ill, and elderly. Many live alone. They are dependent on receiving services such as wound care and medication administration on a daily basis. Others require home health aides to help them perform the essential activities of daily living, including bathing, toileting and food preparation. Particular concern must be given to those who are wheelchair-bound and unable to leave home without assistance.

   Before September 11, I was one of 20 VNSNY nurses assigned to see active home care cases from approximately Canal Street south to Battery Park from Church Street to the Hudson River. I care principally for elderly patients, and I recognized my responsibility to care for them. Many of my elderly patients have few surviving family members and small circles of friends. I must go to them; they do not and, in many cases, cannot come to me.

VNSNY realized early on September 11 the challenges we faced given our patient population and the fact that 1600 of our patients live in the "restricted area" below 14th Street in Manhattan. I was responsible for 30 of these patients. No public or private transportation was available in this area for many weeks. Phone lines, both land and mobile, did not work or were unreliable. Stores, including grocery stores and pharmacies, were closed. Residents and emergency workers wore masks. People were instructed to keep windows closed due to the heavy smoke. In the area below Canal Street, there was a lot of physical damage and access was very limited. Essentially, it was a war zone.

On September 11, many of my patients saw from their windows the collapse of the World Trade Center (WTC) buildings and the devastation and chaos that enveloped the entire area. And for many, it provoked memories of W.W.II and other traumatic events they had experienced over the course of their lives. As my colleagues and I continue to provide nursing, therapy and other home care services, we are struggling to meet the mental health needs of our patients.

2. **Emergency preparedness must include the resources to transport caregivers to their patients (as well as being able to transport patients to the medical care facilities).**

On the morning of September 11, I was a few blocks north of the WTC en route to my patients when the second airplane crashed into the North Tower. I immediately contacted my team manager who advised me to return home. I was able to get home quickly, as my home is a little more than a mile north and I watched from my balcony as the Towers collapsed. But after contacting some of my patients living in the Tribeca area and hearing the distress in their voices as we talked, I decided I needed to get to them. I packed a backpack with some supplies and headed back downtown on foot, as all transportation had already stopped below 14th Street. After checking my patients door-to-door and caring for people who were scheduled to be seen that day, I began to follow up on those who had been evacuated.

By the end of that first week, a pattern was established—miles of walking daily to care for the sick and help provide for their basic needs such as food. Where possible we contacted patients' relatives, passed along news of their family member, or arranged for patients who had been staying in shelters to be brought to their family members' homes.

The point is that I was only able to get to my patients because I could walk the distances that separated us. And I knew where they were evacuated to or where they lived. Emergency preparedness cannot assume this will always be the situation.

3. **Emergency preparedness will depend on reliable and predictable communications.**

My cell phone worked for a few hours immediately following the attack and then became useless. Our residential phone service lasted a little bit longer – and then became less and less reliable. Using these phones, I was able to remain in contact with my team manager in the hours following the attack.

During these critical hours immediately after the attack, I was essentially operating without any dependable means of communicating with our central office. This indicates, I believe, that either such service be made dependable and reliable in a time of crisis or that a wider use of radio communication be adopted for caregivers.

4. **A corporate lesson – be prepared!**

VNSNY learned many lessons from this tragedy. We are working with government agencies to address public health issues that might arise in the immediate future. We are fine-tuning our disaster planning. And, we have developed a comprehensive bioterrorism readiness plan.

The most important part of our disaster recovery plan was that as soon as the first plane hit, all of our field staff knew that their first priority was to their patients. Management in turn knew their job was to help the field staff to do this. Senior management communicated with city, state and federal agencies to request permission for field staff to enter the restricted zone as well as to offer our help to their efforts. The New York City Office of Emergency Management, the Police Department, and the Centers for Medicare and Medicaid Services all offered greatly appreciated assistance and support.

In the days after the attack, it was also essential to communicate with field staff and make sure that they had all their necessary information on their patients, especially new ones. Masks were obtained to wear in the "frozen" zone. Our information technology unit had a back-up system in place so that no data were lost and communication of patient information was maintained with staff through their portable computers.

As noted, there were problems, however, with communicating with staff, since telephone lines did break down. In response, VNSNY is in the process of formalizing a Business Continuity Plan whereby we are developing policies and procedures to ensure that business operations can continue in the face of outside forces affecting our buildings, our systems, or communication with our staff. Business Continuity Planning must include the assessment of the current environment, the development of business and technology requirements, strategy and plan development, and plan validation through mock exercises. A dedicated VNSNY project team was formed in November 2001 whose purpose is to provide project oversight and to represent all VNSNY corporate entities and business units. Participants from all of the major business areas within VNSNY were selected by the project team to serve as subject matter experts.

Contingency plans need to be developed to ensure redundancy based on a variety of scenarios, from fires and floods to bomb scares and bioterrorist attacks. These plans need to move from the high-level issues (How are your computer systems backed up? How do you plan to communicate with your employees?) to the details involved in addressing each of these issues (What is your relocation plan if employees cannot enter the building? How should staff prioritize patient needs?). Full redundancy of records and databases, as well as a review of how all of your business processes may be affected are essential (How would staff receive information on new patients?).

5. Bioterrorism readiness – Home Care and VNAs must play a role

As our nation begins a major readiness initiative in anticipation of an unimaginable bioterrorist attack, it is important to recognize the vital role to be played by home health agencies across the nation. VNSNY and other visiting nurse agencies (VNAs) have more than 100 years of public health and immunization experience that should be brought to bear on the national and local bioterrorism readiness and immunization planning process.

Home health care is not just an alternative to inpatient care; it is a frontline defense to any biological or chemical threat this country may face and a key component of the public health system. For over one hundred years, VNAs have immunized and vaccinated hundreds of thousands of people, in their homes and at local community sites. VNSNY alone vaccinated over 42,000 individuals in the year 2001, through public programs in conjunction with the New York City Department of Health, and private employers. Recently, VNSNY, under contract with the CDC, screened and immunized postal workers against anthrax in New York City. In the event of a wide-spread epidemic, VNAs and other home health agencies in each city and town are the health care providers with the experience and infrastructure to deliver care in every community and neighborhood on any given day.

During the hours and days following the events of September 11, VNSNY's dedicated nurses continued to reach the affected 1,600 home health care patients located in lower Manhattan. By the end of that week, visual contact was made with each patient, to ensure that all patients had medication, food, water and supplies. VNSNY is also an ongoing participant in the emergency response effort in New York City as a key player in the Mayor's team to formulate a state-of-the-art emergency preparedness plan in light of the September 11 tragedies.

As Congress considers directing billions in grants to states, local governments and other public and private health care facilities, it should call on the experience of VNSNY and other VNAs throughout the nation in planning and designing community-based emergency preparedness plans, enhancing and training personnel and in developing and executing immunization programs. The nation should utilize VNAs' history and expertise in these areas as the country moves to strengthen its public health emergency response system.

VNSNY has developed a Bioterrorism Readiness Plan (BRP) as part of our overall disaster planning, which recognizes the special nature of the response to bioterror threats. Within the Plan the main consideration is to protect the agency employees and patients under care by implementing prevention and control measures. The Plan includes coordinating activities and reporting suspected cases with state and local public health officials. The Agency's Medical Director will alert senior management staff who will coordinate the agency response. A core group of clinicians from each region and each program needs to be established and trained in Bioterrorism and the BRP, including a regional representative from the VNSNY Community Mental Health Department. On a regular basis, the core group of clinicians will provide an annual in-service for professional nurses as well as updates as they occur. In the event of a threat, this core group of clinicians would be key in assisting the program directors and regional administrators in implementing the BRP in each region, and would be the local

source for answering questions. These clinicians would be kept up to date through yearly meetings to plan and review a mock Bioterror drill and regular correspondence as the BRP is periodically updated. We would be pleased to share the details of our comprehensive Plan with all interested agencies and government officials.

Mister Chairman, for myself, for Mrs. Anello, and on behalf of the Visiting Nurse Service of New York, we thank you again for the opportunity to visit with you today. I hope my experiences will help you in your commendable work.

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Hidden Victims

For Elderly Near WTC, A New World of Woe In Sept. 11 Aftermath

Stranded at Home, Thousands Rely on Visiting Nurses To Sustain Health, Hope

'The Last to Be Taken Away'

By LUCETTE LAGNADO
Staff Reporter of THE WALL STREET JOURNAL

NEW YORK—"I am going out of my mind, I am going out of my mind," says 96-year-old Rose Kessler as she ushers Andrea Dale into her apartment, five blocks from Ground Zero, on a bright day in November.

Mrs. Kessler is 4-foot-9 and weighs less than 90 pounds. Her husband is long dead, as is her only daughter, who died at age 34. She takes small, unsteady steps until she reaches the safety of an armchair. She plops herself down and inventories her woes.

Andrea Dale

Her phone is still out, her fingers are too frail to work a cellphone she's been offered, and she lacks the will and energy to venture out very often, even down the hall. Her main joys in life—sitting in a small park just outside her building and paying regular visits to a beauty parlor in the World Trade Center—ended on Sept. 11.

Now she lives as a shut-in, playing solitaire, reading when she's up for it with her one good eye and watching a bit of TV. An aide comes in a few hours each morning, but Mrs. Kessler fears that she'll fall one night and, lacking a phone, have no one to rescue her.

"I'm scared all night," she says.

"I know how upsetting this must be for you," says the 57-year-old Ms. Dale. She takes Mrs. Kessler's hands in hers to comfort her.

A New Mandate

Ms. Dale is a registered nurse with the Visiting Nurse Service of New York, a not-for-profit organization founded in 1893 to administer to the city's burgeoning immigrant population. It's among a handful of agencies, charitable and private, that offer critical nursing care, as well as basic needs—dressing, bathing, preparing meals and feeding—for thousands of elderly in downtown Manhattan.

Before the Twin Towers fell, VNS provided routine care to about 800 people, many of them clustered in buildings such as Independence Towers, where Mrs. Kessler lives, or Southbridge, a clutch of high-rises within four blocks from the World Trade Center. But since Sept. 11, VNS's mission has been to help find and assist the frail and isolated elderly stuck in the "frozen zone."

It's a big job. By one 2000 federal estimate, as many as 6,300 residents 65 years of age and older live within a few blocks of Ground Zero, and at least triple that number reside in neighborhoods below Canal Street that have in some way been disrupted by the terrorist attack. While many seniors with means and family have undoubtedly moved out, significant numbers living on fixed incomes with no family to turn to remained in buildings with damaged infrastructure—dead phones, elevators and cable-television systems, among other things—in areas where most businesses had closed.

Now, as life edges back to normal for much of New York, it doesn't for Ms. Dale's patients.

Mrs. Kessler cries as she wonders aloud why all those young people died just down the block and someone as old as her survived. On Sept. 12, she recalls, many of the elderly in her building found themselves sequestered in the lobby with "all the cripples, the wheelchairs and the canes," waiting for an evacuation bus. The buses came, and crowds of able-bodied younger people commandeered them. "We were down first. We were the last to be taken away," she says.

Ms. Dale patiently hears Mrs. Kessler out, then promises to return as soon as she can. Phone service is being worked on. Maybe her phone will be restored soon.

'The Most Traumatized of All'

Ms. Dale has seen a lot. She was a cop for a while, and a public-health nurse for six years before joining VNS almost two years ago. Her specialty is wound care, but when she steps out of Mrs. Kessler's apartment, she is shaken.

"She seems the most traumatized of all my patients," Ms. Dale says later. "And she is so frail."

Before Sept. 11, Ms. Dale's main territory was Tribeca, a downtown neighborhood of spacious multimillion-dollar lofts and trendy restaurants. Artists swarmed the place in the 1970s and '80s, and financiers followed during the long '90s bull market. The elderly who settled here and elsewhere downtown years before receded into the shadows. Many, like Mrs. Kessler, live in modestly furnished apartments they have occupied for decades.

After the terrorists struck, many elderly people downtown found themselves "totally cut off" from their doctors, grocers and phones, fearful and suddenly "completely dependent" on their nurses, Ms. Dale says.

This put enormous pressure on some 270 VNS employees, including nurses, nurse's aides and therapists who had fears of their own. While cops, firemen and rescue workers toiled in the glare of round-the-clock publicity, Ms. Dale and her co-workers found themselves trudging miles, usually alone, through bad air and ash-dusted sidewalks, clambering up and down darkened stairwells to get to their patients.

One of VNS's first challenges was to persuade home-health-care aides, who typically make $6.75 to $8 an hour, to keep working in an area that most New Yorkers were fleeing as fast as they could. For its nurses, the agency rented several downtown hotel rooms. In one case, six workers piled into one room.

Joyce Strongbow, 43, is a home-health aide on contract with VNS who has a place of her own in the Bronx but lives five days a week with Helen Gilman, a 99-year-old woman. She earns about $700 every two weeks.

She was giving Mrs. Gilman a bath when she heard the first explosion. She dashed to Mrs. Gilman's terrace on North Moore Street, less than 10 short blocks from the World Trade Center complex, and saw clouds of thick black smoke and thousands of people running.

"I started panicking and I told her, 'Helen, we could be killed,' " says Ms. Strongbow, speaking during a visit by Ms. Dale to check on Mrs. Gilman.

Mrs. Gilman looks at Ms. Strongbow and says, "Big coward."

As she approaches her 100th birthday, Mrs. Gilman says, she's too old to be scared. "Either you die or you don't," she says. "What is to be scared about?"

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DOWJONES

Those first few days, Ms. Strongbow says, she herself feared another terrorist attack. And with nearby grocery stores and shops shuttered, the women's food was dwindling. One day, Ms. Strongbow reluctantly ventured out. "I said to her, 'Helen, I am going to walk as long as I can to get some bread' " she recalls.

She wandered through a world she hardly recognized—smoke-filled air, dusty, ghostly buildings, wary cops who stopped and questioned her at every turn—until she found bread.

The two celebrated with sandwiches.

"And I am not even a bread eater," Mrs. Gilman says.

Mrs. Gilman flashes a crisp grasp of the facts, gleaned from her small TV: the thousands dead, the war on terror, the anthrax deaths and scares. What really bothers her, though, is that she can't get out to visit her dog Nicky, who lives with an acquaintance on Coney Island.

As the talk drifts, Mrs. Gilman softens. "How long should you mourn? How long? You mourn as long as it hurts, and then it stops," she says, "like when you lose a daughter." Her own daughter Florence died 14 years ago the same way many in the WTC did: in a fire. "I've had my crying," she says.

Lung Problems

In the days after the attacks, doctors and hospitals saw hundreds of seniors suffering from trauma-related and other conditions. Doctors say they have seen a marked increase in lung problems among their downtown elderly patients since Sept. 11.

There are no official data yet on collateral deaths or illnesses among seniors, but Ms. Dale says two of her patients suffered heart attacks and a third a massive stroke on the day the towers fell.

Arik Olson, a 29-year-old general practitioner who makes house calls on the elderly of the Southbridge complex, says psychological traumas outpaced physical ones among many of his patients. One 99-year-old woman became suicidal, telling him she wanted to jump off her balcony. Others have developed severe death anxieties that they never exhibited before Sept. 11, Dr. Olson says.

The day after the attack, he says, he was stunned to find an 88-year-old woman with Alzheimer's disease—"very senile," bedridden and virtually noncommunicative—sitting up in bed, eager to talk. "The president is coming," she told the doctor, "The terrorists bombed the World Trade Center."

Ms. Dale worried about the emotional condition of Hilda Hayes. She knew that woman, who says she is "over 80, but not much," used to take daily strolls from her apartment on North Moore to the shops below the World Trade Center. Like many seniors in the area, she loved the buildings and found the bustle around them cheery and inspiring.

Just before Sept. 11, Mrs. Hayes had broken both arms and wrists in a bad fall. A week after the attack, she was discharged from the hospital, both arms in a cast, hobbling and unable to use her cane. She returned to a darkened apartment with no food, no help and no working phone.

When Ms. Dale heard of her predicament, she squeezed her in among 30 other patients and pushed past checkpoints to Mrs. Hayes's apartment.

Mrs. Hayes was sitting on a couch, crying. Two hungry cats were her only company.

"There was no food in the house, and she couldn't feed herself anyway," the nurse says.

"I can't live like this," the retired New York City government worker told her.

Ms. Dale went out and bought her some food, and hooked her up with Meals-on-Wheels, a program that delivers cooked dishes to the elderly. Then, she fought to persuade the woman's health-maintenance organization to install an aide for at least a few hours a day.

Ms. Dale recently went back to check on Mrs. Hayes. Her wrists are healing, and her phone now works, but she still spends large stretches of her day with only her cats for company.

When she hears that the arcade of shops she used to frequent is gone, Mrs. Hayes shrugs. "I'll go to other stores," she says, looking away.

Mornings at Gee Whiz

The Twin Towers figured in the pre-Sept. 11 routine of Marion and Rosario Anello, too. Every morning, they left their apartment, with its grand view of the towers, and walked to the Gee Whiz coffee shop, less than three blocks north of the WTC.

Mr. Anello, a retired longshoreman, is 85 and legally blind. Mrs. Anello, 79, led him by the arm. He ate eggs and bacon; she munched on a bialy with cream cheese. They were such fixtures that if they didn't show up, the shop's owner called them to check on them.

Mrs. Anello was working at the polls for the New York City mayoral primary when the first plane hit. She returned to the apartment at noon. The next day, the two were evacuated to a shelter, where they spent a week sleeping on cots. It was there that Ms. Dale caught up with them and tended to the skin ulcer that had afflicted Mr. Anello for months.

Later, after the couple returned to their ash-covered apartment, Mrs. Anello couldn't sleep. She couldn't bear to look out her windows.

Then she couldn't breathe. Within a month, she went into respiratory distress and was rushed to the intensive-care unit at a hospital near the Brooklyn Bridge. She ended up on oxygen.

Friends came over to cook for Rosario, but he missed his wife of 44 years. So one day, he got himself dressed, poked his way downstairs and found a cab—no easy feat in lower Manhattan after Sept. 11. When he showed up at Marion's bedside, she cried. "I thought I saw a ghost," she says.

On the way home, Mr. Anello got into an argument with the police, who weren't going to let his cab go south of Canal Street. "They told me I was pretty fresh for a blind man," he says. Eventually, they let him through.

Mrs. Anello came home eight days later. They mostly stay put, lights dimmed. Mrs. Anello still won't look out the window. "I don't want to look," she says, putting her head on the table and crying.

They don't want to know what happened to Gee Whiz. It is closed. A sign in the window proclaims that the shop will reopen after renovation.

The air has improved around Ground Zero. The mountain of rubble has shrunk. Checkpoints are diminishing. And Mrs. Kessler's phone service has been restored—after "weeks of torture," she says.

She ventured from her apartment for the first time the week after Thanksgiving, to a nail salon with the help of an aide and a walker. She got a manicure. She wore lipstick for the occasion.

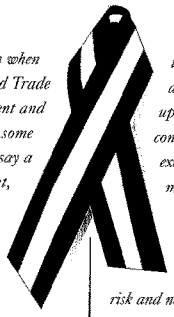
Ms. Dale says her patient has regained some of her feistiness. The mess at Ground Zero no longer preoccupies Mrs. Kessler. Now, she says, she wants to get Osama bin Laden and personally "rip him apart."

SPECIAL ISSUE 2001

FrontLineFocus

• THE NEWSLETTER OF THE VISITING NURSE SERVICE OF NEW YORK •

September 11
How VNSNY Responded



I was at a meeting in midtown Manhattan when word came that a plane had hit the World Trade Center. At first I thought it was an accident and the meeting continued although there was some unease. A short while later, a person came in to say a second plane had hit the other tower. At that point, we all knew it was a terrorist attack. People rushed to telephone their families and workplace. A radio in the background was announcing that there were other terrorist attacks underway and that all airports were closing down. As many as eight hijacked planes might be involved. There was speculation that the White House, Capitol and Pentagon were targets. Someone wondered if the Air Force would try to shoot down the remaining planes.

When I rushed out to head back to my office, there were hundreds of people in the street, all turned toward the World Trade Center where you could see the fire and smoke in the sky. Someone in the crowd gasped and announced that one of the towers had crumbled. People stared down Fifth Avenue in disbelief. A short while later, against the background noise of sirens and emergency vehicles racing south, the other tower collapsed. In the skyline where the World Trade Center had once stood triumphantly, there was now a vast hole.

As I headed uptown, I saw crowds of people running from Times Square and the Rockefeller Center complex because they feared those buildings might be another target for destruction. Most people were calm but also numb from the enormity and shock of what had occurred. While I had to only walk 30 blocks to get to my office, many people were headed toward the Bronx and Brooklyn and had long treks ahead of them. Many shopkeepers were closing up and heading home as well. I could overhear conversations, particularly among young people, exclaiming that this could not be happening, it must be a movie that soon would be over.

When I got back to the office we set up a command center to deal with the crisis and how to deliver patient care to the most high risk and needy of our patients during this emergency. I was immediately impressed with the professionalism and determination of our staff. Despite their own emotional state and personal concerns, they were steadfast and anxious to help in any way possible. It was clear on September 11th and in the days that followed what an extraordinary VNS family we belong to. I agree with one of our nurses from Brooklyn who commented that we at VNS perform the best even in the worst of times.

The events of September 11th are still very much in our minds and our hearts as we try to regain our equilibrium. Here at the Visiting Nurse Service of New York, 24 of our employees lost family members. Six of these family members were firefighters, including William M. Feehan, NYC's First Deputy Fire Commissioner.

Despite our shock and grief, our nurses, therapists, social workers and home health aides did everything they could to be sure that their patients were taken care of and comforted immediately after the attack.

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Most affected were our 1,600 patients who lived in the downtown Manhattan area. Our staff overcame incredible obstacles, including the lack of transportation and communications to locate and treat their patients. They carried surgical masks, medicines, food, water, flashlights and radios to their patients. Some home health aides extended their shifts and stayed with patients confined to their beds for many hours, sometimes overnight, until a replacement arrived.

Nurses rushed to volunteer at triage centers. Community mental health counselors assisted people traumatized by the disaster and volunteered their services at the city's crisis centers. They helped people from many different groups ranging from private companies and public agencies to the NYC public school system. In addition, our hospice bereavement counselors provided services to some of the families of firefighters and others who lost loved ones. These counselors will continue their efforts in the coming year through the city's Project Liberty Program.

In the days and weeks following the World Trade Center tragedy, remarkable stories of staff dedication to our patients emerged from across the agency. In this special issue of *FrontLineFocus*, we feature some of these stories. Please note that these stories represent only a few of the many, many VNS people who maintained agency operations and supported disaster relief efforts during this sad and difficult time. In fact, whenever we interviewed someone for this issue, we often heard from them about other caregivers or support personnel that we should speak to. We're only sorry that time and space did not allow us to include everyone's story.

As you'll see, the Visiting Nurse Service of New York is an organization whose resourcefulness and determination are evident no matter what threat and challenges we face.

Sincerely,

Carol Raphael

Carol Raphael
President and Chief Executive Officer

"proud to be a nurse"

Lisa Heller, a nurse in our AIDS Long Term Home Health Care Program, had just walked into the VNS Brooklyn office when she heard people saying that a plane had hit one of the World Trade Center buildings. As the morning unfolded and more horrible details became known, Lisa did what thousands of other New Yorkers were doing at that time — she began contacting family members and friends to see if everyone was safe.

Lisa's morning changed when Yvonne Eaddy, the Regional Administrator for the VNS Brooklyn office, got a call from the NYC Fire Department's Emergency Medical Services that nurses were needed on the Brooklyn side of the Brooklyn Bridge to treat civilians who were coming over from Manhattan by the droves. Yvonne asked for volunteers.

At first, Lisa was uneasy about going. At that point, nobody knew what was happening. Two planes had flown into the World Trade Center. Another had just hit the Pentagon and there was a report that a fourth plane had crashed into the remote countryside of Pennsylvania. Rumors were rampant. "I had a moment of doubt," confesses Lisa. "But then I thought, 'Why am I a nurse if I'm not going to help in a time like this?'"

So Lisa along with several other VNS nurses from the Brooklyn office were taken by police car to the Brooklyn Bridge. There, they joined other nurses and doctors from the area to staff a makeshift triage center to treat civilians. Most of the injuries were bumps and bruises, smoke inhalation, and eye injuries. One woman who was pregnant went into labor.

After about an hour or so, a call went out for nurses and doctors to staff another triage center on the Manhattan side of the Brooklyn Bridge. Lisa volunteered as did many of her VNS nurse colleagues. They were driven across the bridge by a New York City transit bus. By now both World Trade Center towers had collapsed. Nothing could have prepared Lisa or the other nurses for what they were about to encounter.

"It was just devastating," says Lisa. "Everything was gray and covered with thick dust. There wasn't a speck of color."

The doctors and nurses arrived at the triage center, but it was already well staffed. Hoping to be more helpful, Lisa and some other VNS nurses began to wander about lower Manhattan, looking for a triage center that needed assistance. By now, most civilians were gone from lower Manhattan. Lisa and the other nurses saw the most atrocious and saddest things. Overturned cars. Millions of papers lying about on the street. Even a resume from someone's desk. The group of nurses came to a firehouse near the World Trade Center. It was a heartbreaking sight.

"The firefighters were missing six of their men and they were pretty shell shocked," says Lisa. "They looked like little kids who had just woken up from a bad nightmare. Yet they also seemed extremely determined to find their lost brothers." The nurses checked the firefighters' lungs and eyes and then moved on.

The group of nurses heard that a trauma center was being set up in Stuyvesant High School so they went there. Lisa spent the afternoon and evening at the high school, manning a station with other VNS nurses. There was a news blackout in the high school. At one point, someone ran into the building shouting, "Get out! Get out! There's a bomb!" It turned out, though, it wasn't a bomb at all. It was 7 World Trade Center: the building had just collapsed.

"I feel lucky that I had the knowledge and skills to be able to help on that terrible day."

While at Stuyvesant High School, Lisa treated firefighters, EMS workers, and police officers for smoke inhalation and cuts and bruises and performed countless eye washes. But no civilian victims showed up. Lisa stayed at her station until about 11:30 at night. By then it was becoming increasingly clear what nobody had the heart to come right out and say — that there would be no survivors.

"I'm very proud to be an American," says Lisa. "And very proud to be a nurse. I feel lucky that I had the knowledge and skills to be able to help on that terrible day."

"flew down by bike"

Michael Soccio, an RN, was in the VNS office at 1250 Broadway when Angela Maloney, a coworker, got a call from her husband who worked at 1 Liberty Plaza down in the Wall Street area saying that a plane had flown into the World Trade Center. "The whole office," says Michael, "went absolutely crazy."

At around 11:00 am, the Manhattan Regional Administrator Ginny Field — just back from jury duty, which had been cancelled — came around asking if any nurses would like to volunteer to help staff triage centers down at the World Trade Center. Michael immediately volunteered.

Michael, who travels around the city by bicycle, was able to get down to the World Trade Center within minutes. He just flew down Second Avenue on his bike. At 14th Street, the police had set up barricades. Michael sailed right past the barricades. It was a different story, though, when he got to Duane and Lafayette Streets. There, Michael was stopped by national guards armed with machine guns. Michael showed the guards his nurse's I.D. and had his nursing bag searched.

Michael helped set up a triage unit at Duane and Lafayette. For the next two hours, Michael and the other medical personnel at the triage unit waited for victims to be brought in — but none arrived. At around 1:00 pm, a police officer came over to the triage unit and told everyone that they were going to start receiving victims. "You're going to have a long night in front of you," said the police officer.

But still no victims arrived.

After about an hour, Michael heard that they couldn't get the victims to them because crushed police and fire department vehicles were blocking the way. So the triage unit was asked to move to Ground Zero.

"I had never heard the term 'Ground Zero' before," says Michael.

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The doctors and nurses were all given respiratory masks to put on. Then NYC buses arrived to take them into Ground Zero.

It was very frightening. The air was completely dark with thick smoke and there was destruction everywhere — blasted out building windows, demolished cars, debris in the streets, and thick grey silt on every surface imaginable. At one point, Michael saw an overturned donut cart on the sidewalk. Donuts were spewed out all over the street.

"It was like a war zone," says Michael.

The buses were about one block from the World Trade Center, when they had to quickly back up — the third World Trade Center building was about to collapse. The buses then brought Michael and the other medical personnel to Stuyvesant High School, where Michael helped set up a triage center. He stayed there into the evening. At about 8:00 pm, with still no civilian victims showing up, Michael, numb, frightened, and shocked by all he had witnessed that day, left to go home.

"just being there changed my life"

Marietta Guido, a social worker for VNS CHOICE, was in a meeting. "Somebody walked in and said a plane had hit one of the towers. We were so immersed in our work on an intense case, it wasn't until later the information started to sink in."

"I come from a place where terrorism is an everyday thing and the way people deal with it is to ignore it," says Marietta. She came to New York from Bogotá, Colombia where there were constant terrorist attacks by the different drug cartels. "The way I dealt with the World Trade Center attack was to go uptown to see one of my patients. When the subway stopped (between stations) for 10 minutes, I got in touch with the panic. Finally the train moved to the 59th Street station, then the subways shut down. I recall very vividly the sound of sirens that wouldn't stop. I walked back to the office at 32nd Street feeling in shock and called the people I care for to make sure they were okay."

"On Tuesday and Wednesday, I pretended I was okay; my feelings were elsewhere. On Thursday, I volunteered at the Armory at Lexington and 25th to be with families who were reporting loved ones who were missing. I could see the magnitude of the tragedy, the families and their pain, people with lists of five names. Never have I felt so useless and so speechless. Nothing I could say would bear their pain.

"Those families will never know they changed my life forever, but they really did. Just to be able to be so close to human beings who are in so much pain. Just being there, accompanying them, changed my life."

"who's here for supportive care?"

Alice Keating, VNS CHOICE Member Support Consultant, was in her car on the East River Drive going to a case conference in Brooklyn. "I hear Imus on the radio talking about a fire at the WTC. I think they're talking about 1993 — their voices are calm and measured. Then they mention a hole in the building. "Traffic on the Drive came to a halt. Alice saw a low-flying plane. Just as she thought, "It's going to hit the other building!" the plane slammed into the north tower.

Moments later there was a whirl of sound. Emergency vehicles sped past in the hastily cleared left lane. Traffic police eventually redirected Alice and the other drivers to the northbound lanes of a drive suddenly empty of cars but starting to fill with people fleeing from the financial district. Alice picked up two men and a woman and dropped them off on 14th Street where she lives.

Alice checked in with the office from home and was told not to come in. CNN, another tenant, had received a threat and the building might be evacuated. Alice and her husband decided to walk over to St. Vincent's Hospital and donate blood. Hundreds of other New Yorkers had the same idea and the line stretched around the block. Alice then checked in with the emergency staging area for doctors and nurses. "They were mainly looking for med-surge people," she said, referring to nurses who work in the medical and surgical units of a hospital.

"We were just waiting around until someone asked, 'Who's here for supportive care?'" Alice raised her hand.

Special help was needed for a young woman who worked at the WTC and who had 2nd & 3rd degree burns over 75% of her body. "She just walked in the door to go to work," explains Alice, "and was engulfed by a fireball. She couldn't understand what was happening."

Alice was able to focus on the patient while the other doctors and nurses focused on cleaning and treating her burns. Her mission changed when the young woman's husband arrived. He also worked in the WTC. That morning he was still at home taking care of their baby when he got word his wife was injured. "He was alone and beside himself," says Alice.

"In a disaster, you have to get people to talk about it," says Alice, calling on her experience in mental health and as an on-call disaster nurse. The husband was frantic about his wife, her injuries, whether she would live. He was also stunned over the devastating collapse of the two buildings. "They both knew so many people who worked in the towers," said Alice. He was worried. "Who was all right? Who wasn't? Who had they lost?"

Alice sat and listened intently as the man talked about his wife, their baby, and their life together. "She's a fighter," he said. Throughout the day, she relayed information back and forth, translating "medicalese" into plain English. Occasionally she'd get sent to the supply closet for more saline. They were using buckets of it to clean the young woman's burns. On one such trip, Alice encountered one of emergency room nurses standing alone, sobbing.

Late in the afternoon, the decision was made to move the woman to the burn unit at New York-Cornell Hospital. "I told him her burns were compatible with life and this was the best place for her to be."

The woman was transferred at 6:30 pm. At 7 pm Alice and the other volunteers were released.

As of November 6th, the young woman is still in the burn unit, continuing to be a fighter.

"going to stay no matter what"

Patrick Luib, an RN and Performance Improvement Specialist, was in a staff meeting in Brooklyn when a nurse came back from the field with the news. Patrick managed to reach a friend at home who worked in one of the towers. After listening to her describe in vivid detail the horrors she'd seen from her 56th floor office, he went outside for a much-needed breath of fresh air. "The air was already polluted with a pungent odor," Patrick says. "I noticed ash floating on this clear, sunny day."

Patrick went back inside and saw that the receptionist had passed out. Her husband worked in one of the buildings. Everybody was in a state of shock.

Emergency Medical Services relayed a request for volunteers to help with triage efforts through the Brooklyn's Sheriff's Office.

Patrick, Erik Mortensen, RN, Lisa Baez, RN, and John Ide, the Spiritual Counselor for the hospice program, were among those who responded. They arrived at the foot of the Brooklyn Bridge to find VNS nurses Kathleen Martin, Joy Lee, Magalie Louis and Consuelo Celestine already at work in the midst of the chaos.

A steady flow of office workers evacuated from the Financial District filled the bridge. Some had been injured when the two planes slammed into the towers, sending a shower of broken glass and other debris onto the plaza and streets below. Others had been caught in the frightening clouds of ash and grit let loose by the towers' collapse. Some were in shock.

"A Hasidic man covered in ash from head to foot was shaking all over," says Patrick. "We used a syringe from my nursing bag to irrigate his eyes. The other nurse held his hands and told him he was safe."

Serious injuries were sent to another site for treatment. The nurses treated dozens of lacerations, eye irritations and cases of shock on the spot.

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"One of the first patients I treated was a 25-year-old New York Stock Exchange worker. She still had her blue vest on. She had eye irritation and right arm pain, a possible fracture. We sent her to the hospital for x-rays. I held her hand as we waited together for an ambulance.

"The real disaster was across the bridge. As the numbers of patients started to decrease, we got permission from Emergency Medical Services to board a bus which took us to City Hall." As the group searched for triage sites, they "started a journey we will never forget. The amount of ash and papers that littered the streets was incomprehensible. Stranded vehicles were covered with ash. We walked past Ground Zero. The thick gray ash had turned to mud. Boots and shoes littered the street from people running away. The heat was intense. Police and firefighters stood there waiting ...waiting because there was nothing anyone could do at the moment. The silence was profound."

The triage sites they found were fully staffed. They were directed to a trauma center being formed at Stuyvesant High School and, along with several others, including a New York Times reporter, helped carry boxes of supplies to the school.

"They were just beginning to set up operations. We were split into teams and team B was sent up to the gymnasium to get some sleep so they could relieve our team in a few hours.

"Team A continued to organize stations — eye irrigation, operating room, burns, lacerations — with the hope that people would be coming. The nurses on Team B couldn't sleep and came back down.

"A wave of people came running into the building from the streets. Someone screamed that a bomb had exploded, but in actuality, another building had collapsed. People started running. The nurses, though, all stayed at their stations. We were going to stay no matter what.

"I decided to assist in the eye wash station. IV bags were hung on lockers with benches in front for people to sit."

Patrick's experience in the field, where one has to be fully prepared, paid off again. In his bag he had one of the few ophthalmoscopes, a device used to check the cornea, inner eye and retina, on the scene.

The relief workers would get one or two drops of local anesthetic in each eye, then each eye was flushed for five minutes. An hour later, they'd be back again. "I was impressed by the way the operation was running. Everyone was working in the same vein." Patrick got on a first-name basis with one fireman who kept coming back to his station. "I joked with him about it, saying, 'How'd you like it this time? Over the ears?' as if I were a barber."

The NY Times reporter noticed and took a picture of the pair.

Patrick worked until 10:30 p.m., waiting for survivors who never came. Two nurses were anxious to get home to their families and Patrick accompanied them to the Brooklyn Bridge. Erik and Consuelo worked overnight, Erik with relief workers at Ground Zero.

Near the bridge, Patrick was stopped by a reporter and film crew from WPIX. "I told her seven of us from VNS did the best we can in the worst of times. The next day a woman in the office said she sat at home watching the news, waiting for her husband who worked at the Marriott Hotel next to the WTC. She cried when she saw me and said, 'I knew that the people down there were safe as long as you and the other visiting nurses were around.'"

"A wave of people came running into the building from the streets. Someone screamed that a bomb had exploded, but in actuality, another building had collapsed. People started running. The nurses, though, all stayed at their stations. We were going to stay no matter what."

The images and odors, experiences and feelings remain fresh to Patrick. On reflection, he says he takes "comfort in the way the agency responded. We all helped out in a very big way. The nurses who went to see their patients and listened to them recount their stories are heroes, too. I also take comfort in my relationships at work. This has only reinforced my belief that I've found my home at VNS."

Visit our Web Site:
www.vnsny.org

"walking to work over the Brooklyn Bridge"

Lily Ruan, a visiting nurse with VNS CHOICE, was driving to work in Chinatown from her home in Brooklyn. She learned about the attack when she got to the Brooklyn Bridge and found it closed.

"I went home and called all my patients. All were okay. The next day, though, the phones were out south of Canal Street." Lily walked over the bridge to check on her patients, a pattern she followed for the next few days.

Everybody had electricity and water. One patient, though, had run out of medication. The prescription had no more refills and the doctor's phone wasn't working. Lily managed to get enough to tide the patient over from an obliging pharmacist.

Many of her patients were very worried. "Most were in the war. I tried to calm them. Some who'd been depressed for years now have a different attitude," Lily says. "They've evaluated their lives and have decided to make an effort to be happy."

"life changing for all of us"

Vince Corso, Coordinator for Spiritual Care & Bereavement Services for VNSNY Hospice Care, was in a team meeting. As reports came in about the first plane, the second plane, the first collapse, the second collapse, the team somehow managed to stay focused on patient care.

"Thanks to the nurses, social workers, chaplains, and volunteers," says Vince, on September 11th and in the days following, "hospice services in the field never missed a beat. Patients were seen, medications given."

Vince and VNSNY Hospice Care social worker Stephen Borow were asked to do a series of eight 90-minute crisis intervention sessions with the employees of the law firm, Cadwalader. With offices on Maiden Lane, they'd gone through the trauma of being near Ground Zero. Many had also lost friends and colleagues.

Between 350 and 400 people attended. "Each group was unique," says Vince. "There were many young people with no experience of death or dying. They wanted to know what to say and do when one of their colleagues, whose husband was lost at the WTC, returned to work."

After a reflection and guided meditation, Vince and Stephen provided an opportunity for people to react and talk about the kinds of emotions they were experiencing. "We also mingled in some education, ways to cope with the range of feelings. It was as helpful to me as the people we facilitated for."

For VNS employees, Vince led about 10 memorial services in all five boroughs. The services included interdenominational prayer, a reading, an opportunity for people to talk about their feelings and anxiety, and to pray for people who had died. "The services were quite moving. There were people who had lost family and friends. They could express grief and feel supported by fellow workers.

> *" Embrace the person next to you. This has been really life changing for all of us. Feed your soul."*

"It's not so much the format as the willingness to be with people and give people a chance to talk. Anger, disbelief, fear...most of the healing comes from expressing feelings."

Vince has also been working with others at VNS and the city to develop an organized bereavement outreach for the families of firefighters.

"People will bounce back," Vince says. "We have the psychic and emotional wherewithal to go on. If you notice someone who's not sleeping, increasingly irritable, out of character or frozen, don't hesitate to reach out. Embrace the person next to you. This has been really life changing for all of us. Feed your soul. Do something beautiful and don't feel guilty. Nourish yourself. Don't get wrapped up in the news."

"we were the lucky ones"

Carmel Tuths, Program Director for VNS CHOICE, saw the burning towers as she walked to work across 23rd Street. "People were standing there, silently staring up. I asked people coming up from the subway from downtown what had happened: 'Terrorist attack.' 'Planes hit.' I thought, 'I have to get to work. There's going to be mayhem.'"

"We sent five nurses down to Ground Zero. Four others were deployed to hospitals. We started doing assessments and had social workers start to do counseling with staff. Several had family members who worked there. One had an aunt who for was unaccounted for, then found in a hospital, 24 or 48 hours later. One nurse lost her best friend.

"Our nurses all pitched in and went out and worked. They're troopers. They just all banded together. They all wanted to do what they do — which is taking care of patients.

"The home health aides were wonderful. Many slept over because they didn't want to leave their patients alone without phones.

"We were the lucky ones ... there's a lot of solace in being able to do something."

"hardly been home"

Lisa Baez, VNSNY Hospice Care Team Manager, had just walked into her office in Brooklyn. The receptionist at the front desk told her the news. She made phone calls, first to family, then to fellow hospice workers.

"Visit or call your patients," Lisa told her team, "and make sure they have all the pain medication they need."

The Brooklyn Sheriff's Office called to request volunteers to help staff a triage site at the Brooklyn Bridge. Several nurses went ahead in a police car. Lisa, Patrick Luib, Erik Mortensen and John Ides, collected gauze, saline and other supplies, then followed.

Thousands of people streamed across the Brooklyn Bridge from Manhattan. Some were totally covered in ash from the towers' collapse. Many had lacerations from flying debris. Lacerations and eye irritations from all the soot in the air were treated on the spot. More serious cases were sent to another triage center at a nearby hotel where, by coincidence, an association of emergency room physicians was holding a conference.

When patients didn't come to them, Lisa and another nurse went looking for them. As the stream turned to a trickle, some of the nurses went into Manhattan. Lisa went back to the office, and then ran out to buy some clothes for the coming days. She was afraid if she made it home to New Jersey, she might not get back to work. She was determined to be available for her patients when they needed her.

"Our nurses all pitched in and went out and worked. They're troopers. They just all banded together. They all wanted to do what they do — which is taking care of patients."

In the weeks since September 11th, she says, "I've hardly been home, maybe just once or twice a week." With traffic still unpredictable, she continues to stay with family nearby. "We always keep in close contact with our hospice patients. They've needed a lot of emotional support as well as the reassurance we can give to them."

Special Relief Fund to Aid VNS Employees

Sadly, 24 employees of the Visiting Nurse Service of New York lost family members in the World Trade Center tragedy. To help these families, VNS has created a special fund. If you would like to contribute, please send a check to:

VNSNY Employee Relief Fund
Attn: Lyle Churchill
107 East 70th Street
New York, NY 10021

"keeping in touch"

Marian Haas, Director, Human Resources, was on her way to a meeting. "Someone said a plane had hit. We thought it was a small plane, off-course."

As news of the unfathomable events transpiring downtown reached Human Resources, they reached for the phones. "We were in touch with key program and department heads, the Chief Operating Officer, Vice President for Human Resources," says Marian, naming a few contacts. HR helped with the flow of information, both in and out.

They sought out information about nurses and other staff working in the area near Ground Zero and below 14th Street. About who had missing loved ones. About where to send nurses who wanted to help.

They provided information for managers calling in for help in dealing with their staffs' fears and anxieties. About transportation problems when the subways in Manhattan shut down.

"The day is such a blur," says Marian. "It was just incredible something like this could happen. Not until the afternoon did it really sink in here.

"The nurses were so resourceful in finding out about patients, knocking on doors, checking with neighbors and superintendents. One nurse with a van drove others all around."

The calls to those with missing loved ones was "tough but touching." Besides seeing what kind of support VNS could offer them, "We wanted to make sure they knew our thoughts and prayers were with them."

To Order Our Services:

To make a referral to the Visiting Nurse Service of New York, please call:

1-888-VNS-1-CALL
(1-888-867-1225)

"big hearts and special skills"

September 11th was primary day in New York City. Keri Hicks, Division Coordinator, Community Mental Health, saw the first plane hit while she was voting. "My polling place had a clear shot down Washington Street. I raced to get a cab to try to get to work. I knew we'd be busy."

Keri's group provides community mental health services for the city, including disaster-related services. "We called the city and told them we were available to assist. The initial 24 hours of any crisis, though, is really all about first response efforts. Mental health response begins a little later. The next day we got the call to be on alert."

Community Mental Health Services (CMHS) has been involved with many disasters in the city. Social workers spent months working closely with the families of TWA flight #800, and they also provided counseling services after the horrible fire at the Happy Land night club. What happened at the World Trade Center, however, was "like nothing else in scope and emotion," Keri explains. "We were affected tremendously by the events, and had to find a way to manage our own pain and grief and fears as we helped others."

Community Mental Health staff are, in Keri's words, "uniquely ready" to help. While many mental health professionals have clients or patients come to them, Community Mental Health goes wherever the situation takes them. "We're used to working in stressful conditions. We're used to working in other people's spaces."

The group has also donated countless hours at the family assistance centers, sending 8 to 10 social workers to work 8-hour shifts. Some employees are now giving 20-hours a week on their own time. "We have a lot of people with very big hearts and special skills so they can be really helpful."

For the first time, CMHS has been responding to the needs of VNS employees as well, working closely with both Hospice and HR, running support groups in all 5 boroughs.

While continuing to deal with the immediate effects of September 11th, CMHS counselors are also gearing up to handle the expected influx of longer-term problems, particularly depression, in the months to come.

"hooking up patients and families"

Millie Bonizio, Patient Service Manager, Congregate Care, was sitting in her office at 1250 Broadway when her husband called, asking, "Did you hear the news?" "I was shocked. I said, 'You're lying, get out of here!'" Millie relates the story of one of her nurses, Andrea Dale, who was taking a few well-deserved days off and couldn't be interviewed.

Andrea, a Congregate Care Nurse, lives and works downtown in what became known as the "frozen zone." On September 11th, she watched the attack with horror from her apartment. After calling the office, she rushed down to one of her buildings, 310 Greenwich Street, which is right near Ground Zero.

By the time she made her way through the crowded streets, police had already started to evacuate the building. Andrea, who came to VNS from the police department, finagled her way in. Her patients are mostly elderly and some, including one 93-year-old, didn't want to leave. There was no time for a discussion. The police didn't even let one home health aide grab her purse before they rushed her and her patient out of the building.

Andrea, using a cell phone with terrible reception, tried to stay in contact with Millie, in an attempt to hook up patients with their families and arrange transportation out of the area. Those who had no families, or whose families lived out of town, were transferred to shelters.

All but one patient at 310 Greenwich was quickly accounted for. A younger woman, wheelchair-bound, couldn't be found. "We knew she was okay," says Millie. "She had talked to her mother, but we couldn't physically find her." Later VNS discovered the woman had made it to a hotel on her own.

During the following days, Andrea visited her patients in the shelters more as a comforter than as a nurse. She told Millie they were scared and finding it hard to sleep on cots. One patient only stayed a few days until her son arrived from Massachusetts. A couple in their 80s weren't so lucky. They were there more than a week until 310 Greenwich reopened.

The residents of 80 North Moore and 40 Harrison were able to remain in their own apartments but faced other difficulties. Only emergency vehicles were allowed in the area. Most shops and businesses were closed. Andrea and other Congregate Care staff worked closely with the Red Cross to make sure the residents had food, medications and other supplies.

Andrea reported that many of her patients are trying to deal with both anxiety and guilt. They're asking, 'Why were we spared when so many young people died?'

"we got calls from China, Hong Kong, Malaysia"

For Amy Hop-Yee Mung, a Patient Services Manager who works in the VNS Manhattan office at 1250 Broadway, September 11th wasn't a good day to begin with. Ginny Field, her Regional Administrator, was on jury duty and a member of Amy's team — Team 16 — was out on vacation. (Amy manages a team of 13 nurses who provide home health care services to approximately 365 patients in lower Manhattan, including Chinatown. Three other teams — Teams 12, 14 and 15 — also provide home health care services to lower Manhattan.) And then, at about 8:50 am, Amy got a frantic call from one of her nurses saying she had just seen a plane crash into the World Trade Center.

Like many people when they first heard the horrific news, Amy thought it was an accident. As more and more details became known and the scope and gravity of the catastrophe grew, Amy and the other Patient Service Managers immediately began contacting the nurses who were out in the field. They wanted to make sure their nurses were safe and to let them know what had happened. As it turned out, half of Team 16's nurses had witnessed the event firsthand.

"Can you work in the field?" Amy asked each nurse on Team 16. She knew that they were only human

and that, having seen such a nightmarish thing, it might be difficult for them to continue to care for their patients. But each of Team 16's nurses — including one who had a cousin who worked in the World Trade Center and had not been heard from — stayed on duty. (Five of the nurses helped staff triage units.) Amy told all of the Team 16 nurses to call and check on their families and make sure they were all safe.

"I asked my nurses to stay in touch with me and call every two hours," says Amy.

Within the first hour of the attack, all bridges and tunnels into Manhattan were shut down. Subways and trains stopped running. People were streaming across bridges on foot to get home. By the end of the day, some subways and trains had begun running again on a limited schedule. A number of Team 16's nurses live out on Long Island or, like Amy, in New Jersey. They were worried that if they went home that night, given the uncertainty of the situation, they might not be able to get back into Manhattan the next day to care for their patients.

Amy felt the same way — as did other VNS nurses. The agency began calling hotels to see if it could get rooms for the nurses. But because thousands of people were stranded in the city, it was difficult to find a hotel that wasn't booked solid. Three rooms were finally located at the Warwick Hotel at 54th Street and Sixth Avenue. Amy and six nurses stayed in one of the rooms.

The majority of the patients in lower Manhattan are elderly and frail. Many speak only Chinese or Spanish and quite a few are bed-bound. In the days following September 11th, most were without electricity and phone service and a number didn't even know what had happened. They smelled smoke outside their buildings, and, not surprisingly, they were terribly frightened. The nurses on Teams 12, 14, 15 and 16 made a special point of checking in on each patient, even if the patient was not scheduled to be seen. The nurses wanted to make certain that all of their patients were safe. They also wanted to ease the patients' fears and provide them with the latest news.

"Around this time, we began receiving calls from worried family members who live overseas," says Amy. "We got calls from China, Hong Kong, Malaysia. Since there was no phone service in lower Manhattan, the family members had no way of finding out if their parents or grandparents were safe. So they called us. We were able to tell them that we had already checked on their family members."

Many of the elderly patients that Teams 12, 14, 15 and 16 provide home health care services to live in buildings that have high concentrations of other elderly residents. After checking in on their own patients, the nurses looked in on how the building's other elderly residents were doing. The nurses also helped out in other ways as well. One nurse gave an elderly patient a shower. Since no businesses were open in lower Manhattan, some nurses walked up to pharmacies above 14th Street to fill their patients' prescriptions. (They also checked to see if any other elderly residents in the building needed their prescriptions filled.)

"The nurses on Teams 12, 14, 15 and 16 made a special point of checking on each patient, even if the patient was not scheduled to be seen."

Due to the fires at the World Trade Center, the air quality in lower Manhattan was particularly bad. On Thursday, September 13th, Ginny Field, who was back at work because her jury duty had been cancelled, was able to find 200 industrial respiratory masks ("the good ones," says Amy, "the ones with filters"). Since phone service was out and the nurses were all out in the field, it was impossible to reach them. In order to get the masks to the nurses as soon as possible, Millie Moy-Thompson, a per diem nurse, drove Amy down into lower Manhattan so Amy could hand the masks out to the nurses. Amy knew all of her nurse's rounds — she knew the streets the nurses were likely to walk down and the times they were likely to be there. Amy gave each nurse a mask as well as masks for each nurse's patients.

When you speak to Amy about September 11th, she goes out of her way to stress that it was a team effort that got them through those difficult days. "Everyone pitched in," says Amy. "Even VNS nurses who didn't work in Manhattan. They came in and helped us out so our nurses could get a rest."

"this patient can't be left alone"

Lillie Howard is one of three Partners in Care Home Health Aides who take care of the same patient, a woman confined to a wheelchair who communicates with her eyes and a signboard. Lillie works the 9 pm to 9 am shift. She and her patient were watching the "Today Show," waiting for Keyleen Johnson, the next aide, to arrive. Lillie heard a loud boom, "then sirens running wild."

Lillie knew it wasn't thunder. The day was sunny and clear. Perhaps a truck collision? She glanced at the TV and saw a picture of a thick, black cloud billowing from the World Trade Center. She went out on the terrace and saw the same devastating sight, just blocks away.

Keyleen arrived and reported that there was smoke all over. As Lillie came in from the terrace, the other plane hit. "That's not an accident," she told Keyleen. "This looks like a suicidal thing going on."

Lillie had no idea when she left that it'd be several days before she'd be back. It took her more than six hours to reach her home in Queens after a harrowing trip through lower Manhattan and nearly losing her way in the dark clouds of soot and smoke. There was no way she was going to get back to work for her 9 o'clock shift.

But Keyleen, Lillie and Yvonne St. Martin, the third home health aide, "all pooled together and made it work," says Lillie. They all knew that "this patient can't be alone." Keyleen stayed with the patient until Thursday morning when Yvonne arrived with a police escort. Lillie managed to find her way around the police barricades to return on Sunday. She stayed until the following Tuesday morning.

Lillie, Keyleen and Yvonne are now back to their regular schedules. But while their schedules may be back to normal, the area still isn't.

"It's like a war zone," Lillie says. "And there's that smell. You get off the train and smell that charred, dead smell." Just a few blocks away is "where the empty space is."

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Senator CRAIG. Well, thank you very much. I do want to get Marion's testimony and then I have several questions I want to ask and still try to keep us all on schedule here.

Next our last testifier and I must tell you, Marion, certainly not our least. We thank you for your patience in being with us. Marion Anello, an elderly patient of Ms. Dale's, has her own personal experience to tell us out the very experience and circumstances that Andrea Dale found herself serving. So, if you would please proceed. There you go. Thank you.

Ms. ANELLO. I thank you for having me. I am Marion Anello. I am 80-years old. I live a block and a half away from the World Trade Center. I was working that day on the Board of Election in my building on the second floor. When the first plane hit the tower everything shook: the windows, the blinds, everything. We didn't know what happened. When the second one hit, the maintenance man came downstairs and said the World Trade Center was just hit. We have a 60-inch television downstairs in the senior citizens room, pulled it out, and we put it on. When we saw what happened, it was a terrible thing. We closed up the Board of Election because there was nobody coming down any more, so we got a phone call to close it. Put everything in the back of the machines and we closed it and went upstairs. I live on the fourth floor with my husband. When I sat down on the chair I saw the second building come down. It crashed right in front of my face. It was terrible. All I heard was glass crashing, crunching. It was a terrible thing to see. Not to see the other two buildings over there was more disaster.

Well, my husband and I were talking about it. What could we do. These are crazy people anyway. Two weeks later I landed in the hospital with a lung infection from all the smoke and the debris and everything from downtown. I was in the hospital for 8 days. I came home after the eighth day. Now my husband wanted to come and see me in the hospital. I told him not to come because he is blind. I told him I am coming home, but he came anyway. He came home. He was on his way home in a taxi, somebody got him a taxi downstairs. He got to Canal Street, the cop wouldn't let him pass. So the tax driver said I have a blind man here. He lives at 310. He's got to get home. So he said, you are very fresh for a blind man. He said, "What do you want me to do? Walk? I can't walk."

Anyway, another police car passes and says what is the trouble? He said—the taxi man said I have a blind man over here. he said he has got to get home. He lives at 310. He said go ahead. Anyway, he called me in the hospital. I said how did you get home. Why are you so late? He says they wouldn't let me through beyond Canal Street so anyway, that is my story.

Oh, yes, excuse me. I am a little nervous, you'll have to excuse me. OK. That night of September 11, getting back to my story, they evacuated us from the house. All of us had to get out. We had no hot water. We had no heat, no water. We all had to get out of the building. Five hundred tenants had to get out. They had three buses waiting for us outside to take us to the Washington Irving High School. I lived in the shelter for 8 days. I tell you, it wasn't very nice and that is nothing like home.

They brought us home after the eighth day, and I came home I was so glad to have my house and to sleep in my own bed. I slept on a cot for 8 days. I don't know how the homeless do it, but God bless them anyway. That is all I have to say. I am just happy to be home, that is all. I hope it doesn't happen again.

Senator CRAIG. Marion, thank you for your testimony. That is extremely valuable because for those of us who attempt to look at it through papers and reports and policies sometimes, in all fairness, we miss the emotion, and it is very important that we understand that as we work through these difficulties and develop and coordinate programs.

Andrea, you obviously serve the area that Marion lives in, and you talk about the preparedness or the efforts now at greater levels of preparedness and coordination. If I were to ask you what would be the top two or three lessons you have learned and things would you want to change to improve the circumstance you were in following September 11, what would that be?

Ms. DALE. Well, of course we had difficulty with the communication. I had two——

Senator CRAIG. My notes said communications right off the top.

Ms. DALE. I had two phone services at home, one local, one long distance, and the service at home is undependable. I had my cell phone and that wasn't working downtown at all. My cell phone worked the first day, so I wasn't able to make contact with my office. We have computers. We communicate by phone lines, and we also had trouble with the phones at my office, so an alternative means of communication that would be more dependable would be one thing I would consider very important.

Second, you know, I don't mind walking and I had it very easy compared to a lot of people, but I had to walk miles and miles every day just to get to the checkpoint, through the checkpoint, and to my patients and back and then to go see some who were evacuated. So, I got it all done in the course of a day. I had some all the way over in the shelters on East 17th Street because their care needed to be continued despite the evacuations. I felt if there could be a better way to compile a central list of knowing who had been evacuated. There were certain people I had to put in more efforts to try to determine whether or not they had actually been evacuated because they had the right to refuse. It wasn't mandatory, and some had to be persuaded. So as it turned out, there was one gentleman I had in the Battery Park City area and Tribeca. I had a very large area at that time. My resident in Battery Park City had refused to be evacuated and I think it was probably because he couldn't take his dog with him. He landed up on the floor and I wasn't allowed to go down there, and I had been assured everybody had been evacuated. He was eventually found on the floor and he had sustained a fracture having fallen when it was dark. Those would be three key items.

We have, of course, emergency disaster planning. I don't think we had anticipated anything quite like this.

Senator CRAIG. Well, I doubt that any of us could possibly have imagined this, and you are right. Although our planning must encompass worst case scenarios as best the human mind can create

them and then develop systems for them. You mentioned an elderly fellow staying behind because his dog could not go I assume.

Ms. DALE. Pets were not allowed to go. They were not brought to the shelters, although the ASPCA did establish a plan to go around collecting pets if you could give them a house key. Lots of people in New York City are so devoted to their cats and dogs.

Senator CRAIG. We all are. I have pets and I am just wondering in your recommendations where in the case of evacuations not being mandatory and people not wanting to leave because of their pets is there anything that mentioned that or talks to that as to how we might be able to deal with that sides of the dimension of people's willingness to participate?

Ms. DALE. No, there is nothing mentioned I just mentioned because I did spend a lot of time just investigating after I had determined where most of my patients were then I went to look for people I had a harder time finding. I interviewed a lot of people. I spoke to police officers and military police. We were going to try to enter a locked building. The second day I found a military policeman who was able to tell me that this couple I was concerned about had been persuaded to leave because they were going door to door as had been mentioned earlier. They did a really good job. They went around and told everybody you have 5 minutes to leave. Get your medicine and we will be back for you. Well, they didn't state it was—I think eventually it was mandatory in one of my buildings in that building. I think they had mentioned something about it. They suspected gas leaks or something.

Ms. ANELLO. That is right.

Ms. DALE. I think they mentioned suspected gas leaks.

Ms. ANELLO. That is why we were evacuated. We had gas leaks. No water, no heat.

Senator CRAIG. Thank you both very much. That is valuable testimony, to have firsthand testimony as to the actual area itself and people your age and needs, Marion, and how they got served. Thank you very much.

Ms. ANELLO. She was very helpful to me. That is right. Bless her heart. She is a good girl.

Senator CRAIG. Michael, prior to your experience on September 11 had you ever had any emergency training or any kind of training within your office complex that assisted you?

Mr. BENFANTE. Other than routine fire drill to the extent where you leave your office and you were shown where the stairwells are on each level.

Senator CRAIG. Were those fire drills taken seriously by your office and your staff?

Mr. BENFANTE. Yes. For the most part, we all followed the procedure. I do remember that you are supposed to have a designated fire marshal, so to speak, for each office and then a secondary one. Just might want to consider where there are offices with turnover, you might want to consider just someone that is always there not so much as an outside sales office. I happen to be one of those I think I was more of a secondary one than a tertiary one, but other than just routine fire drills.

Senator CRAIG. The wheelchair that you used to bring Tina out, obviously you could not have brought her out on her electric wheelchair.

Mr. BENFANTE. She was actually adamant about bringing that down, but it was too big. I just told her to leave it behind.

Senator CRAIG. Well, now was that portable or emergency wheelchair part of the office or was it there because of her situation? What caused that wheelchair to be there at the time?

Mr. BENFANTE. It was actually because of Tina. From what I understand, Tina was also working at the World Trade Center during the 1993 attack and as a result of that attack, there were certain procedures put in place, I think one of them being that emergency wheelchair.

Now, I think it should be mandatory that any person with a disability that is confined to a wheelchair, whether they remember to have one or demand to have one there or not should be there, should be required. So I don't know if it was part of a requirement or, if it was just part of Tina requesting it be there.

Senator CRAIG. Well, I am sure it is fortunate for both Tina and you and your partner that it was there.

Mr. BENFANTE. Yes, very fortunate. It just made the evacuation a lot easier.

Senator CRAIG. Well, Michael, your testimony is special. I am sure that many people have praised you, as they should, for your help and persistence under those most difficult circumstances. I think all of us when we hear of people like you and testimonies given question ourselves over whether we could have performed as well under those circumstances. My congratulations to you.

Mr. BENFANTE. Thank you, Senator. Just one thing.

Senator CRAIG. Please go head.

Mr. BENFANTE. All things considered, I agree with Congressman Gilman that it was a tremendous emergency response. I know there were many lives lost, but I think just in the way that our Fire Department and Police Department and rescue workers responded there were more lives saved and it just should be acknowledged.

Senator CRAIG. Well, I appreciate you for saying that. Certainly I am not critical and I don't know of many who are. We look at the circumstance and the magnitude of the situation and recognize really how well everyone performed. What we are in pursuit of now whether it is FEMA or CDC or others is where do we go from here. Several of you mentioned our preparedness for 2000 and a suspected problem, and there was a major investment nationwide at that time for communications systems and computerized systems as related to a potential shutdown which did not occur. But it did create a preparedness that obviously has helped us and helped this situation to some extent. No, I don't think anyone is being critical, and I thank you for saying that. The question is where do we go from here to improve upon both services coordination and Federal, state, local systems working together thank you.

Mr. Jellinek, you mentioned your experience with a private-public environment. I guess my question to you is what obstacles did you encounter as it relates to the cooperation between the public-private sector?

Mr. JELLINEK. I think overall it was a tremendous response working together. I think New York is such a heavily populated city and we are broken up into 59 different community boards. There needs to be more of a community-based response. For example, if you worked in programs in the community and sometimes you don't—a lot of people don't live in that community. Those people did not know where to go. They could have gone to other communities and other programs to lend their help. So I think there is also these informal relationships where you have at the post office or you have with the different businesses in the community. I think to begin to work that a little more in terms of making sure the relationships are there if things break down that you can work with a very local level.

I appreciate the need to have Federal interagency responses as well as state responses. But at the city level the action occurs on a local level and unless the people on the ground floor of the meal deliveries are trained as to what is going to happen and who they go to—and nobody was prepared—at least I wasn't prepared, let's put it this way, for this kind of magnitude of tragedy. The thing that I raise is that as time goes by that we keep diligent in terms of putting these preparedness plans in place and take them seriously, and so I would urge that there be some sort of mandate on a very local level that people work together.

Senator CRAIG. Well, I appreciate you saying that. I come from a very rural setting. I grew up. My nearest neighbor was seven miles away in a rural ranching environment. While we think of help coming in from the outside, it always would get there too late. We really had to think locally and think neighbor to neighbor and always did. I think that while I agree that Federal, state, local cooperation is tremendously important as it relates to training and communication and we are finding out that the right hand in some instances on September 11 did not know what the left hand was doing. There is no question that those who are there if properly trained at the moment the circumstance occurs can save lives as we know and be that first line. Of course, fire departments certainly were doing that in part immediately in the first instants. But I think your admonishment or at least observation that local is as critical as national is very true as we coordinate that. Thank you.

Mr. JELLINEK. May I say one thing.

Senator CRAIG. Yes.

Mr. JELLINEK. It is not an admonishment but an observation.

Senator CRAIG. No, no, no, I appreciate that. It really isn't. But it is a valuable observation and I agree with that.

Wayne, again, coordination state, Federal agencies, one or two of your remaining thoughts. If you had the ability to say tomorrow this would be different because I know it would improve the circumstance I have to operate under, what might that be?

Mr. OSTEN. Senator, I think the one area that needs to be incredibly close coordination between Federal and state is on responding to a biological event. I mean as bad as the Trade Center was and the effects of that, the concerns of a biological event going undetected for a period of time and how you respond to that, that needs an—and I am sure Dr. Ostroff would agree with that—that needs

to be close corporation between the Federal Government and state as well as the locals because its the locals that will immediately deal with the problem. That would be my No. 1 priority.

Senator CRAIG. Wayne, that is something we worry about.

Doctor, I am going to jump across the table to you with this observation and I would appreciate your reaction from where CDC is today versus where it was at the beginning.

I just got back into our office building 2 weeks ago. I was in the Hart Building. My offices and some of the staff around you were in the Hart Building. One of the things I observed is that the best knowledge that was available after the anthrax exposure in the Hart Building when there was a determination to evacuate—and I say this as no criticism—the best information that was available and the advice that was given us by CDC on that day to communicate to our staffs was advice that was invalid 30 or 40 days later as we began to pick up knowledge and experience based on the woman here in New York and certainly the woman in Connecticut. This tremendous change in knowledge occurred based on the type of anthrax, the size of the spores, the airborne character of them. Would you comment not only in relation to what Wayne has just said but where CDC is at this moment in cooperation with FEMA in not only better coordination but programs in relation to new knowledge.

Dr. OSTROFF. Thank you, Senator. I will start my comments by saying that when the anthrax episode happened, an event like this had never happened before. We were relying primarily on scientific information that was in most cases decades old from totally different types of settings. We were trying to use that information and base our decisions on information that in some cases turned out to be quite accurate and in some cases certainly did not. I can tell you that here in New York, as well as in Washington, DC. on a day-by-day basis as we went through this episode, we learned every single day. We refined what we were doing on a day in and day out basis as we acquired more information. Here in the city of New York, certainly the way we responded at the various media outlets, from NBC to ABC to CBS and the New York Post was different each time. We learned from each experience. If we don't do that, then I think we are foolish because you have to learn from that experience.

Senator CRAIG. Would you hold for just a moment. We need to change another tape.

Dr. OSTROFF. So we did certainly learn a lot. I will also say that we have a lot to learn. We will continue to try to massage the experience that we had over the last several months so that we can make the best informed decisions as we move forward. I think the good news, and I will say this quite frankly, is that most of the decisions that were made, in retrospect, were the right ones. We did I think, by and large, protect most people during this episode and I think that is much to our credit.

I will say if I may, as opposed to some of the other comments that were made, I am a bottom-up guy. I think that, at least in public health, the responsibility as well as the expertise is as much at the Federal level as it is at the local level. The solutions and the infrastructure here in New York City may be very right for New

York City, and may be very wrong for a place like Idaho. I think it is going to be quite important for each place to come up with solutions that are appropriate based on what they have to work with and what they have to build. The one other thing I will mention is one of the things we also learned: while it may be fine for New York State to develop their plan and for Connecticut to develop their plan and for New Jersey to develop their plan, many of these episodes as we went through them were multistate; that was true within Washington, DC., and certainly that was true here in New York City. It affected people in New Jersey, it affected people in Connecticut. While the facilities may have been here in New York, the people were in a different state. The same was true in New Jersey with people in Pennsylvania and Delaware. That is why we need to be able to coordinate these types of activities.

Senator CRAIG. Doctor, thank you very much. FEMA is going to have to leave us and catch an airplane. David, while we always look at FEMA after the disaster to help, to bring in resources, to direct and then, in some instances, to help rebuild on a individual basis. One of the things that in a previous hearing last week I heard from you all and Joe was there speaking about his training and a substantial new role for all of that and coordination, recognizing your time and you can be very brief, I appreciate that because our time is up here also, you just might broach that for a second as I think it is a new role for FEMA to be participating in.

Mr. PAULISON. That is an excellent observation. Three things came out of the World Trade Center that we kind of knew were out there, but it really came to a head: One, is communications and interoperability, you know. One agency couldn't talk to another agency, even through a command post, and that is intolerable; we have to deal with that.

Two, is a nationwide instant command system. All of the fire departments use the same instant command system, and it has been nationally recognized as the one we want to use, but other agencies are not on board yet. That creates some problems when you have your command post set up where everybody is participating and we have to deal with that.

Also mutual aid. What happened in New York is the same thing that happened in Miami during Hurricane Andrew. We had people coming from everywhere who were not asked to come in, and it overwhelms the local system. You can't feed them, you can't house them, you don't know what their credentials are, whether they are really firefighters or whether they are really paramedics or what their expertise is. They are just coming in to help. We have to stop that. Somehow we have to be able to deal with just an overwhelming response—people who want to come in and help but may not be the right people to help.

Third, and I do agree with the doctor, that we have to have more robust local planning or emergency plans at the local level because that is where the rubber hits the road and that is what FEMA's role is, to help with that, and we are going to be doing that through training; the President's proposal on his budget for three and a half billion dollars to go to first responders is geared to deal with that, and that is where we are in that, and we are ready to roll as soon as the Congress approves that. Thank you.

Senator CRAIG. David, thank you and your associate for being with us.

Alexander, let me turn to you before I conclude with Richard. There are so many things that I would love to ask you, and we have had some of your associates down and firefighters from other departments around the country visiting with Congress since the September 11 situation. But here in New York is there any view of or do you sense a need as it relates to training within your professional ranks to deal more with the prioritizing of seniors as it relates to their needs and to those people who are the disabled, any new stuff coming out of the September 11 experience that you would suggest would become a part of your training?

Mr. PARZYCH. Well, I think our training is adequate in that we are staying with our standard procedures except for like a September 11; that isn't standard procedures. In other words, most of our procedures are if the people are not in danger in a high-rise building or a fireproof building, we do not remove them, you know, for a fire or some kind of an emergency. We have had areas to be evacuated which were larger than just let's say a whole building because of gas leak or something like that, but nothing on the scale of September 11. I think it is hard to be prepared for that. I think the Fire Department an outstanding job getting so many people out with the help of the people themselves, and I think the cooperation has to come with the community, with the disabled and the aging to with not having laws, but we do have procedures in a high-rise building, as you say, and here is a problem: The Port Authority doesn't have to comply with our laws because they are a state agency that are in the city. So the bombing on 1993 sort of made them open their eyes to comply with our laws, which made this time much better. Having fire safety directors, having fire drills and as fire safety directors fire wardens and our fire marshals, but that is a minor point. But in my building I am a fire warden, and we do take it very serious, especially—we just had a drill. If I don't take it serious, no one will, and it is important. So, the laws we have on the books now are very good. There are improvements, but I think it is a cooperation with in high rise buildings the fire safety plan, which is a mandated plan for these hotels and office buildings to require to give us the location of where the handicapped people are and what shifts there are. There is no real coordination of training or anything more specific than that. We are probably going to look into that and maybe make that a little more specific, but we are supposed to have when we arrive there a list of who needs help and where they are. We may not know exactly what the handicap is, we might have to refine that, but again, depending on what the circumstances are, we may not want to get 50,000 people out of a building. That is going to be very unusual, and I think my only personal opinion is the next one may be biological which you have 50,000 people just walking out and spreading it further, which we are involved with with hazmat, so hazmat and that training I think has to be beefed up.

As far as mutual aid and recall, we had a system there. I was not at the World Trade Center. Our command staff went there. I had them be back, and we instituted our total recall and we had mutual aid with every community we had, which is a designed plan

as OEM said; we didn't have people just coming in and volunteering. They had to get approved to come in with our dispatcher. At the World Trade Center, that was a different circumstance. It was tough to control who was coming in. But for the rest of the seven and a half million people we had a system that came in to protect them at the time.

Senator CRAIG. Thank you very much for those thoughts, those ideas and some of what you are employing.

Let me turn to you now, Richard, and we will ask you to be our last as I ask this question. You had mentioned in your testimony you are in the business of drafting a special report or special proposals on special needs folks. If you could share with us some of the three or four let us say top recommendations that will be involved in that draft that might—not only are they going to work here in New York, but might be something that we would want to look at at a Federal level whether it be with FEMA or the health and welfare, health and human services and aging.

Mr. SHEIRER. Well, as we went around the table today you heard a lot of recurring: communications, the registry. It is very, very important. One of the things we use almost every day is those persons who could be affected by power outages and the utilities in our town are mandated to have a list of anybody in every building who would be affected if they lost power; so when we do have a power outage, those are the first things we check on are those what we call LSEs to make sure that they are OK. How we expand that to include every person with special needs in New York is going to be a real challenge, but it is a real necessity to make sure people like Marion and her husband get what they need and we know where they are; to try and be able to get them their medication so they don't have to leave their home if we can avoid it. In this instance there was no way of avoiding just the enormous relocations that we had to do. I mean, there were tens of thousands of people in Battery Park City in north and south that we moved out and people north of the Trade Center. We had no recourse in that; it was just absolutely essential. But having a registry of those persons with special needs like the man that Andrea spoke of who refused to leave or didn't tell us that he wasn't going to leave is very important so we can do a follow-up. A little thing, a little aside, we do have a plan for pets and we have tried to incorporate it, but no plan that we had could encompass the numbers that we experienced. Even with our coastal storm planning, we asked people ahead of time to start thinking about what you will do with your pet because it is going to be impossible for everybody to take their pet to a shelter.

The communications issue is a critical one for everyone, for people who live in the buildings and reside, the public health community, the public safety community, and the number of responders that we had at the World Trade Center and the number of frequencies, there was frequency overload that just could not be helped because of the number of messages. How you address that, we don't have the answers yet. In terms of telephone communications, this being Murphy's law, the one building that was probably most affected other than the Trade Center buildings themselves was the Verizon building which knocked out virtually all commu-

nications in lower Manhattan right away. We had to get them back to even get the financial markets back. So, there were a lot of things that happened, and we are all looking at that including Verizon.

The transportation issue, we had to close Manhattan and we have to find a way to get people in and out. IDs are a problem. There were a number of people that we had to have arrested with false IDs who went into the site. We had a couple reporters who posed, one as an ATF agent and one as a firefighter to try and get in and get stories and pictures and there were just individuals who were up to no good. We caught a few in the access to the concourse, so it is a very difficult problem.

The need to identify caregivers, Meals on Wheels, people have a universal identification is something we are going to look at and hopefully will never have to use to the extent we would have had to now.

The sheltering system. Marion's experience of being there for 8 days, that is very difficult. We have done everything we can to try to make it as habitable as possible, but it is virtually impossible. These are the issues we want to look at. We do have—I will leave you a copy of it—our all hazard plan which specifically deals, has a section. It is web-based on people with—seniors and special needs people planning. But having it web-based alone is not enough, and we go further than that. How we can expand it and get community involvement with it is very important.

Many of the people around this table are the people that sit on our task forces for various things, and we would like to bring them all together on this particular issue. Liz Davis, who is my special needs advisor, will probably reach out to everybody. So, there are a number of things, many recurring.

One thing I just want to say about what Michael said. I was at the bombing in 1993, and Chief Cowan, who was just here and left, we were in the lobby of Number One on September 11. There was a marked difference between the way people left that building in 1993 and the way people left that building on September 11. 1993 whether it be because the bomb was at the base of the building or whether there wasn't adequate preparation or training, there was a lot of panic, a lot more chaotic. This time we didn't have the chaos. People were just absolutely terrific. People like Michael will never know how many people like Michael were there helping people get out of that building. We know how many firefighters and police officers and court officers and EMTs did what they did, but the number of just average citizens who helped their fellow citizens, an amazing number. It was just an amazing community effort, and that is something that is lost in New York. New Yorkers really—we may be eight million people, but we are all very real communities, much like small towns. While Idaho may be different being rural, you can go to York Village which has its own character, you can go to the Village, you can go to Bay Ridge, and these are all it communities are very much, very similar, more like small towns, just happen to be part of a big city.

On the issues for bioplanning, Dr. Ostroff and I spent a lot of time together, much more than I had ever thought we would these last few months. One of the things we have in New York City that

gives us a little bit of a heads up, we have a syndromic surveillance system that monitors EMS calls by the category they are and gives us an indication that something is out of whack before it would be readily available. Then we have CDC epidemiologists and Department of Health epidemiologists work back to make sure that the operation we are seeing is not bio, that it could be flu, it could be just whatever it is, but we want to know what causes it. That works very well in New York, and we have expanded it, but it would not necessarily work in Idaho or other communities because you are not ambulance based. But those surveillance systems in terms of hospitals in terms of doctors. We worked now with the large pharmaceutical chains. They cooperated and gave us—we knew the sales of over-the-counter medications so if anything was out of whack in terms of flu medications and then prescribed medications with anonymity, we knew where the big sales of Doxy and Cipro were going and what was going on. These type of systems are worth their weight in gold. It is transferable, but it takes a little work, and that is the way to go. But we will be working on a lot of different issues for the entire special needs and senior community because they're the most vulnerable people in our town and we have the highest obligation to them amongst all others.

Senator CRAIG. Richard, to you, to all of you, a very special thanks for your time here today and your patience, because none of us in Washington have an answer. We are in the business of collecting those from all of you so that we can help prioritize and hopefully supply what is necessary, whether it be organization or resource that will assist you.

I truly agree with you; what will work in New York City will not work somewhere else, but what you learn here may be something that someone else won't have to learn by the sheer experience that you have had. I think that is extremely valuable as we work our way through this. This committee, as I said at the beginning, is not an authorizing committee. But our records and what we supply and what we can provide for other members of the Senate or all of us who serve on this committee also serve on authorizing committees. It will be extremely valuable as we search our way through this, and we hope that we can develop a system that can respond quickly to biological kinds of terrorist attacks because I hope you are wrong, Alexander. I hope that will not be our next one. But there is a strong likelihood that at some time in the future that could occur, and certainly preparedness will mean in the end less—fewer of our citizens will lose their lives, more will be prepared, and my guess is, you are right and Michael is right. Something worked because from the initial attacks at the Tower until the tragedy of the final numbers, within the first 24 to 48 hours those of us on the outside looking in were expecting a much worse situation from the standpoint of human life lost than did occur. To be able to evacuate that many people out in the short time that was given before those towers came down was, in itself, a remarkable thing. While I think it is missed by some in the reports of aftermath, I remember at the time we were talking of 25,000 or 30,000 potential lives lost, only to have it now where it is, although that is tragic.

Ladies and gentlemen, thank you very much, and I will ask that this committee stand in adjournment. I must tell you also, and I

forgot to thank staff for all the work, but I thank them for working with you in preparing for this hearing and again thank them.

[Whereupon, at 4:05 p.m., the committee was adjourned.]

APPENDIX

Garaventa Evacu-Trac CD7 Features

Evacu-Trac should be kept in any multi-storey building where disabled people live, work or visit. It can provide a fast, safe and reliable means of evacuation, can help save lives, and can provide disabled people with an equal opportunity for escape in an emergency.

- Folds compactly for storage or may be stored in an optional storage cabinet.
- Unfolds for use in seconds – doesn't have to be picked up.
- For loading, it's low, extremely stable and has a shallow seat area (without sides) to allow easy transfer from a bed or wheelchair.
- The passenger is held firmly in place by three quick-connecting velcro straps.
- Six wheels provide a stable, stroller-type action which allows the attendant to move the passenger down long hallways without effort.
- The weight is balanced over the rear wheels to permit easy cornering.
- Stairway descent requires no operator strength since the weight of the passenger provides the power to descend. A 90 lb. attendant can easily evacuate a 200 lb. passenger.
- During descent, a hydraulic governor limits the speed.
- A fail-safe braking system is always engaged and is released by the attendant during stairway descent. This allows the attendant to stop on the stairway should the passenger need attending or if an obstruction has to be cleared from the stairs.

Using Evacu-Trac CD7 for Emergency Evacuation

The Advantages

Reduces risk of injury and liability exposure

Hand carrying a disabled individual down stairs and out of a building, places both the "buddies" doing the carrying and the person being carried at risk. If a "buddy" strains their back trying to carry the passenger, or drops the passenger, the building owners or managers may be faced with a costly liability suit. Using an Evacu-Trac to carry the passenger eliminates the risk of injury and demonstrates a proactive effort to accommodate persons with mobility impairments.

One small person can independently evacuate a heavy person down stairs

Hand carrying a 250 to 300 lb. person down stairs and out of a building can require up to three or four "buddies". Evacu-Trac enables a single, petite individual to evacuate someone weighing up to 300 lbs. – *without assistance!* This means more rescue personnel are available to help others evacuate, resulting in a faster overall evacuation.

Does not block stairway during evacuation

Hand carrying requiring two or more "buddies" can block an entire exit stairway. This places all persons using the stairway at greater risk. Evacu-Trac requires only 17 inches of stair width, and thanks to its patented braking system, descent speed is controlled by the operator to ensure a safe evacuation alongside other egress traffic. The Evacu-Trac will also maneuver easily on landings to allow traffic to pass, and will stop securely on the stairs if the operator needs to clear the stairway of obstructions.

Reduces evacuation time

Carrying is not only dangerous, it's slow. The Evacu-Trac can move quickly and safely down the stairs or along hallways in less time, and with less effort, resulting in a faster overall evacuation.

Maintains personal dignity

People who are hand carried out of a building are often subjected to the indignation of being placed on the ground while awaiting the return of their wheelchair. With Evacu-Trac the passenger can remain seated in a dry, comfortable and dignified position until help arrives, or until their wheelchair is returned.

BUYER BEWARE!

Not all evacuation devices are created equal!

Do a careful review and evaluation *before* your buy. Refer to the attached "EGRESS PRODUCT COMPARISON" to guide your purchasing decision.

Ask for a hands-on evaluation, or request a free Evacu-Trac Demonstration video to be sent directly to you.

To order a free Evacu-Trac information video on-line go to the following web link
http://www.evacutrac.com/videoform.html
or phone our **Toll Free Number: 1-800-663-6556**

Here are some important questions to consider when deciding on an emergency evacuation device.

- Would you be comfortable riding in it during training?
- Would you be comfortable riding in it during a life-threatening emergency?
- Would you be comfortable operating it during a real emergency?

Remember, you are buying ***Life Safety Equipment!***

Reliability, Ease of Operation and Timely Evacuation are the most important factors to consider when making a purchasing decision.

YOU GET WHAT YOU PAY FOR!

Put ***Quality, Performance and Superior Service*** above price.

If you would like more detailed information on the Evacu-Trac Evacuation device, visit our product website at **www.evacutrac.com** or visit our main website to find out about other GARAVENTA products at **www.garaventa.ca**

EGRESS PRODUCT COMPARISON

When shopping around for an evacuation device you should consider the issues listed below when comparing products.

- **Stability on Flat Surfaces**
  At times it may be necessary to leave a passenger unattended momentarily while opening a door or clearing debris, and you can't always rely on having someone else available to assist.

- **Stability on Stairs**
  At times it may be necessary to stop on stairs to allow stairway traffic to pass, or to clear an obstruction. Though this practice is not recommended, the unit must be capable of remaining parked and stable on the stairway during this period.

- **Descent-speed Governing Mechanism**
  The evacuation device must have a mechanical speed governor and tracks with rugged treads that will limit the maximum speed of descent regardless of the operating environment. Heat, cold or water on the stairway or on the tracks can all affect the friction between rubber and other surfaces. The device must be designed so that its speed is controlled regardless of the conditions.

- **Passenger Restraints**
  Passengers won't always be calm, conscious or have control of their arms, legs or head. The device must be designed so that the passenger can be secured regardless of their condition.

- **Passenger Size Limitations**
  Many people needing evacuation may be heavier or have wide hips. The design of the evacuation device must take these weight and size factors into consideration.

- **Passenger Comfort**
  Although an emergency evacuation descent is not a pleasure ride, the device must take into consideration the fact that many disabled persons are more prone to injury and must be handled more carefully than most able-bodied people. Though the disabled person may not feel a bruise, their body will react to one in the same way and will take longer to heal. Following the emergency descent (and depending on the reason for the emergency evacuation), the building will not be able to be entered for ½ hour or more. During this time the passenger being evacuated must be able to wait, comfortably, for their wheelchair to be returned to them. The design of the emergency evacuation device must take this into consideration.

- **Ease of Transfer**
  Practically speaking, the chances of success during an emergency evacuation will decrease as more people are required to assist, since the unavailability of one or more people can hinder or prevent the evacuation. The device must be designed for use by one person, with that one person being able to single-handedly transfer the passenger and take the passenger down the stairs. The device must be designed so that it is low and stable, open on the sides and will not roll or move during transfer. A typical paraplegic should be able to transfer themselves easily from their wheelchair to the evacuation device.

- **Strength Required to Operate**
  It may not always be possible to have an attendant who is strong enough to lift the passenger, yet that attendant may at times be the only person available to perform the evacuation. As much as possible, the design of the device must take this fact into consideration, and not require excessive physical strength to operate.

- **Carrying Capacity**
  The design of the device must consider the potential weight of a disabled person and must be designed to carry up to 300 lbs. Since it will be used on stairs, the device's weight capacity must contain a safety margin of at least 1.5 times its rated capacity.

- **Weight of Unit**
  The weight of the device is not a major factor in the evacuation process, since the unit should never be carried up stairs and into an emergency situation. Strength, reliability and other factors, as described above, are more important considerations. Emergency preparedness requires that the descent devices be present in sufficient numbers on or above the floor from which the evacuation would take place.

Specifications for an Emergency Evacuation Device for Disabled Persons

1.1 Model Type

The Evacuation Device shall be a Garaventa Evacu-Trac CD7.

1.2 Descent Speed Control Mechanism

The Evacuation Device shall be equipped with a mechanical device that controls the descent speed to a range that is safe for the passenger and the operator. Descent speed may vary slightly based on passenger weight and stair angle. As a standard measurement, on a stair slope of 35 degrees and with a passenger of 220 lbs. (100kgs), the speed control mechanism shall limit the descent speed to a maximum of 3.6 ft/sec (1.1m). This descent speed control mechanism shall limit the maximum speed regardless of the operating environment or strength and size of the operator.

1.3 Rubber Belt Design

The Evacuation Device shall have rubber crawler belts to grip the stair noses. The belts shall have lugs or treads to ensure positive traction with the stair noses. The rubber crawler belts shall have integrated steel wires that minimize the likelihood of stretching or breakage.

1.4 Carrying Capacity and Stair Angle

The Evacuation Device shall be able to carry passengers weighing up to 300 lbs. (136kgs) on a stair slope of up to 40 degrees.

1.5 Passenger Size Accommodation

The Evacuation Device shall be designed so that it does not unduly limit the physical dimensions of passengers that can be carried. The seating sling shall be open on the sides and shall not be designed with bars that surround or restrict the seating area.

1.6 Passenger Restraining Straps

The Evacuation Device shall be equipped with three (3) safety straps to ensure the passenger will be securely restrained in the Device. The safety straps shall secure the passengers legs, mid-section, and chest and arms.

© 2001 Garaventa. As we are continuously improving our products, specifications outlined are subject to change without notice. Please see our web site www.garaventa.ca for the most recent specifications.

1.7 Parking Brake and Stability on Flat Surfaces

When occupied by a passenger, the Evacuation Device must be able to remain stable and stationary when left unattended on flat surfaces. The Evacuation Device shall include a brake system that will prevent it from rolling when unattended in the parked position.

1.8 Emergency Brake and Stability on Stairs

The Evacuation Device shall be equipped with a secondary, fail-safe, emergency braking system, in addition to the main speed control system. While a passenger occupies it, the Device must be able to come to a complete stop on the stairway. It shall be sufficiently stable to remain momentarily unattended. The Evacuation Device shall be able to go from a speed of 3.6-ft per/sec (1.1m) to a complete stop within 1 second, without assistance from the operator.

1.9 Ease of Transfer

The Evacuation Device must be designed so that in the majority of instances, one person trained in proper transferring procedures can single-handedly transfer the passenger into it from a wheelchair. The Evacuation Device's seating position shall not be higher than 12 inches from the floor to the lowest point of the seat sling. The Evacuation Device shall be designed with open-sides (without sidebars) to make the transfer of the passenger easy.

1.10 Usability and Operator Size / Strength Requirements

The Evacuation Device shall be operable, down stairs and across landings with a passenger in place, by one person who has a smaller physical size than the passenger. Size and strength of the operator shall not be a factor in safe operation of the Device.

1.11 Weight of Evacuation Device

The weight of the Device shall not exceed 46 lbs. (20.7kgs).

1.12 Seating Material

The seating material shall be composed of fire retardant fabric.

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1.13 Storage Cabinet (Optional)

Each Evacuation Device shall be supplied with a steel cabinet that will be used to store the Evacuation Device when not in use. The cabinet shall be made of steel with an electrostatically applied baked powder finish. The storage cabinet shall include labeling identifying the contents. The storage cabinet shall be 46.5 inches (1180mm) high, 22.7 inches (576mm) wide, and 13.0 inches (331mm) deep.

This specification has been prepared by Garaventa Accessibility to provide design and operational criteria for Emergency Evacuation Devices.

Please address any comments to:

Garaventa Accessibility
Trac Product Sales Representative
7505 - 134 A Street, Surrey, BC V3W 7B3

OR: P.O. Box 1769, Blaine, WA 98231-1769

Toll Free: (800) 663-6556 (within Canada and the United States)
Phone: (604) 594-0422
Fax: (604) 594-9915

Email: sales@evacutrac.com

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United States Department of the Interior

BUREAU OF RECLAMATION
RECLAMATION SERVICE CENTER
PO Box 25007
Building 67, Denver Federal Center
Denver, Colorado 80225-0007

IN REPLY REFER TO:

Dave Hertner
Garaventa (Canada) Ltd.
7505-134A Street
Surrey B.C. V3W 7B3

December 1, 1999

Dear Mr. Hertner:

The Bureau of Reclamation's Property and Facilities Group recently purchased fourteen Garaventa Evacu-Trac chairs for the safe evacuation of employees from our high rise building.

We examined similar types of evacuation chairs before selecting the Evacu-Trac. We found your equipment to have better structural stability, descent control, ease of operation, and ease of transfering the passenger than the other products we looked at. We also liked the feature of unattended stability. This allows an operator to leave the passenger briefly on stairs or a flat surface and the chair will remain stable with the passenger in an upright position.

Pete Cachet, Facilities Specialist gave a demonstration of the operation of the Evacu-Trac at an All Employees Meeting. A few weeks prior to the meeting, a fire had ignited on our roof. Luckily it was after business hours and only a small number of people had to be evacuated. The demonstration Pete gave was helpful and informative, and reassured Bureau of Reclamation employees that if an emergency occurs in the future, there is a way to safely evacuate everyone. Pete also emphasized that your product is not only essential to our handicapped employees, but to anyone who cannot quickly exit a building through the stairwells like someone temporarily using crutches, a pregnant woman or a person with breathing problems.

As a Purchasing Agent for the Bureau of Reclamation, I conducted extensive market research and determined that the Evacu-Trac was the best product on the market to fulfill the government's needs at a reasonable price.

The information contained in this letter should not be considered an endorsement in a publication or advertisement, but an account of our experience with a product made by Garaventa.

Our acquisition of these chairs was completed through your Denver, Colorado distributer Access Elevator, Inc. Bruce Garvais was very helpful to us and we were pleased with his assistance. Thank you for making your product available to us.

Sue Trujillo

Sue Trujillo
Purchasing Agent

Caledonia Public Schools

Independent School District No. 299
Caledonia, Minnesota 55921
High School - 511 West Main - (507) 724-3316
Elementary - 311 West Main - (507) 724-5205
Community Education - 511 West Main - (507) 724-5139
ECFE - 121 South Marshall - (507) 724-2527

Dr. Miles H. Miller, Superintendent
Mr. Brian Doty, Secondary Principal
Mr. Scott Heckert, Elementary Principal
Mr. Ken Van Den Boom, Athletic Director
Mrs. Patt Guth, Community Education
Mrs. Mary Lou Buesa, ECFE

June 28, 1995

Mr. Bill Larson, Representative
Access Elevator Inc.
3500 South Phillips Avenue, Suite 200
Sioux Falls, SD 57105

Dear Mr. Larson:

Caledonia Public Schools recently purchased two Evacu-Trac units for use in our 2-story high school building as we provide emergency exiting during emergency situations and for fire drills for our wheelchair bound students. While our building does have an elevator, we cannot use it during drills or for emergencies.

We introduced and trained our staff, the local police and firemen, the school board and our wheelchair bound students in the operation and procedures to be used when necessary. We have conducted three emergency evacuation drills with our students and staff.

Both the students and staff feel comfortable with the units and have confidence in their use at all times. The units work very effectively in meeting needs of our school. Local police and firemen are very much impressed with the units and are familiar with the procedures to be used by their staff when called. The ease of operation is fantastic.

The greatest advantage that we have realized since the purchase and installation of these units is the elimination of fear from our wheelchair bound students whenever we conduct drills. They now know that we have a system to provide for their safetly and we do not have to try to convince them that they will not be dropped as they are being carried down the stairs or that we have provided a "safe" room for them to be rescued by the firemen. Please feel free to have any school official contact us at (507) 724-3316 at any time to share our satisfaction and answer their questions.

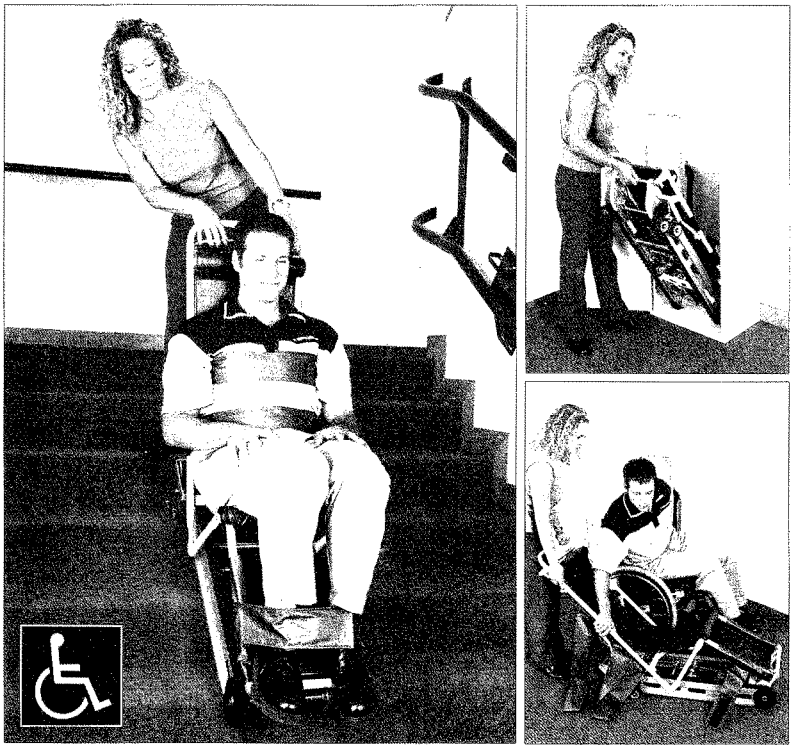
Sincerely yours,

Miles H. Miller, Supt.

An Equal Opportunity Employer

Garaventa Evacu-Trac

emergency evacuation device



The Garaventa Evacu-Trac CD7 is an evacuation device used to move people with a disability or injury down stairways quickly and safely during an emergency. Evacu-Trac's patented speed governor and braking system allow a small attendant to easily evacuate a larger passenger.

GARAVENTA
ACCESSIBILITY
www.garaventa.ca

Garaventa Evacu-Trac CD7

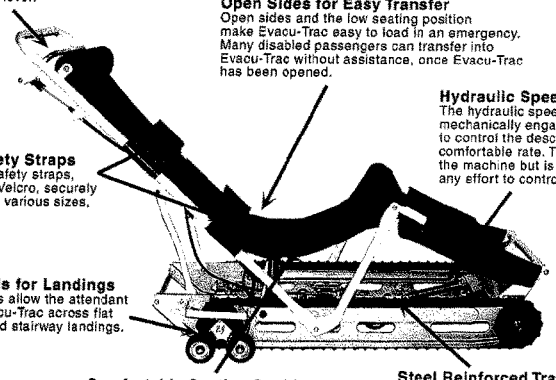
The world's best evacuation chair just got better! The new Evacu-Trac CD7 is easy to use while providing the passenger with increased comfort and safety. The weight of the Evacu-Trac has been reduced by 27%. Turning clearances have also been reduced, making Evacu-Trac even easier to handle on small stairways. Highlighted below are some of the features of the new Evacu-Trac CD7:

Secondary Brake System
Although a governor controls the speed of descent, an additional mechanical brake is provided that will stop and hold Evacu-Trac on stairs. This secondary brake system also serves as a parking brake when Evacu-Trac is stopped on flat surfaces. The failsafe brake engages automatically when the attendant releases the brake lever.

Open Sides for Easy Transfer
Open sides and the low seating position make Evacu-Trac easy to load in an emergency. Many disabled passengers can transfer into Evacu-Trac without assistance, once Evacu-Trac has been opened.

Hydraulic Speed Governor
The hydraulic speed governor mechanically engages with the tracks to control the descent speed at a comfortable rate. The attendant guides the machine but is not required to exert any effort to control the speed.

Adjustable Safety Straps
Three adjustable safety straps, with quick release Velcro, securely hold passengers of various sizes, including children.



Auxiliary Wheels for Landings
Six auxiliary wheels allow the attendant to easily move Evacu-Trac across flat surfaces and around stairway landings.

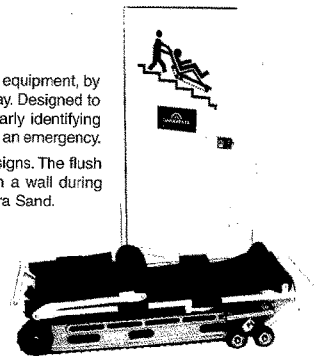
Comfortable Seating Position
Evacu-Trac provides disabled passengers of various sizes with a comfortable seating position. The passenger's head, back, hips, legs and feet are well supported when descending the stairs and when parked after the evacuation.

Steel Reinforced Tracks
Rubber tracks with special saw-tooth lugs securely grip the stairway. Hundreds of steel wires molded into the tracks ensure track strength and durability. The long track length provides stability on the stairway.

Evacu-Trac Storage Cabinet

Protect your Evacu-Trac, as you would any other important life-safety equipment, by storing it in a steel storage cabinet located near the top of the stairway. Designed to hold a single Evacu-Trac, the storage cabinet includes graphics clearly identifying the contents and a quick-release strap for removal of Evacu-Trac during an emergency.

Storage Cabinets are available in surface mount and flush mount designs. The flush mount unit includes finishing trim and is intended to be mounted in a wall during construction or renovation. The standard color of the cabinet is Sahara Sand.



Storage Cabinet Dimensions:

Height 1177mm/46.3in
Width 534mm/21.0in
Depth 331mm/13.0in

Safe, reliable and fast emergency evacuation

In an emergency such as a fire or an earthquake, elevators should not be used. People with limited mobility may be trapped. Garaventa's Evacu-Trac CD7 provides a lifeline to safety.

During an emergency, the passenger is transferred from their wheelchair to the Evacu-Trac. Once positioned in the Evacu-Trac, velcro straps are wrapped securely around the passenger's torso and lower legs. The passenger is then wheeled to the stairway for descent.

During descent the passenger sits in a comfortable, upright position, securely held by three safety straps.

To turn the Evacu-Trac on flat surfaces, the attendant pushes down on the handle and pivots the unit on the rear auxiliary wheels.

When ready to descend the next flight, the attendant squeezes the Brake Release Bar to release the secondary, failsafe brake.

Evacu-Trac glides down hallways on six auxiliary wheels. When the stairway is reached, Evacu-Trac automatically lowers onto its rubber tracks for stairway descent.

Features

- Quick and easy set up for immediate use
- Carries up to 300 lbs.
- Passenger's weight moves unit down stairs, while the governor controls speed
- Failsafe brake brings unit to a complete stop automatically
- Adjustable safety straps
- Stable and self-supporting
- Unique seat design allows easy transfer from wheelchair
- Durable tracks grip stairs securely
- The tracks grip the stairs, regardless of the stair construction material

Benefits

- Provides quick and safe emergency evacuation
- No hand carrying of mobility impaired persons
- Small attendants can easily move heavier passengers
- Easily stores in a secure area when not in use
- Requires minimal maintenance
- Available immediately

Call 1-800-663-6556 to receive our complimentary Garaventa Accessibility CD

The Garaventa Accessibility CD contains extensive product information, Design and Planning Guides, design specs, CAD Drawings and much more!

Visit our web site at www.garaventa.ca

- Detailed product information
- Design specifications
- CAD files
- Design and Planning Guides
- Streaming Videos

email: productinfo@garaventa.ca

Garaventa's Dealer Network

Our network of authorized dealers are ready to provide full assistance and project support from initial site surveys, to assistance with specifications, design and the installation of your Garaventa accessibility products.

Garaventa (Canada) Ltd.
7505 134A Street, Surrey, BC
Canada V3W 7B3
US Mailing Address:
PO Box 1769, Blaine WA 98231-1769
Phone: 1+(604) 594-0422
Toll Free: 1-800-663-6556
Fax: 1+(604) 594-9915
Web site: www.garaventa.ca

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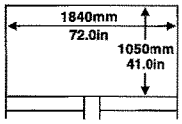
Evacu-Trac CD7 Specifications

Clearances

The diagram below shows typical clearances required on turnback stairways. Actual requirements may vary depending on stairway configuration.



Evacu-Trac Dimensions

Capacity: 136kgs/300lbs
Speed: ..... 1.1m(3.6ft)/sec*
Stair Angle: ..... 40° Max.
Weight: 20.7kgs/46lbs
**varies with weight*

Size Open:
Length 1310mm/51.6in
Width 426mm/16.8in
Height 810mm/31.9in

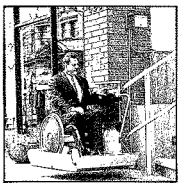
Size Folded:
Length 1100mm/43.3in
Width 426mm/16.8in
Height 270mm/10.6in

Other Garaventa Accessibility Products

Garaventa Stair-Trac

Motorized Stair Climber

This portable wheelchair lift is safe, reliable and easy to use – both indoors and out. Designed to attach under most standard wheelchairs, Stair-Trac allows an attendant to transport a person in a wheelchair up and down stairways.



Garaventa Stair-Lift

Inclined Platform Lift
Models for Straight and Curving Stairways

The Stair-Lift is able to follow straight and curving stairways up several flights of stairs and across horizontal landings. A variety of platform sizes and options allow for extensive customization of the Garaventa Stair-Lift to meet the needs of the user.

Garaventa Genesis

Vertical Platform Lift
Enclosure and Shaftway Models

The Genesis combines elegant styling and quiet operation with great dependability. The Genesis is easy to use and provides a safe and reliable means of access. With many standard and optional features the Genesis can be customized to suit any application.

Contact your local authorized Garaventa dealer for more information.

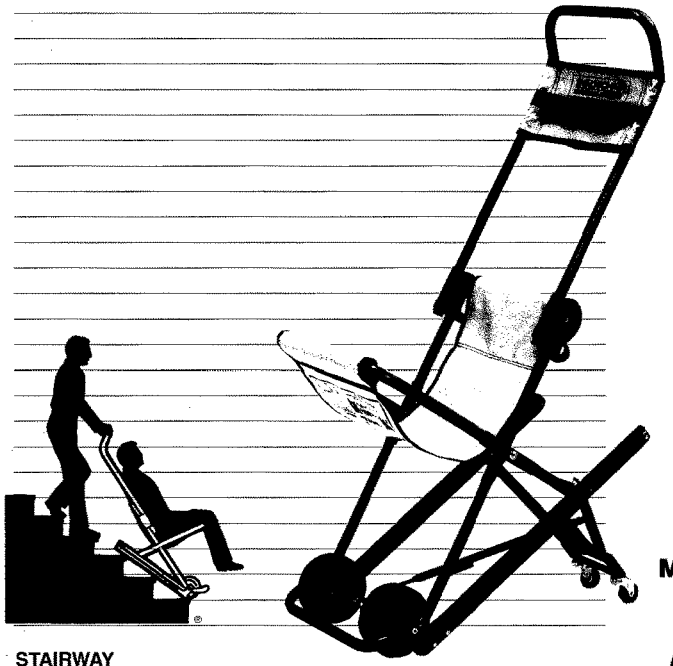
GARAVENTA ACCESSIBILITY
www.garaventa.ca

Authorized Garaventa Representative

The ***Double Duty*** Emergency Wheelchair

EVAC+CHAIR®

For Stairway Evacuation and Emergency Transport



New
Model 300-H
Mark II

STAIRWAY EVACUATION

. . . it glides down stairs

Speed, safety and ease—Three big advantages of **EVAC+CHAIR®** over strenuous two-man hand and staircase wheelchair carries of the past. No one is left behind or forced to attempt the stairs when fire or alarm shuts off the elevators.

EMERGENCY TRANSPORT

. . . it wheels across the floor

Compact, on-the-job storage offers you an instant wheelchair for emergency use to move people quickly through corridors to elevators, exits and curbsides

What Was Needed . . . What Had to be Done

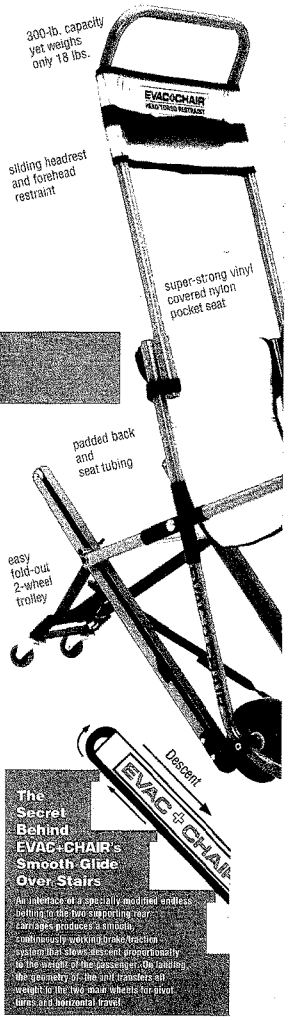
Walk-down evacuations seemed a reasonable enough procedure to me until 1979. That year my wife, a victim of childhood polio, was forced to evacuate her 38th floor office. Luckily the good fortune of a false alarm and a faithful relay of fellow office workers enabled her to escape . . . though very slowly and with great difficulty.

It was then I learned that for many individuals "escape" down firestairs was more "wish" than reality.

My close brush with personal tragedy during my wife's forced evacuation sparked the four-year development of the EVAC+CHAIR® Emergency Wheelchair, an invention now acclaimed by safety professionals as a dynamic life-safety tool of startling originality and simplicity. Most important for you, it allows ***one individual to help another out of a dangerous situation . . . with speed, safety and ease.***

I'm thankful I am now able to give mobility-impaired individuals the same opportunity that able-bodied people have during an emergency evacuation.

David Gunn



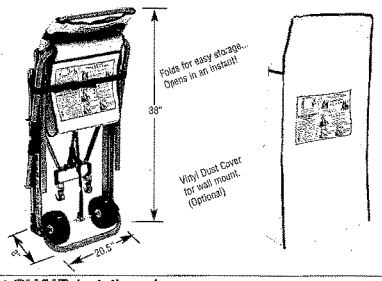
EVAC+CHAIR®

Is Good Business

Since its introduction in 1982, **EVAC+CHAIR**'s acceptance in every sector reflects a fact of contemporary living; it's a one-time investment that can help

- protect organizations against lawsuits
- answer everyone's fears concerning emergency evacuation
- save personnel — both helped and helper — from unnecessary injury.

EVAC+CHAIR dramatically transforms a building's stairs from an insurmountable obstacle to an escape route for all! And it does so with no attachments to stairs, walls or side railing. Light, easy to handle and versatile, **EVAC+CHAIR** is a life-safety tool unequaled in performance.



EVAC+CHAIR is delivered completely assembled and ready for use.

The Secret Behind EVAC+CHAIR's Smooth Glide Over Stairs

An interface of a specially modified endless belting in the two supporting rear carriages produces a smooth, continuously working brake/traction system that slows descent proportionally to the weight of the passenger. On landing, the geometry of the unit transfers all weight to the two main wheels for pivot turns and horizontal travel.

Evacuating **Employees**
Hotel Guests
Students
Patients
Visitors

strong fire ladder quality 1" dia. thick-walled aluminum tubing

down firestairs is no job for the unprepared.

EVAC+CHAIR
Gives You the Help You Need

The light, easy to handle and versatile
EVAC+CHAIR changes the obstacle
of firestairs into a usable escape route for all.
And that includes . . . the handicapped
the unconscious
pregnant women
the older employee
the temporarily disabled
These people account for more than 5% of
your building's population . . . people who cannot
or should not walk down stairs in an evacuation!

unique cantilevered design places seat mere inches above stairs

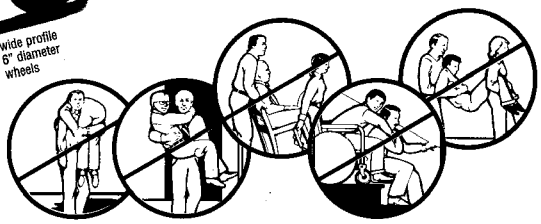
safety belt with quick-release buckle

instructions permanently stamped on seat

wide profile 6" diameter wheels

"Buddy System" Safety
with One-Person Operation.

Evacuation takes nine seconds or less per flight with no back strain for the attendant! Everything is done in complete control with the weight of the seated passenger carried by the stairs, not by straining the arms of the helper.



When you consider the alternatives . . . you'll agree that
EVAC+CHAIR needed to be invented.

Recommended Number of EVAC+CHAIRs When Allocated by Space:

General Population of Office or Building	Units Required
1 to 25	1
26 to 50	2
51 to 75	3
76 to 100	4
101 to 150	5
151 to 200	6
201 to 300	7
301 to 400	8
401 to 500	9
501 to 1,000	2% of total
Over 1,000	20 units plus 1 unit for each 100 over 1,000

Partial List of Customers

AAI Incorporated
A.C. Nielsen Company
ACF Industries, Inc.
Acushnet Company
Aerospace Corporation
Aldrich Chemical Company
Allied Corporation
Amdahl Corporation
American Broadcasting Co.
American Tobacco Company
Am Water Works Service Co.
Ameritech Services, Inc.
Amica Mutual Insurance Co.
Aramco Services Company
Arco Oil & Gas Company
Arlington Fire Department
Arthur Andersen & Company
AT&T Communications
AT&T Human Resources
AT&T Information Systems
Baltimore Gas & Electric Co.
Barden Corporation
Barnard College
Blue Cross/Blue Shield
Boston Financial Data Services
Boeing Company
Boyd/Smith Inc.
Bristol Myers
Bureau of the Public Debt
C-I-L House
CA Dept. of Rehabilitation
CA State Univ, Northridge
CA State Univ, Hayward
California Dept of Forestry
Calif. Polytechnic State U.
Caltex Petroleum Company
Can. Dept. of Nat. Defense
Canadian Security Services
Carnegie-Mellon University
Cedar Point, Inc.
Central Contra Costa SD
Central Intelligence Agency
Central Ohio Rehab Ctr
Champlin Petroleum Co.
Chevron USA, Inc.
Chicopee Research
Children's Museum of Boston
Citibank, N.A.
City of Baltimore
City of Newark
City of Waco, Texas
Coca-Cola Company
Columbia Basin College
Columbia Fire Department
Connecticut R.V.T. Schools
Corps of Engineers
Cotting Sch for Handicapped
CUNY–Hostos Comm College
Dale Singleton Rehab Ctr
David Taylor Naval R&D Ctr
Defense Supply Service
Department of Education
Dept of Veterans Affairs
Dept of Agriculture, CEF
Dept of Labor, State of NJ
Dept of Safety, DCPS
DHHS/Federal Drug Admin
District Council 37, AFSCME
Dix Hills First District
Dominguez Medical Center
DMA Hydrographic/Top Off
Doubleday & Company, Inc.
Doyle Dane Bernback Inc.
Drackett Company
Draper Laboratory, Inc.
DuPont Winterthur Museum
Durfee Attleboro Bank
E.I. DuPont Company
East Range Achievement Ctr
EO/ROVII Off of Civil Rights
Environ. Protection Agency
Eureka Company
Exxon Chemical Americas
Exxon Company–U.S.A.
Facts on File, Inc.
Fairfax Co Public Schools
Fed Bureau of Investigation
First Inter Bank of Arizona
Fitzsimmons Army Med Center
Ford Motor Company
Fort Devens
Frostburg State College
Galbreath-Ruffin Corporation
General Dynamics Corporation
General Mills Inc.
General Motors Corporation
General Services Admin
GM Assembly Division
Goodwill Ind of Ctr Ohio
Hamilton Public Library
Harry Diamond Laboratories
Hebrew Hosp for Chronic Sick
Housing Authority, NJ
Kingsboro Psychiatric Ctr
Kodak Colorado Div.
LA Dept of Water & Power
Labor Canada
Lackland Air Force Base
Lederly Piperacillin, Inc.
Lighthouse for the Blind
Lighthouse of Houston
Livonia Public Schools
Los Alamos National Lab
Louisiana Land & Explr. Co.
MA. Devel Disabilities
Manistee Area Public Schools
Marathon Oil Company
MARC Center
Mass. Rehab Center
Mayflower Hotel
McGraw-Hill, Inc.
Nashua School District 42
National Capitol Commission
National Institute of Health
Nat Multiple Sclerosis Soc.
National Park Service
National Weather Service
Naval Air Development Center
Naval Avionics Center
Naval Facilities Eng Cmds
NAVELEXSYSENGCEN
Navy Strategic Systems
New England Telephone Co.
New Jersey Bell
Ninth Coast Guard District
NOAA-National Weather Service
Norfolk Naval Shipyard
Northrop Corporation
Norton Respiratory Home Care
Prudential Insurance Co.
Public Service Comm of Canada
Pub Serv Electric & Gas Co.
Public Works–Canada
Puget Sound Naval Shipyard
Ralston Purina Company
Ramapo College
Reader's Digest
Rio Consho Manor, Inc.
Rockwell International
Sacramento Municipal
San Jose State College
Sandia National Labs
Santa Ana College
Saturn Corporation
Security & Exchange Comm
Shell Canada Limited
Shield Healthcare Ctr
Smithsonian Institution
Social Security Admin
Southern NE Telephone
Springfield Armory
Squibb Corporation
St. James Fire Department
St. Joseph's Center
Standard & Poor's
State Farm Insurance Co.
State of Maine
State of Nevada
Stroh Brewery Company
Sudbury Memorial Hosp.
Sun Exploration Co.
Supply & Services, Canada
Travelers Ins Companies
TRW
Tranco Corp.
U.S. Dept. of Commerce
U.S. General Acct Office
U.S. Naval Weapons Center
U.S. Post Offices
Union Carbide Corporation
United Cerebral Palsy of NYC
Univ. of the Dist of Columbia
University of CA, Berkeley
University of CA, Riverside
University of Missouri
University of S California
University of Tennessee
University of Texas
US Army Cold Region R&E Lab
US Customs
US Dept of Health & Human Serv
US Dept of Agriculture
US Dept of Defense
US Dept of Education
US Dept of Energy
US Fish & Wildlife Service
US General Accounting Office
US Insurance Group
US Naval Ordnance Station
US Office of Personnel Mgmt
US Postal Service
US Soldiers' & Airmen's Home
USA St. Louis Area Spt Center
USDA, Department of Education
VA Dept of Education
VA Medical Centers
VA Outpatient Clinics
VA. Dept. of Rehab Serv.
Velsicol Chemical Corp.
Ventura College
Veterans Administration
Venus Trading Corp.
Vistron Corporation
WA. Dept. of Natural Resources
WA. Employment Security Dept.
Washington State University
West Springfield Police Dept.
Western PA Sch for Blind
Westinghouse Electric Corp.
WI Dept of Health & Social Ser
Windsor SE Supv Union #52
Xerox Corporation
Zelman Development
Zenith Insurance Company

EVAC+CHAIR®

has revolutionized the technique for evacuating the disabled via the firestairs. Its many advantages over the strenuous two-man hand or wheelchair carries of the past have made it the standard for safety in all types of facilities.

Corporate Offices & Buildings

Schools and Universities

Fire Departments

Museums, Libraries & Historical Sites

Unions & Associations

Federal Office Buildings

Rehabilitation Agencies

State and City Governments

Hotels

Hospitals & Nursing Homes

US Armed Forces: Shipyards, Air Bases,

Facility Commands, HQs, Support Groups

HPD/General Services
Hughes Aircraft Company
Hunter College, CUNY
IBM Corporation
Illinois Bell Telephone Co.
Imperial Oil Ltd.
Indiana Bell Telephone Co.
Internal Revenue Service
Iowa Wesleyan College
Islip Fire District
J.P. Stevens & Co., Inc.
J. Walter Thompson Company
Jackson Public Schools
Jefferson Parish, LA
Jewish Guild for the Blind
John Hancock Mutual Life Ins.
Keesler Air Force Base
MD Dept of Transportation
Merck & Company, Inc.
Merill Lynch and Company
Metropolitan Dade County
Metropolitan Life Ins. Co.
Michigan Baptist Homes
Michigan Bell Telephone Co.
Ministry of Labour, Canada
MM Aeronautical Center
Mobil Chemical Company
Mobil Oil Corporation
Modesto Junior College
Mount Rushmore Nat Memorial
Municipality, Metro Seattle
N.J.C. Al Hywaylat Hospital
NASA–Dryden Flight Res Ctr
NASA–National Space Labs
Norwich Eaton Pharmaceuticals
NY Int'l & Bulk Mail Center
Office of the Mayor–NYC
Ohio Rehabilitation Services
Pan American World Airways
Paralyzed Veterans of America
Penn Cambria School Dist.
Perkins School for the Blind
Pfizer, Incorporated
Philip Morris Incorporated
Phillips Oil Company
Pierce College
Plaza Hotel
Polaroid Corporation
Port Authority of NY/NJ
Postal Data Ctr., USPS
Procter & Gamble Company

EVAC+CHAIR® is a registered U.S. and foreign trademark of the EVAC+CHAIR® CORPORATION

• Presented "Design of Decade" award by the Industrial Designers Society of America

"Took eleven employees out in the chair, then lent our units to the Fire Department who brought others down from this multi-tenant building. All very pleased with its ease and mobility." *Chairman, Safety Committee*

"Our EMS personnel were particularly impressed with the ease in moving patients and the possibility of avoiding back injuries to our own crew." *Paramedic Coordinator*

"Congratulations for a terrific invention!!" *Wife of a Handicapped Employee*

"We could not have done without it. Served us extraordinarily well in an emergency situation." *Corporate Safety Director*

"I'm impressed with the chair. Easy to handle—lightweight—folds up. Employee feels secure in the chair. Will be very important in case of an emergency." *Federal Security Officer*

"Works well. We keep one on each rig." *Fire Chief*

". . . compactness, light weight and descent on stairs rated as being exceptional . . . the concept is excellent." *Social Security Administration*

"Non-ambulatory were our first priority in a recent emergency . . . then we use our EVAC+CHAIRs for slow moving clients. An excellent product." *Director, Rehabilitation Center*

"The nursing staff has high praise for the unit." *Director, Hospital Nursing Service*

"Great product. Very useful when we lost power and had to move wheelchair employees down and out of the building." *Floor Warden*

"We've evacuated several injured and disabled people from the upper floors of the University. Very satisfied with the EVAC+CHAIR as it is much safer and smoother than other methods (chair lifts and manual carries)." *Security Director, State University*

VISIT OUR WEB SITE: www.evac-chair.com

EVAC+CHAIR®
CORPORATION

17 East 67 Street • New York, New York 10021 • Fax: (212) 737-5616 • Phone: (212) 734-6222

SOME FREQUENTLY ASKED QUESTIONS

How many people does it take to operate EVAC + CHAIR?

Just one to guide the chair and the person seated in it down the steps.

EVAC + CHAIR does 90% of the work itself.

Does EVAC + CHAIR go up steps?

No. In order to keep EVAC + CHAIR simple, light and easy to use we designed it to meet the most common emergency situation, descending straight firestairs and rolling easily on landings and corridors.

Are there any special attachments needed on the stairs or stairwells?

EVAC + CHAIR is all that is required. It uses basic principles of gravity and friction, not gadgets. There is no installation. It's always ready for immediate on-the-job protection.

Can the person seated in the chair fall out?

No. He or she is seated within a pocket seat that "cups" the body securely. The rider is strapped in and sits only inches from the incline of the steps with all weight supported by the stairs. Personal sense of security is complete.

How strong does a "buddy" have to be to guide EVAC + CHAIR?

We recommend that attendants initially practice with a person who weighs about their own body weight. Once the physical sense of operation is experienced, and depending upon the operator's own strength and agility, greater disparities in weight can be handled.

How long does it take to learn to use EVAC + CHAIR?

By following the instructions that come with the unit (they're also printed on the seat) the average person should be proficient with someone his or her own weight within 5 minutes. It's that simple!

SPECIFICATIONS

Size Folded: 38"H x 20.5"W x 8" max. thickness
Weight: 18 pounds
Working Capacity: 300 pounds
Tubing: 1" OD .090 wall 6061-T6 aluminum
Seat: Premium safety belt with quick release buckle
Wall Mounting: J-bracket hardware supplied
Wheels: 6" dia. wide profile
Options: Vinyl dust cover
Traction: Specially modified V-belts by Gates
Operating principle: The interface of endless belting to the rear carriage offers Polymatic Traction™, a smooth, continuously working braking/traction system that slows descent proportionally to the weight of the passenger.
Maintenance: Visual inspection during training
Training: Operation should be practiced during scheduled fire drills. Illustrated operating instructions supplied.
Use Restrictions: Unit is designed for use on straight fire stairs only with hard nosings and with gradients of between 28 and 39 degrees.

EVAC+CHAIR Corp.

NO LIABILITY IS ACCEPTED FOR THE MISUSE OF THIS PRODUCT. A TWO YEAR LIMITED WARRANTY IS STATED IN OUR TERMS AND CONDITIONS.
SPECIFICATIONS AND DESIGN SUBJECT TO CHANGE WITHOUT NOTICE.
U.S. Pat. 4,473,234 U.K. Pat. 2,111,001 S.A. Pat. 82/8071 Canada Pat. 1,198,460 N.Z. Pat. 202276 Australia. Pat. 552823 Other Pats. Pending