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TESTIMONY
NEW YORK AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
JOINT SENATE AND ASSEMBLY ONLINE VIDEO PUBLIC HEARING

SENATE STANDING COMMITTEE ON HEALTH
SENATE STANDING COMMITTEE ON INVESTIGATIONS AND GOVERNMENT OPERATIONS
SENATE ADMINISTRATIVE REGULATIONS REVIEW COMMISSION

ASSEMBLY STANDING COMMITTEE ON HEALTH
ASSEMBLY STANDING COMMITTEE ON OVERSIGHT ANALYSIS AND INVESTIGATION
ASSEMBLY ADMINISTRATIVE REGULATIONS REVIEW COMMISSION

Subject: COVID-19 and Hospitals

Purpose: To review the impact of COVID-19 on New York State's hospitals as well as how current state hospital polices impact the approach to address the COVID-19 pandemic.

Thank you for the opportunity to provide testimony for this hearing regarding the impact of COVID-19 on hospitals. The New York American College of Emergency Physicians (New York ACEP) represents over 3,300 dedicated professionals committed to speaking out for broad access to quality health care, including and especially emergency services.

Provided below are New York ACEP's comments on the issues enumerated in the Senate and Assembly Notice of Online Public Hearing. In addition, New York ACEP submits comments on two requirements imposed by Governor Cuomo and the New York State Department of Health (NYS DOH): 1) Executive Order 202.30 requiring hospital emergency departments to administer a test for COVID-19 to nursing homes residents and to obtain a negative result prior to discharging the resident from a hospital emergency department; and 2) Requirement for specific hospital and ICU capacity.

AVAILABILITY AND DISTRIBUTION OF PERSONAL PROTECTIVE EQUIPMENT (PPE)
New York ACEP members continue to report problems with access to PPE. While most Emergency Departments (EDs) reported they never completely ran out of supplies, providers were forced to ration N95 masks, goggles, face shields and gowns. Staff were required to wear the same N95 masks for full shifts and sometimes for multiple days. Rationing of PPE continues due to tenuous supplies and is a daily concern of those working in the ED.

Several EDs reported, due to shortages of N95 and surgical masks, the guidelines around use and reuse were altered. Staff members in the ED voiced numerous concerns about mask integrity after prolonged use. Due to a worldwide scarcity of PPE, EDs were forced to continue to require staff to practice extended use of surgical masks.

Some EDs in smaller hospitals described the PPE situation as tenuous at best, with most of their medical staff using the same handful of N95 masks since March or April. A small, community hospital reported it has been a significant administrative focus to secure PPE for the hospital but the cost and efforts of doing so have risen exponentially. They have used multiple vendors and encountered cancelled or diverted orders.

A hospital located in an underserved community with poor patient access to primary care and a high poverty level also reported problems with obtaining adequate PPE. It was secured early in the pandemic but had to be rationed to maintain the supply. Items, such as N95 masks, were limited to one per day per staff member.

ADEQUACY OF HOSPITAL INFRASTRUCTURE/ FINANCIAL STRAINS ON HOSPITALS DURING STATE OF EMERGENCY

The pre-existing healthcare system infrastructure in the State was strained long before the arrival of COVID-19. For many years, the New York State Department of Health has aggressively sought consolidation and closure of hospitals. Issues such as bed shortages, especially ICU and specialty beds, are pervasive and compounded every year during peak flu and pneumonia season with patients boarding in the ED for greater than 24 hours waiting for an available inpatient bed. This forces the ED to use alternate treatment spaces such as hallways, waiting rooms, egress corridors and inpatient hallways.

When dealing with a virus that is respiratory spread, these conditions create serious infection control risks. Increased inpatient bed capacity is needed to allow for rooms which can provide droplet precautions to be utilized. Airborne isolation spaces (negative pressure) which are extremely limited need to be increased-perhaps converting rooms with only curtains into rooms with enclosed doors. Staff capacity must also be increased. During the surge of COVID-19, EDs experienced staff shortages, particularly of nurses, respiratory therapists and critical care physicians.

EDs also reported shortages in essential equipment for acute respiratory care, such as laryngoscope blades (traditional and video), ventilators and oxygen. Practices were modified in all these areas to provide resources to frontline staff so that care could be adequately provided to patients.

An unanticipated issue experienced at many hospital EDs was infrastructure issues related to oxygen delivery systems. The need to support a greater number of respiratory patients during the pandemic was not foreseen and weaknesses were revealed. The oxygen delivery systems nearly failed due to the significantly expanded use. Hospitals had to modify their care plans to preserve oxygen at the height of the pandemic.

Hospital inpatient boarding in the ED was extremely challenging during initial re-opening for elective surgeries. The scaled back inpatient units were only available for elective surgery, so hospital inpatients were forced to stay in the ED for extended periods of time. This further compounded capacity challenges and made it difficult to maintain distancing between patients. This is a challenge EDs throughout the state are still experiencing.

At the peak of the COVID-19 surge, volume in many EDs plummeted in the range of 50%, largely due to patient fear of contracting the virus. Currently, volume remains below historical levels at many hospitals, putting physicians, nurses and other essential personnel at risk of losing their jobs. This is a bitter pill to swallow on the heels of fulfilling their duty to provide care in daunting, dangerous and uncharted territory. Maintaining staff should be an utmost priority, especially as we plan for a potential second surge in the fall/winter months.

One academic medical center estimated financial losses at $500 million. Although the ED was a beacon of light during the pandemic and the public has been expressing gratitude, EDs are expecting to have significant budget cuts resulting in physician compensation cuts throughout the state – causing continued concern in keeping physicians within the state to serve the needs of patients. The patient volume remains 70-75% of normal which further impacts the bottom line for the ED and the institution.

The elimination of elective surgical cases had a huge financial impact on hospitals. Multiple service lines were closed and others saw significant decreases in volume. Some EDs in Upstate New York did not experience the surge of cases that occurred downstate, but had significantly reduced patient volumes over a three-month period.

From an education perspective, the inability to have interactive conference sessions such as simulation and small groups is having a significant effect on resident development. There are no away rotations for medical students to "audition" or learn about the culture of a department. There are numerous intangible education downstream effects as a result of COVID-19.

Across the board, Medicaid cuts (1.5%) imposed by the Governor and the New York State Department of Health while emergency departments are faced with rising costs of PPE and providing essential services to the most vulnerable populations is illogical. New York ACEP is gravely concerned about the potential for future across-the-board cuts in Medicaid and the impact on the safety of health care workers and patients.

PANDEMIC PRACTICES AND PROCEDURES IMPLEMENTED BY HOSPITALS IN RESPONSE TO COVID-19, INCLUDING VISITATION AND ISOLATION POLICIES

Visitation and isolation policies and processes led to significant challenges within hospitals. Isolation practices have led to widespread stress and loneliness, experienced to different degrees by patients and staff. Without visitors, patients feel less at ease during their evaluations and/or procedures. Additional communications by phone with family members placed additional strain on nurses and providers due to an increase in time spent during a shift. Discussions by phone regarding care decisions, especially sensitive or difficult ones, were made even more challenging without being able to speak in person to caregivers and family members. End of life visitation remained permissible in some facilities, but due to the fears of many in the public, many patients who died during COVID-19, did so alone.

Elimination of visitation had a significant impact on patient willingness to come to the ED. Many patients who arrived at the ED refused to be admitted when they realized a family member was not allowed to stay with them. Some patients refused Emergency Medical Services transportation to a hospital when they learned family members would be unable to visit them.

When the COVID-19 surge began to flatten, some hospitals eased the visitation ban to allow close family members to the bedside of terminally ill patients. One hospital reported they have started to allow visitors with new restrictions. At this hospital, all patients, employees and visitors are screened before entry into the building for high-risk COVID-19 symptoms, recent contacts as well as recent travel. New admission policies have been developed that require screening for COVID-19 with a lab test, as well as for high-risk clinical and epidemiological risk factors. These results impact the type of isolation and bed the patient receives.

While visitation restrictions are understandable, New York ACEP recommends they be reviewed and possibly changed in the event of a second wave of the virus. Going forward, there should be an ability to easily have frequent virtual interaction between patients, caregivers and families.

There is a need for adequate, rapid turnaround testing capabilities with accurate results. This helps to avoid boarding of patients in the ED and promotes proper patient illness identification, patient and staff safety and valuable contact tracing.

STATE-IMPOSED REQUIREMENTS

Governor Cuomo’s Executive Order 202.30 which provides that any Article 28 general hospital shall not discharge a patient to a nursing home without first performing a diagnostic test for COVID-19 and

obtaining a negative result should be withdrawn. This requirement is not in the best interests of patients and places a significant burden on EDs. Not every emergency department has 24/7 access to COVID-19 tests. If no test is available when the patient is ready for discharge, they must be held in the ED overnight or longer, even if the patient is not symptomatic. This creates a backlog of patients who need emergency care being boarded in hallways and other unsafe areas. The patient's home - the nursing home - is a far safer environment than an ED where they could potentially be exposed to the virus.

The Statewide requirement for specific hospital and ICU capacity created undue harm by limiting bed capacity in those regions without a signification burden of hospitalizations or ICU use. New York ACEP recommends moving to a more flexible model which will not force hospitals to reduce capacity that is essential for operation.

RECOMMENDATIONS FOR THE FUTURE

New York ACEP recommends new policies be put in place to ensure the health care system is better prepared in the event of a resurgence of COVID-19 and that the emergency health care safety net is available to all who are in need of care. Maintaining adequate staff to provide acute patient care needs should be high priority throughout the state.

MORATORIUM ON ANY FURTHER CUTS TO THE HEALTH CARE SYSTEM: The State started the year with a $6 billion deficit which has soared to $14.5 billion since the COVID-19 pandemic started. The 2020-21 State budget enacted in April reduced health care funding by $2.2 billion and included additional across the board cuts to Medicaid. In the face of a second surge of the virus, it is essential emergency health care workers who are working tirelessly on the front lines receive adequate financial resources to meet patient needs.

PPE SHORTAGES: Emergency physicians in nearly every area of the State experienced shortages of N95 masks, face shields, goggles, gloves and gowns. As a result, normal infection control protocols for use and reuse were not possible. Additional resources and policies must be put in place to prepare for a resurgence of the virus.

TESTING: There is a need for adequate, turnaround testing capabilities with accurate results. This helps to avoid boarding of patients in the ED and promotes proper patient illness identification, patient and staff safety and valuable contract tracing.

HOSPITAL BED CAPACITY: The statewide requirement for a specific hospital and ICU bed availability created undue financial harm by limiting bed capacity in those regions without a significant burden of hospitalizations and ICU use. We recommend moving to a more flexible structure so that hospitals are not forced to reduce capacity which is essential for operation.

WORKFORCE SHORTAGES: Investments should be made to address workforce shortages, particularly nurses, respiratory therapists and critical care physicians.

VISITATION POLICIES: Denying patient visitation significantly impacted patient willingness to come to the ED and was inhumane to both patients and their families. These policies should be reviewed and revised. At a minimum, virtual interaction between patients, caregivers and family members should be available for all patients.

On behalf of New York ACEP, thank you for the opportunity to provide this testimony to the aforementioned Senate and Assembly Committees.