CARING FOR SENIORS IN A NATIONAL EMERGENCY: CAN WE DO BETTER?

TESTIMONY BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

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Good morning Chairman Smith, ranking member Kohl and Members of the Committee. Thank you for convening this hearing and for allowing me to testify today about disaster preparedness for seniors, based on my experience serving survivors of Hurricane Katrina in Houston and on behalf of the American Geriatrics Society. The American Geriatrics Society is an organization of almost 7,000 geriatric health care providers.

I'm Dr. Carmel Bitondo Dyer, and I was trained as a geriatrician. Geriatricians are physicians who are experts in caring for older persons and in the study of old age, which is called gerontology; geriatricians complete at least an additional year of fellowship training. I am associate professor of medicine at Baylor College of Medicine and presently the Director of the Geriatrics Program at the Harris County Hospital District. Both those roles provided me the privilege of serving the Katrina survivors who were evacuated to Houston. Following Hurricane Katrina and the destruction of the levees, more than 200,000 men, women, and children were evacuated from Southeastern Louisiana to Texas and approximately 23,000 individuals were transported by bus to the Reliant Astrodome Complex (RAC) in Houston, Texas. While the American Red Cross organized housing in the Astrodome, the Harris County Hospital District (HCHD), constructed a medical MASH unit complete with registration, examination rooms, a pharmacy, blood drawing and x-ray capabilities. Baylor College of Medicine faculty worked with the Harris County Health Department and the Harris County Hospital District to provide the leadership and the physician infrastructure. Nurses, social workers, physicians from every discipline, pharmacists, therapists, phlebotomists and other health care professionals were deployed to the facility to address the medical and social needs of the evacuees. Those of us in Houston who received the evacuees saw persons who were exhausted, their clothes still wet; the evacuees described to us the hardships they had endured.

Based on this experience, I will share with you:

1.) The difficulties encountered by senior citizens
2.) The on-site solution we devised and
3.) Future recommendations for improved disaster preparedness for seniors

In the Reliant Astrodome Complex, evacuees were able to receive onsite medical care. Our statistics show that fifty-six percent of the evacuees seen in the medical unit were 65 years of age and older. Those who were gravely ill were transported by ambulance to a local hospital where their acute medical needs could be properly addressed.

But what about those who were not acutely ill but still sick and unable to advocate for themselves? There were many frail elders and other vulnerable adults who could not scale the stairs to get to the showers, could not read the

signs or hear the announcements providing vital information, could not toilet themselves or administer their medications and were laying on a cot in a stadium. Some of the elderly were disoriented and did not even know where they were. One woman approached a nurse administrator, Beth Cloyd and said: "You know, my family made it to Houston, but I didn't". The elders who had survived told us about being on I-10 for 48 hours in the hot sun, or waiting on their rooftops waiting to be rescued. After hearing their stories, I was certain, even before it was announced, that the majority of the deceased in New Orleans were elders. In Houston more than 60% of the deaths were in persons over the age of 65.

As admirable were the heroic efforts of the Houstonians and others, it is clear that there had been little preplanning to address the needs of frail elders and other vulnerable adults. They languished on their cots unnoticed, usually suffering in silence as busy volunteers attended to the needs of more vocal and able-bodied evacuees. Our solution was to form an ad-hoc team, called SWiFT – the Seniors without Families Triage to advocate for those who were alone and impaired in the Reliant Astrodome Complex. Our team consisted of geriatricians, geriatric nurse practitioners, social workers, adult protective service workers and others who provide aging services in our county. We developed a screening tool to determine who needed which services and in what time frame. We designed, piloted, revised and implemented the SWiFT screening tool in less than 24 hours. We sent nursing-social work pairs to the residential areas of the shelters and they screened for medical illness and applied the SWiFT tool for a period of ten days.

Vulnerable seniors were divided into 3 SWiFT Levels for more effective triage–

- Level 1 evacuees could not perform the activities needed to sustain a minimum standard of safety – they were immediately placed in a residential facility
- Level 2 evacuees could not mange funds or the tasks needed for relocation and they were referred to a local case manager.
- Level 3 evacuees simply needed to be connected with family or friends and were referred to one of the local volunteer agencies.

Over a ten day period we found that 68% of those that we screened were SWiFT Level 1 and could not perform even the most basic tasks such as bathing, toileting or administering their own medicine. It was difficult to locate the seniors who needed help the most; they were interspersed among 20,000 other more able-bodied evacuees.

Another major problem was the inability for family members to locate the frail older relatives. One elderly religious sister from New York, who was visiting her hometown of New Orleans, fractured a hip and was placed in a nursing home just before the hurricane. She was evacuated to Houston and remained delirious

and incoherent due to infection. Despite the fact that she had over 600 family individuals from across the US searching for her, she was admitted to a Houston hospital and deemed a “homeless person”. After three frantic weeks, a family member who is in the FBI was able to locate Sister Annunciata; presently she is recovering and is with family.

The American Geriatrics Society and I are not critical of the efforts made in Katrina. However, it would be a real mistake to not learn from this experience. In order to share what we in Houston learned about seniors in disaster situations, SWiFT members in conjunction with the American Medical Association have compiled a guide that details recommendations for best practices, which is nearly completed. The recommendations from the guide are described below. We do not claim to have all the answers regarding the provision of care for frail elderly in disaster situations, but we hope that our first-hand experiences coupled with the disciplinary expertise of our members and AMA consultants make these recommendations valuable for future planning to meet the needs of older persons in national disasters.

RECOMMENDATION ONE: Develop a simple, inexpensive, cohesive, integrated and efficient federal tracking system for elders and other vulnerable adults that can be employed at the state and local levels. Electronic tracking may help some, however many frail elders lack access to or the ability to use the internet. There will not likely be one-size fits all solution for tracking, but a start would include a standard, numbered color-coded bracelet system.

RECOMMENDATION TWO: Designate separate shelter areas for elders and other vulnerable adults as was done for children. Some seniors at the Reliant Astrodome Clinic eventually organized themselves into groups that facilitated the delivery of services. A practice could be established to gather seniors without family members or advocates into groups in shelter sites that can be attended by medical personnel and volunteers to help with the special needs.

RECOMMENDATION THREE: Involve gerontologists (geriatricians, geriatric nurse practitioners, geriatric social workers, etc.) in all aspects of emergency preparedness and care delivery. In the Reliant Astrodome Complex, geriatricians and geriatric nurse practitioners set up geriatric exam rooms for the assessment and treatment of the more frail seniors. It was clear that geriatricians and other gerontologists were not part of the planning process; had they been it is likely that the evacuation centers would have been better prepared to receive frail elders.

RECOMMENDATION FOUR: Involve region-specific social services, medical and public health resources, volunteers, and facilities in pre-event planning for elders and vulnerable adults. An already established consortium of aging service providers in Houston, called Care for Elders, provided the manpower for the SWiFT triage system.

RECOMMENDATION FIVE: Involve gerontologists (geriatricians, geriatric nurse practitioners, geriatric social workers, etc.) in the training and education of front-line workers and other first responders about frail adults' unique needs. The American Geriatrics Society has already updated its Geriatrics Emergency Medicine Services Program for EMTS with a chapter on disaster preparedness.

RECOMMENDATION SIX: Utilize a public health triage system like the SWiFT Screening Tool© for elders and other vulnerable populations in pre- and post-disaster situations. We believe that the SWiFT triage form could be used nationwide and provide a common language for those who are responsible for providing services to senior citizens.

RECOMMENDATION SEVEN: The personnel charged with overseeing elders and vulnerable adults should maintain a clear line of communication with the shelter's central command. Communication within the shelter should involve technology such as cellular telephones and walkie-talkies.

RECOMMENDATION EIGHT: Provide protection from abuse and fraud to elders and other vulnerable adults. Adult protective services were involved in Houston to help address the exploitation and neglect experienced by the seniors.

RECOMMENDATION NINE: Develop coordinated regional plans for evacuations of residents of long-term care facilities and for homebound persons with special needs (i.e., ventilator-dependent adults).

RECOMMENDATION TEN: Conduct drills and research on disaster preparedness plans and the use of a triage tool, such as SWiFT, to ensure their effectiveness and universality.

Funding is needed for existing programs to continue to plan for such emergencies and provide the infrastructure to accommodate the needs of disasters. For instance, Congress should restore funding to the geriatrics health professions programs, which includes the Geriatrics Education Centers (GECs). The GECs are at the forefront of disaster preparedness and the elderly, having prepared the lead, national curriculum in this area.

There is no place in the US that is immune from natural disasters or terrorism, and with the rapidly increasing number of elders in this country, Congress must prepare to accommodate the needs of seniors in future disasters. Resolution 25 from the 2005 White House Conference on Aging underscored this issue and the need for a coordinated national response. In conjunction with the American Medical Association, we developed the above recommendations for best practices in the management of elderly disaster victims. Now, it is our job to see that Congress enacts these recommendations or that agencies makes plans to implement them.

Geriatricians and other gerontologists should play a major role at the national, state and local levels; however there are likely not enough of us to go around. Disaster preparedness is a major example of where the nation needs the expertise of their geriatrician and gerontology work force.

On behalf of the SWiFT team members, Baylor College of Medicine and the American Geriatrics Society, I would like to thank the committee for holding a hearing on this critical public health problem. We hope that these recommendations are helpful to the committee and others in crafting targeted disaster preparedness plans that can meet the needs of America's seniors. We look forward to working with you to ensure the swift adoption of these recommendations.