Statement of

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Before the Special Committee on Aging

United States Senate

Hearing on "Preparing Early, Acting Quickly: Meeting the Needs of Older Americans During a Disaster"

October 5, 2005

It is my pleasure, Chairman Smith and distinguished Senators, to address you today concerning the role of local public health departments in protecting older Americans during disasters. I am going to talk about two aspects of this issue: 1) How Duval County has addressed the needs of the elderly and other special populations in anticipation of disasters; and 2) how the nation can use its resources for public health preparedness more effectively to continue protecting the elderly, as well as all of us.

The nation's 3000 local public health departments play essential roles in disaster preparations and response. It makes no difference whether a disaster is a hurricane or an act of terrorism. Public Health departments are equal partners with Public Safety and other critical agencies in local emergency management systems and are responsible and accountable for the health and well-being of all citizens, and in particular those with special needs. With respect to people with special needs, local health agencies are responsible for their identification and triage, ensuring transportation to appropriate shelters, meeting their medical, mental health and social-service needs while they are in shelter, post-event planning, and ensuring their safe return to home or other venues. In addition, local health agencies are also responsible for ensuring that health and medical systems, e.g., hospitals, dialysis centers, home health agencies, etc, are prepared and respond appropriately as a ***system*** to whatever challenges they face.

Understanding the extensive responsibilities of local health departments is of critical importance to the issues we are discussing, as over the past two decades, as detailed in two Institute of Medicine reports, the public health infrastructure has been allowed to deteriorate

to the point that it does not have the capacity as a whole to respond to the real and potential challenges we face as a nation and as local communities. While the responsibilities of Public Safety agencies are generally understood and funded, the complexities of Public Health's responsibilities are not, and funding has generally not been adequate to ensure our capacity to respond.

Although not perfect, Duval County (Jacksonville, FL) can serve as a case study of a county that has dedicated resources and worked hard to plan for the needs of the elderly and other persons with special needs during situations that would require an evacuation and sheltering. As a coastal city in Florida that is also situated on a large river (the St. Johns River), and with a population of over 800,000, the proximity of dense populations to the coastline and river, coupled with the generally low coastal elevations, significantly increases our county's vulnerability to the storm surge associated with hurricanes and tropical storms. Since 1933, 25 hurricanes have passed within 100 miles of Duval County.

Our Health Department has 800 employees, 13 clinics, and a budget of $50,000,000. We now have seven people working in emergency preparedness, of which four are funded by county general revenue, and three by grants for terrorism and bioterrorism preparedness. However, all 800 staff have specified roles to play in an emergency and understand they are expected and accountable to fulfill them in any situation in which they are asked to do so. Over the past eight years, we have developed significant partnerships with hospitals, law enforcement, fire rescue, Red Cross, Salvation Army, mental health professionals and various other public and private organizations. We have participated in departmental and county-wide tabletop and functional exercises and provided multiple trainings for internal staff and external partners.

Special Needs Planning

Since Hurricane Andrew struck Florida in 1992, there has been extensive planning to respond to the vulnerability of Floridians with special needs in emergency and disaster situations. Florida law now requires that, in order to meet the special needs of persons who would require assistance during evacuations and sheltering because of physical or mental handicaps, each local emergency management agency maintains a registry of disabled persons located within the jurisdiction of the local agency.

Our definition of a special needs person includes the frail elderly, individuals needing assistance with activities of daily living and/or medication administration, persons on dialysis, individuals needing electricity for treatment and/or oxygen, persons needing wound care, and persons with sensory or mobility impairments. We also consider individuals needing transportation during an evacuation as "special needs."

There are great challenges to ensure a *system* is in place to respond to the predicted and unpredictable needs of these special needs citizens. To name a few:

- Appropriate staffing of shelters with medical personnel, access to medication and oxygen, and availability of dialysis must be assured.
- All hospitals, nursing homes, and assisted living facilities must have generators in place to enable them to provide life-sustaining care during power outages.
- Specific shelters must be equipped with generators to assume responsibility for electrically dependent special needs clients and those who require climate controlled environments

- Special equipment, including appropriate cots, hospital beds, lifts, etc. must be in place to respond and care for the needs of the special needs clients.
- Systems must be in place to track clients entering into the shelters and to follow them upon discharge.
- Nursing and other personnel must be fully trained to assume administrative and clinical management responsibilities.
- A post-event plan must be in place to transfer responsibility from Public Health to other agencies after 3-5 days to allow local health departments to fulfill their other post-event responsibilities, e.g., surveillance, community assessments, outbreak investigation, environmental health responses, medication and vaccination distribution, public information, etc.

In response to these challenges, our Health Department, in collaboration with the City of Jacksonville Emergency Operations Center (EOC), has developed several unique programs and procedures to meet the needs of persons with special needs.

- Persons with special needs are either self-identified through a registration form mailed with their utility bill, usually in late spring, or through identification by public and private sector agencies, home care agencies and physicians. Persons who have been identified are then evaluated by health department nurses to determine their appropriate shelter placement in the event of evacuation.
- A searchable database that includes extensive information about each person in the registry, e.g., their demographics, physicians, pharmacy, home health agency, emergency contact persons in and out of town, permission to search their home,

medications, disabilities, special medical needs, transportation requirements, residence in a surge zone, etc. is maintained. The data base allows us, long before the projected arrival of gale force winds, to determine the number of people needing hospital and special needs shelter placement, and those with specific or non-specific transportation requirements, e.g., ambulance, wheel chair van, car, bus, etc. We then generate a plan for special needs evacuation and transportation and recommend when it should begin.

- An "Adopt-A-Shelter" program was developed in which each hospital in the city has assumed responsibility for staffing, medical supplies, and support of a Special Needs Shelter in the event of an emergency evacuation. This ensures that these shelters are fully staffed during the event, including reserve personnel, and fully stocked with resources. It also precludes the need to go through the process of identifying resources each time an event occurs, and frees-up Health Department staff to fulfill other functions.

- A contract with a medical supply company identifies all resources required to support a special needs shelter, requires them to keep an inventory available at all times, and to deliver these supplies to each shelter prior to them opening. In addition, if post-event plans require shelters to be relocated, the company is expected to transport the supplies between venues.

- A Medical Reserve Corps, that includes 500 physicians, nurses, respiratory therapists, etc., has been established, trained and prepared to support the Department and hospitals.
- Ham operators are present in all shelters to ensure continuity of communications with the Emergency Operations Center and the City and County Government

- There is an 800 MHz radio system that connects public health with the shelters and hospitals to ensure communication linkages with the health system for which the Health Department is accountable. In addition, the Health Department is connected to all Public Safety agencies and the EOC through this system.

Lessons Learned

Over the last several years, a number of lessons have been learned in our community and as a result of Florida's responses to hurricanes. In 1999, Hurricane Floyd, a category 4 storm, posed a severe threat to Florida's entire east coast and prompted the evacuation of millions of residents from South Florida, including Duval County. We learned from Hurricane Floyd to begin evacuation of people with special needs as early as possible and during daylight hours, even if it means some people will eventually be evacuated unnecessarily. The importance of developing a close relationship and trust with the media before the event, and for accurate, frequent and consistent communication with the public cannot be overstated.

From a public policy perspective, we empathized with the plight of the hospitals in New Orleans, as two of Jacksonville's hospitals are located on the river and will flood with a Category 3 hurricane. Their plans call for them to evacuate to higher floors; however, either their generators or their electrical switches are still on the first floor. We strongly recommend that funds be identified to correct such problems in our health care institutions, so that hospitals can continue to provide care throughout all but the worst hurricanes. Providing local communities with flexibility to use the resources that have been allocated through Homeland Security funding would help in this regard.

Since September 11, 2001, the nation has devoted additional resources to public health preparedness. Public health departments, through grants to the states, have been asked to undertake a huge number of new tasks, with funding that is nowhere equal to the expectations. Local health departments have received, on average, about enough money to buy a large pizza for each household in their communities since 9/11. Moreover, we have been asked to "switch gears" regularly in how we spend these modest funds, to address whatever the particular priority of the day may be, be it smallpox or anthrax. This approach is not viable or sustainable.

Perhaps the most important lesson learned from hurricanes Katrina and Rita is that we can't afford to focus on just selected terrorist threats. It is imperative that we develop a public health infrastructure that is capable of addressing all hazards, all of which present challenges in caring for vulnerable older Americans. This requires a strong, sustained effort that focuses on the underpinnings of all disaster preparedness – skilled professional staff, ongoing training and exercising, redundant communications, highly developed disease surveillance and environmental health capabilities, and continued improvement in coordination among all the first responders, hospitals, health care professionals, and volunteers in every community. A national organization, e.g., the National Association of County and City Health Officials (NACCHO) should be used to ensure the distillation of knowledge, distribution of resources, and access to information related to benchmark programs to local health departments occurs to the extent that they can be prepared to meet the needs of communities.

We have a long way to go and are greatly concerned about losing ground once again, if Congress adopts the Administration's proposal to cut the funding for state and local health department preparedness by 14% in FY 2006. We are facing too many threats, from

hurricanes to avian influenza to biological terrorism, to place such a low national priority on improving the nation's local public health system.

Summary Recommendations

The following list of recommendations is provided as a framework and context for ensuring that the critical roles and responsibilities of Public Health can be fulfilled in a systems response to any type of disaster. In particular, Public Health has the lead role in assuring the needs of special needs citizens, including the elderly, are fulfilled in any type of emergency requiring sheltering.

1. Public Health departments are equal partners with Public Safety and other critical agencies in local emergency management systems, and are responsible and accountable for the health and well-being of all citizens, and in particular those with special needs. Although some new federal resources have been received through CDC and HRSA, they have been insufficient to overcome years of neglect of the nation's public health infrastructure. Adequate funding is required to ensure a Public Health infrastructure is in place to meet the challenges local health departments face in their response to disasters.

2. There will never be enough resources in local health departments to support personnel dedicated specifically to disaster responses. As a result, all staff in local health departments must be trained, prepared and expected to respond to all types of emergencies.

3. The response to disasters must be a *systems* response. Local health departments must take the responsibility and be prepared to assume responsibility for the coordination of all elements of the health system's response to disasters, including sheltering of special needs citizens.

4. The infrastructure to support a comprehensive response to the requirements of special needs citizens must be in place, as well as the capacity to ensure its implementation.

5. State laws need to require local jurisdictions to maintain searchable databases of those with special needs, with broad ranging definitions of "special needs."

6. Benchmark programs and innovative approaches to Public Health's response at the local level, including responding to those with special needs, must be disseminated to the 3000 local health departments in the US, and support provided for capacity building. The National Association of County and City Health Officials (NACCHO) is well positioned to assume this role and responsibility.

7. Relationships with all media modalities and outlets must be established prior to the event, with a common understanding of their critical role to be played established.

8. Greater flexibility must be provided to local health departments to use current categorical federal dollars for an all-hazards approach to emergency systems development and to provide infrastructure capacity. Current funding has focused on preparing for specific agents or acts of bioterrorism. It has stymied all-hazards preparedness. We need to ramp up the entire public health infrastructure-trained workforce, communications, all-hazards plans, etc. Only that will give us the flexibility to save the greatest number of lives when disasters hit. In addition, these

resources should also be able to be used to ensure hospitals, dialysis units and other critical health services are able to respond in emergency situations.

9. Different parts of the nation face different threats, and different localities have completely different mixes of resources. There is no "one size fits all" plan or practice to help the elderly and persons with special needs –we have to let local Health Departments, who work in the context of the overall emergency planning system in their jurisdictions, make the best of limited resources by using them to strengthen their capacities systematically. We need to look at what they can do now and then expand that so they can do more for more people. Jumping from one high priority to a different one each year prevents us from making overall sustained progress in improving public health preparedness

We in the Public Health sector are deeply concerned that, just as we are making some progress, a 14% cut in the funds for public health preparedness has been proposed and included in the Continuing Resolution that Congress just passed. There could be no worse time to cut back preparedness funding.

Thank you for holding this hearing and for your support of public health. I'll be happy to respond to any questions you may have.