

**INCLUSIVE DISASTER MANAGEMENT:
IMPROVING PREPAREDNESS,
RESPONSE, AND RECOVERY**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

NOVEMBER 18, 2021

Serial No. 117–10

Printed for the use of the Special Committee on Aging



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

46–553 PDF

WASHINGTON : 2022

SPECIAL COMMITTEE ON AGING

ROBERT P. CASEY, JR., Pennsylvania, *Chairman*

KIRSTEN E. GILLIBRAND, New York
RICHARD BLUMENTHAL, Connecticut
ELIZABETH WARREN, Massachusetts
JACKY ROSEN, Nevada
MARK KELLY, Arizona
RAPHAEL WARNOCK, Georgia

TIM SCOTT, South Carolina
SUSAN M. COLLINS, Maine
RICHARD BURR, North Carolina
MARCO RUBIO, Florida
MIKE BRAUN, Indiana
RICK SCOTT, Florida
MIKE LEE, Utah

STACY SANDERS, *Majority Staff Director*
NERI MARTINEZ, *Minority Staff Director*

C O N T E N T S

	Page
Opening Statement of Senator Robert P. Casey, Jr., Chairman	1
Opening Statement of Senator Tim Scott, Ranking Member	3
PANEL OF WITNESSES	
Sue Anne Bell, Ph.D., Assistant Professor, School of Nursing, University of Michigan, Ann Arbor, Michigan	6
Wanda Spurlock, Ph.D., Professor, College of Nursing and Allied Health, Southern University and A&M College, Baton Rouge, Louisiana	7
Randy Creamer, Vice Chairman, South Carolina Voluntary Organizations Active in Disaster (VOAD), Columbia, South Carolina	9
Danielle Koerner, Volunteer Management Coordinator, Delaware County De- partment of Emergency Services, Rutledge, Pennsylvania	11
CLOSING STATEMENT	
Closing Statement of Senator Tim Scott, Ranking Member	30
APPENDIX	
PREPARED WITNESS STATEMENTS	
Sue Anne Bell, Ph.D., Assistant Professor, School of Nursing, University of Michigan, Ann Arbor, Michigan	35
Wanda Spurlock, Ph.D., Professor, College of Nursing and Allied Health, Southern University and A&M College, Baton Rouge, Louisiana	43
Randy Creamer, Vice Chairman, South Carolina Voluntary Organizations Active in Disaster (VOAD), Columbia, South Carolina	52
Danielle Koerner, Volunteer Management Coordinator, Delaware County De- partment of Emergency Services, Rutledge, Pennsylvania	54
QUESTIONS FOR THE RECORD	
Sue Anne Bell, Ph.D., Assistant Professor, School of Nursing, University of Michigan, Ann Arbor, Michigan	59
Wanda Spurlock, Ph.D., Professor, College of Nursing and Allied Health, Southern University and A&M College, Baton Rouge, Louisiana	63
Randy Creamer, Vice Chairman, South Carolina Voluntary Organizations Active in Disaster (VOAD), Columbia, South Carolina	67
Danielle Koerner, Volunteer Management Coordinator, Delaware County De- partment of Emergency Services, Rutledge, Pennsylvania	67

INCLUSIVE DISASTER MANAGEMENT: IMPROVING PREPAREDNESS, RESPONSE, AND RECOVERY

THURSDAY, NOVEMBER 18, 2021

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:32 a.m., via Webex and in room SD-562, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senators Casey, Gillibrand, Blumenthal, Rosen, Kelly, Warnock, Tim Scott, Braun, and Rick Scott.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

The CHAIRMAN. The hearing will come to order. Today's hearing will examine gaps in disaster management that cause people with disabilities and older adults to be overlooked. Whether it is hurricanes or wildfires or the next pandemic, people with disabilities and older adults must have a seat at the planning table.

This hearing is particularly timely for a state like Pennsylvania which has suffered through devastating floods and tornadoes just this summer, spawned by the remnants of Hurricane Ida, of a record-setting Atlantic hurricane season, part of a record-setting hurricane season. This hearing also comes after more than 190 nations reaffirmed their commitment to take into account the needs of people with disabilities at the Glasgow Summit on Climate Change.

People with disabilities and older adults are often the ones hardest hit by disasters, but they are not given a voice in the management process. The 2018 Camp Fire in California serves as a stark reminder of this fact. The Los Angeles Times reported shortly after that fire that 53 of the 69 deaths—53 of 69 deaths—were to people over the age of 65.

To ensure the safety of people with disabilities and older adults, they must be included in each phase of disaster management. That means in the preparation phase, response phase, the recovery and mitigation efforts that are undertaken.

That is why I have introduced a piece of legislation to deal with some of these issues. It has got a long name, the Real Emergency Access for Aging and Disability Inclusion for Disasters Act, or the REAADI Act, R-E-A-A-D-I, REAADI. This is Senate Bill 2658.

This bill would ensure that people with disabilities and older adults have a voice at every stage of disaster management. It would require accessible information about planning for disasters, making sure that that information is available to everyone, including those with disabilities. It would make sure that shelters and temporary housing are accessible to older adults and people with disabilities.

It is not only natural disasters we need to be concerned with. The COVID-19 pandemic has made it clear that disasters are not limited to weather events. Roughly one quarter of the 760,000 deaths during this pandemic have been in nursing homes or other long-term care facilities, where most residents are older adults or people with disabilities.

The bottom line is we must continue to invest in bold policy solutions to save lives and strengthen communities. The Build Back Better Bill will include a once-in-a-generation expansion of home- and community-based services. It is based upon a bill that I introduced, the Better Care Better Jobs Bill. What we are trying to do there is to create better jobs for those who are doing this important work, home- and community-based services work, better care for seniors and people with disabilities who are served, and better support for family caregivers. These investments will mean better preparation for disasters and emergencies.

Today we will hear testimony how better access to home- and community-based services can help save lives during a disaster. We will also hear crucial testimony that people affected by disasters need to maintain their health care throughout the response and recovery phases of disaster management.

The Build Back Better legislation and the recently passed Infrastructure Bill will make historic investments in reducing the speed and effects of climate change. All of these bills are a recognition of what the science is telling us, that climate change is causing natural disasters the likes of which we have never seen before.

Unprecedented weather, health, and manmade disasters make it necessary to have a whole-community approach to emergencies. People with disabilities and older adults must have a seat at the table when we are doing that planning. As we often hear, representation matters, and in disability and aging communities there is an old expression, "Nothing without us that is about us." "Nothing about us without us." That should hold true for disaster planning as well.

I want to say to the Ranking Member, Ranking Member Scott, before I turn to him, I am happy to join you, Senator Scott, on your bipartisan FEED Act, Senate Bill 19, which would make it easier for small and mid-sized restaurants to provide nutritious meals to people during disasters.

Senator TIM SCOTT. Thank you, Mr. Chairman.

The CHAIRMAN. I thank you and thanks for introducing the bill. With that, I will turn to Ranking Member Scott for his comments.

**OPENING STATEMENT OF SENATOR
TIM SCOTT, RANKING MEMBER**

Senator TIM SCOTT. Thank you, Mr. Chairman, first for your leadership on this Committee and second for joining the FEED Act, a very important piece of legislation that will help us tackle the challenges of food insecurity, especially during the height of disasters.

Thank you to our witnesses for being with us today.

Older Americans and people with disabilities are more vulnerable to natural disasters, and we must do everything we can to protect them.

Mr. Chairman, I recognize how hard Hurricane Ida hit your State in September and how Pennsylvanians responded as they always do, with courage and with strength.

The Palmetto State, we are all too familiar with floods, hurricanes, and other natural disasters. Like so many other South Carolinians, I will never forget the 1,000-year flood in 2015. After those floods, we were hit the next year by Hurricane Matthew. We experienced tragedy and triumph.

Folks like Janice and Gene Davis, a wife and husband in Hilton Head, represent the strength of South Carolinians during a response to a natural disaster. Gene owned an auto painting business. Janice was a caregiver to Jo Scott, an 88-year-old widow. When it became unsafe for Jo to stay home, Janice and Gene drove through the storm to pick her up. With the power out, streets flooded, and trees down, they drove Jo to her son's home in St. Louis, Missouri, more than 800 miles away.

South Carolina has proven a leader in disaster management. The University of South Carolina's Hazards & Vulnerability Research Institute developed a tool that estimated a county's vulnerability to disaster. The tool, the Social Vulnerability Index, includes elderly persons and individuals with special needs. The Index now includes all counties in the United States, and FEMA has adopted in it in their National Risk Index.

The first step in effective disaster management is, of course, prevention. That is why I introduced bipartisan legislation with Senator Schatz, the Repeatedly Flooded Communities Preparation Act. This seeks to provide more resources to those areas of our Nation that consistently and continuously flood. They are flood-prone communities. The legislation would break the costly cycle of repeated flooding and building by providing our communities with the tools to take proactive steps to reduce flood risk and safeguard homes and businesses.

Even the best preparation cannot stop every disaster. Once a disaster happens, we also need solutions to assist in those communities. That is why I introduced the FEED Act with Senator Murphy from Connecticut. I am very thankful that our Chairman has joined the FEED Act. The FEED Act would increase food security for older Americans and others during emergencies by opening up a pathway for food producers, restaurants, and nonprofits to partner with their State and local governments to meet the needs on the ground. It is through reforms like the FEED Act that we are able to assist local communities in the midst of a disaster.

Last, we must also continue to work to improve post disaster recovery. In South Carolina, as in many southern states, heirs' property is passed down by inheritance. In the wake of disasters, FEMA regulations have reflected unjust discrimination against those heirs who are disproportionately poor and minorities because they simply cannot afford to clean the titles. Clear the titles. These homeowners have been ruled ineligible for the disaster assistance they should receive. This resulted in FEMA denying twice as many requests for disaster aid in majority minority counties as the national average.

In August, Senator Ossoff and I sent a letter to Homeland Security Secretary Mayorkas, urging FEMA to review and revise its practices. As a result, FEMA changed its policies in September. FEMA will now accept a broader range of documentation to prove home ownership and occupancy, such as receipts for home repairs or improvements, a long overdue correction of something that was simply not right. I am pleased with this progress and urge FEMA to do more to better support people in rural areas.

The poorest homeowners, often in rural America, receive half of what wealthier homeowners do in home repair assistance. There is a 17-point gap between the denial of aid for higher income owners versus poorer homeowners, who tend to live in rural places like rural South Carolina.

FEMA accepts 90 percent of disaster requests of \$7.5 million or more compared to just 6 percent for requests of \$1.5 million or less. While damages in more urban areas often easily reach \$10 million, larger amounts of damage in rural areas do not often meet that total.

I look forward to working with you, Mr. Chairman, as we look for ways to help our seniors weather the storm and be better prepared for the outcome that will be positive, especially for those who are also with special needs and disabilities. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member Scott.

It is Thursday, because we have got a lot going on, there will be Senators in and out of this hearing and juggling hearings. I know the Ranking Member is one of those Senators having to juggle two big hearings.

We were joined, and have been joined, by Senator Braun of Indiana, Senator Rosen of Nevada, and Senator Rick Scott of Florida.

Let me turn now to our witnesses. I will introduce them one after another before their testimony, but our first witness is Dr. Sue Anne Bell. Dr. Bell is an assistant professor at the University of Michigan, where she focuses her research on how disaster preparedness at the Federal, State, and local levels can affect individual health outcomes following disasters. She is also a nurse, scientist, and family nurse practitioner who has worked on the ground responding recently to Hurricane Maria and, of course, the COVID-19 pandemic.

Thank you, Dr. Bell, for being with us today and sharing your expertise with the Committee.

Our second witness is Dr. Wanda Spurlock, a professor in the College of Nursing and Allied Health and Southern University and A&M College in Baton Rouge, Louisiana. Dr. Spurlock recently

served as co-chair of a national policy expert roundtable on emergency preparedness for older adults. Her research focuses on disaster preparedness, response, and recovery for older adults, including the role of family caregivers and skilled nurses in disaster management.

Thank you, Dr. Spurlock, for being with us today and sharing your expertise with the Committee.

For witness number three, I will turn to Ranking Member Scott to introduce our next witness.

Senator TIM SCOTT. Thank you, Mr. Chairman. It is my pleasure to introduce today Randy Creamer of Columbia, South Carolina. Randy is Vice Chairman of the South Carolina Voluntary Organizations Active in Disaster, known as VOAD. He is also the Director of Disaster Relief for the South Carolina Baptist Convention and member of the VOAD in the Palmetto State. For over three decades, Randy has served on the front lines to help respond to disasters in South Carolina and around the country.

Randy serves with the South Carolina VOAD Executive Committee to enhance coordination among dozens of voluntary organizations including Habitat for Humanity, the Salvation Army, and the American Red Cross. South Carolina VOAD is an affiliate of the national VOAD, which is an association of nonprofit and voluntary organizations striving to mitigate and alleviate the impact of disasters. Many American companies and corporations are partners and supporters of this network. South Carolina VOAD member organizations cover a broad range of missions and technical expertise. Volunteers lead in many aspects of disaster response and recovery, from preparing meals and starting amateur radio operations to removing debris and building new homes.

Randy's testimony today will discuss the role of voluntary organizations in disaster relief and lessons learned from his decades of experience.

Randy, we appreciate your leadership and hard work to help improve disaster relief for South Carolinians and your neighbors. Thank you for being with us here today. We look forward to your testimony.

The CHAIRMAN. Thank you, Ranking Member Scott. Our final witness is Ms. Danielle Koerner from Rutledge, Pennsylvania. Ms. Koerner has experience with disaster management in many different ways. She is, first of all, the mother of Joseph, a 9-year-old who lives with a disability, and previously she cared for her mother with early onset Alzheimer's. Ms. Koerner is also the Volunteer Management Coordinator for the Delaware County Department of Emergency Services in Pennsylvania, in southeastern Pennsylvania.

I want to thank Ms. Koerner for being with us today and for sharing her expertise with the Committee.

Now we will proceed to our witness statements. We will begin with Dr. Sue Anne Bell.

Dr. Bell, you may begin.

**STATEMENT OF SUE ANNE BELL, Ph.D., ASSISTANT
PROFESSOR, SCHOOL OF NURSING, UNIVERSITY
OF MICHIGAN, ANN ARBOR, MICHIGAN**

Dr. BELL. Chairman Casey, Ranking Member Scott, and distinguished members of the Committee, it is an honor to testify before you today regarding inclusive disaster management. I am grateful for the opportunity to address this Committee and appreciate your continued support of this critical issue that affects older adults and people with disabilities.

Let me state at the outset that the way we currently mitigate, prepare for, respond to, and recover from disasters is not inclusive or equitable. In this testimony, I will describe that older adults and people with disabilities remain disproportionately affected by disasters, that disruptions in access to health care and necessary supports are a critical need to be addressed in inclusive disaster management, that strategies to promote aging in place throughout the phases of a disaster can better support older adults, and that a whole community approach to disasters is essential.

I am a researcher who studies disasters and health, focusing on how to promote healthy aging in the face of an increasing number of disasters. I am also a nurse practitioner by training, and I regularly deploy to disasters across the U.S. I witness firsthand the effects of the disasters I study, the challenges of healthy aging during and after a disaster, and the consequences of these events on individuals and communities. Much of my work is focused on supporting individuals with health care needs throughout a disaster.

In my experience providing health care in Puerto Rico after Hurricane Maria, you might think that I treated injuries or provided some kind of emergency care. In actuality, though, the majority of the patients I treated were there for basic primary care and management of chronic health conditions—diabetes, high blood pressure, and kidney disease, for example, conditions that require and benefit from regular and sustained access to health care.

When communities are disrupted by a disaster, so are the supports for those that live there and the normal patterns of functioning in those communities. The loss of basic infrastructure such as electricity or transportation can cause serious care interruptions, especially access to health care, which can have long-lasting health effects, especially for those with chronic conditions.

Our team published a study that looked at how this disruption affects long-term health through the lens of cancer care, and we found that people with a cancer diagnosis who lived through Hurricane Katrina died at a significantly higher rate than people with the same characteristics and types of cancer who did not live through a hurricane. Our takeaway was that it was not the hurricane itself but, rather, the lack of access to health care and normal patterns of healthy living after the disaster that contributed to the greater rate of deaths.

Inclusive disaster management should include promoting aging in place throughout the phases of a disaster, with the goal of supporting older adults to stay in their preferred living environment. In our study of home health agencies affected by Hurricane Harvey in Texas, 76 percent reported a disruption in services despite that 99 percent of agencies reported having the required emergency pre-

paredness plans in place. Nearly half of the disruptions of care services lasted 1 week or longer.

We have also studied older adults' preparedness through a large national poll. Participants reported feeling confident that they were ready to address a disaster but also reported low levels of preparedness actions, the actual steps to be ready for a disaster, like having an evacuation plan or putting together a disaster preparedness kit. Critically, among older adults who rely on electrical medical devices, that is, nonbattery-operated medical devices such as an oxygen concentrator, only one in four had an alternative power source such as a generator.

I and my colleagues have also learned from home-based care providers who have worked through recent disasters, including Hurricanes Harvey and Irma and now the COVID-19 pandemic. Some of our findings are that home-based care represents an excellent insertion point to support readiness and to provide older adults with the tools they need to protect their health during an emergency.

We also found that home-based care is frequently not included as part of the health care response to disasters, where the focus is on hospitals and nursing homes. Home-based care organizations reported feeling left on their own to care for patients after disasters, where patients would be left on their own if home-based care was not available. Including home-based care organizations as a partner in emergency preparedness planning is essential.

Inclusive disaster management must include systems for continuity of care throughout all phases of a disaster, and that starts with strengthening relationships in the whole community among emergency managers, health care coalitions, aging organizations, home-based care providers, to name a few, and most importantly, including the voices of older adults and people with disabilities centered as the key stakeholders.

Thank you again for the opportunity to participate in today's hearing.

The CHAIRMAN. Dr. Bell, thank you for your statement.

Before we introduce our next witness, I also want to acknowledge we have been joined by Senator Warnock of the State of Georgia.

Next we will turn to Dr. Spurlock.

Dr. Spurlock, you may begin.

**STATEMENT OF WANDA SPURLOCK, Ph.D., PROFESSOR,
COLLEGE OF NURSING AND ALLIED HEALTH, SOUTHERN
UNIVERSITY AND A&M COLLEGE, BATON ROUGE, LOUISIANA**

Dr. SPURLOCK. Thank you, Chairman Casey, Ranking Member Scott, and distinguished members of the Senate Special Committee on Aging for affording me the opportunity to speak with you today. My name is Dr. Wanda Raby Spurlock, and I am a professor of nursing at Southern University and A&M College located in Baton Rouge, Louisiana.

For over 2 years following Hurricane Katrina, my School of Nursing delivered primary health care services at one of the largest FEMA transitional trailer sites in the State. Based on our unique experiences, I will highlight a few of the important issues that were evident and that impact the well-being of older adults and persons of disabilities when confronted with major disasters.

Timely access to medical and support services following a disaster is critical. However, treatment for chronic conditions, such as hypertension and diabetes, can often be delayed for period of time, leading unfortunately to poor health outcomes. Many older adults had lost their assistive devices and home equipment needed to monitor and treat various medical conditions. In addition to being separated from prior systems of health care, these evacuees were also separated from their social support networks, including family and friends, some of whom had been evacuated to other states. Our work has revealed that most evacuees did not have an emergency plan in place in the event of a disaster, highlighting the need for more targeted work in this area.

Detailed information about the School of Nursing's role in delivering health care following Katrina can be found in the publication by Spurlock, Brown and Rami, "Delivering Primary Health Care to Hurricane Evacuees: The Role Schools of Nursing Can Play," published in the American Journal of Nursing.

Based on my experiences in the disaster arena, the following key issues are paramount regarding older adults and persons with disabilities and should be addressed in disaster planning, funding, and policy decisions:

1. Effective and holistic planning is critical to the success of disaster response and recovery, the full inclusion of older adults, disabled persons, and others with access and functional needs is necessary to mitigate the impact of disasters on these vulnerable populations.
2. Access to health care and other supportive services is critical following a major disaster, especially when evacuees are forced to relocate to other states, thereby risking the loss of desperately needed long-term care services and supports.
3. Training and resources must be made available to support community-based organizations to ensure equitable access to services and programs, to prepare and support vulnerable populations during and after disasters, including integration back into the community.
4. Prioritization in disaster research funding to inform evidence-based action and policy decisions that support the needs of older adults and persons with disabilities across diverse ethnic and minority groups is warranted.

As a Nation, we must continue to seek solutions to overcome the unique challenges that older adults and persons with disabilities face when preparing for, responding to, and recovering from disasters. I was pleased to read about several recently introduced legislation that addresses many of the issues that I have presented.

The passage of the Real Emergency Access for Aging and Disability Inclusion, REAADI Act, will ensure that the life experiences and voices of persons with disabilities, older adults, and others with access and functional needs are included in the preparation, response, recovery, and mitigation of disasters. This inclusion is paramount to ensuring the best possible outcomes for these vulnerable populations.

The Disaster Relief Medicaid Act, DRMA, ensures that Medicaid-eligible persons forced to relocate from an area under a Presi-

dential disaster declaration to another State will be able to maintain their Medicaid-supported services, including home-and community-based services. Passage of DRMA will address many of the issues that impacted the health and wellbeing of evacuees following Hurricane Katrina and also will impact their health in future disasters.

As the Nation continues to recover from the COVID-19 pandemic and in preparation for future disasters, the FEMA Empowering Essential Deliveries, FEED, Act allows the government to pay 100 percent of the cost to states and localities so that they can partner with restaurants and nonprofits to prepare nutritious meals for vulnerable populations desperately in need.

In closing, I would like to thank you again for this opportunity to share my thoughts and experiences as a nurse clinician, educator, and researcher.

I once read a quote by Mahatma Gandhi, “The true measure of any society can be found in how it treats its most vulnerable members.” Progress has been made in disaster planning, response, and recovery although there remains work to be done to ensure the best possible outcomes for older adults. Passage of these legislations will present a significant step in solving many of the issues that I have presented, and I commend the Senate Special

Committee on Aging for shining a national spotlight on this important issue.

Thank you.

The CHAIRMAN. Dr. Spurlock, thank you for your testimony.

We will turn next to Mr. Creamer.

STATEMENT OF RANDY CREAMER, VICE CHAIRMAN, SOUTH CAROLINA VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTER (VOAD), COLUMBIA, SOUTH CAROLINA

Mr. CREAMER. Good morning, Chairman Casey and Ranking Member Scott and members of the Committee. My name is Randy Creamer. I am a native and resident of South Carolina. Over the past 35 years, I have served as a volunteer and a professional assisting those affected by natural and manmade disasters. Bringing health and healing and hope to individuals and families and communities has been the most rewarding work of my life. Thank you for the opportunity to share a brief testimony.

National VOAD, as already mentioned, is an organization that provides cooperation, communication, coordination, and collaboration, and fosters more effective delivery of services to communities affected by disasters. Founded over 50 years ago, National VOAD is a coalition of 70 of the Nation’s most reputable national organizations. They are faith-based, community-based, and other non-profit organizations as members.

Our South Carolina VOAD is committed to the “4 C’s,” with a strong focus on communication amongst members engaged in a specific response. Our VOAD in South Carolina is not operational in the sense of telling any organization what they can or cannot do, or where they can or cannot serve. We strive to enhance effectiveness in assisting those who are hurting.

Many volunteer organizations are involved in the initial response only. Others may not be involved for weeks or even months, but

each organization brings its strengths to the table. Few, if any, of those organizations are engaged from the first hours of an event to the complete recovery, which can take several years.

The South Carolina Baptist Convention became involved in disaster relief in 1990 following Hurricane Hugo. Today we have 2,500 volunteers who have attended our training, completed background checks as part of our credentialing process, and prepared to assist others affected by disasters in South Carolina, across the U.S., and occasionally even internationally. We are part of the larger Southern Baptist Disaster Relief Network that encompasses all 50 states. This year we sent 19 teams to the Hurricane Ida event. Those teams went to both Louisiana and Pennsylvania, serving.

Our primary task is to provide immediate assistance after various wind events like tornadoes or hurricanes or thunderstorms or flood events that can occur after a tropical system or some heavy rain event. Our volunteers typically sleep in church buildings on cots or blowup mattresses, and they bring along mobile showers and laundry trailers and volunteer cook teams and all the logistical support that they need.

Another major task is to partner with the Salvation Army and the American Red Cross when mass feeding is required to support those who have been evacuated and support those who are unable to prepare meals for themselves.

Aside from myself and two coworkers, all South Carolina Baptist disaster relief is provided by volunteers, most of whom are retired. Our volunteers are motivated by their personal faith in Jesus Christ and the desire just to love God and love others. They are our most valuable resource.

The American Red Cross and the Salvation Army lead the way in providing mass care. United Methodist congregations provide much of the same kind of service as Baptist. The Presbyterian Disaster Relief and Adventist Community Services Disaster Response are other major partners that lead the way in the long-term recovery. We are blessed with numerous partners.

Over the years, we have learned a number of critical lessons. We have learned the disaster impacts increase substantially on structures and houses that have preexisting deferred maintenance issues.

We have also learned that we cannot do everything. You have to find your niche and really do it well.

We have learned that we cannot help everyone. We have to prioritize and identify the most vulnerable. Our priority is on those who are unable to help themselves. They lack financial resources, have no one else to help them, for example, widows, single adults, certainly retired folks or grandparents raising grandchildren, single parents.

We also strive to help our body of first responders that are often neglecting their own personal needs and family needs because they are serving the community.

Finally, we have learned that we have to allow our volunteers a great deal of leeway in the ways that they respond, like if they discover a lady lost her refrigerator and all of her food and we are just there to take trees off the roof, but in turn they buy her a refrigerator and restock her pantry.

In closing, I am pleased to say that for 54 years we have been involved in and depended on retirees for most of our volunteers within the Southern Baptist Network. As one generation ages out, the next one steps up. Today we are excited with the number of college students that join us. We look forward to serving our neighbors in disaster relief for years to come, and we do appreciate the opportunity to share a little bit about our story.

The CHAIRMAN. Mr. Creamer, thank you for your statement. We appreciate you being here.

We will next turn to our fourth and final witness, Ms. Koerner.

**STATEMENT OF DANIELLE KOERNER, VOLUNTEER
MANAGEMENT COORDINATOR, DELAWARE COUNTY
DEPARTMENT OF EMERGENCY SERVICES,
RUTLEDGE, PENNSYLVANIA**

Ms. KOERNER. Chairman Casey, Ranking Member Scott, and members of the Committee, my name is Danielle Koerner, and I will be speaking today as an advocate, former unpaid caregiver, and as a first responder and emergency planner. Thank you for this invitation to share my professional and lived perspectives on this topic.

I sit before you a circumstantial expert. For the past 20 years, I have volunteered and worked in the field of emergency services in Pennsylvania, first as an EMT and paramedic providing direct patient care and advocacy, then in education regulatory compliance.

In 2012, my husband and I were blessed with the arrival of our first son, Joseph. He was born healthy but with multiple deformities and congenital amputations in his extremities, requiring surgical intervention, ongoing therapy, and adaptive equipment. In 2015, my 54-year-old mother was diagnosed with early onset Alzheimer's and dementia, and my husband and I became her primary live-in caregivers while my father continued to travel for work. I became an expert at anticipating needs, adapting everyday situations and tasks to the physical needs of my son and cognitive and behavioral needs of my mother.

I had binders of bills tabulated with notes about insurance coverage and payment plans, calendars full of appointments. I gained a new vocabulary and set of skills specific to advocacy for my child and mother, and began to think 10 steps ahead for every task to assure that the needs of my loved ones would be met in everything that we did, both in non-emergency "blue sky" situations and "dark sky" emergencies. I built contingency plans for care, kept outgrown medical equipment in case something broke, and kept extra comfort items in strategic areas to soothe fears and calm erratic behaviors.

To say that I received a crash course in accessibility and advocacy would be an understatement. I became a survivor before an emergency had occurred.

In 2018, my mother lost her fight. I was both devastated and grateful that she had found peace. It was that same year that I was offered the job of Outreach and AFN, or Access and Functional Needs, Coordinator for the Delaware County Department of Emergency Services. I leapt at the opportunity, hoping to integrate my lived experience with professional knowledge of emergency services, both to honor my mother and assure that people like my son were

considered before, during, and after disasters and emergencies happened.

Very quickly I learned that my primary function in this new professional role was to be the voice in the room reminding planners and responders that one size never fits all, that accessibility means more than wheelchair ramps, that not all disabilities are physical, and that all of us will likely have an access need at some point in our lives.

I also found myself regularly educating planners and responders that individuals who live every day with disabilities, seniors who have access needs, and individuals who are unpaid caregivers or survivors, a good way to describe them is “pre-survivors” even before the emergency has happened. Often, they are surviving against the odds, outliving expectations and resources, making due with inadequate services, living situations or equipment, and recovering from medical, financial or emotional setbacks because of their personal normal. We, as responders, planners, emergency managers and as policymakers, cannot begin to plan for the whole community without first embracing this knowledge.

The reality is that if we want to be successful in disaster mitigation the work must also be done in the fields that operate independent of emergency management, the everyday “blue sky” supports. We must focus on assuring that circumstances that make individuals pre-survivors are addressed well before the disaster occurs and stop limiting our conversations on inclusive disaster practices to the disaster itself.

Working to enhance accessibility to government services by streamlining technologic and paper platforms, useful resources and applications, simplifying processes and terminology, expanding regular operation hours for services, and assuring that resources are known to those who most need it through multi-outlet and media messaging are all just as important as ensuring physical accessibility to buildings.

Investing in workforce development and support for direct care and medical professionals, as well as case managers and social workers, is another critical piece of the puzzle.

Addressing our Nation’s housing crisis through the lens of accessibility and bolstering programs designed to increase independent and supportive living for individuals who need it most, expanding the criteria for Medicaid and Medicare reimbursement and coverage, assuring financial support to unpaid caregivers, and increasing programs that offer respite services will help.

These examples only begin to scratch the surface of this topic. The best way to ensure optimal outcomes for pre-emergency survivors is to ensure that they have unobstructed access to the supports that they require daily and to include individuals with personal knowledge of these requirements to guide the process.

The frequency and intensity of natural disasters are increasing, and the emergency response workforce is decreasing. Paid and volunteer workers are harder than ever to find in my field of work. If we can improve the lives of individuals with disabilities, seniors with access needs, and unpaid caregivers before the emergency happens, we will exponentially increase the resiliency when it does.

Thank you for your time today.

The CHAIRMAN. Ms. Koerner, thank you for your testimony. I will start a round of questions with you. I want to say with regard to your testimony, as well as our other witnesses, all four witnesses, it is especially heartening when witnesses can bring to a hearing not just professional lived experience but also personal experience, and that is true of all of our witnesses today, and that is certainly true of you, Ms. Koerner.

In your testimony, you said you leaped at the opportunity to work in disaster management to, quote, integrate your lived experience with professional knowledge of emergency services, both to honor your mother and assure that people like your son were considered before, during, and after disasters happen.

Unfortunately, not every community is as fortunate as your community to have an expert with lived experience to serve that community, in your case, to serve in Delaware County in the emergency services department. For those communities without a person with lived experience at the planning table, national services like technical assistance, like a technical assistance center, can help State and local governments with inclusion, in other words, to do the work that you and others have done locally.

The question I have for you is: How would enhanced representation and technical assistance programs like those included in my legislation, the REAADI Act—how would that help to save lives during disasters?

Ms. KOERNER. Thank you for that question. First, I have to advocate that every community strive to include local stakeholders who have disabilities, caregivers, advocates, and seniors who have access need at their local process wherever possible, understanding that these individuals may not have a background in emergency management.

That being said, having access to individuals who have both personal, lived, and professional experiences through national technical assistance programs will connect these communities with critical information during planning, expert guidance during the response and then later during the recovery process. While knowing that needs truly are in the community and knowing what those needs are in the community is the first step, having the access and expertise to address them strategically is what will ultimately increase life-saving communications and operations.

The CHAIRMAN. I was noting on the second page of your testimony one paragraph that, at least for me, summarized a lot of your testimony and what we have got to focus on in terms of a list of priority areas for our work. You indicated in the middle of the page, quote, working to enhance accessibility to government services by streamlining technologic and paper platforms; second, simplifying processes and terminology; third, expanding regular hours of operation for services; and fourth, assuring that resources are known to those who most need them through multi-outlet and media messaging that are just as important as assuring physical access to buildings. That is a good summary of what we would hope every community would be able to avail itself of.

Ms. Koerner, thank you for your testimony.

I will move my second question to Dr. Bell. In your testimony, you talked about the research you had done on the health effects

of disasters on people with chronic conditions, which is more than 80 percent of seniors. You found that survival rates were lower for people exposed to Hurricane Katrina than for those that did not experience a storm likely due to a disruption in access to health care.

You noted, quote, the loss of basic infrastructure can cause serious care interruptions, especially access to health care, which has long-lasting effects for those with chronic conditions, unquote, quoting again from your testimony. Going without health care is, of course, for all of us unacceptable.

I introduced a particular piece of legislation called the Disaster Relief Medicaid Act to ensure that people affected by disasters can keep their Medicaid coverage. People are uprooted, and they move, and we want to make sure they can still access Medicaid if they have had to move.

Can you discuss how policy solutions like this act would help people access their medical care and, indeed, even save lives following a disaster?

Dr. BELL. Thank you for that question, Chairman Casey. I think one important thing to consider is that disasters do not respect State lines and neither do health care needs. Thinking about how to access for people—thinking about how people can access health care needs who have Medicaid, the ability to access their health care needs in a different State where they may have evacuated to is crucial. We have to think about ways to meet health care needs, and this is a solution that feels or seems fairly straightforward if we can eliminate unnecessary delays and red tape that have characterized past disasters.

The CHAIRMAN. Well, Dr. Bell, thanks very much for that answer and also for your testimony. I was noting in your testimony at one point something that—and I hope I can get back to this later, but it really kind of jumped off the page. This is on page three. You start the paragraph by talking about older adults and people with disabilities are disproportionately affected by disasters. The next sentence is “Disasters are not natural.” That is, for a lot of people, counterintuitive.

You explain by talking about hazards such as hurricanes, wildfires, and tornadoes are weather events that occur as natural processes but that we know that the impacts of climate change advance is driving this, and then you say, and I am quoting, “The impact these events have on communities is largely human-made and influenced by social, economic, geographic, and political processes.” I will get back to you, I hope, a little later about that, to have you walk through that, but that was an interesting formulation for me to read and to give me a better perspective on what we are up against.

I will turn next to Dr. Spurlock. You have a unique perspective in that you research disaster management and you live in southeastern Louisiana, which has seen—to say that you have experienced severe weather events, extreme hurricanes over the past two decades, of course, is an understatement. Not many regions of the country have had as much in the way of disasters and challenges as the State of Louisiana and that section of the State.

In your written testimony, you noted that “populations are not equally impacted by a disaster.” How would equitable representa-

tion through the programs that we outline in the REAADI for Disasters Act—how would that equitable representation create life-saving approaches during disasters?

Dr. SPURLOCK. Yes. Thank you, Chairman Casey. We know from our research, and it is widely accepted, that certain populations will experience a disproportionate burden when confronted with disasters and those populations mainly include older adults and persons with disabilities of all ages. We know in terms of some of the changes that occur with aging, including impaired sensory functioning, impaired vision, hearing, especially impaired mobility and changes in cognition and chronic medical problems that necessitate ongoing treatment with medications and sometimes life-saving equipment, can put those populations at a greater risk when it comes to response to hurricanes or any type of disaster, including recovery phase.

I was pleased to learn about legislation that has been introduced that will bring representatives from vulnerable populations to the table to actively participate in disaster planning because we know that the success of the recovery and the response phases will largely depend on the efficacy of plans that have been put in place to mitigate some of the negative disaster outcomes that can occur. Not only bringing them to the table is important, but also including a diverse representation of older adults and persons with disabilities in recognition that their life experiences and needs can widely vary. These represent significant steps toward solutions to improve our disaster response.

The CHAIRMAN. Well, thanks for making the point about not only representation but equitable representation and highlighting some of the legislative approaches and even solutions we can bring to bear.

I am going to jump back Dr. Bell to highlight another segment of your testimony. In your testimony, you indicated that, quote, inclusive disaster management should include promoting aging in place throughout the phases of a disaster, with the goal of supporting older adults to stay in their preferred living environment, unquote.

You also noted that in your study of over 2,000 older adult respondents that although the majority felt confident in their ability to address a disaster they actually have taken low levels of preparedness actions, like having a disaster plan and kit. This highlights, of course, the need for support in turning intention into action.

Your research has also shown that home-based care providers are an excellent starting point for disaster management.

Can you discuss how investing in home-and community-based service will improve the ability of older adults and people living with disabilities to remain healthy and safe leading up to, during, and after disasters?

Dr. BELL. Thank you for that question. We know already that people want to stay in their preferred living environment and having home-and community-based services are the kind of supports that can help them stay in these settings. Home-based and community support services, investing in these is a good idea in general. We already know that the population of older adults is increasing,

and home-based care needs and the home-based care industry will have to increase as well to be able to meet these needs, so investments in this area in general are an important need.

During a disaster, if staying at home is the safest option, then let us give providers and older adults and people with disabilities the tools to be able to stay at home and live through a disaster safely in their preferred living environment. We can start by investing in home-based care and community supports, disaster preparedness, and response capabilities.

Another thing that we can do is to encourage that whole community approach that we have already talked about, where home-based care organizations, community supports, emergency managers, and the stakeholders themselves, older adults and people with disabilities, can better interact together around inclusive disaster management.

The CHAIRMAN. Well, thanks very much for that and highlighting the kind of setting we are talking about, that if you are in a home-based setting that allows for the caregiver to be obviously more present and potentially more able to do the kind of planning with that older adult or that person with a disability.

Just a brief follow-up, Dr. Bell. One thing we are trying to do now is to allocate time for Senators as they come back from other hearings in the next 10 minutes or so. I will be asking a few additional questions, but as a follow-up, one of the central elements of the Build Back Better legislation will be an investment in home- and community-based services. It is predicated on a piece of legislation I introduced, the Better Care Better Jobs Act, with which I know you are familiar.

Doctor, in regard to that legislation, I wanted to ask, how much would the policy that is embedded in the Better Care Better Jobs Act—how would that support both homecare workers and family caregivers to improve the prospects for dealing with disaster management for those that the individual worker is serving, in this case, a person with a disability or an older adult?

Dr. BELL. Well, I think what it comes down to is we need the kind of investments that can better support this industry, the home-based care industry. By home-based care, I think it is important to define that this is not—this includes an array of health care that is provided in the home. That could be skilled nursing services, physical therapy, other types of rehabilitation therapy, and also homecare, which is support and assistance with activities of daily living that are necessary to allow for individuals to come—to continue living in their home.

Advancing policy that can better support these industries and these providers themselves to provide the kind of care that can support individuals and communities is really critical. I think it is very important that we start thinking of this as mitigation measure, if we are thinking about inclusive disaster management, that health care occurring at the home is a new normal going forward, and we need to make investments that support that.

The CHAIRMAN. Well, Doctor, thanks very much.

I want to turn next to Mr. Creamer. I was particularly impressed by the scale of the volunteer efforts that you made reference to in

your testimony and the number of communities you and so many others have served. It is remarkable.

I noted as well that you made reference to one of a number of your teams going throughout the country, including to Pennsylvania. As a Senator from Pennsylvania, as a citizen, I appreciate the help that was provided in those terrible circumstances in communities that we faced. A lot of the communities this summer and fall were communities in the southeastern part of the State, where Ms. Koerner is doing her work, so it is entirely possible that they were crossing paths with folks that she was working with.

My question for you, Mr. Creamer, is you provided a fulsome description of how the volunteer workforce can address many of the immediate needs that people experience in a disaster. The work that the South Carolina VOAD does is critically important. Can you tell us how the volunteer workforce coordinates with community needs in more formal supports such as Ms. Koerner's emergency management program?

Mr. CREAMER. Yes, sir. Thank you for the question. When we go into communities like Horsham, Pennsylvania, where we were north of Philadelphia just a few weeks ago—

The CHAIRMAN. Right.

Mr. CREAMER. We seek to connect with officials in those counties and those communities immediately. We will go to a fire chief, police chief, emergency manager for a county or parish. Sometimes it is pastors in local communities. They can steer us in the right direction, where the most vulnerable populations are concentrated, that need the most help. Here are the things that we can offer, and then you direct us to where we can be most effective to help and assist you in your time of need. We are looking very much at the local officials there to give us that guidance and direction. That is our point of connection.

The CHAIRMAN. Well, it is noteworthy in your testimony about the challenges that volunteers face. Sleeping in church buildings on cots and blowup mattresses, that could be challenging for someone at any age, and we are grateful for the work that they do and that you and others have made apparent today in your testimony.

I will now turn again to an additional question as we wait for one or two Senators who are on their way.

Ms. Koerner, I will turn back to you now that we have made reference to, as Mr. Creamer did, southeastern Pennsylvania. Appreciate the work that you have done in our State and in a big county like Delaware County. For those of you who do not know, it is a suburban Philadelphia county. It is, gosh, I think about our fourth or fifth largest county in the State after Philadelphia, Allegheny, Montgomery, and Bucks. Delaware County I know is well more than half a million people, so there is a lot of challenges when a disaster hits in a high population, suburban community.

Ms. Koerner, you talked in particular about your personal circumstances being a "crash course in accessibility and advocacy" and preparing to be "a survivor before an emergency." So that kind of crash course is not only a good preparation for you and your family. It is, of course, of great value to the people of Delaware County and our State generally.

The REAADI for Disasters Act and the recently implemented Pandemic and All Hazards Preparedness and Advancing Innovation Act, another long name which we use the acronym PAHPA. Then that word “innovation” was added when we reauthorized the legislation, the preparedness legislation which has been—was first acted on way back in 2006 and has been reauthorized several times since then.

In both of those bills, part of the focus of both of those bills is the creation of advocacy, I’m sorry, the creation of advisory councils with a high level of aging and disability representation to inform disaster management planning. If you are going to have a strategy in place at a national or State or regional level, and you make it a priority to address the impact of a disaster on an older American or a person with a disability, you have got to have representation, as Dr. Spurlock made reference to earlier, representation on those advisory councils.

The good news is we have advisory councils. The bad news is they need to be put into action. It has been far too slow. We will get to that later.

The question I have for you, Ms. Koerner, is: How have your experiences as a family caregiver shaped your approach to disaster management at a very local level?

Ms. KOERNER. Thank you for the question. I learned very quickly from my mother and from my son that needs should never be assumed but always anticipated. Assuming needs was a really good way to offend my mother, who was, prior to her diagnosis, probably the most capable woman I have ever known, so instead, anticipating her needs and taking her lead was a much better approach.

Now as the mother of a budding preteen who happens to have physical differences, the same applies. He has far more to teach me when it comes to what he needs than I have to teach him.

Working with, and seeking out, input from individuals who have access and function needs is the only way to learn what the needs of our community really are and how best to anticipate areas where assistance may be needed during and after the disaster emergency has occurred, as well as gain invaluable insight as to how we can work to overcome challenges by taking their lead. Really striving to make sure that we are coming into the situation knowing that we are there to take their lead and we are there to serve them I think is the best way to approach the situation, and that is what I have tried to bring into my work.

The CHAIRMAN. Well, it has to help enormously to have personal experience in addition to professional lived experience. That combination I can only imagine. I have never done this kind of work myself, but I can only imagine the positive impact it must have on someone who is challenged by, or even overwhelmed by, a disaster, to be able to talk to someone who can relate to them on a very personal level, being able to say I have some experience with this kind of circumstance or my in your case, your mom and your son and other family experiences that you can relate to them as opposed to someone without that experience who might have the expertise but may not have the personal experience and the understanding that you can bring to bear when you encounter someone who is really

in jeopardy and not knowing what the next hour or the next day will bring, when they are overwhelmed by a disaster.

I have often told the story about my own experience as a legislator, having some sense of what people undergo when they experience a natural disaster, but not really fully understanding it at least in my own case until 2011. We had terrible, devastating flooding in several parts of our State. I live in northeastern Pennsylvania, and I remember visiting rural communities in northeastern Pennsylvania and seeing the devastation but also just seeing how violated individuals felt, in a very deeply personal way.

I tell the story often about a friend of mine who is a lawyer in a neighboring county, and he was the most confident, upbeat, even cocky person you would ever want to meet. Never down. Always upbeat. Always ready to tackle any problem. Full of self-confidence.

When I said hello to him at a stop at a disaster site, where there was terrible flooding and a lot of families had their homes either flooded out completely or badly damaged, his was one of the homes. I remember walking up to him, you know, putting my hand out to shake his hand, thinking that he would say, you know, I had some flooding, but I am good. As soon as I shook his hand and looked in his eyes, he started to cry. I never thought I would ever see this very strong, confident person be so devastated, so it gave me an insight I did not have before. I can only imagine, Ms. Koerner, the number of times you have been able to draw upon your own experience.

Dr. Bell, I will jump back to you for an additional question. We know that this kind of preparedness, emergency preparedness, is a top concern of several government agencies. In the Federal Government, the Department of Health and Human Services Inspector General just released an annual report. I will not make detailed reference to it but just holding it up. This is a Health and Human Services Inspector General report which is a report of management challenges for the Department. This was just released earlier this week.

It comes after our Nation has spent 2 years living with a pandemic, that as I made reference to earlier, that terrible number that keeps going up of 760,000 lives lost in the grip of the pandemic. COVID-19 has been a lesson in preparedness shortfalls, reinforcing why the Department's independent watchdog says that HHS must do much more to prepare for these emergencies.

Dr. Bell, the Obama Administration updated emergency preparedness rules for both Medicare and Medicaid providers for the first time in a quarter century. These were implemented in 2017. In light of the pandemic and the Inspector General's concerns as expressed very recently, are Medicare's emergency preparedness rules sufficient—sufficient—to address the needs of people with disabilities and older adults in nursing homes and other congregant settings during disasters?

Dr. BELL. Thank you for that question. You mentioned the COVID-19 pandemic, and over the course of the past 18 months of the pandemic I have had the opportunity to visit a number of nursing homes where I provided training in personal protective equipment use and conducted voluntary infection control assessments in order to support staff, their own safety and the safety of

the residents of those homes, so definitely an area that is near and dear to me.

You mentioned the CMS emergency preparedness rule, which I believe was introduced in 2016 and put into effect in 2017. The goal of the emergency preparedness rule was to implement national standards for healthcare organizations that are receiving Medicare and Medicaid funding. This was introduced, I believe, largely to avoid the kind of tragedies that have been seen in nursing homes and other health care settings prior to 2017, but unfortunately, we are still seeing many of those challenges and lack of preparedness even after the implementation of the rule.

I think a couple things about the Inspector General's report and the emergency preparedness rule itself. One is that the rule was implemented now between four and 5 years ago, and we do not have a substantial amount of evidence to understand if the rule is working in the way that it should be working.

I think it is important to note that the intention of the rule is an important and a good one. Facilities should be—should have emergency preparedness plans, and they should be preparing their employees using a set of standards, so that is an important one.

The rule was implemented with a fair bit of leeway, allowing healthcare organizations to determine the type of training and drilling and plans that they wanted to do. I think that there is a balance between allowing this leeway and being overly prescriptive. That really matters for low performing settings that do not have good training, drilling, and plans in place. It may unnecessarily penalize, or not—maybe penalize is not the right word. It may be unnecessarily prescriptive for organizations that do put a fair bit of emphasis on being prepared.

I think what my recommendation or solution is, is to provide better opportunities for tailoring of emergency preparedness planning for organizations for thinking about older adults and people with disabilities. How can we better tailor emergency preparedness plans to the organizations that are providing care for those individuals? How can we do a better job of supporting organizations in their emergency preparedness planning without providing new—or without taking away some of that leeway that has been successful.

The CHAIRMAN. Doctor, thanks very much.

I will turn next to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman.

Let me ask a question of Mr. Creamer as it relates to heirs' property and the importance of the changes that have been made based on the request that we submitted, Senator Ossoff and I. When recovering from disasters, how big a problem was the lack of a title to heirs' property for rural, majority minority counties in South Carolina?

Mr. CREAMER. Thank you. Thank you for the question, Senator Scott. In our role going in, in the early hours, the first few days of doing what we do in helping that initial recovery and mitigating continued damage, that was not that big of an issue.

The issue really becomes huge when we start the rebuilding, long-term recovery process, or if that resident is trying to access different sources of financial assistance, be that particularly the FEMA assistance for damage to a homeowner. That proof of title

is almost a deal-breaker in those instances. It does not stop us from doing what we do, but when it moves into long-term recovery it is a huge obstacle.

The work that the organization we have down in the Charleston area, that is helping with that, has been huge to help those families that have owned property for upward—well over 100 years, but there is no proof of title, and they do not have the resources to go do a title search many times.

Senator TIM SCOTT. I see. In other words, the work that you do, which is excellent work by the way—thank you for doing it. It is not impeded by the heirs' property challenges that we see across the country and specifically throughout the South.

When it comes to receiving the resources from FEMA, the heirs' property, the lack of a clear title—I should be clear. I am so used to saying "heirs' property" as if everybody listening to us knows what heirs' property really is. In fact, they may not. As land is passed down within families, you have so many heirs. Sometimes no individual person within that family has clear title. Therefore, heirs' property is property really held in common in many ways. That common property being held in common does not give any specific person the right to advocate on behalf of that property, so that also stops that family of individuals from being able to receive assistance from FEMA. Is that what I heard you say, sir?

Mr. CREAMER. FEMA and other sources of assistance. It can be from faith-based organizations. Everybody wants proof of property ownership.

Senator TIM SCOTT. Yes, sir. Thank you very much.

Dr. Spurlock and Dr. Bell, do you agree that we need more flexible funding to support local restaurants cooking fresh, healthy meals during disasters? In other words, the FEED Act that we have spent a lot of time working on, that both the Chairman and I are now co-sponsors of. Would it not be helpful to have more funding support for local folks who understand and appreciate the severity of the challenges faced by those communities where the disasters happen within?

Dr. SPURLOCK. Yes. Thank you for that question and statement. As a resident of Louisiana, having experienced numerous disasters, namely hurricanes and floods, I know firsthand of the importance of having those types of resources available. Recently following Hurricane Ida in my community, we experienced power outages. I did personally for over five days or so. Myself, and other individual households lost all of their perishable goods from the refrigerator and freezer.

A larger percentage of persons with disabilities reside in southern states. States that border the Gulf of Mexico are more prone to these types of disasters.

Poor communities oftentimes where older adults live are considered food deserts.

Senator TIM SCOTT. Yes, ma'am.

Dr. SPURLOCK. Yes. Just having the availability of resources on the ground to be able to offer a warm, nutritious meal, served with a smile, in a person's local community, so they aren't faced with additional hardships such as having to seek transportation to drive miles to perhaps locate a restaurant that is open, only to find that

the line is several blocks long. Still having to leave hungry and not having access to a nutritious meals, so that's a really win-win, I think for all parties involved.

Senator TIM SCOTT. Thank you, ma'am. If you are waiting in a line that long, Mr. Chairman, you are going to be hungry and frustrated. Yes, so that is a fact. Thank you, ma'am.

The CHAIRMAN. Mr. Creamer, Mr. Scott, thank you very much. We will turn next to Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. You know, when it comes to something this important, to where it is random in its occurrence and we know that it is inevitable over time, I think we ought to do something that puts better processes into place. It would mean that you have got to make sure that when you do have to be quick and be responsive that you have got the funding in place, number one, and then also guidelines where you are not wasting any time before you can actually get to the issue at hand because so often it seems like we are ill prepared in terms of the immediacy of it, in terms of whatever structure and processes that should be in place, where there is fumbling around.

The bigger issue is probably how we pay for it in the long run. For things of this significance, most places would have a designated rainy-day fund, to where it would be funded separately, where it would be ready to go. Ideally, it would be in the context as we become more fiscally responsible over time, borrowing money to pay for our operating budget currently to the tune of about 25 percent and soon to go up even to a higher percentage. I think there really needs to be some reform on general fiscal issues here.

I would like to direct my question here to Mr. Creamer. Tell me what you think the current status is on the guidelines, the processes, the things that are needing to be in place, to where you know what to do when the tragedy, the event, occurs?

Then what are your thoughts on establishing a rainy-day fund? I have got legislation that would like to do that, to where we are not then on an ad hoc basis having to put funds into play, to where we have better, ready-to-go functions and processes, number one, and then number two, a rainy-day fund that will support it, where we are not scrambling around in terms of how to fund something in the immediacy of the incident. Mr. Creamer?

Mr. CREAMER. Thank you sir. A great question. Yes, I agree wholeheartedly the second question, the part dealing with funding, to have a rainyday fund in your back pocket, so to speak, that you can draw from would be a huge asset because funding does become such an issue for everything that we are doing. Even in our role of volunteers, we cannot do what we cannot fund, so having that as a backup is certainly warranted as such.

Looking at the ways that we can be prepared and how we do it is just positioning both the professional, if you will, response as well as utilizing some of the volunteer respond groups across the country as a huge asset and just both working together, having those communicate closely. Our VOADs enable us to do that through our states as well as the national level. That is the best way we have is to have those relationships, to know each other, and to work and be ready prior to any kind of event, any kind of challenge that we experience.

Senator BRAUN. Well, thank you. As a closing comment in general, for anyone watching out there, we currently have a Federal budget that runs around \$4.5 trillion, and we currently raise revenues to the tune of \$3.5 trillion. That is a structural trillion-dollar deficit that we have come to accept and kind of shrug off as not being important. That does not work in any other place. All State governments live within a framework, to where they generally have cash reserves and rainy-day funds set up.

It also brings to light that in the amount of money that we are currently wanting to spend, and that remains to be seen how much of that will be borrowed versus paid for, I think certainly it is clear that the financial stress on the country and for all the places that look to the Federal Government, including the Medicare Trust Fund, which is about ready to go kaput here in four and a half, 5 years, due to high health care costs and putting too benefits in there. Our elderly depend on it for their health care. Social Security, it has got about another 10 or 11 years. We have been paying into that since the FDR days.

I think this idea of taking care of natural disasters and doing it in a responsible way also begs the question: When are we going to get our financial house in order here in D.C., generally?

Thank you.

The CHAIRMAN. Thank you, Senator Braun. I will turn now to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman. This is a question for all the panelists. Working with local emergency management is such a critical component of disaster relief and, frankly, the response or the coordination.

In an earlier life, Mr. Chairman, I was the Chairman of the Emergency Operations Center for Charleston County during hurricanes and natural disasters, and so I spent a number of 24-to 36-hour days in the command center where we had an opportunity to try to coordinate the response teams' efforts on behalf of communities before, of course, the hurricanes or natural disasters happened. We would have meetings every year, praying and hoping that we did not have to mobilize a team, but realizing that is always an "if," not a "when." Or, a "when," not an "if."

One of the things that I realized during that time was the importance of having everybody on the same page, whether that was the voluntary efforts, the law enforcement, the EMS, the fire, the councils themselves. Then we, in Charleston County, had 17 different municipalities. We had to have all 17 heads of government working with the county, plus the volunteer apparatus and all the fire departments, all the law enforcement agencies and all the nonprofits that we wanted to be a part of that process. The importance of that local coordination cannot be usurped or replaced by a Federal top-down approach to natural disasters.

My question for the panel is: What are the best practices voluntary organizations and local emergency managers should follow to ensure volunteers are included—and I want to emphasize "included"—in all phases of disaster management? That really, from my perspective, means from the beginning. The beginning is not the day before the disaster. It is all year long as we all know that we are going to have to face them in the future.

What are the best practices that we should embrace and be aware of?

Dr. SPURLOCK. Yes, thank you. This is Dr. Spurlock. I think that is an excellent point that you make because really the planning has to be ongoing. We know that hurricane season ends, fortunately, in 2 days, on November—

Senator TIM SCOTT. Yes, ma'am.

Dr. SPURLOCK. Yes. Our work in terms of increasing our, you know, preparedness and ability to be able to respond to these unforeseen disasters is ongoing. As you mentioned, it is really—I think it is a community, you know, based support because when disasters ensue it is going to be at the level of the local and the communities that are going to need to initially respond to meet the needs of their populations.

I think that is also when it is really critical to have overall knowledge of the overall health of the various communities because that has to be taken into consideration because it will determine more or less the scope of services that will have to be deployed and also in terms of the disaster response as well. We know that many of our communities throughout our Nation exist today in poor health status, and all of those statistics are readily available to us through the America's health care rankings. We know in terms of the various, you know, social determinants of health and how they can drive more or less a community's ability to be able to respond to a disaster, so all those have to be taken into careful consideration.

By bringing all the individual organizations to allow them to become stakeholders, to have a voice, and then not to overlook sometimes organizations that can really play a critical role at the community level, namely, faith-based organizations. I witnessed this firsthand following Hurricane Katrina, how those faith-based organizations immediately stepped up the plate and started to open what we sometimes refer to as pop-up, you know, type of shelters. That gave tremendous support, you know, to the community at large.

Sometimes also, overlooking the resources that academic settings can bring, you know, to the table as well because they are, you know, embedded in the community. Persons who are employed in those, you know, organizations have a really good, you know, mindset and viewpoint in terms of the overall needs of the communities.

Once we can pull all of those resources together, as we were able to do as a school of nursing following Hurricane Katrina, to get involved in that health care for extended periods of time, we realized that no one institution can go at it alone. It is really the whole of the community—academic settings, public and private partnerships. That is incumbent upon us to garner out resources and to step up when disasters do hit our communities and also to have an ongoing plan and dialog.

Senator TIM SCOTT. Thank you.

Dr. SPURLOCK. Thank you.

The CHAIRMAN. Senator Scott, thank you very much. We will turn now to Senator Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman.

Dr. Spurlock, thinking about the dedicated staff who care for older adults in nursing homes, what is the most critical piece or lever that we can use to ensure that they are prepared for the next disaster. What is the best way we can ensure that the needs of older adults and people living with disabilities are known and anticipated in a disaster?

Dr. SPURLOCK. Thank you. I am really so pleased to be able to participate in this hearing today because it really shines a national spotlight on this issue.

Of course, nursing homes might oftentimes lack the resources that are in place in private institutions, other larger healthcare industries or acute care hospitals may have access to. I think there is an ongoing need for funding in terms of resources and for ongoing education for disaster preparedness, to be able to make decisions regarding evacuation compared to sheltering in place. These are critical decisions that must be made in long-term care settings.

I think mainly to support the staff is to give them the necessary resources in terms of education and preparedness, as we saw with the COVID-19 pandemic, for the staff to have the necessary personal protective equipment available to them to be able to use on a day-to-day basis.

Senator GILLIBRAND. In the current and escalating climate crisis, we will continue to see and experience extreme weather events. Climate change, together with other natural and human made health stressors, influence our health and well-being in numerous ways. From the pandemic, our experiences can be vastly different within the same State, city, and even same house, depending on a person's age and their physical and mental health.

We need to do better to support and anticipate how disasters can affect different groups of Americans and marginalized Americans, and we can do better by including people with diverse capabilities and experiences in planning discussions.

I am proud to support Chairman Casey's Real Emergency Access for Aging and Disability Inclusion for Disasters Act, or the REAADI Act, which would really work toward ensuring that older adults and people with disabilities are involved in the preparation and response and recovery and mitigation of disasters.

Dr. Bell, how would a National Commission on Disability Rights and Disasters help ensure the gaps in inclusive disaster planning and response and recovery are closed?

Dr. BELL. Thank you so much for that question. I think the National Commission, which by my understanding will have a large makeup of people with disabilities, will center the needs of the disability community and the aging community. I think the Commission itself is made up of—or, the mandate of the Commission is to draw from a diverse group of stakeholders, which is really when we talk about a whole community, what we really do need is to understand—I understand there is a local coastal emergency manager that, for example, will be on the committee versus a non—you know, area—from a noncoastal region. There is disability advocates and representatives that are making up the Commission.

I think that it is—the goals of the Commission are important and needed and will advance inclusive disaster management.

Senator GILLIBRAND. Thank you.

Ms. Koerner, thank you for sharing your professional and lived experience on the importance of including people with diverse capabilities in the disaster planning process. What are the significant gaps in inclusive disaster planning response and recovery that you noticed through your experience? What resources did you find most helpful?

Ms. KOERNER. Thank you so much for that question. Here in southeastern Pennsylvania, we are part of a really fantastic team of individuals made up of multiple backgrounds and diverse capabilities, areas of expertise, called the Southeast Regional Task Force Access and Functional Needs Subcommittee.

During the pandemic response, during the response post-Ida, and even back with Isaias, one of the things that we did was turn to this group of individuals to determine where the gaps were and make sure that nothing was being left out and really looking to that group of individuals to make sure that when we were forming our response and forming our communications, it was really through a whole community lens.

I think one of the things that we noticed early on was, you know, a need to improve communication. We worked with a lot of our community partners to make sure that everything was accessible from multiple language perspectives, from written and nonverbal communication perspectives, and making sure that we were getting the message out through multiple different sources, so that was something that we saw early on and were able to respond to specifically because we had individuals with that background, with that personal experience, and with that area of expertise.

I really think that the value that individuals from all different backgrounds that they bring to the community and bring to this topic really cannot be devalued at all.

Senator GILLIBRAND. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks very much, Senator Gillibrand. We have three Senators awaiting questions: Senator Rosen, Senator Blumenthal, and Senator Kelly.

Senator ROSEN. Thank you, Chairman Casey, Ranking Member Scott. It is a really important hearing, and I appreciate everyone who is here and all the witnesses today.

I want to talk a little bit about something happening in my State and across the West is extreme heat and wildfires because around the world and, of course, here in the United States climate change has worsened and the devastating impacts of wildfires and extreme heat, particularly in western states like mine, Nevada, has just been devastating. Already this year, we have seen over 49,000 wildfires burn over 6.5 million acres of land, including several recently affecting Nevada, like the Tamarack and Caldor Fires, which forced residents in parts of Douglas County to evacuate their homes amid a declared State emergency.

Worsening wildfires not only pose a serious threat to human life, to our health, to personal property, to wildlife, and of course, our seniors, some of the vulnerable. That is why I recently introduced the Fire Information and Reaction Act. It is bipartisan legislation that directs NOAA to establish a new program to improve wildfire forecasting and detection because more accurate predictions and

warnings, they really can protect lives and livelihoods, not just of Nevadans but for everyone.

Dr. Bell, as someone who has been deployed to provide clinical nursing care in response to western wildfires, what can you tell us about what you have seen about the frequency and severity of the fires as they are impacting our most vulnerable, of course, seniors, rural Americans, people of color?

Dr. BELL. Thank you for that question. I have had the opportunity to deploy to western wildfires and was at the Paradise, California wildfires, working in a shelter to provide primary care and emergency care. You know, one important thing to think about is that these wildfires displace broad swaths of populations from their homes and from their communities.

I know I have talked a lot about the importance of aging in place and the importance of staying, you know, in the preferred living environment, and that is not possible when evacuations are in order after wildfires. We really have to be thinking about, for older adults and people with disabilities, how can we better improve our planning around short notice and no notice evacuation and sheltering needs, as these needs, we can expect them to increase in the future.

Senator ROSEN. Thank you. I appreciate that. I look forward to working with you on that, for sure, to be sure we have the right places to put people in emergency and beyond.

I want to move on to speaking of emergencies and during disasters, mobile clinics. We know how mobile clinics, and of course during COVID, what a difference they made.

Dr. Spurllock, you know, your testimony. You discussed how in the aftermath of Hurricane Katrina Southern University and local FQHCs, they made use of these mobile health units to deliver regularly scheduled care to displaced residents, emergency care and the like. Mobile units have been doing this for COVID-19, of course, across the country and in my State of Nevada throughout the pandemic. Susan Collins and I have bipartisan legislation to provide communities greater access and flexibility to use Federal funds to deploy mobile health units, particularly in rural areas and underserved areas of Nevada and Maine that we have a lot of.

Dr. Spurllock, can you tell us more about the vital role mobile health units can play in serving seniors, of course, during a disaster? We know they serve other times. How can we use these mobile health clinics that play that important role to deliver health care?

Dr. SPURLOCK. Yes. Thank you for that question. Little did we know when our School of Nursing acquired our mobile unit that we would deploy it in actual hurricane response efforts. Prior to that, we were already within the community, trying to reach our vulnerable populations who otherwise would not have accessibility to health care services. We had already engaged in outreach to rural areas to seniors, to homeless populations, to battered women's shelters, and we had a health care infrastructure already in place that would allow us to be able to have a rapid response to meet the needs of the hurricane evacuees.

Mobile units are really irreplaceable because the mobile units, of course, are clinics on wheels. When a clinic is on wheels, you can

actually deploy it to diverse settings and actually go to where the health care needs are.

Those mobile units, when they are staffed with health care providers, in our instance, we used family nurse practitioners and an advanced practice nursing model in collaboration with a family practice physician and also called upon our many years of partnerships with other healthcare agencies and organizations throughout the community, many of whom served the needs of older adults and persons with disabilities and, as you mentioned, the federally Qualified Healthcare Centers. We could bring all of those services to what I would refer to as a one-stop shopping, so to speak.

They were all deployed into, you know, central areas to where the hurricane evacuees would have immediate access to our services and then also to promote continuity of care to reduce the likelihood of fragmentation and the hurricane survivors could also receive the services and follow-up care at the same site.

Thank you.

Senator ROSEN. Well, thank you. I really think that mobile health care, telehealth, whether it is an emergency or not, they really provide and expand access and improve and save lives, so thank you.

My time is over. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rosen, thanks very much. I will now turn to Senator Blumenthal.

Senator BLUMENTHAL. Thank you very much, Mr. Chairman. I want to thank all our witnesses for their testimony today, very helpful and informative.

In Connecticut, we have 845,000 adults over the age of 60. We have serious storms, like every other State in the country, often causing flooding, transportation failures, roads devastated. We often have these superstorms, which are becoming the new normal, that can be devastating for seniors, causing them to evacuate and then even more depressing when they try to return to their homes because there is serious property damage, everything from downed trees to holes in roofs and the litany of problems that can be caused to homes.

I am grateful to Chairman Casey for the Disaster Relief Medicaid Act, which I have co-sponsored, which ensures that individuals eligible for Medicaid who are forced to relocate during a disaster are able to continue access to Medicaid supported services.

We focus a lot on the service aspect of disaster relief, but I want to ask our witnesses about the property aspects and, most particularly, access to property insurance, the money that is needed to repair the roofs and the windows and remove the trees and make homes again livable.

I have found many of our elderly have trouble accessing insurance, more trouble than others, because, they number one, may not keep records that are necessary for accessing insurance, number two, they can be confused by the litany of criteria and technical requirements, and number three, they may not have the access to communication, whether it is internet or cell phones, especially if cell phone service is down, that others may because they can do it from work.

Let me ask all of our witnesses whether you think that property insurers and insurance needs to be made more accessible, more easily available to seniors in the wake of these natural disasters.

Dr. BELL. I will take that one. I think that is a great question that comes with a lot of complexity.

Of course, we want our most vulnerable of our citizens to have the resources they need to live through a disaster and to return to their homes and be safe. We also have a lot of complexity involved in how we can support individuals through Federal funding, to access Federal funding to recover from disasters. I think that is a key point to think about is how can we reduce some of the complexity around insurance and access to insurance and also accessing the benefits that insurance payments provide.

I also think that—you know, that is a fairly complex question to even tackle and one that needs, you know, probably its own hearing if I do say, you know, when we think about the National Flood Insurance Program and the challenges that individuals have in living in, you know, communities affected by climate change and accessing insurance in the future.

Senator BLUMENTHAL. It may be worth its own hearing, but I really think it is a vital part of this picture because the seniors or elderly trying to go back to where they live, and often they have lived there for a very long time and they have emotional connections, often find it very difficult to deal with insurance companies. Trying to aid them, as my office often does, is also made more difficult because they may not have prepared for this kind of disaster as long as they may have lived in their homes.

They deserve relief from the property insurers. They need and deserve the reimbursement for making their homes livable again, but often the insurance companies fail to provide the kind of aid that they should.

I welcome your interest, and I hope the other witnesses are interested as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Blumenthal.

I want to thank everyone who made this hearing possible today. I am going to start with Ranking Member Scott and his team as well as my staff and so many others who made it possible. On top of that list are the witnesses who appeared today, Dr. Bell, Dr. Spurlock, Mr. Creamer, and Ms. Koerner, for their testimony and for both the personal experiences they bring to bear on these issues as well as their professional experience, and we are grateful they are with us today.

As we have heard today, natural disasters are increasing in both frequency and severity. The COVID-19 pandemic has shown us that we need to prepare for the compounding effects of both disasters and public health emergencies. People with disabilities and older adults are disproportionately at risk for negative health outcomes and death due to these disasters. We know that. We have got to do something about that, and these disparities must be remedied. I think we have made some progress today in recommending some of those remedies.

We need to prioritize the voices of seniors and people with disabilities, especially from communities that are too often left behind.

The READI for Disasters Act legislation I have introduced will mandate that people with disabilities and older adults will be included in all phases—all phases—of disaster management and provide resources for communities to plan more inclusively. That is what that bill will do.

Our witnesses' research that they have summarized today shows that the majority of seniors and people with disabilities prefer to live in their own homes, in their own communities, and emergency planning should reflect that preference.

I want to turn just to the—finally to the mechanics of our hearing in addition to reiterating our thanks to all the witnesses for contributing both their time and their expertise. If any Senators have additional questions for the witnesses or statements to be added, the hearing record will be kept open until next Monday, November 29th.

Ranking Member Scott was pulled away a couple of times to other hearings. He will submit a statement for the record, which will be made part of the hearing record.

The CHAIRMAN. With that, we want to thank all who participated today, and this will conclude our hearing.

[Whereupon, at 11:20 a.m., the Committee was adjourned.]

CLOSING STATEMENT OF SENATOR TIM SCOTT, RANKING MEMBER

Thank you Chairman Casey and all of our witnesses.

Today we heard from true heroes - experts and local leaders on the front lines during disasters.

We learned that while we are making progress, there are still gaps that remain in our nation's disaster mitigation, preparedness, response and recovery, especially for older Americans and Americans with disabilities.

When an emergency strikes, it is the local first responders who are the first on the scene.

We must do everything we can to support and empower local communities in their most vulnerable times, especially for their most vulnerable citizens.

For South Carolina specifically, and many other coastal and southern regions, I am working to: 1) Improve flood mitigation, 2) Allow locally owned restaurants and nonprofits to participate in programs to feed disaster victims, and 3) Ensure Black homeowners who lack clear legal title to their property have equal access to FEMA disaster recovery funds.

We must build on previous bipartisan legislation to help older Americans and Americans with disabilities before, during, and after disasters.

I look forward to working in a bipartisan manner to make this happen.

Again, thank you to everyone here today.

Your testimonies help us to do our work to better support older Americans.

I yield back.

APPENDIX

Prepared Witness Statements

Testimony before the Senate Committee on Aging

Hearing Titled:

Inclusive Disaster Management: Improving Preparedness, Response, and Recovery

Sue Anne Bell, PhD, FNP-BC

Assistant Professor

Institute for Healthcare Policy and Innovation and School of Nursing

University of Michigan

November 18, 2021

Chair Casey, Ranking Member Scott, and distinguished members of the Committee, it is an honor to testify before you today regarding inclusive disaster management. I am grateful for the opportunity to address this Committee and appreciate your continued support of this critical issue that affects older adults and people with disabilities. Thank for the opportunity to participate in today's hearing.

The way we currently mitigate, prepare for, respond to, and recover from disasters is not inclusive—or equitable. In this testimony, I will describe: 1) that older adults and people with disabilities remain disproportionately affected by disasters, 2) that disruptions in access to healthcare and necessary supports are a critical need to be addressed in inclusive disaster management, 3) that strategies to promote aging in place throughout the phases of a disaster are needed to support older adults, and 4) that a whole community approach is essential to address inclusive disaster needs.

In my day-to-day life, I am an assistant professor at the University of Michigan, where I conduct research on disasters and health, and particularly on how to promote healthy aging in the face of an increasing number of disasters. The goal of the research I do is to understand how communities and the healthcare systems within them can better support their aging residents through the phases of a disaster. My hope is that our team's work will help support older adults to live their healthiest lives as our nation faces an increasing number of disasters.

I am also a nurse practitioner by training, and I regularly deploy to disasters across the United States as part of a federal disaster response team. I spent a month in Puerto Rico after Hurricane Maria providing healthcare in local gymnasiums and in temporary tents. I supported infection control practices in emergency shelters during the Paradise, California wildfires in 2018. And over the course of the COVID-19 pandemic, I have spent months in a response mode; from receiving patients at the Princess Cruise ship quarantines in March of 2020, to teaching nursing home staff about safe personal protective equipment (PPE) use and conducting voluntary assessments of skilled nursing facilities, to opening the first Federal Emergency Management Agency (FEMA)

mass vaccination center in February of 2021. I witness firsthand the things that I study – the challenges of healthy aging in a disrupted environment, and the consequences of these events on individuals and communities.

In my disaster response role, I receive the highest level of training in order to be prepared to address immediate and pressing medical emergencies, and you might think I use this training in these deployments. But actually, the vast majority of the care I provide in the days and weeks after a disaster is for individuals who cannot get their basic health needs met in the aftermath of a disaster. In my experience providing health care in Puerto Rico after Hurricane Maria the majority of the patients I treated were there for basic primary care and management of chronic health conditions—diabetes, high blood pressure, and kidney disease for example, conditions that require, and benefit, from regular and sustained access to healthcare.

Older adults, and people living with disabilities are disproportionately affected by disasters. Disasters are not natural. Hazards such as hurricanes, wildfires, and tornadoes are weather events that occur as natural processes—and we already know that as the impacts of climate change advance, we will see these events become more frequent and more extreme. However, the impact these events have on communities is largely humanmade and influenced by social, economic, geographic, and political processes. Characterizing disasters as natural implies we can't do anything about them, but the truth is we can. Time and again, we see that disasters most often disproportionately affect those populations who are already impacted by policy choices and discourses of inferiority in our society—such as older adults and people with disabilities.

Older age itself does not make an individual more vulnerable to disasters. Social isolation, frailty, chronic and comorbid diseases, and cognitive impairments such as dementia—all issues common among older adults—do, however. These become more challenging to address after a disaster. Besides that, 85% of US older adults have one or more chronic diseases requiring regular health care. When a community is affected

by a disaster, the services that community offers are affected too. Older adults who depend on functioning communities to stay healthy are also affected.

Further, there is no centralized system for collecting, reporting, and sharing data on these kinds of gaps after a disaster. This means we are unlikely to make systematic changes in how we address care for these individuals before the next event occurs. For now, we are using information and data gathered from indirect sources to try to draw conclusions about the impacts of disasters. A recent report, in which I am a co-author, from the National Academies of Science, Engineering and Medicine focuses on improving data collection and research methods to more accurately understand the health—and mortality—consequences associated with large-scale disasters. Titled “[A Framework for Assessing Mortality and Morbidity After Large-Scale Disasters](#),” this report provides recommendations centered on advancing approaches and systems for estimating mortality and morbidity associated with disasters.

My work centers on understanding how disasters affect the health of older adults. We use existing large sources of data, such as Medicare claims records, to try to connect the dots between healthcare use and older adults after disasters. Our research team is interested in knowing what are the drivers for hospitalizations after disasters, specifically What is putting older adults into the hospital or long-term care after disasters? This has helped us think about what the impacts of disaster on older adults are outside of the initial shock of the disaster and to consider what are the enduring health consequences older adults may face. In one study we [recently published](#), using eight of the largest hurricanes in recent years (determined by assessment of financial impact), we examined hospitalization data from the Centers for Medicare and Medicaid Services in areas affected by one or more of these major storms. We found that hospitalizations for adults 65 and older increased between 10 and 23% across each of these eight storms in the month after the hurricane than when compared to the rest of the year. As an additional analysis, we excluded the first three days after the disaster, hypothesizing that those three days would account for admissions that were acutely storm related, such as trauma and injuries. When excluding those three days, we still found that

admissions remained substantially higher, accounting for substantial numbers of additional admissions. It is important to consider the larger impact of this on older adults and healthcare organizations. Considering that there were over 60 major disaster declarations in the United States in 2019 alone, intervening to address the underlying reasons for healthcare use after disasters is critical.

Disruptions in access to healthcare and necessary supports are a critical need to be addressed in inclusive disaster management. When communities are disrupted, so are supports for those that live there and normal patterns of functioning. The loss of basic infrastructure such as loss of power or transportation may cause serious care interruptions, especially access to health care, which can have long-lasting health impacts.

We studied how this [disruption affects long-term health through the lens of cancer care](#). Our question here was, how does living through a disaster affect long-term survival when living with a serious health condition? New Orleans, affected by Hurricane Katrina was the setting, and we used data from the National Cancer Institute's SEER cancer registry, which is arguably the best possible source of cancer data available. Individuals in the study with a cancer diagnosis who lived in New Orleans during Hurricane Katrina were matched to individuals who were diagnosed with cancer in the same time frame in other non-affected areas, and who had similar household characteristics. We found a 15% higher mortality among the Katrina-exposed group, suggesting that the disruption in community functioning caused by the hurricane was a contributor to dying earlier. These results make sense empirically, since we already know that missing needed chemotherapy can be extremely detrimental to health and well-being. What we don't know, is how the findings from this study would translate on a larger scale, as in when looking at a number of different types of disasters, or when looking at a number of chronic health conditions outside of cancer.

In 2017, the Centers for Medicare and Medicaid Services (CMS) enacted the Emergency Preparedness (EP) Rule which established requirements specific to

planning, preparing and training for emergency situations. Compliance with the EP rule is required by CMS in order to participate in Medicare and Medicaid programs. The EP rule was designed to promote preparedness at the healthcare organization level, leaving flexibility in determining the amount and depth of training, drilling, and demonstration of competencies to the organization to determine. This design was intentional, giving a fair bit of leeway in how healthcare organizations can comply with the rule.

Thinking about supporting individuals with dementia care on an organizational level can provide an example of the utility of the EP rule. For people with dementia, the disruption in normal patterns of daily living caused by a disaster can be highly disorienting and lead to acute changes in health and well-being. Changes in caregiving or a change in a familiar living environment may occur due to evacuation or a power outage for example. Consistent medication administration may be altered, and daily routines may be disrupted. These and other effects are inherently stressful and may contribute to increased frequency of behavioral disturbances, which already occur commonly in persons living with dementia. Such behavioral symptoms may be the trigger for long-term nursing facility placement or result in the use of antipsychotic medications which are associated with poor outcomes among persons with dementia. The EP rule was enacted to prevent these kinds of catastrophic consequences to vulnerable seniors, however, planning is needed that is specific to these individual needs in order to avoid adverse outcomes. Providing support in terms of tailoring interventions and programs aimed at improving readiness for different types of healthcare organizations—and patient needs— is an important consideration.

Strategies to promote aging in place throughout the phases of a disaster are needed to support older adults. A goal of inclusive disaster management is to promote aging in place throughout the phases of a disaster, with the goal of supporting older adults to stay in their preferred living environment. Disasters disrupt normal functioning. After any disaster, people just want to go home and continue living their lives, but in order to do so, they must have the services they need in place. [In our study](#)

[of home health agencies affected by Hurricane Harvey in Texas](#), 76% reported a disruption in services, despite that 99% of agencies reporting that they had required emergency preparedness plans in place. Nearly half of these disruptions lasted one week or longer. We've also studied [older adults' preparedness](#) in a national poll of over 2000 respondents, where participants reported feeling confident they were ready to address a disaster, but also reported low levels of preparedness actions—the actual steps to be ready for a disaster like having an evacuation plan or putting together an emergency preparedness kit. Critically, among older adults who rely on electrically-dependent medical devices, such as non-battery-operated devices, only 1 in 4 had an alternative power source.

Our team [has also learned from home-based care](#) (including home health) providers who have worked through recent disasters; Hurricanes Harvey, and Irma, and the COVID-19 pandemic. Home-based care providers are in the homes of their patients' day in and day out, often with established and trusted relationships built over time and that occur with the familiarity of the home setting. Some of our findings are that home-based care represents an excellent insertion point to support readiness, and to provide older adults with the tools they need to protect their health during an emergency. But we also found that home-based care is frequently not included as part of the health care response—where the focus is on hospitals and nursing homes, and home-based care organizations reported feeling left on their own to care for patients after disasters—where in turn those patients would be left on their own if home-based care was not there.

Priority recommendations to address and improve inclusive disaster management are:

- 1) **Center older adults and people with disabilities as key stakeholders.** Older adults and people with disabilities must be the central focus and central actors in inclusive disaster management.
- 2) **Ensure systems are in place for continuity of care and aging in place throughout the phases of a disaster.** That starts with strengthening relationships in

the whole community—between emergency managers, healthcare coalitions, aging organizations, home based care providers, to name a few, and most importantly older adults and people with disabilities. Considering the Emergency Preparedness rule as a base, healthcare organizations can build tailored preparedness and response plans that are specific to the needs of older adults and people with disabilities.

3) Improve and address strategies for evidence-based disaster mitigation, preparedness, response and recovery. Uniform systems for data collection, recording, and reporting disaster-related data are needed in order to advance inclusive disaster management. To do this, existing data systems and tools must see sustained investments for improvement, starting at the local, state, tribal and territorial level.

Thank you for the opportunity to present to the committee. I am ready and willing to assist in any way.

**Aging Testimony of
Wanda Raby Spurlock
RN, GERO-BC, PMH-BC, CNE, FNGNA, ANEF, FAAN**

**Inclusive Disaster Management: Improving Preparedness,
Response and Recovery**

Thank you Chairman Casey, Ranking member Scott and distinguished members of the Senate Special Committee on Aging for affording me the opportunity to speak today on such a timely and relevant issue. My name is Dr. Wanda Raby Spurlock, and I am a Professor of Nursing at Southern University and A&M College located in Baton Rouge, Louisiana, one of the gulf states most frequently hit by natural disasters, more specifically hurricanes.

On a professional basis, I initially became involved in disaster preparedness, recovery, and response in 2005, following hurricane Katrina, one of the deadliest and costliest hurricanes in the nation's history, making landfall on August 29 as a strong category 3 hurricane. Fast forward to the 16th year anniversary of Katrina to hurricane Ida, a category 4 hurricane that made landfall on the same day and in virtually the same part of the state. Hurricane Ida brought back a flood of memories for me and other Louisianans who were fortunate to survive these extreme weather events.

It's hard to believe that Hurricane Katrina made landfall 16 years ago. As if it was yesterday, I remember sitting in my den watching television in the sweltering heat, with the sound of the generator roaring in the background. My entire neighborhood had a massive power-outage that lasted for many days. I couldn't believe the images that were being broadcasted on TV. The horror of the devastation and human suffering were unimaginable! The flooding, people clinging to rooftops with hand scribbled signs begging for help, while others were stranded in attics. I also remember the vivid pictures from the superdome located in New Orleans, approximately 80 miles from Baton Rouge, of elderly persons slumped over in wheelchairs,

diabetics, and sick children who needed their medications and treatments and some who had died due to the lack of these. It was absolutely overpowering and shocking. At this time, I was not aware of the role that myself, other faculty and staff would play in our School of Nursing's (SON) unprecedented disaster recovery efforts through the extended engagement of its resources in the delivery of primary healthcare services. This was made possible by the SON's existing healthcare delivery infrastructure consisting of a stationary in-house clinic, the Family Health Care Center, and a fully equipped 40-foot-long mobile health clinic, "the Jag Mobile," (named after the University's mascot) that was already involved in the delivery of community-based healthcare services to the homeless, battered women and other vulnerable populations.¹

Within 2 days after the landfall of Katrina and the massive evacuation of residents from the New Orleans area, a Red Cross shelter was opened on Southern's campus. Without hesitation, nursing faculty, including advanced practice nurses i.e., family nurse practitioners, provided care to hundreds of evacuees of all ages with varying health care needs. Following this initial engagement of faculty in recovery efforts, the school's FHCC deployed the Jag Mobile to area "pop up" shelters at local faith-based institutions to meet the health care needs of evacuees that were continuing to pour into Baton Rouge. By September, the Red Cross shelter located on Southern's campus and pop-up shelters around the city began to gradually close, while evacuees were moved to alternative housing sites, including transitional trailer communities. Left with limited options for health care services, it became increasingly difficult for evacuees to obtain medical care, especially for chronic health conditions such as asthma, hypertension, and diabetes

¹The FHCC was funded by the Louisiana Department of Health and Hospitals, Health Demonstration Grant Project No. 95-ER-HS10483; the U.S. Department of Health and Human Services; Health Resources and Services Administration, Office of Rural Policy: 4D1ARH00074-01-01. Funding for disaster recovery services was provided through a Social Services Block Grant CFMS No. 642967 and by the Louisiana Governor's office of Elderly Affairs, CFMS Nos. 642757 and 630654.

and to obtain prescriptions for medications to treat these conditions, often resulting in acute exacerbations. By this time, hospital resources were already strained, and emergency rooms were flooded. In addition to treating acute injuries and medical and psychological conditions, a surge of visits was related to medication refills. Additionally, many had lost their assistive devices (i.e., walkers, canes, eyeglasses), wheelchairs, and home equipment such as glucometers, humidifiers, pumps, and inhalers, placing them at an even higher risk for poor health outcomes. In addition to being separated from their prior systems of healthcare, many evacuees were separated from their routine social support networks, including family and friends, some of whom had been evacuated to other states.

In recognition of the barriers that evacuees would face in obtaining health care services, the Dean, along with SON faculty developed a plan to “adopt” Renaissance Village, the largest transitional trailer community in Baton Rouge and surrounding areas. The plan included obtaining approval from the Federal Emergency Management Agency (FEMA) officials to provide desperately health services and to utilize a host of public and private partnerships to deliver a range of on-site services. In October, after a series of meetings between the SON’s leadership team and FEMA officials at the local command center, the green light was given. I was also responsible for coordinating and scheduling all health care services delivered at this 500+ trailer site and served as the liaison between the School of Nursing and other healthcare organizations.

Utilizing an advance practice nursing model, family nurse practitioners with prescriptive authority and a collaborative practice agreement with a family practice physician, delivered on-site primary healthcare services via the Jag Mobile, consisting of biweekly visits. The mobile

health clinic also served as a clinical site faculty, registered nurses enrolled in the master's family nurse practitioner program, and undergraduate nursing students. Coordination of door-to-door visits was made to identify older adults in need of more specialized care and additional follow-up for cognitive, sensory, and functional impairments. These visits prompted arrangements for onsite and community-based referrals to organizations and health care providers to address a host of unmet needs of older adults and those with disabilities, including coordination for delivery of medications and other supplies. Optometry services, physical therapy, and mental health services were provided onsite by other participating agencies. A mobile clinic, operated by a federally qualified health care center, also participated in weekly scheduled visits to the transitional trailer community and eventually, home health services were made available on-site. In our encounters with older adults, and their family members, we found that the majority did not have an emergency plan in place in the event of a disaster, highlighting the need for more work in this area.

This is just one example of the many untold stories of how the “whole of communities” including educational institutions and public and private partnerships, band together when a disaster strikes to support local and statewide disaster response and recovery efforts.

More information about the SON's role at Renaissance Village including its exit strategy and lessons learned, can be found in the following publications:

Spurlock, W., Brown, S., Rami, J. (2010). Delivering primary health care to hurricane evacuees: The role schools of nursing can play, *American Journal of Nursing*, 109(8), 50-53.

Rami, J., Singleton, E., **Spurlock, W.**, & Eaglin, A. (2008). A school of nursing's experience with providing health care to hurricane Katrina evacuees. *Journal of the Association of Black Nursing Faculty*, 19(3), 102-106.

The one lesson that we have all learned through the many disasters that have occurred is that populations are not equally impacted by a disaster. Nearly half of the deaths resulting from

hurricane Katrina occurred among older adults. Similarly, in 2012, as reported by the New York Times, approximately half of those who died following Hurricane Sandy, were age 65 or older. It has also been noted by the National Council on Disabilities that persons with disabilities, especially those living in poverty were disproportionately left behind in hurricane Katrina. A plethora of information has been disseminated regarding the aftermath and devastation caused by other hurricanes including Harvey, Irma, and Maria that all made landfall in the United States in August and September of 2017, and most recently, Hurricane Ida (August 2021). We can probably all recall the tragic deaths of older adults, especially those residing in nursing homes, highlighting deficiencies in emergency preparedness, response and recovery for vulnerable older adult populations residing in these settings.

Less widespread publicity has been given to how natural disasters have impacted the lives of non-institutionalized older adults (those residing in the community) and persons with disabilities who maybe solely dependent on others for safety and well-being. The older adult population is the segment of the US population that is growing the most rapidly. According to the US Census Bureau, the country will reach a new milestone in 2034, when for the first time in the nation's history, the older adult population, those 65 and older, will outnumber children. Just as the older population is growing, so is the population with disabilities, further highlighting the importance of the hearing being held today. Approximately 61 million adults in the United States have some type of disability in mobility, cognition, independent living, hearing, vision, or self-care. Cognitive impairment can be caused by a wide range of conditions, including but not limited to Alzheimer's disease, where advancing age is the greatest risk factor.

In June of 2018, I served as the Co-Chair of a National Policy Expert Round Table, conducted in partnership with the American Red Cross Scientific Advisory Council and the

American Academy of Nursing to address gaps in disaster preparedness and management for older adults, a rapidly growing population. The full report is published in *Closing the Gaps: Disaster Preparedness, Response and Recovery for Older Adults*.² A set of 25 evidence-informed recommendations was developed using a rigorous consensus, decision making process guided by a systematic review of literature and an evaluation by an expert panel on disaster preparedness, response, and recovery. The final recommendations are based on six identified emergency domains: (1) Individual and unpaid caregivers; (2) Community services and programs; (3) Healthcare professionals and emergency response personnel; (4) Care institutions and organizations; (5) Legislative/policy; and (6) Research.

Findings from the report underscore that while disaster preparedness is vital for people of all ages, older adults are more vulnerable and experience more casualties after a natural disaster or emergency due to several outstanding factors including²

1. Older adults have greater prevalence of chronic health conditions, multimorbidity, cognitive impairment and medication concerns during disasters.
2. Older adults have a greater dependency on assistive devices, supplies and support requirements during disasters.
3. Likelihood of issues of social isolation in older adults.
4. Potential for psychological distress.
5. Gaps in caregiver preparedness, especially those who care for persons with dementia

² <https://www.redcross.org/content/dam/redcross/training-services/scientific-advisory-council/253901-03%20BRCR-Older%20Adults%20Whitepaper%20FINAL%201.23.2020.pdf>

In conclusion, based on my unique experiences in the disaster arena, especially following hurricane Katrina, the following key issues are paramount regarding older adults and persons with disabilities and should be addressed in disaster planning, funding of research, and policy decisions:

1. Knowledge of the local population's overall state of health is critical when planning for acute, intermediate, and long-term recovery because it will influence the scope of services and levels of care that will be required and the community's capacity to recover.
2. Because effective and holistic planning is critical to the success of disaster response and recovery, the full inclusion of older adults, disabled persons, and others with access and functional needs, is necessary to mitigate the impact of disasters on these growing populations.
3. Training and resources must be made available to support community-based organizations to ensure that at-risk older adults and all persons with disabilities have equitable access to services and programs to prepare and support them during and after disasters, including integration back into the community.
4. Prioritization in disaster research funding to inform evidence-based actions and policy decisions that support the needs of older adults and persons with disabilities across diverse ethnic and minority populations is warranted.

As a nation, we must continue to address solutions to overcome the unique challenges faced by older adults and persons with disabilities in disasters. I was pleased to read about the recently introduced legislation that addresses the issues that I have presented:

² <https://www.redcross.org/content/dam/redcross/training-services/scientific-advisory-council/253901-03%20BRCR-Older%20Adults%20Whitepaper%20FINAL%201.23.2020.pdf>

1. The Real Emergency Access for Aging and Disability Inclusion (REAAID) for Disasters Act.³ Passage of this Act will ensure that the life experiences and voices of persons with disabilities, older adults and others with access and functional needs are included in the preparation, response, recovery, and mitigation of disasters. This inclusion is paramount to ensuring the best possible outcomes for these vulnerable groups.
2. The Disaster Relief Medicaid Act (DRMA)⁴ ensures that Medicaid eligible persons forced to relocate from an area under a presidential disaster declaration, to another state, will be able to maintain their Medicaid supported services, including home and community-based services. Passage of DRMA, will address many of the issues that impacted the health and well-being of evacuees who were forced to relocate to other states following Katrina, as well as in future disasters.
3. As the nation continues to recover from the COVID-19 pandemic, and in preparation for future disasters, the FEMA Empowering Essential Deliveries (FEED) Act, allows for the federal government to pay 100% of the cost to states and localities to partner with restaurants and nonprofits to prepare nutritious meals for vulnerable populations.

In closing, I would like to take the opportunity to thank you again for affording me the privilege of sharing my thoughts and experiences as a nurse clinician, educator, researcher,

³ <https://www.congress.gov/bill/117th-congress/senate-bill/2658?q=%7B%22search%22%3A%5B%22REAAID+for+Disasters+Act%22%2C%22REAAID%22%2C%22for%22%2C%22Disasters%22%2C%22Act%22%5D%7D&s=1&r=1>

⁴ <https://www.congress.gov/bill/117th-congress/senate-bill/2646?q=%7B%22search%22%3A%5B%22Disaster+Relief+Medicaid+Act%22%2C%22Disaster%22%2C%22Relief%22%2C%22Medicaid%22%2C%22Act%22%5D%7D&s=2&r=2>

⁵ <https://www.govtrack.us/congress/bills/117/s19>

and advocate for older adults and persons with disabilities. I recall reading a quote by Mahatma Ghandi, “The true measure of any society can be found in how it treats its most vulnerable members.” I think this quote speaks to the duties and responsibilities that we have as a nation to ensure the safety and well-being of older adults and persons with disabilities before, during, and after disasters. Progress has been made with disaster planning, response, and recovery. Although, hurricane season officially ends in a few days, there remains work to be done. Passage of these legislations will present a significant step in solving many of the issues that I have presented. I commend the Senate Special Committee on Aging for shining a national spotlight on this important issue.

Opening Testimony of Randy Creamer of Columbia, South Carolina

US Senate Special Committee on Aging Hearing November 18, 2021

Good morning, Chairman Casey, Ranking Member Scott, and members of the Committee. My name is Randy Creamer, a native and resident of South Carolina. For over 15 years I served as a local church pastor and volunteer assisting those affected by natural and man-made disasters. For almost 20 years I have worked professionally in disaster relief. Bringing help, healing and hope to individuals, families, and communities has been the most rewarding work of my life. Thank you for the opportunity to share a brief testimony.

National VOAD (Volunteer Organizations Active in Disaster) promotes Cooperation, Communication, Coordination, and Collaboration and fosters more effective delivery of services to communities affected by disaster. Founded over 50 years ago, National VOAD is a coalition of 70+ of the nation's most reputable national organizations (faith-based, community-based, and other non-profit organizations) and 56 State or Territory VOADs.

South Carolina VOAD is committed to the 4 C's with a strong focus on communication amongst members engaged in a specific response. We strive to enable each VOAD member to exercise its own strengths in complete freedom – our VOAD is NOT operational in the sense of telling an organization what they can or cannot do, or where they can or cannot serve – we strive to enhance effectiveness in assisting those who are hurting.

Disaster events do not require every VOAD member to respond simultaneously. Many volunteer organizations are involved in the initial response only; others may not be involved for weeks or even months. Each organization brings its strengths to the table, and few, if any, are engaged from the first hours to the complete recovery which may be several years later.

The South Carolina Baptist Convention became involved in disaster relief in 1990 following the ravages of Hurricane Hugo. Today we have 2,500 volunteers who have attended training, completed background checks as a part of our credentialing process, and prepared to assist others affected by disasters in SC, across the US, and on occasion internationally. We are part of the larger Southern Baptist Disaster Relief network that encompasses all 50 states. This year, South Carolina Baptist Convention sent 19 teams to Louisiana and Pennsylvania in response to Hurricane Ida.

Our primary task in South Carolina is to provide immediate assistance after various wind events, such as tornadoes, hurricanes, and thunderstorms, or flood events resulting from tropical systems or other heavy rain events. Our volunteers typically sleep in church buildings on cots or blow-up mattresses and bring mobile shower and laundry trailers, volunteer cooking teams, and other logistical support for such operations.

Another major task is to partner with The Salvation Army and the American Red Cross when mass feeding is required to support those evacuated from their homes or unable to prepare meals for themselves. We have five mobile kitchens with a total capacity of approximately 55,000 meals per day.

Aside from myself and two co-workers, **All** South Carolina Baptist service is provided by volunteers, most of whom are retired. **All** equipment – trailers loaded with chainsaws, power washers, generators,

convection ovens, tilt skillets, sanitation equipment, tractors, skid steers, etc. – is owned by local Baptist associations or churches, and prepared and maintained by volunteers with the support of an occasional local business. Our volunteers are motivated by their personal faith in Jesus Christ and desire to love God and love others – they are our most valuable resource.

In South Carolina the American Red Cross and The Salvation Army lead the way in providing mass care. United Methodist congregations provide much the same service as Baptists in initial debris removal and flood recovery. Presbyterian Disaster Relief and Adventist Community Services Disaster Response are other major partners in SC that lead the way into long-term recovery. We are blessed with numerous other partners.

We have learned a lot of lessons over the years:

- Disaster impacts increase substantially on structures/houses that have pre-existing deferred maintenance issues.
- Don't try to do everything; find your niche and do it well.
- We can't help everyone – we must prioritize and identify the most vulnerable/neediest cases. Our priority is on those who are unable to help themselves, who lack financial resources, or have no one else to assist them. For example – widows, senior adults, grandparents raising grandchildren, single parents, uninsured/underinsured; we also count it a privilege to assist first responders who usually delay their family and property needs to serve their community.
- Allow volunteers to respond in additional spontaneous ways – like replacing a refrigerator and spoiled food for an elderly woman where we were simply removing trees from her roof; assisting an African-American congregation with not just the removal of flooded contents but long-term repairs; seeing displaced residents living in tents in Mexico Beach, FL, and providing everything from food to toilet paper; or realizing an older man you'd waved at as you passed his home for three days had died suddenly and responding by preparing meals for his grieving family for three days around his funeral.

In closing, I am pleased to say that for 54 years Southern Baptist Disaster Relief has depended on retirees for most of our volunteers – as one generation 'ages out' the next steps up. In recent years a growing number of college students are volunteering – it is an energetic scene to see the generational gap bridged. We see a similar trend in other South Carolina VOAD members, and we look forward to serving our neighbors in disaster relief for many years to come.

Thank you for the opportunity to share our story. I look forward to your questions.

Testimony of Danielle Koerner
U.S. Senate Special Committee on Aging
November 18th, 2021

Chairmen Casey, Ranking member Scott, and members of the Committee, my name is Danielle Koerner, and I will be speaking today as an advocate, former unpaid caregiver, and as a first responder and emergency planner. Thank you for this invitation to share both my professional and personal lived perspectives on the topics of inclusive Disaster Planning, Response and Recovery.

I sit before you as a circumstantial expert. For the past 20 years I have volunteered and worked in the field of emergency services in Pennsylvania, first as an EMT and paramedic providing direct patient care and advocacy, and then in education and regulatory compliance. In 2012, my husband and I were blessed with the arrival of our first son, Joseph. He was born healthy, but with multiple deformities and congenital amputations in his extremities requiring surgical intervention, ongoing therapy, and adaptive equipment. In 2015, my 54-year-old mother was diagnosed with early onset Alzheimer's and Dementia, and my husband and I became her primary live-in caregivers while my father continued to travel for work, and my sister supported us from afar.

I became an expert at anticipating needs, adapting everyday situations and tasks to the physical needs of my son and cognitive and behavioral needs of my mother. I had binders of bills, tabulated with notes about insurance coverage and payment plans, and calendars full of appointments with therapists, doctors, specialists, and support staff. I gained a new vocabulary and set of skills specific to advocacy for my child and mother and began to think 10 steps ahead for every task to assure that the needs of my loved ones would be met in everything we did, both in non-emergency 'Blue Sky' situations, and 'Dark Sky' emergencies. I built contingency plans for care, kept outgrown medical equipment in case something broke, and kept extra comfort items in strategic areas to sooth fears and calm erratic behavior.

After my mother's passing, I still do all these things, but only by half. To say that I received a crash course in accessibility and advocacy would be an understatement. I became a survivor before an emergency had occurred.

In 2018 my mother lost her fight. I was both devastated, and grateful that she had found peace. It was that same year that I was offered the job of Outreach and AFN (Access and Functional Needs) Coordinator for the Delaware County Department of Emergency Services. I leapt at the opportunity, hoping to integrate my lived experience with professional knowledge of emergency services both to honor my mother and assure that people like my son were considered before, during and after disasters and emergencies happened.

Very quickly I learned that my primary function in this new professional role was to be the voice in the room reminding planners and responders that one size never fits all, that access means more than wheelchair ramps, that not all disabilities are physical, and that all of us will likely have an access need at some point in our lives, either by disease, accident, or simply from aging.

I also found myself regularly educating planners and responders that individuals who live every day with disabilities, seniors who have access needs, and individuals who are unpaid caregivers are survivors (a good way to describe them is “pre-survivors”) even before the emergency has occurred. Often, they are surviving against the odds, outliving expectations, and resources, making do with inadequate services, living situations, or equipment, aging out of services, and recovering from medical, financial, or emotional setbacks because of their personal normal.

We as responders, as planners, as emergency managers, and as policy makers cannot begin to plan for the Whole Community without first embracing this knowledge.

The reality is that if we want to be successful in disaster mitigation, the work must also be done in the fields that operate independent of emergency management, the “everyday” ‘Blue Sky’ supports. We must focus on assuring that the circumstances that make individuals pre-survivors are addressed well before the disaster occurs and stop limiting our conversations on inclusive disaster practices to the disaster itself.

Working to enhance accessibility to government services by streamlining technologic and paper platforms used for resources and applications, simplifying processes and terminology, expanding regular operation hours for services, and assuring that resources are known to those who most need them through multi-outlet and media messaging are all just as important as assuring physical accessibility to buildings.

Investing in workforce development and support for direct care and medical professionals, as well as case managers and social workers is another critical piece of the puzzle. Addressing our nation’s housing crisis through the lens of accessibility, and bolstering programs designed to increase independent and supported living for individuals who need it most, expanding the criteria for Medicaid and Medicare reimbursements and coverage, assuring financial support to unpaid caregivers, and increasing programs that offer respite services will help.

These examples only begin to scratch the surface of this topic. The best way to ensure optimal outcomes for pre-emergency survivors is to ensure that they have unobstructed access to the supports they require daily, and to include individuals with personal knowledge of these requirements to guide the process.

The frequency and intensity of natural disasters are increasing, and the emergency response workforce is decreasing. Paid and volunteer workers are harder than ever to find in my field of work. If we can improve the lives of individuals with disabilities, seniors with access needs, and unpaid caregivers before the emergency happens, we will exponentially increase their resiliency when it does.

Thank you for your time today.

Questions and Responses for the Record

U.S. Senate Special Committee on Aging
“Inclusive Disaster Management: Improving Preparedness, Response, and Recovery”
 November 18, 2021
 Questions for the Record
Dr. Sue Anne Bell

Chairman Robert P. Casey, Jr.

- 1) In a lengthy story published recently, the Wall Street Journal explored the challenges that climate change poses for U.S. electric utilities and the corresponding increase in power outages (Arian Campo-Flores and Katherine Blunt, “America’s Infrastructure Struggles With New Weather Forecast,” Nov. 15, 2021). The story highlighted several examples of disasters that led to power outages this year, such as summer flooding brought on by Hurricane Ida in Pennsylvania, the prolonged cold snap in Texas, and record-breaking heat in eastern Washington. As climate change stresses Our Nation’s power infrastructure and the frequency of blackouts continues increasing, what steps should emergency planners take to ensure people with disabilities and older adults are taken care of when a power outage occur?

Response:

Thank you for highlighting this important problem. Regular and dependable electrical power is essential in promoting and maintaining the public’s health. Between the aging U.S. energy infrastructure and the increased frequency of extreme weather events occurring as a result of advancing impacts of climate change, large-scale power outages are expected to increase—yet the knowledge we need to address these outages through policy intervention is limited. Extended and repeated loss of power related to extreme weather events has often been viewed as an unfortunate fact of life, but as recent events have shown, widespread power outages represent a serious risk to public health. Large-scale outages can affect public transportation, refrigeration, communication, elevators and garage doors, temperature regulation, and water pumping equipment, and can increase carbon monoxide poisoning (through incorrect use of generators) and contribute to falls and other injuries. In addition to power loss that occurs as a direct result of disasters, many communities now face public safety power shutoffs that occur as a preventive measure exacted during extreme weather conditions to protect populations at risk of large-scale wildfires. These shutoffs are conducted by electric utilities to reduce wildfire risk from dangerous weather conditions. Shutoffs such as this are expected to continue—often sporadically and with little warning—as utilities struggle to upgrade to fire-resistant electrical systems. This is all to say— plans must be in place to support individuals, taking an inclusive approach, during large scale power failures. I have the following recommendations:

1. **Whole community approach.** Emergency planners must work together to build a whole community response. That includes working with emergency response groups and among others aging and disability advocacy groups, volunteer organizations, and now more importantly than ever, utility providers. There is a saying in emergency management, “You never want to exchange business cards during the disaster,” meaning

that establishing these relationships before a disaster event is critically important. These relationships should include creating, drilling and executing on shared plans as critical steps to achieving readiness for these events. Finally, inclusive disaster management planning should be done with the key stakeholders as the focus, therefore centering older adults and people with disabilities is key.

2. Utilize and develop support structures. Not only do we need to more effectively use the existing structures that are already in place, but there remains an urgent need to develop short and long-term plans for power outages, especially for older adults and people with disabilities. As an example, one of these existing structures is the [HHS emPOWER](#) program which provides federal data, mapping, and artificial intelligence tools to identify the number of Medicare beneficiaries who rely on electricity-dependent medical devices or other health care services in communities across the U.S. However, tools like emPOWER are only helpful if they are functional, practical and applicable for use by the end-users they were designed for. Congress should consider expanding upon the resources and training that can be made available to end users through programs such as emPOWER.

3. Access to alternative power sources. Emergency plans should consider access to alternative power sources during a power outage. Supplying battery back-ups to individuals who rely on electrically-dependent medical devices is one consideration. Including charging stations as part of response planning is another consideration. Outside of health care needs, this is particularly important in promoting family communication and reunification. Long-term mitigation strategies in particular are needed, such as renewable energy sources.

Senator Mark Kelly

- 1) Fire season in Arizona used to be early May to mid- to late-June or early July. But as it's gotten hotter and drier, we're in a constant threat of fire. By June of this year, 250,000 acres had already burned across Arizona.

And our population is aging. People over 65 were the fastest growing group in Arizona in the past decade, and by a decade from now, we're expected to have as many people over 60 as we do under 17. So as our population changes, we have to ensure our preparedness procedures change along with it.

Your testimony suggests that we aren't doing enough on a broad scale to properly evaluate lessons learned—especially as it relates to changes in our climate—and turn them into improved policy.

Could you elaborate on this? How can Congress be helpful here?

Response:

Speaking from my perspective as both a disaster researcher and a disaster responder, I strongly agree with your assertion that we are not doing enough to address and improve policy around our response to disasters. The way we operate in response to disasters in the United States takes a **reactive stance** towards responding to disasters. We move from one major response to the next, seriously taxing our emergency response capacity to the point that there is virtually nothing left—in terms of both funding and workforce—to focus on the critical issues of both disaster mitigation and disaster preparedness. My recommendations to address this include:

1. **Funding.** Regular, sustained and increasing funding is needed to support local and state entities to mitigate, prepare for, respond to and recover from disasters. It is well-known that public health investments occur cyclically, increasing (such as now with the COVID-19 pandemic) when there's a crisis, and decreasing in times of 'calm.' Funding for state and local health departments for emergency preparedness has steadily declined since Hurricane Katrina in 2005. These programs fund activities that focus on making communities, including their older residents, more resilient to disasters. Without funds to support these activities, older adults will continue to suffer disproportionately. Funding should be directed to better support the core capabilities needed to develop a robust public health system. This should include dedicated positions and allowances for education and training.
2. **Leverage Data and Technology.** A critical need exists for investments in systems of data (collection, analysis and dissemination) that can guide all phases of the cycle of a disaster (mitigation, preparedness, response and recovery). There has long been a reliance on case studies or after-action reviews that has continually hindered informing future disaster responses. Dissemination of data should occur in a proactive manner and be structured in way is useful in informing disaster planning and response.
3. **Focus on the local communities.** Efforts should focus on the needs of communities, and those who will most be affected by disasters within these communities. After all, disasters start and end locally. By equipping those who are on the front lines at the local level to be ready for these events, there will be a cadre of responders who share the knowledge and values of the community.
4. **Disaster mitigation as the cornerstone.** My final recommendation is for Congress to strengthen its commitment to disaster mitigation. Mitigation is the process of eliminating or decreasing the impacts and risks of hazards through those proactive measures that can be taken before an emergency or disaster occurs. An [often-cited statistic](#) describes that every \$1 invested in disaster mitigation by federal agencies saves society \$6. Some common examples of mitigation are avoiding building homes on floodplains, engineering bridges to withstand earthquakes, and creating and enforcing effective building codes to protect property. Specific to this question, each of the first three recommendations I have made—increasing disaster funding, making local investments to both protect communities from disasters and ready its citizens, and leveraging systems of data—are

all mitigation activities that are crucial to improving policy around inclusive disaster management.

- 2) Heat-related deaths are the number one cause of weather-related deaths in the United States, and seniors are particularly at high risk of developing heat-related illnesses.

Maricopa County is one of the hottest counties in the country, and Arizona sees the greatest number of heat-related deaths out of any state. In 2020, Maricopa County reached a new high, with 323 deaths. This is not acceptable, because heat illness is largely preventable.

As we continue to see increases in average summer temperatures and worsening heat waves year over year, how do disaster management policies need to evolve to confront the dangers posed by these extreme heat events? In your experience, how does access to air conditioning and cooling centers factor in to disaster planning?

Response:

A recent study in the journal [The Lancet Planetary Health](#) described over 5 million deaths globally per year related to extreme temperatures. In the study, while more people had died of cold than heat over the twenty-year study period, heat-related deaths were increasing, while cold-linked deaths were dropping. As the impacts of climate change advance, policy around inclusive disaster management must consider extreme heat in mitigation, preparedness, response and recovery actions. Disaster management already functions from an all-hazards approach, meaning that planning focuses on developing capacities and capabilities that can be translatable across a spectrum of different emergencies. This doesn't mean that planners are ready for each and every emergency, but rather have the tools to address a broad range of emergencies, including heat emergencies. Indeed, places known to be at risk for extreme heat should have preparedness plans to address heat emergencies at a minimum, and those that have not traditionally been at risk for these events need to put plans in place. This is especially important given that heat emergencies develop slowly, where significant or quantifiable impacts may not be seen until after multiple days of extreme heat, and in the past, communities have not been ready to address these events until those significant impacts were already being seen. Access to air conditioning and cooling centers are important factors that exist in a toolkit of disaster planning around heat emergencies. But there are many others, and I will return to the overarching theme of many of my responses in today's testimony—that mitigation must be considered a critical mission in reducing disaster impacts. Mitigation for heat emergencies can include long-term community infrastructure improvements, such as [heat island reduction strategies](#)—developing green or cool roofs, cool pavements, and increasing vegetation and trees. Planning measures should also include comprehensive heat response planning as I mentioned above, as well as education and awareness of those most affected such as older and adults and individuals with disabilities.

U.S. Senate Special Committee on Aging
“Inclusive Disaster Management: Improving Preparedness, Response, and Recovery”
 November 18, 2021
 Questions for the Record
Dr. Wanda Spurlock

Chairman Robert P. Casey, Jr.

- 1) In a lengthy story published recently, the Wall Street Journal explored the challenges that climate change poses for U.S. electric utilities and the corresponding increase in power outages (Arian Campo-Flores and Katherine Blunt, “America’s Infrastructure Struggles With New Weather Forecast,” Nov. 15, 2021). The story highlighted several examples of disasters that led to power outages this year, such as summer flooding brought on by Hurricane Ida in Pennsylvania, the prolonged cold snap in Texas, and record-breaking heat in eastern Washington. As climate change stresses Our Nation’s power infrastructure and the frequency of blackouts continues increasing, what steps should emergency planners take to ensure people with disabilities and older adults are taken care of when a power outage occur?

Response:

Climate change is expected to drive more frequent and intense weather-related events i.e., hurricanes, historic flooding, and heat waves, resulting in power outages that impact millions of the nation’s most vulnerable citizens at any given point in time. When power outages occur, older adults and persons with disabilities are at a greater risk for negative health outcomes and injuries, including death when exposed extreme temperatures. Power outages that result in the interruption of medical care have been identified as a major cause of increased mortality rates in the immediate months following a major disaster. In addition to disrupting refrigeration needed for medication storage and food safety needs, power outages can result in the loss of electricity to power medical devices and monitoring equipment. Although planning for disasters has been a priority of federal, state, and local entities for many years, these efforts often fall short of considering the complex needs of community dwelling older adults and persons with disabilities during power outages that can last days or weeks depending on the extent of the damage or strain placed on the infrastructure. Several tools and strategies can be used by emergency planners and managers, especially at the local levels, to identify hard to reach, at-risk groups and populations. Use of voluntary, confidential registries through local emergency response agencies, can be used to identify and locate at-risk groups, such as older adults and persons with disabilities who require additional assistance with emergency response services based on specific needs. However, when registries are established, procedures must be put in place to ensure that the information is updated as needed and is kept confidential. Emergency planners can also utilize the Center for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI), developed to assist emergency managers to identify and map communities most likely to need support during all phases of a disaster. Especially helpful during the preparedness phase of disaster, the SVI also collects data on household composition & disability, including age of household members. Emergency planners should also ensure that local and state-wide

contingency plans exist for community access to climate-controlled sheltering facilities that meet ADA guidelines.

September is National Preparedness Month. Therefore, emergency planners, utilizing a “whole community approach” should collaborate with local governmental entities, health care organizations, educational institutions, and public and private organizations that serve the needs of older adults and persons with disabilities to ensure that they have accessibility to targeted disaster preparedness information, including the necessary components of a disaster plan. It is also recommended that the person with a disability, the older adult or caregiver notify the utility company in advance when a household member requires the regular use of electrically powered medical equipment or other medical devices to determine if it qualifies the individual to be listed as a life sustaining equipment customer. Likewise, a personalized disaster plan should include advanced notification of medical supply companies for information regarding a backup power source such as a battery.

Senator Mark Kelly

- 1) Heat-related deaths are the number one cause of weather-related deaths in the United States, and seniors are particularly at high risk of developing heat-related illnesses.

Maricopa County is one of the hottest counties in the country, and Arizona sees the greatest number of heat-related deaths out of any state. In 2020, Maricopa County reached a new high, with 323 deaths. This is not acceptable, because heat illness is largely preventable.

As we continue to see increases in average summer temperatures and worsening heat waves year over year, how do disaster management policies need to evolve to confront the dangers posed by these extreme heat events? In your experience, how does access to air conditioning and cooling centers factor into disaster planning?

Response:

Adapting to extreme heat is expected to become even more challenging due to climate change. Therefore, disaster management policies must evolve to address “heat preparedness” as specific component of disaster management policies. “Heat preparedness” is a critical component of a community’s emergency response and should address access to air conditioning and cooling centers (i.e., facilities such as community centers, senior centers, religious facilities). Extreme heat is known to cause more deaths than any other weather-related hazard. Air-conditioning is an important protective factor against heat related illness and death, especially during a heat wave. Therefore, disaster management policies should evolve to ensure that local communities incorporate “heat preparedness” plans into their existing disaster plans. Because effective disaster planning begins at the local level, a “whole community” planning approach is critical to ensure that older adults, especially, have access to air conditioning and cooling centers during summer months to prevent heat and weather-related illnesses and deaths. To this end, local or county health and emergency planning and response departments should be engaged in “heat preparedness” planning with local

organizations and stakeholders that provide services to seniors such as local Councils on Aging, senior centers, Meals on Wheels programs and other congregate meal sites, Area Agencies on Aging, senior housing developments, and religious organizations. However, in planning for the operation and location of cooling centers, consideration should be given to ensure accessibility for older adults and persons with disabilities and functional needs. Depending on the site and availability of resources, other services can also be incorporated into cooling centers such as meals and transportation. Likewise, these centers should be available in diverse communities to reach a wide range of population demographics. In addition to emergency cooling centers, heat preparedness policies should also incorporate emergency bottled water distribution sites.

- 2) I've met with hotshot firefighters who regularly put themselves in harm's way to try to contain these fires. Earlier this year, I spoke with a team who shared the challenges they face with mental health care following these experiences. Sometimes it's from losing a team member or injuring themselves. Other times, it's the mass destruction they've witnessed. It's traumatizing.

In 2010, the Schultz Fire burned about 15,000 acres of land in northern Arizona. A decade later, Northern Arizona University released a survey where they'd asked respondents about their mental health after the fire. One in four people said the fire and subsequent flooding caused them significant stress. Just under one in five people agreed their mental health has suffered because of the fire or flooding.

Could you describe how these sorts of symptoms of trauma or stress might be exacerbated in an aging patient who has existing vulnerabilities? What kind of supports do we need to make sure are available to folks in these disaster scenarios and in the years after?

Response:

Although stress, anxiety and depression-like symptoms are common reactions following a disaster, these emotional responses can result in distress for older adults, placing them at significant risk for poor mental health outcomes. With advancing age, symptoms of trauma and stress can be exacerbated by physical illnesses, functional disability, cognitive impairment, loss of social support networks and issues of social isolation. Examples of other factors influencing vulnerability include preexisting psychiatric or substance use disorders, socioeconomic status, educational level, prior exposure to trauma, and accessibility to healthcare. It is important to routinely integrate mental health services into emergency and medical preparedness and response to disasters. Because timely identification and treatment of mental health conditions are important to facilitate optimal recovery, mental health assessments should be incorporated into triage services in emergency rooms, shelters, and other points of contact with disaster survivors. Establishment of networks and linkages between community-based mental health centers, behavioral health facilities, social service agencies, crisis counseling and suicide prevention centers, and other agencies and programs that provide mental health and support services is critical to the short and long-term success of disaster planning and recovery services for older adults. These networks and linkages can be facilitated through memorandums of understanding and agreements between community

leaders, governmental agencies, private and nonprofit sectors, faith-based and disability organizations, that work collaboratively to build a strong infrastructure to provide mental health services and support.

Individuals may require long-term treatment for mental health conditions following exposure to traumatizing disaster events. Mental health consultation and referral services, grief and bereavement therapy, support group services, and access to 24 hour/7 day/week disaster distress toll-free helplines are examples of support services that should be readily available to disaster survivors. Older persons residing in rural areas may have limited access to health services due to existing mental health provider shortages. The use of telemental health services has surfaced as one solution to expand accessibility to mental health services, in these geographic locations. It's important to remember that older adults may not ask for help due to the belief that asking for help is a sign of weakness. Some older adults may also refuse help due to the stigma surrounding mental illness. Therefore, educational outreach, public health messaging and advertisements should use communication strategies that counter stigma while offering hope.

- 3) We've spoken a lot about the importance of making a plan and a backup plan. Coming from NASA, that is always my MO. But I'm wondering about folks who rely on durable medical equipment for their everyday lives and the reality that sometimes, in an emergency, it's just not possible to take those with you or ensure they'll be charged with power or at the right temperature.

In your response work, have you seen examples of communities that have successfully taken advanced action to ensure an inventory of durable medical equipment in disasters for people who need it most?

Response:

Loss of or damage to durable medical equipment can become a significant issue when persons must leave their homes or evacuate for safety reasons when confronted with a disaster of any type. In my disaster response work, I've witnessed the efficiency of agencies such as the Red Cross in shelter operations, working to meet the well-being and safety needs of persons who depend on common durable medical equipment such as canes, walkers, and wheelchairs. It is my experience that individuals and community-based organizations are eager to donate medical supplies, including durable equipment following a disaster. I have witnessed healthcare organizations and religious organizations with healthcare outreach services donate new and used durable medical equipment when they are made aware of existing needs within the community. Although often overlooked, this is an area that requires special attention, especially considering the growth of the older adult population and the increased frequency and intensity of weather-related events. Public service announcements are useful in alerting persons or organizations of existing needs for durable medical equipment, drop off sites, times of operation, etc.

U.S. Senate Special Committee on Aging
“Inclusive Disaster Management: Improving Preparedness, Response, and Recovery”
 November 18, 2021
 Questions for the Record
Mr. Randy Creamer

Chairman Robert P. Casey, Jr.

- 1) In a lengthy story published recently, the Wall Street Journal explored the challenges that climate change poses for U.S. electric utilities and the corresponding increase in power outages (Arian Campo-Flores and Katherine Blunt, “America’s Infrastructure Struggles With New Weather Forecast,” Nov. 15, 2021). The story highlighted several examples of disasters that led to power outages this year, such as summer flooding brought on by Hurricane Ida in Pennsylvania, the prolonged cold snap in Texas, and record-breaking heat in eastern Washington. As climate change stresses Our Nation’s power infrastructure and the frequency of blackouts continues increasing, what steps should emergency planners take to ensure people with disabilities and older adults are taken care of when a power outage occur?

Response:

I disagree with the assumption that ‘climate change’ is the source of all the threats to our power grid. Nevertheless, electrical providers could possibly increase their attention to mitigating tree and vegetative growth more aggressively to prevent trees from bringing down power lines during weather events’ Local county development boards have done a poor job in preventing development in high-risk areas. We now have millions of persons residing in coastal and riverine areas that should never have been permitted. Flood events will be a regular occurrence because we’ve built homes where floods have always historically occurred. On an individual basis, emergency planners can continue to develop and educate ‘how to’ information related to preparing for disaster events. Focus on ‘Family Preparedness’.

U.S. Senate Special Committee on Aging
“Inclusive Disaster Management: Improving Preparedness, Response, and Recovery”
 November 18, 2021
 Questions for the Record
Ms. Danielle Koerner

Chairman Robert P. Casey, Jr.

- 1) In a lengthy story published recently, the Wall Street Journal explored the challenges that climate change poses for U.S. electric utilities and the corresponding increase in power outages (Arian Campo-Flores and Katherine Blunt, “America’s Infrastructure Struggles With New Weather Forecast,” Nov. 15, 2021). The story highlighted several examples of disasters

that led to power outages this year, such as summer flooding brought on by Hurricane Ida in Pennsylvania, the prolonged cold snap in Texas, and record-breaking heat in eastern Washington. As climate change stresses Our Nation's power infrastructure and the frequency of blackouts continues increasing, what steps should emergency planners take to ensure people with disabilities and older adults are taken care of when a power outage occur?

Response:

Thank you for the question, Chairman Casey. Emergency planners should work with their local community human service entities and emergency responders to understand the needs within their community before the emergency occurs. This work allows for the opportunity to identify individuals who have access needs in their communities and pre-identify where support is likely to be needed during the emergency and plan accordingly. Providing information about individual preparedness to these agencies to in turn distribute to community members is a great way to reach individuals who may not be identified by emergency planners already and assure that they have information to work to increase their personal preparedness.

During long-duration outages, emergency planners may determine that sheltering is needed. In these cases, shelters should follow current inclusive best practices. If this occurs, it is also important to note that many individuals who have access and function needs may chose to stay in their residence because their environment has been adapted specifically for their needs over going to a shelter, even if they are told that the shelter has been adapted to their needs. In these cases, considerations to support these individuals in their home wherever possible should be taken.

Work to establish centralized Warming, Cooling, or Power stations within the community to support residents while the power is restored is a great way to support the mobile community. When these locations are established, they should be done so with an eye to accessibility and assure that ample access to charging is available for Durable Medical Equipment (DME) that requires charging such as power wheelchairs. For individuals who are unable to leave their homes or make use of community Warming, Cooling, or Charging Stations, considerations should be given to how to support individuals in their home.

Functional Assessment Service Teams (FAST) are an excellent resource for short and long-term deployments. Engaging in advance with these teams to review plans and community needs is a best practice.

Senator Mark Kelly

- 1) You mentioned in your testimony that in your role in Delaware County, you're often the one serving as the educator. You're often the one teaching others about ensuring accessibility and what that really means. Delaware County is lucky to have you.

It's important that communities handle preparedness at the community level, so they can craft plans and responses to fit their particular needs. But that can also lead to major disparities and inconsistencies across the country. Not every emergency department has someone like you in the room.

There are so many tools and technologies at our disposal now to ensure accessibility. But as we see time and time again, they just aren't being used. How do we do a better job to ensure communities are actually taking advantage of these tools?

Response:

Thank you for this question, Senator Kelly. This is something that keeps me up at night, to be frank. The work that we do to alert community members to services and tools must be ongoing, ever evolving, and done with the knowledge that despite our best efforts, there will be individual who will never know that they exist. Partnering with trusted community entities to assure that they are aware of these resources and encouraging them to share them with the community is a great way to assure that these resources are known. Inter-agency resource sharing between entities that serve the whole community will also broaden the reach of these resources and tools.

Additionally, working at every possible level to assure that these resources are current, in working order, and function as they are meant to is a critical component of this process. Sharing information with the community about a resource that no longer works, is outdated, or does not function as it should erodes public trust in these resources and can alienate individuals who need them the most.