

**Testimony of
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**Special Committee on Aging
Hearing on Disaster Preparedness and Response: The Special Needs of Older Americans
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Good morning Chairman Collins, Ranking member Casey and distinguished members of the Special Committee. Thank you for the opportunity to testify today to share my experiences and perspectives on opportunities to better support older Americans both in times of disaster and every day. I am Dr. Karen DeSalvo, a physician and former Health Commissioner for the City of New Orleans.

I am honored to participate in this panel with my distinguished colleagues. Disaster Preparedness and Response for Older Americans is a topic about which I have great passion – both as a doctor and public health professional. Raising awareness of the challenges they face and opportunities to better support them is a critical conversation.

Though there has been a great deal of progress in the last decade, more can be done. My goal is to share with you some of my experiences from New Orleans as a physician and as Health Commissioner and to offer solutions aimed at building a stronger infrastructure and support network to improve outcomes for some of the most vulnerable in our community – older Americans.

Experiences from the front lines

Hurricane Katrina

It is now a dozen years since Hurricane Katrina wrought devastation to my hometown of New Orleans. In New Orleans, though we escaped the direct impact, our catastrophe was failed flood walls, leading to inundation of our city with water for weeks and devastation of our entire health care and public health infrastructure. From 911 to major hospitals, access and capacity were submerged, along with Charity Hospital, the primary provider for the poor and uninsured in New Orleans.

According to a report from the Louisiana Department of Health and Hospitals, 986 Louisiana residents died as a result of Hurricane Katrina. Older adults were disproportionately impacted: the mean age of victims was 69 years with 63% over the age of 65. Amongst the dead were 70 people who died in nursing facilities either during the storm or in the days immediately following landfall.

I was actively practicing medicine and most of my patients were older adults. It was a terrible feeling to know that my most vulnerable patients were disconnected from me, from their therapeutic regimens and care. At the time, like most of the country we were a paper-based health care system and those medical records turned to useless bricks. As people quickly evacuated or later landed in shelters or on rescue boats, they most often did not have their medicines or even a good list of them. This meant that essential information to guide clinicians

trying to help displaced patients was not available. And those of us still in New Orleans did not have the capability to find our patients easily or to mine data to identify vulnerable patients in need of additional help.

There were exceptions; Ochsner Health System and the Veterans Affairs health system were digitized and, as a result, able to provide more seamless care such as refilling medications for chronic disease or preventing gaps in cancer care. The contrast was stark and a great motivator to us in the health care system to make a transformational change that would link everyone to a medical home. By digitizing the health care records, we could have a [health system more resilient for disaster](#) and for every day. This shift would be particularly critical for older Americans who tend to have a higher burden of significant medical problems and more complex medication regimens.



New Orleans, like the rest of the nation, has transformed and now has a digital health care infrastructure that is increasingly connected. It also includes patient portals so that people can view their records to find up-to-date medication lists and medical histories. This [infrastructure was used during Hurricane Harvey](#) in Houston shelters to access health information in a way we only dreamed about 12 years ago during Katrina.

Hurricane Isaac

Six years after Hurricane Katrina, I had begun my service as Health Commissioner for the City of New Orleans. It was during my tenure, in August of 2012, that [Hurricane Isaac](#) roared ashore in Louisiana some seven years to the day that Hurricane Katrina had landed. Fortunately, New Orleans, like much of the country had heeded the lessons learned in the health care and public health system. We were better prepared. Words from Senator Collins at the time of Katrina were a rallying cry for me: “...the last time officials should be exchanging business cards is in the midst of a crisis.” My efforts as a physician, advocate and now public official focused on building a more connected system to support those in need in the wake of disaster. In the intervening years, Louisiana and the New Orleans community had developed more targeted emergency and disaster preparedness planning for older residents and those with special needs such as those in nursing home settings.

One of these actions by the New Orleans Health Department was the creation of a medical special needs registry to maintain a list of those most in need of assistance for evacuation during preparations or in response operations. We had been working aggressively to shift from paper to

an electronic, searchable version. By 2012, we had improved our registry of high-risk individuals with special medical needs and had tripled the number of residents enrolled.

In advance of the storm's landfall, we reached out to these high-risk individuals directly and through social and traditional media to offer opportunities for evacuation, providing transportation for those who wanted to leave. We worked with the dialysis network to ensure that people accessed dialysis early and we coordinated with newly developed medical homes to see that people received supports, including adequate supplies of medications to carry them through potential disruptions of pharmacies.

In the end, Hurricane Isaac did not flood New Orleans proper. Rather, the challenge New Orleans faced was prolonged power outage. Hurricane Isaac was a particularly problematic storm for power outage because it had a large wind field, which remained strong for days. This prevented repair crews from assessing outages and restoring power. More than 900,000 customers in Louisiana lost power representing half of the population. 400,000 were still without power September 1st, four days after landfall.

The health care system fared well because of improvements in emergency preparedness made following Katrina. Though some hospitals lost power early in the storm, their back-up generators functioned as expected and maintained operations at facilities with very few exceptions. We were also watching the nursing homes carefully, and fortunately they reported working generators at their facilities as well.

As the days dragged on, I found myself standing in the Emergency Operations Center being asked by our power company to give them guidance on the prioritizing power restoration. Hospitals were already on the priority power restoration list and returned to normal function for their inpatient and outpatient services. The question at hand was how to prioritize the remainder of our facilities and neighborhoods.

The situation was further complicated by reports that seniors were struggling with the heat. For a variety of reasons, many high-risk individuals had not evacuated, despite our efforts to assist those in independent living situations. This included those in nursing homes and assisted living, but also people living in subsidized, high-rise housing around the city.



Without information on where individuals with the most risk were clustered, we were compelled to go [door to door for 3 days](#) to try to assess need and help prioritize power service restoration. For those who would, we evacuated them to a newly established medical special needs shelter in the city.

Leveraging Data and Technology

Following Hurricane Isaac, we worked with the HHS Assistant Secretary for Preparedness and Response to create more efficient and effective methods of identifying the most vulnerable in our community, not only to target power restoration, but also to support them in other hazards as well. We needed an approach that could scale to support the approximately 2.5 million Medicare beneficiaries who are electricity-dependent for medical and assistive equipment.

In June 2013, HHS and the City of New Orleans [piloted](#) a first-in-the-nation emergency preparedness drill. Using Medicare claims data we identified individuals with electricity-dependent durable medical equipment and securely disclosed it to a local health department. Along with first responders (particularly the fire department), we visited the homes of people identified on the list from CMS as being electricity dependent. We wanted to know if Medicare claims data was accurate in identifying individuals using a home oxygen concentrator or ventilator. It was 93% accurate. In addition, of the 611 people that the claims data had identified in the New Orleans community, only 15 were on our medical special needs registry. The drill findings reinforced our hope that medical claims data could be useful in improving preparedness and response for high-risk populations.

This effort, now called [emPOWER](#), has been scaled by HHS and is available to help first



responders in planning and response. Every community can use the map to find the total of Medicare beneficiaries with electricity-dependent equipment claims at the U.S. state, territory, county, and zip code level. “Real-time” natural hazard and NOAA severe weather tracking services identify areas that may be impacted by disaster events and by prolonged power outages.

HHS continues to deploy emPOWER to support communities in disaster including in the recent hurricanes Harvey and Irma, as well as for other emergencies ranging from boil water advisories to tornadoes.

Beyond the headline disasters

It is easy to focus on the national disasters that make headlines and on those who seem most frail such as those living in nursing homes. There is indeed work that needs to be done to ensure their safety in major events. The added expectations in the Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Rule are steps in the right direction. If robustly implemented by the providers, they could provide further protections for seniors.

Those older Americans who are not in CMS regulated institutions, but rather are in community-based settings, living independently are also at significant risk. These older Americans need our help not only in disaster but every day. They are exactly the people who wanted to “shelter in place” for Hurricane Isaac and likely every other major event. They want to stay in their homes and will resist evacuation to a shelter, including one with medical personnel. These are the people that we should focus on as we work to make the next order improvements to our disaster preparedness and response plans.

These are the bulk of the people that I saw as I went door to door after Hurricane Isaac. Many are in federally subsidized housing, living alone or with other debilitated peers. What I saw was heart breaking. For many, they were trapped on higher floors, unable to navigate the stairs to escape when the elevators stopped working because they were wheel chair bound, dependent on a walker or simply not strong enough. What was clear was that they were not only isolated because of a hurricane, but were living on the edge every day. Any small disaster can easily cause them to decompensate.

Leveraging tools like emPOWER to build more complete Medical Special Needs Registries is a start. But they also need “human touch” on an ongoing basis to help build their resiliency to withstand disasters large and small. The evidence is clear that older Americans are more likely to be lonely and socially isolated and those circumstances are associated with increased risk of medical complications and death. Efforts underway by national groups such as AARP’s [Connect2Affect](#) to address social isolation are an important start, but these programs should also help link seniors with emergency preparedness personnel and programs.

Opportunities to Strengthen Preparedness and Response

Though we have made progress, we must do everything we can to protect the most vulnerable in our communities, with special attention to older Americans. It is in that vein, that I offer actions that would build a stronger infrastructure and support network to improve outcomes for some of the most vulnerable in our community – older Americans.

1. Leverage data and technology

The reach of a tool like **emPOWER** should be expanded to a broader group of at risk individuals using data from Medicaid and private payers. In addition, technology tools like emPOWER are only helpful if the local officials are aware of the resource and able to use it. Congress could provide resources to support training exercises by the Public Health Service Commission Corps to test the use of emPOWER in communities across the nation and help prepare the Public Health Service Commission Corps members to use the tool in disaster response.

Older Americans will be best served if their health information is available when they are needed to inform care and evacuation decisions before, during and after disasters. The infrastructure is in place for this vision to be a reality but behavior in the health system is preventing technology from helping people when they need it most. Data blocking is one such behavior. Congress has already taken action to advance interoperability of electronic health records and other health data systems through the MACRA and 21st Century Cures legislation. In particular, expectations for providers to attest that they are not **blocking data** and the additional authorities for HHS are an important step to improve data flow on behalf of consumers. Congress should press the Administration to accelerate their timeline to develop educational, incentive based and punitive measures to address blocking. Furthermore, Congress should encourage the Office of the National Coordinator for Health Information Technology in partnership with the Assistant Secretary for Preparedness and Response to continue working with states and local communities on efforts aimed at leveraging electronic health record information for disaster preparedness and response. It is essential to quickly ensure private and secure data flow for existing health information given the opportunities on the horizon as new technologies like telehealth and wearable technology will be increasingly ubiquitous and able to support older Americans in preparedness and response.

2. Support local public health infrastructure

Local public health agencies are the only health entities with statutory responsibility to address preparedness and response. But they are under-resourced across the country, impairing their ability to support communities, including older Americans. The specific efforts that are often under-resourced include: Medical Reserve Corps, Medical Special Needs Registry, and preparedness staffing. Congress could ask the National Academy of Medicine to undertake a review of needs for local public health preparedness funding and make recommendations on approaches to addressing the gap.

Congress should provide resources to support public and private sector programs that address loneliness and social isolation. The **Medical Reserve Corps (MRC)** is one such potential. It is a national network of volunteers, organized locally to improve the health and safety of their communities. The MRC volunteers include medical and public health professionals, as well as other community members who may not have a health care background. MRC volunteers are an essential tool to strengthen local public health and improve emergency response capabilities. They could also be an essential resource to build individual and community resilience between disasters.

3. Protect Consumers

The **Centers for Medicare and Medicaid Services Emergency Preparedness Rule** is an opportunity for the public and private sector to strengthen their all hazards disaster planning. CMS should work with ASPR, OASH, the CDC and state Medicaid programs to ensure a robust implementation including mock disaster exercises (table tops) in conjunction with local public health and/or regional HHS staff. Disaster plans should

also require review to ensure adequate details such as representation in incident command meetings with emergency preparedness leads, logs tracking generator maintenance, generator fuel plans, and transportation contracts for evacuation.

Congress should encourage the Administration to build a **best practices tool kit for local regulation** to support the development of state and local laws, ordinances, and policies that can provide additional protections for older Americans during disasters. These might include building permit expectations requiring elevators and emergency exit lighting be supported by generators.

Conclusion

In closing, protecting those most vulnerable in our communities should continue to be our priority. Thanks to the combined efforts of the health care sector and first responders to apply solutions to lessons learned from previous challenges such as Hurricane Katrina, as a nation we are better prepared and more resilient to successfully address disaster response and preparedness for our seniors. We must ensure an ever more effective and rapid response to disasters that threaten older Americans. This applies not only to those older Americans living in institutions, but also to those in community based settings who can be more disenfranchised and at higher risk. What is also essential, is that we pay attention to their needs not only in disaster, but in their every day. Doing so is vital to ensuring that all communities across the nation are prepared to respond to and recover from future public health disasters, fulfilling our collective promise to never again repeat the chaos, disorder, and despair that followed Hurricane Katrina.

Thank you again for the opportunity to testify. I will be happy to work with you on any of these issues as you consider your opportunities to strengthen support for older Americans. I look forward to your questions.