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## CATASTROPHE! ELDERS OUT OF EMERGENCY LOOP

By **PAUL KLEYMAN**

Nina Tumosa grew up in rural Maine, where she kept a typical emergency kit in her car including basic first-aid supplies, a blanket, a candle and a change of clothes. “But when my dad was living with me, I had to put in extra batteries for his hearing aid; I had an extra pair of old glasses for him; I put in some medications, and so on.”

Tumosa, a professor in the Department of Internal Medicine, Division of Geriatrics, at Saint Louis University in Missouri, understands what most people would think should be obvious to authorities on disaster preparedness: that older adults are a vulnerable population group needing special consideration in plans for coping with catastrophes. Yet, she spoke for other expert panelists last spring at the 2006 Joint Conference of the National Council on Aging and American Society on Aging when she stated, simply, “We’ve got a long way to go.”

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### LITTLE CONSIDERED

According to Tumosa, president-elect of the National Association of Geriatric Education Centers (NAGEC), and other experts on bioterrorism and emergency preparedness in aging (BTEPA), older adults customarily have been little considered in planning that prepares to cope with major disasters. Yet, states the report *Ageism in America*, published this year by the International Longevity Center-USA (available online at [www.ilcusa.org](http://www.ilcusa.org)), “Each year, older persons are disproportionately affected by extreme heat, extreme cold and fires.” The median age of those who died in the Chicago and Milwaukee heat waves of 1995, says the report, was 75.

A decade later, when Hurricane Katrina struck on Aug. 29, 2005, at least 60% of the 1,600 who perished were age 60 or older, noted Howard L. Rodgers III, executive director of the New Orleans Council on Aging/Area Agency on Aging. Underlying the recent arrest of a respected surgeon and two nurses for allegedly hastening the deaths of at least four older patients at New Orleans’ Memorial Medical Center by lethal injection is the strain placed on health and service professionals having to make well-meaning, if misguided decisions because of a lack of food, water, electricity, transportation, housing, medical help and generally poor planning. Also, Rodgers and others have sharply criticized the inadequate response at the state and, especially, federal levels.

Writing in the recent *Aging Section Connection* newsletter of the National Association of Social Workers, Rodgers revealed that only two months prior to Katrina, the Mayor’s Aging Advisory Council, which he chairs, “informed the city’s Homeland Security Department of its concern for the lack of transportation. But while it was known that possible consequences included elderly and poor people perishing, no one expected the situation to actually arise.”

And a study by the Government Accountability Office (GAO) titled “Disaster Preparedness: Limitations in Federal Evacuation Assistance for Health Facilities Should be Addressed” (GAO-06-826, July 20, 2006), found that the federal National Disaster Medical System (NDMS) is not designed to move nursing home residents. Even though NDMS officials had to scramble to arrange appropriate care to residents after transferring them to mobilization centers for victims of Katrina, federal documents, including the Department of Health and Human Services National Response Plan, still don’t address the problem.

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**NOT OBVIOUS**

Nationally, Tumosa participated in a project in which six of the 51 academically based Geriatric Education Centers (GECs) around the United States developed curricula to train healthcare and service workers in various settings how to assist elders in disaster situations. Surprisingly, she said, the centers found themselves in a national effort to convince funding agencies and decision-makers in emergency preparedness “that the geriatric population is a vulnerable group that needs special attention.” She went on, “This was not obvious to a lot of people, and we really had to do a lot of talking, a lot of lobbying, a lot of educating, a lot of communicating.”

In another example, in June the Institute of Medicine (IOM) released a trio of reports showing that the U.S. emergency medical system in the United States “is overburdened, underfunded and highly fragmented.” The reports call on Congress to allocate more funds to hospitals for uncompensated emergency care, to establish a network for regional care and to provide additional equipment and training for pediatric care.

However, IOM panel chair Gail Warden, former head of the Henry Ford Health System, Detroit, told the *Philadelphia Inquirer* (June 14, 2006) that these measures would not address three primary contributors to overcrowded emergency rooms: the aging of boomers, the growing number of uninsured patients and lack of access to primary doctors.

Ironically, said former NAGEC president Robert Roush, the effort to include older adults in disaster planning following the events of Sept. 11, 2001, was triggered by the publication of *Bioterrorism: Guidelines for Medical and Public Health Management* (Chicago: AMA Press, 2002). Written by Nobel Laureate Donald A. Henderson, who directs the U.S. Office of Public Health Preparedness, and “a bunch of other really smart folks,” Roush said, the book defined vulnerable populations only as young children and pregnant women. Roush, who directs the Texas Consortium of Geriatric Education Centers at Baylor College of Medicine, Houston, passed the book on to Baylor’s chief of geriatric medicine, who agreed with him that “there’s not a single thing in here about geriatrics. The words *aging* or *elderly*—they just aren’t there.”

Roush and others went into action and secured modest funding from the federal Health Resources Service Administration (HRSA) for the six GECs to develop materials to train the nation’s first responders, primary care physicians and other health and emergency personnel in essential geriatrics. The chair of NAGEC’s Bioterrorism and Emergency Preparedness Committee since 2002, Roush said the group soon concluded that older people are subject to natural disasters far more often than to human-induced disasters, so they broadened their focus from bioterrorism only to an all-hazards response. He added, “Let’s don’t forget the bad guys, but in the meantime we know we have many more threats” to the well-being of elders.

Roush also stressed that special treatment of elders in emergencies is an international issue. Having compromised immune systems and numerous disabling or limiting conditions, elders are especially vulnerable in occurrences ranging from heat waves in France to tsunamis in Sri Lanka. “We need to be mindful of our fellow global villagers and apply what we can learn from the international perspective to the state and the national levels,” he stated.

Tumosa emphasized that in the wake of a catastrophe, geriatric health professionals have proved invaluable in assisting younger disaster victims. For example, she said, when Katrina refugees were sent to St. Louis, many “were acting like they were elderly: They were confused, disoriented and frightened.” Even some people in their 30s, buffeted by the leading edge of the hurricane, had trouble remembering “where they were, where they had been the night before, what medications they were on or what illnesses they were being treated for,” she said.

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**SIX GEC PROJECTS**

The six BTEPA projects dealt with such concerns as homebound elders, older people with hearing loss and other sensory deficits, special housing considerations, cultural and language barriers, and lack of access to medications. Tumosa said that a white paper presenting an overview of the project, which was drafted in 2004, was in its final editing processes as *Aging Today* went to press, and will eventually be released by HRSA with 14 others on different aspects of emergency preparedness.

Meanwhile, professionals in aging can get a preliminary summary of the project published by Tumosa’s department in a special issue of its newsletter, *Aging Successfully* (Fall 2004). The 24-page publication can be downloaded at [http://aging.slu.edu/newsletters/SLUFall2004\\_Vol3.pdf](http://aging.slu.edu/newsletters/SLUFall2004_Vol3.pdf). Another publication from the BTEPA project is the article “Bioterrorism and Emergency Preparedness in Aging

(BTEPA): HRSA-Funded GEC Collaboration for Curricula and Training,” by Arleen Johnson, Robert Roush and colleagues, in *Gerontology and Geriatrics Education*, volume 26, issue 4.

The BTEPA project has also yielded distance-learning modules and resource material; a video on mental health issues; three CD-ROM instructional games for health and service professionals on emergency preparedness and community issues (in English and Spanish), as well as nursing home concerns; educational mnemonic aids; a learning module on sensory loss; and other materials. For a list and links, contact Tumosa at (314) 894-6560 or [tumosan@slu.edu](mailto:tumosan@slu.edu).

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#### GECS JEOPARDIZED

An additional impediment to the potential effectiveness of the BTEPA project, though, is that in December 2005, congressional budget cutters completely eliminated funding for all 51 GECs for fiscal year 2006. Tumosa said that the entire network of GECs is needed to disseminate the new BTEPA information in a timely manner to appropriate community agencies, first responders and first receivers, as well as to train and retrain healthcare professionals. A project summary states that the GECs are needed “to develop and to use measurable criteria to document knowledge gains necessary to prevent loss of life and minimize trauma to affected persons.”

Currently, she said, the GECs can operate through Dec. 31, 2006. Past that date, many centers that have additional nonfederal funds can continue on a limited basis. Congress is considering restoration of funding for GECs and related programs for 2007, but “we are a long way from salvaging the GEC network,” she said. Tumosa added that with the GECs effectively powered down for the coming year, even if funding were restored, HRSA will have lost the capacity and momentum enabling it to handle the grant process for BTEPA, at least until August 2007. ❖