



2007 Interagency Action Plan

**For the Emergency Preparedness
Of People with Disabilities and
Special Health Needs**

**State of Hawaii
February 2007**

Working Group

State of Hawaii Departments or Agencies (alpha)

Department of Education (DOE)
Department of Health (DOH)
Department of Human Services (DHS)
Disability and Communication Access Board (DCAB)
Executive Office on Aging (EOA)
State Civil Defense (SCD)
State Council on Developmental Disabilities (DDC)

County Departments or Agencies (alpha)

City and County of Honolulu, Civil Defense Agency
County of Hawaii, Civil Defense Agency
County of Kauai, Civil Defense Agency
County of Maui, Civil Defense Agency

Community Agencies (alpha)

American Red Cross (ARC)
Healthcare Association of Hawaii

Agencies Representing Individuals with Disabilities (alpha)

County of Hawaii, Mayor's Committee on Persons with Disabilities
County of Kauai, Mayor's Advisory Committee for Equal Access
County of Maui, Mayor's Commission on Persons with Disabilities
Hawaii Association of the Blind
Hawaii Services on Deafness

**This document is available in large print or Braille.
Contact the Disability and Communication Access Board
at (808) 586-8121 (V/TTY)**

Background

In the wake of the September 11th terrorist attacks and the more recent disasters of Hurricanes Katrina, Rita and Wilma of 2005, the inability of the system to respond to the needs of persons with disabilities or other special health needs became more apparent as a major deficiency in our overall community emergency preparedness and response system. The State of Hawaii and its jurisdictions would fare no better than mainland locations in meeting the needs of persons with disabilities were similar events to occur tomorrow. The disasters, coupled with the growing recognition that people with disabilities or special health needs are a more vulnerable population in an emergency or natural disaster when their daily survival mechanism, coping skills, and support systems are interrupted, have emphasized the need to prepare a strategic plan which addresses the unique circumstances of persons with disabilities and special health needs in disaster preparedness planning.

A Harris Poll commissioned by the National Organization on Disability in November 2001 discovered that 58% of people with disabilities did not know whom to contact about emergency plans in their community. Some 61% of those surveyed had not made plans to quickly and safely evacuate their homes. And, among those individuals with disabilities who were employed, 50% said that no plans had been made to safely evacuate their workplace. All of these percentages were higher than the percentages for people without disabilities.

The Working Group was originally convened in October 2005 to address this issue. Participants consisted of the Disability and Communication Access Board, State Department of Health, State Civil Defense, State Department of Human Services, State Department of Education, State Council on Developmental Disabilities, County Civil Defense Agencies, American Red Cross, Executive Office on Aging and Healthcare Association of Hawaii. In 2006, the Working Group's membership expanded to incorporate representatives from disability groups statewide: County Mayor's Committees/Commissions on Persons with Disabilities, Hawaii Association of the Blind, and Hawaii Services on Deafness.

A 2006 Plan was issued in February 2006 from the Working Group. This 2007 Plan represents an update to the prior version incorporating amendments to the existing goals and objectives along with additional information reflecting progress made since the 2006 Plan was issued. In addition, the Working Group recognized the importance of transportation services for persons with disabilities and special health needs and included a new goal relating to transportation services in the 2007 Plan.

This Action Plan is not a comprehensive emergency preparedness document, nor is it a special health needs response plan. It is a roadmap to ensure that other legislative, administrative, or programmatic efforts are inclusive of the issues of people with disabilities or special health needs. This document does not propose an entirely separate set of emergency procedures or plans. It is an acknowledgment that the interests of people with disabilities and special health needs must be made a part of overall community efforts. Everyone will benefit if the overall system is better prepared

to respond to the entire community including people with disabilities or special health needs. Finally, the Plan is in recognition of the fact that people with disabilities and their caregivers have as much responsibility as any other citizen to prepare for surviving an emergency.

This Plan focuses on those individuals with disabilities (physical, mental, or health-related) that may compromise their ability to respond or respond as effectively as the general population. While many people will have unique needs in an emergency, such as those resulting from limited English speaking skills, homelessness, pet ownership, geographic isolation, cultural isolation, single parent status, criminal offender status, chemical dependency, or low income status, this Plan does not specifically address those circumstances at this time.

The Working Group has chosen to focus on emergency preparedness, notification, and sheltering in this Plan as the most pressing issues. The Working Group acknowledges the importance of other issues such as infrastructure recovery and long-term support system. This Plan is an evolving document and other issues will be integrated into the Plan as the efforts of the Working Group continue.

Population Described

There is no absolute definition of the population of individuals with disabilities or special health needs for the purposes of this Plan. However, the population can be described, rather than defined, by its needs in the event of an emergency or disaster, and can be clustered by their level of independence and need for health or medical support acknowledging that even with the best of 'descriptions,' the population is not homogeneous and does not come together through a common service delivery system. For the purposes of this discussion the population can be very broadly described and clustered into the following categories as outlined by the American Red Cross national guidelines:

Level I:

Level I individuals are those with disabilities who are independent and capable of self-care or care by those who are their daily caregivers (exclusive of the need for electrical power, generator, etc.). This includes the following persons, as a non-exhaustive list: those who use wheelchairs but are capable of transfer from their wheelchair; those with stable, controlled conditions such as arthritis; those with mild to moderate muscular conditions with a stable or assisted gait; colostomy patients; patients on special diets; those with artificial limbs or prosthesis; those with mechanical devices, such as pacemakers, implanted defibrillators, insulin pumps; those with visual, speech, or hearing impairments; those with managed, non-acute behavioral, cognitive or mental health illnesses; and those with tuberculosis controlled by medication.

Level II:

Level II individuals are those individuals who have ongoing 'enhanced special health needs' and who, by the nature of their condition, need a heightened level of attention. This includes the following persons as a non-exhaustive list: those with attendant medical care and continuous health care support; those with special bed care and/or special toileting arrangements; those with life support equipment; those requiring significant supportive nursing care such as kidney dialysis; those with physician-ordered observation, assistance or maintenance or custodial care; those requiring skilled nursing care due to recent medical treatment; those whose disability prevents them from sleeping on a cot; those who require equipment normally found in a hospital or skilled nursing facility; and those who require assistance in performing activities of daily living or have health conditions whereby they cannot manage for themselves in an evacuation shelter.

Level III:

Level III individuals are those individuals who need acute medical care. This includes women giving birth, and individuals having a heart attack, individuals experiencing trauma or injury: people who would otherwise simply be a part of the general population. In the case of a disease outbreak or certain other disasters (such as a tsunami or hurricane), a significant portion of the population may immediately be thrown into this category.

The terms "individuals with disabilities" and "individuals with special health needs" are often used interchangeably. For the purposes of this document and disaster management and planning, the term "individuals with disabilities" will refer to both Level I and Level II individuals. "Individuals with special health needs" will refer only to Level II individuals. "Individuals with actual medical needs" refers to Level III individuals and are not the subject of this Plan.

Population Quantified

The absence of a universal definition of the population of individuals with disabilities or special health needs makes it difficult to definitively quantify the population. While there are broad estimates of the number of people who have a variety of conditions, there is no single 'count' of people with disabilities or special health needs. The absence of this data is due to the fact that (1) 'disability status' or 'special health needs status' are often only declared for the purpose of obtaining eligibility for a program, service, or benefit and (2) disability status is not necessarily a permanent characteristic of a person, such as age, race, or gender. Emergency preparedness and evacuation provides no incentive or reason for this population to self-identify without a demonstrable benefit to their disclosure. Therefore, for the purposes of planning we must rely on the best estimates based upon other community service data and figures.

The U.S. Census Bureau, 2000 Census of Population and Housing reflected a Hawaii population base of 1,211,537. The same census/survey identified 199,819 individuals, or approximately 16.5% of the non-institutionalized population over age 5 as having a disability or a “long lasting sensory, physical, or mental impairment.” Recognizing that this excludes a significant portion of people with disabilities because they live in institutions or long-term care facilities, the actual figure will be higher.

Thus, the U.S. Census Bureau estimates that 54 million Americans, or about 20% of the U.S. population are individuals with disabilities. Extrapolation to the Hawaii 2004 population base of 1,262,840 people yields an estimate of 252,568 individuals with disabilities.

Some people with disabilities will not require special assistance during an emergency because they are able to take care of themselves. Therefore, while some 16.5 - 20% of the total population have a disability, the national planning average used by emergency management offices, according to an informal national survey conducted by the National Office on Disability, is notably lower at 10 – 13% (National Council on Disability, 2002). This figure encompasses only those who need help in an emergency, acknowledging that many people with disabilities are capable of self-support.

Based upon those figures of 10 – 13% extrapolated to Hawaii’s population, the estimated number of people with disabilities for the purposes of emergency management planning is between 126,284 and 164,169 individuals. There is no further estimate as to what percentage of those individuals would require various levels of care.

In order to better quantify the 126,284 – 164,169 population estimate, we must quantify the individuals we can identify through the service delivery system. We can locate concentrations of individuals without identifying individuals by name by counting the number of people in clustered group living arrangements. These clusters and groups may change over time, but the number usually will remain consistent. (Since the residential facilities are limited by occupancy and licensing regulations and most facilities are at or near capacity, the number of individuals will not change dramatically until new facilities are opened.)

For example:

Care Home A is licensed for 5 individuals. Care Home A is providing custodial care for 5 individuals and, unless it ceases to provide such services, we can expect 5 individuals living at a specific location to need ‘extra help and attention’ in the event of an emergency.

Attachment A lists clusters of individuals with disabilities or special health needs who can be identified by where they live. Such programs can be identified by the state agencies that either license or fund the residential programs. This includes: Adult Residential Care Homes, Expanded Adult Residential Care Homes, Assisted Living Facilities, Developmental Disabilities Domiciliary Homes, Adult Foster Homes, Child Foster Homes, Special Treatment Facilities, Therapeutic Care Facilities, Skilled Nursing

Facilities, Intermediate Care Facilities, and Mental Health Group Homes. Attachment A reveals that there are approximately 12,300 people living in 1,842 identified clustered group living arrangements under some 'control' by the State of Hawaii. This is an unduplicated count.

Recognizing that most people with disabilities or special health needs do not live in a congregate group setting but rather are integrated into the community, often living semi-independently or in the care of their family, additional efforts must be taken to identify those individuals.

For example:

Individual A is frail, elderly, and has a disability. Individual A lives at home, but due to medical fragility, receives services from the Public Health Nursing Branch.

Individual B is elderly, in a wheelchair, and lives alone with rotating support of his children. He receives Meals on Wheels due to being homebound.

Individual C is similar to Individual B, but attends a day activity program instead of receiving Meals on Wheels.

Individual D is a person with a developmental disability, has a case manager through the Department of Health and receives a variety of personal care services to enable the family to keep him at home. Individual D receives SSI as well and does not attend any group program.

Currently there is no comprehensive aggregate list to identify those individuals with disabilities living in our community. No efforts are proposed to 'count' or identify those individuals. However, the Plan proposes, in its goals and objectives, to identify the array of social service, health, and education agencies or organizations who provide direct services and have client customer bases. This effort will help us reach individuals to develop individualized readiness plans.

Basic Premises and Assumptions

- (A) Although the circumstances of individuals with disabilities or special health needs may be different from the general population at-large, with the assumption that their needs are 'greater,' the means to address those needs must be integrated into the overall, general plans for emergency readiness and evacuation for the general population. A 'separate' emergency management plan for individuals with disabilities or special health needs is not appropriate. We cannot plan for 'special health needs populations' in isolation. If the general infrastructure of emergency preparedness, evacuation, and response is not increased for the population as a whole, planning for this population alone will be an exercise in frustration.
- (B) Emergency readiness is foremost an individual's personal responsibility, or, if the person is in the care of another person, the caregiver's responsibility. Increased personal readiness for a person with a disability or special health need is even more important to ensure that the person's unique challenges or needs are met.
- (C) While some other states have started to create registries of persons with disabilities, we feel it is not recommended, as the state or county levels of government do not have the capability to keep the registry up-to-date nor to meet the possible expectation of those on the registry that they will be 'rescued,' thereby creating a false sense of security.
- (D) All shelters made available to the population at-large should be physically accessible for Level I individuals who have the capability of self-care or have a personal attendant or caregiver to assist them.
- (E) A selected number of locations, whether they are some of the above shelters or other locations, should be designated for more intensive health support as noted above for Level II individuals.
- (F) Hospitals should be reserved for Level III individuals who are acutely ill. The role of a hospital is to respond first to its inpatient population and secondly, as a back-up to other hospitals.
- (G) The population of individuals who have disabilities or special health needs may include people who have become disabled as a result of the disaster. It may also include non-resident tourists whose location and personal medical needs will vary at any given time. While the immediate response of the community will need to accommodate those individuals, the primary planning efforts will be focused on the resident population whose disabilities are known prior to the emergency.
- (H) People with disabilities or special health needs should remain as a unit with their family or caregivers and should not be separated from their families due to their requirements for additional care. Thus, shelters must be prepared to accept a blend of individuals in order to keep families intact.

Goals and Objectives

This Plan sets forth seven (7) Goals as listed below:

Goal 1: All pre-designated locations used and managed as emergency evacuation shelters shall meet minimum requirements for facility access in the area of ingress and use of restroom (toilet) facilities to meet the needs of Level I individuals.

Goal 2: The capacity of the community to “shelter-in-place” shall be increased.

Goal 3: The number and dispersion of community emergency shelters as centers to provide augmented health support for Level II individuals shall be increased, with the long-term goal of having ALL community shelters able to support Level II individuals.

Goal 4: An accessible public and professional personal emergency readiness campaign shall be developed to assist everyone to make plans for themselves and their families in the event of an emergency. Individuals with disabilities or special health needs shall have an emergency evacuation plan in place developed by themselves or by their caregivers to implement in the event of a notification of evacuation.

Goal 5: Education shall be provided to all health care providers in order that appropriate emergency evacuation plans for health care facilities and/or settings are in place.

Goal 6: Individuals with disabilities or special health needs shall receive notification of an evacuation through the State Civil Defense mechanisms in an accessible format.

Goal 7: Each County shall have a plan for providing accessible transportation for individuals with disabilities and special health needs who have no transportation options or means to get to and from an emergency shelter.

Each Goal with its corresponding Objectives and relevant background information is described in detail in subsequent pages. The agencies listed after each objective are responsible for implementing the objective, with the lead agency or agencies noted with an asterisk (*). The lead agency or agencies are responsible for convening the identified players (and any others not identified in the Plan) to achieve the stated objective, including the development of strategies and actions to implement the objective.

Many other initiatives to enhance and strengthen the overall emergency management system will benefit people with disabilities. Only goals specifically targeting or directly impacting people with disabilities or special health needs are listed.

Goal 1: All pre-designated locations used and managed as emergency evacuation shelters shall meet minimum requirements for facility access in the area of ingress and use of restroom (toilet) facilities to meet the needs of Level I individuals.

Objective 1.1: Retrofit/harden schools used as community shelters, with priority to those schools already identified as ADA Transition Plan or Architectural Barrier Removal schools of the Department of Education to meet already developed baseline facility requirements for hardening and accessibility. **(State Civil Defense*, Department of Education*, County Civil Defense Agencies)**

Objective 1.2: Obtain State Capital Improvement Projects funds and upgrade sites to ensure that those sites meet the minimum facility requirements for accessibility and sheltering. **(State Civil Defense*, all Working Group partners)**

Objective 1.3: Amend Hawaii Revised Statutes to require all new state buildings and facilities, as appropriate, to have the capability to serve as an emergency evacuation shelter to tie into the Governor's administrative directive. (Note: All new buildings and facilities by law will be physically accessible.) **(State Civil Defense*, all Working Group partners)**

Objective 1.4: Provide basic training to shelter operators and assigned workers in responding to the needs of persons with disabilities or special health needs as shelter occupants (e.g., how to respond to service animals, handling mobility devices, etc.) using training modules developed by the National American Red Cross. **(American Red Cross*, Healthcare Association of Hawaii, Department of Health, Disability and Communication Access Board, State Council on Developmental Disabilities)**

Background and progress to-date:

Although all shelter facilities may not have the capability of serving those individuals who have specialized medical or health needs, many individuals with mobility impairments, individuals with chronic but not serious medical or health conditions, and individuals with mental impairments without other medical or health needs should be able to go to the nearest emergency evacuation facility in close proximity to their home and be with their family if they have the ability to self-care or bring an individual with them who can attend to their unique needs. Community shelters provide basic protection from the disaster at hand with minimum services and such locations provide 'only a roof over one's head' to protect individuals from the immediate harm of the disaster. To satisfy 'program access' requirements for site accessibility for people with disabilities, sites must minimally include parking, accessible routes, ingress/egress, and restrooms.

In recognition of the fact that the majority of community shelters are located in schools operated and managed by the Department of Education (DOE), a significant effort was made to ensure that the efforts already underway by the DOE to remove

architectural barriers would be coordinated with civil defense efforts to harden facilities. Using the information from the State-mandated §103-50 review process conducted by the Disability and Communication Access Board (DCAB), the list of DOE schools undergoing renovation for disability access through Transition Plan (TP) or Architectural Barrier Removal (ABR) Projects were cross-referenced with the list of community shelters to coordinate construction efforts to identify sites that can be both hardened and accessible. State Civil Defense is inspecting shelters to determine retrofit hardening options using appropriations from the Legislature. In FY 2005, \$2,000,000 was appropriated for both FY 2005 and FY 2006; \$4,000,000 was appropriated for FY 2007; \$8,000,000 is being sought for each of FY 2008 and FY 2009.

In 2006, a Governor's administrative directive was drafted which requires that plans for all newly constructed state buildings be reviewed by State Civil Defense (SCD) to ensure that they have the capability to serve as community shelters in addition to the purpose for which they are primarily constructed.

In addition to being physically able to accommodate Level I individuals, sensitivity to the needs of individuals with disabilities will help maintain a person with a disability and his or her family in the shelter.

Goal 2: The capacity of the community to “shelter-in-place” shall be increased.

Objective 2.1: Amend Hawaii Revised Statutes to provide ongoing grants to create a means to offset costs incurred for the plan, design, construction, and equipment related to new construction, alterations, or modifications to a qualified facility that retrofits, updates, or hardens the existing structure or structures to permit sheltering in place, as established by State Civil Defense. *(State Civil Defense*, all Working Group partners)*

Objective 2.2: Assist owners or proprietors of licensed health care settings or day facilities for people with disabilities through site consultation to assess their facility for hardening to be able to shelter in place, develop evacuation plans to ensure compliance/conformance with County Civil Defense procedures and guidelines, and use the financial incentives provided in Objective 2.1 to retrofit their facilities. *(Department of Health*, Department of Human Services*, State Civil Defense)*

Objective 2.3: Increase the capacity of the general community to become aware of the “sheltering in place” option by providing information about grants and funds available for making such renovations to individual residences and/or neighborhood community centers. *(State Civil Defense*)*

Background and progress to-date:

The number of shelter spaces in the community is inadequate for the general population, let alone the additional requirements for Level I or II individuals. Encouraging adult residential care homes, assisted living facilities, nursing facilities, other similar health care settings, as well as community centers and senior housing to shelter in place will allow individuals in such settings to continue to receive appropriate levels of care during disasters and other emergencies. Also, by increasing the capacity of the community to shelter in place, people will be made safe without the need to be transported (thus freeing up the transportation arteries while providing more spaces in the community shelters).

The Departments of Health (DOH) and Human Services (DHS) took an active role in promoting the concept of “Sheltering in Place” and “safe rooms” with managers of the respective Departments’ licensed homes. Strong interest was expressed and DOH determined there were many providers receptive to “hardening” conceptually, but activities are currently pending. Once State Civil Defense (SCD) standards are in place at the end of November, DOH and DHS can continue implementing activities with licensed facilities to pursue the option of sheltering in place. This effort will begin a broader campaign to educate the community at large about the option for “sheltering in place.”

Initially the Working Group explored the option of implementing a “tax credit” for retrofitting homes. However, the ceiling for the tax credit was set at \$2,100 per facility; inadequate for the inclusion of nursing homes and assisted living facilities. Therefore, Objective 2.1 was reworded to approach the State Legislature of Hawaii for funding for

ongoing efforts to harden facilities to allow for sheltering in place. The Department of Accounting and General Services (DAGS) provided feedback at the December 18, 2006 Working Group meeting. The consensus of the group was that if there was any legislation involving tax credits for hardening facilities it should be 10% of the cost incurred for renovations instead of 4% as originally worded in Objective 2.1 of the Action Plan. Increasing the tax credit to 10% will offer a greater incentive to harden facilities for sheltering in place.

SCD, in coordination with DOH and in consultation with DCAB, has initiated a project utilizing approximately \$140,000 from the State's Homeland Security funding. Working through the State DOH's Office of Health Care Assurance, outreach to the licensed group living facilities will focus on surveying these locations for their capacity to shelter in place and make recommendations for structural changes if sheltering in place is a viable option and simultaneously assisting managers in emergency readiness efforts.

Goal 3: The number and dispersion of community emergency shelters as centers to provide augmented health support for Level II individuals shall be increased, with the long-term goal of having ALL community shelters able to support Level II individuals.

Objective 3.1: Establish minimum facility and space requirements for a Level II Special Health Needs shelter to include, but not be limited to, the availability of back-up electricity (generator), refrigeration, toilet facilities and water, and hardening criteria applicable to all shelters. **(State Civil Defense*, Department of Health, Disability and Communication Access Board)**

Objective 3.2: Establish a minimum staffing pattern (quantity and type of staff) for staff oversight and operations of a shelter to serve Level II occupants. **(Department of Health*, Healthcare Association of Hawaii)**

Objective 3.3: Secure appropriate commitments to activate staff as identified in Objective 3.2 to staff the designated Level II shelters in the event of an emergency. **(All agencies)**

Objective 3.4: Identify and geographically designate/locate the projected number of individuals who would be classified as needing Level II care. **(Department of Health*, Department of Human Services*)**

Objective 3.5: Implement the needed retrofit of identified Special Health Needs Level II shelters, either existing or new, in each of the counties and ensure that those shelters meet the minimum requirements set forth in Objective 3.1. **(State Civil Defense*, County Civil Defense Agencies)**

Background and progress to-date:

Although facilities should not exclude people with mobility impairments from entrance due to architectural barriers, the nature and selection of sites, the lack of electricity and refrigeration at all sites, and the lack of adequate medical personnel make it unrealistic to have each site capable of rendering medical support in the immediate future. Hospitals are not the appropriate location, as their first priority must be caring for the acute medical patients in their facilities, secondly, supporting other acute care hospitals, and third, supporting the mission of public health.

Therefore, a selected number of shelters should be designated to fulfill those needs, whether they are portions of the shelter facilities or entirely new locations with a long-term goal of having all shelters being capable of serving Level II individuals.

Baseline Requirements for Level II Shelters

Occupancy by an individual with a disability is likely to require more space than a person without a disability due to the possible presence of additional equipment, service animals, or a companion caregiver, and thus determining an appropriate square footage

minimum requirement is necessary for planning purposes. Currently ten (10) sq. ft. per person is used for the general population and approximately forty (40) sq. ft. per person is used for a special needs Level II space to allow for auxiliary aids, equipment, and possibly an aide. These figures are for planning purposes only to calculate overall need and capacity.

Identification of Level II Shelters

SCD has identified approximately thirty (30) locations to serve as Level II shelters, noting that the final selection may change based upon inspection and input from the community. The first phase of retrofit will encompass the following locations: on Oahu – Farrington High School, Kaimuki High School, Castle High School, Pearl City High School, Leilehua High School, and Nanakuli High School; on Maui – Baldwin High School, Lahainaluna High School, and Kihei Elementary; on Kauai – Kauai High School and Kapaa High School; on the Big Island – Kealahou High School and Hilo High School. To reiterate, these locations are part of the first phase only. Development of the remainder of the list is open to negotiation.

While the selection of the initial group of Level II shelters was based on the physical characteristics of the school and their geographic location (to ensure dispersion of sites island-wide and statewide), another factor in the selection of facilities should be proximity to where people with Level II needs reside. To this extent, DOH, as the lead, with DHS, have mapped the location of all facilities under their licensing jurisdiction on a GIS system. While the clientele may change due to turnover, the facilities and their locations will be relatively stable for planning purposes. This information, while collected and mapped, has not been used yet to prepare community shelters for the possible impact on-site.

DCAB will conduct a statewide survey of agencies serving people with disabilities to develop a population profile and demographic analysis. Statistical data obtained from this survey will be used to develop a projected population dispersion of people with disabilities that will assist in determining the location of Level II shelters for the second phase of this objective.

Funding the Level II Shelters

Although requests to outfit Level II shelters as an ‘investment’ were made in prior Homeland Security Grant applications were not approved, SCD will continue to incorporate similar requests for FY 2007 and FY 2008 applications. Thus, state funding has become the primary source of funds to-date for the acquisition of back-up generators, refrigerators, and other equipment.

Staffing Level II Shelters

Ensuring that a shelter is physically accessible, is hardened, has appropriate supplies, has appropriate space reserved, and has the appropriate infrastructure of water, electricity, and refrigeration is the first part of the equation of a successful Level II

shelter. The second part is ensuring that services and operations within the Level II shelter exist. While ARC volunteers are able to operate a Level I shelter, once opened, their capability to provide the enhanced health or medical needs of Level II individuals is severely limited in actuality, as well as legally, with liability for staff. Therefore, determining how a Level II shelter is to be staffed with an appropriate minimum staffing pattern and commitments to activate personnel is critical to success. Resolving this issue has been identified as a key focus in 2007. While no agreement has been reached, preliminary meetings have begun with DOH (in the lead) and ARC, and other relevant community health organizations to address the issue.

Goal 4: An accessible¹ public and professional personal emergency readiness campaign shall be developed to assist everyone to make plans for themselves and their families in the event of an emergency. Individuals with disabilities or special health needs shall have an emergency evacuation plan in place developed by themselves or by their caregivers to implement in the event of a notification of evacuation.

Objective 4.1: Standardize a statewide 'Individual Emergency Readiness Procedure' message to be used in an outreach effort to include persons with disabilities, their families, and caregivers. *(State Civil Defense*, County Civil Defense Agencies, Department of Health, Disability and Communication Access Board, American Red Cross)*

Objective 4.2: Develop a comprehensive list of organizations serving persons with disabilities and/or the elderly population with estimates of their direct client caseloads or membership, to form the foundation of a statewide public education program. *(Executive Office on Aging*, Disability and Communication Access Board*, Department of Health, Department of Human Services)*

Objective 4.3: Conduct a comprehensive statewide public and professional education outreach program to agencies that provide services to people with disabilities and special health needs based upon the materials developed in Objective 4.1 with emphasis on Level II individuals first. The public education and outreach program shall be multilingual based upon state ethnic needs and integrated with a community-wide public education effort for all. *(State Civil Defense*, Department of Health*, Department of Human Services*, Department of Education, County Civil Defense Agencies, American Red Cross, Disability and Communication Access Board, State Council on Developmental Disabilities, Executive Office on Aging)*

Objective 4.4: Integrate emergency evacuation planning into the plans of clients who have a case manager in the Department of Health, Department of Human Services or their contracted agencies. *(Department of Health*, Department of Human Services*)*

Objective 4.5: Integrate the emergency evacuation planning of special education students into the school-wide plan. *(Department of Education*)*

Background and progress to-date:

Emergency preparedness/readiness is first and foremost an individual responsibility or, in the case of those without the capacity to self-care, the responsibility of their caregivers. Communication is the lifeline of emergency management and is even more critical for persons with disabilities. Many are unemployed (and thus do not

¹ "Accessible" means facilities are accessible for persons with disabilities, as well as provision of effective communication for persons who are deaf, hard of hearing, blind, visually impaired, or speech impaired.

receive information from the workplace), socially isolated, homebound, or unable to benefit from customary means of communication because of sensory or cognitive limitations of their disability. A heightened outreach program using materials already developed by organizations including the ARC, through support groups and social service agencies such as Meals on Wheels and community health nurses may be the best way to encourage individual preparedness. Awareness and readiness messages and materials for persons with disabilities must be similar to those provided to the population at-large but also customized for specific groups based upon acknowledged limitations and likely problems to be encountered as a result of those limitations. A public and professional education campaign will increase the ability of these individuals to plan and survive in the event of an emergency or disaster.

DCAB is currently updating a database of agencies providing services to individual with disabilities statewide. DCAB has added an "Emergency Preparedness" link to an updated web site, and has agreed to act as the central clearinghouse for disability-related information and allow agencies listed to be used as the basis for Objective 4.3.

Community Outreach Efforts to Educate Groups

In July 2006, the Executive Office on Aging (EOA) hired a temporary employee to collaborate with SCD on the design of outreach methods and development of accessible information tools to support the education of persons with disabilities as well as their families and friends. This was an effort to enhance outreach and community education.

Hawaii Services on Deafness and DCAB co-sponsored a training on September 18, 2006 titled "Emergency Responders and the Deaf and Hard of Hearing Community: Taking the First Steps to Disaster Preparedness." The training was developed by Telecommunications for the Deaf and Hard of Hearing and conducted by a trainer from the Community Emergency Preparedness Information Network (CEPIN). On September 19, 2006, a train-the-trainer session was conducted to develop a pool of trainers (first responders and persons who are deaf) to conduct similar trainings in Hawaii.

DHS developed a PowerPoint presentation and presented it to forty (40) Senior Companions on Oahu. The presentation emphasized helping elderly people have a realistic plan for their sheltering needs based on the availability of Level II shelters.

Community Outreach Efforts to Educate Individuals

A collaborative effort was undertaken with the creation of a working group comprised of representatives from DHS (Nursing Home without Walls), and DOH's Developmental Disabilities Division (DDD); Family Health Services Division (Children with Special Health Needs Branch), Community Health Division (Public Health Nursing Branch), Adult Mental Health Division, and Children and Adolescent Mental Health Division. The group convened several meetings to review and discuss the draft plan and to work within each of the respective Departments' divisions to meet Objective 4.5.

Each of the departmental divisions addressed this effort through staff training and development of tools or instruments to use with clients to assist with readiness planning.

DOH-DDD case managers (CM) met with individuals living alone and those living in inundated flood areas, as first priority, to provide education and assistance in preparing disaster preparedness kits, and informing clients of nearby evacuation shelter(s). CMs also educated and reviewed the disaster preparedness information with families and/or caregivers. All individuals will have their Client Emergency form completed and have been provided a copy to pack with their disaster preparedness kit. When necessary, DOH-DDD purchased backpacks from ARC. Individuals who are medically fragile and/or with limited communication capacity who may need a MedicAlert bracelet/identification have been identified.

All DHS Adult and Community Care Services Branch CMs assessed clients regarding their civil defense needs. Four hundred fifty one (451) clients were identified as needing Level II shelters and one hundred twenty five (125) will need assistance from the Department, either to get to the shelter or care for them once they are there. A database with this information was developed.

The Senior Companion Program trained one hundred twenty (120) volunteers to assemble emergency readiness kits in the County of Hawaii. Volunteers worked individually with clients to assemble their own kits. The program will be expanded through Helping Hands Hawaii.

Goal 5: Education shall be provided to all health care providers in order that appropriate emergency evacuation plans for health care facilities and/or settings are in place.

Objective 5.1: Strengthen the administrative oversight of licensing of all health care facilities to review the evacuation plans of the facility to ensure compliance with County Civil Defense procedures and guidelines. *(Department of Health*, Department of Human Services, Department of the Attorney General)*

Objective 5.2: Disseminate evacuation procedures and guidelines by the County Civil Defense Agencies to ensure consistency and appropriateness of disaster plans as developed by health care providers. *(County Civil Defense Agencies*)*

(Objective 2.2 also impacts meeting this goal.)

Background and progress to-date:

The Working Group has identified group living arrangements categorized in Attachment A that are licensed by the government where a significant number of individuals with disabilities or special health needs reside. By definition, these individuals are not able to live independently in the community and thus reside in a setting where they are dependent, due to their disability or age, on the care of a paid provider. These providers are reimbursed for their caregiving services and are regulated by administrative rules and regulations, either federal or state or a combination of both, concerning health, safety, and other factors, as appropriate.

Concerns have arisen relative to the adequacy and appropriateness of the evacuation plans of these facilities and the care providers. The plans are developed as a condition of licensure but are not approved by the respective licensing authorities. Thus, incorrect assumptions or understanding of the function of community shelters and hospitals may result in inappropriate responses in an evacuation. Additionally, facility caregivers may face competing interests of protecting their own families while continuing to provide for those individuals with disabilities or special health needs in their custodial care. Efforts to ensure that the legal obligations to provide care are continued during a disaster or emergency, whether sheltering in place or at a community shelter, should be increased.

In an attempt to address Objective 5.1, DOH has developed recommendations for facilities regarding nutrition/food safety requirements, and has shared it with providers and plans to incorporate it into future training. A concern was raised that there is nothing in State law that allows the County Civil Defense agency to enforce compliance by the health care facilities. DOH will continue ongoing efforts to ensure compliance.

Currently the Oahu Civil Defense Agency assists health care providers by providing planning guidance and templates in order for them to develop necessary evacuation procedures. This assistance is made available to all levels of health care providers from individual care homes to large-scale clinical facilities. Concerns were

raised about health providers “developing” evacuation procedures. Follow-up is needed in the counties to determine if plans developed by providers are consistent and appropriate.

SCD is currently reviewing all of the respective county guidelines and developing standardized statewide guidelines for distribution by DOH to all providers to use in the development of effective and appropriate disaster/evacuation plans. At the time of initial licensure, DOH reviews all policies and procedures and plans for compliance guidelines, and annually during inspections/surveys reviews evacuation plans, observes the ability of the facility to execute effective drills (primarily relating to fire right now, but would be similar with the exception of getting into a vehicle and going somewhere if they will go to a shelter). DOH will also work with DHS to ensure that guidelines are shared with DHS certified/licensed settings/agencies in order to develop consistency in both Departments. Through the collaborative efforts with SCD to provide education and training as well as assessment for sheltering in place, we will be able to enhance awareness and are moving to effect a provider community that will be better prepared to address disasters and the care of their residents/consumers, etc., during any event.

Goal 6: Individuals with disabilities or special health needs shall receive notification of an evacuation through the State Civil Defense mechanisms in accessible formats².

Objective 6.1: Secure agreements with all broadcast media to (1) provide open captioning on all television announcements of pending or current disasters, (2) ensure that crawl messages across a television screen do not run in any area reserved for closed captioning, as this will make both sets of messages unintelligible for deaf and hearing viewers, (3) coordinate with sign language or other language interpreters to be available to work with local television stations during emergencies, and (4) provide an aural description of emergency information in the main audio. If the emergency information is being provided in the video portion of the programming that is not a regularly scheduled newscast or newscast that interrupts regular programming (e.g., the programmer provides the emergency information through “crawling” or “scrolling” during regular programming), this information must be accompanied by an aural tone. **(State Civil Defense*, Disability and Communication Access Board)**

Objective 6.2: Obtain a TTY at all key emergency information lines (including, but not limited to, State Civil Defense, County Civil Defense Agencies, National Weather Service, and the American Red Cross) and ensure that all staff at the agencies are trained about TTY use. Collaborate with the Disability and Communication Access Board to locate appropriate resources for the purchase of TTY equipment and to set-up TTY training following equipment purchase and installation. **(State Civil Defense*, Disability and Communication Access Board)**

Objective 6.3: Ensure that the web sites of agencies providing information on disasters (including, but not limited to, State Civil Defense, County Civil Defense Agencies, National Weather Service, and the American Red Cross) are accessible to persons with disabilities (i.e., “Bobby-approved” or the equivalent). **(Oahu Civil Defense Agency*, State Civil Defense, Other County Civil Defense Agencies, Disability and Communication Access Board, National Weather Service, American Red Cross)**

Objective 6.4: Research and investigate alternatives for the provision of an alert paging system to warn individuals who are unable to hear the conventional siren of a possible emergency to include, but not be limited to, wireless services, and develop agreements to implement a system. **(State Civil Defense*, Disability and Communication Access Board)**

Objective 6.5: Conduct an analysis of the feasibility of a Reverse 911 system to initiate messages to registered individuals in an emergency. **(State Civil**

² “Accessible format” means information provided to the general public about an emergency must also be simultaneously and effectively communicated to people with disabilities (captions provided for people who are deaf and spoken for people who are blind).

Defense*, County Civil Defense Agencies, Disability and Communication Access Board)

Objective 6.6: Educate service providers about TTYs and other equipment individuals with disabilities use to obtain information about local emergencies. ***(State Civil Defense*, County Civil Defense Agencies*, Disability and Communication Access Board)***

Background and progress to-date:

Notification of an impending disaster, time permitting, and the call to evacuate is done by the counties. People with disabilities or special health needs and their caregivers should expect to receive information through the same notification system as the population at-large, not through the social service or health systems, whose workers will be preparing for staffing the emergency as needed. A significant challenge, as yet unresolved with no single recommendation, is how to reach the population of people who are deaf, hard of hearing or blind that may not receive notification through the traditional means as the general population.

The needs of persons who are blind have not been included on possible problems with current notification systems. When text is scrolled across the bottom of television screens, a beep to indicate a message is being scrolled on the screen. The message is not presented verbally creating a message in non-compliant format. Scrolled messages should also be read aloud to ensure everyone has equal access to information presented in one format. Objective 6.1 covers how the broadcast media provides emergency information. It was not clear if changes in the law to require emergency information be provided be made at a local or national level. Efforts will be made to contact the Federal Communications Commission to determine if a change is needed at the federal level to ensure all persons with disabilities are able to obtain such information in a manner similar to that provided to the general public.

To address the need of alternate telephone communication systems, SCD has contacted DCAB for technical assistance regarding where to procure appropriate equipment. County Civil Defense agencies have not contacted DCAB regarding procuring such equipment. Follow-up needs to be made with the County Civil Defense agencies.

SCD received a grant from Homeland Security to develop a pilot project for five hundred (500) people to test a computerized alert system. The pilot project is in its development phase initially for first responders. Whether the system will function for people who are deaf, hard of hearing or deaf-blind is not yet known. However, SCD will include a number of people with disabilities with communication issues in the target population to test the system in the pilot project.

Any public announcements made to alert the general public via the media (i.e., television), need to be monitored to ensure the message conveyed is accessible to everyone. For information about emergencies to be understood by everyone, including

individuals with disabilities, it should be transmitted in accessible formats to ensure that emergency warnings are conveyed. Accessible formats include reading scrolling text so people who are blind will be aware of the warning, and ensuring that information provided verbally is available via captioning for persons who are deaf or hard of hearing. Transmitting information in accessible formats will ensure that everyone in the general public (with and without disabilities) is alerted to occurrences in the environment.

To address emergency notification to everyone in the community, the County of Hawaii recently installed and has an operational Reverse 911 system. The County Civil Defense Agency reported that it is working well. The City and County of Honolulu is investigating the type of emergency notification system that will effectively serve a county with a large population base. When a determination is made, a system comparable to the County of Hawaii will be established on Oahu. The County of Kauai is also investigating notification options. These notification systems cost between \$70,000 - \$75,000. The County of Maui has elected not to use the phone system for emergency notification because it is usually overloaded during an emergency even though the public is asked not to use the phone.

Goal 7: Each County shall have a plan for providing accessible transportation for individuals with disabilities and special health needs who have no transportation options or means to get to and from an emergency shelter.

Objective 7.1: Develop an operational service plan at the county level for transportation in the event of an emergency and publicize the information to county residents. *(County Transportation Agencies*, County Civil Defense Agencies*, Department of Transportation)*

Objective 7.2: Incorporate transportation options developed into the comprehensive statewide public and professional personal readiness outreach programs under Objective 4.3. *(State Civil Defense*, Department of Health*, Department of Human Services*, Department of Transportation*, Department of Education, County Civil Defense Agencies, American Red Cross, Disability and Communication Access Board, State Council on Developmental Disabilities, Executive Office on Aging)*

Background:

The “2006 Interagency Action Plan for Emergency Preparedness of Persons with Disabilities and Special Health Needs” did not include a distinct goal with objectives relating to transportation. Identifying and ensuring emergency shelters were accessible for persons with disabilities were the primary foci during the first year of the Plan. Community input has emphasized that transportation for persons with disabilities living independently but not able to drive or transport to a shelter is as important an issue to address as developing accessible shelters. If individuals with disabilities or special health needs are unable to get to a shelter they may be left vulnerable in an unsafe community location. It was also emphasized that development of a personal emergency evacuation plan (including transportation to and from the shelter) is an individual responsibility for persons with and without disabilities. Various situations may exist or occur when an individual with a disability or special health need does not have any transportation options available. In these situations, government will be the only option as a transportation provider. The State and the counties need to collaborate, plan, and inform the community of any available accessible transportation options during an emergency. As a transportation issue, the lead agency would be the County Transportation agencies, but in an emergency they would take direction from the County Civil Defense agency.

The community input regarding transportation highlighted the very difficult problem facing the neighbor islands versus Oahu. Regular, consistent, and accessible public transportation, either fixed-route or paratransit, is not available on the neighbor islands even in non-emergency situations as it is on Oahu. Therefore, any transportation planning effort must be county specific. County Transportation agencies, especially on the Neighbor Islands where the population is smaller and more manageable compared to the City and County of Honolulu may choose to establish working relationships with various health and human service agencies that maintain database(s) of client caseloads. Such information will assist in emergency transportation response, but

should not be construed as a registry maintained by the county either within the transportation agency or civil defense agency. Transportation options will vary and their effectiveness in response will depend on the type of emergency and the amount of lead-time that Civil Defense has to notify the community. It is also dependant on whether or not the transportation system is able to function during an emergency (i.e., in a tsunami transportation may continue in non-inundation zones).

Past experience has revealed that any “emergency” will likely result in a massive transportation gridlock making travel very congested even with the availability of a personal vehicle or, in the case of Oahu, an operating public transit system.

Transportation system officials have also emphasized the need to protect vehicles from damage (due to a hurricane) to ensure their operability post-emergency. This may result in the shutdown of any public transit system earlier than the public realizes. For persons with disabilities and special health needs who may stay in their homes as long as possible with their own supports, the lack of transportation at the “12th hour” will be a huge problem.

The group recognized that off-island evacuation for medical care for visitors, or other reasons remain a concern, which may incorporate airline/airport, or military transport systems. However, this Plan’s focus relates to on-island ground transportation needs, particularly from home or a day location to a shelter or location out of a hazard zone (i.e., tsunami).