



2008 Interagency Action Plan

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

**State of Hawaii
January 2008**

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, Department of Emergency Management
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 Centers for Independent Living
Hui Kupuna VIP
National Federation of the Blind
National Multiple Sclerosis Society, Hawaii Division

This document is available on the DCAB web site
www.hawaii.gov/health/dcab/

To request a large print or Braille copy
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BACKGROUND

In the wake of the September 11th terrorist attacks and the subsequent 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 political 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.

A 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 membership of the Working Group 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. In 2007 the Hawaii Association of the Blind no longer had a representative on the Working Group and Hawaii Services on Deafness closed at the end of June. Both agencies were removed from the list of the Working Group members. Several new agencies joined the Working Group in 2007: Hui Kupuna VIP representing individuals who are elderly and have a disability, the Hawaii Centers for Independent Living and the National Multiple Sclerosis Society, Hawaii Division representing individuals with disabilities, and the National Association of the Blind representing people who are blind and visually impaired.

The Interagency Working Group initially developed the first Plan in February 2006 with six (6) goals. It was updated in February 2007 with the addition of a Goal 7 that focused on transportation needs of the target population. This current 2008 Plan represents an update to the prior versions incorporating amendments to the existing goals and objectives along with additional information reflecting progress made and suggestions from the community statewide. It is the intent of the Interagency Working Group to review and revise the Plan on an annual basis.

In Fall 2007 the Centers for Disease Control (CDC), U.S. Department of Health and Human Services through the Public Health Emergency Preparedness Cooperative Agreement, allocated funds to sponsor statewide public forums to review and comment on the 2007 Plan. Forums were conducted during October 2007 in each county. Specific counties developed their own invitation lists of key representatives from agencies, advocates, individuals with disabilities, family members and caregivers. Attendance at each forum was diverse, resulting in comments and suggestions that were creative and unique to each location. Representatives from Guam and American Samoa were invited to and included at the Oahu forum, along with two representatives from each neighbor island forum. Using this methodology to obtain input resulted in development of this 2008 Plan that represents the needs of a broader base of Hawaii's community of people with disabilities.

This Action Plan is not an 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. The Plan 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.

TARGET POPULATION

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 (ARC) national guidelines:

Level I Care & Shelters:

Individuals going to a Level I shelter are people 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 I shelters are public evacuation shelters, often referred to as "mass care" or "general population" shelters.

Level II Care & Shelters:

Individuals who go to Level II shelters are people 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 a Level I general population evacuation shelter.

Level II shelters are not freestanding shelters. Rather, they are spaces within a Level I “mass care” or “general population” shelter for individuals needing Level II care.

Level III Care:

Individual requiring Level III care are people 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 included into this category. There are no Level III shelters. Individuals needing Level III care should be served in a hospital.

For the purposes of this document and disaster management and planning, the term “individuals with disabilities” will refer to individuals requiring both Level I and Level II care. “Individuals with special health needs” will refer only to people requiring Level II care. “Individuals with actual medical needs” are not the subject of this Plan.

An important change in terminology was made in the 2008 Plan, compared to the 2006 and 2007 Plans. Rather than using the terms “Level I,” “Level II,” and “Level III” to describe individuals, the terms are used in this 2008 Plan to describe level of care and shelters or shelter spaces. The terminology change reflects the use of “people-first” language in lieu of labeling people. Also, the 2008 Plan references Level III care, instead of a Level III shelter. As such, a Level III shelter does not exist. Individuals requiring Level III care should be served in a hospital.

Another compelling reason to avoid categorizing people in levels is because the care required by an individual with a disability may change dramatically due to the emergency or the conditions surrounding an emergency. For example, a person who uses a wheelchair may be ordinarily able of independent living and self-care due to home accessibility modifications; however, the same individual may require Level II care because in a shelter the restrooms are not accessible with no grab bars or because there is no raised bed for the individuals to transfer onto and sleep.

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 2006 population base of 1,285,498 (Hawaii Data Book, 2006) people yields an estimate of 257,100 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 128,550 and 205,680 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 128,550 – 205,680 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.

Appendix 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 individuals with disabilities living independently in the community. No efforts are proposed to 'count' or identify such individuals. However, the Plan proposes, in its goals and objectives, to identify the array of social service, health, and education agencies or organizations that provide direct services and have customer-bases which include people with disabilities. This effort will help to assure that individuals with disabilities develop emergency readiness plans as an integral part of their individual service plans through community service agencies. For individuals with disabilities and special health needs who do not use community service agencies, individual emergency readiness is a personal responsibility that may be enhanced through a coordinated community media outreach campaign.

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 do not recommend this 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 Level I shelters available to the population at-large should be physically accessible for individuals with disabilities who have the capability of self-care or have a personal attendant or caregiver to assist them.
- (E) A selected number of locations within Level I shelters should be designated for more intensive health support as noted above for Level II care.
- (F) Hospitals should be reserved for individuals who are acutely ill needing Level III care. 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 all individuals, this plan focuses 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.

GOALS AND OBJECTIVES

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

Goal 1: Level I public emergency evacuation shelters shall meet minimum requirements for facility access to enter/exit and use toilet facilities.

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

Goal 3: The number and dispersion of public emergency evacuation shelters able to provide augmented health support with Level II shelter spaces shall be increased, with the long-term goal of having ALL public emergency evacuation shelters contain Level II shelter spaces.

Goal 4: 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 licensed health care providers in order that appropriate emergency guidelines for health care facilities and/or residential settings are in place.

Goal 6: All notification of pending emergencies and evacuation shall be accessible to persons with disabilities using multiple methods of delivery.

Goal 7: Individuals with disabilities or special health needs shall have an emergency evacuation transportation plan developed by themselves or their caregivers to implement in the event of notification for evacuation.

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: LEVEL I PUBLIC EMERGENCY EVACUATION SHELTERS SHALL MEET MINIMUM REQUIREMENTS FOR FACILITY ACCESS TO ENTER/EXIT AND USE TOILET FACILITIES.

Objective 1.1: Retrofit/harden all public emergency evacuation shelters, with priority to those schools already identified as ADA Transition Plan or Architectural Barrier Removal schools of the Department of Education (DOE), 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 (CIP) funds and upgrade current public emergency evacuation shelters 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 (HRS) to require all newly constructed state buildings and facilities, as appropriate, to have the capability to serve as a public emergency evacuation shelter for up to 130% of occupancy. (Note: All new buildings and facilities are required by law to be physically accessible per HRS §103-50.) *(State Civil Defense*, all Working Group partners)*

Objective 1.4: Provide approved American Red Cross training to all Level I shelter workers to respond to the needs of persons with disabilities or special health needs (e.g., how to respond to service animals, how to handle mobility devices, etc.). *(American Red Cross*, Department of Health, Disability and Communication Access Board, State Council on Developmental Disabilities)*

Objective 1.5: Increase the pool of trained shelter workers, including persons with disabilities, so that public emergency evacuation shelters can be more responsive to the needs of persons with disabilities and special health needs. *(American Red Cross*, all Working Group partners)*

Objective 1.6: Amend Hawaii Revised Statutes (HRS) to allow public funds to be used for privately-owned and approved public emergency evacuation shelters open to the public. *(State Civil Defense*, and all Working Group partners)*

For background and progress to-date on Goal 1 see Appendix B.

GOAL 2: THE CAPACITY OF THE COMMUNITY TO “SHELTER IN PLACE” SHALL BE INCREASED.

Objective 2.1: Amend Hawaii Revised Statutes (HRS) to provide grants to offset costs incurred for the plan, design, construction, and equipment for a qualified facility (to include private facilities) that retrofits, updates, or hardens its existing structure 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, including retirement homes, through site consultation to assess their facility for hardening 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. *(State Civil Defense*, Department of Health, Department of Human Services)*

Objective 2.3: Educate the general community on “sheltering in place” options by providing information about grants and funds available for making renovations to individual residences and/or private facilities (i.e., neighborhood community centers). *(State Civil Defense*)*

Objective 2.4: Create tax incentives for private owners, builders, developers and care facilities to provide shelter in place options in new construction. *(State Civil Defense*, all Working Group partners)*

For background and progress to-date on Goal 2 see Appendix C.

GOAL 3: THE NUMBER AND DISPERSION OF PUBLIC EMERGENCY EVACUATION SHELTERS ABLE TO PROVIDE AUGMENTED HEALTH SUPPORT WITH LEVEL II SHELTER SPACES SHALL BE INCREASED, WITH THE LONG-TERM GOAL OF HAVING ALL PUBLIC EMERGENCY EVACUATION SHELTERS CONTAIN LEVEL II SHELTER SPACES.

Objective 3.1: Establish minimum facility and space requirements for Level II special health needs shelter spaces to include, but not be limited to, the availability of back-up electricity (generator), refrigeration, accessible toilet facilities and water, and hardening criteria applicable to all shelters. **(State Civil Defense*, Department of Health, American Red Cross)**

Objective 3.2: Establish a minimum staffing pattern (quantity and type of staff) for staff oversight and operations of a Level II shelter. **(Department of Health*, Healthcare Association of Hawaii, American Red Cross, Medical Reserve Corps)**

Objective 3.3: Secure appropriate commitments to activate staff as identified in Objective 3.2 to staff the designated Level II shelter spaces in the event of an emergency. **(Department of Health*)**

Objective 3.4: 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)**

For background and progress to-date on Goal 3 see Appendix D.

GOAL 4: 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: 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 as well as agency readiness and shelter in place survey. ***(Executive Office on Aging*, Disability and Communication Access Board*, Department of Health, Department of Human Services)***

Objective 4.2: Conduct a comprehensive statewide public and professional education outreach program using a standardized statewide 'Individual Emergency Readiness' message to agencies providing services to people with disabilities and special health needs. 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 4.3: 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 4.4: Integrate the emergency evacuation planning of students with disabilities in the school-wide evacuation plans of public schools, private schools, and early intervention programs. ***(Department of Education*)***

For background and progress to-date on Goal 4 see Appendix E.

GOAL 5: EDUCATION SHALL BE PROVIDED TO ALL LICENSED HEALTH CARE PROVIDERS IN ORDER THAT APPROPRIATE EMERGENCY GUIDELINES FOR HEALTH CARE FACILITIES AND/OR RESIDENTIAL SETTINGS ARE IN PLACE.

Objective 5.1: Ensure the administrative oversight of licensing of all health care facilities includes the review of emergency guidelines of the facility to comply with County Civil Defense procedures and guidelines. *(Department of Health-OHCA*, State Civil Defense*, County Civil Defense Agencies*, Department of Human Services)*

Objective 5.2: Assist health care facilities to develop emergency plans. Conduct periodic random reviews of the health care facility plans to assure appropriateness of the plans. *(State Civil Defense*)*

Objective 5.3: Develop a means to assess privately owned residential settings for senior citizens, other than assisted living facilities, to determine whether the resident should shelter in place or go to a public emergency evacuation shelter during a disaster. *(Executive Office on Aging*, County Area Agencies on Aging)*

For background and progress to-date see Appendix F.

GOAL 6: ALL NOTIFICATIONS OF PENDING EMERGENCIES AND EVACUATION SHALL BE ACCESSIBLE TO PERSONS WITH DISABILITIES USING MULTIPLE METHODS OF DELIVERY.

Objective 6.1: Secure agreements with visual 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 include the interpreter in all messages broadcasted, 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 a program that is not a regularly scheduled newscast does not interrupt regular programming (e.g., “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 on TTY use. **(State Civil Defense*, Disability and Communication Access Board)**

Objective 6.3: Provide information in an accessible format¹ on the web sites of the following agencies providing information on disasters: FEMA, State Civil Defense, County Civil Defense Agencies, National Weather Service, and the American Red Cross (i.e., “Bobby-approved” or the equivalent). **(Oahu Department of Emergency Management*, State Civil Defense, Other County Civil Defense Agencies, Disability and Communication Access Board, National Weather Service, American Red Cross)**

Objective 6.4: Research alternatives (to include pictograms or graphics) for the provision of an alert paging system to warn individuals who do not hear, understand, or comprehend the conventional siren of a possible emergency to include, but not be limited to, wireless services, and develop agreements to implement a system. Research should include an analysis of the feasibility of new technology to initiate messages to individuals with disabilities in an emergency. **(State Civil Defense*, Disability and Communication Access Board)**

For background and progress to-date see Appendix G.

¹ “Accessible format” means that 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, and simple graphics for people with cognitive disabilities).

GOAL 7: INDIVIDUALS WITH DISABILITIES OR SPECIAL HEALTH NEEDS SHALL HAVE AN EMERGENCY EVACUATION TRANSPORTATION PLAN DEVELOPED BY THEMSELVES OR THEIR CAREGIVERS TO IMPLEMENT IN THE EVENT OF NOTIFICATION FOR EVACUATION.

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 Education, County Civil Defense Agencies, American Red Cross, Disability and Communication Access Board, State Council on Developmental Disabilities, Executive Office on Aging)*

For background and progress to-date on Goal 7 see Appendix H.

APPENDICES

Appendix A

Listed below are clusters of individuals with disabilities or special needs who can be identified by where they live in a clustered group living arrangement. Such programs can be usually be identified by the licensing process of the State of Hawaii.

Type of Facility	# Hawaii		Kauai		Maui		Molokai		Lanai		Oahu		Total	
	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	beds
Adult Residential Care Homes (ARCH) Arch I & II	48	211	16	73	13	61	4	31	0	0	413	2232	494	2608
Expanded ARCH	14	28	1	2	1	2	1	3	0	0	160	347	177	382
Therapeutic Living Programs (TLP)	2	12	2	12	2	23	0	0	0	0	9	60	15	107
Special Treatment Facility (STF)	4	49	0	0	4	75	0	0	0	0	30	577	38	701
Developmental Disabilities Domiciliary Homes (DD Dom Homes)	1	5	0	0	1	5	0	0	0	0	30	133	32	143
Assisted Living Facility (ALF)	1	220	1	100	1	144	0	0	0	0	7	1280	10	1744
Intermediate Care Facility–Mentally Retarded in the Community (ICF-MR-C)	0	0	0	0	4	24	0	0	0	0	14	67	18	91
Residential Alternatives for Care in the Community (RACC)	44	88	4	8	19	38	1	2	0	0	574	1158	642	1294
Intermediate Care Facility-Skilled Nursing Facility(ICF/SNF)	8	720	5	318	4	498	1	3	1	10	31	2547	50	4096
Mental Health – Adult Group Living Sites	15	97	7	33	9	60	0	0	0	0	62	429	93	619
Developmental Disabilities Foster Homes (DD Foster Homes)	4	6	9	16	8	13	0	0	0	0	252	494	273	529
Total	141	1436	45	562	66	943	7	39	1	10	1582	9324	1842	12314

Appendix B

Goal 1: Level I public emergency evacuation shelters shall meet minimum requirements for facility access to enter/exit and use toilet facilities.

Background and progress to-date:

All public emergency evacuation shelters may not have the capability of serving those individuals who have specialized medical or health needs. However, 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 public emergency evacuation shelter closest 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. Public emergency evacuation shelters provide basic protection from the current disaster 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 requirements for 'program access' for people with disabilities, sites must minimally include parking, accessible routes, enter/exit, and restrooms.

Recognizing that the majority of community shelters are located in schools operated and managed by the DOE, a significant effort was made to ensure that the efforts already underway by the DOE to remove architectural barriers would be coordinated with State Civil Defense (SCD) efforts to harden facilities. Using the information from the State-mandated HRS §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 was cross-referenced with the list of community shelters to coordinate construction efforts at sites to be both hardened and accessible. SCD is inspecting shelters to determine retrofit hardening options using appropriations from the State Legislature. Two million dollars was appropriated for both FY 2005 and FY 2006; \$4 million was appropriated for FY 2007; \$8 million is being sought for each of FY 2008 and FY 2009.

In the spring and summer of 2007, American Red Cross and SCD conducted statewide public emergency evacuation simulations and education fairs. The shelter simulations included both Level II and pet friendly shelters spaces on the same campus where Level I shelters are located. Exercises were a learning experience for all volunteers involved and were an indicator to ARC and SCD that more training is needed. In addition to being physically able to accommodate individuals with disabilities who can use a Level I shelter, sensitivity to the needs of individuals with disabilities and special health needs, as well as to the elderly, will help maintain a person with his or her family in the shelter.

Objective 1.3 makes a reference to "130% of occupancy." The occupancy rate Takes into account employees in the facility and individuals who may be visiting the building. During a disaster it may become necessary to go beyond the 100% occupancy rate. For employees' peace of mind, it is desirable to allow family members to be included in the

number sheltered at a particular site. The figure was increased to 130% to address the inclusion of family members who may need to shelter at the site.

With respect to Objective 1.4, the national American Red Cross has initiated a course nationally to provide training to all shelter workers, including volunteers, on ways to best serve people with disabilities in the mass care (Level I) shelter environment. The Hawaii Chapter of the American Red Cross will implement teaching this course in early 2008. The course is approximately one day (8 hours) in duration with 4 hours in a classroom setting and the other 4 hours in an individual self-study, online format. The online portion is open to anyone, while the classroom setting will initially be limited to those individuals considered part of a Red Cross' "shelter team." These team members are registered with the American Red Cross, and thus can be trained in advance of the actual emergency. Members of shelter teams are provided with training in many subject matters, of which disability awareness and sensitivity are just one component. It was also noted that having on-site training for people with skills to work with individuals with disabilities or special health needs after the emergency is not practical due to the immediacy of the situation. Those individuals should be encouraged to volunteer in advance and go through the classroom training identified above. Thus, a new Objective 1.5 was added to the 2008 Action Plan to augment the volunteer pool to be more responsive to the needs of persons with disabilities in the Level I shelter environment. Educating people ahead of time about sensitivity to individuals with disabilities and their needs will improve the environment in Level I shelters and resolve a previously unmet need. Providing training to improve awareness about people with disabilities will not satisfy the need for staffing Level II shelters which require skills of a health care professional, but it will go a long way in addressing the needs of people with disabilities to be treated equitably at a Level I shelter. Disability awareness and sensitivity training need to be provided to professionals (i.e., doctors or health care or human service providers, etc.) with some medical or health care skill to create (expand) a pool of volunteers to staff Level II shelters.

With the current shortage of public emergency evacuation Level I shelter spaces, it is clear that creating public emergency evacuation shelters needs to expand beyond public schools and into the private sector. Incentives need to be created to entice private sector businesses, such as hotels, business offices, neighborhood community centers, etc., to retrofit and open up their sites and allow their spaces to be used as a public emergency evacuation shelter. Objective 1.6 reflects the need to reach the private sector for additional Level I shelter spaces. Retrofit entails upgrading of windows, doors, skylights, and other components vulnerable to high winds and flying debris, and incentives could include but not be limited to tax credits and the use of public money to harden privately owned facilities.

In 2006, a Governor's administrative directive was drafted which requires that plans for all newly constructed State buildings be reviewed by SCD to ensure that they have the capability to serve as public shelters in addition to the purpose for which they are primarily constructed. The directive is still pending finalization.

Appendix C

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

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 individuals with disabilities or special health needs who may require additional assistance at less than the acute care level. Encouraging adult residential care homes, assisted living facilities, nursing facilities, other similar health care settings, 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 public emergency evacuation shelters.

The American Red Cross defines “shelter in place” as a precaution aimed to keep a person safe while remaining indoors. When one shelters in place it may mean using a small, interior room, with no or few windows to take refuge. It does not necessarily mean sealing off the entire home or office building. Depending on the type of emergency situation that has been declared, instructions will be provided if people are told to shelter in place. Instructions on sheltering in place are provided on the American Red Cross web site at <http://www.redcross.org/services/disaster/beprepared/shelterinplace.html>. Different instructions are provided if a person is at home, school, work, or in a vehicle. If there are any chemical, biological or radiological contaminants released into the environment, there may be a need for sheltering in place. If this type of emergency occurs, local authorities would provide information over the television or radio about how to protect oneself and family. Instructions to shelter in place are usually provided for the duration of a few hours, not days or weeks.

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 their respective Departments’ licensed homes. Strong interest was expressed and DOH determined there were many providers conceptually receptive to “hardening”, but activities are currently pending. Once SCD standards are in place, DOH and DHS can continue implementing efforts 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, an amount that is inadequate for nursing homes and assisted living facilities. Therefore, Objective 2.1 was reworded to seek grants to harden facilities to allow for sheltering in place. The Working Group discussed various tax strategies that might have an impact. In

Objective 2.4, the consensus of the Working Group was that any legislation involving tax credits for hardening facilities should be 10% of the cost incurred for renovations instead of 4% as originally proposed to offer a greater incentive to harden facilities for sheltering in place.

SCD, in coordination with DOH and in consultation with DCAB, initiated a project utilizing approximately \$150,000 from the State's Homeland Security funding. This action was undertaken in reference to Objective 2.2. Working through the State DOH's Office of Health Care Assurance, outreach to the licensed group living facilities will focus on educating providers on their emergency preparedness responsibilities, conducting a survey on their interest/willingness to shelter in place, and conducting an initial assessment of sheltering capability (e.g., single wall construction). Viable and interested candidates are referred to SCD. Updated information about this project is included under the 'Background' section of Goal 5 in Appendix F.

Appendix D

Goal 3: The number and dispersion of public emergency evacuation shelters able to provide augmented health support with Level II shelter spaces shall be increased, with the long-term goal of having ALL public emergency evacuation shelters contain Level II shelter spaces.

Background and progress to-date:

Although facilities should not exclude people with mobility impairments 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 expect every public emergency evacuation shelter site be capable of rendering medical support with Level II shelter spaces 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. These spaces are Level II shelter spaces where Level II care can be provided. At the present time, all level II Shelter spaces planned are portions of Level I shelters, although in the long run, a free standing shelter with only Level II spaces is an option. The long-term goal is to have all Level I shelters contain Level II shelter spaces. In 2007, DOE campuses with special education classrooms that included ADA compliant restrooms, showers and kitchens (which include refrigeration), have been designated to contain Level II shelter spaces.

Baseline Requirements for Level II Shelter Spaces

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. 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 (for a level II space) and approximately twenty (20) to forty (40) sq. ft. per person is used for a special needs Level II space to allow for auxiliary aids, equipment, and possibly a caregiver. These figures are for planning purposes only to calculate overall need and capacity.

Identification of Level II Shelter Spaces

The selection of the initial group of Level II shelter spaces in 2006 was based on the physical characteristics of the schools 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, has mapped the location of all facilities under their licensing jurisdiction on a

GIS system to show a clientele base of approximately 12,000 (see Appendix A). While the clientele may change due to turnover, the facilities and their locations will be relatively stable for planning purposes. This information will be used to prepare public emergency evacuation shelters for the possible impact on-site, even though it is limited to 12,000 beds in State licensed facilities.

Funding the Level II Shelter Spaces

For Objective 3.4, SCD reported that in activities in 2007 included inspecting and identifying thirty (30) predesignated public emergency evacuation shelters that could be used as Level II shelters. An appropriation of \$6 million tied into the DOE's barrier removal and Transition Plan must be expended by the end of FY 2008, SCD requested \$6 million from the Legislature for the past two (2) years, but received no appropriation. Therefore, a new request for \$10 million will be made during the 2008 Legislative session to retrofit shelters.

Although requests to outfit Level II shelter spaces as an 'investment' made in prior Homeland Security Grant applications were not approved, SCD will continue to incorporate similar requests for FY 2008 and FY 2009 applications. Thus, State funding has become the primary source of funds to-date for the acquisition of backup generators, refrigerators, and other equipment.

Staffing Level II Shelter Spaces

Ensuring that a shelter is physically accessible, is hardened, has appropriate supplies, has appropriate reserved spaces, and has the appropriate infrastructure of water, electricity, and refrigeration is the first part of the equation of establishing a successful Level II shelter spaces. The second part is ensuring that services and operations exist to assist those needing Level II care. While American Red Cross volunteers are able to operate a Level I shelter their capability to provide the enhanced health or medical needs for a select group of individuals with disabilities and special health needs is severely limited in actuality, as well as legally, with liability for staff. Therefore, determining how Level II shelter spaces are 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 to success of this goal. While no agreement has been reached, preliminary meetings have begun with DOH (in the lead) and American Red Cross, and other relevant community health organizations to address the issue.

Appendix E

Goal 4: 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.

Background and progress to-date:

Emergency 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 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 American Red Cross, through support groups and social service agencies such as Meals on Wheels, and community health nurses may be the best way to encourage individual readiness. Awareness and readiness messages and materials for persons with disabilities must be similar to those provided to the population at-large but also must be 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 with disabilities to plan and survive in the event of an emergency or disaster.

DCAB is currently updating a statewide database of agencies providing services to individuals with disabilities. The database will be used by DCAB to conduct a survey to determine if emergency readiness information is being provided to consumers with disabilities or special needs on a regular basis. DCAB has added an "Emergency Preparedness" link to its 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 4.1.

Community Outreach Efforts

The Disability and Communication Access Board (DCAB) and Hawaii Services on Deafness (now defunct) co-sponsored two (2) days of trainings in September 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). One day focused on emergency responders and the deaf and hard of hearing community taking the first steps to disaster preparedness. A second day was a trainer session 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.

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 4.3. 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 Management & Information Services Branch (CMISB) case managers (CM) met with individuals living alone, living with elderly parents unable to prepare their own emergency supplies, and those living in inundated flood areas (homeless) 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 Information form (which includes personal information, location of closest emergency shelter locations, family/emergency contacts (buddies), communication needs/primary language, emergency kit/prostheses/medical apparatuses/supplies, primary medical doctor, pharmacy, use of service animal, day program and/or employer, and list of medications) completed and have been provided a copy to pack with their disaster preparedness kit.

When necessary, DOH-DDD purchased backpacks from the American Red Cross (ARC). Laminated bag tags were also created to be attached to the ARC purchased backpacks that states: "Emergency Information Can Be Found in the Bag" to assist individuals who may have limited communication skills and in need of assistance at the evacuation shelters and/or in need of medical care at the hospital post disaster. CMs have promoted "personal preparedness planning" in their discussion with the individuals, families, and/or caregivers.

Secondly, the individual's Client Emergency Information form identifies at least two (2) buddies who may be the individual's family member, friend, or neighbor that has agreed to assist the individual in the event of a natural disaster. The buddy's role is to be with the individual whether "to shelter in place" or to mobilize to a nearby emergency shelter or hospital for medical care, if needed. In the event one buddy is unavailable, the second buddy will be contacted in an emergency.

CMISB is getting ongoing assistance from the DOH Environmental Planning Office to input a priority group of individuals' Client Emergency Information onto their GIS mapping system. The maps reflect all islands and identify the locations of Foster and Domiciliary Homes, Emergency Sites, and Flood and Tsunami Evacuation Zones. This tool will assist

State Civil Defense and other emergency support efforts prior to and following post-disaster assessments.

The Quality Assurance Unit staff from the DDD Disability Supports Branch (DSB) developed and implemented a curriculum for Emergency Preparedness for Adult Foster caregivers. From January to December 2007, monthly classes on emergency preparedness were conducted to a total of 175 potential adult foster home caregivers. From April 2007 to December 2007, a more intense curriculum was conducted to a total of 84 current adult foster home caregivers. These ongoing classes included a PowerPoint presentation, sample of "go-kits" from ARC, and a 20-minute film on hurricanes in Hawaii. Many caregivers have never experienced or seen the impact of a hurricane.

The caregivers were asked to bring in their client charts so the instructors could help them fill out the Client Emergency Information forms to take with them in case of an evacuation. A multiple-choice 10-question test was given to both caregiver groups to evaluate the caregivers' understanding of the information presented.

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.

Comments from Working Group members and community forum participants in fall 2007 reflected a concern as to how visitors with disabilities would be notified of emergencies and provided information about emergency procedures in the event of a disaster. Because the majority of visitors stay in hotels or lodgings regulated by statute, under Hawaii State law the hoteliers have a responsibility related to emergency situations and the welfare of hotel guests and to provide information to and evacuate their guests (including guests with disabilities), if necessary. All visitors, including those with disabilities, are not identified before they arrive in Hawaii, making advanced individual planning unrealistic. Visitor safety appears to be a recurring issue, and thus representatives from the Hawaii Hotel Association or the visitor industry will be invited to attend future Working Group meetings.

Appendix F

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

Background and progress to-date:

The Working Group has identified group living arrangements categorized in Attachment A that are licensed by the State of Hawaii 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, has shared it with providers and plans to incorporate it into future training. A concern was raised that nothing in State law allows the County Department of Emergency Management to enforce compliance by the health care facilities. Thus, DOH will continue ongoing efforts to ensure compliance. Currently, the City and County of Honolulu's Department of Emergency Management assists health care providers by providing 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.

SCD is currently reviewing 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. The focus is currently on fire safety. DOH will also work with DHS to ensure that guidelines are shared with DHS certified/licensed settings/agencies in order to develop consistency between both Departments. Through the collaborative efforts with SCD to provide education and training, as well as assessment

for sheltering in place, the community will be able to enhance awareness within a provider community that will be better prepared to address disasters and the care of their residents/consumers, etc., during any disaster.

To meet Objective 5.2 (and also Objective 2.2), DOH entered into a memorandum of agreement (MOA) with SCD to begin the process of training community based providers (also residents of these settings and family members of those residents) while simultaneously gathering data on their clientele and willingness to shelter in place. Training sessions have begun on Oahu and the contractor is hoping to complete training statewide by June of 2008. To date, over thirty-six (36) settings have received training. These have included assisted living facilities, adult residential care homes, Community Care Foster Family Homes, Developmental Disabilities Domiciliary Homes, Adult Foster Homes for the DD/MR, Therapeutic Living Programs and Special Treatment Facilities. After being informed of the criteria for sheltering in place, ten (10) facilities (including nursing homes) have indicated willingness and were referred to an engineer for follow up. The contractor has also provided attendees with documents and a CD to provide training for their staff, residents and family members to ensure awareness and the need for preparedness. SCD representatives will be making unannounced visits to a sampling of the providers to ensure that disaster plans have been developed and assess those facilities that have indicated an interest in sheltering in place.

Comments from Working Group members and community forum participants also reflected a need to outreach to groups in the elderly community, who might be living in settings which are not licensed by the state as a regulated health care setting, but nonetheless are vulnerable in the event of an emergency. Thus, a new Objective 5.3 was added to the 2008 Plan to address developing a method to assess privately owned residential settings for senior citizens to determine if sheltering in place is a viable option. Representatives from the Condominium Association Institute, Area Agencies on Aging (AAA), and Catholic Charities will also be invited to attend future Working Group meetings.

Appendix G

Goal 6: All notifications of pending emergencies and evacuation shall be accessible to persons with disabilities using multiple methods of delivery.

Background and progress to-date:

Notification of an impending disaster, time permitting, and the call to evacuate is initiated 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. However, the Working Group recognized that many people with cognitive or developmental disabilities may not understand the content of an announcement. For such individuals, dependence upon a caregiver, family, friend or social service/health agency is critical.

In the 2007 Plan, Goal 6 focused on notification to evacuate. In the 2008 Plan, Goal 6 was rewritten to reflect notification of pending emergencies in addition to an evacuation recognizing that most announcements do not reach the level of a formal evacuation notice. The Plan also recognizes that no single means of notification will be sufficient, nor reach all disability groups. Therefore, redundancy of effort is critical to successful notification of the target population. The fact that “no one system will meet the needs of all, but many systems will meet the needs of a majority” must be emphasized to reach many groups with diverse needs and abilities to receive and comprehend a message.

The needs of persons who are blind also have not been addressed adequately with current notification systems. When text is scrolled across the bottom of television screens, there is a beep to indicate a message is being scrolled on the screen. If the message is not also presented verbally it is in an inaccessible format to people with visual impairments. Scrolled messages should also be read aloud to ensure everyone has equal access to information presented at the same time. Objective 6.1 focuses on the provision of emergency information by the broadcast media. It was not clear if a change in the law to require how emergency information is provided must 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.

A significant challenge is how to reach the population of people who are deaf or hard of hearing who may not receive notification through the traditional means similar to the general population. To address the need of alternate telephone communication systems, as delineated in Objective 6.2, SCD has contacted DCAB for technical assistance regarding placement of appropriate equipment. In 2007, SCD obtained and installed a TTY on a dedicated phone line. Currently, appropriate placement for the TTY unit is being addressed. One option is to place it with the State Warning Point (SWP) in SCD. Once the correct placement of the unit is determined, follow up training to educate the staff about the use of the TTY and communication access will be provided by DCAB. County Civil

Defense Agencies have not contacted DCAB regarding procuring such equipment. The City and County of Honolulu's Department of Emergency Management is researching the use of a computer system that accepts TTY calls. However, if a computer TTY system is installed, calls made through the video relay service may slow down the operation of the equipment. Follow up needs to be made with the County Civil Defense Agencies.

People who are deaf and hard of hearing have options beyond the TTY to access telephone services with recent advances in technology. Those options include hearing carry over, voice carry over, video relay services, and video interpreter services. These options will continue to change with the development of technology. For these reasons prior 2007 Action Plan Objectives 6.5 and 6.6 were combined into a new Objective 6.4 to reflect "research to include new technology" to cover as many innovative approaches and advances as possible.

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, initially for first responders, is in the development phase. Whether the system will function for people who are deaf, hard of hearing or deaf-blind is not yet known. SCD initiated the pilot project in 2007 working with the new notification system. Of the initial five hundred (500) people, three hundred (300) slots are reserved for first responders, and two hundred (200) slots are designated for persons with disabilities. The program has various ways to notify people: e-mail notification that requires software to produce a pop-up notice on a computer screen; voice notification to voice or wireless (cellular) phone to send an SMS (short message system or text message) to a wireless phone a pre-scripted computerized message on the TTY of the registered user; and finally, sending a message to a pager. Currently, there are seventy-five (75) people registered in the area leaving one hundred twenty five (125) remaining slots for individuals with disabilities. The project will continue through 2008 with an opportunity for more people to register. Once registered, a person is registered permanently. Exercises or practice drills were being conducted in-house at SCD to refine the messaging system. Once SCD is comfortable with the system, monthly tests will be conducted with registered users. A predetermined date would be given to users to know when to expect messages. If the message is not received, the user will know something is wrong and inform SCD to make the correction. At the end of the project, SCD will determine if this is an effective means to notify people with communication disabilities of impending emergencies, and decide whether or not to continue and/or expand the project.

Any public announcements, made to alert the general public via the media (e.g., 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, the information 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. Graphics or pictograms should also be included for clarity to make the message understandable to persons with cognitive disabilities. Transmitting information in

accessible formats will ensure that everyone in the general public (with and without disabilities) is alerted to occurrences in the environment.

Input obtained during the October 2007 statewide forums included feedback that encouraged focus on people with cognitive disabilities when posting any type of notification or information. Messages should contain simple graphics or pictograms that would make the information understandable regardless of the individual's reading ability. Warnings and emergency notification with graphics would also make the message understandable to visitors to Hawaii who have limited English proficiency, thus improving the understanding of warnings for everyone. Objective 6.4 was thus developed to reflect this concern.

Additional input from the October 2007 forums reflected a consistent statewide sentiment that notification systems for the public at large, not just for persons with disabilities, was extremely inadequate. Thus, many suggestions focused on strengthening the infrastructure of the system as a whole (e.g., improved tower functioning, satellite communication systems, repair of nonfunctional sirens, additional back up generators for radio stations) and improved general notification systems (e.g., better use of road signs, care-a-vans, flashing street lights, Ham radio operations, bull horns, condominium owner associations, and neighborhood watches). Improving the overall system will trickle down to benefit persons with disabilities. As the community network becomes stronger and more knowledgeable, individuals with disabilities will have more people upon whom they can rely.

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 similar system will be established on Oahu. The County of Kauai is also investigating notification options. These notification systems cost between \$70,000 and \$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.

The County of Hawaii has been very innovative with alert systems being initiated. In 2007 a demonstration project called Project Lifesaver was instituted to track persons with Alzheimer's, Down's Syndrome, Autism or mental health issues or who tend to wander if unattended. Project Lifesaver uses a bracelet with an electronic tracking system that uses an FM signal to locate the wearer. The tracking range is only within a few miles of the device. Once the person is found, information from the device is connected to a computer that will list who to call once the individual is found. An active tracking device assists in locating the person quickly and can make the difference in saving a life. The County has ten (10) bracelets as part of a pilot project, and eight (8) bracelets have been assigned to individuals. In the event of an emergency, and if the person wanders off it would be easier for the person to be located if they were wearing a Project Lifesaver bracelet. The results of this demonstration project may have implications for how similar devices can be used during an emergency.

A concern raised by the Working Group was that people with disabilities and special health needs do not all have access to computers or wireless technologies being addressed in the objectives. If the person, the family member or caregiver does not have access to a radio, television or computer/wireless technology (due to finances or geography), then personal planning becomes more important. This re-emphasizes the point that individuals with disabilities and special health needs, their families and caregivers are ultimately responsible to make plans for their own safety and well being for emergencies and disasters that may necessitate evacuation or sheltering in place. This may need to include developing a local network system with neighbors or a natural support group.

Planning and preparing on a statewide level includes research and investigation of alternatives, even though everyone may not have access to all options. Responsible planning efforts need to involve as many viable alternatives as possible, and through the repetition using various methods; the message will hopefully reach as many individuals in the public as possible.

Appendix H

Goal 7: Individuals with disabilities or special health needs shall have an emergency evacuation transportation plan developed by themselves or their caregivers to implement in the event of notification for evacuation.

Background and progress to-date:

The 2007 Plan included a Goal 7 that placed the onus on each county to develop a plan to provide accessible transportation to and from emergency shelters. However, during the October 2007 statewide forums, it became clear that no transportation plans were being developed by government agencies for implementation during an emergency for either the general population or specifically for individuals with disabilities. In addition, 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. 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. Therefore, it is necessary for individuals with and without disabilities to include transportation to a shelter or safe haven as an integral part of their emergency readiness plan.

Community input continued to emphasize 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. To illustrate that transportation should be incorporated into individual emergency preparedness responsibilities, Goal 7 was amended to shift the focus back to the individual to include it as part of his or her personal plan. 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 may 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. In an emergency the county transportation agency would take direction from the County Civil Defense or Department of Emergency Management agency. All county transportation systems will revert under the control of the county emergency management departments. Many emergencies (e.g., flood, earthquake) will not offer significant information to provide advanced notice. When advanced notice is available (e.g., hurricane) transportation systems will operate until it becomes unsafe for both the drivers and the vehicles. Vehicles will most likely be

prioritized to transport stranded groups or areas and will not be able to respond to individual requests.

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.

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 to be 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).

Appendix I

Acronyms

ACRONYM	MEANING	DESCRIPTION
AAA	Area Agency on Aging	County agencies focusing on the needs of people who are elderly
ABR	Architectural Barrier Removal	Removal of physical barriers in an existing building that restricts access to the building for a person with a disability.
ADA	Americans with Disabilities Act	Civil rights law passed in 1990 to protect people with disabilities from discrimination in employment, state and county government services, transportation, services from private businesses, and telecommunication.
ARC	American Red Cross	Organization that was chartered to help relieve the suffering caused by disasters. Provides health and safety training to disaster volunteers who respond regularly to house and apartment fires, and are prepared for larger disasters like hurricanes, tsunamis, and floods.
ARCH	Adult Residential Care Home	Residences licensed by the State of Hawaii's Department of Health, Office of Health Care Assurance. Licensed homes can accept and care for adults with special needs.
CDC	Centers for Disease Control and Prevention	An agency of the U.S. Department of Health and Human Services that provided funds through their Public Health Emergency Preparedness Cooperative Agreement to support the statewide Emergency Preparedness Forums for persons with disabilities and special health needs. The CDC works to protect public health and the safety of people, by providing information to enhance health decisions, and promotes health through partnerships with state health departments and other organizations.

ACRONYM	MEANING	DESCRIPTION
CIL	Centers for Independent Living	A consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities; and provides an array of independent living services.
CMISB	Case Management and Information Services Branch	Provides outreach to the community, including community education and information to identify and provide necessary supports to individuals with developmental disabilities. Provides Home and Community-Based Services for individuals with developmental disabilities and mental retardation.
DDD	Developmental Disabilities Division	An agency within the State of Hawaii's Department of Health.
DHS	Department of Human Services	Provide programs, services and benefits, to empowering people who are the most vulnerable in Hawaii.
DOH	Department of Health	Protects and improves the health and environment for all people in Hawaii.
DOT	Department of Transportation	A State department in the Executive Branch of government that is responsible to plan, design, construct, operate, and maintain State facilities in all modes of transportation, including air, water, and land.
FEMA	Federal Emergency Management Agency	A federal agency that is part of the U.S. Department of Homeland Security responsible for the reduction of the loss of life and property and protect the Nation from all hazards, including an established location/facility in which local and State staff and officials can receive information pertaining to an incident and from which they can provide direction, coordination, and support to emergency operations. natural disasters, acts of terrorism, and other man-made disasters, by leading and supporting the Nation in a risk-based, comprehensive emergency management system of preparedness, protection, response, recovery, and mitigation.

ACRONYM	MEANING	DESCRIPTION
GIS	Geographic Information Systems	An information system used to input, store, retrieve, manipulate, analyze and map geographically referenced data or geospatial data. Can be used in planning and decision making for scientific investigation, resource management, and development planning.
HRS	Hawaii Revised Statutes	Codified Hawaii State laws passed by the State Legislature.
MOA	Memorandum of Agreement	A cooperative agreement in the form of a written document between parties to cooperatively work together on an agreed upon project or meet an agreed upon objective. May include money payment from one party to another.
SHN	Special Health Needs	For the purpose of this Plan, it is an individual who may have special health needs that require medical care or assistance beyond what the person can do for him or herself during an emergency.
SCD	State Civil Defense	The State agency responsible for preparation for and the carrying out of all functions, other than functions for which military forces are primarily responsible, to prevent, minimize, and repair injury and damage resulting, or which would result, from natural disasters or others caused by an attack.
TTY	TeleTYpewriter	Device that allows people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate. Allows the user to type text messages. A TTY is required at both ends of the conversation in order to communicate. Like a traditional modem for land-lines, a traditional TTY will only work on analog mobile phone networks, not digital. Therefore a special digital TTY mode must be used with digital mobile phones.

Appendix J

Glossary of Terminology

TERM/PHRASE	SCOPE	DEFINITION
Access or Accessibility	During readiness and notification of a disaster or emergency	People with various types of disabilities are included (instructed when needed), in planning for an emergency or disaster, and responsible agencies are familiar with and provide accessible alerts to the public, in order to ensure everyone is aware of the situation. Planning also includes ensuring that people with disabilities can enter, exit and receive services at designated public emergency evacuation shelters.
Accommodation	During readiness and notification of a disaster or emergency	In terms of emergencies and disaster, agencies responsible to assist people with disabilities in personal preparedness and notification are also responsible to ensure effective communication (i.e., provision of interpreters, print materials in alternate format, etc.) is occurring. Notifications on television stations should be captioned (and interpreted, if possible), and any crawl messages should be narrated. Making public emergency evacuation shelters accessible is also a government responsibility, and plans are being made and implemented. Accommodations for individuals to have equal access to services available at a public shelter are also being made, but are not yet operational. County transportation providers are currently working on plans regarding getting people with disabilities to and from public emergency evacuation shelters.
Action Plan	Interagency Action Plan for the Emergency Preparedness of People with Disabilities and Special Health Needs	A coalition of State, county and private agency representatives that convened to draft the "2006 Interagency Action Plan" to acknowledge the interests of people with disabilities or special health needs, and make it part of overall community efforts in planning, developing and responding to the entire community during an emergency or a disaster. The Plan is updated annually.

TERM/PHRASE	SCOPE	DEFINITION
Harden	“to harden a facility”	To reinforce a home or facility to protect it against hurricane force winds.
Notification	Systems used to alert the public of impending disasters or emergencies such as, sirens, television and radio announcements, text messages, pagers, digital signage, and the Internet.	Systems used to rapidly disseminate accurate emergency information before, during and after a disaster to protect life, to prevent or limit casualties and minimize chaos.
Pet	Pets provide companionship to many people, and are dependent on their owners for safety and wellbeing. Recent disasters have shown that many pet owners will not seek proper shelter if it means abandoning their pets.	Any domesticated animal (i.e., cat, dog, etc.) that is kept as a companion.
Pet friendly shelter	Act 117 from the 2006 Hawaii State Legislature requires the Director of State Civil Defense to operate and maintain emergency shelters during disasters to make suitable arrangements and accommodations for pets.	Administrative rules shall be promulgated, pursuant to Section 128-27, HRS, to establish criteria, requirements, conditions, and limitations for providing suitable arrangements and accommodations for the sheltering of pets in public shelters.
Preparedness	Actions taken to save lives before and during a natural disaster. It ensures people are ready for a disaster and respond to it effectively.	Requires figuring out what to do if essential services break down, developing a disaster plan, and practicing the plan. Preparedness activities include forecasting and warning systems, stocking an emergency preparedness kit with supplies, and knowing where the nearest emergency shelter is.
Readiness	Personal preparedness including actions that individuals take before a disaster or emergency strikes.	Actions taken by an individual to minimize the damage from a disaster or emergency to possessions and improves chances of survival.
Redundancy	Repeating, doing, or providing the same information to the public in various formats	Providing information through various modes of communication allows the majority of the public to receive emergency warnings in a manner that is accessible to the specific individual.
Retrofit	To add or change a facility or home to make it able to withstand a specific kind of wind force (Level III, IV or V hurricane).	To furnish with parts or equipment after the time of original manufacture.

TERM/PHRASE	SCOPE	DEFINITION
Reverse 911	Automated warning system from 911 to wired telephone numbers in a specific jurisdiction.	A company who purchased the software can purchase a database of telephone numbers from the phone company, overlay mapping on it, and set up the capability to call a lot of people at once on their home phone with a short voice message about the emergency and a warning to evacuate.
Service animal	An animal, in Hawaii it's usually a dog, individually trained to provide services for a person with a disability.	The ADA defines a service animal as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. Certification about the animal's training may not be requested as proof that the animal is a service animal. A service animal is not a pet, and per the ADA, a person with a disability who uses a service animal has the right to have the animal accompany them to most public places.
Shelter in place	When a person, family or group of individuals decide to stay at home through a disaster, instead of going to a designated shelter.	When sheltering in place, it is better to have a safe room installed for protection. If the facility is not certified as a shelter, it may be unsafe to stay in place.
Simulation	Planned activity to allow volunteers and the community to practice evacuating to an emergency shelter	Emergency shelter simulations for Level I (general) shelters, pet shelters and Level II shelters were conducted by State and County Civil Defense agencies in conjunction with American Red Cross this year. Practicing evacuating to an emergency shelter in the community provides everyone involved the opportunity to practice what is planned (similar to a fire drill). It allows the volunteers to interact with people with disabilities and special health needs coming into a shelter, as well as people with disabilities to know what to expect at an emergency shelter and what types of information to bring with them. It also provided the American Red Cross and State Civil Defense to better plan staffing ratios needed in similar shelters.