

# Reaching Vulnerable Populations in Public Health Emergencies

**Augusta, Maine • April 10, 2007**



CONFERENCE PROCEEDINGS

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**Reaching Vulnerable Populations  
in Public Health Emergencies**

Conference Proceedings  
Augusta, Maine  
April 10, 2007





Dear Colleague,

On behalf of the Maine Center for Public Health, the Maine Center for Disease Control and Prevention, and the Harvard School of Public Health Center for Public Health Preparedness we would like to thank you for your interest in the Maine statewide conference, **Reaching Vulnerable Populations in Public Health Emergencies**, held on April 10, 2007 in Augusta, Maine. Convening this event was an important step in enhancing our public health infrastructure to support vulnerable populations during an emergency and has led to new collaborations, the development of community partnerships, and a greater engagement in preparedness planning for all those involved.

As part of the follow-up to the conference, the Maine Emergency Management Agency invites you to participate in a series of regional workshops aimed at improving the emergency preparedness of people with disabilities and the elderly. We strongly encourage you to attend. We also ask that you continue to highlight the lessons learned from the conference by sharing these proceedings with your colleagues, family, and friends.

Thank you again for your commitment to public health preparedness and to protecting the lives and health of all our community members in times of emergency. We look forward to working with you again on future initiatives that serve Maine's vulnerable populations.

Regards,

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The conference planning committee was formed by members of the *Statewide Training Committee for Medical, Behavioral, and Public Health Emergency Preparedness*, and representatives of organizations that serve vulnerable populations. The *Statewide Training Committee for Medical, Behavioral, and Public Health Emergency Preparedness* is comprised of representatives from key agencies involved in emergency preparedness planning in Maine. The committee meets quarterly to determine opportunities for collaboration, and also organizes the annual statewide conference on public health preparedness, of which this year's theme was vulnerable populations.

**The planning committee would like to thank the following Americorp volunteers for recording notes at the conference:** Rye Hagerlin, Caity Hager, Carrie Kindleberger, Liz Macotte, Joyce Mathews, Stephanie Miller, Jamie Standish, and Kristen Wagner.

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## EXECUTIVE SUMMARY

On April 10, 2007, representatives from over 120 community-based organizations and leaders in emergency management and public health convened at the Augusta Civic Center, in Augusta, Maine, for the statewide conference, *Reaching Vulnerable Populations in Public Health Emergencies*. The conference was sponsored by the Maine Center for Public Health, the Maine Center for Disease Control and Prevention, and the Harvard School of Public Health Center for Public Health Preparedness as part of a series of broad-based, collaborative initiatives intended to improve Maine's overall response capacity.

The conference aimed to assist participants with the integration of provisions that safeguard the lives and health of vulnerable populations into standard emergency response plans. The conference also presented a unique opportunity for members of Maine's public health and emergency response communities to come together with representatives of community-based organizations and service providers to share experiences, resources, and lessons learned, as well as to develop new partnerships and programs to enhance preparedness planning for vulnerable populations.

The agenda for the day included a historical perspective on emergencies and vulnerable populations, as well as presentations on state and local strategies to improve emergency planning for vulnerable populations. Additionally, six breakout groups were held in order to identify barriers to preparedness, and also potential strategies to overcome these barriers, for specific vulnerable groups. These vulnerable groups included: cultural/geographic isolation, disabilities, economically disadvantaged, elderly, limited language proficiency, and youth. Breakout discussion items were then reported back to the larger conference group, which offered suggestions for future directions of emergency management planning in Maine.

This report attempts to capture the scope of knowledge, challenges, and experiences reflected by participants and staff at the conference by summarizing both the large-group and breakout sessions, as well as addressing key themes raised during the day. These themes include: the necessity of developing universally accessible services and systems, building trust between the response community and vulnerable populations, involving vulnerable populations in planning and response, and empowering individuals to personally prepare.

Qualitative methods, including notes recorded at the symposium and follow-up interviews with discussion-group facilitators, were used to create these proceedings. The information contained in these proceedings is what was presented by the panelists and speakers at the conference. Their sources were not identified.

During late August 2005, as Hurricane Katrina devastated the Gulf Coast, the nation was awakened to a great inequity in emergency preparedness planning for vulnerable populations\*. The hurricane displaced hundreds of thousands of people, and claimed more than 1,200 lives in New Orleans alone. Strikingly, 74% of the deaths were persons over the age of 60, and 50% were over the age of 75. This was despite the fact that elderly residents constituted less than 12% of the total population (AMA, 2006). In the storm's aftermath, reports came to light of how the elderly, and other at-risk groups, were unable to evacuate the city or access emergency services for reasons related to chronic illness, disability, and financial constraints. Due to oversight or neglect, there existed no formal mechanisms for reaching out, or ensuring assistance, to the increasingly vulnerable segments of the population, resulting in their unnecessary harm and suffering (NCD, 2006).

No community is immune to disaster and Hurricane Katrina was a powerful lesson for the entire nation on the need for more accessible and inclusive emergency response plans and services. In Maine, where the elderly comprise approximately 14% of the state's total population (the highest percentage in the country), 12% of the population lives below the federal poverty line, and 20% of the population has a disability, developing programs and partnerships that support emergency preparedness planning for vulnerable populations is now a high priority among members of the emergency management and response communities (US Census Bureau, 2005). As part of a series of initiatives, the Maine Center for Public Health (MCPH), in collaboration with the Maine Center for Disease Control and Prevention (Maine CDC), and the Harvard School of Public Health Center for Public Health Preparedness (HSPH-CPHP) sponsored a statewide conference entitled, **Reaching Vulnerable Populations in Public Health Emergencies**. The event was held on April 10, 2007 at the Augusta Civic Center in Augusta, Maine.

A total of 200 participants, representing more than 120 different organizations from across the state, attended the day-long event. The audience was comprised of local and state leaders in emergency man-

agement and response, including members of the public safety, public health, and healthcare communities. Additionally, representatives of community-based organizations and providers serving Maine's vulnerable populations, such as long-term care facilities, group homes, visiting nurses associations, community health centers, social service agencies, and advocacy organizations, attended the conference (See Appendix A: Participant List).

The conference aimed to assist participants with the integration of provisions that safeguard the lives and health of vulnerable populations into standard emergency response plans by:

- Identifying the unique impact past disasters have had on vulnerable populations;
- Identifying emergency needs and considerations of at-risk populations in their communities;
- Identifying local resources, agencies, and organizations to participate in emergency preparedness planning for vulnerable populations;
- Promoting the welfare of vulnerable populations during emergencies.

The agenda for the day included a historical perspective on emergencies and vulnerable populations, as well as presentations on state and local strategies to improve emergency planning for vulnerable populations. Additionally, six breakout groups were held in order to identify barriers to preparedness, and also potential strategies to overcome these barriers, for specific vulnerable groups. Breakout discussion items were then reported back to the larger conference group, which offered suggestions for future directions of emergency management planning in Maine.

\* In the context of emergencies and disasters, the terms "vulnerable" or "at-risk" populations are used to describe community members unable to access or utilize the traditional resources available in an emergency. Vulnerable populations can include, but are not limited to, persons who are physically or mentally disabled, medically-compromised, shelter dependent, culturally or geographically isolated, low-income, or have a limited ability to read or speak English.



*Symposium participants listened to morning plenary sessions including Ms. Hilary Styron's keynote address: Historical Perspective on Emergencies and Vulnerable Populations.*

**A. Welcome and Introductions**

**Commissioner Brenda Harvey**, Commissioner of the Maine Department of Health and Human Services (Maine DHHS) began the conference by reflecting on the critical importance of emergency planning for the state of Maine, and in particular for vulnerable populations. She stated that the Maine DHHS is committed to preparedness planning for all, and that while the needs of the state may seem to have outstripped its available resources, emergency preparedness planning has inspired efficiency and creative thinking within the department. Commissioner Harvey also asserted that serving vulnerable populations is everyone's responsibility and that with its well-defined state and regional planning structure, the state of Maine is poised to enhance preparedness planning for vulnerable populations. Before ending her address, Commissioner Harvey thanked the planning committee for the privilege of introducing the conference and commended the audience on their participation.



*Commissioner Brenda Harvey, Commissioner,  
Maine Department of Health and Human Services*

**B. Historical Perspective on Emergencies and Vulnerable Populations**

**Mr. Don Ward**, of the Maine CDC, introduced the keynote speaker, **Ms. Hilary Styron**, Executive Director of the Emergency Preparedness Initiative (EPI) within the National Organization on Disabilities (NOD). Ms. Styron began her presentation by asking how many members of the audience

had a personal preparedness plan (a minority of participants raised their hands). She then asked how many participants had a preparedness plan at work (a majority of the participants' hands were raised). Ms. Styron remarked that the amount of hands raised were typical for conferences and meetings at which she has presented and asked the audience at what point did their life at home, versus work, become less valuable. She then cautioned the audience that despite the presence of an organizational plan, if they are not prepared at home, then they are not prepared at work.



*Ms. Hilary Styron, Executive Director, Emergency Preparedness Initiative, National Organization on Disabilities*

Ms. Styron stated that no community is immune to disaster and highlighted recent emergencies, including ice storms and severe floods, that have impacted the state of Maine. She then shared the story of her organization's inception following the events of September 11th, and the stark realization that the response community was unprepared to meet the needs, both immediate and long-term, of persons with disabilities. Today, her organization seeks to ensure that community advocates, community-based service providers, and individuals with special needs and disabilities are included in the four phases of emergency management: mitigation, preparedness, response, and recovery, as they best know what their needs are and how they should be addressed in an emergency.



Maine floods. Photograph courtesy of NOD.

Ms. Styron next shared the results of a Harris survey, conducted by EPI in 2003, 2004, and 2005, regarding the preparedness of persons with disabilities.

- In 2003, 44% of persons with disabilities knew who to contact about home and workplace emergency plans.
- In 2005, post-Katrina, 54% of persons with disabilities knew who to contact about home and workplace emergency plans.
- In 2004, 76% of emergency managers did not have a paid expert to plan for special needs issues, and 73% of emergency managers reported that no funding had been made available to address special needs issues.
- In 2004, 42% of emergency managers had a public awareness campaign for people with disabilities, however only 3% of these emergency managers said materials were available in alternative formats.

Ms. Styron urged the audience to improve preparedness efforts for those individuals who may be less prepared through outreach and education initiatives. She informed the audience that the FY07 Urban Area Security Initiative Grant Guidance includes language for special needs planning and may serve as a potential funding source to address planning issues for vulnerable populations.

Ms. Styron also emphasized the importance of developing public awareness materials that are available in multiple, accessible formats, and that include useful and appropriate content for vulnerable populations. She suggested that generalized advice such as “run, duck, and cover” is not applicable if a person is a wheelchair user or is visually-impaired. Similarly, when horns are used to gain a crowds’ attention, individuals who are deaf or hard-of-hearing are not effectively reached. Ms. Styron asserted that without comprehensive information and an accurate understanding of their options, individuals are not empowered to make decisions about their lives and health in an emergency.

Throughout her presentation, Ms. Styron discussed the impact of specific disasters on vulnerable populations and highlighted lessons learned from her own experience in emergency preparedness planning. She began by discussing the 1989 Loma Prieta Earthquake.

- Persons with disabilities did not receive as many earthquake-related preparedness materials as did persons without disabilities.
- There was a critical need for water, however persons with disabilities were unable to stand and wait in long supply lines.
- Shelters lacked the capacity to treat individuals with disabilities and did not stock life-sustaining medications for chronic conditions.
- Temporary housing (i.e. travel trailers and mobile homes) were inaccessible.
- Persons, in general, did not know where to go to receive information on disaster housing and/or relief services.
- Responders and volunteers at the disaster recovery centers were unfamiliar with how to properly support or assist persons with disabilities.

Ms. Styron recommended that communities implement multiple systems to distribute critical resources such as food and water for persons with limited mobility, and cautioned the audience that people have disabilities both hidden and obvious. Persons who seem able-bodied may in fact not be able to stand in lines for long periods of time.

Ms. Styron stated to the audience that the Strategic National Stockpile does not contain general medications, and likely never will. She indicated conversations regarding continuity of medications during an emergency have occurred since 1989 and there is yet to be a successful solution. Therefore, she said it is incumbent upon the response community to educate persons to carry their medications with them in an emergency.



*Man evacuates his home during Hurricane Katrina, leaving behind all of his possessions with the exception of his medications. Photograph courtesy of the NOD.*

Ms. Styron also emphasized the need for behavioral awareness and sensitivity training among shelter staff. She suggested that interpersonal relations are critical to shelter accessibility.

Ms. Styron reiterated that many persons will be unable to access aid or assistance unless multiple forms of communication and outreach are implemented within shelters. She recommended shelter and care sites employ teletype writers (TTY) and televisions with closed-captioning, in addition to broadcasting and posting announcements over intercoms and in designated spaces.

Ms. Styron next discussed the impact of Hurricane Andrew in 1991 on persons with disabilities.

- Persons who were deaf and hard-of-hearing were not alerted by the emergency broadcast system and did not evacuate.
- Transportation plans for universally accessible evacuations did not exist.

Ms. Styron described how the devastating effects of a lack of accessible transportation were witnessed again during Hurricane Katrina, more than a decade after it was first recognized as an issue in the aftermath of Hurricane Andrew. She implored the audience to develop evacuation plans, as well as outreach services, to assist persons with disabilities during a disaster. She recommended the audience begin by assessing their existing capabilities and transportation mechanisms, as well as assessing what resources can

be leveraged in an emergency. She recognized that many communities are not resource-rich, and therefore encouraged communities to plan for acquisition of resources through mutual aid and collaboration.

Ms. Styron also shared a positive example of preparedness planning involving persons with disabilities. Following the World Trade Center bombings in 1993, the Associated Blind of New York (a local service provider for low- and no-vision persons) worked with the New York Fire Department to develop a building evacuation plan and practice regular drills with their clients. On September 11<sup>th</sup>, when the lights went out in the twin towers, Associated Blind members knew how to evacuate and were able to assist their fellow colleagues.

Ms. Styron continued her historical perspective on vulnerable populations and emergencies by discussing the 1994 Northridge Earthquake and the 1997 Minnesota Red River Floods.

#### Northridge Earthquake

- Many persons with disabilities were refused access to American Red Cross (ARC) shelters.
- Shelter staff assumed individuals with disabilities had medical conditions. Persons were inappropriately triaged and sent to hospitals, increasing the surge in patients and thus decreasing the capacity of hospitals to effectively respond to true emergencies.

#### Minnesota Red River Floods

- Persons with disabilities experienced many barriers, including inaccessible disaster relief centers, and temporary housing.
- Disaster relief materials were unavailable in alternative formats and did not meet Federal Communications Commission's (FCC) requirements for accessible information.



*A mass shelter after the Red River Floods.  
Photograph courtesy of the NOD.*

Ms. Styron next highlighted both the importance of including vulnerable populations in regular exercises and drills, as well as the importance of personal preparedness and responsibility, by sharing an example of workplace un-preparedness. In 2001, Mr. Paul Ray, a contract programmer who was quadriplegic, had worked at the Ford Motor Company for 18 months, when his office had its first fire drill. When the fire alarms went off, Mr. Ray, who worked on the second floor, went to the elevator bank. There, he learned that the person in charge of safety for the building did not know he worked in the facility and did not have an evacuation alternative to stairs.

Ms. Styron encouraged the audience to revisit their work plans and make provisions to include persons with disabilities. Ms. Styron also encouraged the entire audience to take responsibility for their preparedness planning and to self-identify if any special accommodations are needed for oneself during an emergency.

Ms. Styron next discussed the preparedness challenges of the 9/11 and the 2003 California Wildfire emergencies, and their unique outcomes on persons with disabilities.

#### 9/11

- Many television broadcasts were not accompanied by visual reports; scrolling messages were oftentimes blocked.
- An increased rate of captioning errors due to high anxiety and long working hours made it necessary for deaf and hard-of-hearing persons to decode and unscramble the emergency information.

- Flashing lights were not accompanied by audio announcements.
- The inability to use TTY, amplified phones, and other equipment dependent on electricity was problematic for many deaf and hard-of-hearing individuals.
- A national Reverse 911 phone-based public warning system with TTY capability was not used.
- One man's final image as he left the 80th floor of the World Trade Center and escaped to safety, was that of a room full of people using wheelchairs and walkers waiting to be rescued. These persons did not make it out of the building.
- Translucent tape previously installed at the Pentagon to help employees and visitors with low vision evacuate the facility made it possible for dozens of individuals with sight to flee the smoke-filled corridors.

### 2003 California Wildfires

- Visual images often did not include printed names of specific areas and neighborhoods.
- The lack of captioning kept many people with hearing impairments from appreciating the danger.
- Many broadcasters were fined by the FCC.
- Persons with hearing impairments were unaware of evacuation announcements from patrol cars and bullhorns.
- Emergency housing and shelters were inaccessible.

Ms. Styron expressed frustration that similar mistakes regarding vulnerable populations are made during each and every disaster, and that the lessons learned are very rarely integrated into emergency preparedness planning.

Ms. Styron next described and promoted the principle of *Universal Design*, which is to design and produce products that promote equal opportunity for use by individuals with or without disability. Examples of universal design include the implementation of:

- Multiple modalities of communication including interpreters, TTY, Reverse 911, captioning, and Communication Access Realtime Translation (CART) services;
- High-visibility signs that are well-lit and contain pictures which can be easily understood;
- Accessible shelters, dispensing sites, housing, etc. that are compliant with the Americans with Disabilities Act (ADA).

Ms. Styron also shared statistics on the percentage of non-institutionalized persons age five and older with a disability in each of Maine's counties.

Statewide - 18%  
 Androscoggin - 22.4%  
 Aroostock - 25.2%  
 Cumberland - 17.1 %  
 Franklin - 19.8%  
 Hancock - 19.1%  
 Kennebec - 21.0%  
 Knox - 17.4%  
 Lincoln - 19.8%  
 Oxford - 21.8%  
 Penobscot - 19.5%  
 Piscataquis - 26.3%  
 Sagadahoc - 18.3%  
 Somerset - 22.3%  
 Waldo - 19.8%  
 Washington - 27%  
 York - 18.9%

Ms. Styron indicated that these are very high percentages. She then recommended that if the audience was unfamiliar with these numbers, that they immediately visit [www.census.gov](http://www.census.gov), as well as work with disability advocates present at the conference. She said it is imperative that emergency planners have an understanding of the vulnerabilities present in their community.

Ms. Styron also shared images of Hurricane Katrina, offering observations as well as recommendations for emergency preparedness planning initiatives, based on her experience as a member of the Special Needs Assessment for Katrina Evacuees (SNAKE) team.

- **Hurricane Katrina was a national emergency.**

- It was an overwhelming experience not just for residents and volunteers along the Gulf Coast, but also for persons in receiving states.
- The hurricane surged resources across the country.

- **The most underserved group was the deaf and hard-of-hearing. Persons were repeatedly traumatized as a result of not being able to communicate for an extended period of time.**

- 80% of shelters did not have TTY's.
- 60% of shelters did not have TVs with open caption capability.
- Only 56% of shelters had areas where oral announcements were posted.
- Less than 30% of shelters had access to American Sign Language (ASL) interpreters.
- Positive shelter developments were announcements made both orally and visually and shelter managers that designated a resource board, of which they have control, to place special announcements and emergency information.



A deaf section and resource board were established within the Reliant Astrodome Complex after Hurricane Katrina. Photograph courtesy of the NOD.

- **During Hurricane Katrina, 85.7% of community-based elder and disability service providers did not know how to access the emergency management system. 54% of shelter operators did not have any working agreements with a disability or aging-specific organization.**

- **Many individuals were unable to evacuate for reasons related to mobility impairments, caring for family members, lack of transportation, and fear or mistrust of services.**

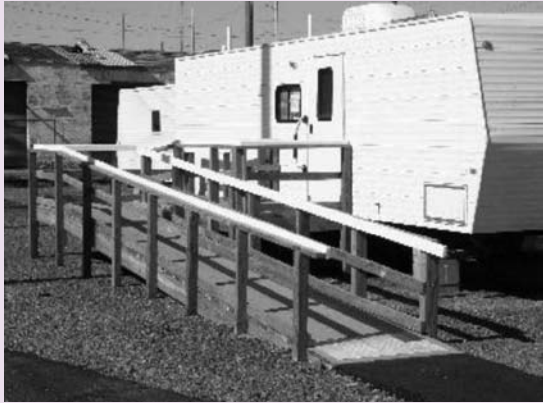
- Educate the public about the meaning of both voluntary and mandated evacuations.
- Determine policies for persons who refuse to evacuate.



Many home healthcare patients were unable to follow the evacuation order for New Orleans. Photograph courtesy of the NOD.

- **Only five percent of the temporary housing provided by the Federal Emergency Management Agency (FEMA) was accessible to persons with disabilities, while more than 25% of the population was in need of accessible housing.**

- Following an Alabama lawsuit, the amount of accessible shelters has recently increased to seven percent.
- Providing accessible facilities is a matter of law. As an emergency manager, one should become familiar with the ADA. A guide for state and local governments about how the ADA applies to emergency management is available online.



Accessible versus non-accessible temporary housing. Photographs courtesy of the NOD.

- **Residents and clients of nursing homes and assisted living facilities were abandoned during Hurricane Katrina.**

- ❑ Hospitals, nursing homes, and assisted living facilities must develop emergency plans, which include pre-established relocation facilities and transportation providers, to protect their patients, residents, and clients in the event of an emergency. Failure to provide these services amounts to medical negligence.
- ❑ As they are often relied upon to assist during an evacuation, a community's emergency manager also bears responsibility for ensuring hospitals and long-term care facilities have emergency plans in place. As an emergency manager, one should: identify the locations of nursing homes, assisted living facilities, and hospitals within their community, conduct outreach and technical assistance for long-term care facilities regarding their

plan development, and review long-term care facilities' emergency response plans for gaps, duplications, and consistency with emergency management agencies.

- **Major mental health issues were present for both community residents and emergency responders. First responders, clinicians, and individuals involved in the response were emotionally overwhelmed by what they were seeing and experiencing.**

- ❑ Integrate mental health professionals and "psychological first aid" into planning.
- ❑ As an emergency responder, one must take care of one's self as well as others during an emergency.



Nursing home patients were abandoned in a parking garage during Hurricane Katrina. Photograph courtesy of the NOD.



Emergency responders take a moment during the relief process. Photograph courtesy of the NOD.

- **Scarce resources contributed to overcrowding, a lack of privacy, and even criminal activity in the shelter environments.**

- ❑ Onsite security must be provided at shelters, emergency dispensing sites, and disaster recovery centers.

Ms. Styron also emphasized the importance of leveraging assets and building partnerships for resource sharing, and offered several recommendations for how this might be accomplished.

- **Centralize resources for a mass care situation and develop special needs resource centers.**
- **Integrate vulnerable populations' personal support networks into community-wide planning, including families, advocacy groups, and community-based organizations by:**
  - ❑ Developing Memorandums of Understanding (MOU) and mutual aid agreements with community-based organizations and service providers to assist with patient evacuation, sheltering, and healthcare in an emergency;
  - ❑ Utilizing the Voluntary Organizations Active in Disaster (VOAD) system;
  - ❑ Educating community-based service providers about how to access the local emergency management agency.

During her comments on Hurricane Katrina, Ms. Styron asserted that assets should not be pre-positioned if there is a risk of emergency since they are likely to be lost during a flood or other disaster. She also asserted that public safety officials need training and education about working with persons with disabilities.



*An ambulance washed away during Hurricane Katrina. Photograph courtesy of the NOD.*



*Persons with disabilities can participate in a variety of emergency response activities. From left to right: a decontamination drill includes persons with disabilities; a group of deaf women assist with data entry at a disaster recovery center. Photographs courtesy of the NOD.*



*Miami Herald photograph of New Orleans police officers forcing two young men to face down while attempting to discover if they are armed before allowing them to proceed past Paris Avenue of exit I-10. The men are trying to explain that they are deaf and need to look up and read lips to communicate. Photograph Courtesy of the NOD.*

Ms. Styron next commented on a nationwide plan review conducted by EPI. She revealed that not one city or state across the country has an adequate or effective plan addressing special needs populations.

Ms. Styron encouraged the audience to review the National Response Plan for which the federal government is currently soliciting feedback. She suggested that as experts in the fields of emergency planning and/or serving at-risk persons, their feedback has the potential to enhance national plans for vulnerable populations.

Ms. Styron also described ways in which persons with disabilities can serve as emergency responders, including volunteering as a member of a community's Medical Reserve Corp (MRC) or Community Emergency Management Team (CERT). She stated that it is important to empower persons with disabilities to prepare by including them in both the planning process and in functional exercises. She stated that this is also an educational opportunity for the response community.



Ms. Styron concluded her presentation by encouraging the audience to become agents of change, and to truly commit time and resources towards developing emergency tools and response protocols for vulnerable populations. She charged members of the response community in the audience with the greater inclusion of persons with disabilities, and other vulnerabilities, in all phases of emergency management. She also reminded the audience they took an oath to serve and protect and that this holds especially true during a disaster, even when it may be inconvenient to their lives or loved ones. She also charged persons with disabilities to take action to protect oneself in an emergency and to collaborate with the emergency management and response community. She stated that community plans cannot be perfectly customized and that it is also the individual's responsibility to make a plan. Finally, she indicated that strengthening the partnerships between vulnerable populations and the response community will improve the nature, sensitivity, and quality of response for all people in times of emergency.

### C. Maine Statewide Strategies to Improve Preparedness for Vulnerable Populations

Mr. Ward next introduced **Dr. Dora Mills**, Director of the Maine CDC, who provided a brief overview of past emergencies in Maine and their impact on vulnerable populations, as well as current emergency planning initiatives at the state level.

Dr. Mills began her presentation by sharing the story of a deaf man named "Red" and his experience during the flooding of the Kennebec River in April of 1987. The disaster was one of the worst in the state's history, with the river rising over 35 feet following days of rainfall and melting snow. The disaster resulted in more than 200 million dollars worth of damages for the state and 215 destroyed homes. At the time of the emergency, the state had yet to develop a closed captioning system for emergency broadcasts, and consequently Red was not alerted to the evacuation notices. When water poured through the first floor of his home, he moved to the roof, residing there for the night. The next morning he waded his way to a neighbor's for help, his home having been destroyed by the flood.

In the weeks following the disaster, Red attempted to seek assistance from the state. However, state

agencies were unprepared to provide services to a deaf person. He was left to wait hours in lines, often ignored or pushed aside, and became increasingly frustrated by the difficulty in communicating with officials. Dr. Mills asserted that it was the system that was disabled, not Red, and that his experience highlights the importance of identifying vulnerable persons prior to an emergency, ensuring that multiple modalities of communication exist before, during, and after an emergency, and incorporating vulnerable persons into the planning process.

Dr. Mills stated that while Maine has made substantial improvements related to emergency preparedness over the last 20 years, including the relocation of homes from flood plains, training for code enforcement officers on flood plain management, and the more commonplace use of interpreters, TTY, and closed captioning, there is still much to be done for vulnerable populations. Dr. Mills next shared another example of a Maine emergency and its unique impact on vulnerable populations.

Dr. Mills stated that during the 1998 ice storm, communication towers were impacted across the state, including the emergency broadcast system, making it difficult to warn or prepare most of the population. Utilizing radio lines, the state implemented volunteer phone banks and a reverse 911 system to locate individuals in need of assistance and to ensure people were provided necessary information and resources. Neighbors called in donating goods and services, and volunteered to check on persons in need. Dr. Mills stated that while this response effort helped a great deal of people it still was not accessible to all. The incidence of Carbon Monoxide poisoning increased during the storm, particularly among the elderly, due to the misuse of basement generators. Two elderly individuals died, and another 275 persons were admitted to Maine emergency rooms for documented carbon monoxide poisoning. In the event of a future emergency requiring a phone bank, Dr. Mills indicated that they would employ both a TTY line and interpreters, as well as work in coordination with 211 to distribute emergency information.

Dr. Mills stated that emergency managers across Maine must be aware of the vulnerabilities that exist throughout the state and went on to describe vulnerable groups.

- Maine is the “oldest” state in the country, in terms of the oldest median age and the highest proportion of people over the age of 65.
- Maine is home to a number of new immigrants from Somalia, Southeast Asia, and Latin America who face both cultural and linguistic barriers.
- Maine has a significant population of Native Americans.
- Maine ranks among the poorest states in the nation, with many persons living below the federal poverty line.
  - ❑ Washington County has the greatest percentage of households (20%) in poverty.
  - ❑ Cumberland County has the greatest number of households (9000) in poverty.
- 1 in 5 Mainers has either a developmental, sensory, mental, and/or physical disability.
- 1 in 10 Mainers are addicted to or abuse alcohol and drugs.
- 1 in 10 Mainers experience frequent mental distress.

Dr. Mills stated that vulnerabilities such as age, disability, poverty, and limited English proficiency, are not only ubiquitous, but often overlapping and requiring specific strategies. She then suggested all persons, including emergency managers, closely examine themselves and their families in order to gain a greater appreciation of less obvious vulnerabilities. Dr. Mills expressed how she had previously not considered her or her family vulnerable, but realized both her elderly mother and children may experience difficulties if she was not with them at the time of an emergency.



*Dr. Dora Mills, Director, Maine CDC*

She encouraged emergency planners to develop strategies to reach the greatest amount of people during a crisis. She also suggested that when developing preparedness materials, emergency managers consider whether persons can see, hear, and understand the messages, as well as take the actions necessary to protect their health and safety. She also encouraged emergency management to collaborate with and integrate community-based agencies into community plans.

Dr. Mills described state actions to integrate vulnerable populations in emergency preparedness efforts, including:

- The development of tracking systems to identify at-risk individuals, such as voluntary registries;
- The promotion of cultural diversity training and language access training;
- The development of continuity of operation plans at the Maine DHHS to assure safety net services, including the Women, Infants, and Children (WIC) program and food stamps, are available in an emergency;
- The establishment of the Offices of Minority Health and Disaster Behavioral Health Services within the Maine DHHS.

Dr. Mills also stated that the Maine CDC is taking steps to enhance the state's public health infrastructure, including regionalizing epidemiology services and upgrading laboratory functions, to ensure early detection and effective response in the event of an emergency.

Dr. Mills next asserted that providing for vulnerable populations in an emergency requires cooperation and planning at the federal, state, local, familial, and individual levels. She strongly encouraged personal preparedness, including exercising disaster plans and confirming systems are in place to assist oneself during an emergency. She stressed it is everyone's responsibility to make certain that vulnerable persons are prepared, and if they are prepared, the state of Maine as a whole is better prepared.

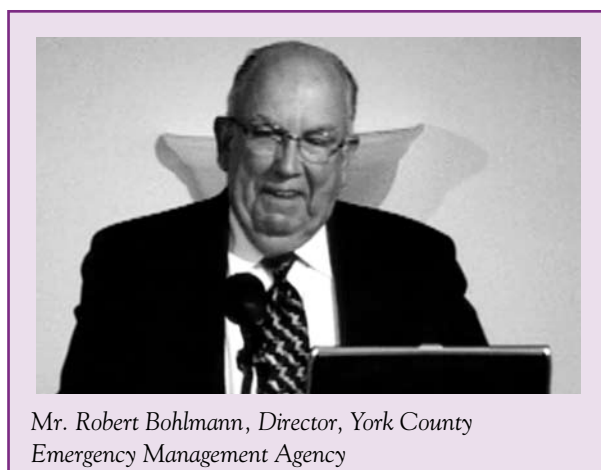
Dr. Mills concluded her presentation by stating that actions speak louder than words, and asked the audience to leave the conference determined to engage their family, friends, neighbors, and colleagues in preparedness planning.

#### D. Improving Preparedness for Vulnerable Populations at the Local Level

**Ms. Pam L'Heureux**, Assistant Director of the York County Emergency Management Agency (YCEMA), introduced two leaders in local emergency preparedness planning: first, **Mr. Robert Bohlmann**, Director of the YCEMA and Maine Liaison to the International Association of Emergency Managers, and second, **Ms. Julia Bell**, Executive Director of the Maine Council on Disabilities and member of the Developmental Disabilities Council.

Mr. Bohlmann began his presentation by stating that all emergency management and response begins at the local level, and asserted that identifying and reaching vulnerable populations are local responsibilities. Mr. Bohlmann encouraged local emergency planners to undertake initiatives to locate vulnerable members of their communities, and enhance plans to accommodate their needs. He acknowledged that the perfect plan does not exist and advocated that after every disaster emergency management agencies update their plans to reflect lessons learned.

Mr. Bohlmann next discussed the roles and responsibilities of local emergency management agencies and provided action items for local emergency managers to implement in their communities. He first suggested that emergency management officials identify likely hazards in their community and plan appropriately. For example, in Northern Maine, local communities are unlikely to be impacted by tsunamis, but are likely to face ice storms. Mr. Bohlmann recommended



*Mr. Robert Bohlmann, Director, York County  
Emergency Management Agency*

developing an all-hazards plan with addendums for specific geographic emergencies.

He also advocated for the inclusion of community-based organizations and advocacy groups in emergency planning efforts, suggesting that while members of the response community are experts in emergency management, they are not experts on the needs of vulnerable populations. Mr. Bohlmann commented that in his experience, advocacy groups and care centers are very supportive of emergency management and planning efforts. He then stated that the most important role of emergency management is to act as the coordinating agency and bring key stakeholders together.

Mr. Bohlmann also recommended that local emergency managers construct a gap analysis or assessment to determine needed services, as well as identify available resources, in an emergency. He suggested that Maine's resources are more far-reaching than often given credit, and that while many people bemoan their lack of assets compared to that of a city's, small communities are better able to know and manage their population in an emergency.

Mr. Bohlmann urged local emergency managers to set an example for the community and develop a personal preparedness plan.

Mr. Bohlmann next discussed the responsibilities of community members in preparedness planning for vulnerable populations. He recommended communities assist in the identification of vulnerable populations and the development of needs assessments. He encouraged persons who require extra assistance in an emergency, as well as long-term care and group

facilities, to self-identify themselves to emergency management. He reminded the audience that as emergency managers they are unable to address the needs of individuals if they are unaware that those needs exist. He also stressed the importance of keeping such information confidential. Similar to previous speakers, Mr. Bohlmann emphasized the need for personal preparedness. He encouraged persons to develop a home plan and exercise it regularly.

In conclusion, Mr. Bohlmann encouraged emergency management and community-based organizations to work together to provide input and develop comprehensive, community-wide plans. He felt both sides must be willing to be open, to disagree, and come together for discussion regarding emergency planning for vulnerable populations. He emphasized that building relationships and partnerships, utilizing expertise, and sharing resources are the keys to success in emergency response. To highlight his point, Mr. Bohlmann shared a story of how during a snowstorm he reached out to a local organization to assist with the evacuation of wheelchair-bound residents from an assisted living facility. A MOU was previously in place and the plan was implemented effectively. Before leaving the stage, he requested that the audience members share their lessons learned with his agency and commended them on their attendance at the conference.

Ms. Bell then spoke about her experiences relating to emergency preparedness as both a member of a government agency, and as a member of disability non-profit and advocacy organizations at the local, state, and federal levels. Ms. Bell began by describing how her interest in disability advocacy developed at age 12 when she witnessed discrimination and differential treatment towards her peers with hearing impairments. She also shared that several of her children have disabilities, and she herself has a personal disability from a traumatic brain injury.

She next described participating in a meeting where everyone was deaf (besides herself) and the communication difficulties and resulting isolation she experienced. Similar to Dr. Mills, Ms. Bell remarked that it is not individuals who are disabled, rather it is the system. She also stated she does not utilize the term 'special populations' due to its negative connotations.



*Ms. Julia Bell, Executive Director, Maine Council on Disabilities*

Ms. Bell next suggested that the emergency management community needs to define more specific groups of vulnerable populations for planning purposes. She stated that many individuals will be overlooked within the broad-based categories (i.e. the disabled) presently used to describe vulnerable populations. She also stated many persons have multiple vulnerabilities and may not fit into a specific category. She next shared information about persons with vulnerabilities in Maine.

- More than 40% of the population has one or more conditions that could be considered vulnerabilities in an emergency.
- An estimated 23,000 persons living in Maine have a developmental disability. Fewer than 50% of these individuals receive services from the state or other agencies.

Ms. Bell stated that the response community cannot assume that by working with community-based organizations, the majority of vulnerable persons will be reached in an emergency. She suggested emergency planners also provide outreach to vulnerable persons within the general community who are not served by organizations.

Ms. Bell next stated that individuals with disabilities face issues every day surrounding their functional needs, and thus are unlikely to immediately participate in emergency planning. She felt persons with disabilities must be engaged by their local communities and that emergency managers must identify networking opportunities. She recommended emergency managers:

- Study their city or town's demographics;
- Engage contacts that are trusted by vulnerable populations within the community;
- Identify contact points with organizations that distribute newsletters or publications, including media outlets, communication organizations, churches, support groups, and food banks;
- Attend community-based organizations' meetings;
- Develop self-identification registries, as well as a plan for scheduled updates and renewal of information;
- Create a list of personal preparedness supplies utilizing pictures and made available in accessible formats.

Ms. Bell also made recommendations for creating accessible spaces and communicating with various vulnerable populations, in order to include these persons in emergency planning meetings and sessions.

- Tables should have at least a 30" inch clearance and aisles should be 36"-62" wide.
- Meeting organizers should let all participants know where things are located and guide them through the meeting area.
- Written information should be distributed at a basic reading level and in multiple accessible formats.
  - Material must be easy for people to read and understand. Otherwise, the individuals will throw it away, lose it, or not use it.
  - Persons who are blind or visually-impaired may need materials in large print, on CD-ROM, and/or in Braille.

Ms. Bell also listed general communication guidelines, including:

- Always face the audience, do not speak while writing on a board or flip chart;
- Utilize closed captioning to assist the deaf or hard-of-hearing, individuals with cognitive disabilities, and persons who are non-English speakers;
  - Open caption or interpreters should be positioned so that persons are able to see the aid and the speakers.
- Provide a transcript following the session;
- Use respectful language;
- Presume the audience's competence;
- Use a normal tone of voice;
- Speak with a person at eye level;
- Listen attentively and let a person know if you do not understand what he or she is saying;
- Utilize amplification systems;
- Offer a voluntary option for persons to provide information about their functional needs;
- Speak to the individual, not the interpreter.
  - Persons whom are deaf or hard-of-hearing look not only at the interpreter, but also the speaker for body and facial expressions.

Ms. Bell next encouraged emergency planners to identify their resources in the surrounding areas and to think beyond county boundaries. She indicated, in the event of a large-scale emergency or public health threat, communities may have to rely on mutual aid agreements.

She also encouraged emergency planners and their staff to prepare to address vulnerable populations' functional needs in an emergency by:

- Planning for access to care and life-sustaining medications during an emergency;
- Developing a safety net and additional services for persons with socioeconomic disadvantages who are unable to stockpile food and goods;

- Providing accessible transportation for persons with disabilities and their equipment;
- Developing a network of community-based organizations available to provide food, supplies, or licensed mental health and healthcare workers;
- Planning for the restoration of financial benefits;
- Planning for alternate communication systems, accessible shelters and services, and accommodations for service animals.

Ms. Bell also stated that emergency managers must prepare to receive vulnerable populations, and all their family members, at shelters within their local communities. She suggested that persons will not want to become separated from their family members and that provisions must be made to provide for the entire family, including those with functional needs.

Near the end of her presentation, Ms. Bell expressed how the term vulnerable populations can encompass

anyone and everyone depending on their situation at any given moment in time, and that emergencies will have a profound effect on everyone's lives. She stated that emergency managers will have to plan for the unexpected since until an emergency occurs one will not truly know the composition of their community, or what staff and resources will actually be available. She then mentioned that families will generally be staff members' number one priority, with their job responsibilities and the community second.

Ms. Bell reiterated the importance of welcoming any and all individuals who want to become involved in emergency planning, building trust amongst collaborators, developing and nurturing networks, making preparedness activities easy for various populations, and utilizing peoples' abilities to prepare for an emergency.

Ms. Bell concluded her remarks by emphasizing that everyone in the community needs to work together to enable emergency planning for all populations. She then shared a quote from Henry Ford:

*“Coming together is beginning,  
keeping together is progress,  
working together is success.”*

*– Henry Ford*

## SECTION III

## BREAKOUT GROUPS ON VULNERABLE POPULATIONS

Conference participants self-selected into six breakout groups to discuss the emergency needs of specific vulnerable populations. While vulnerable populations can be defined in a number of ways, for the purposes of the conference the planning committee utilized the national Centers for Disease Control and Prevention's (CDC) recommended categories of at-risk persons in an emergency for the breakout group topics. The CDC has proposed these groupings to assist emergency planners with a framework to identify populations that may have special needs and may not necessarily be included in any one particular vulnerable population. The categories include: age, cultural/geographic isolation, disabilities, economically disadvantaged, and limited language proficiency. The conference planning committee divided the age group into two breakout groups: youth and the elderly.

The breakout sessions provided an opportunity for participants to identify barriers to preparedness, as well as potential strategies to overcome these barriers, for particular vulnerable populations in Maine. Each group was accompanied by one or more panelists who served as a subject matter expert and presented on the topic. Groups also included one or more facilitators whose purpose was to guide panelists through key discussion points developed by the conference planning committee.

### Key Discussion Points

- Define the target population being discussed, possibly including subgroups that may need specific attention.
- Identify the particular strengths and vulnerabilities that one needs to consider as they assist vulnerable persons to prepare for emergencies.
- Identify strategies for communities seeking to engage vulnerable people at risk. What strategies have proven helpful in the past? What approaches have not worked?
- Identify organizations that might be particularly helpful to communities as they seek to engage vulnerable people in emergency preparedness.

- What are the most appropriate channels of communication for reaching this group? What are some test messages that are likely to be needed?

Reconvening after the breakout sessions, **Dr. Paul Campbell**, of the HSPH-CPHP, introduced and facilitated a report-back, where a representative from each of the six groups briefly presented highlights from their discussion.

This report attempts to summarize the ideas and themes shared during each breakout session utilizing content collected from notes recorded by Americorp volunteers attending the conference. The key points for each group as identified during the representatives' reports are listed below the corresponding session summary.

### Cultural/Geographic Isolation Breakout Group

#### FACILITATOR:

**Carl Toney**, University of New England (UNE), Center for Transcultural Health

#### PANELISTS:

**Kolawole Bankole**, Public Health Division, City of Portland, Maine  
**Lisa Sockabasin**, Office of Minority Health, Maine CDC

#### Introduction

The panel began this session by acknowledging the changing face of Maine. In the past 5 years, there has been a large percent increase in the number of minorities in Maine, including an approximate 27% increase in the number of Hispanics, a 26% increase in the number of African-Americans, and a 16% increase in the number of Asian and Pacific Islanders. As the state diversifies there is an increased need for broad-based community services that reach and respect all residents. However, the growing population is outpacing system-wide changes, and the isolation of minority groups from services remains a significant issue both in an emergency, and in regards to everyday activities.

### **Target Population and Subgroups**

The panel identified groups whom they felt would be particularly isolated or vulnerable, and would require additional outreach or specialized services, in an emergency.

- Migrant/seasonal workers
  - ❑ Approximately 12,000 migrant workers pass through Maine each year.
  - ❑ These individuals are geographically isolated in remote work camps.
  - ❑ Many workers do not speak English and may be unable to effectively communicate in an emergency.
- Recently resettled refugee and immigrant communities
  - ❑ These individuals may need additional outreach due to limited English proficiency and/or differing cultural notions of what it means to be prepared and to respond.
  - ❑ Undocumented residents may not access services in an emergency due to a fear of being detected and/or prosecuted.
- Homeless persons
  - ❑ These individuals lack the financial means, and communication and support networks, generally required to respond in an emergency.
- Native American communities
  - ❑ Many Native Americans live on reservations and speak tribal languages, and similar to seasonal workers, may be both geographically and/or linguistically isolated.

The panel expressed how an awareness of the vulnerabilities present in a community is the first step in addressing disparities in both health and preparedness. They also emphasized the importance of data collection in order to develop an accurate picture of a community's racial and ethnic minorities, and other culturally-isolated groups. They suggested that the United States Census is limited in its potential to collect data on the homeless population and undocumented residents, as well as persons unable to read or write English, and recommended that instead of using the census, healthcare providers and/

or institutions play a significant role in garnering data about a community's makeup. While hospitals are currently required to collect information on ethnicity and race, the panel recommended that they also collect data about languages spoken at home in order to determine languages present in the community and the need for corresponding interpreters in an emergency.

The panel stated that a barrier to comprehensive data collection is that many persons do not want to answer questions regarding their race and ethnicity due to fears of stigmatization and discrimination. Therefore, healthcare professionals must be able to educate their patients on the importance of being counted, as well as accurately communicate how collecting such information will be put to beneficial use. The panel recommended healthcare centers promote cultural competency training for their staff in order to improve patient interaction and communication. The Office of Minority Health is currently developing a statewide plan for cultural competency training to be available within the year.

### **Strengths and Vulnerabilities**

The panel next identified the vulnerabilities culturally-isolated persons may experience in an emergency.

- A general apathy exists among all populations in regards to emergency preparedness. There is a strong sense that the government and/or community will provide for individuals in an emergency. The result is that many people have not engaged in any personal preparedness planning.
- Limited English proficiency prevents many culturally-isolated persons from receiving accurate and timely information before, during, and after an emergency. Furthermore, if materials are translated, many people will remain un-reached since they may not read or write in their own language.
- Issues of trust remain the largest vulnerability for culturally-isolated individuals. Fear of stigmatization or discrimination may make individuals reticent to identify themselves in an emergency.

- Emergency response procedures may be at odds with cultural norms and worldviews (i.e. it may be inappropriate to gather men and women together in mass shelters and/or quarantine may represent oppression to individuals having left countries with repressive governments).

### **Strategies for Assistance**

To address these challenges, the panel discussed the importance of “framing” emergency preparedness and response messages. They suggested developing materials and resources with customized and culturally-specific information, recognizing both traditional language and images of traditional people. They also stressed the necessity of eliciting feedback from communities about what their needs are and/or what appropriate services are in an emergency. The panel described “putting the community within the driver’s seat” as key to building trust between the response community and marginalized persons.

The panel indicated that the method of communication is as important as the message when conducting outreach to culturally-isolated groups. They stated that pamphlets, television, and newspapers are ineffective means for reaching isolated groups, and instead suggested person-to-person interaction. The panel recommended identifying and incorporating “bridging agents” [these are trusted persons within culturally-isolated groups] into emergency management plans and drills. Bridging agents are able to provide information to emergency managers about the population and can play a key role in educating the population about emergency preparedness. Agents are able to present information plainly, and build trust. Bridging agents can also train other members of the community to serve as outreach workers. The panel shared several examples of potential “bridging agents” including:

- Representatives of community-based organizations and providers, such as community health centers, social service agencies, and advocacy organizations;
- Offices of Multilingual and Multicultural Affairs;
- School systems;
- Crew bosses for the delivery of preparedness education and emergency communications to migrant and seasonal workers.

The panel also stated that the emergency response community, and in particular members of public safety, require cultural competency and sensitivity training in order to more effectively partner with culturally-isolated groups for the purposes of preparedness. They felt the conference was an important start, but that the conversation surrounding preparedness and vulnerable populations needs to continue in order to foster greater understanding.

The panel concluded the session by stating that there are no simple answers, and while targeted approaches will take a great deal of work, they are absolutely necessary to saving lives in an emergency. The panel also emphasized how despite the now increased visibility of gaps in emergency preparedness planning, issues of inclusion and accessibility for culturally-isolated populations are not new. Rather, recent disasters have magnified the disparities which exist in everyday life. They recommended persons work to breakdown barriers for all community services and that this will forge a higher quality response for everyone in times of emergency.



Mr. Carl Toney, University of New England Center for Transcultural Health

### Key Points

#### Representative:

**Mr. Carl Toney,**

University of New England (UNE),  
Center for Transcultural Health

- It is important to recognize and respect the uniqueness of the various communities and cultures present in Maine.
- Persons experience literal isolation, and also linguistic and cultural isolation, due to being held beyond the pale of the regular social environment.
- There exist many unique challenges and complexities in working with communities that possess a very different world view and/or set of health beliefs. Therefore the response community will want to consider:
  - Bridging their actions with persons' previous experiences;
  - Translating messages into different cultural contexts, in addition to different languages;
  - Identifying persons within communities to lead the way.
- The response community is up against a ticking clock and action must be taken soon to address issues of disparity.
- There are creative and dedicated people across the state ready to make a difference.

### Disabilities Breakout Group

#### FACILITATOR:

**Nancy Intrieri-Cronin,** Autism Society of Maine

#### PANELISTS:

**Laura Antranigian,** Developmental Disabilities Council

**Jodi Benvie,** Disability Rights Center

**Steve Hoad,** State Independent Living Council

#### Target Population and Subgroups

The panel began their presentation by explaining how a person's physical, cognitive, social, and/or psychological condition can impair function and potentially hinder their ability to prepare for, and effectively respond to, a disaster. This includes persons with:

- Chronic conditions;
- Developmental disabilities;
- Limited physical mobility;
- Limited sensory awareness;
  - Deaf or hard-of-hearing
  - Visually-impaired
- Mental illness;
- Multiple chemical sensitivity;
- Temporary conditions or injuries (i.e. broken bones);
- Traumatic brain injuries.

#### Strengths and Vulnerabilities

The panel next described the unique challenges and vulnerabilities persons with disabilities often experience in emergencies.

- Shelters are not accessible.
  - Physical barriers including curbs, steps, narrow doorways, and inaccessible parking lots, phone booths, showers, toilets, beds, and food and drink services are a hindrance for persons with disabilities.
  - Adequate provisions for service animals are not readily available.

- ❑ Communication barriers result from inadequate numbers of interpreters and translation devices for the hearing- and visually-impaired, and/ or a lack of symbols and pictures for individuals unable to easily comprehend elaborate verbal instructions.
- There exists the inability to refill life-sustaining medications when pharmacies and doctors offices are closed in an emergency.
  - ❑ Several panelists suggested that addressing the need for extended supplies in an emergency requires policy-level changes to the longstanding statewide/federal issue regarding 30-day limit on medication supplies.
  - ❑ The panel recommended that persons ask their doctors for photocopies of their prescriptions as an act of personal preparedness and keep these copies on their persons.
- There are limited amounts of accessible vehicles available to transport persons with disabilities. Furthermore, current pick-up points are insufficiently determined, preventing disabled individuals from reaching them in a timely manner, if at all.
- Compiling location information for the purposes of transporting disabled persons, and offering other assistance, in an emergency is challenging due to persons' reticence to identify themselves.
- Group facilities and individuals' dependant on visiting attendants, service delivery agencies, or outreach services may be left without basic necessities for prolonged periods of time if social services are unavailable during emergencies.
- The Health Insurance Portability and Accountability Act's (HIPAA) privacy rule potentially limits the amount of medical information that can be shared or obtained in a disaster, thereby hindering the provision of emergency healthcare.

### ***Strategies for Assistance***

In order to appropriately address many of these challenges, the panel recommended that the response community make efforts to include individuals with disabilities in the emergency preparedness planning process. This requires the response community to make local and state stakeholder meetings, exercises, and drills more accessible to persons with disabilities by holding them at both convenient times and locations. The panel also suggested that members of the response community attend the discussion groups and meetings held by persons with disabilities and their representative organizations. The panel indicated that this would aid in developing relationships that encourage open communication and trust before a crisis occurs, since individuals with disabilities are often justifiably concerned about having their needs and rights respected.

The panel reminded members of the emergency response community to plan with persons with disabilities and not for them. They stated that in order to effectively serve persons with disabilities, the response community must ask such persons what their needs are in an emergency and how they should be addressed.

The panel also emphasized the importance of empowering persons with disabilities to develop personal preparedness and family response plans, including creating disaster kits and communication procedures. The panel also stated that it is critical for persons present at the conference to act as models for their communities by developing their own emergency plans before encouraging others to do so. The panel indicated forms are available on many state and federal websites to assist persons with developing their own emergency plans.

The panel next discussed with the audience several strategies for further including persons with disabilities in emergency planning and response, as well as aiding the response community in identifying, locating, and reaching at-risk individuals in an emergency, by:

- Utilizing broad-based media such as newspapers, radio, TV, internet, and town meetings to deliver public education on emergency preparedness;
- Sponsoring one-on-one and group discussions about personal preparedness;
  - ❑ The panel stated that each person present in the breakout group should be responsible for bringing the information discussed [today] to one other person, who in turn can share it with clients/family members.
- Delivering preparedness information door-to-door;
- Creating social stories and developing scenarios for families and individuals to work through what they would do in an emergency;
- Distributing preparedness information by utilizing existing supports and social service networks, including:
  - ❑ Social service providers
  - ❑ Schools
  - ❑ Local civic/social/religious organizations
  - ❑ Home healthcare organizations
  - ❑ Advocacy coalitions
  - ❑ Professional organizations
- Involving service organizations (i.e. Meals on Wheels, postal workers, and Area Agencies on Aging) in the identification and location of community members in need of assistance;
- Establishing voluntary registries enabling vulnerable persons to self-identify their locations and needs;
- Cross-training the response community, especially first responders and the media, in the use of various communication modalities and devices (i.e. voice-to-text, text-to-voice, TTY, pagers, closed captioning) to ensure their use in an emergency;
- Conducting outreach and ensuring that local businesses critical to a community's survival are prepared (i.e. grocery stores, pharmacies).

The panel concluded their discussion by reminding members of the audience that public bodies are held accountable for providing equal services to persons with disabilities. They recommended emergency managers review the ADA Guide for State and Local Governments on emergency preparedness planning. The guide is available on the Department of Justice's website.



*Ms. Nancy Intrieri-Cronin, Autism Society of Maine*

### **Key Points**

#### **Representative:**

**Ms. Nancy Intrieri-Cronin,**  
Autism Society of Maine

- There are many different types of disabilities, and all persons fit into the category at one time or another.
- There are no experts in the field of emergency preparedness and vulnerable populations, and everyone has permission to ask questions about people's needs.
- Everyone who talks the "preparedness" talk must also walk the walk. It is unfair to ask a person with a disability to prepare when one's self has not.
- Local responders must build trust and engage their communities in the emergency preparedness planning process.
- Multi-faceted community involvement (i.e. government, community-based organizations, and businesses) in preparedness planning is critical during an emergency.

**FACILITATOR:**

Sara Gagne-Holmes, Maine Equal Justice

**PANELISTS:**

Christa Dillihunt, HealthReach

Community Health Centers

Rachel Newman, Southern Kennebec

Child Development Corporation

Juanita Taylor, Sebasticook Family Doctors

Jesse Leah Vear, POWER

Shawn Yardley, City of Bangor Health and Welfare

**Target Population and Subgroups**

The panel began this session by issuing the audience a pre-test regarding the economically disadvantaged (See Appendix B: Economically Disadvantaged Pre-test). They then provided data on the size of the target population in Maine. Within the state, one out of ten persons live below the federal poverty line, and one out of three persons are considered poor or near poor. They then stated that while the economically disadvantaged includes anyone unable to meet their family's basic needs without some form of assistance, certain groups are likely to have a higher proportion of individuals living in poverty. These include:

- The elderly;
- Single-woman head of households;
  - 69% of households below the federal poverty line are led by females with 2+ children.
- The rural poor;
- Disabled individuals and their caretakers.

In addition to these groups, the panel stated that the working poor, persons without healthcare, children attending daycare centers, pregnant women, and women and children living in domestic violence shelters, may also be in special need of outreach services.

The panel espoused the importance of challenging one's own assumptions when working with economically disadvantaged persons. They stressed that a person's life circumstances can change rapidly due to a health crisis, job loss, or a myriad of other rea-

sons, and that everyone has the potential to become disadvantaged. The panel also encouraged the audience to acknowledge that they have some form of dependence either on family, friends, neighbors, or communities.

**Strengths and Vulnerabilities**

The panel stated that the economically disadvantaged population has numerous strengths in an emergency, including resourcefulness, independence, and compassion. The panel stated that economically disadvantaged persons are often among the first people to respond and offer assistance in a disaster situation, since they know what it means to be in need. However, despite their strengths, the panel acknowledged that financial constraints can limit the ability of many persons to undertake suggested emergency preparedness and mitigation activities. Therefore, the panel recommended promoting preparedness tasks that can be easily accomplished regardless of economic status, such as:

- Developing lists of medications, including doses and times taken;
- Developing lists of local shelters;
- Making copies of drivers' licenses, social security cards, and insurance information.

The panelists stated that while it can be difficult to encourage preparedness buy-in and investment in resources for hypothetical events (i.e. stockpiling canned food) among persons who are challenged in meeting their day-to-day needs, these suggestions require no money and can be very empowering.

**Strategies for Assistance**

The panel suggested strategies for engaging, reaching, and providing for the economically disadvantaged population.

- Provide quarterly information with Reverse 911.
- Develop Public Service Announcements and televised broadcasts.
- Develop one page information sheets with "In Case of Emergency" suggestions, prior to an emergency.

- ❑ Respect that people come from different backgrounds by using simple, clear language for information sheets.
- Send emergency preparedness information home with school children to raise awareness and begin a dialogue with parents.
- Hold community-wide information sessions that are accessible to persons with low-incomes, by:
  - ❑ Providing transportation and childcare (let this be known on fliers);
  - ❑ Offering reimbursements, not scholarships, for persons to attend (the language used is important for empowerment purposes).
- Mandate organizational participation in emergency preparedness through grants.
- Utilize existing social networks and service providers, such as:
  - ❑ Houses of worship;
  - ❑ Schools;
  - ❑ Neighbors.
- Ask about and listen to low-income persons' self-described needs and capacities.
- Develop procedures to ensure access to emergency food stamps, general assistance, and unemployment compensation in an emergency.

The panel next discussed barriers to implementing these strategies, most significantly the lack of both funds and staff available at the local level to develop plans. To address the existing barriers, they recommended regionalizing shelters to consolidate resources, making creative use of available community resources, such as utilizing school buses to provide transportation in an emergency, and developing a corps of volunteers to supplement staff. They also suggested cross-training staff in various essential positions to assure continuity of operations in an emergency and the increased capacity to serve.

The panel ended their presentation stating that if emergency planners hope to reach economically disadvantaged persons in advance of an emergency, emergency managers must go within the community. The panel suggested this is a critical step in building trusting relationships, as well as self-confidence among the economically disadvantaged. Finally, the

panel stated that the greatest resource available to everyone is the "NOW". They encouraged the audience to anticipate and answer needs while resources are available and lives are not at stake.



*Ms. Kellie Miller, Maine Primary Care Association*

### **Key Points**

#### **Representative:**

**Ms. Kellie Miller,**  
Maine Primary Care Association

- Any one at any time can be classified as a person who is economically disadvantaged; most persons are one paycheck away from an emergency.
- The emergency response community can continue to plan, but until they ask and listen to persons who are struggling with being economically disadvantaged everyday and what resources work for their lives and circumstances, response strategies will be ineffective.
- Planning for vulnerable persons must be carried forward from the statewide conference to regional meetings where it is critical to engage vulnerable persons in community-level planning.
- The response community must use plain-speak; tell persons exactly what will be discussed at meetings and what is being requested of participants.
- The response community must work with community-based organizations and providers to help them integrate emergency preparedness into their daily services.
- Emergency preparedness must be interwoven into persons' daily lives and become part of the culture of what is done at work and home.

### FACILITATOR:

**Ann Conway**, Maine Center for Public Health

### PANELISTS:

**Leslie Bray**, Senior Spectrum

**Gloria Caouette**, Elder Independence of Maine

**Karen Elliott**, Adult Protective Services,  
Maine DHHS

**Pam L'Heureux**, York County EMA

### Introduction

After welcoming the audience and introducing themselves and their organizations, the panel indicated that preparing the elder population is a critical priority for the state of Maine. They stated that elders comprise approximately 14.4% of the state's total population, and factors such as diminished mobility, sensory awareness, and/or mental capacity, often associated with aging, jeopardize their safety in an emergency. The panel further stated that financial constraints and a common reliance on others for care limits the ability of many elders to take action to prepare themselves for emergencies, and also potentially prevents elderly individuals from accessing standard emergency resources and services in a disaster. The panel suggested that the most recent and powerful example of this is Hurricane Katrina, when during the storm,

- 56% of people age 65 or older were either with dementia or impaired, without family or friends, and/or unable to access services;
- 65% of elderly individuals were without vehicles.

The panel next discussed a 2006, eight-county assessment of special populations in Maine's Northeast region, which indicated that elder adults are likely unprepared for disaster. The assessment, sponsored by the Northeastern Maine Regional Collaborative, found that more than half of all households had not engaged in any disaster planning. Among households with at least one member age 65 or older, 75% had not obtained any information on emergency preparedness, and 70% had not discussed what they would do in an emergency.

### Target Populations and Subgroups

The panel next acknowledged that while the term "elderly" is used to describe persons over the age of 65, there is enormous variation within this population. They stated that elder persons can be resilient, self-sufficient, and very independent. Many are pillars of their communities. The panel also suggested that many elders are empathetic and want to be active in a crisis as part of the solution, not part of the problem. They shared an example of how in mass shelters after Hurricane Katrina, grandparents would sit in a circle around their grandchildren to protect them.

However, the panel felt that while many elders are fully capable of supporting themselves and their loved ones in an emergency, the response community cannot ignore the vulnerabilities of other elders. The panel mentioned elder persons of particular concern in an emergency as being:

- Elders living alone or whom are socially isolated;
  - Persons may have limited awareness of services.
- Elders living in rural communities;
  - Issues exist regarding transportation services for these persons.
- Elder seasonal residents of Maine;
  - Persons may be unfamiliar with, or not connected to, state and community agencies.
- Elders with disabilities;
  - 39% of elder Mainers identify as having some form of disability.
- Elders living below the federal poverty line;
  - These persons are unable to prepare stockpiles of medication and supplies.
- King caregivers (frail elders that are caretakers for adult children, and other frail elders);
- Elders who receive mild care.
  - These individuals do not have round the clock caretakers and can be the most vulnerable in an emergency.
  - Their caregivers are often long-distance (one hour or more away).

- ❑ Informal caregivers, such as neighbors and friends, may not realize an elder person is intending to rely on them in an emergency.

### **Strategies for Assistance**

The panel proposed multiple strategies for determining high-risk elders in need of additional outreach, and providing information and services to such persons in an emergency.

- Utilize the SWIFT assessment tool, developed in the aftermath of Hurricane Katrina to triage elderly persons in mass shelters, to support pre-disaster planning. The tool assesses elders on three levels:
  - ❑ Persons unable to perform tasks of daily living such as eating or bathing;
  - ❑ Persons unable to perform instrumental activities of daily living such as shopping or paying the bills;
  - ❑ Persons in need of some assistance, but are mostly independent.
- Identify community demographics and map the community to identify vulnerable neighborhoods and locations.
- Access the Lifeline program which provides lists of vulnerable persons.
- Work with the post office to determine people in need of assistance.
- Develop plans and services with the network of providers serving the elderly (they are often aware of vulnerable members of the community), such as:
  - ❑ Nursing homes and long-term care facilities;
  - ❑ Care managers and care management services;
  - ❑ Healthcare providers and members of the medical community;
  - ❑ Community-based organizations and service providers;
  - ❑ Faith-based organizations;
  - ❑ Neighbors, friends, and family within the community.

- Utilize new technology like tone alerts to spread messages.
- Utilize 211 and other call-in services for information and warnings.
- Distribute information to local business.
- Provide emergency preparedness information at town halls and other community facilities.
- Provide information utilizing Meals on Wheels and the public school system.
- Utilize public service announcements and engage the media as a first responder.
  - ❑ Invite the media to participate during exercises and drills.
- Develop a drive-thru system allowing for more access to medication in an emergency (i.e. pandemic influenza) and collaborate with pharmacies to refill prescriptions through ARC shelters.

The panel expressed concerns about the ability of community organizations and service providers, on which many elderly are dependent, to continue their operations in an emergency. They suggested that many caregivers may not report to work in an emergency due to desires to secure their own health, family, and property, while those who do report to work may likely experience burnout. The panel also stated that in an emergency, organizations may be unable to operate due to a lack of resources. For example, Meals on Wheels stocks a ten day supply of food, and will be impacted if supply lines are down in an emergency. The panel stressed the importance of these organizations developing contingency plans in collaboration with local emergency management. They encouraged local emergency management to provide assistance to community organizations and businesses, thus ensuring they have a basic plan.

The panel also emphasized the importance of personal preparedness and recommended that individuals and families take the following steps:

- Develop a list of one's medications to keep in a car or wallet;
- Develop an emergency meeting place;
- Develop a transportation plan;

- Confirm plans with friends and neighbors;
- Determine emergencies more likely to impact one's community and plan supplies accordingly.

The panel reminded the audience that by preparing oneself for an emergency, one is better able to help others during a crisis.

The panel concluded by advocating for elders to be treated with respect, dignity, and proper care during an emergency and in all times.



Ms. Judith Metcalf, University of New England, Division of Community Programs

### Key Points

#### Representative:

**Ms. Judith Metcalf,**

University of New England, Division of Community Programs

- Maine has a large elderly population requiring significant outreach across the state.
- Maine elders are very proud, dignified, and independent.
  - Independence serves as both a strength and weakness since many persons do not like to ask for help.
- Elders have a great sense of community and institutional memory from which to draw upon.
- Caregivers must be prepared in order to effectively support their clients, family, friends, and/or neighbors in an emergency.

- Elder adults, community-based organizations, and the media must be drawn into community-wide strategic planning.
- Communications related to emergencies must be accessible to the entire public.

### Limited Language Proficiency Breakout Group

#### FACILITATORS:

**Rebecca Hoffmann-Frances,** Disaster Behavioral Health Services, Maine DHHS

**Josh Frances,** Southern Regional Resource Center

#### PANELISTS:

**Noel Bonam,** Maine Office of Multicultural Affairs

**Donna Lerman,** University of Southern Maine Muskie School

**Meryl Troop,** Maine Office of Multicultural Affairs

#### Target Population and Subgroups

The panel opened their presentation by discussing the title of the breakout session. They recommended instead of limited language proficiency that the group be classified as persons with limited English proficiency, for whom there may be resulting communication barriers in an emergency. These include:

- English-speaking persons with low-literacy;
  - 14% of persons age 16 and over possess low-literacy skills.
- Persons not speaking English or for whom English is a second language;
  - In a crisis situation it is common to resort to a first language when panic can prevent someone from remembering a new language.
  - Persons may have low-literacy in both English and their first language, thus translated materials aren't always effective.
- The culturally deaf (persons deaf since childhood or educated at a deaf school) for whom ASL is their first language and may not read or understand English.
  - There exists a wide spectrum of hearing loss; if a person has recently become deaf they are unlikely to understand ASL.

- ❑ Deaf persons from other cultures may not know English or ASL.
- Concrete thinkers/cognitive impairments;
  - ❑ The panel shared an example of a mother given an antibiotic for her child's earache; the antibiotic was put in the ear not the mouth.
- Recently resettled refugee and immigrant communities.
  - ❑ Persons may be experiencing additional trauma.
  - ❑ Potential for limited comprehension (even if speaking English), for example persons may not know what a stove or microwave is, or how to use a battery radio.

### **Strategies for Assistance**

The audience expressed frustration at how the range of special needs for these various persons can sometimes seem too immense to address. For example, one audience member stated that it was an impossibility to plan for the over 100 different languages spoken in Maine. The panel acknowledged that targeted approaches are challenging given the limited resources available and shifting demographics, and while there does not exist a one-size-fits all solution, they recommend employing a broad approach that reaches the greatest number of people. This proposed strategy may include:

- Developing preparedness materials or arranging interpretation services for the three largest language groups:
  - ❑ Somali
  - ❑ Spanish
  - ❑ French
- OR
- Translating one simple sentence such as "In an emergency, please contact \_\_\_\_" into 100 languages;
- Developing materials/brochures that utilize pictures instead of words;
  - ❑ One panelist suggested that the response community not develop any text-heavy or dense materials. In an emergency, all persons desire information in a simple, easy to understand way.

- ❑ Examples are available for free from the ARC.
- Creating public service announcements;
- Developing readers that enable persons to learn English as a second language and about emergency preparedness simultaneously;
- Employing staff that can speak multiple languages;
- Utilizing 211 to provide emergency preparedness information;
  - ❑ Versions are available for the deaf and hard-of-hearing and in multiple languages.
- Providing emergency information to children within the schools.
  - ❑ Children learn English more easily and can share information with their families.

The panel next discussed how emergency managers should use non-technical language in an emergency and on preparedness materials. They asserted that the medical and preparedness terminology commonly employed by the emergency management and response communities is often difficult to translate into other languages, and moreover many English-speaking persons are in fact unfamiliar with the meanings of the terms. They suggested employing simple picture messages and/or common language that people of varying backgrounds and ages are likely to understand. They also recommended that emergency management and response agencies sponsor workshops and collaborate with interpreters to develop appropriate terms and phrases in multiple languages, including ASL, so they are prepared to interpret any expressed ideas in an emergency.

The panel spoke about the importance of partnering with individual communities, and including persons within the limited English proficiency category in planning initiatives. They suggested that the best way to develop culturally appropriate materials and services is to ask the community itself by attending their sponsored meetings and activities. The panel also encouraged the audience not to make assumptions about the capabilities of persons in an emergency, but to ask directly about their needs.

### **Potential Partners**

The panel recommended that emergency management and response agencies combine efforts with community organizations to better serve persons with limited English proficiency in an emergency, such as:

- Adult Education Services;
- Literacy Volunteers of America;
  - ❑ Access [www.homesafetyliteracy.org](http://www.homesafetyliteracy.org) for free materials.
- The Office of Multicultural Affairs;
- The Maine Migrant Health Program;
- The Office of Minority Health;
- Community health and outreach workers from within the target group;
- Catholic Charities;
  - ❑ Provides refugee services and interpreters.
- Association of Late Deaf Adults;
  - ❑ Promotes closed-captioning.
- Maine Center on Deafness;
  - ❑ Pilot program to distribute text pagers for emergency use.
- Pine Tree Society and Bangor Interpreting;
  - ❑ Networks for ASL translators.
- National hotlines available for translation services.

The panel also suggested the audience review the Maine Multi-Cultural Resource Guide and Deaf Resource Guide, which lists all known agencies that provide specialized services to persons facing communication barriers. These organizations are likely to be aware of sponsored tables and activities where emergency planners can involve vulnerable persons. The resource guides are available at [www.maine.gov](http://www.maine.gov).

The panel reminded the audience that their discussion [today] was not a matter of political correctness, but was an effort to ensure that vulnerable persons have equal rights to safety and security in an emergency as a matter of law. They stated that the American Disabilities Act and the Federal Rehabilitation Act provides guidelines for ensuring communication ac-

cess to persons who are deaf and hard-of-hearing, and the Civil Rights Act prohibits discrimination against persons based on national origin. The panel asserted that information must therefore be provided in languages people can understand, and that ensuring access to communications and information in an emergency is paramount to saving lives



*Ms. Meryl Troop, Maine Office of Multicultural Affairs*

### **Key Points**

#### **Representative:**

**Ms. Meryl Troop,**  
Maine Office of Multicultural Affairs

- Addressing language access and communication access issues is work that the response community needs to do all the time, even when there are no easy answers.
- Taking all the challenges in serving other groups [discussed at the conference], and adding the overlay of a communication barrier, makes all the other stressors even more insurmountable.
- Communication barriers are universally shared. Persons providing a service experience a shared communication barrier when a person does not communicate in their same language.
- In order to reach persons outside mainstream communications, emergency management must go to their meetings and events, and build trust. These persons will not be attending the response community's workshops.

## Youth Breakout Group

### FACILITATOR:

Nancy Dube, Maine Department of Education

### PANELISTS:

Laurie Canton-Lemos, University of Southern Maine

Sue Henry McKenzie, Southern Maine Parent Group

### *Target Population and Subgroups*

The panel began by stating that while the youth category includes anyone under the age of 20, there is enormous variability within this population group. They indicated that the needs of pre-school, elementary, and high school age students are very different and require a range of plans. They then identified subgroups in need of specific attention and services related to emergency planning. Groups included:

- Pre-natal youth and pregnant women;
- Youth with special needs;
  - ❑ These individuals may need continued access to medications and ventilators during an emergency.
  - ❑ Must plan for children with claustrophobia or who are autistic and unable to stay in one place for more than 24 hours.
- Youth with behavioral health issues;
- University students that are from out-of-state;
- Youth living in poverty;
  - ❑ 21% of Maine's total population lives in poverty.
  - ❑ Persons are unlikely to have access to cell phones, internet, and other waves of technology.
- Youth attending summer camps;
- Youth not connected to schools or parents (i.e. homeless, runaways, couch surfers);
  - ❑ This population often feels vulnerable in shelter situations and may not seek help in an emergency.

- ❑ Planners should attempt to ban this population together.
- 20 to 30 year old adults with the mindset of youth.

### *Strategies for Assistance*

Throughout their presentation, the panel emphasized the importance of school-based preparedness. However, they recognized that there are substantial barriers in motivating schools to participate in local emergency preparedness planning. They suggested schools are overburdened and can be resistant to outside intervention. The panel recommended that local emergency management engage school nurses and guidance counselors in planning initiatives and community exercises as they are often receptive to preparedness planning. They also suggested inviting members of the school board to community meetings where preparedness will be discussed, and attending both work-shop days and parent-teacher conferences to explain the importance of the meeting process and enlist volunteers. Finally, they stated that parents need to request that teachers and administrators become involved in the planning process.

The panel also indicated there is pending legislation which mandates all schools in Maine institute an emergency plan. However, it needs more support from both within schools and the public in order for it to pass.

The panel then made recommendations for how schools can become more prepared for an emergency.

- Conduct an assessment of available resources at the school and within the community.
- Ensure emergency medical staff is available after a disaster on school grounds, or when school is in session, to assist students.
- Develop a plan to communicate with parents and reconnect children with family members.
  - ❑ Determine an off-site location for parents to receive information from a designated communication point person.

The panel next addressed the need to involve parents in schools' emergency preparedness planning.

They emphasized that parents either often do not have a plan or have a plan which conflicts with the school's. The panel acknowledged that it can be difficult to engage parents in any school activities, let alone planning for events that may or may not happen, but still offered several recommendations for increasing communication with parents around this important issue.

- Educate parents about preparedness at parent-teacher conferences.
- Encourage parents to develop emergency preparedness kits that include a supply of medications for special needs children to keep at the schools.
- Include the school's emergency plan in the student handbook.
- Send emergency preparedness information sheets, requiring parent's signature, home with students.
  - Determine parents' plans if children are in school during an emergency.
  - Determine emergency back-up contacts if parents are unavailable.
- Invite parents to in-house days at schools to raise awareness about school disaster plans.
- Require emergency preparedness plans, following the immunizations-requirement model.

The panel also raised the issue of hospitals' interaction with youth during an emergency. They stated that many hospitals are concerned with the legal ramifications of treating youth that may be seeking assistance in an emergency without the presence of family. To address this issue, the panel recommended hospitals collaborate with schools to identify local students and provide relevant contact information for family members. They suggested that hospitals and area schools develop MOUs, and consult with attorneys, prior to an emergency to determine how they will share information during disaster.

The panel then discussed the importance of community planning for the youth population. They stressed that the community cannot rely only on school plan-

ning, but must also have plans for when schools are out of session. The panel made several suggestions for community planning surrounding youth issues.

- Ensure emergency shelters are supplied with formula (without water) and diapers.
- Publicize the different capabilities and resources of various shelters in order for families to seek appropriate shelter depending on their children's needs (i.e. shelters that provide special medications and/or medical attention).
- Provide security and protection in shelter environments to ensure youth are not victimized during disasters.
- Identify community members trained to deliver babies within the home, such as midwives and retired medical nurses.
  - The panel emphasized Maine is rich in people with skills unconnected to hospitals.
- Involve local churches, Girl Scout and Boy Scout leaders, and child care workers in the planning process.
- Engage and empower older youth to be part of the solution during the recovery process; utilize and occupy them as volunteers when schools are shut down.
- Collaborate with schools to have students make preparedness baskets for themselves or others as part of a community project.
  - Create a stock-pile of emergency kits to be distributed to people in need during an emergency.
- Develop MOUs with local food stores for shelter supplies during an emergency.
- Develop plans for children on MaineCare who may not have access to medication supplies in an emergency.
- Ensure safe environments for children to continue to play in an emergency.
- Develop plans for assisting in the reunion of families.
- Develop plans for childcare in order to enable staff to work during an emergency.

- Work with family planning agencies to ensure teenagers access to birth control and counseling during an emergency.
- ❑ In an emergency, the stress and the breakup of families may lead to an increase in sexual activity, as well as domestic and child abuse.

The panel concluded their presentation by emphasizing the need for schools, parents, hospitals, and communities to plan together, instead of separately. They also stated that while it's easy to discuss issues related to emergencies and vulnerable populations in the recent aftermath of an emergency, such as Hurricane Katrina, it takes a larger commitment to ensure change in plans and protocols before another emergency occurs.



*Ms. Nancy Dube, Maine Department of Education*

### Key Points

#### Representative:

**Ms. Nancy Dube,**

Maine Department of Education

- All youth are vulnerable, however special consideration must be made during planning for youth with physical, mental, and emotional vulnerabilities and middle and high school children without a home.
- There is a critical need to plan for how to reconnect youth with family members and/or responsible adults if they become separated during an emergency.



*Dr. Paul Campbell, Harvard School of Public Health Center for Public Health Preparedness*

### Breakout Group Reports with Panel Response

#### FACILITATOR:

**Dr. Paul Campbell,** Harvard School of Public Health Center for Public Health Preparedness

#### PANELISTS:

**Mr. Don Ward,** Maine CDC

**Mr. Steve Trockman,** Southern Maine Regional Resource Center

**Ms. Suzanne McCormick,** Maine Red Cross

**Ms. Rayna Leibowitz,** MEMA

Following the representatives' reports, Dr. Campbell introduced four panelists, **Mr. Don Ward, Mr. Steve Trockman, Ms. Suzanne McCormick,** and **Ms. Rayna Leibowitz,** who are immersed in emergency preparedness planning in Maine, and asked them to offer responses to the day. Mr. Ward began by declaring that more work needs to be done in the area of emergency preparedness and response for vulnerable populations, as well as noting the ubiquity of the problem, in that the issue stretches across Maine. He stated that any solution or approach, while not state-level, needs to be statewide. He also emphasized the need to work together. Mr. Ward expressed how impressed he was with the depth and creativity of solutions proposed at the conference and that it is a source of pride for Maine to be able to respond with such unique ideas. He next stressed the importance of focusing on vulnerable persons' abilities and not their disabilities, and respecting persons' independence. Mr. Ward then identified actions public health practitioners can take in order to plan more effectively, including:

- Continue sharing and exchanging information [such as at the statewide conference] and at the community level;
- Go to the meetings and activities of vulnerable populations and their organizations;
- Better define and identify vulnerable groups;
- Expand groups considered vulnerable to include persons living with HIV/AIDS and other chronic conditions;
- Review data and modify surveillance systems to collect information on vulnerable populations in emergencies;
- Initiate dialogue and move things forward in a positive and aggressive sense from where public health stands and not simply respond to the description and discussion of problems.

Mr. Trockman spoke next. He stated that the emergent theme of the conference seemed to him the importance of “bridges” between emergency planners and individuals and groups. He stated that he sees family members, neighbors, and first responders as potential bridges between emergency planners and individuals, and government offices, faith communities, and community outreach services as potential bridges between emergency planners and groups of people. He then indicated that the questions that remain are how to get preparedness messages to groups through such bridges and how to get information back about group needs. He stated that questions also exist about how to provide and access response resources and how to measure and evaluate preparedness among vulnerable populations. Mr. Trockman ended his remarks by stating that emer-

gency planners need to empower vulnerable populations through data, health education, and plans, and also with access to individual and population-based care in an emergency. Finally, he stated that populations also need to be empowered by giving them a seat at the planning table and a clear and powerful voice in decision-making, as well as by demonstrating trust in communities to make and implement decisions that are best for themselves.

Next, Ms. McCormick shared the key ideas which resonated with her from the conference. These included the need to connect, educate, plan, bridge, and build. She then expressed, as a representative of the ARC, that everyone at the conference was their potential partner in both planning and response, and went on to describe several successful examples of past partnerships, including partnering with Goodwill Industries (GI) to train staff on how to shelter-in-place and care for their clients in an emergency. The ARC has also partnered with local area agencies on aging and the City of Portland’s Office of Minority Health to develop train-the-trainer initiatives for the elderly. Ms. McCormick stated that the ARC is a resource with tools and expertise available to government and community groups, and has a strong willingness to work with various persons and organizations to make Maine better prepared.

Ms. Leibowitz was last to speak and expressed a desire to re-emphasize that emergencies are first local events and that response is first local. She stated that emergency planning and preparedness is not something that can be done as effectively at the state level. She then encouraged participants to take the messages learned at the conference back to their communities and spread it around their networks.



*From left to right: Mr. Don Ward, Maine CDC, Mr. Steve Trockman, Southern Maine Regional Resource Center, Ms. Suzanne McCormick, Maine Red Cross, Ms. Rayna Leibowitz, Maine Emergency Management Agency*

She also encouraged participants to spread the message that preparedness is first a personal action. Ms. Leibowitz then stated that planning means looking at what are a community's needs and vulnerabilities, and also what are a community's resources and response capabilities. She also stated, that while not an easy task, emergency management must plan to make communications thorough, appropriate, and effective. Finally, she indicated that creating networks is vitally important to the emergency preparedness arena and encouraged the audience to continue to collaborate and involve themselves in the planning process.



*Ms. Kris Perkins, Director, Office of Public Health Emergency Preparedness*

Dr. Campbell then invited the keynote speaker, Ms. Hilary Styron, and **Ms. Kris Perkins**, Director of Maine's Office of Public Health Emergency Preparedness within the Maine CDC to offer closing remarks. Ms. Styron held up a report entitled: *Recommendations for Best Practices in the Management of Elderly Disaster Victims* and read from the cover

"He who is prepared has won half the battle." She advocated that this be the slogan for the day. She then stated that the audience was by far the largest and most diverse she has seen at the places she has presented and thanked the conference planning committee for their obvious hard work. She also acknowledged the thousands of volunteers and emergency workers that responded, and continue to respond, to Hurricanes Katrina and Rita and do excellent work. She then stated that planning needs to be all-hazards, all-persons, all the time. Her final comment was that there is a common resistance for people to listen to persons who are not like themselves and that emergency managers' best strategy is to recruit vulnerable persons to relay messages to other vulnerable persons.

Ms. Perkins thanked the audience for their attendance and for what she felt was laying out the work for the state. She stated that the conference brought together a variety of perspectives, and that this indicates Maine has made great strides in planning. There are now excellent networks, partnerships, and collaborations that did not exist until very recently. However, she acknowledged there is still a long road ahead, but that the commitment, energy, and expertise in evidence at the conference will make a large difference.

Dr. Campbell gave final thanks to persons involved in organizing the conference and promised the day's discussions would continue in the state.

The MCPH, Maine CDC, and HSPH-CPHP remain committed to understanding and addressing disparities in emergency response, as well as conducting education and outreach activities to enhance preparedness for vulnerable persons. The conference, ***Reaching Vulnerable Populations in Public Health Emergencies***, was an important step, of many to come, intended to generate community involvement around preparedness planning for vulnerable populations in Maine. The sponsoring organizations seek to continue to work with participants to address the issues, barriers, and action items set forth at the conference.

Throughout the fall of 2007, the Maine Emergency Management Agency (MEMA) is sponsoring eight regional meetings regarding emergency preparedness planning for persons with disabilities and the elderly in Maine. Local responders and representa-

tives of community-based organizations are invited to attend. Additionally, the MCPH, Maine CDC, and HSPH-CPHP, in collaboration with the Maine Office of Elder Services, New England Alliance for Public Health Workforce Development, and MEMA, are developing a web-based course entitled ***Maine's Elders and Emergencies: Working for the Future*** to aid senior citizens, caregivers, and service providers in preparing for disasters. The course will be available during late fall of 2007.

Conference participants are encouraged to continue their efforts to strengthen programs and plans for vulnerable persons in emergencies by participating in these activities, and aiding in the development of new initiatives. Feedback is welcomed and appreciated. Through collaboration and diverse partnerships, it is envisioned that we can better serve and protect all people in times of emergency.

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## APPENDIX A: Participant List

### Reaching Vulnerable Populations in Public Health Emergencies Augusta Civic Center

April 10, 2007

Last Name	First Name	Title	Organization	E-Mail
Adams-Contino	Nancy	Public Health Nurse	Public Health Nursing	nancy.adams-contino@st.me.us
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Arsenault	Sharon	Region 2 Mental Health Team Leader	Maine DHHS	sharon.arsenault@maine.gov
Ashbrook-Ellis	Amy	Public Health Nurse	Maine CDC/DHHS	amy.ashbrook-ellis@maine.gov
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Austin	Claire	Case Workder	Maine DHHS	claire.austin@maine.gov
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Barrett	Judy	Public Health Administrator	Kennebunkport Public Health Department	jbarrett@town.kennebunkport.me.us
Bartlett	Ted	Deputy Director	Waldo County Emergency Management Agency	deputyemadirector@waldocountyme.gov
Bartlett	Mary Frances	Director Health & Welfare	City of Augusta	mary@augustamaine.gov
Bastian	Tia	Regional Epidemiologist	Maine CDC	tia.bastian@maine.gov
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Beard	Thomas	Director of Clinical Operations	Sebasticook Family Doctors	tbeard@sfdchc.org
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Benvie	Jodi	Advocate	Disability Rights Center	jbenvie@drcme.org
Bickerstaff	Morgan	Emergency Services Associate	American Red Cross of Southern Maine	bickerstaffm@usa.redcross.org
Birkhimer	Nancy		Maine CDC	
Birkinbine	Catherine	Clinical Coordinator	CHANS Home Health Care	cbirkinbine@midcoasthealth.com
Birmingham	Sylvia	Director	Knox County EMA	sebema@knoxcounty.midcoast.com
Bodnar	Judith	Licensed Clinical Social Worker	Red Cross	judysunshine@prodigy.net
Bohlmann	Robert	County Director	York County EMA	rcbohlmann@co.york.me.us

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**APPENDIX B: Economically Disadvantaged Pre-Test**

**“Reaching Vulnerable Populations in Public Health Emergencies”  
Economically Disadvantaged Break Out Group**

**April 10, 2007**

**1:00 – 2:30 pm**

**PRE-TEST**

This pre-test is for your information only and to assist you in our breakout discussion to ensure that we reach at risk populations who are Economically Disadvantaged. The questions are posed as True/False or Multiple Choice. (Please circle your selected answer.)

1. The term, “Special Needs” is the appropriately used term within disaster services and the emergency management world.

True or False

2. Most people know what to do during a public health emergency.

True or False

3. What is the maximum amount of money that persons can make and be at 100% of the federal poverty level as:

- |                           |                              |
|---------------------------|------------------------------|
| A. An Individual Annually | B. A Family of Four Annually |
| a. \$10,200               | a. \$20,650                  |
| b. \$12,250               | b. \$22,725                  |
| c. \$14,275               | c. \$24,645                  |
| d. \$16,500               | d. \$26,675                  |

4. Which types of people would you consider to be Economically Disadvantaged:

- a. Those who receive MaineCare services
- b. Young adults between the ages of 21 and 35
- c. The elderly
- d. Anyone

5. One successful strategy to engage people at risk in emergency preparedness is to work with organizations providing direct services.

True or False

(OVER PLEASE)

6. If people knew what was expected of them and what to expect from their community, provider, and/or others, during a public health emergency, we could reduce fear and panic.

True or False

7. In a public health emergency, one of the most important educational messages to emphasize is personal preparedness.

True or False

8. Providing notice in the newspaper is the best way to engage economically disadvantaged individuals in the planning process.

True or False

9. In an emergency situation which of the following will be problematic for economically disadvantaged individuals/families:

- a. Lack of transportation
- b. Limited supply of prescribed medications
- c. Ability to access Medicaid services, if not previously enrolled
- d. All of the above

10. Over 65% of disaster victims will go to the closest and most “familiar” treatment facility (i.e. a community health center, a physician’s office or hospital).

True or False

#### SCORE Your Knowledge!

All 10 correct answers: You are a leader in Reaching Vulnerable Populations. Serve on local committees to ensure that your community is doing all that it can!

5-9 correct answers: You are a rising star in Reaching Vulnerable Populations! Gain more knowledge by working in your community to ensure that everyone’s needs are met!

Less than 5 correct answers: Thank you for choosing the Economically Disadvantaged break out session to gain more knowledge. Knowledge is power – so please share your new found knowledge with others in your community to ensure a “Stronger Community of Preparedness”!



For more information or to receive additional copies contact  
the Maine Center for Public Health at 207-629-9272 or  
<http://www.mcph.org>



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