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Disaster Planning Requires Time, Resources, Collaboration

Health care providers have long prepared for natural disasters such as floods, hurricanes, blizzards, and tornadoes, but they are now acutely aware of the need to prepare for nuclear, biological, or chemical (NBC) terrorism, as well. Lacking protection from the elements, homeless people are especially vulnerable to natural and manmade disasters and Health Care for the Homeless providers are at various stages of emergency preparedness. The articles in this issue of Healing Hands examine preparations being made by the health care community, a special role for HCH mobile providers, and emergency management standards required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The word “emergency” has taken on new meaning since the terrorist attacks of September 11, 2001. JCAHO defines an emergency as a natural or manmade event that suddenly or significantly disrupts the environment of care (e.g., damage to a building from a storm), disrupts care and treatment (e.g., loss of utilities), or changes or increases demands for an organization’s services (e.g., bioterrorist attack).¹

Prior to September 11th, the Boston Health Care for the Homeless Program was involved in emergency preparedness as then defined—“for hurricanes, fires, power outages, and other natural or accidental emergencies that would affect our clients or the health care delivery system,” says **Greg Wagoner, MD**, Medical Director. “Since September 11th we’ve been involved in more intensive planning for potential mass casualty events that are purposely committed.”

Health care providers are aware of the need for emergency planning—according to a 2003 survey of federally qualified health centers by the National Association of Community Health Centers (NACHC), 73 percent of health centers that responded have a disaster plan. However, only 9 percent of health centers feel *adequately* prepared for a community disaster (emphasis original).² Survey respondents cited the need for training, followed by improved equipment and supplies.

DISASTER PLANNING 101 Communities and the HCH providers that serve them are at varying levels of readiness for natural and manmade disasters. Those that appear well prepared share several things in common: a specific emphasis on disaster planning, close coordination among community providers, an incident command

structure and alternate methods of communication, plans to “shelter in place” (create a barrier between individuals and potentially contaminated air outside) or evacuate, and knowledge of how they fit into the broader community’s emergency plans.

Conduct a hazard vulnerability analysis (HVA). Modified emergency management standards issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in January 2001 require JCAHO-accredited health care organizations to conduct a formal, documented hazard vulnerability analysis (HVA). An HVA, Dr. Wagoner explains, describes the probability that a particular type of emergency will take place and how it will affect your agency and your clients. “In Boston, the probability of earthquake is low, but its impact would be high,” he says. The key is to identify how prepared you are for each hazard that is likely to occur.³

Develop, implement, and test your plan. Disaster management plans must be comprehensive but easy to use, updated regularly, and tested in emergency drills. “It is no longer sufficient to develop disaster plans and dust them off if a threat appears imminent,” according to JCAHO. “Rather, a system of preparedness must be in place everyday.”⁴

In the wake of September 11th, St. Vincent’s Hospital Manhattan discovered that its plan was too voluminous to be useful to staff, says **Yvonne Wojcicki, MS, MTASCP**, Safety Officer for St. Vincent’s Hospital Manhattan and Director of NBC Preparedness for St. Vincent Catholic Medical Centers. “We’ve streamlined our plan with a series of checklists and designed it so you can ‘rip a page and go,’” Wojcicki says.

JCAHO requires that disaster plans address the four phases of emergency management: mitigation, preparedness, response, and recovery.¹

Mitigation activities lessen the severity and impact of a potential emergency (e.g., having generators in the event of a utility failure).

In addition to its role of providing federal relief in the wake of a natural or manmade disaster, the Federal Emergency Management Agency (FEMA) offers pre-disaster mitigation training materials for community-based organizations and emergency managers.^{3a}

Preparedness activities build organizational capacity to manage the effects of an emergency should one occur. They include:⁵

- Create a list of local emergency numbers.
- Make a list of all staff.
- Determine when staff will likely be available.
- Decide how to communicate with staff and clients.
- Share names of designated persons in charge with other service providers.
- Post the emergency plan on a bulletin board.
- Develop an evacuation plan.
- Prepare a kit to take with you.
- Create a plan to shelter in place.

Planning for alternate methods of communication among staff and other emergency personnel is important because land lines or cell phones may be inoperable. Options include two-way radios, pagers, wireless personal digital assistants (PDAs), satellite phones, and designated Web sites.

Response activities control the negative effects of emergencies. This involves both emergency management and actions that all staff must take. In the event of a mass casualty incident in Boston, HCHP would set up an incident command structure at its 90-bed respite center, Barbara McInnis House. The incident commander would analyze the situation and activate appropriate policies and procedures.

At the Alameda County Public Health Department HCH program, all staff carry a card with detailed information of what to do in the event of a natural disaster (e.g., earthquake) or terrorist attack, notes **G.G. Greenhouse, MSW**, Director. Patient service representatives at Camillus Health Concern, Inc., in Miami are instructed to cancel patient appointments for the next 2 days when a hurricane watch is issued. Signs on the doors alert potential walk-in clients, says **Mary Langer**, Administrator of Office Operations.

Recovery actions are directed at restoring essential services and resuming normal operations. Recovering lost revenue, if possible, and offering support to staff are two recovery activities.

Collaborate with the community. Effective disaster plans can't be developed in isolation, but collaboration is not always easy, Dr. Wagoner notes. "The concept of community-wide preparedness is new to most health care organizations," according to JCAHO. Many communities are "'waiting for someone to call the meeting.'"³

Anthony Donovan, BSN, didn't wait for someone else to call. Donovan is manager of the Keener Clinic, one of 32 clinics serving homeless people operated by St. Vincent's Hospital Manhattan Department of Community Medicine. On September 12, 2001, he

called other health care and emergency organizations on Ward's Island, where the Keener Clinic is located, including the Manhattan State Psychiatric Hospital and the New York City Fire Department training facility. "Now we know what resources we have and how we can help each other," Donovan says.

In preparation for the recent Democratic National Convention in Boston, HCHP met with government and community representatives to develop plans for homeless people who would be displaced by the tight security around the Fleet Center. Dr. Wagoner credits the fact that there were no incidents involving homeless people to this "well planned and coordinated effort."

Common Symptoms of Exposure to Contaminants¹

- Nuclear – nausea, fatigue, nonhealing burns
- Biological – flulike symptoms (high fever, headache, exhaustion) that worsen and cause respiratory failure within days, rash that progresses to pustular vesicles
- Chemical – pinpoint pupils, vomiting, salivating, choking, redness and blisters, gastric emptying

New Orleans' freeze plan for homeless people is signed by all city agencies and nonprofit organizations that participate, and these groups meet monthly from September to March to monitor how the plan is working. When the temperature drops below 38 degrees in New Orleans, shelters remain open 24 hours a day and are allowed to double their occupancy, notes **Willie Mae Martin, MSW**, Director of HCH for the City of New Orleans Health Department.

Depending on the emergency, health care providers may be cut off from other agencies with which they have emergency arrangements. "We lost communications because the city office of emergency management was in the World Trade Center," Wojcicki says. "You have to prepare to handle an emergency alone."

Know the role HCH will play. As a primary health care provider, HCH may be called on to serve individuals impacted by a disaster. In Alameda County, CA, the HCH mobile medical van would be a first responder in the event of a chemical spill from the nearby Clorox® plant, Greenhouse says. In other cities, the primary role for HCH providers is to serve their own clients in the event of a disaster. "Our clients are very vulnerable physically and psychologically and we have to get to our sites to serve them," Donovan says.

Be prepared to treat casualties. After a flood or earthquake, health care providers may see common illnesses or injuries, but the prospect of NBC terrorism raises the stakes. "Few clinicians have presence-of-mind awareness of the signs and symptoms of bioterrorism agents, such as anthrax, smallpox, and plague," JCAHO notes (see box).⁴ Only one quarter of family physicians surveyed about preparedness for bioterrorism felt prepared.⁶

Disaster casualties may not have physical injuries. For every one physical casualty caused by terrorism, there are an estimated four to 20 psychological victims.⁴ This was the case in Manhattan in the

days after September 11th, when St. Vincent's Hospital prepared for victims that never came. Instead, they opened their family support center to thousands of family members of victims who needed something to eat, a shoulder to cry on, and possible word of their loved ones. By the time the city took over this role, St. Vincent's had served some 6,000 people. "It was a powerful emotional experience," Wojcicki says.

Homeless people also suffered emotional trauma as a result of September 11th, notes **Barbara A. Conanan, RN, MS**, Director of SRO and Homeless Programs for St. Vincent's Hospital Manhattan Department of Community Medicine. "Often, our clients couldn't articulate their feelings verbally, but they came in with physical complaints, such as chest pain and stomach aches for which there were no physical findings," Conanan says. Those who had been previously traumatized, such as rape victims, were especially vulnerable.

Participate in training. In the NACHC survey, 94 percent of respondents cited training as their number one need related to emergency preparedness. In Tulsa, OK, staff of the Tulsa Day Center for the Homeless, Inc., are participating in a series of training modules sponsored by the Tulsa Citizens Corps. The Tulsa Day Center provides day and evening shelter and a nurses' triage clinic. Staff are being educated about the impact of language and diversity issues in an emergency, among other issues. "If we're sheltering in place, language barriers and special dietary needs may be an issue," says **Judy Ward**, Development Director. Several Day Center staff will take Community Emergency Response Team (CERT) training, a 7-week

course funded through the federal Citizen Corps program to teach emergency preparedness, disaster medical operations, and light search and rescue to members of the community.⁷

Help homeless people plan for emergencies. Few HCH programs have the staff or resources to help homeless people prepare their own disaster plans. In Tulsa, the American Red Cross adapted its family disaster training to focus on the needs of people who are homeless.⁸ Case managers and outreach workers in Boston prepared homeless people for increased security at the Democratic National Convention and helped them make alternate plans.

Homeless people may be particularly vulnerable in a situation where individuals are told to stay at home. In Boston, HCHP is working on an addendum to its emergency plan that will spell out systematically how to help people on the street get to safe places.

Seek funding for disaster planning. Many HCH programs cite lack of funding as a significant barrier to disaster planning. In a 2001 survey of health centers, NACHC found that many lack financial resources for drugs, supplies, clinical training, and improving information systems.⁹

In Boston, HCHP uses grants from foundations and the city Department of Public Health to support the work of its Emergency Preparedness Task Force, which meets every other week. A Hospital Bioterrorism Grant from the Health Resources and Services Administration (HRSA) has allowed St. Vincent's Hospital Manhattan to increase preparedness in such areas as communications

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When Disaster Strikes, HCH Takes to the Streets

"It started raining on a Friday, and it looked like a normal day. Nobody realized how much and how fast it was raining," says **Marion Scott, MSN, RN**, Project Director of the Harris County Hospital District HCH program in Houston, TX. When Tropical Storm Allison subsided after 5 days in June 2001, nearly 37 inches of rain was recorded at the Port of Houston. Allison is the costliest natural disaster in Houston's history.¹⁰

OUTREACH TO THE NEWLY HOMELESS The ranks of homeless people swelled as a result of the storm, and HCH responded. "The street outreach model is an excellent foundation for responding to disasters," Scott says. As The Salvation Army, Red Cross, and Federal Emergency Management Agency (FEMA) set up relief sites, HCH parked its mobile medical van outside. Clinical staff treated skin conditions caused by wading in high water, diarrhea, and psychological trauma. In collaboration with City Health

Department personnel, they gave immunizations for tetanus. Patients who lost medications (and in many cases their cars) and/or those needing additional primary care services were given tokens and taxi vouchers to go to the nearest Hospital District Community Health Center.

Homeless shelters also expanded their services to accommodate newly homeless individuals and HCH began conducting increased evening hours at shelter clinic sites, as well. The HCH received additional one-time funding from HRSA to support disaster intervention efforts. Scott has requested funds to purchase a 26-foot mobile medical unit to expand street outreach efforts and to provide increased penetration into communities affected by catastrophic events.

TRAINING THE RED CROSS The October 1989 Loma Prieta earthquake, measuring 7.1 on the Richter scale, was centered

60 miles south of San Francisco. Sixty-two people died, 3,000 were injured, and property damage totaled \$7 billion.¹¹ The Alameda County Public Health Department HCH program sent staff to Red Cross planning meetings. "We already had a schedule of shelters for homeless people we visited, so we fit their shelters in, along with seeing our regular clients," says G.G. Greenhouse.

In addition to treating individuals made homeless by the earthquake, HCH staff trained Red Cross nurses on medical problems they might encounter in homeless people, such as lice and scabies. "Most people in their shelters had been housed, but anybody on the streets could show up," Greenhouse says. HCH staff served residents of Red Cross shelters up to January of the following year. Though they never recovered their costs for this additional work, Greenhouse says. "If disaster strikes, you do what you have to do."

Disaster Planning *Continued from page 3*

and decontamination. In 2002, health centers and Primary Care Associations in eight states used funds from the Centers for Disease Control and Prevention (CDC) and HRSA to develop and implement disaster plans and purchase personal protective gear and communications equipment.⁹

Take care of staff. Staff are on the front line of emergencies, and they must be supported so they can do their jobs effectively and confront their own emotional reactions. JCAHO emergency standards call for the management of staff activities—including housing, transportation, and incident stress debriefing—and staff and family support activities.¹

SOURCES & RESOURCES

1. JCAHO. (December 2001). Mobilizing America's Health Care Reservoir. *Joint Commission Perspectives* Special Issue, 21 (12). www.jcrlinc.com/subscribers/images/pubs/pdfs/JCP-2001-December.pdf
2. Subramanian A, McKinney D. (2004). *Ready or Not? Two Years after September 11th Health Centers Work Steadily to Prepare for Future Disasters.* Special Topics Issue Brief #4. Washington, DC: NACHC.
3. A JCAHO HVA assessment tool is available from the American Society for Healthcare Engineering at www.hospitalconnect.com/ashel/pdfs/secure/2001FebTechDoc.pdf.
- 3a. See www.fema.gov/tab_education.shtm.
4. JCAHO. (2003). *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems.*
5. Tobin K, Freeman P. (May 2004). *Emergency Preparedness: A Manual for Homeless Service Providers.* Boston: The Center for Social Policy. www.mccormack.umb.edu/csp/prepare.jsp
6. Resources for clinicians include the CDC Health Alert Network (HAN) at www.phppo.cdc.gov/HAN/Index.asp and the Clinicians' Biodefense Network at www.hopkinscbn.org. See also Coomber P, Armstrong R. (Undated). *Coping with an Attack: A Quick Guide to Dealing with Biological, Chemical and "Dirty Bomb" Attacks.* Washington, DC: National Defense University. www.ndu.edu/ctnsp/WMD%20Tipsheet.pdf
7. See <http://training.fema.gov/EMIWeb/CERT/>.
8. See www.redcross.org/services/disaster/beprepared/.
9. Pinkelman M. (May/June 2004). Disaster Preparedness in Today's World. *Community Health Forum*, 5 (3).
10. See www.srh.noaa.gov/hgx/projects/allison01.htm.
11. See www.dis-inc.com/lomaprie.htm.

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