Disaster Planning for Vulnerable Populations: Leveraging Community Human Service Organizations Direct Service Delivery Personnel

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Introduction: Given the variability, complexities, and available resources for local vulnerable populations, it is clear that preparing effectively for catastrophic events cannot be accomplished with a single, simple template. Inclusion of Community Human Service Organizations' (CHSO's) direct service delivery personnel ensures that emergency disaster planning efforts for vulnerable populations are effective and responsive to unique needs and constraints. By leveraging existing local resources, it extends the preparedness system's reach to the whole community. **Background:** CHSO personnel already perform community-based services and directly engage with vulnerable and special needs populations; typically they are on the front lines during an emergency event. Generally, however, the CHSOs, staff, and clients are neither adequately prepared for disasters nor well integrated into emergency systems. To address preparedness gaps identified during Hurricane Sandy, regional CHSO and local health department partners requested that the Columbia Regional Learning Center provide preparedness trainings for their agencies and staff responsible for vulnerable clients. **Methods:** Evaluation of this initiative was begun with a mixed-methods approach consisting of collaborative learning activities, a function-based assessment tool, and a 5 Steps to Preparedness module. **Results:** Results from a survey were inclusive because of a low response rate but suggested satisfaction with the training format and content; increases in awareness of a client preparedness role; and steps toward improved personal, agency, and client preparedness. **Discussion:** Direct service delivery personnel can leverage routine client interactions for preparedness planning and thus can contribute significantly to vulnerable population and community disaster readiness. Trainings that provide preparedness tools can help support this role. **Lessons Learned:** CHSO personnel are knowledgeable and have the expertise to assist clients in personal preparedness planning; yet, there are challenges around their ability and willingness to take on additional responsibilities.

KEY WORDS: **community preparedness recovery, C-MIST, community, human service organization, vulnerable populations**

In the last decade, communities across the United States have seen the impact that large-scale emergencies and disasters can have on vulnerable populations. Given the variability, complexities, and available resources for local vulnerable populations, it is clear that preparing effectively for catastrophic events cannot be accomplished with a single, simple template. Inclusion of Community Human Service Organizations' (CHSO's) direct service delivery personnel in client preparedness can ensure that emergency disaster planning efforts for vulnerable populations are effective and responsive to unique needs and constraints. By leveraging existing local resources, it extends the preparedness system's reach to the whole community.

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The Columbia Regional Learning Center (CRLC), located at the Columbia University Mailman School of Public Health, a funded PERLC*, focuses on the power of community engagement and integration into preparedness systems, the risks of human vulnerability, and the complexities of vulnerable population disaster readiness. A fundamental focus of our center's training program is to improve community preparedness—the whole of a community—by increasing and strengthening disaster readiness for vulnerable populations. Well-integrated community preparedness relies on the interdependence of agency-staff-client preparedness to promote and sustain client independence and resilience throughout the disaster continuum. Agencies, staff, and social service networks that serve vulnerable populations require collaborative trainings to address the wide range of unique needs and planning concerns, often overlapping and complex. The CRLC developed a participatory workshop that leverages the knowledge and experience of direct service delivery personnel to inform and create client preparedness tools that address personal preparedness and functional needs.

The purpose of this article is to describe the rationale for development of and experience in conducting a participatory training workshop for CHSO direct service delivery personnel. We provide a description of a core training element: collaborative engagement of direct service delivery personnel. The CRLC also presents methods used to understand training impact and transformation of information from training to staff participation in agency, staff, and, most importantly, client emergency preparedness activities.

Background

In the aftermath of Hurricane Sandy, CRLC's regional CHSO and public health partners identified gaps in their preparedness plans and requested that the CRLC provide preparedness trainings for local agencies and staff responsible for vulnerable clients. During the course of training discussions, it became clear that clients required multiple support and services and that staff would need relevant preparedness tools to assist clients in being disaster ready. These discussions helped us understand the following about preparedness: (1) agency, staff, and client preparedness are interdependent[1]; (2) client preparedness must include a direct understanding of the vulnerable population's unique needs; and (3) an efficient and meaningful way to reach vulnerable populations is through social network (CHSO) points of contact: direct service delivery personnel. Engaging direct service delivery personnel and the inclusion of a function-based approach to understand and address the needs of vulnerable populations are central elements of the workshop.

Policy change advocates Enders and Kailes argue that "traditional response and recovery systems are often not successful at meeting many human needs."[2] They offer a different perspective to address vulnerable population needs prior to, during, and after disasters: "special needs" generally includes people with functional needs who would be "better served during disasters" through the use of a function-based framework for disaster planning to improve functional support services, service delivery and training.[2] In her testimony before the US House of Representatives, Marci Roth, Director of the Office of Disability Integration and Coordination, at the Federal Emergency Management Agency, describes management and operational challenges in that the term "special needs" "can be vague and inconsistent in definitions; a functional needs approach would ensure more effective direct community wide planning tasks."[3] Federal guidelines now incorporate direction for inclusion of a functional needs approach to preparedness planning.

The Public Health Emergency Preparedness Capabilities document states that emergency planners must engage multiple stakeholders in *activities that represent the functional needs of at-risk individuals and promote resources that address these needs*.[4] The 2013 National Response Framework provides a definition of "special needs" that is qualified by functional areas that emergency planners are to consider: "populations whose members may have additional needs before, during and after an incident, in functional areas, including but not limited to Communication, Medical care, Maintaining independence, Supervision, Transportation, known as C-MIST."[5,6] The inclusion of a function-based approach is overwhelmingly supported by the Federal Emergency Management Agency and the American Red Cross in their disaster shelter planning and operations.[3,7]

To inform module content and support learning activities relevant to the objectives, particularly function-based approach (C-MIST), the CRLC sought literature that would describe function-based approach trainings in a public health setting, engaging direct service delivery staff as subject matter experts, learning activities and tools that would foster staff acceptance in taking on a role in assisting their clients in personal preparedness. The CRLC found little in the public health setting that met the criteria; however, we did find coalition

*The PERLC program is designed to address the preparedness and response training and education needs of the public health workforce. Supported by Federal funding (2010 to date), the program includes 14 centers in Council on Education for Public Health accredited Schools of Public Health. For additional information, see www.cdc.gov/phpr/perlc_factsheet.htm.

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trainings that supported C-MIST and frameworks that described trainings with formal social networks.

Some of the most comprehensive emergency preparedness guidelines and recommendations for training formal networks such as CHSOs and their staff that directed much of the workshop development comes from the National Organization for Disability's guidelines for emergency planners, responders, and trainers[8]; British Columbia Coalition of People with Disabilities' community training that uses a Social Organizational Framework to reach, partner with, and train social service networks[9]; and a community outreach model as described in preparedness guidance from National Council on Disability,[10] which describes the value of a participatory collaborative approach in trainings. Format is participatory and provides opportunity for collaboration on the fidelity of content and usefulness of learning activities.

Methods

Partner agencies recruited CHSO representatives for the trainings. In total, the CRLC trained 143 CHSO direct service delivery staff members such as case workers, managers, and coordinators from (local and state) agencies from: alcoholism and substance abuse services, behavioral health, children's services, Commission for the Blind, domestic violence services, developmental disabilities services, elderly services, family health centers, Healthy Start, hospice, hospitals, independent living, long-term care, low-income services, Medical Reserve Corps, mental health, regional economic community action programs, rehabilitation and nursing centers, and visiting nurse services.

Evaluation of this initiative was begun with a mixed-methods approach consisting of collaborative learning activities, a function-based assessment tool, and a 5 Steps to Preparedness module. Results from a survey were inclusive because of a low response rate but suggested satisfaction with the training format and content; increases in awareness of a client preparedness role; and steps toward improved personal, agency, and client preparedness.

Discussion

Overall, the long-term goal is to increase and strengthen disaster readiness for a community's most vulnerable population. To accomplish this, the CRLC must increase and target efforts to more directly reach vulnerable populations to ensure that they are better prepared personally by integrating their needs and presence into emergency disaster planning systems.

The most valuable asset for emergency preparedness and response planners is a knowledgeable, well-trained, and integrated workforce that is representative of the community's resources. The inclusion of CHSO direct service delivery personnel, who have intimate knowledge of their clients' vulnerabilities and can best identify specific key issues and planning considerations throughout all phases of a disaster, provides targeted planning and management for CHSOs, their staff, and emergency planners. Furthermore, the application of a function-based framework approach in planning efforts ensures that community-wide emergency disaster planning activities are effective and responsive to vulnerable population's unique needs and constraints.

Engaging direct service delivery personnel in participatory and collaborative training workshops that provide meaningful tools to help them assist their clients is a promising solution to currently inadequate emergency plans for a community's most at-risk members. The survey feedback and comments by planning partners offer encouragement that CHSO personnel would be effective agents of change to increase the disaster readiness of their vulnerable clients. However, recalling the theme of agency-staff-client interdependence also acknowledges the stated constraints of ability and willingness to take on this additional role. There are other lessons learned from our experience and provide possible solutions.

Lessons Learned

1. Future trainings will include representatives from agency leadership. A highly participatory training workshop that combines personal preparedness, for staff and client, and C-MIST templates for client assessment and management appears to be a promising approach to engaging CHSO direct service delivery staff and by extension, reaching vulnerable populations to increase their personal preparedness. However, it cannot be assumed that training staff alone is sufficient.
2. Future trainings must include functional needs framework. As indicated in each training and awareness presentation, the uptake of incorporating functional needs in public health and health care trainings is not well known.
3. Future trainings must include an interactive component of staff personal preparedness. Many workshop participants indicated that they did not have a personal-professional emergency plan. A key action to achieving staff "buy-in" to adopt a client preparedness role was to "see value" in the personal preparedness action steps for themselves.
4. Recommendations: Invite representatives from agency leadership to future trainings.

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In conclusion, the CRLC offered an innovative training to reach and improve preparedness levels for vulnerable populations. In addition, a secondary outcome was that CHSO personnel created their own personal-professional preparedness plan and thus also improved agency preparedness.

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