NATIONAL ORGANIZATION ON DISABILITY
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Report on Special Needs Assessment for Katrina Evacuees (SNAKE) Project

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I. BACKGROUND

Hurricane Katrina reinforces lessons learned regarding management, policy and training issues identified in previous large scale disasters such as Hurricane Andrew, the Loma Prieta and Northridge earthquakes, and September 11th Terrorist Attacks. The catastrophic scope and impact on seniors, people with disabilities, and individuals who are medically dependent in the Gulf States amplified the problems and made them all the more evident. This report confirms what has been recognized for years that traditional response and recovery systems are often not able to successfully satisfy many of these human needs.

The Federal census of 2000 determined that 19.3 percent of all Americans over the age of five years have a disability, related either to transportation, employment, or self-care. The census shows 23.2 percent of New Orleans residents as disabled, a total about one-sixth above than the national average. Nearby, hard-hit St. Bernard Parish has almost the same proportion with 23.4 percent of its citizens having a disability. Prosperous Jefferson Parish has a disability population of 21 percent, almost ten percent in excess of the national average. Little difference can be found in Mississippi. Hancock and Jackson, the two counties that hug the Gulf Coast and absorbed Katrina's worst blows, have a disability rate of 27.1 and 21.3 percent respectively.

Latest Statistics

As of September 20, 2005, the U.S. Department of Homeland Security reports the following:

- 89,400[1] evacuees are safely housed in shelters nationwide.
- Approximately 1.2 million registrations for individual assistance via telephone and the internet have been taken for Alabama, Louisiana, and Mississippi.
- Approximately 54,800 housing damage inspections have been completed.
- Approximately 83,000 housing units are being prepared for occupancy.
- More than 63.1 million liters of water and more than 26.8 million meals ready to eat have been distributed.
- 44 Disaster Recovery Centers are open in Alabama, Florida, Louisiana, Mississippi, and Texas.

Although local, state, regional, and Federal government agencies play a major role in disaster planning and response, traditional government response agencies are often ill equipped to meet the needs of disability and aging populations during emergencies. The typical approach to delivery of emergency services is not designed to provide the essential help required by these segments of our country's population.

[1] This number includes all individuals in known shelters. However, reports have confirmed that there are many informal shelters or unmandated shelters housing evacuees.

A network of disability and aging specific organizations utilize government and private sector resources to serve the various segments of their clientele. There is no single organization that is capable of serving everyone. This network of providers represents a vast array of national, state, regional, and local human and social service organizations, faith based organizations, and neighborhood associations.

Organizations with a history of specialized service delivery to the disability and aging populations have built their reputations on unique and credible connections trusted by the people they support. Their refined skill-sets and expertise represent a unique know-how and understanding that is a valuable, but often overlooked, source of knowledge. These organizations must be included as partners during emergency planning, preparedness, response, recovery and mitigation activities if local, regional, state and Federal, public and private response agencies are to deal effectively with and to understand the needs, geography, demographics and resources of individuals within their local areas.

Knowledgeable disability and aging specific organizations are prepared to address issues related to the population they traditionally serve.

Most of the issues uncovered by this report can be rectified by long-term studies with action steps that require recommendations beyond the parameters of this account. However, as Hurricane Katrina events transition from the emergency to recovery phase, there are immediate and short-term actions that can be implemented which will vastly improve how the needs of seniors and people with disabilities are met. These issues were common to all affected states.

II. PURPOSE

The singular purpose of this project was to capture a snapshot in time through a representative sampling of experience and observation on the ground. It is recognized that a full and comprehensive review of the impact of Katrina on the special needs population, like all aspects of this national disaster, will be undertaken and completed over time. This project is meant to be an immediate capture of ground information to inform further reviews.

III. TERMINOLOGY

For purposes of this report, the term "**disability and aging specific**" will be used in place of "special needs". The special needs label often used as "emergency responder short cut language" to describe the disability and aging populations is admittedly confusing and unclear. Some people interviewed were unclear as to what groups are actually included in this term. Some responder's definition of who was included in the group was quite narrow.

Within the emergency management field the term S/N "**special needs**" is defined in multiple ways. Often, important segments of this diverse group are overlooked (i.e. people with hidden disabilities, people with serious mental illness, people with intellectual and cognitive disabilities, people with a variety of visual, hearing, mobility, emotional and mental disabilities and activity limitations.)

The term **shelter** means different things to different people. For the purposes of this report the following definitions are used:

> **General Populations Shelter or Shelter**: A facility selected to provide a safe haven equipped to house, feed, provide a first aid level of care, and minimal support services on a short-term basis (e.g. Astrodome).
>
> **Special Needs Shelter or Medical Needs Shelter**: Similar to a general population shelter in service, however, can provide a higher than first aid level of care. There is currently no standard or consistency with these types of shelters.
>
> **Refuge of Last Resort**: This is a facility not equipped with supplies or staff like a shelter. It is a place to go as a "last resort" when there is no alternative left in which one can get out of harm's way. These are often spontaneous.

A **Disaster Recovery Center** (DRC) is a facility established in, or in close proximity to, the community affected by the disaster where persons can meet face-to-face with represented federal, state, local, and volunteer agencies to:

- Discuss their disaster-related needs
- Obtain information about disaster assistance programs
- Teleregister for assistance
- Update registration information
- Learn about measures for rebuilding that can eliminate or reduce the risk of future loss
- Learn how to complete the SBA loan application
- Request the status of their application for Assistance to Individuals and Households

IV. PROJECT OVERVIEW

The National Organization on Disability's (N.O.D.) Emergency Preparedness Initiative (EPI) is currently providing outreach, awareness, and education under a grant from the Department of Education Rehabilitation Services Administration. Within the approved grant deliverables is a component for **"tracking special needs in disasters"**. With this deliverable in mind, N.O.D. coordinated and deployed four rapid assessment teams into the Gulf Coast States (Alabama, Mississippi, Louisiana, and Texas) to capture time-sensitive data on the impact and service delivery to those with disabilities, seniors, and medically managed persons affected by Hurricane Katrina. This representative sampling of experience and observation on the ground is not meant to be a comprehensive review or study.

N.O.D. believes that this report can be used to address immediate challenges and to suggest further review to identify systemic points of weakness and opportunities for immediate actionable corrections that will alleviate suffering during emergency response operations. In addition, this data may support the review and implementation of corrective actions and new protocols to improve the emergency management system, as determined by the appropriate authorities.

The Special Needs Assessment 4 Katrina (SNAKE) project was an extremely fast operation with the singular goal of capturing systemic points of breakdown or immediate actionable correction to suffering. The project was initiated in the spirit of humanitarian oversight for the benefit of all. This was an extremely time-sensitive operation as the opportunity to capture appropriate data and accounts will dissipate with the closing of several major evacuation shelter operations.

N.O.D./EPI has been monitoring the disaster from pre-event into the early recovery operations. It appears that the disability and aging specific communities were woefully under-prepared individually. EPI has been in touch with several of the authorities within the effected region, as well with Federal entities in Washington, DC. At this point there appears to be no singularly coordinated response available for the specialized populations tracked by the SNAKE teams.

V. TIME LINE

The dynamics of a disaster are very fluid and fast shifting, nonetheless, the process of transitioning impacted populations to short and eventually long-term recovery solutions/services begins immediately. The opportunity to capture system approaches, or lack there of, diminishes each day. This is not to say that the impact is resolved but it is a recognition that some special needs issues become evident after a longer period of time following the trigger event. In the future, it is clear that to be truly effective, this type of rapid assessment team must:

- Be on the ground as part of the first deployed team, and
- If not part of the Federal effort, then local and state entities addressing the special needs issues, must at a minimum, have a direct means to communicate the issues to higher authorities for immediate action.

VI. SNAKE OPERATIONS

SNAKE Field Team Composition
Each team consisted of three experienced emergency management professionals, one of which served as a team leader; one a subject matter expert in disability and aging populations during disasters; and another was responsible for transfer of data to the analysis team.

SNAKE Field Operations
Four teams were deployed to major hub shelters and operations centers in areas immediately affected by Katrina as well as to shelters in outlying areas, including those that are hundreds of miles away. Deployment decisions were based on reports from an intelligence officer already on the ground that conducted advance work at all listed locations as of 9/9/05.

The teams deployed for a total of four days including two days for travel and two full days for field operations to the State Emergency Operations Center (EOC) in Louisiana, Mississippi, Alabama and Houston, Texas. From these entry points, the teams determined their site visits after gathering ground intelligence, as the information from the field was ever-changing. All

team leaders remained in constant contact with the primary project contact during the deployment.

In addition to the field teams, N.O.D. relied on the information provided by several trusted sources. Some of these sources included emergency management professionals such as an EOC representative from a large, urban Office of Emergency Management (OEM) assigned and deployed in the first wave under Emergency Management Assistance Compact (EMAC); a doctor with a pre-deployed Disaster Medical Assistance Team (DMAT) who has experience with disability emergency issues; and a representative of the Federal aging network, who established service systems for the region – to list a few.

SNAKE teams met with 26 individuals from 18 shelters (including operations both American Red Cross affiliated and non-affiliated), 4 community based organizations, and 8 emergency operations centers.

Data gathered included:

- information about short-term response efforts, how gaps were identified and filled in the immediate phase, and
- information on long-term recovery efforts currently being established, gaps that exist and how they are being addressed, and
- information to support or disprove "stories" that emerged from the disability and senior communities.

SNAKE Analytical Team
Assembled for a total of six days, the analytical team consisted of five subject matter experts experienced in special needs and emergency management. This team briefed the group operation teams before deployment. The report, as follows, is organized using format of an actionable report. It uses a briefing format and not extended narrative.

SNAKE Report Evaluation Process
Using an evaluation tool created by the SNAKE Analytical Team, the ground teams assessed shelter conditions as related to disability and aging populations. The survey was organized into four major areas:

- sheltering
- management, policies and training
- resources and
- community-based organizations.

The teams looked for strategic level, programmatic and systemic issues. The evaluation process included interviews with lead officials responsible for S/N (if identified), interviews with lead emergency management officials, as well a visual review of shelter conditions as it relates to special needs. Evaluation documents were, with difficulty and delay due to ground conditions, completed electronically and dispatched to the Analytical Team by email and fax for analysis and report generation.

VII. FINDINGS

The percentages listed below are based on a small data pool. While estimated to mirror the larger system support services, these are from 30 surveys not the reported 700 or more shelters that were opened.

To the extent possible, shelter selections should be conducted prior to a need, allowing for an inventory of facilities with the most accessible elements available. Given that these facilities are not meant to be long-term housing opportunities it must be recognized that during emergencies they become congregate facilities. Minimal accessibility should include physical route access within the structure, use of the accessible restroom facilities, communication access within the facility including the announcements being made, to list just a few. However, depending on the type and scope of the disaster, facilities might be utilized to shelter populations that are not, under these conditions, assessed ahead of time. It is critical to have informed staff who can make programmatic adjustments in the absence of structure accessibility.

All people should have a plan in place to shelter with friends and family. Even a medical needs shelter is a place of last resort. Individuals must be advised about how to make decisions regarding their own safety, including planning for evacuation. Shelters are meant as life boats (crowded, limited supplies, threatening outside environment, etc.), not luxury liners and are only a transitional/temporary situation until long-term accommodations can be put in place.

Management, Policies, and Training

50% of those interviewed had policies, plans and guidelines for accommodations in place prior to Hurricane Katrina. Only 36% had someone with expertise onsite to provide guidance regarding appropriate accommodations.

Resources

54% of the respondents did not have any working agreements with disability and aging organizations prior to the event. 50% made contacts with those organizations as a result of their Hurricane Katrina experience.

Community Based Organizations

The gap between emergency management and disability and aging specific organizations widened when the organizations serving these populations tried to connect with the emergency management community - 85.7% of these community-based groups answered that they did not know how to link with the emergency management system.

Shelter Assessments

The quality of the shelters spanned the continuum of models from good practices to unorganized, and chaotic. Coordination and communication among shelters was difficult or completely lacking. This lack of coordination and communication made the work of the disability and organizations, already over taxed, more difficult. This also impaired the deployment of needed volunteers, such as registered nurses and other medical teams.

There were some exemplary shelters that were opened quickly by community entities on their own volition, by individuals with little or no shelter experience. For example:

- An abandoned and dilapidated school was restored to code by a cadre of local volunteers, including electricians, plumbers, engineers and many college students. Evacuees residing in this shelter have abundant amenities available to them. Elaborate medical services are provided, including physicians, registered nurses, mental health practitioners and pharmacists. Day and evening clinic hours are scheduled for both the evacuees residing in the shelter as well as those who had been relocated to temporary housing. Other elements contributory to the overall comfort of the evacuees include day care, a computer room with internet access, an 'around the clock' snack area staffed by ARC, and a separate living area for each family decorated with pictures.

- A city mayor designated the convention center as general and medical needs shelter and appointed a local hero, a respected retired military officer to oversee the entire operation. The services provided, including, a 'Deaf' center with interpreters, accessible shuttle service, three recreation rooms, playground, game room, adult and children's library, movie theater, TV rooms, puppet shows, massage center, internet access, post office, bank, ATM, housing assistance, chapel, NA/AA meetings, barber shops, family reunification, employment opportunities. There was as extensive volunteer structure in the shelter, at times 1 to 1 ratio of volunteers to evacuees. "This was the place to be" with carpeted floors, good lighting, and the volunteers all outfitted in "Operation Compassion" t-shirts, a very pleasant environment.

- Another community-operated shelter is described as having 'no bureaucracy'. Anything that was needed was provided by the community to evacuees, including those with disabilities. The shelter was able to support long term stays and the goal was to assist in the transition of those who choose to return back into the community.

Contrast that with the poor living conditions and a paucity of services and amenities provided in another of the shelters. This shelter was described as having, "extremely poor conditions" Which included, lack of space, overcrowding, scores of evacuees outside shelter in tents, lack of food and drink, unsafe play area, no privacy areas, no mental health or social services on-site, several riots involving evacuees and law enforcement. It was described as, "there was major shelter client despair."

- Two-thirds of those surveyed indicated they had questions regarding disability and aging needs in the intake/shelter registration process. However they expressed concerns that the Red Cross intake process only minimally identifies people with "special needs."

- Shelters claimed to have basic accessibility and supplies for people with mobility disabilities. The most underserved group were those who are deaf or heard of hearing. Less than 30% of shelters had access to American Sign Language interpreters, 80% did

not have TTY's, and 60% did not have TVs with open caption capability. Only 56% of shelters had areas where oral announcements were posted so people who are deaf, hard of hearing or out of hearing range could go to a specified area to get or read the content of announcements. This meant that the deaf or hard of hearing had no access to the vital flow of information.

VIII. MAJOR ISSUES & RECOMMENDATIONS

The issues listed in the following section of the report are based on the analysis and information that was available to the SNAKE Teams while conducting the assessments. We acknowledge the efforts of the Interagency Coordination Council and other entities involved in addressing the urgent needs of the disabled and special needs populations impacted by Hurricane Katrina.

Immediate Issues

I-1: Disability, Activity Limitations and Aging Issues Addressed Through Medical Model
Assistance provided to disability and aging populations often over-emphasizes medicine instead of independent living or advocacy models. This perspective resulted in some people being separated from families and support networks and transferred unnecessarily to medical shelters or nursing homes. Others were not identified because of the lack of trained eyes as well as the lack of or inadequate screening questions. This caused some individuals' conditions to deteriorate to the point that they did require transfer to a hospital, nursing home, or medical shelter. Early response service coordination offered through disability literate organizations could have prevented many of these transfers.

Disability and aging specific populations who need long-term services must have the right to receive such services in the community. The Katrina aftermath must not lead to a reversal of options where people who have been able to live independently with community-based services are forced into institutions in order to receive necessary services.

Recommendations:

- Utilize the skill sets and expertise of disability specific and aging organizations to help prevent deterioration, expensive hospitalizations, or nursing home placements for some evacuees.
- Assist people in quickly replacing critical durable medical equipment (DME) and essential medications to speed a return of their level of functioning, allowing them to manage independently in a general population shelter and in temporary housing.
- Continue to provide the services, support benefits and programs, including Medicaid, to maintain the integrity of the family unit and to allow individuals to live in the community as they rebuild their lives.
- Add questions during all intake processes (shelter, American Red Cross or FEMA applications, and/or other services) that help to identify needs and/or issues of disability and aging individuals. This will allow for more appropriate assistance, referrals, and long-term solutions.
- Ensure that disaster relief services include Federal financing to provide *medically necessary* long-term services in community settings.

I-2: Fiscal Impact on Disability and Aging Specific Organizations Involved In Response

Disability and aging specific organizations who are heavily involved in the Katrina response effort are reporting that their budgets are being depleted.

Recommendation:

- Provide these organizations with supplemental government funding to continue their critical role in the response effort.
- Like after 9/11, philanthropic organizations wishing to contribute need to know about the unintended disaster consequences to front line service organizations that are providing necessary services at the risk of financial damage to the long-term health of their own organization. There is a clear need and a gap to be filled. A cautionary lesson from 9/11 addressed by the Disability Funders Network is that these well intentioned givers need to enlist subject matter experts to assess their giving decisions to be sure that funds are appropriately donated and distributed to organizations providing value-added services in concert with the overall response and recovery system.

I-3: No Use and Under-Use Of Disability and Aging Organizations

The immediate Katrina response reflected no use or, under-use of and sometimes just ignored offers of help from disability and aging specific organizations. There is often no designated entity or individual to "own" and coordinate disability and aging issues.

Each community based organization that was interviewed reported difficulty in gaining access to emergency management authorities to coordinate response and service delivery. This leads to sometimes well intentioned but misguided actions only adding to the management difficulties on the ground.

Recommendation:

- Create a team that mirrors the management structure of the National Response Plan to be put in place to support disability and senior issues. The federal level must have a designated person for these issues who reports directly to the Principal Federal Officer (PFO). This person must have the operational emergency management experience as they become apparent during the response and recovery operation. He/she must be vested with the responsibility, authority, and resources for providing overall day-to-day leadership, guidance and coordination of all emergency preparedness, disaster relief and recovery operations of the federal government on behalf of disability and senior populations. He/she should be in regular contact with other members of the U.S. Department of Homeland Security (DHS) senior staff, including the Director of FEMA as well as the members of the Interagency Coordinating Council on Emergency Preparedness for People with Disabilities, state and local authorities. [2]
  He/she should work directly with an Assistant Field Coordinating Officer (FCO), at each established Joint Field Office (JFO), someone who is focused on special needs issues with an operational background, as well as an expertise in the subject matter. This allows

[2] The response to Katrina was coordinated on many levels of government. As such, while the SNAKE Teams were conducting the research and analysis for this report, several efforts within the disability community were able to become reality. One of these efforts was the agreement of US Homeland Security Secretary Chertoff to send a special needs expert to act as liaison with the PFO located in Baton Rouge and Houston to address the Katrina and Rita response and recovery issues for the special needs population. The Interagency Coordinating Council on Emergency Preparedness and People with Disabilities was able to see this effort through and it is our hope that a qualified special needs expert becomes a permanent part of the PFO team for disaster response.

for a means and mechanism for issues to be brought up the command chain for resolution. This Assistant FCO would then be supported by a multi-jurisdictional team of similarly qualified experts in the field. Teams should consist of federal, state, and local (or regional) representatives who are knowledgeable in emergency management and disability and aging services.

The teams will oversee information dissemination, resource allocation, and service coordination among disability and aging organizations and address issues such as accessible transportation, essential durable medical needs, enrolling of students in temporary special education classes and employment, etc.

The team on the ground would include people with expertise/advocacy backgrounds in the state and local communities (and services available in such communities) to which these individuals should have access, and be present in shelters, temporary housing and other assistance centers. The team would institute information systems for people with disabilities and seniors, identify their support/service needs, and their access to needed supports services.

The teams must be skilled in assessing the general health, well-being and access to support and services needed by the disability and aging populations found in shelters and temporary settings.

They must also be able to orient quickly shelter personnel and emergency managers regarding these needs. This is not unprecedented, as this is exactly what was done after 9/11 in the DASC and the DFO so that service agencies and people working face-to-face in the communities had this awareness training.

While there were numerous government and non-profit agencies doing assessments in the field (e.g. Louisiana Department of Health and Hospitals), it is apparent that there is no unified approach for coordinating this work. The above structure would help to coordinate the many resources that can be placed in the field.

I-4: Disaster Recovery Centers

FEMA officials reported a plan to open a disaster recovery center ("mega DRC") in Houston sometime during the week of September 19th. They are planning to include agencies from all levels of government as well as not-for-profit and community based organizations but must ensure that disability and senior organizations are represented.

Recommendations:

- FEMA, in coordination with local and state authorities, should invite disability and senior groups to participate in the planning, and secure space in the facility. These centers must incorporate local, state, and Federal disability and aging organizations and services into their service delivery process in order to assist with transitioning from shelters to temporary and/or permanent housing, and accessing an array of other services.
- These organizations must develop mechanisms to coordinate with each other to maximize resources and eliminate duplication of effort. One such effort that can be modeled in a DRC is the system established by the 9/11 United Services Group in New York City.

Multiple service organizations came together to coordinate casework, service delivery, and to identify and resolve gaps in services. This allowed for the most appropriate assignments while eliminating duplicative efforts and resources.

- Allow opportunities for cross-training so that organizations become familiar with existing programs and can make appropriate referrals.
- Recognizing that not all individuals go to the disaster centers, descriptions of services should be disseminated using multiple communication arteries (radio, TV, internet, fax sheets, posters, etc.).

I-5: Emergency Information Needed In an Accessible Format
Broadcasters and public emergency management agencies continue to fall short in their responsibilities to modify their information procedures. The FCC's rules require that accessible information be made available to members of the disability community in times of emergency. Section 79.2 of the FCC's rules require that emergency information be provided in an accessible format. The rules further require that all critical details must be made accessible. Critical details include, but are not limited to, specific details regarding the areas that will be affected by the emergency, evacuation orders, detailed descriptions of areas to be evacuated, specific evacuation routes, approved shelters or the way to take shelter in one's home, instructions on how to secure personal property, road closures, and how to obtain relief assistance.

Recommendations:

- The FCC must immediately issue strong statements that remind video programming distributors, including broadcasters, cable operators, and satellite television services that they must comply with their obligation to make emergency information accessible to people with hearing and vision disabilities.
- The FCC needs to acknowledge that these requirements (given the scope of Hurricane Katrina) need to continue in the recovery phase because information is still just as crucial in the aftermath as it is during the response and recovery phases. Communication should include impacted states and areas taking in the evacuees.

Long-Term Issues:

LT-6: Service Coordination Many people need assistance with activities of daily living (i.e. dressing, feeding, toileting, and for some, assistance with activities requiring judgment, decision-making, and planning), as well as, in some cases, primary medical care. Individuals frequently require assistance in arranging services and coordinating among multiple providers. The aftermath of Hurricane Katrina has led to large-scale displacement that has interrupted the networks of support that individuals with disabilities have. People will need knowledgeable help in arranging essential services in new environments with limited contacts and little knowledge of local resources. At the same time individuals seek assistance in arranging and coordinating services while they are scrambling to meet other essential needs such as housing and access to food.

Recommendation: See Issue #4 Recommendations to address this issue.

LT-7: Accessible transportation

To start the recovery process, accessible transportation is critical for some people with disabilities. In many cases, accessible transportation did not appear to be available.

Recommendations:

- Ensure locations selected are serviced by accessible transportation.
- Public transit agencies should ensure that all transportation between shelters, housing and disaster relief centers is accessible.

LT-8: Cross Training

Disability and aging specific advocates and service providers need to strengthen their understanding of emergency management local and state systems. In order to improve effectiveness, they need a quick orientation to emergency management organizations and structure, as well as to the roles of traditional recovery organizations such as FEMA, the American Red Cross, and other Voluntary Agencies Active in Disaster (VOAD).

Likewise, emergency managers need to strength their understanding of disability and aging populations. This falls into many different areas including donations management, sheltering, feeding, service delivery, etc.

The misguided impression that aging and disability issues is not of concern to general shelter managers was a stated assumption expressed by several shelter managers. There must be a realization that all shelters, emergency managers and disaster relief centers, serve disability and aging populations even if not specifically articulated in their task assignment or mission statement. People with disabilities do have various disability-specific needs (e.g., transferring from wheelchair to cot, providing guidance to a blind person through crowds to the restroom) that are not burdensome and that shelter staff can be trained to perform. Many of these people do not need a medical shelters or segregated services. However, many of these people are in need of a variety of complex, and sometimes not well understood, community services to reestablish and piece segments of their lives back together.

Recommendation:

- Both emergency managers and disability and aging specific organization should engage in some quick cross orientation/training meetings.
- Emergency management staff should acquire basic knowledge of the emergency management local and state systems. FEMA courses G197 Emergency Planning and Special Needs Populations (training for local and state emergency planners and organizations serving seniors and people with disabilities) and IS 197 (once available) would be a start.
- Use disability and aging specific organizations to strengthen responders understanding of:
  - Which organizations can offer what services under what conditions.
  - People with disabilities are not a homogenous group but rather have differing capabilities, opinions, needs, and circumstances, and no one individual or organization speaks for all people with disabilities.

LT-9: Durable Medical Equipment (DME)

People with disabilities were sometimes forced to leave expensive DME (augmentative communication devices, wheelchairs, walkers, respirators, etc.) at airports, bus loading areas, shelters, etc. Customized power chairs can cost up $30,000 - $40,000.

Recommendations

- When transporting individuals, make every effort not to separate users from their DME's.
- Tag with the owner's name all DME not easily replaced or that must be left behind.
- Attempt to return a DME to an owner as soon as possible. Use systems similar to posting missing children's photos on specific web sites.
- Vendors and responders should look to the National Emergency Resource Registry that was recently expanded as a direct result of the impact of Hurricanes Katrina and Rita.
- Consider creation of a national stockpile of DME or add to the Centers For Disease Control Strategic National Stockpile to ensure readily available supplies of durable medical goods would be available to communities.

LT-10: Finding Accessible, Affordable, Safe Housing and Communities

Finding accessible, affordable, safe housing and communities has never been easy for people who live with mobility and activity limitations. Even before Katrina, there was a serious shortage of housing options for people with disabilities. Post Katrina, the task of finding temporary and permanent housing and communities will be even more difficult.

The immediate and long-term rebuilding process offers a unique opportunity to build, on an unprecedented scale, accessible communities and accessible and adaptable housing. This will help thousands of people with disabilities maintain or improve their ability to live independently and will enable hundreds of thousands of people, regardless of disability, to age-in-place as they acquire activity limitations. This includes the wave of baby boomers that begin turning 65 in 2006.

Lack of accessible housing opportunities for individuals with disabilities does and will continue to result in unnecessary and expensive institutionalization. Available data discloses that the costs of providing appropriate housing options for people with disabilities is well worth the investment because of the significant savings that results from enabling people with disabilities to live in the community, find employment, and pay taxes.

Recommendations:

- As a rebuilding measure in the Gulf Coast States, government should make all funding requests contingent on changes in building codes to stress accessibility for persons with disabilities, including:
    - The US Access Board's new construction and alterations guidelines - ADA Accessibility Guidelines (ADAAG) for Recreation Facilities. The guidelines will ensure that newly constructed and altered recreation facilities meet the requirements of the ADA and are readily accessible to and usable by individuals with disabilities.
    - ADA and ABA Accessibility Guidelines (7/23/04) that update access requirements for a wide range of facilities in the public and private sectors as covered by the law.
    - The US Access Board's draft guidelines regarding public rights-of-way which cover pedestrian access to sidewalks and streets, including crosswalks, curb ramps, street furnishings, pedestrian signals, parking, and other components of public rights-of-way.

- Offer significant tax incentives for the design and construction of housing and other buildings and facilities that adopt visitability standards.
- Establish regulations that incorporate a basic level of universal access with at least one, zero-step entrance and wide interior doors in every new home and multi-family dwelling units financed in whole or part by Federal funding.
- Facilitate immediate collaboration between disability design experts familiar with universal design concepts and contracting Federal officers who will promulgate and enforce regulations involved in construction of temporary and permanent housing.
- Create significant tax incentives for the design and construction of universally accessible or adaptable temporary and permanent housing GOING BEYOND the minimum requirements found in the Fair Housing Act Amendments of 1988.

Policy Issues:

P-11: Gulf Opportunity Zone

President Bush has proposed the creation of a Gulf Opportunity Zone, encompassing the disaster region in Louisiana, Mississippi and Alabama. Within this zone, incentives for job-creation, tax relief for small businesses, and loans and loan guarantees for small businesses, including minority-owned enterprises would assist in getting the region up and running again.

Recommendation:

- When the Enterprise Zone is created ensure that the interest of people with disabilities and seniors is specifically included in the criteria for funding.

P-12: Medicaid Is a Critical Benefit

Medicaid is a critical benefit for a significant number of people with disabilities including individuals with physical or sensory impairments, mental illness, mental retardation, autism and other developmental disabilities, cerebral palsy, epilepsy, traumatic brain injury, HIV/AIDS, diabetes and other chronic conditions. Because Medicaid and its comprehensive benefits package is the predominant provider of disability-related services, it has a unique capacity to meet the needs of people with disabilities in the aftermath of Hurricane Katrina.

Many people with disabilities will need to reestablish support networks in the areas where they have been relocated. This is especially important for people with serious mental illness, many of whom rely on a therapeutic regimen that creates stability in their lives. Given the emotional trauma and toll following Hurricane Katrina, it is wise to anticipate new mental health needs resulting from post traumatic stress disorder, increased incidence or increased severity of anxiety disorders, depression, alcohol and substance abuse. The variation in Medicaid coverage limits for mental health services from state to state presents additional challenges.

Recommendations:

- Legislation is proposed to provide disaster relief Medicaid to all affected survivors. This approach is critical to people with disabilities. A streamlined application process with self-certification must be included in order to direct Medicaid resources to providing services and not to administering a complex eligibility determination process.
- Federal policy must ensure that broad access is available for current recommended treatments, including access to needed medications and treatment for alcohol and

substance abuse. Coverage for these services must be available to survivors even in cases where the need for services is in excess of typical benefit limits.

IX. Conclusion

All levels of government experienced systemic failures in their efforts to respond to the needs of the disability and aging populations following Hurricane Katrina. It is time now to move from lessons learned to lessons applied. Emergency professionals and response organizations must seek out and utilize the expertise of disability and aging networks to reduce or eliminate barriers to effective service delivery. People with disabilities must become familiar with emergency protocol in order to work effectively with emergency responders before, during and after an emergency. N.O.D. has been committed to these cooperative efforts through our Emergency Preparedness Initiative launched immediately following the tragedy of 9/11. Today, N.O.D. proposes to establish an independent Task Force comprised of stakeholders to examine how the issues identified in Hurricane Katrina can be applied to future emergency planning and response. N.O.D. will disseminate the Task Force findings widely and will present a comprehensive list of recommendations to decisions makers at the federal, state and local levels.

We, as a nation, can do more to improve the outcomes for people with disabilities and the aging population the next time disaster strikes—and there will be a next time.

Survey Notations

This data is representative of only a small sampling and is not intended, nor appropriate, to apply findings to the over 700 known facilities (and the many unknown) that were opened to shelter Hurricane Katrina evacuees.

The survey tool developed very quickly by the Analysis Team and the individual surveys are provided as an Appendix. The surveys were intended to be topic guide roadmap or check-off list for the ground teams. Therefore, some inconsistencies have been noted in the findings. For example, 25.9% of respondents said that there was a special needs services desk, while 50% of respondents said there was signage for special needs services desk.

The data from Louisiana was inputted for qualitative data, but the qualitative data was given mostly by phone and fax due to access limitations to internet connectivity.