

## Public Health Emergency Planning Toolkit

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Prepared for the Association of State and Territorial Health Officials by the  
World Institute on Disabilities

# Toolkit for Inclusive Public Health Emergency Planning

This toolkit is designed to answer questions and provide information for audiences working towards disability inclusive planning. The toolkit prioritizes inclusive planning and provides overarching guidance and considerations that can be applied to a variety of health and public health systems and structures. This toolkit, while not exhaustive, highlights key planning considerations to ensure public health emergency plans include people with disabilities. This toolkit is intended to be used in conjunction with other department and agency plans, as well as disability agencies in the local jurisdiction.

## Planning Concepts of Inclusion in Emergency Plans

There are many planning concepts to consider when creating, modifying, and implementing public health emergency plans for the whole community. This section introduces some essential planning concepts and principles that provide the foundation for inclusive planning.

### People with a Disability and Disasters

According to the World Health Organization (WHO), there are over a billion people in the world who have a disability. In the United States, [an estimated one-in-four people \(approximately 26%\)](#), live with a disability. People may have different disabilities, including visible and invisible disabilities. Invisible disabilities include medical conditions such as diabetes or seizure disorders, health conditions requiring medication, traumatic brain injuries, cognitive disabilities that impact a person's ability to understand or process information, being deaf or hard of hearing, or having low vision.

People with disabilities are consistently disproportionately impacted by disasters. According to WHO, and the United Nations, research has shown that people with disabilities [are two-to-four times more likely to be injured or die in a disaster](#). Disasters can lead to new disabilities while exacerbating existing ones. There are many factors contributing to this inequity, including a lack of inclusive planning; lack of awareness and knowledge in all phases of the disaster cycle; sociological barriers (e.g., lack of access to emergency and disaster assistance, misperceptions, lack of disability training for responders, inaccessible response systems); and implicit social bias.

The COVID-19 pandemic perpetuated triage policies that exclude or disadvantage people based on their disability, including via implicit quality-of-life assessment when determining allocation of scarce resources; lack of accessibility and capacity to assist people with disabilities; and categorical exclusion from treatment based on disability.

### Key Principles of Inclusion

Inclusion must be integrated into all activities and is accomplished through a collaboration with people with disabilities throughout the planning process. The following are key principles to be applied in all planning efforts.

**Equal Access:** People with disabilities must be able to access the same programs and services as the general population.

**Physical Access:** People with disabilities must be able to access locations where emergency programs and services are provided.

**Access to Effective Communication:** People with disabilities must be given the same information provided to the general population.

**Inclusion:** People with disabilities have the right to participate in and receive the benefits of emergency programs, services, and activities.

**Integration:** Emergency programs, services, and activities typically must be provided in an integrated setting.

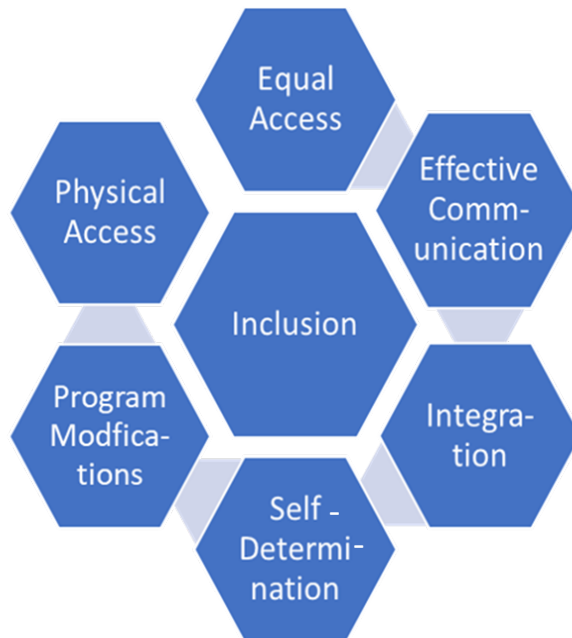
**Program Modifications:** People with disabilities must have equal access to programs and services, which may entail modifications.

**No Charge:** People with disabilities may not be charged to cover the costs of measures necessary to ensure equal access and nondiscrimination.

**Self Determination:** People with disabilities must be provided opportunity for personal choice and self-determination to the same degree as the general population with respect to participation in any programs and services.

### **Collaborative Planning: Nothing About Us Without Us**

To achieve disability inclusion in emergency planning, people living with disabilities must be included in and integrated into all facets of emergency planning. The disability community are subject matter experts in inclusion and are key partners in planning. Collaborative planning with people with disabilities requires agencies to partner with stakeholders from the disability community as equals.



The accepted best practice of a whole community approach can help achieve collaborative planning. The whole community approach is based on three principles found in the [FEMA Whole Community Approach to Emergency Management Principles, Themes, and Pathways for Action](#). They are:

1. Understanding and meeting actual needs.
2. Engaging and empowering all parts of the community.
3. Strengthening what existing practices already works well in communities.

When applying these principles to collaboration with the disability community, the planning process and the plans become more inclusive. Disability community partners provide valuable information on existing needs, lived experience, and proven solutions. People with disabilities are best able to judge their own needs and are therefore the most knowledgeable about selecting solutions.

According to the [World Institute on Disability](#), **“The rights of people with disabilities do not disappear in times of crisis.”** Therefore, inclusive disaster planning is imperative and cannot exist without a strong partnership with people with disabilities.

## **The Communication, Maintaining Health, Independence, Safety and Support, and Transportation Framework**

Not all people with the same disability have the same need. Therefore, it is important to not only consider the “disability type” or “label” when conducting emergency planning, but to also evaluate the “functional needs” of people with disabilities. The U.S. Department of Health and Human Services (HHS) uses a functional needs framework to identify and understand the needs of people with disabilities and others with access and functional needs in emergency planning and preparedness.

The framework includes five essential functional needs categories: [Communication, Maintaining Health, Independence, Safety and Support, and Transportation \(CMIST\)](#). CMIST provides a useful and flexible framework for emergency planning and response, emphasizing the functional needs that should be addressed so that topic areas can be specifically considered. The chart below expands on each functional need area of the framework.

<b>C</b>	<p><b>Communication</b></p> <p>Some people have difficulties receiving and responding to information. People with communication needs may have reduced or no ability to see, hear, or speak. They may also have limitations understanding or learning. This category also includes people who cannot speak, read, or understand English.</p>
<b>M</b>	<p><b>Maintaining Health</b></p> <p>For the purposes of emergency planning, this category includes people who need assistance with daily living activities, such as a grooming, bathing, eating, dressing, or toileting. This also includes people who are managing their chronic, contagious, or terminal illnesses, as well as people requiring services or supplies such as medications, IV therapy, feeding tubes, dialysis, oxygen, or suction to continue to manage their medical needs.</p>
<b>I</b>	<p><b>Independence</b></p> <p>Some people use medication or assistive devices to function independently daily. This includes use of mobility aids (e.g., wheelchairs, walkers, canes), communication aids (e.g., hearing aids, computers), medical equipment (e.g., syringes, oxygen), or service animals.</p>
<b>S</b>	<p><b>Safety, Support and Self Determination</b></p> <p>Some people may require support to maintain their physical safety if they experience dementia; Alzheimer’s; brain injury; or psychiatric, behavioral, mental, cognitive, intellectual, or developmental disabilities. Individuals may require assistance when making decisions for their own self-determination.</p>
<b>T</b>	<p><b>Transportation</b></p> <p>Transportation is an essential part of emergency planning. People who do not drive because of a disability, legal restriction, temporary injury, age, poverty, or lack of access to a vehicle are included in this category. Transportation needs include accessible vehicles, drivers, and methods to on- and off-board.</p>

## Inclusionary Planning

Emergency preparedness plans have a specific and important role in a jurisdiction’s plans and are pivotal to the inclusive planning process. There are many types of emergency plans, each of which meets different needs. Planners are responsible for ensuring that agencies’ and partners’ plans coincide and are compatible.

### Public Health Plans Review

A key component of community resiliency is ensuring all members of the community are included in the preparation for, response to, and recovery from a crisis. Planners should review or develop plans with an eye for disability inclusion by using the tools in this resource to ensure plans are developed with the whole community in mind.

## Planning in Collaboration with Other Response Partners

Planning for community resiliency does not occur in a silo. Depending on the type of emergency, a public health agency's role may be secondary to other lead agencies. In a pandemic, [Emergency Support Function #8](#) of the federal capabilities structure assumes that the public health agency will be the lead agency. This is different from a mass casualty event, such as an evacuation from a hurricane, where the public health agency may play a supporting role, such as by evaluating shelter locations for sanitary conditions and tracking disease outbreaks in the shelter to minimize the spread of illnesses.

Agencies should coordinate developed public health emergency or disaster plans with the local jurisdiction emergency management offices. The public health agency should also be prepared to coordinate with whomever is designated as the lead agency for other emergency support functions (ESFs). For example, [ESF 6](#) (Mass Care, Housing, and Human Services) is often led by health and human services while [ESF 2](#) (Communications and Alerting) is often led by public communications. Understanding everyone's role in the disaster and how agencies interconnect is essential to assisting the community in crisis situations.

## Utilizing the National Incident Command System

The [National Incident Command System \(ICS\)](#) model provides command, control, and coordination of a response. It provides a means to coordinate the efforts of individual agencies as they work towards protecting lives, property, and the environment. Training and information on ICS are free to the public via [FEMA](#). It is important that public health personnel and planners have a thorough understanding of ICS when writing or reviewing plans. Agency and department plans must coordinate and correspond with one another, and a thorough understanding of ICS allows planners to create plans that do not conflict with those of other agencies.

# Public Health Emergency Preparedness Domain Guidance

## Public Health Emergency Preparedness Requirements

The [Public Health Emergency Preparedness \(PHEP\) requirements](#) are founded from the [2006 Pandemic and All-Hazards Preparedness Act \(PAHPA\)](#) that enhanced public health preparedness and response to expand to an [all-hazards approach](#). PHEP lays out a roadmap for developing public health emergency preparedness programs. It provides standards to assist public health departments with their strategic planning, using preparedness capabilities and domains. To guide activities, this toolkit utilizes the PHEP domain format requirements and provides tips and tools for ensuring inclusive planning in the domains of:

- Community resilience.
- Incident management.
- Information management.
- Counter measures and mitigation.
- Surge management.

## Strengthen Community Resilience

Community resilience addresses the community's ability to withstand, adapt, and recover from a disaster or public health emergency. General strategies and activities under this domain include determining the risks to the health of the jurisdiction; coordinating with community partners to disseminate information through all phases of an incident; and supporting recovery needs for public health and related systems.

The section below describes important considerations for disability inclusion in community resilience.

### Demographic Data Research

Developing demographic information that is specific to the disability community is critical when providing applicable processes in a disaster. A first step is to work with agencies in the jurisdiction that collect information, as well as with existing data sources. Such might include the county/city department on disabilities or human and social services departments that provide programs and services to the disability community.

National demographics resources can provide additional overarching disability-related demographics for the jurisdiction. National demographics sites include:

- [The Social Vulnerability Index](#)
- [Cornell University Disability Statistics](#)
- [American Community Survey User Guide](#)
- [CDC Data and Statistics on Disability and Health](#)
- [HHS Empower Map](#)

### Identifying Community Function

A second and critical action is coordination with community partners who can provide information on how the community functions on a daily basis, help form connections with community leaders, and accurately assess the needs of people with disabilities. Outside partners can include support organizations such as Centers for Independent Living, Voluntary Organizations Active in Disasters, and other community services that focus on assisting disability populations. These relationships are not only a valuable source of data, but serve as force multipliers for community resources.

### Identifying and Supporting Recovery Needs for Public Health

Individuals with disabilities often have the greatest needs and most difficulty returning to their baseline level of living after a disaster. Reinvestment and return of critical support systems for people with disabilities after a disaster can extend beyond the duration of some public services (e.g., accessible housing and transportation, in-home health services). This further strains their personal resources and delays a return to a pre-disaster level of independence.

Strategies for inclusive recovery include:

- Identifying needs that could be most impacted by a disaster in advance, and developing plans that account for these potential losses.
- Pre-positioning of resources or services that then can be readily available after the disaster.
- Training case managers, social workers, disaster recovery staff, and volunteers to assist people with disabilities in accessing services.
- Enhancing recovery and people’s ability to maintain independence by better understanding the unique needs of individuals with disabilities post-disaster.
- Including partner organizations and agencies that focus on disability needs and services in disaster recovery centers.
- Ensuring disaster recovery centers and other facilities are physically and programmatically accessible.
- Planning for pre-event disaster housing for people living with disabilities (Appendix A: *Post-Disaster Housing Planning for People with Disabilities* provides guidance to assist jurisdictions with planning).
- Ensuring people with disabilities do not experience additional impact and potential loss of independence when required to shelter in place (Appendix B: *Guidance for Inclusive Sheltering in Place* provides considerations for planning for provision of services when these events occur).
- Developing canvassing or wellness check procedures that can be implemented post-disaster to rapidly identify the needs of the community, including individuals with disabilities.

## Strengthen Incident Management

Incident management is the ability to activate, coordinate, and manage public health emergency operations throughout all phases of an incident through the use of a flexible and scalable incident command structure, which is consistent with the National Incident Management System and coordinated with the jurisdictional incident, unified, or area command structure. Specific inclusive strategies for this domain include:

- Integrating a disability, access, and functional needs technical specialist in the incident command system to provide subject matter expertise and serve as a liaison with organizations that support disability populations.
- Inclusion and engagement of persons with disabilities in the planning, design, and execution of exercises and drills.
- Development of disability stakeholder groups or task forces that are involved in emergency operations plans review or revision.



## Strengthen Information Management

Information management is the ability to develop and maintain systems and procedures that facilitate the communication of timely, accurate, and accessible information, alerts, and warnings using a whole community approach. It also includes the ability to exchange health information and situational awareness with federal, state, local, territorial, and tribal governments, and partners.

All emergency or disaster related messages and information must utilize inclusionary messaging strategies. Messages should be meaningful to people living with disabilities and integrate their needs. Messages must be delivered in a way that is culturally appropriate, meaningful, and useful to the person receiving the message. This includes public service announcements, public warning and notifications, and messaging delivered throughout the course of the event.

Planners should consider multiple formats for communication, including verbal, written, accessible media, public announcements, one-on-one in-person communication, and interpretive and translation services. Personnel who are crafting and disseminating public messaging need to be trained in accessible messaging techniques.

*Appendix C: Appropriate and inclusionary Language for Developing Documents and Effective Communication* provides information to assist in crafting and disseminating accessible messaging and information.

## Strengthen Countermeasures and Mitigation

Countermeasures and mitigation are the ability to distribute, dispense, and administer medical countermeasures to reduce morbidity and mortality. This is often viewed as how a public health agency distributes medications in disasters, such as vaccines and medications from strategic stockpiles after terrorist events. However, strategies also include the ability to develop and implement non-pharmaceutical health and safety measures.

The section below describes important considerations for disability inclusion in countermeasures and mitigation.

### Inclusive Points of Distribution

Disaster response often requires establishing a centralized location where survivors can pick up relief and essential supplies. These are called Points of Distribution (PODS). When developing inclusive POD plans, ask the following questions:

- Is the POD in an accessible location?
- Has someone with disability accessibility expertise visited the POD to identify any outstanding accessibility needs before it is opened to the public?
- Are POD staff trained to assist people with disabilities, including physical, sensory, cognitive, and intellectual disabilities?

- Are registration areas designed with consideration for people with mobility issues or those who cannot stand for extended periods of time?
- Is there assistance available for people who are filling out forms or receiving instructions (i.e., interpreter or translator services, individual assistance with filling out forms, quiet spaces)?
- Does signage follow the guidelines and requirements for ADA accessibility?
- Are way-finding services available for those who are blind, have low vision, or have cognitive disabilities?
- Is accessible transportation available to help transport people with disabilities to the POD?
- Does the distribution plan include individuals who are unable to leave their homes?
- Are follow-up instructions written in an inclusionary manner and available in multiple formats? (see Appendix C for *Appropriate and Inclusionary Language for Developing Documents*)

### **Non-Pharmaceutical Interventions**

When developing non-pharmaceutical interventions, consider how interventions may create a disproportionately negative affect on people with disabilities. For example, loss of a caregiver, service animal, or personal assistive services can create significant barriers for a person living with disabilities to carry out critical daily activities like eating, toileting, or moving around.

### **Strengthen Surge Management**

Surge management is the ability to coordinate partners and stakeholders to ensure adequate public health, healthcare, behavioral health services, and resources are available during events that exceed the normal capacity of the public health and medical infrastructure of an affected community. This includes coordinating expansion of access to public health, healthcare, and behavioral services; mobilizing medical and trained volunteers as surge personnel; conducting congregate location surveillance and public health assessments; applying disability accommodations and functional needs support services; and coordinating with organizations and agencies to provide fatality management services.

### **Mass Care Services**

Mass care services can encompass several services that the jurisdiction may need to provide to survivors of a disaster, including evacuation, sheltering, feeding, human services (e.g., medical/mental health, case management, infant and children’s needs, security, housing, transportation), and volunteer and donations management. Public health agencies may play varying roles under mass care, depending on the structure and responsibilities defined in the jurisdiction’s operational plans.

The following checklist outlines some steps for mass care preparedness, planning, and response related to people with disabilities and/or access and functional needs. In some instances, these responsibilities may belong to the local jurisdiction and public health will play a supporting role. Shelter facilities include the following types: general population shelters, non-traditional shelters, medical shelters, evacuation or reception centers, disaster assistance and resource centers, mass or congregate feeding sites, PODs, safe refuge sites, resettlement processing centers, and decontamination sites.

- ✓ Identify and designate an individual to serve as a disability, access, and functional needs technical specialist who will be available in the Public Health Command Center or jurisdiction's EOC to provide technical assistance for people with disabilities.
- ✓ Identify community partners who support disability populations and include them in mass care planning and training. Develop coordination and notification processes with these agencies to better incorporate them into the response process.
- ✓ Work with emergency management to determine the roles and responsibilities of public health experts in the shelter settings.
- ✓ Provide technical expertise related to functional needs support services and shelter placement so that people with disabilities can maintain their independence.
- ✓ Engage with local disability-led organizations to provide expertise to the response.
- ✓ Coordinate adequate and appropriate personal assistive services in shelter and other congregate settings.

### Medical Surge

A medical surge describes the jurisdiction's ability to provide adequate medical services during an event to meet community needs, when those needs exceed the existing capacity. Addressing medical surge involves two aspects of services, surge capacity and surge capability. Surge capacity is the ability to address the volume of need, while surge capability is the ability to address the range and specialization of care needs. This checklist outlines some medical surge considerations related to inclusion, equity of services for people with disabilities, and access:

- ✓ Establish roles and responsibilities for coordination of medical surge response.
- ✓ Establish process for chain of command and control in a medical surge event.
- ✓ Pre-plan how individuals with disabilities will be triaged and treated in a social model vs. a medical model.
- ✓ Ensure volunteers receive training in disability etiquette, person-centered approach, and assisting individuals with disabilities.
- ✓ Plan to perform environmental health assessments and screenings.
- ✓ Provide expertise related to decontamination of people with disabilities or with chronic medical conditions to include:
  - Providing accommodations through the decontamination line for people who need physical assistance.
  - Decontaminating durable medical equipment and replacing it in the event that it is damaged or destroyed.

- Replacing consumable medical supplies (e.g., oxygen tubing).
- Communicating with and explaining the decontamination process to individuals with cognitive or intellectual disabilities (e.g., explain they need to remove clothes).
- Decontaminating service animals.

### Mass Fatality

While ESF #8 assigns the lead role for mass fatalities to public health experts, mass fatality plans are frequently written differently to assign the lead role to another department. However, public health should be prepared for this role.

- Collaboration with the jurisdiction’s emergency management and medicolegal authority (e.g., coroner, medical examiner, justice of the peace, judge), especially related to pandemics/epidemics, mass fatalities, and biological exposure events that will require an inclusive and accessible epidemiological surveillance or investigation.
- Coordinating with partner agencies in the development of a mass fatality family assistance center to ensure physical, programmatic, and communication access needs of persons with disabilities.
- Coordinating mass fatality-related stress management, de-escalation, clinical services, wellness checks, and counseling support for the community to address pre-disaster and disaster caused mental health support needs.

### Conclusion

This toolkit is designed for use by a wide audience to provide general direction, information, guidance, and considerations for ensuring that emergency operations plans are fully accessible and disability-inclusive.

The principles of inclusion and their application should be applied to all disaster planning and to every disaster event. Key steps to achieving these goals are:

- Engaging with the disability stakeholders.
- Understanding the actual needs in the disability community.
- Providing equal access to all disaster programs and services.

These principles and practices will contribute to minimizing disproportionate impact of disasters and increasing equity for people with disabilities.

## Appendix A: Post-Disaster Housing Planning for People with Disabilities

This section provides guidance on how to incorporate the capabilities of jurisdictions and community partners to support and optimize recovery for their communities as it's related to post-disaster housing needs and community members who may be disproportionately impacted by a disaster. Individuals and families may be left homeless and have temporary or permanent housing as an unmet need.

Disaster housing for people with disabilities may take longer to locate due to their additional needs. As part of mitigation and preparedness strategies, there should be a pre-disaster assessment of potential accessible temporary housing assets, as well as long-term permanent housing strategies for housing individuals and families after a disaster that results in loss of homes or residences.

The need to plan for temporary and permanent housing post-disaster is increasingly complex and critical for individuals with disabilities and others with access needs and/or functional needs. Traditional residences may not accommodate specific accessibility needs. Pre-identification of accessible housing reduces or eliminates the disproportionately long time that individuals with disabilities and others with access and functional needs may be forced to remain in temporary situations. Using a collaborative whole community approach means involving stakeholders who are representative of all aspects of the community in planning and implementation actions, including:

- Representatives from government agencies who have a role in providing disaster housing and wraparound services, such as the County Department of Planning and the Office for People with Disabilities.
- Nonprofit organizations.
- Local land developers and builders (especially those with experience in universal access).
- Volunteer organizations.
- Disability and disability-led organizations.
- Faith-based organizations.
- Chambers of commerce and small business representatives.
- Organizations representing the needs of children, seniors, people with access and functional needs, people with limited English proficiency (LEP) and historically underserved populations.
- Organizations representing culturally sensitive locations (e.g., tribal sacred grounds) and/or historical sites.

### Defining Accessible Housing

Accessible housing does not only refer to physically accessible structures. Programs and services that are necessary for maintaining health and independence should also be available, and information about these programs should be effectively disseminated. Programmatic accessibility can include:

- Access to public and accessible transportation (for appointments or employment).
- Access to healthcare system (e.g., home health, community clinics, pharmaceuticals).
- Access to social and community services (e.g., schools, employment facilities, behavioral supports, social and recreational resources, services that support activities of daily living, community networks of support).
- Access to mail (for medications or receipt of Social Security payments).
- Access to ground floor and single-story community resources.
- Access to electricity and water (for people who are dependent on electricity for their medical equipment, refrigeration, health maintenance).
- Communication resources (e.g., cell and telephone connections, publicly available devices).

## Additional Resources

- Planning Considerations Disaster Housing, Guidance for State, Local, Tribal and Territorial Partners, FEMA, May 2020. <https://www.fema.gov/sites/default/files/2020-07/planning-considerations-disaster-housing.pdf>
- National Mass Care Strategy: <https://nationalmasscarestrategy.org/category/fema/>
- CDC maintains a Social Vulnerability Index (SVI) based on U.S. Census data to determine a community's social vulnerability. CDC defines social vulnerability as the resilience of communities confronted by external stresses on human health (e.g., natural or human-caused disasters or disease outbreaks). Factors such as poverty, crowded housing and lack of access to transportation impact social vulnerability. <https://svi.cdc.gov/>
- CDCATSDR Social Vulnerability Index: <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>
- HUD's Homeless Assistance Programs: A Guide to Counting Unsheltered Homeless People, 2008. [https://files.hudexchange.info/resources/documents/counting\\_unsheltered.pdf](https://files.hudexchange.info/resources/documents/counting_unsheltered.pdf)

# Appendix B: Guidance for Inclusive Sheltering in Place

Sheltering in place is a response to an emergency that creates a situation in which it is safer to remain in the building rather than evacuate. Shelter-in-place is generally a response to short situations up to 72 hours. This may indicate a hazardous situation such as a hazardous chemical release or a severe weather event. A shelter-in-place warning may be issued for several reasons, including but not limited to:

- A hazardous materials release requiring sealing up windows and doors may be necessary.
- An active shooter or active threat situation (may also be known as lock down).
- Inclement weather such as a severe storm or tornado, which may require sheltering in place but away from windows.

Sheltering in place can provide immediate protection and limits exposure to a hazard. Advantages of sheltering in place to the whole community include immediate implementation, as well as allowing people to remain in familiar surroundings and access to everyday necessities such as the telephone, radio, television, food, and clothing, durable medical equipment, consumable medical supplies, medication, comfort items, home modification equipment (e.g., lifts, ramps, modified counters and showers, audible alarms, visual alarms), and in-home supports (e.g., screen reader software, back up batteries, in-family personal assistants, installed equipment, special diet foods).

However, the amount of time people can safely stay sheltered-in-place is dependent on the availability of necessary resources and supports, such as their in-home supply of food, water, medications, medical care, utilities, backup power source, assistance with activities of daily living, need for out-of-home services (e.g., dialysis, food services, in-home skilled nursing), and access to accurate and reliable information. Individuals with access and functional needs should be a priority for restoration of services and safety checks, as they may be at greater risk throughout a prolonged shelter-in-place order.

## Shelter-in-Place Considerations

Prior to recommending an evacuation order, public health officials will evaluate the benefit of in-place sheltering or relocating the at-risk populations to an area of lesser risk. Considerations include:

- The population at risk and its capability and resources to implement a recommended protective action. This includes accommodations for any unique risks the event poses to individuals with disability or access and functional needs.
- Time required for some individuals with disabilities and access and functional needs to prepare for and respond to a shelter-in-place notification.
- The capability to communicate with the population at risk.
- The resources and readiness to facilitate and/or conduct community wellness checks to

individuals who may need assistance.

- The capabilities and resources of the response organizations to implement, control, monitor, and terminate the protective action.

## Considerations for Wellness Checks and Canvasing

If the shelter-in-place warning is required for a period of 12-24 hours or more, it may be necessary to implement wellness checks for individuals who require daily assistance with activities of daily living or medical needs; inclusive of people who:

- Receive daily meal service.
- Receive daily home health, skilled nursing, or personal assistance services.
- Are electricity dependent for life sustaining equipment.
- Live alone.
- Are required to self-quarantine or isolate and have limited support systems.

Jurisdictions can facilitate wellness checks in cooperation with public health agencies and service providers/vendors, who provide support services to people with disabilities and other access and functional needs.

## Public Warnings

Fully inclusive and accessible emergency public warnings should be issued using multiple modalities and in accordance with the Communications Guidance (Appendix C) and should provide incident specific information and instructions including supplemental information for individuals who may need additional assistance. Once the incident is stabilized, the “all clear” messaging to the public should also be fully inclusive and accessible.

## Additional Resources

- Planning Considerations: Evacuation and Shelter-in-Place Guidance for State, Local, Tribal and Territorial Partners, Department of Homeland Security, July 2019, <https://www.fema.gov/sites/default/files/2020-07/planning-considerations-evacuation-and-shelter-in-place.pdf>
- Ready.gov, Sheltering-in-Place, Department of Homeland Security Website, <https://www.ready.gov/shelter>
- Personal Preparedness for Individuals with Disabilities: Sheltering in Place and Evacuation, September 8, 2020, <https://www.phe.gov/Preparedness/planning/abc/Pages/shelterinplace.aspx>, U.S. Department of Health and Human Services, ASPR



- Emergency Preparedness and Response, Shelter in Place, Centers for Disease Control and Prevention (CDC), September 29, 2017, <https://emergency.cdc.gov/shelterinplace.asp>

# Appendix C: Appropriate and Inclusionary Language for Developing Documents and Effective Communication Guidance

## Inclusionary Messaging

All disaster-related messages and information related to planning, preparedness, response, and recovery are to use inclusionary messaging. This means that verbal messages, written messages, and signage should be meaningful to — and integrate the needs of — persons with disabilities and others with access and functional needs. Messages must be delivered in a way that is culturally appropriate, meaningful, and useful to the shelter guests. The guidance below provides basic direction.

## Plain Language

Plain language is language that is understood with ease, such that the audience’s focus is on the message content and not the message.

## Word Choice

- Use the simplest, most understood word. For example, use “walk” instead of “ambulate,” or “get” instead of “obtain.”
- Do not use technical or industry specific words or acronyms when speaking.
- Use descriptive concrete words that have a single meaning. For examples, use “12 inches of standing water” instead of “flooded.”
- Do not use slang, colloquialisms, or industry-specific terms that may not be universally understood.

## Phrases

Use phrases and references that are universally known to the recipients of the message. For example, “stay in your home” is more universally understood than “shelter-in-place.”

## People First Language

People first language means prioritizing and focusing on the individual person. A disability is a part of the many characteristics that make up the person, as well any access or functional needs. People first language describes what the person **does** or **needs**, rather than what the person **is**. Some people chose to use ‘identity first language’ which puts the disability first and identifies the importance of the disability in framing their life experiences. People first language must be used for public information related to all emergency services and procedures.

Inappropriate language that emphasizes limitations, carries a negative connotation, perpetuates a negative stereotype, uses condescending euphemisms, or portrays people with a disability as a patient because of the disability, should never be used.

Examples of appropriate vs. inappropriate language are:

Use	Don't Use
Person with a disability	Differently-abled
Person who uses a wheelchair	Wheelchair bound
Person who has had a stroke	Stroke victim
Accessible restroom	Disabled restroom
Person with a brain injury	Brain damaged

## Accessible Messaging

All communication should be provided in accessible formats to ensure usefulness and usability. Accessible format means that the recipient can receive and access the information. One method of communicating information will not work for all people, yet emergency messaging must inform all stakeholders. Therefore, emergency related information must be provided using multiple strategies.

## Written Documents

There are some considerations that will apply to the development of all written documents regardless of delivery method in order to create readable and accessible documents:

- **Contrast:** Use high-contrast colors for text and background.
- **Color:** Printed material is most readable in black and white.
- **Point Size:** Larger font between 12- and 18-point font is preferred.
- **Font Style:** Avoid complicated or decorative fonts. Choose standard fonts with easily recognizable upper- and lower-case characters (e.g., Arial, Calibri, and Verdana).
- **Font Weight:** Bold or heavy font are recommended when providing emphasis for a word or phrase, while italics or upper-case letters are not.
- **Spacing:** Wide space between letters is preferred.
- **Paper Finish:** Using a matte or non-glossy finish cuts down on glare for ease of reading.

## Large Print Documents

Converting documents to large print may be necessary when providing universally accessible written information. Characteristics which have the greatest effect on the readability of large print documents can be ranked as follows: spacing, font size, contrast, and font style. Some basic considerations for large print conversion are found below. Although this list reflects font and formatting needs for large print materials, it can be applied to all other mediums to maximize the readability and universal accessibility.

### Font

Bold, sans serif, mono, or fixed space fonts such as Adobe's Verdana, Helvetica, Tahoma, or Arial are desirable.

### Layout and Formatting

- Text displayed in blocked paragraphs that are aligned left are preferable.
- Large print documents, with a line spacing (leading) of at least 1.5.
- Double spacing between paragraphs is necessary for readability.
- Text in full width format is preferred to two columns.
- Bullets should be large solid dark bullets, with double spacing between items.
- Large print document paper should have a matte or dull finish to reduce glare.
- The use of color or italics is not acceptable.
- Low vision readers have trouble with graphs, charts, and pictures in documents. They should be isolated on individual pages accompanied by explanatory captions.

### Electronic Distribution

Documents that will be available electronically, whether prepared separately or part of an existing web resource, must be compliant with [Section 508 of the Rehabilitation Act](#) requirements for full accessibility of information. [Web Content Accessibility Guidelines \(WCAG 2.1\)](#) provide recommendations for making web content more accessible and meeting the requirements of the Rehabilitation Act Section 508. Subject matter expertise in section 508 compliance should be sought to assist in development of all electronic resources.

Examples of accessibility compliance for electronic documents include:

- User must be able to navigate using a keyboard only. All elements must be keyboard accessible.
  - **Note:** Drag-and-drop and hotspot interactions are not.
- Anything that is conveyed through text attributes (e.g., color coding, text style) must also be conveyed using another method.

- Text/background color contrast must be significant.
- Any components that use flash/blinking must be >2Hz or <55Hz.
- Any audio must have closed captioning or text available on screen and synchronized.
- Include text equivalent for all non-text elements and must be readable by a screen reader.
- All video or visual information must be audio described.
- Navigation on the page must be organized in order for a screen reader to move between elements in a logical way that follows the order that a person would read the information.
- Screen readers must be able to skip repetitive navigation links.

### Dissemination

Maintain relationships and partnerships with communication resources in the jurisdiction, including translation and ASL interpretation services, local community and human services, religious and cultural points of contact, and educational institutions. Provide these partners the opportunity to be familiar with public information prior to dissemination.

Apply the following principles to plans related to the development and preparation of documents:

- **Announce It:** Inform partner agencies of upcoming information.
- **Caption or Transcribe It:** Ensure that it is captioned and transcribed.
- **Picture It:** Add visual aids whenever possible to clarify written word.
- **Describe It:** Add descriptions to all visual aids.
- **Email It:** Prepare multiple formats including electronically accessible.
- **Relay It:** Share it with partner agencies for local dissemination.
- **Text It:** Send information by electronic text for audio translation.
- **Post It:** Place information in multiple locations for repetitive access.
- **Interpret It (Language and Sign):** Provide interpreted copies and interpreters.
- **Repeat It (Frequently):** One distribution is not adequate to meet everyone.

Follow principles of inclusion, accessibility, and repetition to maximize effectiveness and universality of communication and information for dissemination of all emergency or disaster related information in steady state times and in an event. This allows maximum use of jurisdictional resources and

empowerment of stakeholders to effectively act on their own behalf and in conjunction with agency efforts to ensure safety and health of all persons.

## Additional Resources

- Best Practices and Guidelines for Large Print Documents used by the Low Vision Community; authored by the Council of Citizens with Low Vision International An Affiliate of the American Council of the Blind Arlington, VA. July 12, 2011, <https://www.acb.org/large-print-guidelines#:~:text=Large%20print%20documents%2C%20with%20a,be%20aligned%20left%20w here%20possible.>
- DIY Resources for Closed Captioning and Transcription; 3Play Media, Boston, MA., <https://www.3playmedia.com/>
- Clear Print Accessibility Guidelines; CNIB; <https://cnib.ca/sites/default/files/2018-07/CNIB%20Clear%20Print%20Guide.pdf>
- Section 508 Compliance, June 30, 2020, <https://www.hhs.gov/web/section-508/index.html>
- United States Access Board; Guidelines and Standards; 2019., <https://www.access-board.gov/>
- Creating Accessible Documents; Accessible Technology, University of Washington; 2019., <https://www.washington.edu/accessibility/documents/>
- Guidelines for Writing about People With Disabilities, <https://adata.org/factsheet/ADANN-writing>