

PACIFIC ADA-EMERGENCY MANAGEMENT AND PREPAREDNESS  
INCLUSION OF PERSONS WITH DISABILITIES  
OCTOBER 8, 2020

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>> LEWIS: Welcome to the emergency management and preparedness inclusion of persons with disabilities webinar series. I'm Lewis Kraus from the Pacific ADA Center, your moderator for this series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network.

The ADA National Network is made up of ten regional centers that are federally funded to provide training, technical assistance, and other information as needed on the Americans with Disabilities Act.

You can reach your regional ADA center by dialing 1-800-949-4232.

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As always in our sessions, only the speakers will have audio.

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And use the webinar ID 155545130.

I do want to remind everybody, the webinar is being recorded, and it will be able to be accessed on the ADApresentations.org website in the archives section of Emergency Preparedness Area next week.

This is the eighth year of this webinar series which shares issues and promising practices in emergency management, inclusive of people with disabilities, and others with access and functional needs.

The series topics covered emergency preparedness and disaster response, recovery, and mitigation, as well as accessibility and reasonable accommodation issues under the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the ADA, and other relevant laws.

Upcoming sessions are available at ADApresentations.org under the Schedule tab in the emergency management section.

These monthly webinars occur on the second Thursday of the month at 2:30 eastern, 1:30 central, the 12:30 mountain, and 11:30 a.m. Pacific time.

By being here, you are on the list to receive notices for future webinars in this series.

Notices go out two weeks before the registration and open that webinar to registration.

You can follow along the webinar platform with the slides.

If you are not using the webinar platform, you can download a copy of today's PowerPoint presentation at the ADApresentations.org web page in the schedule section of the Emergency Management area.

At the conclusion of today's presentation, there will be an opportunity for

everyone to ask questions.

You may submit your questions using the chat area within the webinar platform and the speakers and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation.

To submit your questions, as shown on this screen, you can type them into the chat area text box, or if you are using key strokes, press alt and H, and enter the text in the chat area.

If you are listening by phone and not logged into the webinar, you can ask your questions by emailing them to [ADAtch@adaPacific.org](mailto:ADAtch@adaPacific.org).

If you if you experience any technical difficulties, you can type your comment in the text box and hit enter, and if you are using a keyboard, you can use alt H to access the chat box.

You can also tell us any technical assistance difficulties by emailing to [ADAtch@ADAPacific.org](mailto:ADAtch@ADAPacific.org), or call us at 510-285-5600.

Today's ADA national network learning session is titled American Red Cross Disaster Response During the COVID-19 Pandemic.

Inclusive emergency planning isn't as scary and out of reach as it sometimes feels.

Emergency managers from city, county, and state level and FEMA's Region 9 disability -- this session will cover American Red Cross and the Red Cross efforts to make their efforts accessible during the COVID pandemic.

Today's speaker is Mary Casey-Lockyer, the lead for the disaster health services at national headquarters for the American Red Cross.

She has deployed to 20 disaster relief operations, and she is currently assigned the senior medical advisor to the national disaster operations for the Red Cross.

Mary serves as the Red Cross liaison to the secretary of operations center at the Department of Health and Human Services.

So, Mary, I will now turn it over to you.

>> MARY: Thank you so much, Lewis.

I hope you can hear me all right.

Just let me know if you can or cannot.

Thank you, everyone, for attending this presentation.

It's a real honor to be asked by Lewis and the group to present to all of you.

I may have met some of you or even talked with some of you.

So, thank you again for attending.

I really appreciate being able to talk about the American Red Cross and our disaster response during this COVID-19 environment.

I did not put this on a slide because these numbers keep changing daily, but I want to give you a sense of the environment that we're in.

So, today's report, we have a little over 7.4 million COVID cases in the United States.

We have over 210,000 deaths from COVID-19.

Very, very sad.

The case rate change for 24 hours, the past 24 hours, is 0.5%.

The seven-day rate of change for cases is equal to plus 4.8%.

The case numbers have actually dropped 34.5% since July 24th.

Sounds very good news.

The deaths, the 24-hour change is 0.3%, with a seven-day change of minus

4.6%.

I think this really points to the fact that clinicians and healthcare providers are really trying to understand this disease better and tackling it in different ways.

You might have heard a lot about dexamethasone that President Trump is taking and that is a steroid, and they've learned this has really helped COVID-19 patients.

Now I'll give you some other information, which is not so up beat.

So out of the 56 jurisdictions, that's states and territories, 30 jurisdictions are in a trend upward for COVID cases.

15 jurisdictions are staying somewhat the same, and 11 jurisdictions are trending downward.

That's not such good news.

The percent of ER visits, however, for COVID-like symptoms, is only at 2%, and that is good.

The positivity rate of the tests that are taken, it is 5%, and that seems like good news, but you really have to understand the denominator, and we aren't testing as much as we probably should be.

I will tell you a little word about response right now.

In the national shelter system, there are 12 congregate shelters.

Not all of those have population.

There's only 207 population in a congregate setting.

In non-congregate, however, which is the hotel settings, there are 14,776 clients in those non-congregate shelter settings, and that includes the clients from the wildfires in California, from Hurricane Laura and Hurricane Sally, and all of the rest, and now we have Hurricane Delta barreling down again into the same area of Louisiana probably that Hurricane Laura hit.

So we are preparing for that, and I'll go through the presentation, and if you have questions about preparations for that, you can ask at the end.

So, as you see, we're going to talk about what Red Cross had to do because of COVID.

So we had to create a doctrine, which is guidance.

We had to create processes.

And we created a new virtual world.

You'll see on the other side of this slide, you'll see a picture of a face shield, goggles, persons meeting virtually, a gown, N95 mask, and gloves, all of which we had to acquire if we had a congregate sheltering situation.

So, next slide, please.

I always like to talk about the mission of Red Cross.

I think it's very important for us to really understand what the mission is and to remind ourselves why we do what we do.

The American Red Cross prevents and alleviates human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors.

I have been pleasantly surprised at how many of our volunteers are willing to go out in this COVID environment and help all of our clients.

Next slide, please.

So what are the Red Cross's priorities during this COVID environment?

Our mission has not changed, and that's why I read the mission statement there, our mission definitely has not changed.

How we deliver the Red Cross mission has changed.

The safety of our workforce and clients is of paramount concern.

The use of non-congregate settings for sheltering clients is preferred during this pandemic.

Of course, it is safer to be in an enclosed area than in a large gymnasium.

But everyone is welcome, that commitment has not changed.

We will make every effort to get the resources that an individual might need due to a disability to them wherever they are located in their response.

So, next slide, please?

So what are we looking at in this non-congregate shelter environment.

Well?

Shelters may include hotels, motels, RV campgrounds, a lot of that is going on in California right now, single family cabins and campgrounds, or even tents.

We have not used tents.

We've had a couple of single family cabins, but we have very many, as you can tell, almost 15,000 clients in non-congregate settings in Louisiana and Texas.

Now, the model for this non-congregate sheltering may include a reception center in the immediate aftermath where people can evacuate to.

This unfortunately is a congregate setting, so we would have COVID-19 screening, but it may be limited in their reception environment.

The goal is to get clients to a safer single room or cabin as quickly as possible.

And again, our mission hasn't changed, only the way we accomplish our mission has changed.

Next slide, please.

So we're going to talk a little bit about the non-congregate sheltering environment.

Screening may be conducted at the non-congregate site for responders and clients.

And this screening would include temperature check, asking about any symptoms, asking if they've tested positive for COVID and how soon or how -- has it been 14 days since you've been tested?

Important pieces of information.

Disaster health services will conduct virtual wellness checks on every family household in that non-congregate sheltering.

I'll get to what we have learned already, but that was our plan, let's put it that way.

So we have an initial wellness check, which also includes what we call the C-MIST interview.

I hope many of you are aware of the C-MIST model.

The Red Cross has adopted this model to help us discern the needs of the clients and to help the clients really identify their own needs.

So, C is for communication.

M is for maintaining health.

I is for independence.

S is for safety, security, and most importantly, self-determination.

T is for transportation needs.

We've also added some questions around housing, which might alert us

quicker to individuals who are experiencing homelessness or precarious housing, and so we can get our community partners started early on how to assist them through a more -- to their recovery.

We also communicate relevant client needs to the shelter site manager, so each one of these hotels has a site manager.

They may not be there 24/7.

But they would maybe go geographically from one place to another, maybe a couple hotels a day.

So that information and the Red Cross clients can talk to a Red Cross representative.

So non-congregate sheltering.

If the wellness checks identify anyone with possible COVID-19 symptoms, clients will be asked to self-isolate in hotel rooms until public health or their healthcare provider gives them direction.

We want to keep the continuity of care for our clients, and so we always encourage our clients so contact their own healthcare providers.

Recross will notify public health, and ask for guidance.

The shelter site manager will also be notified, as will the facility manager be notified.

This is not against confidentiality.

The United States is in a public health emergency, declared by the secretary of Health and Human Services, and therefore this is a need-to-know public health information.

Disaster health services responders, either virtually or on site, will continue to monitor a client's condition.

And a C-MIST interview is completed on all family units.

Next slide, please.

So what kind of services are at the non-congregate shelters?

Acquisition of hotels with ADA compliant rooms is a priority.

We are well aware that we will have clients that will need to have an ADA compliant room, and that is the priority for us.

Red Cross disability integration specialists in collaboration with disaster health services responders assist disaster relief operations in meeting the needs of individuals with access and functional needs, including those with disabilities.

That has been our normal plan, and it continues within the COVID environment.

Assistance with activities with daily living can be provided by disaster health services responders who are licensed healthcare providers, or contracted personal care assistants, home health providers, or clients' own personal assistants caregiver.

Personal protective equipment is available to these caregivers, and that means gloves, mask, and down.

Needed supplies such as adult briefs, infant diapers, comfort kits, replacement and medication, durable medical equipment, sorry for the acronym on the slide, or consumable medical supplies are available and will be distributed to anyone in need.

Next slide, please.

Okay.

Non-congregate services also include any kind of unique diets.

Low sodium, low fat, et cetera.

Safe sleep options for infants and toddlers will be available if not provided by the non-congregate setting.

So infant sleep boxes.

Translation services in assistive technology will be made available or acquired when the need is satisfied.

Information dissemination, such as the status of the client's home area, re-entry instructions, available community recovery programs, FEMA registration, or Red Cross recovery programs will be delivered to clients through multiple modalities.

Including but not limited to text or email.

Text has shown to be a really great way of communicating with clients.

It appears that texts is more palatable to clients than having many phone calls, and I'll talk more about that in a few minutes.

So there are challenges to the non-congregate setting.

The geographic location of hotels may be widespread.

And this is in order to acquire the needed hotel rooms, but also to acquire the needed ADA compliant rooms, so we have had issues moving people away from where the event occurred, and having widespread hotels, which means a lot of work for our responders.

Of course, there is some isolation of clients, too.

Clients will need to be more proactive in their own recovery journey to notify Red Cross of their needs.

We have a wonderful story about a deaf gentleman who just couldn't get any information about the status of his home or what exactly was going on, so he decided he was just going to plunk himself down right in the middle of the hotel lobby and wait until he could find some information.

And one of our Red Cross responders was able to communicate with him vaguely in sign language and he got the information he need and he was very happy to return to his room with the information he needed.

So that will happen.

The other thing about the non-congregate area is the high touch environment.

Clients are contacted multiple times for different reasons by responders, mostly in the virtual setting, so that means a phone call.

So casework, Disaster Health Services, Disaster Mental Health may contact the household primary contact multiple times.

This can create a really Big Brother environment and cause resentment by the household.

I'll talk about the lessons learned in a couple minutes.

COVID-19 environment.

Our staff is skinny.

Skinny staffing is a reality.

And non-compliance of wearing masks creates fear both for clients and responders.

So there is some noncompliance, we know.

We require masks be worn in common areas of non-congregate settings for responders and clients.

And in a congregate setting for both also.

What are the lessons we have learned already?

And we've learned a lot.  
Everything takes longer in the COVID-19 environment.  
If we could do a task in four hours, it's going to take eight hours.  
If we could find a stable recovery solution for clients in a week, it's going to take two weeks.  
So everybody takes longer.  
Disaster response operational leadership will mostly be virtual, which has a learning curve.  
We have to learn the platform.  
We use Microsoft Teams.  
That's not an endorsement.  
That's just what we use.  
But it takes a while to get -- how do you conduct virtual leadership on platforms?  
And so this takes some learning.  
Especially not so much with job directors and other leaders that use it all the time, but when you have volunteers who maybe don't use that platform very often, except maybe through an occasional regional divisional meeting, there's quite a steep learning curve.  
Personal protective equipment, PPE, you hear about that all on the media these days, might not be in the right place during the immediate response phase.  
We did have some questions -- a question about where we had pre-deployed personal protective equipment, but in some of the early disaster response, it wasn't in exactly the right place for the event and had to be transferred with that time, so we learned that.  
The distribution of meals is different, so what we are doing is using a single meal container for each individual.  
We set it down, either on the table or near the hotel room, and step back and the client retrieves that.  
So we have to have singly packaged meals, which is your requirement that not all of our vendors can do.  
So it isn't a sort of buffet line like you have in a congregate shelter, and we don't have anyone spooning something into a container for you.  
And it does require a different feeding strategy.  
Pet care must be factored into the equation for hotel acquisition.  
We don't want anyone not evacuating just because we can't get them a hotel room that takes a pet.  
So this has been a challenge, and something we've worked on.  
Signage is harder to place in non-congregate settings.  
So we have some very big hotels in New Orleans right now.  
But they belong to Hilton and Residence Inn and all the other kinds of facilities.  
And so it's harder to put our signage into a hotel lobby, where there might be other guests that haven't been affected by the hurricane.  
So that's been a challenge around communication.  
Next slide, please.  
So, we have had to utilize some contract staff, and the contract staff may be needed to meet needs, and this process takes time.  
And requires on-the-ground supervision.

So we have had to get some contract staff, both for health services and for some other functions.

And it does take time to get them on the ground and know our processes. Red Cross recovery programs will need to use more virtual options.

In-person client case work will require a higher level of protection for clients and responders.

So if we are doing shelter transition case work, which you might have to do if your home was completely destroyed, we have now acquired plexiglas walls so that we can actually talk with a client at a table.

It's sort of what you see on your grocery stores every day.

Local and state public health entities are stretched, and may not have the capacity to assist with testing, screening, or contact tracing.

It's just the reality.

Social distancing to six feet is hard, and it's difficult to calculate the six-foot distance.

So you can see it in pictures.

You can see it on TV.

When there's a reporting on some event, that although people are trying to be six feet apart, nobody really knows exactly what six feet means.

The other thing is, in general, when people put on a mask, they feel protected, but what is happening with that mask is they're protecting others, it's not protecting them.

But they feel as though they are a little bit more invincible, and so may not need to be six feet apart.

And it has been a challenge, both for responders and clients, too.

So I'm now going to move into the congregate sheltering world.

This is inevitable.

I have up here, inevitable if large hurricane or wildfire occurs, we are here. Just this morning, the state of Louisiana is planning for three shelters, I think it was about 1,000 feet, or 500 each.

And they are planning for congregate sheltering in response to Hurricane Delta.

Whether that will actually occur or not, we're not quite sure, but that is the planning that is going on.

Lots of hotels are being taken up by the almost 15,000 people in Louisiana. So they will be here.

We will have congregate sheltering.

We hope to keep them small.

Probably to 50 people each.

But evacuation centers are required to have 60 square feet per individual. That's quite a bit larger than normal.

Congregate shelters post impact, we will try to have 110 square feet per individual.

We have a little banner on the slide that says this will cut the shelter capacity by half, and that is the truth, and that will be all over the United States.

Screening and isolation care areas will be established.

Only disaster health services responders will work in these isolation care areas.

And this is for symptomatic clients.

We had a horrible norovirus outbreak a couple of years ago, and the State of California was wonderful in helping, but, you know, there's all sorts of infectious diseases that happen in a congregate setting.

So this is not just for COVID.

Local public health agencies will be notified and each client in isolation care area.

Again, this is due to the public health emergency that has been declared and extended by the secretary of Health and Human Services.

Next slide, please.

So this is a picture of how we would set up a congregate sheltering operation.

As you can see, the event occurs, caused for need of emergency sheltering.

We hope this would be less than 14 days.

What I heard this morning is that Louisiana may have congregate shelters until the storm passes, and then the clients will be assessed to meet the non-congregate, and they will be moved into non-congregate settings as quickly as possible.

We pretty much assume that public health may not be present, and the reason is because they are trying to respond to a massive pandemic.

As you can see, the client stick figures here are going to enter into the screening process, there will be two Red Cross screeners.

They may want to go to friends and family, or if they're critically ill, they may be transported to a healthcare facility.