

# Disaster Response Guidance for Health Care Providers: Identifying and Understanding the Health Care Needs of Individuals Experiencing Homelessness

## I. Introduction and Overview

The goal of this toolkit is to stimulate planning for the provision of clinical care to individuals experiencing homelessness in advance of a disaster. This toolkit offers practical tools that clinicians can use to facilitate pre-disaster coordination and planning, disaster response, and recovery. The toolkit is organized around four themes:<sup>1</sup>

1. Needs Identification and Assessment
2. Prevention of Hospital System Surge and Coordination of Care
3. Medical Capacity Available for Ready Mobilization in Disasters
4. Information and Education Resources

This toolkit's primary objectives are to:

- Assess the medical and behavioral health needs for individuals experiencing homelessness.
- Raise awareness of pre-disaster planning and coordination needs specific to clinical service providers for individuals experiencing homelessness.
- Enhance the capacity of clinical care settings with providers experienced in serving people who are experiencing homelessness and provide expanded care following a disaster or public health emergency.

To help meet these objectives, the toolkit catalogues promising practices and models across a range of local, non-profit, and federal organizations that could be adopted for use in communities experiencing homelessness.

## II. Needs Identification and Assessment

Individuals experiencing homelessness have unique access and functional needs because of their persistent exposure to the weather, transiency, limited access to nutritious food, serious and complex medical conditions, mental illness and/or co-occurring substance use disorders, and higher risk for communicable diseases (Christensen, 2005; McMurray-Avila, 1999; IOM, 1988; Ramin, 2009). When a disaster strikes, these access and functional needs become exacerbated, thereby requiring a reliable network and service delivery system of clinicians familiar with the unique needs of individuals experiencing homelessness and their pre-existing needs. Maintaining pre-disaster clinical services for this population is critical to long-term recovery. Prior planning, and coordinating a response that reaches across agencies and systems, can advance recovery from disasters. The sub-sections below offer an array of resources and tools for use by clinicians before, during, and after disasters to provide care to individuals experiencing homelessness.

### *Assessing Medical and Behavioral Health Needs and Evaluation*

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<sup>1</sup> These themes evolved from the 2013 Advancing & Redefining Communities for Emergency Management 4<sup>th</sup> Annual Conference, sponsored by the Veterans Emergency Management Evaluation Center (VEMEC) of the US Department of Veterans Affairs and the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the US Department of Health and Human Services.

- To support public health practitioners and emergency management officials to rapidly determine the health status and basic needs of an affected community, the Centers for Disease Control and Prevention (CDC) created the [Community Assessment for Public Health Emergency Response \(CASPER\)](#). This surveillance tool utilizes valid statistical methods to gather information about health and basic needs, allowing public health and emergency managers to prioritize their response and distribution of resources accurately. CASPER can also be used for conducting Health Impact Assessments or other community-level surveys during non-emergency situations. For example, one could use a community-level survey to assess the potential impact of disasters and emergencies on individuals experiencing homelessness in a specific community (CDC, 2012).
- Many individuals experiencing homelessness are reluctant to disclose their status either out of shame, fear of stigma, or concerns about being denied an equal level of care. The [Housing Status Assessment Tool](#) offers state health and human service agencies a series of questions that can be used to assess an individual’s housing situation without directly asking the individual if they are experiencing homelessness (Albanese, 2009).
- In an effort to prevent and end homelessness among veterans, the National Center on Homelessness Among Veterans (NCHAV) created a [universal risk assessment of homelessness](#) in collaboration with several partners including the US Department of Veterans Affairs. The Homelessness Screening Clinical Reminder identifies veterans and their families’ at-risk for homelessness or having recently become homeless, ensures those who are at-risk or experiencing homelessness are referred for appropriate assistance, and updates the current living situations for veterans (NCHAV, n.d.).
- To fill the gap left by standard clinical practice guidelines with regard to addressing the special challenges faced by patients experiencing homelessness, the [Health Care for the Homeless Clinicians’ Network](#) developed a series of adapted clinical guidelines on a wide range of medical issues including asthma, chronic pain, HIV/AIDS, and reproductive health care (NHCHC, n.d.a). See Table 1 for more information on taking the medical history from individuals experiencing homelessness to make a diagnosis or inform a diagnosis.

**Table 1: Examples of Adapted Clinical Guidelines for Assessing the Needs of Individuals Experiencing Homelessness**

- Individual/family history of asthma, chronic otitis media, anemia, diabetes, cardiovascular disease, tuberculosis, sexually transmitted infections including HIV, hospitalizations.
- Current medications, including psychiatric, contraceptive, over-the-counter medications, dietary supplements, any “borrowed” medicine prescribed for others.
- Diet, food resources, preparation skills, liquid intake.
- Coping skills, resourcefulness, abilities, interests.
- Military history.
- Substance abuse history.
- Psychiatric and trauma history.

- Veterans experiencing homelessness may be at increased risk for negative outcomes because of their **cumulative trauma and consequent access and functional needs** (Brown, 2013). Therefore, understanding if a veteran has previous traumas or a diagnosis of post-traumatic stress disorder (PTSD) may provide helpful information in determining their current risk factors following a disaster (National Center for PTSD, 2014a).

- Attention to issues of **cultural competency**<sup>2</sup> is critical when developing and reviewing disaster plans for providing clinical care to individuals experiencing homelessness during and/or after a disaster. One way to ensure disaster plans reflect the reality and diverse needs of individuals experiencing homelessness is to include individuals who have experienced homelessness in disaster planning, response, and recovery activities (Phillips, 1998; SAMHSA, 2003a). Individuals experiencing homelessness come from various backgrounds; therefore, it is important for clinicians to recognize how the diverse experiences, beliefs, and values of these individuals will impact how they will access medical services during and after disasters (SAMHSA, n.d.a). In addition, bi-lingual services (i.e., the need for medical interpreters and the availability of a language line) and cultural sensitivity to displaced populations can result in a more inclusive recovery response (Phillips, 1998). See Table 2 for more information (SAMHSA, 2003a).
- Additionally, individuals experiencing homelessness have strengths that may include survival skills, creativity, expertise in multiple areas and more. Clinicians should consider **assessing individuals experiencing homelessness for strengths as well as needs**; while also recognizing needs may shift as circumstances change.

<b>Table 2: Guiding Principles for Cultural Competence in Disaster Mental Health Programs</b>
<b>Principle 1:</b> Recognize the importance of culture and respect diversity.
<b>Principle 2:</b> Maintain a current profile of the cultural composition of the community.
<b>Principle 3:</b> Recruit disaster workers who are representative of the community or service area.
<b>Principle 4:</b> Provide ongoing cultural competence training to disaster mental health staff.
<b>Principle 5:</b> Ensure that services are accessible, appropriate, and equitable.
<b>Principle 6:</b> Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.
<b>Principle 7:</b> Involve as “cultural brokers” community leaders and organizations representing diverse cultural groups.
<b>Principle 8:</b> Ensure that services and information are culturally and linguistically competent.
<b>Principle 9:</b> Evaluate and improve the program’s level of cultural competence.

*Accessing Services*

- Individuals experiencing homelessness at the time of a disaster may be eligible for **disaster case management services** available through the Administration for Children and Families (ACF), Immediate Disaster Case Management program (IDCM) program. IDCM services may be implemented following a Presidential declaration of a disaster for Individual Assistance (IA),

<sup>2</sup> Cultural competency is defined as “the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each (National Technical Assistance and Evaluation Center for Systems of Care, 2009).

when requested by an impacted state, and in support of the Federal Emergency Management Agency (FEMA). IDCM services can help connect individuals with disaster-caused unmet needs with resources and services of multiple agencies. If individuals or families experiencing homelessness are affected by a disaster, and as a result, lose services such as food support, shelter, behavioral health treatment, or other services they received pre-disaster, IDCM can assist with re-connecting them to resources and services post-disaster (ACF, n.d.a).

- Engagement of clinicians with **community health centers** prior to and during disasters could significantly enhance response to individuals affected by disasters. The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) supports the Health Center Program Grantees. Health centers are community-based, primary health care providers caring for individuals that live in underserved socio-economic areas. These health centers have developed expertise in providing services to individuals experiencing homelessness with both acute and chronic medical and mental health conditions (Edgington, 2009). In addition to providing ongoing medical care, health centers represent a constant in the midst of expected chaos during disasters, which is particularly important for individuals experiencing homelessness. HRSA-supported Health Center Program Grantees have specific emergency management expectations as a function of their grant. These expectations are outlined in the Health Center Emergency Management Program Expectations, Policy Information Notice (PIN), 2007-15 (HRSA, 2007).

#### *Mental Health Considerations*

- **Mental health programs for individuals experiencing homelessness** during and following a disaster require a longer-term commitment to the provision of services for the following reasons: (1) initially, there is under-utilization of mental health services because people are in survival mode or are reluctant to seek services; (2) due to stigma, there is resistance to requesting mental health services; and (3) it is necessary to build trust and reliability with the population experiencing homelessness before expecting people to share their most personal needs and concerns (Madrid, 2008).
- Wherever possible, **co-locating mental health with medical services** is an effective way to facilitate mental health services utilization. Using mobile units to deliver medical and mental health services together has proven to be effective in bridging access barriers to services in diverse communities (including individuals experiencing homelessness). The mobile units are a valuable way to reach and provide mental health and medical services to individuals who are often disengaged and in harsh and isolated living conditions or who have experienced trauma. Mobile units also have the advantage of bringing services to where individuals experiencing homelessness are located, thereby providing needed services to people who may otherwise have limited access to transportation to reach health care services.
- State and local agencies and provider organizations should **assess disaster behavioral health capacity** and its integration into all planning, preparedness, response, and recovery efforts. ASPR 's Disaster Behavioral Health Capacity Assessment tool aims to facilitate effective collaboration and communication across agencies as information is gathered and strengths and weakness are identified. Reaching out to partners locally and at the state level will strengthen relationships and collaborations so that behavioral health is more fully integrated into all emergency and disaster planning, response, and recovery efforts (ASPR, 2014b).

#### *Resources*

- The National Health Care for the Homeless Council (NHCHC) offers a variety of resources for clinicians working with individuals experiencing homelessness on a daily or regular basis. Key

resources include adapted clinical guidelines and [General Recommendations for the Care of Homeless Patients](#) (Bonin, 2010), which is a foundational **guideline for clinicians treating individuals experiencing homelessness** for the first time or for many years.

- To access the full list of resources on emergency preparedness for individuals experiencing homelessness, review the resources page on the [NHCHC website](#). Resources related to emergency preparedness are divided into categories including: Disaster Planning for People Experiencing Homelessness, Health Care Delivery During a Disaster, Building Collaborations, and Policies and Procedures (NHCHC, n.d.b)

### III. Prevention of Hospital System Surge and Coordination of Care

During a disaster, the demands on critical health care settings are exponentially increased and the capacity of the health care workforce is stretched by the emergent needs of the public as well as individuals experiencing homelessness who previously had limited care alternatives. In this context, the resulting hospital system surge may challenge any triaging processes in place, overwhelm the health care delivery system, and delay or defer non-urgent, but needed care from being delivered. In addition, when communicable diseases may be the driver or the by-product of a disaster, minimizing any undue risk of exposure and transmission to non-acute individuals is an important consideration. Appropriate planning is needed to prevent health care settings, shelters, and other congregate sites from becoming incubators for disaster-driven communicable illnesses and disease.

Strategic planning for these considerations involves three elements: pre-event care management and planning, pre-event triage and resource allocations, and surveillance monitoring.

#### 1. *Pre-event care management and planning*

Pre-disaster planning should emphasize **implementing in-reach strategies at emergency departments (ED) and hospitals** to redirect individuals experiencing homelessness and engage them in more appropriate settings for their continuity of care needs. However, redirecting should only occur after the hospital has addressed the immediate medical needs of the individual seeking care.<sup>3</sup> Emphasis on routine in-reach strategies can be useful in helping individuals establish relationships with regular primary care providers, such as community health centers. If such relationships are developed prior to an incident, individuals may be less likely to turn to the hospital to meet non-emergency needs during or after a disaster.

The Department of Veterans Affairs (VA) Homeless Patient Aligned Care Team (HPACT) program is an example of an in-reach effort that redirects individuals experiencing homelessness to non-ED health care services before a disaster or emergency. This VA program seeks out veterans experiencing homelessness who rely on ED care and enrolls them in a **specialized homeless “medical home” program** that provides comprehensive primary care, mental health, and social services such as supportive housing. Collectively, the national network of VA HPACTs has reduced ED use and hospitalizations 25 percent by effectively redirecting support for acute and chronic care needs and expediting housing placement (VA, 2013).

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<sup>3</sup> This is critical given that failing to address immediate medical needs is a violation of the 1986 Emergency Medical Treatment and Labor Act which ensures public access to emergency services regardless of ability to pay. (Source: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html>)

Pre-disaster planning also needs to focus on developing **health and hygiene protocols at emergency shelters** to minimize secondary exposure risk and to develop plans for mobile, on-site triage. Increased management capacity, including expedited communication procedures within and across agencies and in these settings, is necessary to quickly enact protocols to care for patients with sub-acute care needs without an ED visit.

2. *Surveillance monitoring*

Before a disaster, it is essential to **map community assets, resource needs, and specific demographic data for individuals experiencing homelessness** in order to anticipate and effectively plan for an event. During a disaster, understanding and appreciating the wide scope of need, especially among individuals with access and functional needs and traditionally disenfranchised populations, is equally critical. It is important that communities also understand and are aware that youth and families experiencing homelessness often double up with other families. Surveillance is therefore necessary to monitor volume and type of need at both health care and community settings in order to ensure adequate resources are directed where they are needed. This also allows for secondary needs and consequences of a disaster to be quickly identified and managed.

3. *Pre-event triage and resource allocations*

Pre-event triage and resource allocation requires **maintaining and monitoring the inventory of community health care resources** to ensure they are adequately stocked, staffed, and prepared to treat individuals experiencing homelessness. Necessary capabilities include dispensing medications; having staff available (either on-site or remotely) that can identify and address sub-acute, but urgent conditions as well as chronic conditions; and providing mental health support to address ongoing emotional needs and stress management during a disaster. Additional considerations should be given to ensuring that methadone maintenance and other vital continuity services (i.e., dialysis) are maintained within the community to avoid surge demand on acute health care settings. Lastly, employ both aggressive triaging protocols within these settings and alert the community of plans to ensure the availability of resources.

#### **IV. Medical Capacity Available for Ready Mobilization in Disasters**

Building medical capacity for disasters can be considered in three phases: pre-disaster planning, response during a disaster, and post-disaster recovery activities. Detailed information about each phase and related resources are provided below.

1. *Pre-disaster planning*

Individuals experiencing homelessness are often not well-connected to human services, less equipped to voice their needs, and therefore, may be less visible to disaster responders. Finding and effectively communicating with these individuals requires specific knowledge of their conditions, locations, and building a level of trust. Therefore, it is important for key stakeholders including individuals experiencing homelessness, disaster response teams, and public health officials to **develop relationships with health care and service providers who treat individuals experiencing homelessness before a crisis occurs.**

For example, Healthcare Coalitions funded under ASPR's Hospital Preparedness Program<sup>4</sup> coordinate preparedness for, response to, and recovery from the adverse health impacts of a disaster in partnership with local, state, tribal, territorial and federal emergency management agencies (ASPR, 2014e). Inclusion of providers experienced in the delivery of health care to people experiencing homelessness in Healthcare Coalitions will ensure that the needs and resources required to serve this population will be identified by key partners and may help to prevent hospital surge once a disaster occurs.

In addition, given the stresses of daily living for individuals experiencing homelessness, the trauma of an environmental or human-made disaster can lead to crisis (Washington, 1998). Therefore, consider developing a disaster preparedness plan around three themes: (1) establishing and improving communication across various health and human service agencies; (2) coordinating comprehensive primary health care delivery (accessibility and coordination of organizations for effective and efficient health care delivery within the context of priority needs for individuals experiencing homelessness); and (3) developing a sense of community among agencies, clients, and public health departments that facilitates self-care and access to services for individuals experiencing homelessness and ensures trauma-informed service delivery.

## 2. *Response during a disaster*

**Coordination and communication between agencies providing disaster relief is critical**, as is communication with, and directly to, populations experiencing homelessness (Washington, 1998; Leung, 2008; Rodwell, 2010). Increasing awareness of the disaster or crisis through traditional channels such as shelters, clinics, news media, and current technology such as social media and cell phones is important. As resources permit, mobilizing specific teams to find, locate, and treat individuals and families experiencing homelessness should be undertaken.

Healthcare Coalitions coordinate the health care response through the Emergency Support Function 8,<sup>5</sup> and develop and exercise plans for the public health and medical response in collaboration with public health and emergency management (DHS, 2013). Depending on the type of crisis, there may be a need to procure and distribute medical supplies, medications, or preventive measures to service providers treating individuals experiencing homelessness (Leung, 2008). While treatment of patients suffering from communicable diseases is the same regardless of housing status, the post-hospitalization management of individuals experiencing homelessness requires special isolation precautions or treatments that require careful planning. For example, the health care response must undertake pre-planning to address the housing needs of individuals who lack housing following hospitalization and who are recovering from communicable diseases and may still be considered infectious. In these situations, group settings such as shelters would not be an option; therefore, private housing would have to be

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<sup>4</sup> Healthcare Coalitions funded under ASPR's Hospital Preparedness Program, are a formal collaboration among health care organizations and public and private sector partners that work to prepare for and respond to an emergency, mass casualty, or catastrophic health event. Members include, but are not limited to Hospitals, Emergency Medical Services, Skilled Nursing Facilities, Emergency Management Agencies, Local Health Departments, Home Health Agencies, Federally Qualified Health Centers, End Stage Renal Disease Facilities, Community Health Centers, Rural Health Clinics, Ambulatory Surgical Centers, Psychiatric Residential Treatment Facilities, Hospice, and Community Mental Health Centers.

<sup>5</sup>For more information, review the National Response Framework, which also includes further details on Emergency Support Function 8.

arranged for continued recovery and health care. Potential housing options can include motels or pre-planned alternate care sites that have rooms where individuals can be isolated.

3. *Post-crisis recovery activities*

“After action” reports on post-crisis recovery activities and **honest assessments of successes and failures are critical to improving planning** for the next disaster. In recent years, there have been many natural disasters (e.g., hurricanes and floods) and communicable disease outbreaks (e.g., severe acute respiratory syndrome and pandemic influenza) that have a greater impact on individuals with access and functional needs such as individuals experiencing homelessness. It is imperative to document and build upon the lessons learned from these events including those from the agencies that provide relief after such disasters.

In terms of medical capacity building and mobilization in times of disasters, the literature is sparse and many best practices are local and learned from experience. Therefore, the most important lesson would be to establish collaborations and a working relationship with local stakeholders in advance of a disaster. Stakeholders can include representatives from communities experiencing homelessness, health centers and service providers caring for individuals experiencing homelessness, health care and mental health care coalitions, public health agencies, community health care facilities, and emergency management personnel.

*Examples of Medical Capacity Available for Mobilization*

1. **Continuity of Operations (COOP) planning:** COOP planning focuses on helping organizations identify and plan for continuing essential functions before, during, and after any disaster or emergency. Creating a COOP plan and working through the supporting planning process will assist health care and service organizations in being prepared to provide health care services for individuals experiencing homelessness.<sup>6</sup>
2. **Community Health Centers:** Community health centers are community-based, patient-directed non-profit organizations that provide comprehensive primary and preventative health care to medically underserved communities and individuals with access and functional needs, including individuals experiencing homelessness. They reduce unnecessary visits to hospitals and keep down health care costs with quality care (HRSA, n.d.; NACHC, n.d.). To support emergency management activities, health centers may be able to support the following activities: (1) surveillance of unusual outbreaks and diseases; (2) outpatient surge capacity and triaging systems; (3) education of community and patients; (4) vaccination and mass prophylaxis; (5) strengthen capacity to address post-event public demands, i.e., mental health issues; (6) integrated role in city-wide emergency response efforts; and (7) internal staff education, clarification, and identification of staff roles.
3. **Industry Patient Assistance Programs:** The Partnership for Prescription Assistance (PPA) is a one-stop shop for patients to apply for a number of manufacturer assistance programs (PPA, 2014). While these programs are available at any time, there are expedited procedures for patients applying for assistance following a disaster (PPA, n.d.).

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<sup>6</sup>Additional resources on COOP planning are provided in the V. Information and Education Resources section of the toolkit (pg. 11).

4. **Emergency Prescription Assistance Program (EPAP):** This program allows any enrolled pharmacy in the United States and its territories to use existing electronic pharmacy systems as an infrastructure to efficiently process prescriptions and durable medical equipment (DME) for individuals who are eligible (ASPR, 2014d). Specifically, EPAP provides prescription drugs and limited DME to individuals affected by a disaster of national significance with no other health insurance (ASPR, 2013b). EPAP is not automatically available; rather it must be requested by an impacted state, under activation of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, and requires FEMA approval before the program is available after a disaster (FEMA, 2015).
5. **Disaster Medical Assistance Team (DMAT):** A DMAT is a group of medical personnel designed to provide medical care during a disaster or emergency. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized. DMATs are principally a community resource available to support local, regional, and State requirements, however, as a National resource they can be federalized (ASPR, 2014c).

## V. Information and Education Resources

The following section is divided into specific categories to highlight relevant resources that may be useful to clinicians during and immediately following a disaster. The resources listed below may help to reconnect or expand the network of service providers for individuals experiencing homelessness.

### *Behavioral Health*

- [Disaster Behavioral Health Coalition Guidance](#). This guidance provides a framework to develop disaster behavioral health coalitions that help facilitate communication across provider groups, coordinate behavioral health care efforts, and help identify existing and emergent needs (ASPR, 2014a).
- [Disaster Distress Hotline](#). Call 1-800-985-5990 or text “TalkWithUs” to 66746 (TTY: 1-800-846-8517). This Helpline and text service is available 24 hours a day, seven days a week, year-round and is staffed by trained counselors from a network of crisis call centers located across the U.S. Text service is also available for Spanish-speakers and TTY for people who are Deaf/Hearing Impaired (SAMHSA, n.d.b).
- [Disaster Events and Services for Persons with Co-Occurring Substance Abuse and Mental Health Disorders](#). This tip sheet was developed by the SAMHSA, Co-Occurring Center for Excellence to address disaster-related issues for persons with co-occurring disorders. For health care providers specifically, this tip sheet suggests basic guidelines when encountering an individual with a suspected mental or addictive disorder. This includes integrating screening, assessment, and treatment planning from the initial contact with the patient and/or client for more effective treatment (SAMHSA, n.d.c).
- [Disaster Planning Handbook for Behavioral Health Treatment Program](#). The Technical Assistance Publication (TAP), *Disaster Planning Handbook for Behavioral Health Treatment Programs*, provides guidance for developing or improving the behavioral health treatment program’s disaster plan. This TAP addresses the planning needs specific to programs that offer prevention services, outpatient or residential treatment, medically managed detoxification, and medication-assisted treatment (SAMHSA, 2013).
- [Disaster Response for Homeless Individuals and Families: A Trauma-Informed Approach](#). This factsheet provides information on rates of people experiencing homelessness and key

considerations when planning for these populations using a trauma-informed approach during and after a disaster. This approach recognizes that sensitivity to trauma can improve communication between responders and individuals experiencing homelessness and facilitate compliance with public health directives (ASPR, 2013a).

- [Psychological First Aid Field Operations Guide](#). This is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short- and long-term adaptive functioning. The guide is for first responders, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings (National Center for PTSD, 2014b).
- [SAMHSA Behavioral Health Disaster Response App](#). This app launched by SAMHSA offers first responders immediate access to field resources for aiding disaster survivors. The app can help first responders search for and map behavioral health services providers in the impacted area, review emergency preparedness materials, and send resources to colleagues. In addition, the app can be preloaded onto a smartphone to ensure that it is readily available and accessible during a disaster with necessary tools and articles (SAMHSA, 2014).
- [Self-Care After Disasters](#). This tip sheet from the Department of Veterans Affairs provides information on steps that can be undertaken for self-care after disasters (National Center for PTSD, 2014c). For more information about coping after any trauma, see [Self-Care and Coping](#) (National Center for PTSD, 2014d).

#### *Clinics, Hospitals, and Shelters*

- [Administration for Children and Families' National Domestic Violence Hotline](#). 800-799-SAFE (7233) is a 24-hour hotline where advocates assist victims, and anyone calling on their behalf, by providing crisis intervention, safety planning and referrals to local service providers.
- [At-Risk Populations and Pandemic Influenza Planning Guide](#). The goal of this guide is to provide state, territorial, tribal, and local health officials and agencies with usable tools and recommendations for developing their individual plans for individuals with access and functional needs, including people experiencing homelessness, during an influenza pandemic (ASTHO, 2008).
- [CDC's Clinical Outreach and Communication Activity \(COCA\)](#) prepares clinicians to respond to emerging health threats and public health emergencies by communicating relevant, timely information related to disease outbreaks, disasters, terrorism events, and other health alerts (CDC, 2014).
  - COCA collaborates with national clinician organizations across the U.S. to communicate information about disease outbreaks, disasters, terrorism events, and other health threats. These COCA Partner Organizations serve a wide variety of health care professionals including: Physicians, Nurses, Physician Assistants, Pharmacists, Veterinarians, First Responders, and Public Health Practitioners. Through COCA partnerships, CDC is able to rapidly distribute information to clinicians during a public health emergency (CDC, n.d.).
- [Mental Health All-Hazards Disaster Planning Guidance](#). This is a general guide developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) for substance abuse and mental health clinics that can be adapted to support health care and service providers who treat individuals experiencing homelessness. It contains processes for preparedness, response,

mitigation, and recovery in the event of an emergency or disaster and includes form templates and hazard vulnerability analysis (SAMHSA, 2003b).

- [National Clearinghouse on Families & Youth: Ready for Anything - A Disaster Planning Manual for Runaway & Homeless Youth Programs](#). This manual of planning worksheets is designed to help construct a successful disaster response plan for runaway youth and youth experiencing homelessness. The manual focuses on the three areas critical to successful disaster planning – prevention and preparedness, response, and recovery (ACF, n.d.b).<sup>7</sup>
- [The National Health Care for the Homeless Council \(NHCHC\)](#) is a network of more than 2,000 doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness. The NHCHC collaborates with government agencies and private institutions and provides support to more than 250 Health Care for Homeless grantees in all 50 states.
  - The NHCHC offers a broad range of resources including webinars and self-directed online courses on topics such as implementing harm reduction strategies and health care for the people experiencing homelessness. In addition, regional and tailored trainings and technical assistance opportunities are available.

#### *Continuity of Operations Planning*

- [Crisis Standards of Care](#). The Institute of Medicine has published three toolkits on crisis standards of care that contains key concepts, guidance, and practical resources to aide participants within health care systems at federal, state, and local levels develop plans for continuity of care during emergencies (IOM, 2012; IOM, 2013; IOM, 2009).
- [Emergency Preparedness Toolkit for Community Health Centers and Community Practice Sites](#). This toolkit provides streamlined information, tools, and templates to encourage continuity of operations planning for Community Health Centers. In addition, the toolkit is intended to be used by medical service providers to assess access and functional needs, create an emergency preparedness plan, train staff, evaluate staff readiness, and connect with local emergency management planners to better understand how resources and expertise can be used during an emergency response (Center for Health Policy and the New York Consortium for Emergency Preparedness Continuing Education, 2007).

#### *Cultural Competency*

- [Developing Cultural Competence in Mental Health Programs: Guiding Principles and Recommendations](#). This guide provides background information, guiding principles, recommendations, and resources for developing culturally competent disaster mental health services.
- [Guidance for Integrating Culturally Diverse Communities into Preparedness and Response: A Toolkit](#). The Department of Health and Human Service's Office of Minority Health's toolkit provides preparedness planning and response agencies, organizations, and professionals with practical strategies, resources and examples of models for improving existing activities and developing new programs to meet the needs of racially and ethnically diverse populations (OMH, 2011).
- [Mapping Your Community: Social Determinants that Influence Emergency Preparedness](#). The DelValle Institute for Emergency Preparedness in conjunction with a bureau of the Boston Public Health Commission provides interactive, all-hazards education focused on reducing the public

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<sup>7</sup> [http://ncfy.acf.hhs.gov/sites/default/files/ready\\_for\\_anything.pdf](http://ncfy.acf.hhs.gov/sites/default/files/ready_for_anything.pdf) (Noteworthy: Page 26 & 28 include facility records and records checklists for assessing among other things, the security of client records, insurance and financial information).

health and safety consequences of emergencies and disasters. This specific course provides an overview of the social determinants of health that influences differences in health status throughout Boston neighborhoods and shape health outcomes after emergencies. Participants also learn how health inequalities amongst communities lead to a disproportionate exposure and impact from emergencies (Delvalle, 2014).

- [The National CLAS Standards](#). The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. Review the National CLAS Standards for further guidance on providing culturally and linguistically appropriate services (OMH, n.d.).

## VI. References

- Administration for Children and Families (ACF), Department of Health and Human Services (HHS). Disaster Case Management. n.d.a. Available from: <http://www.acf.hhs.gov/programs/ohsepr/disaster-case-management>. [accessed 2014 December 5].
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