Continuum of Care Model:

Caring for Elders during Disasters

A Guide for Community-Based Planning

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Welcome to the Continuum of Care Model:
Community-Based Planning Guide for Caring for Elders during Disasters

The purpose of this project is to provide information and resources to guide and support local communities in their efforts to develop and sustain a continuum of care for elders during disasters. This document, along with the Step-by-Step Companion Toolkit available as a separate PDF, provide a comprehensive guide to communities for engaging elder care stakeholders in the preparedness, response, and recovery cycles of all-hazards disaster management.

The project's mission was to develop a methodology and planning guide to assist local communities to identify and resolve gaps that may exist in their continuum of healthcare and support for elders during disasters. The continuum model for community-based planning provides both a framework and a process for identifying potential gaps in a community's healthcare and support system for elders during disasters. The model makes no assumptions about the preparedness and capabilities of the many organizations and agencies (stakeholders) involved in caring for elders during disasters. Rather, at a local level, the continuum model provides an opportunity for communities to bring together key stakeholders to identify potential areas of risk and develop remedies and resources for improving the community's level of preparedness to care for elders during disasters.

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The project team expresses its sincere appreciation to the following groups and individuals for their assistance in promoting the project and contributing to its success.

- The project's **Core Planning Team** provided expert guidance and extensive linkages to the broader community of stakeholder groups utilized in the development of the project's key concepts and tools. Special thanks are extended to the **Association of Area Agencies on Aging**, the **Florida Association of Aging Services Providers**, and the **Florida Council on Aging**, for successfully engaging key informants in their respective stakeholder groups to the work of this project. The project's Core Planning Team Roster is s provided on the following page.

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- The ninety-three **representative stakeholders** who, in 2012 attended one of four stakeholder workshops held in locations across the state of Florida to gather information about how elders are cared for during disasters. Their discussions and input along the way helped to define and refine the continuum model. In addition, these key informants completed Key Stakeholder Surveys, providing valuable insights into the dependencies and inter-dependencies that exist throughout the continuum of healthcare and support services for elders.
- **Pinellas County Emergency Management**, **Pinellas County Health Department,** and the **Area Agency on Aging of Pinellas-Pasco**, for hosting a community workshop to present the continuum model for community-based planning. Special thanks to Debbie Peck (Office of Emergency Management), Jason Martino (Area Agency on Aging), and Amber Boulding (Florida Health in Pinellas County).
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Project Objectives (over three years)

- Identify Florida's elder healthcare stakeholder communities summarizing their day to day and disaster-related roles, responsibilities, care, and support services, and provide accessibility to local and state community partners and stakeholders.
- Develop a model for a "Continuum of Healthcare for Elders during Disasters" for use by local communities to prepare for and respond to the complex healthcare care and support needs of elders during disasters.
- Establish a methodology for engaging and accessing the stakeholder communities represented in Florida's continuum of healthcare and support services for elders during disasters.
- Support the integration of elder care stakeholder communities into local and state disaster preparedness, response, and recovery systems, including planning, training, and exercise as defined by the National Response Framework, the National Incident Management System (NIMS), Florida's Comprehensive Emergency Management Plan, and the Florida Public Health and Healthcare Preparedness 2012 – 2014 Strategic Plan.

Project Rationale

Florida's elder population (60 years and older) represents the largest demographic percentage of the State's population (Florida Department of Elder Affairs). Essential healthcare and support services required by this population are significantly complex and may rapidly increase and change over the life cycle of a disaster.

On a daily basis, essential services and support for elders are provided by a wide variety of public, private, and community-based stakeholders. This includes home- and community-based

organizations, informal support networks, and healthcare facilities providing various levels of care in residential settings.

While some elders reside in assisted living facilities or nursing homes, the majority (93%) of Medicare enrollees aged 65 years or older live in independent settings rather than in nursing homes or other congregate settings, and nearly one-third of this group lives alone. For many older adults, independent living is made possible only with help from friends, family, and many varied community-based support services such as meals, home-based health care and personal care services. Collectively, these many and varied stakeholders and care providers comprise the continuum of healthcare and support system for elders in a community. (CDC Report, 2012)

Since all disasters are local events, a community's healthcare system capacities may become overwhelmed. Foreseeable gaps in a community's continuum of healthcare and support systems place vulnerable elders at varying levels of risk. This is exacerbated by a lack of familiarity with elder vulnerabilities and the healthcare and support services continuum that exists in the community. This lack of awareness hinders a community's ability to coordinate preparedness, response and recovery activities, thus diminishing the ability to coordinate with one another in the care of elders during disasters.

The number of healthcare and support stakeholders, their scope of services, accessibility, and capabilities vary between communities. This represents the "normal" level of elder healthcare and support for a given community. It is important to note that the Continuum of healthcare and support services is not solely defined within the geographical boundaries of a given community. Continuum stakeholders may be linked to elder populations within a community through regional networks, interstate service agreements, travel time and distance, mail or package services, or other dependencies or interdependencies.

Gaps in the Continuum

Florida's hurricane experience has shown that during a community emergency or disaster, there are event induced gaps that will occur in the healthcare and support continuum. Event-induced gaps affect the dependencies and interdependencies of the stakeholder roles and capabilities. These gaps are not equal in priority or severity of impact.

Gaps in the continuum and the resultant unmet needs place the elder population and those caring for them at serious risk of injury or loss of life. Additionally, at the local level there may not exist a comprehensive framework that can identify and address the gaps in the continuum and the critical unmet needs of elders. Gaps in the continuum are in many cases foreseeable, and with preparedness and response planning strategies, may be augmented.

The Continuum Model as developed through this project incorporates and builds upon a community's existing healthcare and support services continuum. The model provides a comprehensive framework for developing and understanding the community's resources, stakeholders, infrastructure, and planning system. Communities that use this model to codify their healthcare services and support continuum for elders during pre-event "normal" conditions are better able to identify and mitigate gaps in their continuum.

Why is this approach needed?

- Emergency planners often lack awareness of the vulnerability and complex care requirements of many elders
- The scope of healthcare stakeholders for elders is broad and complex with many dependent and interdependent roles and responsibilities to coordinate and integrate
- Communities (& stakeholders) have varied levels of preparedness, planning and response capabilities/capacities for elders during disasters
- Elder care stakeholders may not be actively integrated into the community's emergency management planning
- Community planning may not be sufficient to identify, engage and integrate all key stakeholders involved in elder care during disasters

Project Value indicators and Lessons Learned

Throughout the entirety of the project, beginning with the establishment of the project's statewide CPT to the final community-based planning workshops, several themes emerged reflecting the value of the project and lessons learned for future planning. These key findings are listed below:

Value Indicators

- During the development and testing of the continuum model in communities across Florida, personal relationships were forged as stakeholders across the healthcare and support services continuum learned from each other.
- The project brought together community stakeholders in workshop settings where they shared a common purpose and interest: care of elders during disasters.
- In communities where workshops were conducted, the continuum model (flower petals) resulted in a more comprehensive understanding of the dependent and inter-dependent relationships among healthcare and support stakeholders. This understanding provided a foundation for the development of collaborative planning relationships.
- The educational segments and discussions in the workshops filled a knowledge gap among stakeholders regarding the vulnerability and complex needs of elders during disasters, and the roles and responsibilities of stakeholders in emergency management.
- The value of the workshops in terms of educational content, discussion-based format, and broad-based participation representative of the full continuum provided a solid foundation for future comprehensive and integrated community-based planning.

Lessons Learned for Community-Based Planning

1. Relationship-building *across stakeholder groups* is the foundation for building a community-based continuum of healthcare and support services for elders during disasters.
2. Community-based planning for the care of elders during disasters should be led by community's essential leadership partners: the local EM, ESF 8 and corresponding area agency on aging (aging and disability resource center). Other stakeholders (ESFs) should also participate to ensure the full representation of the community's continuum of care for elders during disasters.

3. Comprehensive and integrated emergency management planning must be inclusive of all stakeholder groups. It must address stakeholder dependencies and inter-dependencies and foreseeable gaps across the continuum. Likewise, community-based training and exercise programs must also include elder care stakeholders, as they are key partners in the healthcare and support continuum.
4. A discussion-based workshop format, together with a simple visual tool like the continuum of care model, is a powerful combination. It provides stakeholders with an opportunity to immediately recognize their significance in the community's continuum of care and stimulates a more thorough discussion of integrated planning.
5. The continuum model is a valuable tool for Healthcare Coalitions, now under development across the state. As shown in this project, the continuum model helps to ensure the integration of healthcare and support stakeholders into local preparedness, response, and recovery systems.

Evolution of the Continuum Model for Community-Based Planning

This section describes the evolving process and milestones that resulted in the continuum model for community-based planning for elders during disasters.

Developing a Core Planning Team (CPT)

Established in year one, the CPT provided the project with valuable information and perspectives regarding the current state of emergency preparedness and response planning for the elder population. Expert advisors representing the following key stakeholder groups were appointed to serve:

- 2-1-1 agencies (information and referral network)
- Alzheimer's caregiver support organizations
- Area agencies on aging
- Behavioral health providers
- COAD/VOAD (when active in a community)
- Councils on aging / aging network provider organizations / Senior centers
- Dialysis centers
- Emergency management
- Energy providers
- Geriatric care managers
- Home health agencies
- Hospitals
- HUD housing (for seniors)
- Nursing homes, assisted living facilities and continuing care retirement communities
- Selected Government partners (Dept. of Elder Affairs, County Health Department, Agency for Health Care Administration (local field office), Adult Protective Services/Department of Children & Families)

The cornerstone for the CPT's success was its cross-sector representation and collaboration of key stakeholder groups providing healthcare and support for elders in Florida. The CPT's value in terms of validating findings and providing direction and connections to local stakeholder groups and their

leaders cannot be overstated. The concept of using local CPTs emerged from the project's statewide CPT and became the foundation for the continuum model for community-based planning

Identification of Key Stakeholder Groups

In year one, the project began the work of identifying key stakeholder groups and their roles and responsibilities and the interdependent and independent functional relationships that would exist during a disaster. The project's statewide CPT was the most significant contributor to this identification process, and the resulting Healthcare and Support System Stakeholders for Elders master list provided a planning baseline that led to a better understanding of the complexity of the healthcare services continuum needed to support elders during disasters. Not all stakeholder groups identified on the master list are represented in every community, but from the list emerged several essential stakeholder groups that any community in Florida could tap for community-based planning for elders.

At the heart of any community's elder services network will be an associated area agency on aging, and likely a senior center and/or a council on aging. These aging stakeholder representatives, together with the local office of emergency management and the local ESF8 representative are the building blocks for a local core planning team.

Representative Stakeholder Workshops

Conducted in the first year, four stakeholder workshops provided additional insight into the depth of services provided and evidence of counties where local efforts are concurrently underway to build healthcare coalitions for better emergency planning and response. In some communities, there was evidence of existing coalitions for aging, healthcare, and/or emergency preparedness, which could benefit from using the continuum model of community-based emergency planning. Ninety-three attendees participated in the four workshops held across the state. At each workshop, there was evidence of existing relationships, as well as opportunities for the development of new relationships as business cards were exchanged and promises of follow-up for future collaboration. The attendees of the workshops were invited to complete a stakeholder survey, which yielded additional information and insights about the dependencies and inter-dependencies among stakeholder groups.

Further Exploration – Representative Stakeholder Survey

Results from the "Representative Stakeholder Survey" conducted in year one provided a general profile of the major types of stakeholders providing care and support for elders in Florida. Answers to probing questions such as *"If the kinds of services your organization provides were unavailable during a disaster, please describe the potential impact this could have on elder served,"* provided the opportunity for follow-up to learn more about the elders served and impact of services provided, as well as the emergency preparedness practices of selected stakeholder. Additional telephone interviews with selected key stakeholders yielded further insight into communication and collaboration patterns among stakeholders on behalf of the elders they serve during disasters.

Collaboration with Emergency Management Leaders

One outcome of the Representative Stakeholder Workshops was the foundation for collaboration with Florida's emergency management leaders. This resulted in the presentation about the project's goals and work at the Florida Emergency Preparedness Association meeting in July 2012. At the Association's subsequent meeting in January 2013, the team was invited to conduct a 2-hour workshop to present the continuum model for community-based planning, where additional feedback was received from an audience of almost 30 emergency management staff. This opportunity was an important milestone for the project as it provided the foundation for moving forward with one of the most important stakeholders – emergency management. Using the feedback and ideas received, the continuum model was further refined and a strategy developed for testing it in a local community.

Validating the Continuum Model for Community-Based Planning

The project team considered several factors in the selection of local communities to test the continuum model. Selection of the communities was based on both rural and urban characteristics, the hazard vulnerabilities, and a community with strong interest from the office of emergency management and their ESF 8 partners. Drawing on the expertise of the project's Core Planning Team, Pinellas County and Duval County were selected as the Community-Base Planning Workshop sites to test and validate the model.

The Community-Based Planning Workshops consisted of:

- Stakeholder introductions which included a summary of their agency/organization's role in elder care
- Project summary and rationale
- An educational component on the Continuum of Care Model, which provided for detailed discussion on the planning considerations.
- The opportunity to document their agency/organization's Continuum of Care (Visual depiction)
- Scenario based discussion on how the Continuum of Care Model could be utilized in the pre-landfall and post-landfall considerations and planning for a Category 3 Hurricane impact.
- Next steps for the integration of the elder care stakeholders into the community's preparedness, response, and recovery systems

Participants in the Pinellas County and Duval County workshops included representatives from: emergency management, nursing homes, Public Health, ESF 8, hospitals, assisted living, home health providers, transportation providers, EMS, Area Agencies on Aging, meals on wheels, adult protective services, the local Department of Elder Affairs (CARES), Women in Crisis, Alzheimer's disease caregiver support services, dialysis, and housing for seniors.

Many of the stakeholders that participated in the project activities have not historically been involved in the formality of the local community's emergency preparedness and response systems.

Feedback from the home health representatives helped clarify that their patient relationships are typically short-term, as contrasted with some of the other home and community-based providers of services to elders. Another contribution was the need to add behavioral health as a key provider/stakeholder in the continuum concept.

In addition to the Pinellas County and Duval County workshops, the continuum model was also tested in a focused workshop organized by Florida Health Care Association for nursing home stakeholders in

Palm Beach County. In attendance were representatives from emergency management, the local department of health, and the local area office of the Agency for Health Care Administration. During this stakeholder-level testing, the continuum model was used to identify the resources and support systems required to sustain elders within the nursing home setting, and to demonstrate the dependent and interdependent variables involved in maintenance of the continuum. A hurricane scenario was used to play out a category 4 storm impacts on a nursing home, and strategies that would be required to maintain the continuum of healthcare services and supports.

This focused session further validated the value and usefulness of the continuum model at the stakeholder level.

Information and feedback gathered from all meetings, workshops, surveys, and reference resources all contributed to the development of the final continuum model for community-based planning presented in this project.

The Continuum Model: A Framework for Community-Based Planning

As previously noted, the elder population in Florida represents the largest demographic percentage of the State's population. Concurrently, in certain communities across the state, this demographic represents the largest demand for healthcare service and support resources. In other communities, the elder demographic is not large, and supporting healthcare services and resources may be located in neighboring communities.

The community-based continuum of healthcare which supports elders on a daily basis and during a disaster is comprised of a complex system of care, support, and services for elders, some formal and some informal. The ability of this continuum to support the elder population during a disaster is predicated on the *dependencies* and *interdependencies* of their community stakeholders. Disasters create conditions that disrupt or make unavailable the continuum of care and services. This "break" in the continuum requires local communities to develop strategies to fill these gaps, which could include facility-based medical care (hospitals, nursing homes), home-based services, medical equipment and supplies, caregiver support, and local transportation and utility systems.

Elder Care Community Stakeholders

The following is a partial list of local community stakeholders comprising a community continuum of care for elders:

- County Emergency Management (EM) & Health Department (ESF8)
- Area Agency on Aging (AAA)
- 2-1-1 agencies (information and referral network)
- Alzheimer's caregiver support organizations
- Behavioral Health Providers
- COAD / VOAD (when active in a community), including Red Cross
- Councils on Aging / Senior Centers / Other aging network provider organizations
- Emergency Response Agencies (e.g., EMS, fire, law enforcement)
- Energy providers
- Home health agencies & geriatric care managers
- Hospitals & other healthcare providers (e.g., clinics, medical equipment, VA)

- HUD housing (for seniors)
- Nursing homes, assisted living facilities & continuing care retirement communities
- Pharmacies
- Renal dialysis centers
- Selected Govt. partners (Dept. of Elder Affairs; Co. Health Dept.; Agency for Health Care Admin.; Adult Protective Serv./Dept. of Children & Families; Veterans' Affairs)
- Transportation providers
- OTHER groups important in the healthcare continuum for elders in the local community

Continuum of Care – Planning Assumptions

Planning assumptions can be characterized as historically repeating and observed conditions, behaviors, and outcomes which, over time, comprise a broad base of knowledge and collective experience. This knowledge and experience can be used to predict future behaviors, conditions, and consequences during disasters. They become assumptions in the sense that there is some level of confidence that during disaster conditions, their presence can be "assumed" as foreseeable and to be addressed.

In the development of the continuum of care model, the following planning assumptions were identified from the stakeholders, resource materials, and the workshops:

- The older adult population is not characterized by age alone.
- Elders are unique; not all individuals age 60+ are frail. Their individual use of the community's healthcare and support services will vary (e.g., less than 3% of Florida's 65+ population reside in nursing homes).
- During a disaster, the needs of elders will increase in complexity and change over the term of the disaster. This may result in increasing decompensation of individuals within the elder community.
- In a disaster environment, healthcare services and supports will be limited, temporarily unavailable, or absent. This can result in negative outcomes for elders as their complex healthcare and support needs will likely exceed the system's ability to respond.
- The reduction of a community's capability to care for elders will result in negative outcomes when the continuum is disrupted or broken.
- A community's resiliency to take care of its elder population depends largely upon its augmentation and/or replacement strategies to reduce or mitigate gaps in the continuum of care.
- Elder care stakeholders represent a complex network of healthcare and support service providers. Their dependent and interdependent relationships must be accounted for in the preparedness, response, and recovery cycles of a community's emergency management system.

The Continuum Model

The continuum model for community-based planning provides both a framework and a process for improving the community's capability to care for elders during disasters. The model guides communities in the development of comprehensive and integrated preparedness, response, recovery and mitigation activities through a comprehensive and integrated discussion of:

- Elder population demographics (demand) and local healthcare and support service stakeholder capabilities (supply)
- Healthcare, community and social support systems present on a “sunny” day
- Dependent and interdependent stakeholder and community relationships
- Disaster risks and vulnerabilities of elder populations during disasters
- Continuity of care and support services during disasters
- Supporting elder care and support priorities
- Key planning considerations and integration of the elder care and support stakeholders into the community’s preparedness, response, and recovery systems

Key Planning Considerations

The Project Team reviewed many different approaches and methodologies for addressing the issue of caring for elders during disasters. The aggregate of those reviews led us to utilize four key planning considerations which incorporate the major issues and considerations which when viewed together make up the Continuum Model. Those four key planning considerations, outlined below and more fully described in the next section, provide the framework for community-based planning for the care of elders during disasters. Analysis of these Elder Care Planning Consideration incorporates a comprehensive discussion of:

1. **Community Profile: Characterizing the Elder Population (People and Stakeholders):** This planning consideration analyzes the size, demographics, and geographical location of a community’s elder population. By identifying and understanding these population characteristics, a community will be better able to identify and provide the essential services, resources, and support systems needed during a disaster. In addition, the analysis must include a review of the key stakeholders involved in providing healthcare services and supports to the elder population.
2. **Disaster Risks and Vulnerabilities for Elder Populations:** Elders are a diverse group and vulnerability cannot be characterized by age alone (CDC Report, 2012). Complex variations in health status, living environments, and social situations of elders make it hard to protect this population during emergencies. This planning consideration examines the risks associated with the vulnerabilities identified.
3. **Continuum of Healthcare and Support Systems for Elders:** The community-based continuum of healthcare which supports elders on a daily basis and during a disaster is comprised of a complex system of care, support, and services for elders, some formal and some informal. The ability of this continuum to support the elder population during a disaster is predicated on the *dependencies* and *interdependencies* of their community stakeholders. Disasters create conditions that disrupt or make unavailable healthcare and support services in a community. The resulting “breaks” in the continuum will require the community to develop strategies to sustain their continuum of healthcare and support services.
4. **Community Preparedness and Response Planning for Elder Populations.** The complexity of planning and preparedness for elder populations requires the involvement of all community stakeholders. This ensures that community-based planning is comprehensive and integrated across stakeholder groups (i.e., the continuum) to address the complex needs and vulnerabilities of elders. By understanding how different types of hazards affect elders, emergency planners can improve their ability to protect vulnerable elders. This fourth

consideration focuses on identifying the prevailing preparedness and planning principles that should be used across a community's continuum of healthcare and support services.

Planning Consideration #1: Community Profile – Characterizing the Elder Population (People and Stakeholders)

The starting point in this analysis is a determination of the size, demographics, and geographical location of a community's elder population. Concurrently, it is important to have a comprehensive understanding of the type, location, and number of healthcare and support stakeholders that provide services to the elder community. By identifying and understanding these population and support characteristics, a community will be better able to identify and provide the essential services, resources, and support systems needed before, during, and after a disaster. In addition, the analysis must include a comprehensive review of the key stakeholders involved in providing healthcare services and supports to the elder population.

Consideration of this planning consideration includes analysis of:

- Elder demographics, including geographic locations
  - → Residential areas/mapping
  - → Healthcare and support service providers (stakeholder groups)
  - → Aggregation and number of elders living "independently"
- Consideration of elder population vulnerabilities
- Gaps which may occur in the community's ability to support their elder community

Elder Population Demographics and Locations (CDC Report, 2012)

- Basic epidemiologic data can be used to guide planning for the delivery of services, medications, durable medical equipment, and other materials needed to support elders during all phases of an emergency.
- Using geographic information systems (GIS): GIS mapping technology allows officials to coordinate information about the locations of vulnerable older adult populations, community resources to help elders, and potential hazards.
- Understanding where elders are located and how they might be adversely affected by different types of emergencies can help local planners and first responders prepare for how they will meet the needs of elders during an emergency.
- Building, maintaining, and using registries: Registries can be developed to provide information about specific types of help—such as medical equipment, transportation, or evacuation assistance—that vulnerable elders will need during an emergency. They also can serve the broader purpose of identifying elders who might need any type of help in an emergency.
- Using shelter intake procedures to identify vulnerable elders in the community: This information can be used to identify elders who may need special help.
- Emergencies also can disrupt the healthcare and support systems that many elders rely on. For many elders, independent living is made possible only with help from friends, family, and in-home services that provide meals, home-based health care, and help with chores and personal care needs. In fact, the majority (93%) of Medicare enrollees aged 65 years or older live in the community, rather than in nursing homes or other congregate settings. Nearly one-third of this group lives alone.

As cited in the CDC's report, *Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies* (2012), it is difficult to predict what groups of people will be most affected by future emergencies. However, events such as the 2004-2005 hurricane seasons, and the 2011 earthquake and tsunami in Japan have shown that there are characteristics of elders put them at greater risk of illness and death during many types of emergencies. For example, elders may have impaired mobility, diminished sensory awareness, multiple chronic health conditions, and social and economic limitations—all of which can impair their ability to prepare for, respond to, and adapt during emergencies.

Emergencies also can disrupt the support systems that many elders rely on. For many elders, independent living is made possible only with help from friends, family, and in-home services that provide meals, home-based health care, and help with chores and personal care needs. In fact, the majority (93%) of Medicare enrollees aged 65 years or older lives in the community, rather than in nursing homes or other congregate settings. Nearly one-third of this group lives alone.

Elder population demographics and the capability of the community to provide essential resources becomes a critical component of planning, before, during, and after a disaster.

The Elder Adult Population (CDC Report, 2012**)**

The older adult population is not characterized by age alone. Different laws use different parameters to define this population, especially in terms of when people become eligible for services. For example, although adults are generally eligible for Medicare coverage at age 65, they also become eligible for services and protections at age 60 under the Older Americans Act (OAA). The services provided under the OAA include many types of assistance -- such as meals, home health services, personal care, and transportation -- that help elders continue to live in their communities.

Another important community planning consideration that influences whether elders need help during an emergency is whether they live in a long-term-care facility or in a community setting. Community-dwelling elders may pose more complex challenges for planning officials than those in long-term-care settings because these facilities may already be governed by specific regulations. To remain in their homes, many community-dwelling adults rely on care from family members or caregivers or from services provided by area agencies on aging, community organizations, or home health agencies. Interruption of these services during an emergency can compromise the self-reliance and independence of community-dwelling elders. For these reasons, there needs to be a concentrated focus on the protection of elders who live in their homes in the community

While there are many common aspects related to the aging process, one of the unique findings is that aging is individual and the effects may have some similarities also reflect variances which may not be easily accounted or planned for. Advanced age alone does not equate to vulnerability as frailty is individually evidenced and defined. Thus there is a wide range of independence of elders residing in the community in 'independent' or 'assisted' living environments.

Key Community Stakeholders Groups

- Alzheimer's caregiver support organizations
- Area agencies on aging
- Behavioral health providers
- COAD/VOAD (when active in a community)
- Councils on aging (aging network provider organizations)
- Emergency management
- Energy providers
- Geriatric care managers
- Home health care agencies
- Hospitals
- Primary Care Physicians
- Specialty Clinics
- HUD housing (for seniors)
- Nursing homes, assisted living facilities and continuing care retirement communities
- Dialysis centers
- Pharmacies
- High Rise Associations
- EMS
- Senior centers
- 2-1-1 agencies (information and referral network)
- Local and State government partners (Department of Elder Affairs, County Health Department, Agency for Health Care Administration Local Field Office, Adult Protective Services/Department of Children & Families)
    - Other Community-based providers

Planning Consideration #2 – Disaster Risks and Vulnerabilities for Elder Populations

A 2012 report from the CDC describes elders as a diverse group in terms of their physical and mental health, and vulnerability cannot be characterized by age alone. Complex variations in the health status, living environments, and social situations of elders also make it hard to protect this population during emergencies. For example, an independent older adult who lives on the 18th floor of a high-rise building may suddenly become vulnerable if the electricity goes out during a hurricane, shutting down the building's elevators. Elders are at increased risk of disease and death during emergencies because of factors such as the following:

- A higher prevalence of chronic conditions, physical disability, cognitive impairment, and other functional limitations.
- Dependence on support systems for medical care, medication, food, and other essential needs.
- Potential limitations in their mobility, their access to transportation, or other aspects of functional autonomy.

In addition to the direct relationship between age and the prevalence of chronic conditions, nearly 82% of Medicare beneficiaries have at least one chronic condition, and 64% have multiple conditions. The treatment of these conditions may require daily medications, specialized equipment, or care coordination.

- If elders are not able to get the medications, equipment, or special care they need, they can be at increased risk of complications and death during an emergency.
- In addition to the above challenges, Kilijanek and Drabek (1999 as cited in Seff) noted that the elderly do not seek financial support after disasters for a variety of reasons, including:

    - They feel others may need the help more than they do.
    - They do not like “welfare” handouts.
- They tend to seek insurance payouts and reconstruction of damaged property later than other adults, leaving their homes at risk from subsequent storms.
- Additionally, in the wake of Hurricanes Katrina and Rita, it became clear that the elderly are disproportionately vulnerable to hurricanes. In fact, of the 1,330 people known to have died along the Gulf Coast, 71% of those in Louisiana were older than 60years, 47% were over 75 years, and at least 68 persons died in nursing homes.

Vulnerabilities of Elder Populations during Disasters

Unfortunately, community disaster planning frequently fails to allow for the needs of older citizens before, during, and after hurricanes. In December 2005, the American Association of Retired Persons (AARP) convened a conference of governmental, scientific, and public sector experts to discuss ways to improve disaster preparedness for the elderly. The report which was issued after the conference noted several factors that predispose the elderly to morbidity and mortality from hurricanes (Gibson 2006, as cited in Seff). They include:

- The elderly frequently suffer from multiple comorbidities.
- They have functional limitations, including sensory, physical, and cognitive impairments.
- Visual impairment affects 13.9% of adults aged 65–74 19.1% of those aged 74–84, and 30.3% of those aged 85 and over.
- Hearing loss affects 31.4% of adults aged 65–74, 43.9% of those aged 74–84, and 58% of those aged 85 and over.
- Elderly people often suffer from loss of taste, smell, and/or touch sensation, which leaves them more at risk for nutritional deficiencies and danger from fire or gas leaks.
- Aging tends to diminish the efficiency of both sensory and muscular systems, rendering the elderly more at risk in disasters because of prolonged reaction.
- They often take multiple medications and medications can increase risk for hypotension, falling, and confusion.
- Sudden cessation of medication (e.g., running out of medications after a disaster and no physicians’ offices or pharmacies are open to refill) can lead to life-threatening consequences.
- They usually rely on caregivers for assistance.
- Many suffer from generalized “frailty,” which can best be understood as a lack of biological reserve and resilience.
- Older citizens are much more susceptible to extremes of heat and cold that often accompany disasters (e.g., extreme heat in the hurricane season in Florida).
- Many suffer from social isolation, especially those living alone and in rural areas.
- After disasters, there can be significant worsening of health issues as a result of the compounding loss of loved ones and friends, loss of income, loss of shelter (e.g., destroyed homes), loss of social status, etc.
- As a general rule, elderly people are much less likely to seek mental health counseling because they perceive mental illness as “weakness.”
- They may be less likely to evacuate, leaving their homes, belongings, and healthcare and support systems.

Clinical Risk Management

Clinical risk management is a process that assists professionals to recognize foreseeable risks which could result in consequence and likelihood of probable events that if not, identified, planned for, and addressed could cause undesired outcomes up to harm.

Using a systematic approach which includes assessment and risk reducing related to the medical, physical, emotional, psychosocial, sensory awareness, and environmental factors have a direct relationship to resilience and survival. The ability for the Elderly to prepare for, respond to, and recover from a disaster hinges on a variety of factors that often are not under their immediate control.

The most common characteristic of aging to be planned for is the deterioration of physical ability. This relates to activities of daily living (ADLs) as evidenced by impaired balance, decreased motor strength, poor exercise tolerance, functional limitations, etc. Physical disabilities often are intensified by medical co-morbidities, active medical diagnosis, complications from medical treatments, and use of medications.

Patient Risk Tools

Patient risk categorization tools exist at a State or national level. A review of the literature revealed some efforts on behalf of State and national associations for home care and hospice agencies to provide guidance on the development of emergency plans and use of an abbreviated patient assessment tool. HHAs participating in Medicare/Medicaid programs are subject to Federal and State regulations and must undertake disaster planning; however, those regulations do not specify the content of plans, and personal care agencies do not appear to have such plans in place (5).

Several examples of patient risk categorization tools were reviewed. The first documented patient classification system was introduced in 2001 by Barbara Citarella (e-mail correspondence. August 24, 2009, as cited in Seff).

In a 2005 letter to home care and hospice agencies, the New York State Department of Health mandated that emergency plans be revised to incorporate a patient risk classification system (6). The sample classification system proposed in the letter is a three-level system, structured as follows:

> **Level I: High Priority.** Patients in this priority level need uninterrupted services. In the case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patients who require life sustaining equipment or medication, those who need highly skilled wound care, and unstable patients who have no caregiver or informal support to provide care.
>
> **Level II: Moderate Priority.** Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.
>
> **Level III: Low Priority.** The patient may be stable and has access to informal support to provide care. The patient can safely miss a scheduled visit if basic care is provided by family members, other informal support, or by the patient himself.

Another classification system, developed by a State home care association in 2007 and based on Citarella's earlier version, uses a similar approach to the three-level system described above, and offers examples of patient types for each category:

> Examples of patients classified as **Level 1 (High Priority):** A patient who is bed-bound or paralyzed, ventilator dependent, unable to meet physiologic and safety needs, or who requires daily insulin injections for diabetes but is unable to self-administer the medication.
>
> Examples of patients classified as **Level 2 (Moderate Priority):** A patient who uses equipment such as an oxygen tank, suction pump, nebulizer, or patient-controlled analgesia pump.
>
> Examples of patients classified as **Level 3 (Low Priority):** A patient who is mobile and independent in functioning or a patient who needs uncomplicated routine wound care.

Elders Are Not a Homogeneous Group

For disaster planning purposes, it is important to realize that elders are far from a homogeneous group. Gillick (1994, as cited in Seff) defined four groups of elders whose characteristics and differing needs must be borne in mind when planning for hurricanes:

1. **Robust elders**—those elders who maintain vigor in their later years. Although they may have health challenges, this group is able to fend for themselves as they do not suffer from functional disabilities.
2. **Frail elders**—those elders who have serious health problems and who use all of their capacity for survival. They have little or no functional capacity with which to respond to a disaster. Fernandez et. al (2002, as cited in Seff) give the following definition of frail elderly from an emergency management viewpoint:

   Individuals aged 65 years or older with physical, cognitive, social, psychological, and/or economic challenges that will likely limit their ability to perform, or have performed for them, one or more of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) during and after a disaster. Frailty is really a syndrome separate from the normal aging process—including unintentional weight loss, muscle weakness, slowed gait, exhaustion, and low physical activity.
3. **Elders with dementia**—loss of cognitive function renders these elders unable to understand what is happening during a disaster. They are not capable of making informed decisions and lack the ability to prepare for or respond to hurricanes.
4. **Dying elders**—for these elders, disasters can lead to serious questions of patient autonomy and control while increasing the burden on already stressed family members.

Planning Consideration #3 – Continuum of Healthcare and Support Services for Elders

Planning for the care of elders during disasters begins with an understanding of the community's Healthcare and Support Continuum for Elders.

During disasters, vulnerable elders represent a population demographic whose essential life support needs and services are significantly complex and rapidly increase and change over the life cycle of a disaster.

On a daily basis, essential services and support for elders are provided by a wide variety of public and private state and community-based stakeholders. While some elders reside in assisted living facilities or nursing homes, the majority (93%) of Medicare enrollees aged 65 years or older live in independent settings rather than in nursing homes or other congregate settings, and nearly one-third of this group lives alone. For many elders, independent living is made possible only with help from friends, family, and many varied community-based support services such as meals, home-based health care and personal care services. Collectively, these many and varied stakeholders and care providers comprise the continuum of healthcare and support system for elders in a community.

The Continuum of healthcare care and support services for elders identifies and describes an integrated system that spans the comprehensive and complex array of elder health and support services in a community. It creates the framework where all stakeholders are linked together on the basis of their dependencies and interdependencies, and provides for the optimum day to day delivery of community healthcare and support services for elder populations.

The number of stakeholders, scope of services, elder accessibility, and stakeholder capabilities varies between communities, and represents the “normal” for a given community. It is important to note that the Continuum of healthcare and support services is not solely defined within the geographical boundaries of a given community. Continuum stakeholders may be linked to elder populations within a community through regional networks, interstate service agreements travel time and distance, mail or package services, or other dependencies or interdependencies.

Our experience has shown that during a community emergency or disaster, there are event driven gaps that will occur in the care and support continuum. Contributing to the gap is the lack of awareness of the care and support services that exist, knowledge of the stakeholder services/support involved, what the stakeholders and support providers are responsible for, and how they coordinate and integrate in the continuum of care for vulnerable elder populations during disasters.

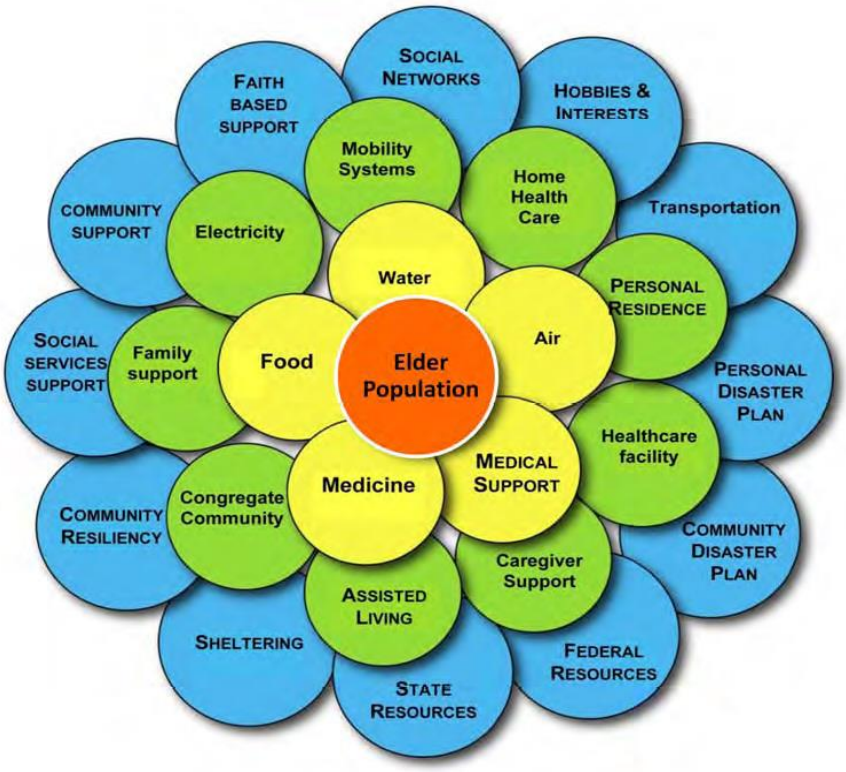
Sustaining the Continuum

Since all disasters are local events, a community’s healthcare and support systems capacities may become overwhelmed. Foreseeable gaps in a community’s continuum of healthcare and support systems place vulnerable elders at varying levels of risk. In addition, the lack of familiarity with elder vulnerabilities, lack of awareness of the healthcare and support services that exist, stakeholder roles and responsibilities and their inability to coordinate and integrate with one another in their continuum of care further diminish the community’s ability to care for elders during disasters.

A Community’s Continuum of Healthcare and Support Services during Normal and Disaster Conditions: A Visual Look

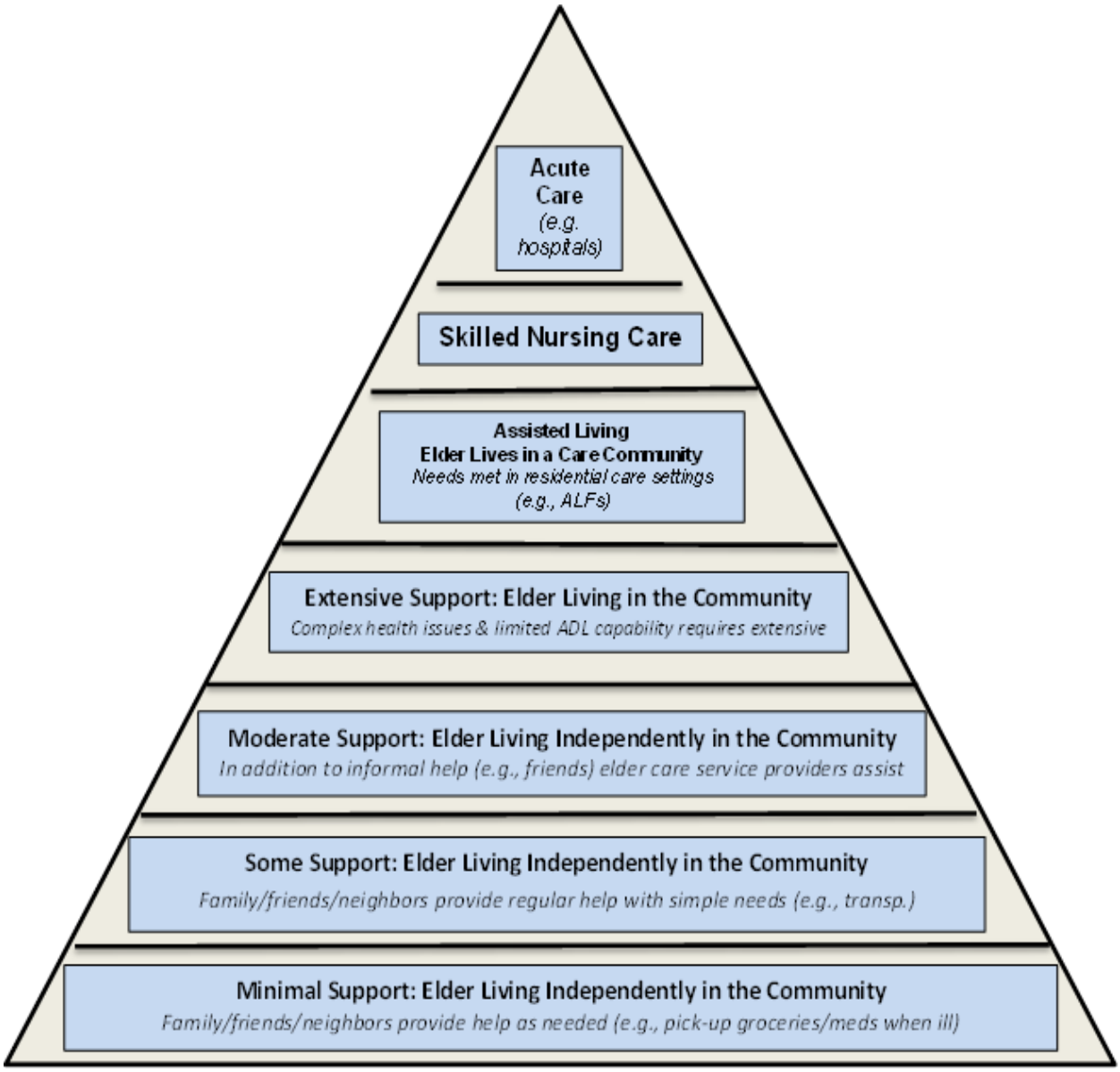
As previously stated, the “normal” continuum of care can be complex and involve many stakeholders. Because of its complexity, a visual depiction is helpful. The following pages portray visual depictions of several continuum of care diagrams during normal (“sunny”) and disaster (“rainy day”) conditions. These visuals reduce the complexity of the analysis and provide stakeholders with a less complex method to identify and track the gaps that may occur in their continuum of care during disaster conditions.

Continuum of Healthcare and Support for Elders
A Complex System

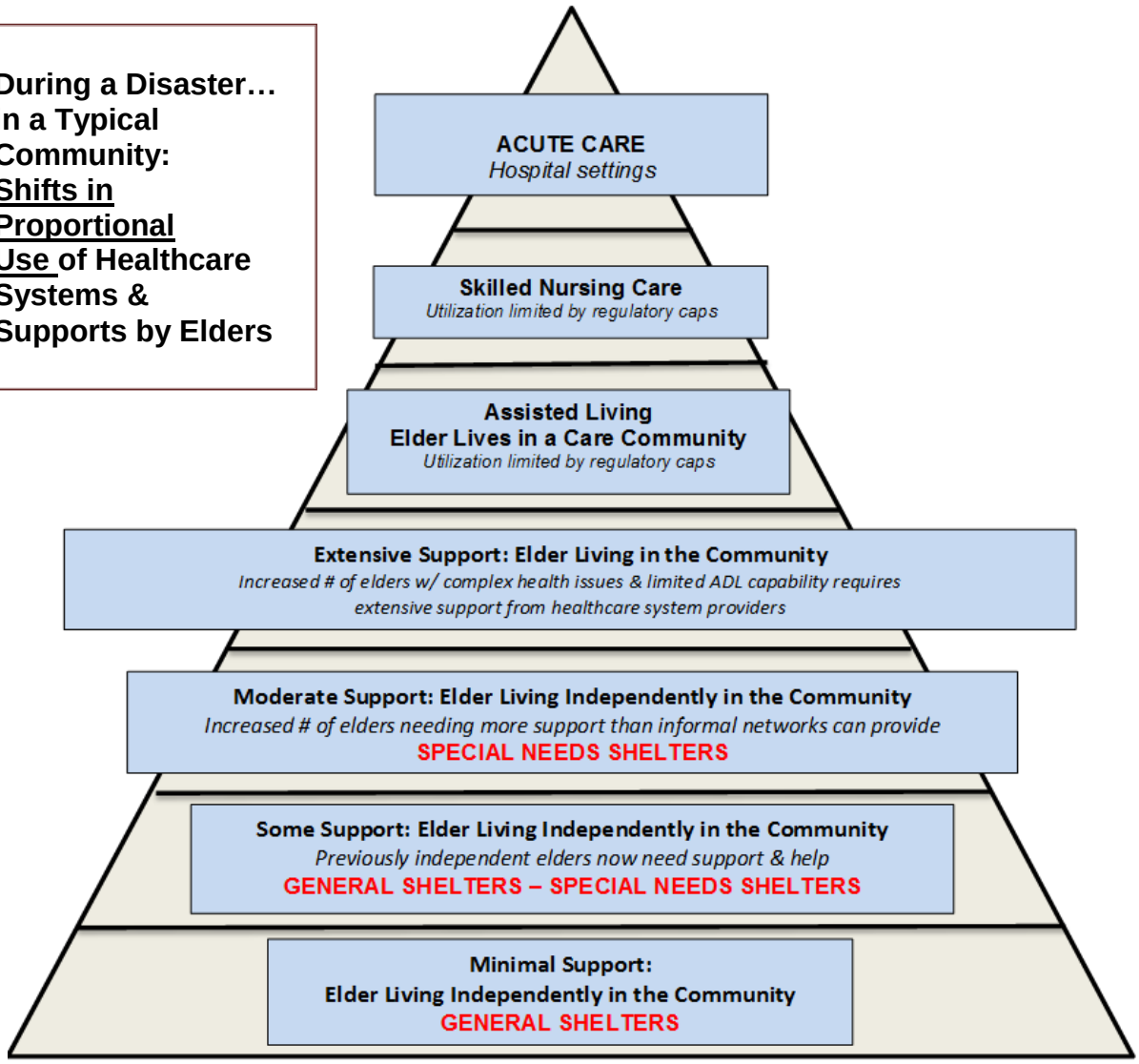


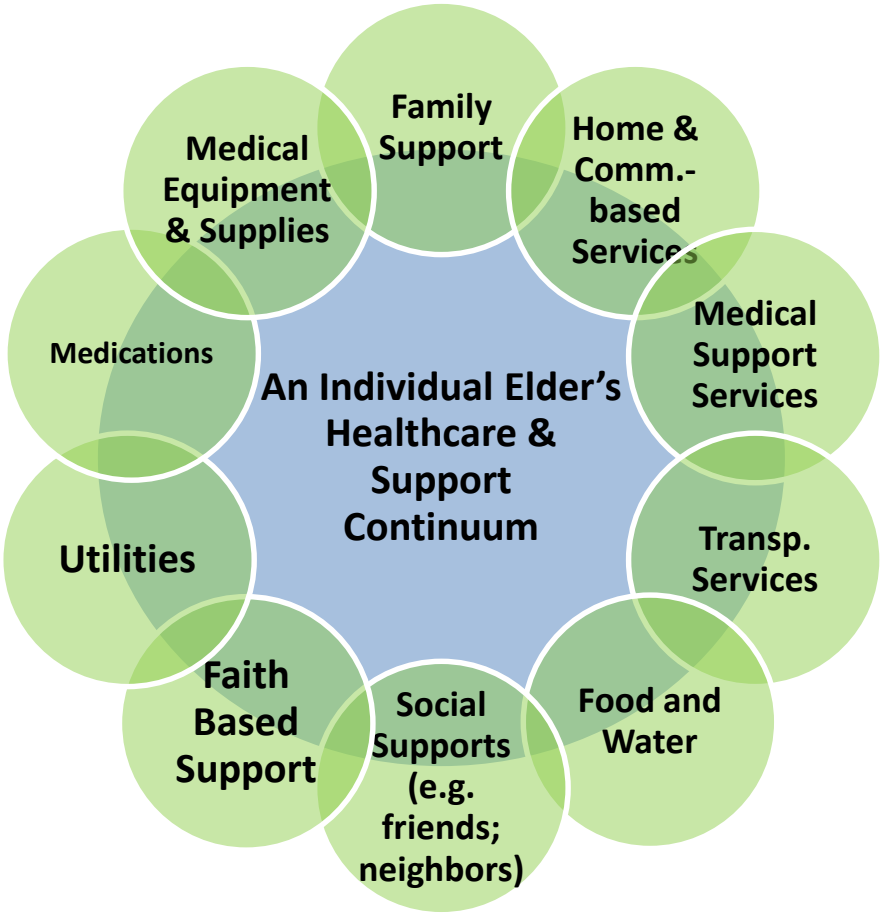
This visual reflects the scope and complexity of the continuum of healthcare and support services for elders in any community. Elders are depicted in the center as the focal point with a cascading priority of support needs and the most essential needs shown in yellow. Other support needs will vary in priority, based on the vulnerabilities of individual elders in the community. The various healthcare and support needs shown above are elements in a continuum of stakeholders linked together in a complex system of dependent and interdependent relationship.

On a Normal Day…
in a Typical Community:
<u>Proportional Use</u> of Healthcare Systems & Supports by Elders

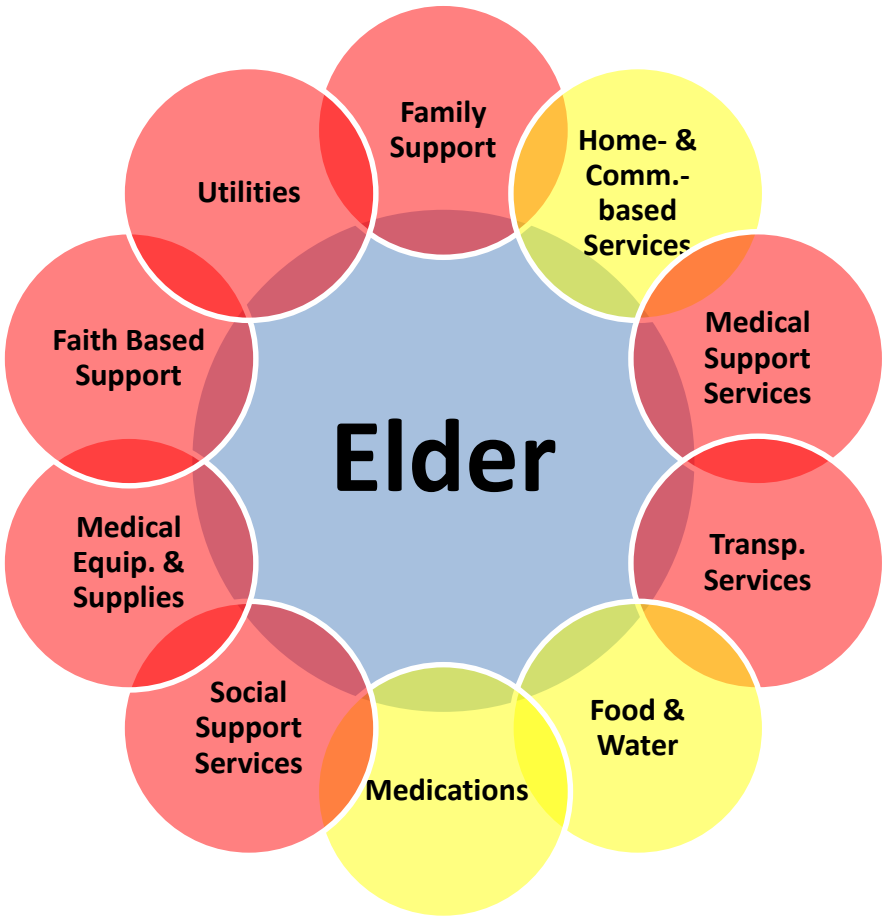


During a Disaster… in a Typical Community: <u>Shifts in Proportional Use</u> of Healthcare Systems & Supports by Elders

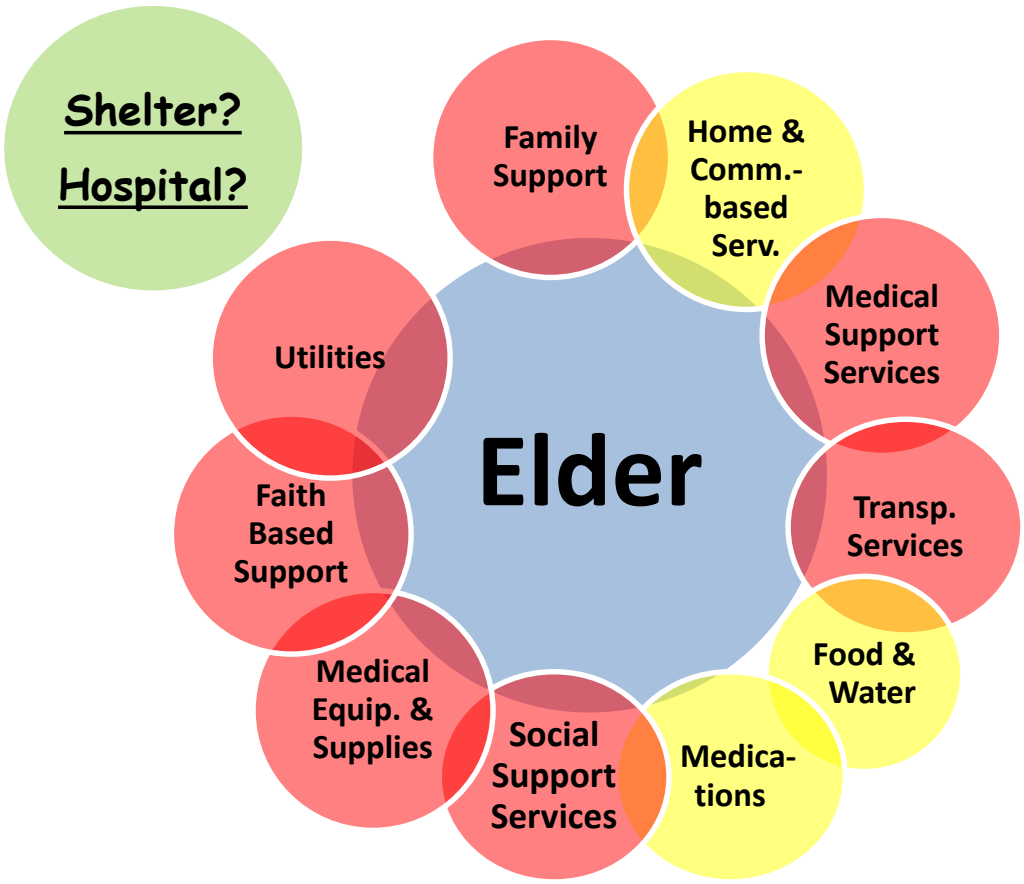




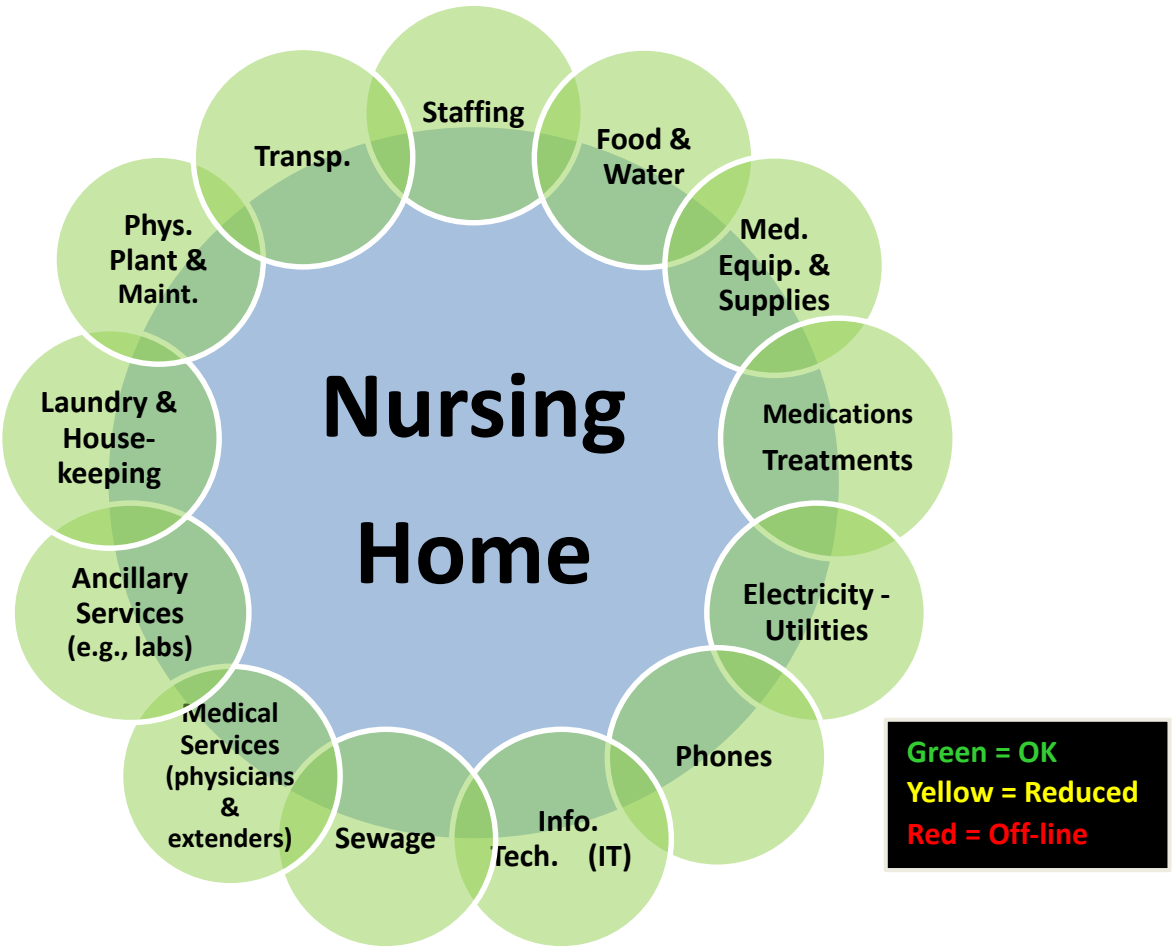
This visual depicts the most common healthcare continuum elements used to support the needs of an individual elder during normal conditions. Continuum elements are supported by many and varied stakeholders, each contributing to the community's continuum of healthcare and support services for elders. For example, the continuum element labeled Medical Support Systems would typically include the following stakeholders: primary and specialty care physicians, dialysis centers, radiology providers, laboratory services, hospitals, and others.



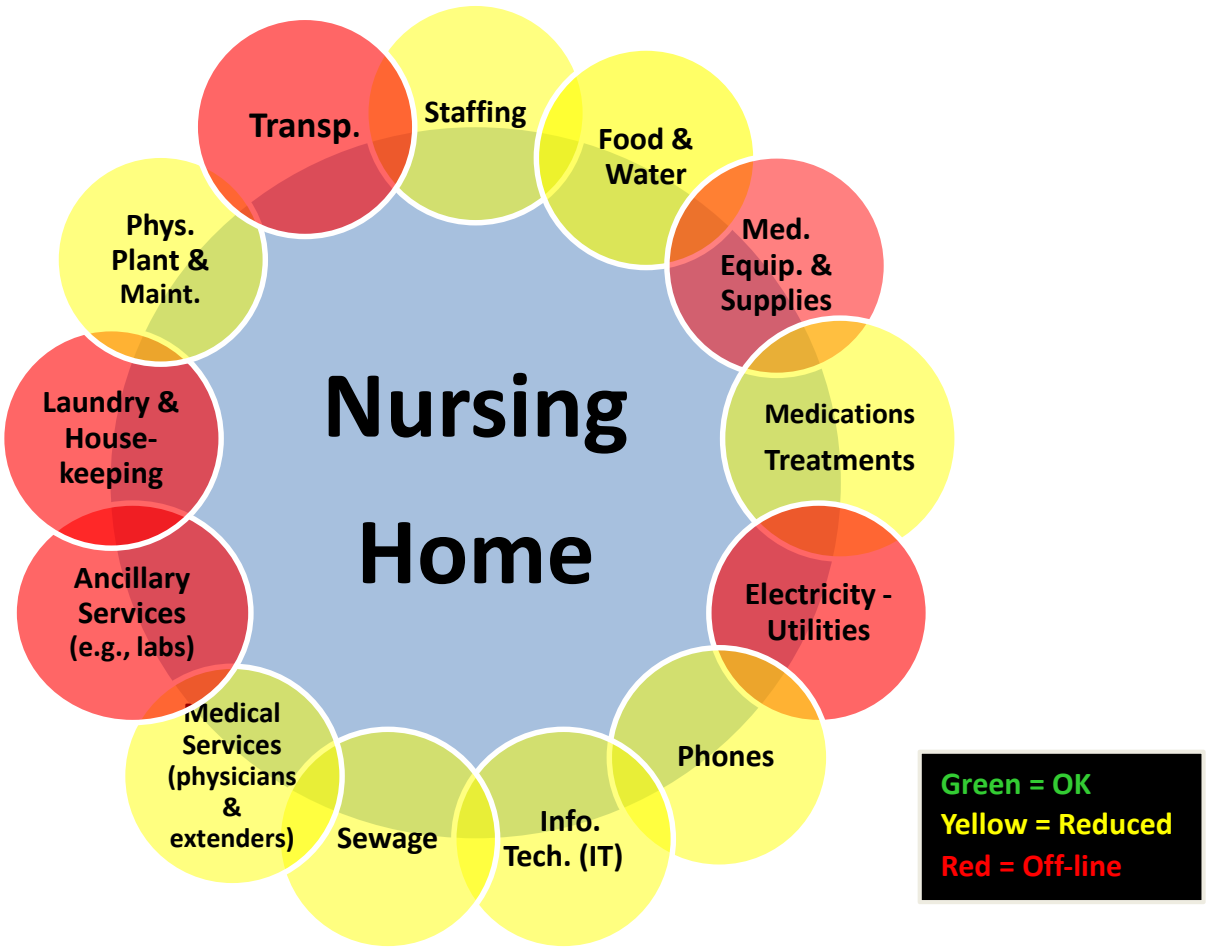
This visual depicts the onset of disaster conditions and the effect they have on an individual elder's continuum of healthcare and support services. The red coloration indicates an off-line healthcare and support continuum element. The yellow indicates partial capabilities, which are now limited and also impact an elder's overall health and well-being. Across the continuum, stakeholders are linked through dependencies and inter-dependencies, making time a critical factor when a stakeholder goes off-line as the situation often impacts another stakeholder's capability to function. For example, with the transportation system off-line (red), elders have limited or no access to medical care. Additionally, elders may be unable to obtain medications because pharmacies are also off-line. Another non-medical but vital continuum element is faith-based support, which when diminished, could trigger social isolation -- a serious concern for an elder population, especially during a disaster.



This visual depicts the continuing disaster impacts, with a further reduction or loss of key stakeholders providing healthcare and support services. The above depiction indicates there will now likely be at least a partial reliance on a shelter environment. There is also the potential for the rapid decompensation of elders who may be unable to compensate for the deterioration of their continuum of healthcare and support services and overall living environment. If the pre-disaster continuum cannot be restored, an elder may decompensate to the point of needing a higher level of care, making transfer to a hospital or other healthcare facility a potential course of action.



This visual depicts the most common healthcare continuum elements used to support the needs of a nursing home during normal conditions. Continuum elements are supported by many and varied stakeholders, each contributing to the facility's continuum of healthcare and support services. For example, the continuum element labeled Medical Services would typically include the following stakeholders: primary and specialty care physicians, dialysis centers, radiology providers, laboratory services, hospitals, and others.



This visual depicts the onset of disaster conditions and the effect they have on a nursing home's continuum of healthcare and support services. The red coloration indicates an off-line healthcare and support continuum element. The yellow indicates partial capabilities, which are now limited and also impact on the nursing home's capability to provide care and services. Across the continuum, stakeholders are linked through dependencies and inter-dependencies, making time a critical factor when an internal support service or capability goes off-line. The loss of a capability often impacts other service or support capabilities. For example, with the transportation system off-line (red), elders have limited or no access to medical care. Additionally, elders may be unable to obtain medications because pharmacies are also off-line.

Planning Consideration #4 – Community Preparedness, Response, and Recovery Planning for Elder Populations

Communities face different planning challenges in preparing for and responding to emergencies depending on the type of hazard. Different types of hazards also can affect elders differently and require specific types of planning. An all-hazards approach to preparedness recognizes the full spectrum of hazards and potential events and includes planning for the more common problems that can occur during an emergency. By understanding how different types of hazards affect elders, emergency planners across the continuum of healthcare and support services can improve their ability to protect vulnerable elders.

Planning must be comprehensive and community-based, representing the whole population and its needs**.** Understanding the composition of the population, —such as accounting for the complex needs of elders, people with disabilities, and others with access and functional needs, must occur from the outset of the planning effort. By fully understanding the composition and requirements of the actual population (including the demographics of the elder community), community-based planning better prepares the community to address potential gaps in the continuum of care, and developing contingency plans to address the gaps.

Additionally, planning for elders must be collaborative across all community stakeholders. Collaboration ensures that plans are integrated and aligned with the community's plans to ensure that elder care and support stakeholders are not planning in isolation. Integrated planning aligns the roles and responsibilities of the elder care stakeholders and factors their dependencies and interdependencies to ensure the sustainment of the community's continuum of care for elders.

With the implementation of Healthcare Coalitions across the state, there is a recognition of the need to reach out to the elder care and support stakeholders. Additionally, the scope of the coalition's stakeholders as defined by the Department of Health and Services (HHS) specifically incorporates the elder care stakeholder community into this initiative. It is important that elder care healthcare and support stakeholders participate in the local coalitions to support their integration into community-based planning. Within the coalition structure, healthcare and support stakeholders, should actively participate in all phases of the community's preparedness, response, and recovery system

Engaging with Community Healthcare Coalitions

As described in the National Guidance for Healthcare System Preparedness, the following is a summary of the purpose and scope of Healthcare Coalitions. Healthcare Coalition (HCC) is a collaborative network of healthcare organizations and their respective public and private sector response partners. Together, they serve as a multi-agency coordination group to assist Emergency Management, through ESF8, with preparedness, response and recovery activities related to health and medical disaster operations. Healthcare Coalitions help improve medical surge capacity and capability, further enhancing a community's continuum of healthcare and support systems in the preparedness, response, and recovery cycles of disaster management.

Healthcare Coalition objectives are consistent with the Continuum of Care Model, with a focus on:

- Building a better community-based, disaster healthcare system;
- Strengthening the local healthcare system by fully integrating disaster preparedness into the daily delivery of care;
- Capitalizing on the links between private healthcare providers and public agencies and groups; and,
- Using an evidence informed approach to improving health and medical preparedness and response.

These objectives can be achieved by planning and organizing local healthcare provider Involvement in emergency preparedness activities. A Healthcare Coalition also augments local operational readiness to meet the health and medical challenges posed by a catastrophic incident or event. This is achieved by engaging and empowering all parts of the healthcare and support community, and by strengthening the existing relationships to understand and meet the actual health and medical needs of the whole community.

Healthcare Coalitions, and ESF 8 planners identify gaps in preparedness, response, and recovery in order to determine specific priorities, and develop plans for building and sustaining healthcare system capabilities across local communities.

These capabilities, and their associated functions and tasks are designed to facilitate and guide healthcare and support systems' planning and ultimately assure safer, more resilient, and better-prepared communities. The HHS Assistance for Preparedness and Response (ASPR) has identified the following capabilities as the basis for Healthcare Coalitions' preparedness, response, and recovery roles and activities:

Healthcare Preparedness Capabilities

Planning Capability 1: Healthcare System Preparedness. Healthcare system preparedness is the ability of a community's healthcare system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term.

The healthcare and support system's role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, elder care stakeholders, community and faith-based partners, state, local, and territorial governments to do the following:

- Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community
- Provide timely monitoring and management of resources
- Coordinate the allocation of emergency medical care resources
- Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders
- Healthcare system preparedness is achieved through a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.

Planning Capability 2: Healthcare System Recovery. Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community.

Planning Capability 3: Emergency Operations Coordination. Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the

public have relevant and timely information about the status and needs of the healthcare delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community response and according to the framework of the National Incident Management System (NIMS).

Integration with public health aligns during the planning process and response operations. This is done in coordination with Emergency Management and ESF #8 planners and is specifically addressed with planning that determines how healthcare organizations priorities and needs are represented in response.

To integrate this capability, healthcare emergency planners should coordinate response plans with Emergency Management and ESF #8 to ensure there is a united public health and medical response during incidents.

Planning Capability 4: Information Sharing. Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of public health and medical related information and situational awareness between the healthcare system and local, state, and Federal, levels of government and the private sector.

This includes the sharing of healthcare information through routine coordination with the Joint Information System for dissemination to the local, state, and Federal levels of government and the community in preparation for and response to events or incidents of public health and medical significance.

An effective intelligence/information sharing and dissemination system will provide durable, reliable, and effective information exchanges (both horizontally and vertically) between those responsible for gathering information and the analysts and consumers of threat-related information. It will also allow for feedback and other necessary communications in addition to the regular flow of information and intelligence.

Planning Capability 5: Medical Surge. The Medical surge capability is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community. This encompasses the ability of healthcare organizations to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised. The goal is rapid and appropriate care for the injured or ill from the event and the maintenance of continuity of care for non-incident related illness or injury.

Integration with public health aligns during planning and response. This is done in coordination with Emergency Management and ESF #8 planners and specifically addresses pre-hospital, affected hospital, and receiving hospital surge management.

To integrate this capability, public health and healthcare disaster planners should coordinate efforts to maximize the use of resources that are available to facilities affected by surge. Primary areas of coordination include public health assistance with resources and integration with public health plans for alternate care sites.

This coordination should assist with resources and space to alleviate surge or enhance operations at healthcare organizations affected by surge.

Disaster Planning Principles

This planning consideration incorporates FEMA's disaster planning principles (FEMA Comprehensive Planning Guide 101 v2). Use of these principles results in all-hazards plans for sustaining the continuum of healthcare and support services for elders during disasters.

- **Disaster planning must represent the complex needs of the whole elder community.** Understanding the composition and complexity of the elder population must occur from the outset of the planning effort. Elders are a diverse group in terms of their physical and mental health, and vulnerability cannot be characterized by age alone. Complex variations in the health status, living environments, and social situations of elders also make it hard to protect this population during emergencies. For example, an independent older adult who lives on the 18th floor of a high-rise building may suddenly become vulnerable if the electricity goes out during a hurricane, shutting down the building's elevators. Elders are at increased risk of disease and death during emergencies because of factors such as the following:
  - A higher prevalence of chronic conditions, physical disability, cognitive impairment, and other functional limitations.
  - Dependence on support systems for medical care, medication, food, and other essential needs.
  - Potential limitations in their mobility, their access to transportation, or other aspects of functional autonomy.
- **Planning must include participation from all stakeholders in the community.** Effective planning ensures that the whole community is represented and involved in the elder care planning process. The most realistic and complete plans are prepared by a diverse planning team, including stakeholder representatives across the continuum who are able to contribute critical perspectives and/or have a role in executing the plan. The demographics of the community will aid in determining who to involve as the planning team is constructed. Including community leaders representative of the entire community in planning reinforces the expectation that the community members have a shared responsibility and strengthens the public motivation to conduct planning for themselves, their families, and their organizations. When the plan considers and incorporates the views of the individuals and organizations assigned tasks within it, they are more likely to accept and use the plan.
- **Planning uses a logical and analytical problem-solving process to help address the complexity and uncertainty inherent in potential hazards and threats.** By following a set of logical steps that includes gathering and analyzing information, determining operational objectives, and developing alternative ways to achieve the objectives, planning allows a community or regional response structure to work through complex situations. Planning helps communities identify the stakeholders and resources available to perform critical tasks and achieve desired outcomes/target levels of performance. Rather than concentrating on every detail of how to achieve the objective, an effective plan structures thinking and supports insight, creativity, and initiative in the face of an uncertain and fluid environment. While using a prescribed planning process cannot guarantee success, inadequate plans and insufficient planning are proven contributors to failure.
- **Planning considers all hazards and threats.** While the causes of emergencies can vary greatly, many of the effects do not. Planning teams can address common operational functions in their basic plans instead of having unique plans for every type of hazard or threat. For example, floods, wildfires, HAZMAT releases, and radiological dispersal devices may lead a community to issue an evacuation order and open shelters. Even though each hazard's characteristics (e.g., speed of

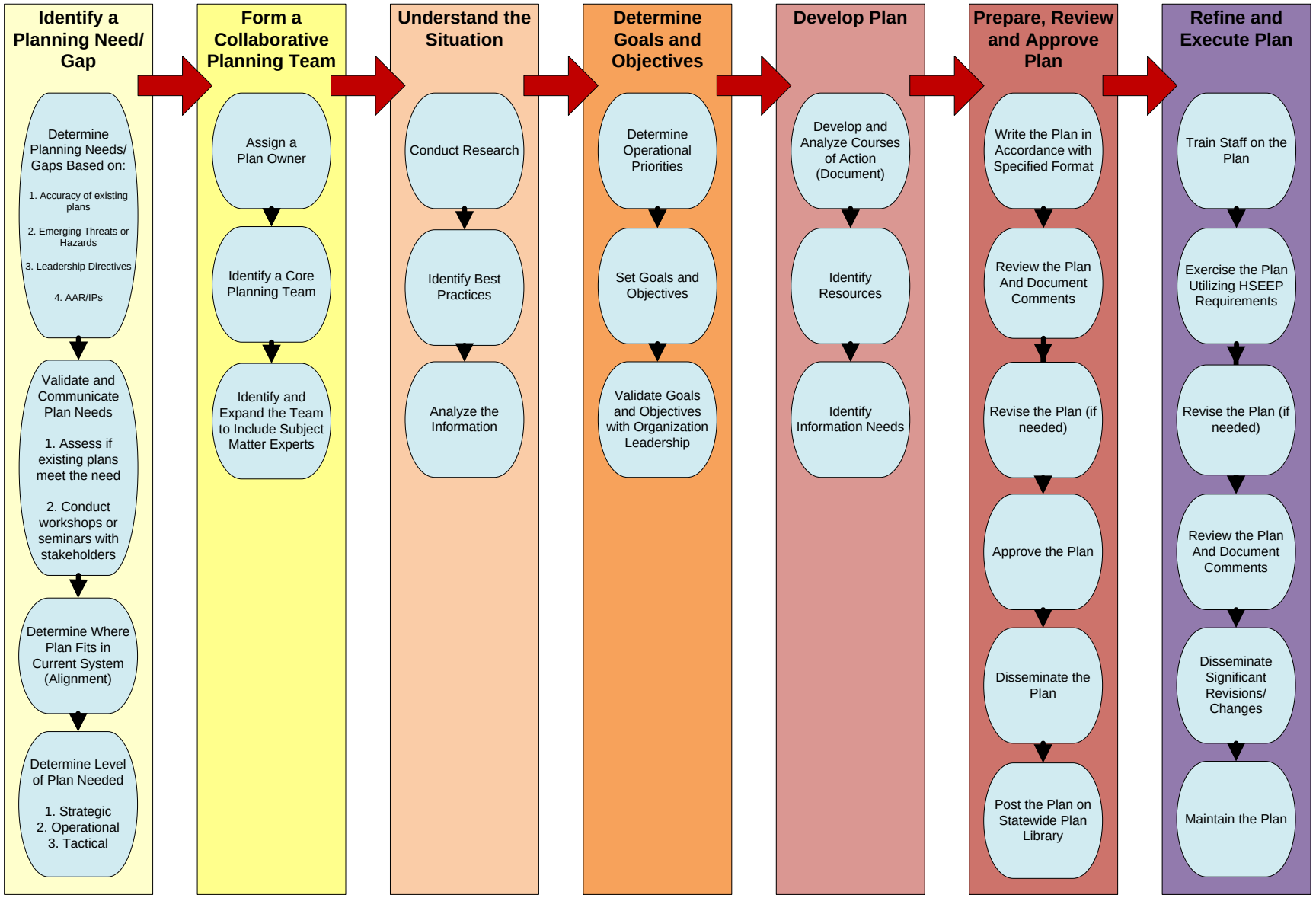
onset, size of the affected area) are different, the general tasks for conducting an evacuation and shelter operations are the same. Planning for all threats and hazards ensures that, when addressing emergency functions, planners identify common tasks and those responsible for accomplishing the tasks.

- **Planning should be flexible enough to address both traditional and catastrophic incidents.** Scalable planning solutions are the most likely to be understood and executed properly by the operational personnel who have practice in applying them. Planners can test whether critical plan considerations are sufficiently flexible to incorporate the needs of elders by exercising them against scenarios of varying type and magnitude. In some cases, planners may determine that exceptional policies and approaches are necessary for responding to and recovering from catastrophic incidents. These exceptional planning solutions should be documented within plans, along with clear descriptions of the triggers that indicate they are necessary.
- **Plans must clearly identify the mission and supporting goals (with desired results).** More than any other planning principle, the clear definition of the mission and supporting goals (which specify desired results/end-states) enables unity of effort and consistency of purpose among the multiple stakeholder groups involved in executing the plan. Every plan consideration should be designed and evaluated according to its contributions to accomplishing the mission and achieving the goal of sustaining the continuum of healthcare services and support services for elders during disasters.
- **On-going event analysis and forecasting depicts the anticipated environment for action.** On-going event analysis and forecasting promotes early understanding and agreement on planning assumptions and risks, as well as the context for interaction. In situations where a specific hazard has not been experienced, planning provides the opportunity to anticipate conditions and systematically identify potential problems and workable solutions. Planners should review existing plans to ensure current assumptions are still necessary and valid. After-action reports (AAR) of recent emergency operations and exercises in the community will help planners develop a list of lessons learned to address when updating plans.
- **Planning identifies tasks, allocates resources to accomplish those tasks, and establishes accountability.** Decision makers must ensure that they provide stakeholders and planners with clearly established priorities and adequate resources; additionally, planners and plan participants should be held accountable for effective planning and execution.
- **Planning includes senior officials, from all stakeholder representatives and key decision-makers throughout the process to ensure both understanding and approval.** Potential planning team members have many day-to-day concerns but must be reminded that emergency planning is a high priority. Senior official buy-in helps the planning process meet requirements of time, planning horizons, simplicity, and level of detail. The more involved decision makers are in planning, the better the planning product will be. Community planners must reaffirm the senior official's understanding that planning is an iterative, dynamic process that ultimately facilitates his or her job in a crisis situation by:
  - Identifying and sharing the hazards, risks, and threat analyses for the community, ensuring to address impacts on the elder population.
  - Discussing readiness and capability assessments, as well as exercise critiques
  - Describing what the healthcare and support service stakeholders will have to do prior to, during, and after an incident to either prevent or minimize the incident's impact.

Senior officials play a critical role in determining when and which plans should be developed or revised. Additionally, they customarily have the authority to approve the final product in coordination with key stakeholders. By participating throughout the planning process, senior officials will better understand how to implement the plan during an incident.

- **Time, uncertainty, risk, and experience influence planning**. These factors define the starting point where planners apply appropriate concepts and methods to create solutions to particular problems. Planning is, therefore, often considered to be both an art and a science in that successful planners are able to draw from both operational experience and an understanding of emergency management principles, but also are intuitive, creative, and have the ability to anticipate the unexpected. While the science and fundamental principles of planning can be learned through training and experience, the art of planning requires an understanding of the dynamic relationships among stakeholders, of special political considerations, and of the complexity imposed by the situation and the population, including elders. Because this activity involves judgment and the balancing of competing demands, plans should not be overly detailed—to be followed by the letter—or so general that they provide insufficient direction. Mastering the balance of art and science is the most challenging aspect of disaster planning.
- **Effective plans tell those with operational responsibilities what to do and why to do it, and they instruct those outside the community in how to provide support and what to expect.** Plans must clearly communicate to stakeholders their roles and responsibilities and how they complement the activities of others. There should be no ambiguity regarding who is responsible for all primary and secondary tasks. This enables stakeholder personnel to operate as a productive team more effectively, reducing duplication of effort and enhancing the benefits of collaboration.
- **Planning is fundamentally a process to manage risk**. Risk management is a process by which context is defined, risks are identified and assessed, and courses of action for managing those risks are analyzed, decided upon, and implemented, monitored, and evaluated. As part of the process, planning is a tool that allows for systematic risk management to reduce or eliminate risks in the future.
- **Disaster planning is not a one-time effort.** Disaster planning is an on-going process for all stakeholders involved in the continuum of healthcare and support services for elders. Conditions and hazards may change planning priorities, personnel and staff will change out, and stakeholder roles and responsibilities may evolve in different ways. Effective outcomes from the planning process will only occur if all considerations of the preparedness cycle, beginning with planning through the evaluation phase, are followed.

EXAMPLE: Integrated and Comprehensive Planning Sequence (FEMA CPG 101)



Project Reference List

Centers for Disease Control and Prevention (CDC). Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies: A Cross-Sector Guide for States and Communities. Atlanta: U.S. Department of Health and Human Services; 2012.

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Seff, L.R., Rothman, M.B., Pekovic, V., Davalos, D. M., & Luna, B. (2007). *Designing a Model All-Hazards Plan for Older Adults: The Role of the Aging Services Network in Assuring Community All-Hazards Readiness for Elders and Providing Assistance to Elders When Disasters Occur*. North Miami: The Center on Aging, Stempel School of Public Health, Florida International University.

Resources

Caring for Elders during Disasters

This resource section lists documents, reports and tools identified during the Caring for Elders during Disasters project. Organized by subject, each listing provides a link to an external URL where the resource may be viewed or downloaded. In some instances, the link directs the reader to a resource located within this Guide, rather than to an external website.

SUBJECT	SOURCE	LINKS & DESCRIPTION
Acronyms: Emerg. Mgt. & Aging Network, Combined	Compiled by project staff from EM and aging network sources	LINK to Acronyms List, within this Guide.
Adult Day Care Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for Adult Day Care
Adult Group Homes & Foster Homes	FL Agency for Persons w/ Disabilities (APD)	LINK to the Florida Administrative Code and Florida Administrative Register Website. In the search box ("Search for Rules in the Florida Administrative Code"), search for "65G-2" to view the applicable rule. The specific sections that address emergency plan requirements are 2.011(23), 2.012(23), 2.013(23), and 2.014(9). Note: A revision to FAC 65G-2 will go into effect on 7-1-14, available at the above link.
Aging & Disability Resource Centers (ADRCs)	FL Assoc. of Area Agencies on Aging (F4A)	LINK to Florida's 11 aging & disability resource centers (ADRCs).
Aging Network – what is it	Administration on Aging	LINK to the Admin. On Aging's 2-page brief describing the aging network.
Aging Network & Emerg. Prep. Resources	Administration on Aging (AoA)	LINK to information about the "aging network." Each county/region in Florida has a designated area agency on aging (AAA), which is the local community's gateway to services and support for elders. LINK to emergency preparedness resources for the aging network, at the Administration on Aging.
Aging Network Emergency Management Planning Criteria (FL)	FL Dept. of Elder Affairs (DOEA) & the US Admin. On Aging (AoA)	LINK to DOEA's Programs and Services Handbook, Chapter 8, Emergency Management and Preparedness (July 2013). LINK to the Administration on Aging's emergency preparedness guidance for the aging network. (Disaster Preparedness Manual for the Aging Network)
Area Agencies on Aging (AAAs)	FL Assoc. of Area Agencies on Aging (F4A) & FL Dept. of Elder Affairs	LINK to F4A's webpage with links to Florida's 11 aging & disability resource centers (ADRCs). LINK to the FL Dept. of Elder Affairs page regarding area agencies on aging, also referred to as aging and disability resource centers (ADRCs).
Assisted Living Facilities Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for ALFs
Caregivers, Elders and Families	Administration on Aging AoA) & FL Dept. of Elder Affairs (DOEA)	LINK to resources and information for individuals, families and caregivers. LINK to the consumer's guide for Florida seniors, section on emergency and safety. LINK to "The Calm Before the Storm," conversations about disaster planning, caregiving, Alz. Disease and dementia.
Centers for Medicare & Medicaid – proposed rule on emerg. prep.	Centers for Medicare & Medicaid (CMS)	LINK to the CMS proposed rule on emergency preparedness, released for comment December 2013; adoption timeline unknown.
County -- Emerg. Mgt. Office Contacts	FL Division of Emerg. Mgt. (DEM)	LINK to a map of Florida for easy access to county emergency management offices in Florida.

SUBJECT	SOURCE	LINKS & DESCRIPTION
County – Emerg. Mgt. Planning Criteria	FL Division of Emerg. Mgt. (DEM)	LINK to the Comprehensive Emergency Planning Criteria for Counties, adopted 2012 (Fla. DEM)
Dementia & Alz. Disease	Alz. Assoc.; National Institute on Aging's ADEAR Center; US Admin. On Aging; National Council of Certified Dementia Practitioners; American Health Care Assoc. et al	LINK to the Alzheimer's Association's resources. LINK to the disaster preparedness tip sheet for Alzheimer's disease caregivers. LINK to Alzheimer's Disease & Disaster Preparedness resources. LINK to the Toolkit for the Aging Network for care of persons with dementia and their caregivers. LINK to tips for first responders (Alzheimer's Dis. & First Responders) LINK to guide for caregivers & families – The Calm before the Storm LINK to Caring for Persons with Cognitive Impairment, a 3-page brief.
Demographic data (elders) by county (FL)	FL Dept. of Elder Affairs (DOEA)	LINK to the 2013 Florida County Profiles – clickable Florida map with resulting population data and elder statistics by county or by DOEA Planning & Service Area (PSA).
Discharge Planning Guidance - Shelters	FL Dept. of Health, Bureau of Preparedness & Response	LINK to the Discharge Planning Resource Guide, published by the Fla. Dept. of Health Bureau of Preparedness and Response, July 2012. It provides information regarding the safe return of persons to their original or other suitable community settings following a stay in a temporary shelter or alternate care site.
Elders – Preparedness tips, resources and guidance for elders	FL Dept. of Elder Affairs (DOEA)	LINK to DOEA's Consumer Resource Guide for Elders – Chapter 8 provides valuable emergency preparedness information. http://elderaffairs.state.fl.us/doea/CRG/2011/CRG_7th_Edition_section_VIII.pdf LINK to additional resources for elders.
Emergency Assistance – The Stafford Act (federal)	Federal Emergency Management Agency (FEMA)	LINK to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which constitutes the statutory authority for most Federal disaster response activities especially as they pertain to the Federal Emergency Management Agency (FEMA) and FEMA programs.
Emergency Preparedness Resources for Licensed Healthcare Providers	Agency for Health Care Admin. (AHCA)	LINK to AHCA's page with resources, requirements and guidance for healthcare facilities they license, including nursing homes, assisted living facilities and home health care agencies.
Federal Preparedness & Response Programs, HHS	Assistant Secretary for Preparedness & Response (ASPR)	Link to the US. Dept. of Health & Human Services, Office of the Assistant Secretary for Preparedness & Response (ASPR), with information about the federal emerg. response structure and guidance and tools for preparedness and planning.
Health & Medical (ESF8) Planning Guidance	FL Dept. of Health (FDOH)	LINK to many resources for county public health planning, including vulnerable populations, and all-hazards preparedness planning criteria for public health.
Healthcare Coalitions (preparedness)	FL Dept. of Health (FDOH)	LINK to the DOH page on healthcare coalitions, collaborative networks of healthcare organizations and their respective public and private sector response partners.
Home care providers – tools & resources	Montgomery County, MD AHRQ	LINK to Emerg. Prep. Checklist for Case Management & Home Care Services. LINK to Home Health Patient Assessment Tools: Preparing for Emergency Triage.
Home Health Agency Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for Home Health Agencies
Home Medical Equipment Providers Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for Home Medical Equip. Providers

SUBJECT	SOURCE	LINKS & DESCRIPTION
Hospice Emerg. Planning Criteria (FL)	FL Dept. of Elder Affairs (DOEA)	CEMP – Format for Hospices
Hospitals Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for Hospitals
Housing Utilization data (FL)	Univ. of Florida, Shimberg Center for Housing Studies	LINK to the Florida Housing Data Clearinghouse – with info on housing needs/supply, subsidized housing & household demographics; includes data on manufactured housing parks.
Information & Referral Organizations	Alliance of Information & Referral Systems (AIRS)	LINK to the Standards and Quality Indicators for Professional Information & Referral Services, page 24-31, Disaster Preparedness
Laws & rules – authority & plan review req. for Emerg. Plans (FL)	Agency for Health Care Admin. (AHCA)	LINK to AHCA's list of laws & rules for emergency plans and their review for facilities licensed by AHCA (January 2014). (AHCA, January 2014).
Literature Review – aging network & emerg. preparedness	Center on Aging, Florida International University	LINK to the Comprehensive Literature Review from the Report, "Designing a Model All-Hazards Plan for Older Adults: The Role of the Aging Services network in Elders and Providing Assistance to Elders when Disasters Occur.
Local (County) Emerg. Management Planning Criteria	FL Division of Emerg. Mgt. (DEM)	LINK to DEM's page with an excel file containing the planning criteria for local counties.
Nurse Registries Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emergency Management Planning Criteria for Nurse Registries (scroll down to Nurse Registries)
Nursing Home & ALF Resources	Centers for Medicare & Medicaid (CMS); Florida Health Care Association	LINK to the CMS S&C Emerg. Preparedness Initiative & Emerg. Preparedness Checklist Recommended Tool (2-28-14). LINK to the CMS emergency preparedness resources page for health care providers and state agencies. LINK to the National Criteria for Evacuation Decision-Making, developed through funding from the John A. Hartford Foundation.
Nursing Homes Emerg. Planning Criteria (FL)	Agency for Health Care Admin. (AHCA)	CEMP – Emerg. Mgt. Planning Criteria for Nursing Homes
Planning Guidance – protecting elders during disasters	Centers for Disease Control and Prevention (CDC)	LINK to the CDC report, "Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies: A Cross-Sector Guide for States and Communities. This report is a cross-sector resource to improve planning for and protection of vulnerable, community-dwelling elders during disasters.
Planning Guidance for Aging Services Network	Center on Aging, Florida International University	LINK to the report, "Designing a Model All-Hazards Plan for Older Adults: The Role of the Aging Services network in Elders and Providing Assistance to Elders when Disasters Occur. This report is a comprehensive analysis of the aging network's role in community-based planning for the care of elders during disasters.
Planning tools for communities & organizations serving elders	Administration on Aging (AoA)	LINK to the federal Administration on Aging, with resources for communities and organizations, including an emergency assistance guide/toolkit for caregivers of persons with dementia.
Promising Preparedness Practices	Centers for Medicare & Medicaid (CMS)	LINK to Promising Practices evident in State Survey Agencies and provider associations. Featured are practices from Florida, New Jersey and Massachusetts.
Stakeholder Groups for Community-Based Planning	Caring for Elders during Disasters Project (Florida)	LINK to the list of common stakeholder groups for community-based planning (continuum model) as described in the Caring for Elders during Disasters Project Guide.
State Plan on Aging (FL)	FL Dept. of Elder Affairs (DOEA)	LINK to Florida's State Plan on Aging – this extensive plan covers the period 2013-2016. Appendix 5 covers disaster preparedness.

ACRONYMS

Legend: Common Aging Network Acronyms (red type)
Common Emergency Management Acronyms (black type)

Acronym	Meaning
AAA	Area Agency on Aging
AAR	After Action Report
ACFP	Adult Care Food Program
ACL	Administration for Community Living (the Admin. On Aging falls under this umbrella)
ACS	Alternate Care Site
ADA	Aged and Disabled Adult Medicaid Waiver
ADA	American with Disabilities Act
ADI	Alzheimer's Disease Initiative
ADL	Activities of Daily Living (see also IADL)
ADRC	Aging and Disability Resource Center
AHCA	Agency for Health Care Administration
ALE	Assisted Living for the Frail Elderly Medicaid Waiver
ALF	Assisted Living Facility
ALS	Advanced Life Support
ALZ	Alzheimer's Disease
AMTS	Alternate Medical Treatment Site
ANE	Abuse, Neglect and Exploitation of the Elderly
AoA	Administration on Aging (U.S. Department of Health & Human Services)
APD	(Florida) Agency for Persons with Disabilities
APS	Adult Protective Services (under the FL Dept. of Children & Families)
ADRC	Aging & Disability Resource Center
ASPR	Assistant Secretary for Preparedness & Response (federal, HHS)
B^3	Bomb, Burn, Blast
BIO	Biological
BLS	Basic Life Support
CARES	Comprehensive Assessment & Review for Long-Term Care Services (FL Dept. of Elder Affairs)
CBO	Community Based Organization
CCE	Community Care for the Elderly
CCP	Casualty Collection Point
CDC	Centers for Disease Control and Prevention (federal)
CERT	Community Emergency Response Team
CEMP	Comprehensive Emergency Management Plan
CHIRP	Comprehensive Health Incident Response Plan
CIRTS	Client Information and Registration Tracking System
COAD	Community Organizations Active in Disasters (similar to VOAD)
COOP	Continuity of Operations Plan
CMS	Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)

Acronym	Meaning
CMS	Consumable Medical Supplies
DART	Disaster Animal Response Team
DCF	(Florida) Department of Children and Families
DCHAT	Disaster Community Health Assessment Team
DECON	Decontamination
DEM	Division of Emergency Management
DRC	Disaster Recovery Center
DMAT	Disaster Medical Assistance Team
DME	Durable Medical Equipment
DMORT	Disaster Mortuary Response Team
DOEA	(Florida) Department of Elder Affairs
DSOC	Domestic Security Oversight Council
ECO	Emergency Coordinating Officer
EDICS	Emergency Disaster Incident Communications System
EHEAP	Emergency Home Energy Assistance for the Elderly Program
EM	Emergency Management
EMO	Emergency Management Office
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESAR-VHP	Emergency System for Advance Registration of Healthcare Professionals
ESF	Emergency Support Function (a list of the 18 ESFs is included at the end of this Acronyms List)
FDLE	Florida Department of Law Enforcement
FEHVR	Florida Emergency Health Volunteer Registry
FEMA	Federal Emergency Management Agency
FEMORS	Florida Emergency Mortuary Operations Response System
FNSS	Functional Needs Support System (federal guidance)
FOG	Field Operations Guide (Florida Incident)
HCBS	Home- and Community-Based Services
HCE	Home Care for the Elderly
HEPA	High Efficiency Particulate Air
HHS	Department of Health and Human Services (federal)
HIPAA	Health Insurance Portability and Accessibility Act (federal)
HVA	Hazard Vulnerability Assessment (or Analysis)
HVAC	Heating, Ventilating and Air Conditioning
I & A/R	Information and Assistance / Referral
IADL	Instrumental Activities of Daily Living
ICP	Institutional Care Program
ICS	Incident Command System
IMT	Incident Management Team

Acronym	Meaning
JIC	Joint Information Center
LEOC	Local Emergency Operations Center
LEPC	Local Emergency Planning Committee
LTCOP	Long-Term Care Ombudsman Program
MCI	Mass Casualty Incident
MCI	Mild Cognitive Impairment
MMRS	Metropolitan Medical Response System
MAA	Mutual Aid Agreement
MoA	Memorandum of Agreement (sometimes called MoU – Memorandum of Understanding)
MoU	Memorandum of Understanding (sometimes called MoA – Memorandum of Agreement)
MOW	Meals on Wheels
NAMI	National Alliance on Mental Illness
NASUAD	National Association of States United for Aging and Disabilities
NGO	Non-Governmental Organization
NH	Nursing Home (often referred to as a SNF – skilled nursing facility)
NDMS	National Disaster Medical System
NFCSP	National Family Caregivers Support Program
NIMS	National Incident Management System
NPO	Non-Profit Organization; also called a 501© organization (see also NGO)
NRP	National Response Plan
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
OAG	Office of the Attorney General
PACE	Program of All Inclusive Care for the Elderly
PPE	Personal Protective Equipment
PSA	Planning and Service Area (Florida has 11 PSAs, designated by DOEA)
RDSTF	Regional Domestic Security Task Force (Florida has 7 regions)
RELIEF	Respite for Elders Living in Everyday Families
RERA	Regional Emergency Response Advisor
SALT	Seniors and Law Enforcement Together
SAO	State Attorney's Office
SCSEP	Senior Community Service Employment Program
SEOC	State Emergency Operations Center
SHINE	Serving Health Insurance Needs of Elders
SHMO	Social Health Maintenance Organization
SITREP	Situation Report
SITSTAT	Situation Status
SLOSH	Sea, Lake, Overland Surge from Hurricanes
SMP	Senior Medicare Patrol
SMRT	State Medical Response Team
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility (sometimes referred to as NH – nursing home)

Acronym	Meaning
SPGO	State Public Guardianship Office
SpNS	Special Needs Shelters
SpNSDPRT	Special Needs Shelters Discharge Planning Response Team
SSI	Supplemental Security Income
START	Simple Triage and Rapid Treatment
SUA	State Unit on Aging (in Florida, this is the Florida Depart. Of Elder Affairs – DOEA)
SWG	State Working Group
SWP	State Warning Point
TTX	Tabletop Exercise
VDHCBS	Veterans Directed Home and Community Based Services Program
VOAD	Voluntary Organizations Active During Disasters
VOCA	Victims of Crime Act

Florida's Emergency Support Functions (ESFs)

All State agencies and volunteer organizations that comprise the State Emergency Response Team are grouped into 18 Emergency Support Functions (ESFs) to carry out coordination and completion of assigned missions. These functions represent specific response activities common to all disasters. Each Emergency Support Function (ESF) is comprised of one or more primary agencies serving as the lead and several other agencies and organizations providing support. For a description of each function and a list of assigned agencies go to: http://www.floridadisaster.org/EMTOOLS/esf.htm .

ESF 1 – Transportation
ESF 2 – Communications
ESF 3 – Public Works
ESF 4 – Firefighting
ESF 5 – Info and Planning
ESF 6 – Mass Care
ESF 7 – Unified logistics
ESF 8 – Health & Medical
ESF 9 – Search & Rescue
ESF 10 – Hazmat
ESF 11 – Food & Water
ESF 12 – Energy
ESF 13 – Military Support
ESF 14 – Public Information
ESF 15 – Volunteers & Donations
ESF 16 – Law Enforcement
ESF 17 – Animal Services
ESF 18 – Business, Industry and Economic Stabilization

Healthcare and Support System Stakeholders for Elders

(June 2014; Caring for Elders during Disasters)

This document lists stakeholders that may be involved in providing health and supportive services to elders in a community. It may be used by local communities to identify the key stakeholders in their respective geographic area.

Home- and Community-Based Services

Alzheimer Caregiver Support Organizations
Behavioral Health Programs
Community Action Programs
Councils on Aging (many and varied services)
Geriatric Care Managers
Homemaker / Companion Services
Meals on Wheels Providers
Senior Centers
Transportation Providers (independent)

Community-Based Medical Care/Services

Dialysis Services
Durable Medical Equipment & Supplies (DME)
Geriatric Mental Health Services
Home Health Agencies
Hospice (home-based care)
Medical Clinics / Doctor's Offices
Memory Disorder Clinics
Pharmacy / Pharmacists
Primary Care Physicians and Clinics
Respiratory Therapy Services

Residential – Medical Care

Continuing Care Retirement Communities (CCRC)
Hospice (short-term inpatient care)
Hospitals
Long Term Acute Care Hospitals
Skilled Nursing Facilities

Residential – Limited Care & Assistance

Assisted Living Facilities (various levels of assistance/care)

Residential – Non-Medical

Condominium Associations (local)
Naturally Occurring Retirement Communities
Planned Retirement Communities (e.g., The Villages)
Senior Housing/HUD Housing

Government Partners

Florida Agency for Health Care Admin.
Florida Agency for Persons with Disabilities
Florida Department of Children & Families, APS
Florida Department of Elder Affairs
Florida Department of Health
Florida Department of Veterans' Affairs
Florida Div. of Emergency Management
Florida Dept. of Business & Prof. Regulation,
Div. of Condominiums, Timeshares& Mobile Homes
Florida Office of the Attorney General
Local Emergency Management
Local County Health Departments

First Responders

Emergency Medical Services
Fire and Rescue
Law Enforcement Agencies

Association & Advocacy Group Partners

AARP
Florida Animal Control Assoc./Animal Disaster Response
Florida Assisted Living Assoc.
Florida Association of Adult Day Services
Florida Association of Aging Services Providers
Florida Association of Area Agencies on Aging
Florida Association of Community Health Centers
Florida Association of Food Banks
Florida Association of Information & Referral Services
Florida Coalition for Optimal Mental Health & Aging
Florida Council on Aging
Florida Chamber of Commerce
Florida Emergency Preparedness Association
Florida Geriatric Care Managers Association
Florida Health Care Association
Florida Hospices and Palliative Care
Florida Hospital Association
Home Care Association of Florida
LeadingAge Florida

Other Stakeholders

Aging and Disability Resource Centers (ADRC)
American Red Cross
Business and Industry (e.g., Publix; local business)
COADs/VOADs (Community Organizations Active in Disasters)
Emergency Preparedness & Response Consultants
Faith-Based Organizations
Food Service Providers / Caterers
Guardians (private or public)
Healthcare (Preparedness) Coalitions
Information and Referral Organizations (2-1-1)
Interagency Councils of Aging Services Providers
Mail Carriers (USPO Carrier Alert Programs)
Ombudsmen
Salvation Army
Senior Advocates (
Transportation Systems
U.S. Postal Service / Mail Carriers
Utility Providers – Water/Sewer
Utility Providers – Energy/Gas
Volunteer Florida (and related local organizations)