



Incorporating Disability, Accessibility, and Functional Needs Populations in Hospital Emergency Planning: A New York City Case Study

By Rosemary McDonnell

Abstract

The COVID-19 pandemic highlighted the disparities in emergency and healthcare planning for vulnerable populations which will influence current and future resiliency initiatives for years to come. While all populations are susceptible to certain hazards that may expose their vulnerabilities in a disaster, populations with no or limited English proficiency, sight limitations, and hearing limitations are especially at risk due to communication and language barriers that they consistently experience. This essay builds off of a study that examined the influence a vulnerability might have on the extent of resources and support that populations who possess these vulnerabilities may receive in terms of emergency preparedness and response in a New York City hospital setting. It will examine best practices for incorporating these at-risk populations into all-hazard emergency plans. It will also examine how healthcare facilities can utilize resources, training, and personnel to support these plans.

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Introduction

Vulnerable populations in healthcare facilities require specialized planning and more involved assistance regarding their personal preparedness and response activities during an emergency. Those with hearing, visual, and language impairments have unique communication, transportation, evacuation, and sheltering needs that must be planned for in advance. If hospitals do not devote attention to these areas, specifically and separately, for each of the three vulnerable populations mentioned, then it can be assumed that their emergency plans for preparedness and response are not sufficient to address the needs of these populations in an emergency. This essay seeks to explore the gap in healthcare emergency planning that exists when considering Disability, Access, and Functional Needs (DAFN) populations. Its objective is to explore one hospital's attempt at bridging this gap and enhancing the sufficiency of emergency planning for DAFN populations in their care, with the hopes of providing guidance for other healthcare organizations who are considering how they can best create a truly inclusive and accessible crisis management program.

Background of the Problem

Typically, the most vulnerable populations are those whose needs for increased assistance are not sufficiently considered in the planning of local response and relief organizations.¹ During emergencies, for example, real-time evacuation information is not generally provided to people with no or limited English proficiency, the hearing and visually impaired, and other special needs groups, and their needs are generally not adequately addressed in most emergency operations plans.² In the wake of Hurricanes Katrina and Rita, which showed that language barriers in evacuation messages were a problem, the states bordering the Gulf of Mexico began revising their emergency plans and procedures to be more inclusive and specifically address communicating evacuation information in multiple languages to meet the needs of a growing diverse population.³ These examples illustrate a pattern of inadequate planning for the needs of these vulnerable populations before disaster strikes and then scrambling to meet their needs after the disaster has occurred. While an all-hazards approach to emergency preparedness is an acceptable form of addressing the general needs of the population, regardless of vulnerability status, each approach needs to address specifically what modifications need to be made to meet the needs of each at-risk population that a healthcare entity may serve.

Legal Requirements

To properly define what level of emergency planning for vulnerable populations is deemed sufficient in hospitals, I reviewed the expectations from regulatory agencies and the law. Following the aftermath and unequal relief efforts of Hurricane Katrina, reforms to the Stafford Act were made to ensure that socioeconomic status was not a basis for discrimination in response and relief efforts following a disaster, and substantial improvements were made to ensure that the nondiscrimination mandate was more expansive and inclusive of all types of vulnerable populations. Hospitals should be mirroring the efforts of FEMA in their emergency response planning activities at their facilities. The disproportionate harm suffered by those already disadvantaged provides special reasons for concern about their plight in disasters.⁴ By following the guidelines set forth by the Stafford Act nondiscrimination mandate, hospitals can ensure that their emergency planning efforts ensure the provision of specialized care and attention to their most vulnerable patient populations in order to avoid any unnecessary and discriminatory harm to their lives or safety.

Regulatory Requirements

In terms of regulatory requirements, hospitals are guided by principles, rules, and standards from various accrediting bodies. The most prevalent accreditor guiding most hospitals and healthcare facilities is the Centers for Medicare & Medicaid Services (CMS). CMS accreditation is necessary for a hospital to be certified as a Medicare and/or Medicaid hospital provider. Currently, the CMS Emergency Preparedness Rule §484.102(a)(3) that addresses this subject

reads as follows: “[The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.”⁵ As seen in this Rule, the requirements for healthcare facilities are vague in terms of immediate emergency planning actions to take when planning for at-risk populations. The Joint Commission offers a bit more specification, in terms of actionable requirements for healthcare facilities, in their standards for this subject: *Standard EM 12.01.01, EP 2: “The hospital’s emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence.”*⁶ As seen in this Rule, the requirements for healthcare facilities are vague in terms of immediate emergency planning actions to take when planning for at-risk populations. The need for more granular language in these standards is apparent, as well as the need for more specific language regarding how these regulations should be met by healthcare facility emergency planners in all areas of communication, resources and assets, safety and security, staff responsibilities, utility management, and patient care needs.

Distinctive Emergency Preparedness and Response Planning Needs of Vulnerable Populations in Healthcare

Many studies have been beneficial in promoting the need for modifying all-hazards plans to specifically mention how an organization will address the needs of vulnerable populations, separating specific sub-groups based on their vulnerability characteristics. In a post-2005 hurricane season analysis, it was shown that combining groups too broadly translates into imprecise planning and, as a result, emergency response failures.⁷ One study of vulnerable populations in hospital and healthcare emergency preparedness planning suggested that medical and public health preparedness organizations, particularly hospitals, are not currently identifying the most vulnerable populations, their locations, and the number of people included as a first step in the assessment process. In addition, they are not extending this assessment to include engaging with service populations to understand critical health delivery barriers and opportunities for disaster planning.⁸ In a study on vulnerability and unmet healthcare needs, researchers chose to operationalize the concept of vulnerability using profiles that account for multiple risk factors that are associated with access to care. This study further demonstrates that a substantial proportion of U.S. adults (about one in five) has multiple risk factors for unmet health care needs and that these risk factors create up to five-fold differences in rates of unmet needs (e.g., delayed medical care) between the highest and lowest profiles, regardless of race/ethnicity.⁹ The literature shows a consensus

on the need to define and address the varying risk factors and vulnerability characteristics of separate populations to account for their healthcare and emergency planning needs, but studies differed in their approaches to providing frameworks for improvement. While one study proposed a function-based framework built on five essential function-based needs (communication, medical needs, maintaining functional independence, supervision, and transportation),¹⁰ another study suggested an integrated healthcare and public health preparedness framework that incorporates the need for integration across the healthcare sector necessary for reducing individual and cultural vulnerabilities (representing both a bottom-up and top-down approach).¹¹ Regardless of the framework chosen, if the unique considerations that need to be made for vulnerable populations remain unaddressed in hospitals, the effects could be debilitating to the entire healthcare system.

New York City Hospitals

Various hospitals throughout New York City participated in a 2023 dissertation study that measured their sufficiency of emergency planning for vulnerable populations with communication barriers (limited English proficiency, sight limitations, and/or hearing limitations). This mixed-methods study, which used survey and interview tools to gather information from NYC hospital Emergency Preparedness Coordinators (EPCs), found that there is a relationship between the vulnerability status of an individual or population with communication barriers and their ability to receive sufficient planning for emergency preparedness and response planning in New York City hospital facilities.¹² This is displayed in Table 1 and Figure 1 below. It also found that there is a relationship between the vulnerability type of a population with communication barriers (i.e., no or limited English proficiency, sight limitations, and/or hearing limitations) and their ability to receive sufficient emergency planning from hospital facilities. Most planning efforts seemed to focus on limited English proficiency populations, with limited hearing populations receiving less attention or sufficient planning, and individuals with limited sight receiving even less. While describing the practical implications of this study, the researcher pointed out a lack of specificity in regulatory standards, a lack of guidance on how exactly to address this issue, and a lack of intentional focus placed on emergency planning for vulnerable populations in healthcare settings from regulatory agencies, public health agencies, healthcare coalitions, and healthcare associations.

Table 1: Table Displaying Mean Total Emergency Planning Sufficiency Scores from Survey for Each Variable

Variable	Total Possible Emergency Planning Sufficiency Score	Total Possible Emergency Planning Sufficiency Score Category	Mean Emergency Planning Sufficiency Score	Mean Emergency Planning Sufficiency Score Category
Public hospital	144	Excellent	39	Poor
Private hospital	144	Excellent	31	Poor
Independent hospital	144	Excellent	23	Very Poor
Health System hospital	144	Excellent	38	Poor
Manhattan hospital	144	Excellent	45	Poor
Brooklyn hospital	144	Excellent	26	Very Poor
Bronx hospital	144	Excellent	26	Very Poor
Queens hospital	144	Excellent	41	Poor
Staten Island hospital	144	Excellent	16	Very Poor
Emergency Room hospital	144	Excellent	36	Poor
Non-Emergency Room hospital	144	Excellent	16	Very Poor

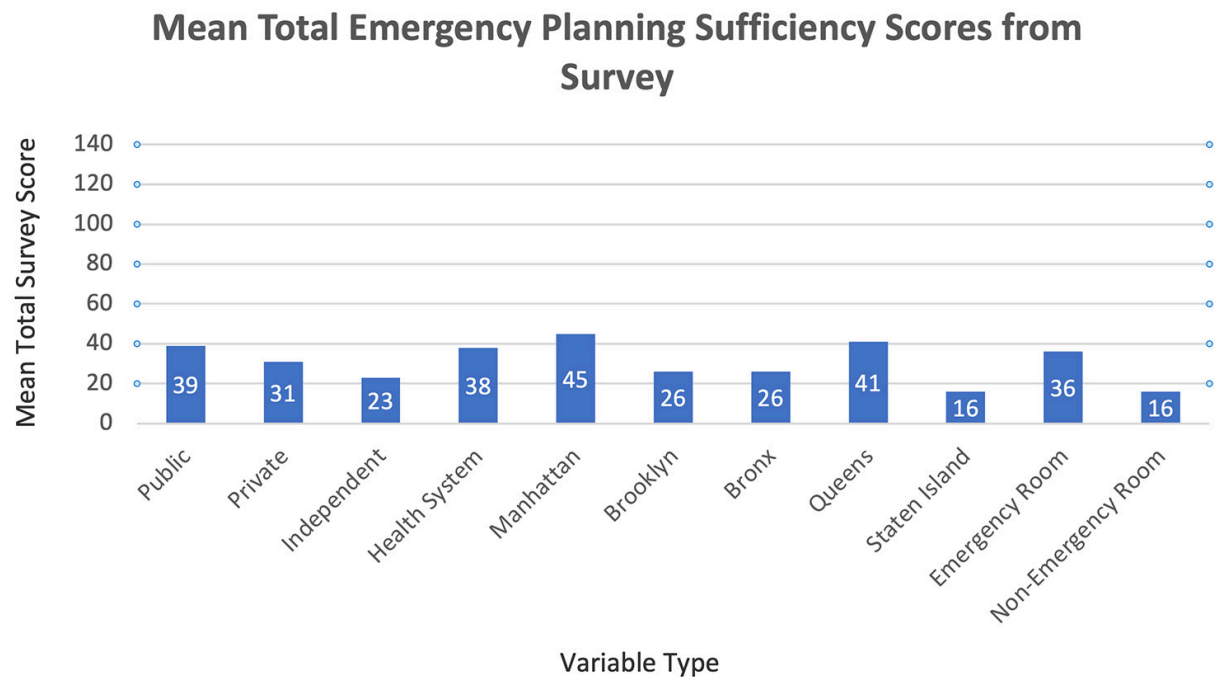


Figure 1: Bar Chart Displaying Mean Total Emergency Planning Sufficiency Scores from Survey for Each Variable

Practical Solutions and Application: A Hospital Case Study

While adequately addressing this issue may require a multifaceted approach from several levels of government and public health, healthcare facilities can still evaluate their specific hospital's level of sufficiency of emergency planning for vulnerable populations with communication barriers. Additionally, they can explore the demographics of these populations, assess the applicability and feasibility of solutions and enhancements to this planning approach, and advocate for support and collaboration/partnerships to address this issue. A reoccurring theme in many interview responses amongst EPCs was that the response during emergencies for these vulnerable populations was thought to be more of a patient care issue than an emergency management responsibility.¹³ Given this connection, it is apparent that any patient care issue or inability of the hospital to provide sufficient patient care (especially during an emergency) should be considered a high-priority issue that should be addressed, supported, and given the necessary resources to ameliorate. It is paramount that EPCs and hospital Emergency Management Departments serve as advocates for these populations in terms of their right to receive proper and sufficient pre-planning for emergencies.

Importance of Stakeholder Engagement

It is equally important that this planning not be done in a silo, but as a multi-disciplinary planning group. As mentioned in several interview responses, hospitals could form a Vulnerable Populations Subcommittee of their Emergency Management Committee tasked with the mission of enhancing and addressing the disparities in their emergency planning for vulnerable populations. EPCs should work to build a support network within the hospital and/or Health System that also advocates for and/or is involved in patient care for these populations (e.g., Social Work, Case Management, ADA offices, Language Access, Deaf Health Services, Guest/Patient Experience, etc.) as well as those involved in emergency planning for the general population, all of whom should share common goals, interests, and hurdles to overcome when it comes to this topic. The author of this study applied this suggestion at the hospital where she served as the EPC, Northwell Health System's North Shore University Hospital located in Manhasset, NY. By creating and building this support network within the hospital and health system which also served as advocates for/are involved in patient care for these populations, the hospital was able to examine deeply how it incorporated disability, accessibility, and functional needs populations into its emergency planning.

Justification

To justify the time and personnel that were dedicated to this Subcommittee's work, the EPC first used regulatory standards from the Center for Medicare & Medicaid Services and The Joint Commission that specifically mentioned vulnerable populations in the scope of hospital emergency planning. A review of this guidance made it clear that it is the hospital's responsibility to determine how they will best meet the criteria for emergency planning for vulnerable populations. These regulations, however, indicate that specialized planning needs to be conducted and vulnerable populations need to be defined and differentiated in emergency plans. Second, the EPC performed an audit of the hospital's current emergency plans that incorporated vulnerable populations. They found that there was no specific mention of vulnerable populations with no or limited English proficiency, limited sight, or limited hearing in the hospital's Emergency Operations Plan (EOP) or any of the annexes (including the Crisis Communication Plan). The EOP very vaguely mentioned vulnerable populations, but it did not differentiate them or specify exactly how the hospital would address their unique needs in an emergency. Other findings included the hospital not incorporating vulnerable populations into their emergency training (e.g., evacuation, active shooter, etc.), not having a specific position in the emergency organizational structure (e.g., Hospital Incident Command System) with duties assigned on their job action sheet specific to addressing the needs of vulnerable populations, and not incorporating vulnerable populations into emergency drills or exercises.

Benefits

Lastly, the EPC attempted to justify the formation of the subcommittee by describing its benefits to the hospital, health system, and community. This subcommittee could help the hospital to accomplish the following.

- Better fulfill regulatory standards by showing CMS and The Joint Commission that we formed a dedicated group to address this issue to better satisfy the requirements of their new standards on vulnerable populations (released July 2022).
- Better serve our hospital's mission by supporting our organizational mission to serve all of our patient populations with exemplary and compassionate care by showing that we are dedicated to every type of patient population, including those that are minorities and may be particularly at-risk.
- Reduce risk. By addressing the gaps in our planning for vulnerable populations, we will be reducing the risk we face of not properly addressing their needs in an actual emergency event. For example, if we had an influx of limited English proficiency patients and weren't able to communicate with them properly, their care could be compromised.
- Enhance our relationship with the community. The relationships we have with the various vulnerable populations which we serve in our community would be strengthened by forming focus groups to inform our subcommittee. The community will become more involved in our emergency and resiliency planning efforts, and they will feel more valued if our hospital takes their unique needs into account in a proactive and considerate manner.

- Enhance our reputation. By exceeding the requirements of regulatory standards and the practices of other hospitals in our region, we would set an example for providing the highest level of care in our emergency operations for every kind of at-risk population we may serve.

Practical Application

After the Vulnerable Populations Subcommittee was approved by hospital leadership and the EPC determined what units and departments from both the hospital and health system level should be involved, we held a kickoff meeting to provide an overview of the mission, goals, purpose, and format of the initiative. The subcommittee chose to start with addressing the needs of three pilot populations (limited English proficiency, limited sight, and limited hearing), as they all share the common characteristic of having communication barriers and requiring specialized forms of communication, especially in emergencies. The subcommittee approved addressing the needs of these three pilot populations first, and then moving on to other populations (e.g., cognitive impairments, mobility issues, etc.) when deemed appropriate. The subcommittee performed an assessment of their current level of sufficiency of emergency planning for these three populations by completing the survey referenced in Table 1 and Figure 1 above.¹⁴ By completing this survey, the hospital evaluated their emergency plans for these populations in each of the six areas that the Joint Commission deems critical to evaluate in an emergency activation, exposing any gaps in these areas which served as the basis for the goals and objectives of the subcommittee. To create an organized approach that was informed by regulatory standards, the subsequent meetings that were conducted each addressed one of the six areas that The Joint Commission deems critical to evaluate in an emergency activation (in the scope of vulnerable populations and their unique needs):

- communication
- resources and assets
- safety and security
- staff responsibilities
- utility management
- patient care needs

Each of these six meetings was helpful in evaluating what the hospital is currently doing in these areas to account for populations with a disability, accessibility, and functional needs within the hospital. They also provided a forum for the group to discuss how to enhance these areas in the scope of emergency planning. After each meeting, action items were consistently added to an overall “Vulnerable Populations Incident Action Plan (IAP)”, which is continuously being updated. These informed the hospital’s strategic goals for enhancing equity and inclusion in resiliency planning for at-risk populations. This subcommittee meets at least quarterly and reports back to the hospital’s Emergency Management Committee on its progress in completing items on the IAP.

Subcommittee Progress

The NSUH Vulnerable Populations Subcommittee made significant progress over the course of a few months in terms of both gathering relevant data and information to inform future decisions regarding emergency planning for disability, accessibility, and functional needs populations in the hospital, as well as in terms of laying the groundwork for initiatives that will eventually be proposed to focus groups within the community representing these populations themselves. One of the first action items completed was gathering the most recent annual demographic data for limited English proficiency, limited sight, and limited hearing patients that were admitted to the hospital. These demographics are not typically evaluated by the EPC, and therefore, some of the data are difficult to attain. Once received, however, the data informed the Subcommittee's future initiatives and planning efforts. For example, the preferred language data was useful in determining which languages should be chosen to display emergency notifications on the hospital's digital signage in common areas. Attempting to gather this demographic data also opened up a conversation regarding how we could better document disability, accessibility, and functional needs in the patient's electronic medical record (EMR) so that these patients could be more accurately identified, tracked, and reported to the hospital's Emergency Operations Center (EOC) when activated.

An action item that the hospital completed in the area of resources and assets was creating a master inventory of all of the devices, equipment, and methods that the hospital utilizes for translation services. These included, but were not limited to, iPad/VRI devices/Rovers on wheels, TTY devices, Dual handset phones, Language Line app downloads, Pocket talkers, etc. Creating this inventory allowed the subcommittee to propose purchasing extra devices to be stored in the EOC, and it allowed the hospital to be able to quickly pull these devices from other areas/units in the event of a mass casualty incident (MCI) where the hospital was to experience a patient surge of populations with communications barriers. This was a low-cost solution that the hospital utilized to enhance its planning for disability, accessibility, and functional needs populations while still incorporating them into the MCI planning process and ensuring communications can be maintained under stressful circumstances.

In the area of staff responsibilities, the hospital created an "Accessibility Officer" position to serve in the Incident Command Structure. The mission of the Accessibility Officer is to ensure that the needs of the disability, accessibility, and functional needs populations the hospital serves are being met before, during, and after any emergency activation by identifying and locating them, eliciting feedback regarding their needs, meeting their needs by engaging a multidisciplinary team, and reporting information back to the Incident Command Team in the EOC. The Accessibility Officer serves under the Incident Command Staff. This position is activated for every ICS activation, and they report directly to the Incident Commander. This placement recognizes the Accessibility Officer's key role as an active part in every incident response and integrates issues that pertain to patients, staff, visitors, and other hospital constituents with access and functional needs. Much of the Accessibility Officer's work involves outreach to departments/organizations that directly provide services and/or advocate for their specialized needs in the scope of patient care,

but they may also work with community organizations such as independent living centers, regional centers, and/or local disability providers to support the integration of individuals with access and functional needs.

Subcommittee Prioritized Goals

The subcommittee has many prioritized goals from the IAP that require eliciting feedback and participation from trusted community partners to accomplish. One of these goals is to incorporate limited English proficiency, limited sight, and limited hearing actors into a full-scale MCI exercise. It is important to not just use actors that are simulating having these disabilities, accessibility, and functional needs, but to have members of those respective DAFN communities participate in the exercise and provide feedback. Using actors who are playing individuals with disability, accessibility, and/or functional needs can distort issues related to the target population. It is always best to use individuals with disabilities and others with access and functional needs in exercises and drills. The hospital has many pre-existing relationships with Community-Based Organizations that represent these populations from which they can request participants.

An action item that the hospital plans to prioritize in the area of patient care needs is developing signage to place outside of the patient room and/or above the patient bed to identify these patients as having disability, accessibility, and/or functional needs, especially for those with communication barriers. For no-notice emergencies that immediately affect life and/or safety (e.g., active shooter), staff may need to be able to quickly and efficiently identify that certain patients may need communication assistance and may not have been able to understand the emergency notification announced overhead. The hospital created an icon system to place outside the patient door, as well as a sign to place above the patient's bed with more details as to their specific disability, accessibility, and/or functional needs. This signage is still being approved by the Legal Department for the Health System, but it will also need to be formed into a policy/procedure for clinical staff to follow. Incorporating this into the hospital's day-to-day care practices will ensure that it will not be forgotten in emergencies. Once the signage and policy are formed, it will be rolled out to patient care services staff in various formats, including huddles, safety rounds, orientation, care councils, etc. Processes and services for accommodating vulnerable populations should be hardwired into daily patient care practices so that they are second nature for staff during an emergency activation.

In terms of the area of communication, for no-notice emergencies that immediately affect life and/or safety (e.g., active shooter), staff also may be unable to use their traditional methods of translation to communicate with patients. In an active shooter situation, for example, staff may be unable to enter the patient room with a translation device if they are barricading themselves in safety. In these instances, the hospital felt it was important to pursue a crisis communications solution that could reach vulnerable populations with communication barriers and integrate with our mass notification system. The hospital must send mass notifications from one trusted source during an emergency so that the messaging is consistent and accurate across all platforms. Digital signage in the patient rooms

(e.g., tv screens) allows for messages to be displayed in large format text (for limited sight populations), visually (for limited hearing populations), and in different languages (for limited English proficiency populations). Unfortunately, this integration is a costly solution that involves working with the mass notification vendor to solve it. Regardless, it is an ongoing initiative that is gaining the support of leadership to pursue and implement.

In terms of the area of utilities, the subcommittee evaluated the hospital's life safety equipment to ensure that visual icons were used to display pictures of devices, such as fire extinguishers, on signs above where they are located; to ensure that all elevators had emergency signaling devices for populations with hearing limitations and telephones to accommodate for populations with limited sight (i.e., Braille signage); and to ensure that the hospital's fire and emergency alarm systems have regularly tested directional sound capabilities (audible signals that lead people to safety in a way that conventional alarms cannot, by communicating the location of exits using broadband noise) or similar features to accommodate for populations with sight limitations. In terms of the area of safety and security, the subcommittee evaluated to ensure that the hospital had illuminated exit and directional signage installed in areas of no- to low-light to assist populations with hearing limitations; to ensure that fire alarms, smoke alarms, and pull stations were integrated with devices that have strobe lights; and to ensure that safety plans and training (e.g., fire, evacuation, etc.) mention vulnerable populations with sight, hearing, or language barriers.

Lastly, after evaluating the lack of incorporation of vulnerable populations into the hospital's written emergency plans, the subcommittee decided that it would be best to create a separate disability, accessibility, and functional needs population annex of the hospital Emergency Operations Plan (EOP). While this annex will be referenced in both the main EOP and accompanying annexes (e.g., evacuation, active shooter, etc.), the subcommittee felt it was important to have one encompassing document that described each population, their needs and/or modifications, and how the hospital plans to accommodate them in an all-hazards approach. By focusing more on the needs, as opposed to the hazard, this plan will have sections dedicated to the evaluations and improvements the subcommittee has made and continues to work on. To mirror the structure of the subcommittee, the plan will be separated into six sections, each representing the six areas that The Joint Commission deems critical to evaluate in an emergency activation (in the scope of vulnerable populations and their unique needs): (1) communication, (2) resources and assets, (3) safety and security, (4) staff responsibilities, (5) utility management, and (6) patient care needs.

As an appendix to this DAFN Annex of the EOP, the subcommittee plans to form a Vulnerable Population Interaction reference guide that will describe how to properly communicate/interact with vulnerable populations with communication barriers. For example, for limited-sight populations, staff should announce their presence, speak out, state the nature of the emergency, and then enter the area. They should also avoid shouting and speak directly to the individual. For limited hearing populations, staff should establish eye contact with the individual, not with the interpreter or "buddy" if one is present. Also, once the individual is in a safe location, they should offer a pencil and paper for written communication if no interpreter or "buddy" is present. This guide can be formatted to one page and distributed to

each unit/department to place in their unit-specific EOP. It can also be used as a just-in-time training tool for staff to promote mindfulness and consideration if they happen to interact with a member of the DAFN community during a stressful emergency. Before both this annex and most of these action items are finalized, the subcommittee plans to conduct focus groups with individuals from the specific disability, accessibility, and functional needs communities that we serve to ensure that we are incorporating them into the planning process and giving them a seat at the table.

Conclusion

Through the work of this subcommittee, it became apparent that disaster planning for disability, access, and functional needs populations in hospitals is a multifaceted issue that requires input, guidance, and involvement from stakeholders outside of emergency management. Engaging stakeholders who interact with these populations and plan for them regarding other services in a daily care setting provided the necessary insight and perspectives from subject-matter experts. However, other departments/units not necessarily familiar with these populations still had very helpful perspectives in terms of how they may meaningfully interact with them in emergencies (e.g., Security, Environmental Services, Patient Transport, etc.). However, even with subject matter experts at the table, it was increasingly difficult for the subcommittee to evaluate current practices without having a comprehensive guidance document or compilation of best practices for hospital emergency planning for disability, access, and functional needs populations. Public health agencies, healthcare coalitions, and healthcare associations should place a more intentional focus on ensuring hospitals and other healthcare facilities are aware of the risk to these vulnerable populations if their needs are not addressed in emergency and resiliency planning. It would be helpful if they could guide us in terms of how to best address this issue with a multidisciplinary and collaborative approach. The subcommittee also learned that while it was helpful to engage a wide array of emergency management and public health entities when developing and testing guidance, it was most important that the planning process engages the vulnerable populations for which the planning is being conducted. Disability, access, and functional needs populations are experts when it comes to their individual and personal needs, and the emergency planning process should be conducted *with* them, not just *for* them. Individually, hospitals can better tailor their efforts to make their procedures and practice more inclusive and resilient for patients with disability, accessibility, and functional needs. While it might require them to intentionally dedicate their own time and resources to the issue, it would be most beneficial to build a team that can support the initiative and be committed to setting priorities for planning and engaging stakeholders to advise, implement, and test the hospital's emergency planning capabilities. It takes one person to stand up and advocate for this issue, but it takes a whole community approach to address it sufficiently.

About the Author

Dr. Rosemary McDonnell serves as the Senior Disability, Access, and Functional Needs (DAFN) Program Manager at DC Homeland Security and Emergency Management Agency, integrating DAFN populations into the emergency planning efforts for the District. She was formerly the Senior Emergency Management Specialist at Northwell Health System, developing and maintaining emergency preparedness and resiliency capabilities for the entire hospital population. Before joining Northwell Health, she served as the Assistant Director of Safety & Emergency Planning in the Department of Emergency Management at Hospital for Special Surgery, as well as the Assistant Director of Emergency Training and Operations for Pace University. She recently graduated from St. John's University in January 2023 from the inaugural cohort of their Homeland Security Doctorate of Professional Studies program. She is a graduate of the June 2022 cohort of the Center for Homeland Security Defense & Security's (CHDS) Emergence Program, as well as the May 2023 CHDS Early Career Radiological Emergency Preparedness Program. Dr. McDonnell serves as an Associate Editor for the *Journal of Homeland Security and Emergency Management* for articles that fall under her subject matter expertise. She is also an Adjunct Associate Professor and Mentor Collective Homeland Security Student Mentor at St. John's University, as well as an Adjunct Professor at Idaho State University, teaching various emergency management and homeland security courses. She may be reached at mcdonner@stjohns.edu.

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