

**OHIO EMERGENCY OPERATIONS PLAN  
EMERGENCY SUPPORT FUNCTION #6 – MASS CARE**

**TAB A: FUNCTIONAL NEEDS**

**PRIMARY AGENCY:** Ohio Community Service Council (OCSC)

**SUPPORT AGENCIES:** American Red Cross (ARC)  
Ohio Department of Aging (ODAge)  
Ohio Department of Alcohol and Drug Addiction Services (ODADAS)  
Ohio Department of Development (ODOD)  
Ohio Department of Education (ODE)  
Ohio Department of Health (ODH)  
Ohio Department of Job and Family Services (ODJFS)  
Ohio Department of Mental Health (ODMH)  
Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD)  
Ohio Emergency Management Agency (OEMA)  
Ohio State Independent Living Council (Ohio SILC)  
Salvation Army (SA)  
Voluntary Organizations Active in Disasters (VOAD)

**I. INTRODUCTION**

A. Purpose

1. The Ohio Emergency Management Agency has adopted the Functional Needs Framework as an organizational model for addressing the needs of special populations with functional limitations and needs during disasters.
2. This Tab provides an overview of the Functional Needs Framework and discusses State-level Support Agency expertise and capabilities and their applicability to the functional needs of the ‘functional needs community’ they each represent.
3. As a whole, the responsibilities of ESF-6 State-level Support Agencies’ involvement in providing assistance to persons with functional needs in mass care operations will be to provide guidance and other assistance to local partner agencies to:
  - a. Promote and sustain independence and self-determination in sheltering and evacuation situations.

- b. Maintain and uphold human and civil rights policies and procedures, laws and regulations.
- c. Provide access to resources to support people’s functional needs.
- d. Ensure that programs and services are accessible to, accommodate, and are inclusive of people with functional limitations.
- e. Document, disseminate, promote and support the use of proven materials, methods and best practices.
- f. Promote and assist in the establishment of mutual aid agreements that integrate the strengths and skills of local agency partners into the emergency service plans and response strategies of local government.
- g. Monitor shelter and evacuation activity, temporary housing and other emergency and disaster assistance centers.
- h. Assess shelter, evacuation and housing intake forms and questions that identify, triage, and track needs for their applicability and efficacy in addressing the functional needs of their target population so that functional independence can be maintained in short-term and long-term emergency service provision.
- i. Work with shelter, evacuation, emergency housing administrators and personnel, and emergency managers to assist them in effectively addressing and responding to the functional needs of their target population and to make available to them resources and methods that are available to address functional needs.
- j. Assist in the training of shelter, evacuation and emergency housing agencies and personnel to effectively address and respond to functional needs populations.
- k. Assist as needed with alerting and notifying functional (special) needs populations regarding their need to respond to emergency operations, including evacuation and sheltering.

## B. Scope

1. The Functional Needs Framework was initially described by June Isaacson Kailes and Alexandra Enders in a May 2006 paper, “Moving Beyond ‘Special Needs’: A Function-Based Framework for Emergency Management and Planning.” The federal government has also adopted this framework for use in the National Response Plan.

2. The Functional Needs Framework is built around five functional needs: Functional Independence needs, Communication needs, Supervision needs, Medical needs, and Transportation needs.
3. The Functional Needs Framework was intended to address the functional limitations of persons who identify themselves as having a disability and the larger portion of persons who do not identify themselves as having a disability, but have limitations in hearing, seeing, walking, learning, language, and understanding.

## **II. SITUATION**

- A. Typically, disaster preparedness and emergency response systems are designed for people for whom escape or rescue involves walking, running, driving, seeing, hearing and quickly responding to directions. Emergency management systems need help with the very specific and sometimes complex needs of people with functional needs. Emergency medical and public service personnel may not be able to adequately address complex functional independence, physical, communication, supervision, and transportation needs because they lack knowledge of available services, the values and goals of independent living and self-determination, human and civil rights laws and protections, and cultural and linguistic issues.
- B. When we engage in emergency management planning, we make an assumption that everyone in the population will be able to successfully participate in sheltering, evacuation and other emergency response operations, but experience has shown us that the majority of the population has one-or-more functional needs that must be addressed before they are able to successfully participate in emergency operations.
- C. The functional needs framework for addressing needs during emergency operations provides a way to effectively address the assignment and management of resources that is not based on a ‘special needs’ framework of diagnostic labels and definitions of disability that are used primarily for programmatic eligibility.
- D. The functional needs framework can be effectively applied to the needs of a broad group of people, including people with disabilities, people with serious mental illness, minority groups, non-English speakers, children, the elderly, single working parents, people without vehicles, people with special dietary needs, pregnant women, abandoned children, prisoners, institutionalized persons, people who are homeless, etc. Other groups with functional needs include people who are morbidly obese, people on kidney dialysis, and people living in zero-vehicle households. In addition, The residents of nursing homes, “hospitals/wards, hospices, and schools for the handicapped”, correctional

institutions, state prisons, halfway houses, etc. have medical or supervision needs that will continue in an emergency.

- E. Some methods of calculating the total of persons with functional needs in emergency operations indicate that 70% of the population has functional needs that might make them less able to effectively participate in sheltering and evacuation operations. It is important to adequately plan for and address their functional needs and to provide for an effective, comprehensive response.
- F. Functional Limitations
  - 1. Using a function-based framework improves resource management in all types of incidents. Using narrow definitions of need based on varying sets of 'special needs' medical diagnosis-based definitions does not foster effective responses in emergencies and disasters or provide adequate direction for the access and distribution of resources to support functional needs.
  - 2. Disability is not limited to wheelchair users and people who are blind or deaf. Individuals with disabilities include those with one or more activity limitations such as a reduced or inability to see, walk, speak, hear, learn, remember, manipulate or reach controls, and/or respond quickly. Some limitations are easily visible, while others such as heart disease, emotional or psychiatric conditions, arthritis, significant allergies, asthma, multiple chemical sensitivities, respiratory conditions, and some visual, hearing and cognitive disabilities may be less visible.
  - 3. Not all people who experience functional limitations consider themselves to have a disability. People with disabilities and functional limitations include those who have:
    - a. Conditions which interfere with walking or using stairs, e.g. joint pain, paralysis, use of a mobility device such as a wheelchair, canes, crutches, walker.
    - b. Reduced stamina, or easily fatigued, due to a variety of temporary or permanent conditions.
    - c. Respiratory conditions due to heart disease, asthma, emphysema, triggered by stress, exertion, or exposure to small amounts of dust or smoke, etc.
    - d. Emotional, cognitive, thinking, or learning difficulties.
    - e. Vision loss.
    - f. Hearing loss.

- g. Temporary limitations resulting from, but not limited to, surgery, accidents and injuries (sprains, broken bones), pregnancy, etc.
4. Functional limitations exist along a continuum of severity and duration – partial to total, temporary to permanent – that affect almost everyone at some point in their lives.
  5. Planning for the inclusiveness of all persons in emergency operations regardless of limitations and the use of a function-based framework for the application of resources to those with limitations will provide for better overall emergency operations.
  6. What individuals with limitations call themselves, how their limitations have been labeled or diagnosed, or which programs they are eligible for is irrelevant to their functional needs.
  7. People with disabilities and activity limitations are very diverse and should not be sidelined or compartmentalized into a special needs box. Special implies difference and isolation. Given that up to 70% of a population might have functional needs, their needs aren't special needs, they are human needs.
  8. Most people with disabilities, functional limitations and functional needs are integrated into and actively involved in society. As time alters our bodies, activity and functional limitations are natural occurrences. There is a high percentage chance that all people will experience a temporary or permanent disability at some point in their lives. More than 40 percent of non-institutionalized people age 65 and over have a disability, although the largest number of individuals with disabilities are in the 16-64 working age population.
  9. People with functional needs should not be viewed as a special interest group that drains resources from the common pool. As discussed earlier, this group makes up the majority of the population, and addressing their needs makes emergency responders better able to address the needs of the population as a whole. Anyone, at any moment, can incur a disability, particularly during emergencies.
  10. Anyone can join the disability community in a moment. Disasters can instantly create many more people with new disabilities and functional limitations. Following such an event, the numbers of people with disabilities, and functional limitation and loss can escalate. In addition, disasters can intensify an individual's limitations through the loss of mobility equipment or due to the stress brought on by the incident. Some people might experience transfer trauma and significant confusion that affects their ability to function independently in a sheltering or evacuation scenario.

11. It is probable that a person with a moderate physical handicap, an elderly person that has limited mobility, and a non-native person who has a limited use of the English language can all get on the same evacuation bus or can all be served at the same shelter.

### **III. CONCEPT OF OPERATIONS**

#### **A. Medical Needs**

1. The population of persons with Medical Functional Needs includes those who are not self-sufficient, or do not have or have lost adequate support from family or friends and need assistance with:
  - a. Activities of daily living such as bathing, feeding, going to the toilet, dressing, and grooming.
  - b. Managing unstable, chronic, terminal or contagious health conditions that require observation, and ongoing treatment.
  - c. Managing medications, intravenous (IV) therapy, tube feeding and/or regular vital signs.
  - d. Medical readings.
  - e. Dialysis, oxygen, and suction administration.
  - f. Managing wounds, catheters or ostomies.
  - g. Operating power-dependent equipment to sustain life.
2. People with visible disabilities tend to be automatically, but sometimes mistakenly, placed in this category. A more specific function-oriented determination of medical needs, discussed below, needs to be incorporated into training on disaster management of medical needs

#### **B. Communication Needs**

1. Most people who have limitations that interfere with the receipt of, and effective response to information are self-sufficient, but need information provided in methods that they can understand and use. This group is a large and diverse population of those who have difficulties hearing, seeing or understanding. They may not be able to hear verbal announcements, see directional signage to assistance services, or understand how to get food, water and other assistance because of a hearing, understanding, cognitive or intellectual limitations.

2. This population includes persons who:
  - a. Are ethnically and culturally diverse.
  - b. Have limitations or are unable to read or understand English.
  - c. Have reduced or no ability to speak.
  - d. Have reduced or no ability to see.
  - e. Have reduced or no ability to hear.
  - f. Have limitations in learning and understanding.

#### C. Supervision Needs

1. Support for individuals who do not have or who have lost adequate support from family or friends must be determined on a case-by-case basis. For example, after an emergency some people with mental illness may be able to function well with healthy responses and coping skills while others with serious and persistent mental illness may need a protected and supervised setting.
2. People with supervision needs can include:
  - a. People who decompensate because of transfer trauma, trauma stressors that exceed their ability to cope, or lack of ability to function in a foreign environment.
  - b. People with conditions such as dementia, Alzheimer's and psychiatric conditions such as depression, schizophrenia, and intense anxiety.
  - c. People who function adequately in a familiar environment, but become disoriented and lack the ability to function in an unfamiliar environment.
  - d. Prison inmates.
  - e. Unaccompanied children.

#### D. Functional Independence Needs

1. Persons with functional limitation needs are those who need assistance to be able to maintain their health and independence, and to be able to manage the stresses of mass sheltering operations. Effectively meeting these needs can prevent secondary conditions and institutionalization for some persons, and can reduce the use of scarce, expensive and intensive emergency medical services.

2. Maintaining functional independence can include:
  - a. Medical stabilization – replacing essential medications (blood pressure, seizure, diabetes, psychotropic, etc).
  - b. Functional mobility restoration – replacing lost or damaged durable medical equipment (wheelchairs, walkers, scooters, canes, crutches, etc).
  - c. Replacing essential consumable supplies (catheters, ostomy supplies, padding, dressings, sterile gloves, etc.).
  - d. Assistance with orientation for those with visual limitations.

#### E. Transportation Needs

1. This group includes persons who cannot operate a motor vehicle due to disabilities, age, addictions, legal restrictions, etc., and those who do not have access to a motor vehicle. This group includes people who are old, poor, and people who need wheelchair accessible transportation. Most non-drivers and people from zero vehicle households can function independently once evacuated to safety.
2. Transportation is a well-established component of emergency response plans, however, the lack of details regarding transportation dependent people may cause some to be put in potentially dangerous situations.

### **IV. ASSIGNMENT OF RESPONSIBILITY**

- A. ESF-6 State-level Support Agency expertise and capabilities are applicable to the functional needs of the ‘functional needs community’ they represent. As a whole, the responsibilities of ESF-6 State-level Support Agency involvement in providing assistance to persons with functional needs in mass care operations is to provide guidance and other assistance to local partner agencies to:
  1. Promote and sustain independence and self-determination in sheltering and evacuation situations.
  2. Maintain and uphold human and civil rights policies and procedures, laws and regulations.
  3. Provide access to resources to support people’s functional needs.
  4. Ensure that programs and services are accessible to, accommodate, and are inclusive of people with functional limitations.

5. Document, disseminate, promote and support the use of proven materials, methods and best practices.
6. Promote and assist in the establishment of mutual aid agreements that integrate the strengths and skills of local agency partners into the emergency service plans and response strategies of local government.
7. Monitor shelter and evacuation activity, temporary housing and other emergency and disaster assistance centers.
8. Assess shelter, evacuation and housing intake forms and questions that identify, triage, and track needs for their applicability and efficacy in addressing the functional needs of their target population so that functional independence can be maintained in short-term and long-term emergency service provision.
9. Work with shelter, evacuation, emergency housing administrators and personnel, and emergency managers to assist them in effectively addressing and responding to the functional needs of their target population and to make available to them resources and methods that are available to address functional needs.
10. Assist in the training of shelter, evacuation and emergency housing agencies and personnel to effectively address and respond to functional needs populations.