ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:

FUNCTIONAL AND ACCESS NEEDS (FAN)/ AT-RISK POPULATIONS ANNEX

July 2019

Table of Contents

Acronyms/Terms 2
Record of Revisions 4
1.0 Introduction 5
1.1 Purpose 5
1.2 Assumptions 5
1.3 Scope 5
1.4 Situation 8
1.5 Applicability 8
1.6 Authorities 8
2.0 Concept of Operations 9
2.1 General 9
2.2 Activation 10
2.3 Organization 10
2.4 Response 10
2.5 Communication 13
3.0 Recovery 13
Attachments:
Attachment 1: Age FAN/At-Risk Population 15
Attachment 2: Diverse Cultures/Language and Literacy FAN/At-Risk Population 27
Attachment 3: Economic Disadvantage FAN/At-Risk Population 35
Attachment 4: Institutionalized Settings/Congregate Care FAN/At-Risk Population 42
Attachment 5: Isolation FAN/At-Risk Population 50
Attachment 6: Medical Conditions and Disabilities FAN/At-Risk Population 58

ACRONYMS/TERMS

ACS	Alternate Care Site
ADA	Americans with Disabilities
ARC	American Red Cross
ASPR	Assistant Secretary of Preparedness and Response
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Program
CILA	Community Independent Living Arrangements
CIR	Catastrophic Incident Response
CFAN	Children with Functional and Access Needs
CMS	Centers for Medicare and Medicaid Services
COIN	Community Organization Information Networks
DCFS	Department of Children and Family Services
DHHS	U.S. Department of Health and Human Services
DME	Durable Medical Equipment
DMORT	Disaster Mortuary Operational Response Teams
DSCC	Division of Specialized Care for Children
E.G.	Example
EMA	Emergency Management Agency
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EMTrack	Commercial electronic multi-functional tracking system
EOC	Emergency Operations Center
ESF	Emergency Support Function
FAN	Functional and Access Needs
FEMA	Federal Emergency Management Agency
FQHC	Federal Qualified Health Centers
HCC	Health Care Coalition
HOH	Hard of Hearing
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration
ID/DD	Intermediate Care Facilities for the Developmentally Disabled
IDHS	Illinois Department of Human Services
IDJJ	Illinois Department of Juvenile Justice
IDOA	Illinois Department of Aging
IDOC	Illinois Department of Corrections
IDOT	Illinois Department of Transportation
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
IEOP	Illinois Emergency Operations Plan
IHFS	Illinois Healthcare and Family Services
IMT	Incident Management Team
IPHCA	Illinois Primary Health Care Association
LE	Law Enforcement

LEP	Limited English Proficiency
LHD	Local health department
LTC	Long-term Care
LTC U-22	Long-term Care Under-22
MABAS	Mutual Aid Box Alarm System
MACS	Multiple Agency Command System
MARC	Multi-Agency Resource Center
MC/DD	Medically Complex for the Developmentally Disabled Facilities
MCI	Mass Casualty Incident
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
NCMEC	National Center for Missing and Exploited Children
NDMS	National Disaster Medical Service
NIMS	National Incident Management System
OPR	Office of Preparedness and Response
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PKEMRA	Post-Katrina Emergency Management Reform Act
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SEOC	State Emergency Operations Center
SES	Socioeconomic Status
SIREN	State of Illinois Rapid Electronic Notification
SLF	Supported Living Facilities
SME	Subject Matter Expert
SMHRF	Specialized Mental Health Rehabilitation Facilities
SNS	Strategic National Stockpile
SODC	State Operating Developmental Centers
SOF	State Operated Facilities/Hospitals
TDF	Treatment and Detention Facility
TMTS	Temporary Medical Treatment Stations

RECORD OF REVISIONS

DATE OF CHANGE	SECTION(S) UPDATED	DATE POSTED
July 2019	Initial development of the annex	

1.0 Introduction

1.1 Purpose

The purpose of the Functional and Access Needs (FAN)/At-Risk Populations Annex is to support the *Illinois Department of Public Health (IDPH) Emergency Support Function (ESF)-8 Plan* by providing operational guidance for all stakeholders involved in an emergency response within the state of Illinois to ensure the needs of FAN/At-Risk Populations are addressed to improve equity in access to emergency response services and resources.

1.2 Assumptions

1.2.1 The *IDPH ESF-8 Plan* has been activated, either partially or fully, at the discretion of the IDPH director.

1.2.2 The Public Health and Medical Services Response Regions (PHMSRR) serve as the primary regional geographical organizational structure for IDPH (see *IDPH ESF-8 Plan: Attachment 3*).

1.2.3 Public health in Illinois provides a critical link to serving FAN/At-Risk Populations.

1.2.4 The information and strategies outlined within this annex to address the needs of FAN/At-Risk Populations are generalized and should be considered a starting point. The specific needs/issues of any individual, groups and/or populations with FAN or that are considered at risk will vary. The information/strategies outlined in this annex will be tailored to the needs of the individual, group and/or population based on available resources at the time of incident and specific identified needs.

1.2.5 Resources will be limited during a disaster. State, regional and/or local response capabilities may not be able to meet all the needs of all FAN/At-Risk Populations at all times.

1.3 Scope

1.3.1 This annex provides the state, regional, and local response guidance on the care of FAN/At-Risk Populations. This annex is intended to support, not replace, any agencies' existing policies or plans by providing key considerations and available resources that may exist at the state, regional, and/or local level to assist responders with ensuring the needs of FAN/At-Risk Populations are addressed.

1.3.2 The *FAN/At-Risk Populations Annex* applies to all services, program areas, response partners, and responders involved in response and recovery activities during a disaster incident in Illinois. The scalability within this annex is related to the FAN/At-Risk Populations affected by the disaster since not all FAN/At-Risk Populations may be involved or affected by all disasters.

1.3.3 The FAN/At-Risk Populations Annex is intended to:

1. Define FAN/At-Risk Populations for the state of Illinois;
2. Identify potential needs/issues that each FAN/At-Risk Populations category may have during disasters;
3. Outline strategies and resources that can assist with addressing the potential needs/issues of FAN/At-Risk Populations at the state, regional, and/or local level.

1.3.4 This annex addresses the following key response components related to FAN/At-Risk Populations:
1. Communication
2. Transportation
3. Safety/Supervision
4. Medical Care
5. Sheltering
6. Maintaining Independence
7. Mass Fatality

1.3.5 The Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) domain strategies addressed in this annex include:
1. Strengthen community resilience
2. Strengthen incident management
3. Strengthen information management
4. Strengthen countermeasures and mitigation
5. Strengthen surge management
6. Strengthen biosurveillance

1.3.6 For the purposes of disaster response in Illinois, FAN/At-Risk Populations are those individuals, groups, and/or populations that may have additional needs before, during, and after a disaster. These additional needs may be related to issues such as physical and/or cognitive disabilities, age, or language skills. The needs of these individuals, groups, and/or populations typically are not fully addressed by traditional or standard response and recovery resources.

1.3.7 There are multiple terms that are frequently used to describe these individuals, groups and/or populations such as vulnerable populations, at-risk populations, functional and access needs, special needs populations, or special medical needs populations. Within Illinois and for the purposes of this annex, the term FAN/At-Risk Populations will be used to describe these individuals, groups and/or populations. Within this overarching term of FAN/At-Risk Populations, Illinois has further defined six categories of FAN/At-Risk Populations to provide greater attention to the unique needs of the different FAN/At-Risk Populations.

1.3.8 This section lists and defines the six categories within the FAN/At-Risk Populations. The Attachments to this annex provide additional information on each of these categories. More than one of these categories can apply to the same individuals, groups, and/or populations. For example, the age category overlaps with all the other five categories. However, for the purposes of this annex and in an effort to fully address all those that may have additional needs during a disaster, all six categories are utilized. Responders and those using this annex will need to cross reference within the six categories based on the individuals, groups, and/or populations they are assisting. FAN/At-Risk Populations categories are defined in this annex and further expanded upon in the attachments to this annex. This was determined to provide responders with the most information possible as they address the needs of FAN/At-Risk Populations and work to ensure equity in access to disaster resources.

1.3.8.1 Age: Due to the unique considerations that exist across the age spectrum, the Age category is divided into:

1. Older adults (≥60 years of age)
2. Adults (18 - 59 years of age)
3. Children (Birth - ≤ 17 years of age)

This breakdown may differ from other age definitions that exist within Illinois and within other annexes (e.g. Centers for Medicare and Medicaid {CMS} defines older adults/seniors as > 65 years of age and children as
< 21 years of age; the IDPH *ESF-8 Plan: Pediatric & Neonatal Surge Annex* defines children as birth through 15 years of age). See *Attachment 1: Age FAN Category* for more information.

1.3.8.2 Diverse Cultures/Language & Literacy: This category is quite expansive due to the numerous and variety of cultural groups that reside in Illinois. In addition to cultural considerations, this category includes those with limited English proficiency (LEP); those with limited ability to read, speak, write, or understand English; those with low literacy levels or who cannot read; and those who are hard of hearing (HOH), deaf, have visual impairments and/or blindness. See *Attachment 2: Diverse Cultures/Language & Literacy FAN Category* for more information.

1.3.8.3 Economic Disadvantage: This category includes: those who have low, limited and/or fixed income; those that live at or below the federal poverty level; those with unstable or unsecured housing; and those who live in public, government funded, government assisted, subsidized, low rent and/or supportive services housing. See *Attachment 3: Economic Disadvantage FAN Category* for more information.

1.3.8.4 Institutionalized Settings/Congregate Care: This category includes: assisted living establishments, shared housing establishments, sheltered care facilities, supportive living facilities, congregate care, specialty hospitals, detention facilities, and state operated developmental centers. See *Attachment 4: Institutionalized Settings/Congregate Care FAN Category* for more information.

1.3.8.5 Isolation: This category includes those who are socially, geographically, and/or culturally isolated as well as those who are temporary residents in Illinois. See *Attachment 5: Isolation FAN Category* for more information.

1.3.8.6 Medical Conditions and Disabilities: This category includes those with: cognitive impairments, mobility impairments, chronic diseases/conditions, acute or temporary diseases/conditions, and dependency on technology, medications, durable medical equipment and/or electricity for their medical diseases/conditions. See *Attachment 6: Medical Conditions and Disabilities FAN Category* for more information.

1.4 Situation

1.4.1 This annex is unique compared to other annexes within the *IDPH ESF-8 Plan* since the size and/or scope of the incident does not determine whether this annex should be activated.

1.4.2 Identification of FAN/At-Risk Populations within Illinois
In an effort to describe, identify, and quantify FAN/At-Risk Populations within Illinois and utilize this information for disaster planning and response, an *At-Risk Populations in Illinois: Data Report* was developed. A wide variety of data sources were used in this report including the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index. The report reviews publically accessible databases that can be used for state, regional, and local planning, response, and recovery efforts. The data can identify areas of need, which can then lend to targeting specific strategies and tactics to address those needs and ensure equity of resources for FAN/At-Risk Populations during all phases of disaster management. This report is available in the Comprehensive Emergency Management Plan (CEMP) and on the IDPH website.

1.5 Applicability

This document is operationally applicable to IDPH. It is applicable as guidance information and/or as a template to all other health/medical and non-medical responders to disasters including but not limited to: local health departments (LHDs), regional hospital coordinating centers (RHCCs), regional health care coalitions (HCCs), local hospitals, emergency medical services (EMS) providers within each PHMSRR, Illinois Emergency Management Agency (IEMA), Illinois Department of Children and Family Services (DCFS), Illinois Department of Human Services (IDHS), Illinois Department of Juvenile Justice (IDJJ), Illinois Department of Aging (IDOA), Illinois Department of Corrections (IDOC), Illinois Department of Transportation (IDOT), emergency management agencies (EMAs), counties, municipalities, private sector, non-profit sector, non-governmental organizations (NGOs), and medical and non-medical response teams, that may need assistance or be called upon to provide assistance during disasters.

1.6 Authorities

1.6.1 The overall authority for direction and control of the response to a public health emergency rests with the Governor. The Governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of activities by the IEMA. The state emergency operations center (SEOC) is the strategic direction and control point for all state emergency response operations.

1.6.2 IDPH is the lead agency for public health and medical response operations. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to support local operations,

1.6.3 Requests for health and medical assistance during emergency events will be routed through IEMA and the SEOC. The request will then be directed by the SEOC manager to the IDPH SEOC liaison to fill. IDPH will determine the best resources from a health and medical standpoint to deploy.

1.6.4 The overall authority for direction and control of IDPH resources and licensees rests with the IDPH Director.

1.6.5 The overall authority for direction and control of non-IDPH health and medical resources is through the individual agency lead official; however, the IDPH Director is the coordinating authority for health and medical assets and resources to support local, regional, and state health and medical response operations.

1.6.6 There are federal laws/regulations/acts that exist to protect FAN/At-Risk Populations before, during, and after disasters. Several key laws/regulations/acts are listed below. This list is not inclusive and additional laws/regulations/acts may be in place. Detailed information, including the specific requirements outlined within the law/regulation/act can be found on the regulating agency's website. The goal of this annex is to assist IDPH and other response partners throughout Illinois in complying with federal laws/regulations/acts to protect FAN/At-Risk Populations during, and after disasters.

1. Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988
2. Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
3. Patient Protection and Affordable Care Act (ACA)
4. Pets Evacuation and Transportation Standards Act
5. Federal Communications Commission: Emergency Alert System Rules
6. Post-Katrina Emergency Management Reform Act (PKEMRA)
7. U.S. Health and Human Services, Pandemic and All-Hazards Preparedness Act
8. Safe, Accountable, Flexible, Efficient Transportation Equity Act
9. Individuals with Disabilities in Emergency Preparedness
10. Americans with Disabilities Act of 1990
11. Older Americans Act of 1965
12. Executive Order 13347 -- Individuals with Disabilities in Emergency Preparedness
13. Rehabilitation Act of 1973
14. Equal Opportunity for Individuals with Disabilities
15. Nondiscrimination on the Basis of Disability in State and Local Government Services

2.0 Concept of Operations

2.1 General

2.1.1 IDPH retains overall primary authority and responsibility to determine the level of public health related risks for the general population as well as FAN/At-Risk Populations in Illinois. The IDPH role in day to day emergency preparedness provides the foundation for response. IDPH is prepared to respond with assistance for the general population and FAN/At-Risk Populations in times of actual or threatened, natural or manmade disasters and emergencies.

2.1.2 IDPH is the lead agency for public health and medical services response for the state of Illinois and has shared responsibility with all responders, both health/medical and non-medical to meet the needs of FAN/At-Risk Populations during disaster.

2.1.3 Although this annex resides within the *IDPH ESF-8 Plan* and IDPH is the lead agency, this does not relieve local emergency management organizations, local and regional health care facilities, local public health departments, other medical and non-medical response agencies or other state agencies of their responsibility to address the needs of FAN/At-Risk Populations to improve the equity in access to emergency response services and resources during times of emergency or disaster, nor does it redirect their responsibilities to IDPH.

2.1.4 The needs of FAN/At-Risk Populations within a community and throughout the state need to be addressed in all disasters regardless of the size and/or scope of the incident.

2.2 Activation

2.2.1 The activation process of this annex follows the same procedures as outlined in the *IDPH ESF-8 Plan* and all of its annexes. Partial or full activation of this annex may occur in any of the following circumstances:

1. Gubernatorial proclamation of a disaster that activates the Illinois Emergency Operations Plan (IEOP)
2. Partial or complete activation of the *IDPH ESF-8 Plan* in coordination with IEMA
3. Any time the Public Health Emergency Operations Center (PHEOC) is open even if the *IDPH ESF-8 Plan* has not been activated.
4. At the discretion of the IDPH director in coordination with IEMA during any emergency or disaster, regardless of size and/or scope involving a threat to public health or the health care system
5. Activation of the IDPH Incident Management Team (IMT) that coordinates public health and medical services response operations

2.3 Organization

2.3.1 This annex aligns with the established organizational framework outlined in the IDPH ESF-8 Plan for the activation and management of IDPH activities implemented in disaster response and recovery. See *IDPH ESF-8 Plan* Section 2.4 for this organizational framework. This annex expands on the capabilities and resources available within and provided by IDPH to adequately meet the needs of FAN/At-Risk Populations during a disaster.

2.3.2 Components of this annex should be integrated into all levels of disaster planning and response within IDPH and its response partners’ response policies, planning and program initiatives.

2.3.3 IDPH and its response partners are expected to train staff within their organizational structure on the components of this annex and to integrate the needs of FAN/At-Risk Populations on all levels (local municipality, county, region and state levels) of planning and response.

2.4 Response

2.4.1 Although IDPH is the primary agency for public health and medical disaster response and recovery actions for Illinois, identification of the needs and allocation of resources to address those needs of FAN/At-Risk Populations is the

responsibility of all response partners/agencies and will require communication and coordination amongst all response partners/agencies.

2.4.2 The Attachments to this annex contain information on all six FAN/At-Risk Populations Categories defined in this annex. The unique needs of the six FAN categories are outlined based on the following response components: Communication, transportation, safety/supervision, medical care, sheltering, maintaining independence, and mass fatality. Strategies and tactics are also included to help responders address these unique needs. Not every individual, group, or population will have all the identified needs. In addition, the list of needs and strategies is not inclusive. Responders should tailor the response strategies, tactics, and resources based on the specific FAN needs present at the time of the incident. Each regional HCC plan and plans at the local level should define in greater detail the FAN/At-Risk Populations within their areas to further ensure appropriate incorporation of the needs of FAN/At-Risk Populations into policy, planning, and program initiatives.

2.4.3 In addition to the detailed strategies outlined in the Attachments for each of the six FAN/At-Risk Populations categories, below are key strategies/tactics that responders should consider for all FAN/At-Risk Populations:

1. Communication:
    a. All information/messages should be:
        - Distributed in languages known to be spoken in the area of the disaster.
        - Reviewed for any word choices that may create a cultural/dialect context conflict.
        - Distributed through various and redundant methods (e.g. TV, radio, social media, text messaging, automatic phone calls, printed signs, existing electronic billboards, community broadcast systems, traffic alert signs, bullhorns, cell phone carriers' alert systems, commercial business' electronic signs, home monitored alarm/alert systems).
        - Distributed in multiple formats at an appropriate reading comprehension level and include the use of symbols/pictures and large font.
    b. Information that should be distributed includes but is not limited to : general incident, evacuation, shelter-in-place, location of shelters, transportation resources, facilities to obtain care or assistance, potential impact of secondary hazards, family reunification process, food and water safety, public health protection, emergency closures or detour notices, closure notices, community meetings, process to report damage, consumer protection issues, curfew and curfew related restrictions, and any other health/safety/security information.
2. Transportation:
    a. Provide transportation to assist with evacuating/ relocating/traveling to dispensing sites, as well as return to home area after a disaster.
    b. Collaborate with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), Illinois Emergency Management

Agency (IEMA), National Disaster Medical Services (NDMS), Mutual Aid Box Alarm System (MABAS), forestry agencies, school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/community centers/senior centers/assisted living and long-term care facilities, and ambulance companies to provide vehicles for transportation.

3. Safety/Supervision:
   a. Implement a screening process at points of contact throughout the disaster to identify those who may need assistance (either as an individual with FAN or as the caregiver for an individual with FAN).
   b. If the primary caregiver is present with the individual or group, keep the caregiver and individual/group together if possible, especially parents with their children.
4. Medical Care:
   a. Collaborate with agencies such as the Illinois Primary Health Care Association (IPHCA) and Federal Qualified Health Centers (FQHC) to provide care during disasters (e.g. vaccinations, mass prophylaxis, obtaining prescriptions) and to share and distribute information.
   b. Assist local health departments (LHD) with implementing their policies to provide medications during mass prophylaxis.
5. Sheltering:
   a. Collaborate with shelter organizers to provide resources, additional medications, equipment, treatments, and other care needs to accommodate specific needs/issues that are identified during the intake process (as applicable and possible) for FAN/At-Risk Populations.
6. Maintaining Independence:
   a. Coordinate delivery of food, water, medications, treatments, and equipment (including fuel to those with a generator) to the FAN/At-Risk individual, group, or population as available to help maintain their independence
   b. Collaborate with responders and community agencies to provide needed resources to assist FAN/At-Risk individuals, groups, or populations maintain their independence during and after disasters.
7. Mass Fatality
   a. Implement public messaging beyond the area of the disaster (statewide/nationwide) to provide an avenue for distant friends/family to contact authorities if concerned their family member(s) may have been in the area of disaster or is missing.
   b. Identify mental health agencies that can provide resources to help cope after an incident.
   c. Request federal resources such as Disaster Mortuary Operations Response Teams (DMORT).

2.4.4 Resource and guidance documents are available in addition to the strategies and tactics outlined in the Attachments. Federal agencies such as FEMA, CDC, CMS, Health Resources and Services Administration (HRSA) have produced guidance planning documents to assist local, regional, and state response agencies with

incorporation of FAN/At-Risk Populations into policies, planning, and program initiatives. In addition, the federal laws/regulations/acts listed in Section 1.6.6 can also provide additional information on requirements that response agencies need to consider during planning and response.

2.4.5 There are many additional state programs and advocacy groups/agencies that may be available to provide assistance with the state, regional, and local response to meet the needs of FAN/At-Risk Populations. Maintaining a list of all state programs and advocacy groups/agencies within this annex is not feasible. Responders should collaborate with community, regional, and state agencies to identify other groups that can assist during a disaster.

2.4.6 During a disaster, to ensure the needs of FAN/At-Risk Populations are being addressed, all response agencies should identify a responder(s) within their organization whose primary focus is FAN/At-Risk Populations. This FAN/At-Risk Populations Specialist role would include: identifying FAN/At-Risk Populations affected by the incident/disaster; identifying the needs of those FAN/At-Risk individuals, groups, or populations affected by the incident/disaster; and implement strategies including collaborating with other response agencies to address the identified needs as indicated based on the focus of that response agency. Assigning a responder with this role will further advocate for the FAN/At-Risk Populations with the goal of improving equity of access to response resources. IDPH will assign the FAN/At-Risk Populations Specialist role to a staff member within the PHEOC.

2.5 Communication

2.5.1 Communication processes will follow the communication pathway outlined in the *IDPH ESF-8 Plan*. See Section 5.0 and Attachment 13 in the *IDPH ESF-8 Plan* for more information.

2.5.2 Many of the response agencies that IDPH will need to partner with are integrated into the SEOC. This can facilitate communication and mobilization of resources. As health, medical, and non-medical needs of FAN/At-Risk Populations are identified on the state level, resource requests for assistance to care for FAN/At-Risk Populations are received from the local/regional level and/or situational awareness information is received into the SEOC. The IDPH SEOC Liaison will contact the SEOC Manager and SEOC Liaison from the response agency(ies) to assist with addressing the identified need/resource requests or to share information. In addition, the SEOC Manager and SEOC Liaison from the other response agency(ies) may contact the IDPH SEOC Liaison to request assistance from IDPH to address needs/resource requests that their agency has identified or to provide situational awareness updates. After interagency requests have been made or information has been shared between SEOC Liaisons, each SEOC Liaison will disseminate information and the requests within their own agency following their intra-agency communication process.

3.0 Recovery

3.1 The recovery process for FAN/At-Risk Populations following a disaster may require a significant amount of time and considerably more resources than the general population.

Overall, the recovery processes should be consistent with the recovery processes outlined in the *IDPH ESF-8 Plan*, Section 6.0. Some strategies and tactics found in the Attachments to this annex can be implemented during the recovery phase to assist FAN/At-Risk Populations with returning to pre-disaster levels as soon as possible.

3.2 The approach to caring for FAN/At-Risk Populations during the recovery phase is identical to the approach during the response phase. To best meet the needs of FAN/At-Risk Populations, responders should tailor the recovery strategies, tactics, and resources based on the specific needs identified by those with FAN after the incident. Each regional HCC plan and plans at the local level should define in greater detail the FAN/At-Risk Populations within their areas to further ensure appropriate incorporation of the needs of FAN/At-Risk Populations into recovery policy, planning, and program initiatives.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

Due to unique anatomical, physiological, and developmental differences, children and older adults are at higher risk during disasters.

Children are defined as less than 18 years of age and represent approximately 25% of the population in Illinois. Children can be divided into different groups based on their age:

- Newborns – less than 28 days of age
- Infants – 1-11 months
- Toddlers – 1-3 years
- Preschool – 4-5 years
- School age – 6-12 years
- Adolescents – 13-18 years

The care that is needed for a child varies based on their age and developmental level. Children with medical conditions and/or disabilities are considered to be children with functional and access needs (CFAN). Other circumstances involving children that may put them at higher risk include:

- the significant amount of time during the week that children spend away from their families
- teenage parents
- runaway/homeless youth
- homeless families
- latchkey children
- foster children
- custodial issues
- children who are home schooled or not in the traditional school system
- children who are in abusive homes or are victims of child trafficking
- non-immunized
- children with limited, inconsistent or no access to primary medical care.

Older adults are defined as those older than 60 years of age. Adults older than 65 years of age represent approximately 13% of the population in Illinois. Certain circumstances that may put older adults at higher risk include:

- living alone, experience social isolation, or have a limited support structure
- limited English proficiency (LEP)
- limited strength and/or mobility issues
- cognitive, physical, and/or developmental disabilities
- guardian and primary caregiver to grandchildren
- guardian and primary caregiver to adults with cognitive, physical and/or developmental disabilities

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

- residing in assisted living or long-term care facilities
- transient individuals who may live in different areas of the country during different seasons
- fixed incomes
- living in rural areas with limited resources.

Adults between 18-59 years of age may also be at higher risk if they have functional and access needs. Due to the overlap of information in all other functional and access needs (FAN)/At-Risk Population categories and the adult population, this group is not specifically outlined in this Attachment.

The table below outlines potential needs/issues that children and older adults may encounter, as well as strategies and tactics that may assist in addressing their needs/issues. This list is not inclusive, and planners and responders should not assume that all the needs/issues are applicable to all individuals, groups and/or populations within these age groups. Strategies and tactics should be tailored after assessing the specific needs of individuals or groups during the disaster or incident. In addition, there may be additional strategies and tactics that can be found in other sections of this plan that apply based on overlapping of the FAN/At-Risk Populations categories (e.g. Age FAN category and Medical Conditions and Disabilities FAN category). NOTE: In addition to the information within this annex, coordination and management of the acute medical care for all children during a disaster is outlined in the *IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex*.

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
COMMUNICATION	Older adults: • Limited availability, unreliable, or no communication methods/tools • Less likely to be on social media • May not have cell phone and only a land line, especially in rural areas • Difficulty communicating due to hearing and/or visual impairments, or may be non-verbal • Limited English proficiency (LEP)	Older adults: • Information/messaging should be sent through various and redundant methods (e.g. TV, radio, social media, text messaging, automatic phone calls). • Allow for additional time to provide information, process information, and follow instructions. • Look directly at the individual when speaking to them. • Provide sign language interpreters, if applicable.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Difficulty providing information (e.g. personal information, medical information, family contact information) • Require additional time to share and process information	• All written information/messages should be distributed in multiple formats at an appropriate reading comprehension level. • Include the use of symbols/pictures and large fonts. • Utilize dementia friendly communication strategies when speaking with an older person with dementia or Alzheimer's disease. • Provide just-in-time training to responders on tips for communicating with older adults and those with dementia. • See *Attachment 2: Diverse Cultures/Language and Literacy FAN Category* for communication strategies for LEP.
	Children: • Age and developmental level of children determines their comprehension level of information provided • Many children are non-verbal due to age, developmental level, fear, or cognitive disabilities, and may not be able to provide any information to responders (personal information, medical information, family contact information) • Information provided by young children may not be accurate (e.g. provide their nickname, not their legal name) • May be resistant to following directions out of fear	Children: • Information should be shared with the parents/guardians present (if available). • Do not separate children from their parents/guardians. • Share information with children based on their age and developmental level. • Provide just-in-time training to responders on ways to communicate with children based on their age and developmental level. • Provide additional time and distraction devices to help decrease the fear in children and improve cooperation. • Limit children's exposure to the media/news. • Provide older children and adolescents with sources for accurate information and inform them of the dangers of inaccurate messages on social media sources.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Collaborate with schools/child care centers to obtain information on the child (especially parental/guardian contact information), if the child is unable to provide this information. • Collaborate with social service agencies, the Department of Children and Family Services (DCFS), and law enforcement (LE) to identify and locate parents/guardians.
TRANSPORTATION	Older adults: • Limited or lack of resources to self-evacuate, relocate, or travel to dispensing sites (e.g. do not drive, rely on caretakers or transportation services) • Mobility issues (e.g. wheelchair bound, bed bound, ambulates with assistive devices) and limited strength to self-evacuate long distances • Require additional time to process information, follow instructions, ambulate, evacuate, and transport • Additional resources are needed to evacuate and transport individuals from assisted living facilities and long-term care facilities • Resistance to evacuate/relocate • Additional resources required to evacuate and later return to home area	Older adults: • Follow Communication strategies to assist with distributing information about transportation resources. • Provide transportation to assist with evacuating/ relocating/traveling to dispensing sites, as well as returning to home area after a disaster. • Collaborate with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), Illinois Emergency Management Agency (IEMA), National Disaster Medical Services (NDMS), Mutual Aid Box Alarm System (MABAS), school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/community centers/senior centers/assisted living, and long-term care facilities, and ambulance companies, to provide vehicles for transportation. • Provide information to all those being evacuated regarding the destination of transportation vehicles. • Provide additional staff/responders as needed and requested to assist those with hearing/visual impairments with safely moving in unfamiliar areas and in/out of transportation vehicles.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	Children: • Ability to self-evacuate depends on age (non-ambulatory), developmental level (may hide out of fear instead of fleeing) and any preexisting physical disabilities (wheelchair bound) • Require safety equipment (e.g. car seats) when being transported in vehicles • At risk for abduction when separated from their families • Additional resources may be required for transportation to maintain children as part of a family unit	• Collaborate with the Illinois Department of Aging's (IDOA) Care Coordination Units to share/distribute information to clients and assist with the coordination of their relocation. Children: • Follow Communication strategies when coordinating transportation of children. • Provide additional resources and responders to assist in relocating/evacuating children or families with children. • Additional resources and responders will be needed to protect children (e.g. prevent abduction). • Establish memorandum of understanding (MOU) and/or pre-identify sources of child safety car restraint systems that can be mobilized during disasters. • Collaborate with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/community centers, child care centers, and ambulance companies, to provide vehicles for transportation.
SAFETY/SUPERVISION	Older adults: • Assistive services, agencies, and/or service animals may not be available for those who are hard of hearing, deaf, have visual impairments, or are blind • Those with dementia and other cognitive disabilities/conditions will need direct supervision	Older adults: • Follow Communication strategies to assist with obtaining and distributing information. • Collaborate with the IDOA's Care Coordination Units to assist with the coordination of obtaining staff/responders to assist with safety/supervision. • Collaborate with assisted living facilities and long-term care facilities to ensure staff are available to assist with

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Legal considerations such as power of attorney/decision making authority/ guardianship, and living wills, as well as access to corresponding documentation	residents and to provide expertise in caring for people with dementia or other cognitive disabilities/conditions. • Provide just-in-time training to responders placed in the role to assist/supervise older adults with dementia or other cognitive disability/condition. • Communicate with families, health care facilities, and long-term care facilities to provide documentation on power of attorney/decision making/guardianship, and living wills. • Collaborate with families, social service agencies (e.g. IDOA), law enforcement, and health care facilities (as indicated and required) to identify who is responsible for caring for older adults who are unable to make their own decisions. • Provide additional staff/responders as needed and requested to assist those with visual or hearing impairments.
	Children: • Family composition may not align with traditional and legal definitions • Reunification of unaccompanied minors, especially younger children who are unable to provide personal and/or family information, is a high-risk situation; custodial issues may exist and further complicate reunification	Children: • Follow Communication strategies to assist with obtaining and distributing information. • Collaborate with families, social service agencies (e.g. DCFS), law enforcement, schools, child care centers, and health care facilities (as indicated and required) to identify who is responsible for caring for children who are unaccompanied by their parent/guardian.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Children are separated from their families for significant amounts of time during the week (school/child care), which increases their risk of abduction, maltreatment, and long-term mental health consequences if disaster occurs during these times • Children need to be supervised for their protection	• Provide additional staff/responders as needed to provide adequate safety/supervision to unaccompanied children to ensure their safety. • Notify Incident Command and follow reunification procedures for any unaccompanied children utilizing available reunification resources (e.g. EMTrack, National Center for Missing and Exploited Children's (NCMEC) Unaccompanied Minor Registry).
MEDICAL CARE	Older adults: • Assistive services, agencies, and/or service animals may not be available for those who depend on home care • Limited, inconsistent, or lack of access to care before disaster • Lost or damaged hearing/visual aids • May have extensive medical conditions and require numerous medications and treatments • May not have a stockpile or may not have brought their medications during an evacuation • May not be able to provide responders with their medical history or medications Children: • May have extensive medical conditions and require numerous medications and treatments	Older adults: • Collaborate with the IDOA's Care Coordination Units to assist with the coordination of medical care resources • Collaborate with agencies such as the Illinois Primary Health Care Association (IPHCA) and Federal Qualified Health Centers (FQHC) to provide care during disasters (e.g. vaccinations, mass prophylaxis, obtain prescriptions) and to share and distribute information. • See *Attachment 6: Medical Conditions and Disabilities* for strategies and tactics. Children: • Collaborate with families, social service agencies (e.g. DCFS), law enforcement, schools, child care centers, and health care facilities as indicated and required to identify any preexisting medical conditions if unaccompanied by parent/guardian.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• If unaccompanied by parent/guardian, may not be able to provide responders with their medical history or medications • Limited, inconsistent, or lack of access to care before disaster • Medical condition may decompensate quickly	• Provide just-in-time training to responders or utilize responders trained to care for children who can identify signs of acute changes in the child's current health state and intervene appropriately. • See *Attachment 6: Medical Conditions and Disabilities FAN Category* for strategies and tactics. • See *IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex* for information on the medical care of children during a disaster.
SHELTERING	Older adult: • Assistive services, agencies, and/or service animals may not be available to allow older adults to shelter in place • Lack of awareness of shelter location • Difficulty navigating in the shelter due to visual impairments • Require more time to process information, follow instructions, and move around within the shelter environment • Traditional shelter bedding, food, bathroom facilities, and reasonable accommodations that may not meet the needs of older adults • May be noncompliant with treatment regimen and may present in an acutely ill state	Older adult: • Follow Communication strategies to assist with: distributing information about shelters; identifying and addressing needs/concerns when entering shelters; and sharing information with those within the shelters. • Collaborate with shelter organizers to provide available resources to accommodate specific needs/issues that are identified during the intake process (as applicable and possible). Resources that may be needed include: adjustable cots/beds, toilet risers, mobility equipment, pharmaceutical needs, medical equipment needs, and access to power/electricity. The American Red Cross (ARC) has a process to set up shelters that are ADA compliant, identify needs of FAN/At-Risk Populations, and provide food and other accommodations based on identified needs. • Collaborate with the IDOA's Care Coordination Unit to assist during and after the disaster. • Allow for additional time to process information, follow instructions, and move around shelter.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Provide additional staff/responders as needed and as requested to assist those with visual impairments and provide care if caretaker is not available (e.g. toileting, feeding, medication administration). • Utilize response teams that can assist with providing care (e.g. medical reserve corps (MRC), disaster medical teams, etc.). • Signage within the shelter should be formatted in large print with a combination of written language and pictures. • Bring information about resources, disaster relief, and reimbursement to the shelter.
	Children: • Require safety/supervision measures if unaccompanied • Traditional shelter bedding, food, bathroom facilities, and reasonable accommodations that may not meet the needs of CFAN	Children: • Keep child with family/parent/guardian. • Collaborate with shelter organizers to provide available resources to accommodate specific needs/issues that are identified during the intake process (as applicable and possible). Resources that may be needed include: adjustable cots/beds, cribs, toilet risers, mobility equipment, pharmaceutical needs, medical equipment needs, and access to power/electricity. Areas for mothers to breastfeed infants should also be identified. The American Red Cross (ARC) has a process to set up shelters that are ADA compliant, identify needs of FAN/At-Risk Populations, and provide food and other accommodations based on identified needs. • Set up a children's play area to allow children space to play and provide them with a routine to assist them with coping.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Collaborate with families, social service agencies (e.g. DCFS), law enforcement, schools, child care centers, and health care facilities as indicated and required to identify who is responsible for caring for children who are unaccompanied by their parent/guardian. • Provide additional staff/responders as needed to provide adequate safety/supervision to unaccompanied children to ensure their safety. • Notify Incident Command and follow reunification procedures for any unaccompanied children utilizing available reunification resources (e.g. EMTrack, NCMEC's Unaccompanied Minor registry).
MAINTAINING INDEPENDENCE	Older adults: • Less financial reserve to be able to maintain their independence for any length of time • Assistive services, agencies, and/or service animals may not be available to help maintain independence. • Require more time to process information, follow instructions, complete tasks, and make decisions.	Older adults: • Follow Communication strategies to assist with identifying what is needed to help older adults maintain their independence during and after the disaster. • Collaborate with responders and community agencies to provide the resources needed to assist older adults to maintain their independence during and after disasters. • Provide food/water after a disaster, especially to those older adults that receive aid before the disaster. • Collaborate with the IDOA's Care Coordination Unit to assist during and after the disaster. • Provide responders with just-in-time training to assist with providing care to older adults. • Provide mental health provisions that are age/ developmentally appropriate. • Provide additional time and adapt the environment to allow older adults to complete tasks independently and make their own decisions.

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	Children: • Dependent on adults for all care/necessities • Older children and adolescents may want to be more independent • Families may not have financial reserves to provide for their family during disasters	Children: • Provide food/water after a disaster, especially to those families that receive aid before the disaster. • Provide additional time and adapt the environment to allow for children to complete tasks independently and make decisions as appropriate based on age, developmental level, and circumstances. • Provide mental health provisions that are age/ developmentally appropriate. • Provide additional staff/responders as needed to assist parents/guardians with supervising their children to allow time for them to identify community resources and next steps.
MASS FATALITY	Older adults: • May be more adversely affected (higher mortality rate) due to co-morbidities from chronic conditions (incident dependent) • Delay in reporting being missing • Difficulty identifying remains • Difficulty locating next of kin • Cultural/religious considerations • Disposal of assistive devices Children: • May be more adversely affected (higher mortality rate) due to age/developmental level (incident dependent)	Older adults: • Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Implement public messaging beyond the area of disaster (statewide/nationwide) to provide information to distant friends/family to contact authorities if concerned their family member(s) may have been in the area of disaster or is missing. • Refer to the Illinois *Pandemic Influenza Preparedness and Response Plan: Fatality Management Annex* for additional information. Children: • Collaborate with families, social service agencies (e.g. DCFS), law enforcement, schools, child care centers,

ATTACHMENT 1: AGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Difficulty identifying remains • Difficulty locating next of kin • Emotionally challenging for families and responders if mass fatality involves the death of children	and health care facilities (as indicated and required) to identify next of kin and to help identify remains. • Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Identify mental health agencies that can provide resources to parents and responders to help cope after the incident.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

The population in Illinois is ethnically and culturally diverse. In addition, a significant percentage of the population in Illinois has limited English proficiency (LEP) which is defined as individuals who have a limited ability to read, speak, write, or understand English, have low literacy skills, cannot read at all, and/or have hearing/visual difficulties (including deaf and blind), that impairs their ability to communicate. Based on the CDC Social Vulnerability Index in 2014 for Illinois, 22% of the population spoke a language other than English at home and an estimated 9.4% of individuals over the age of 5 years identified that they had LEP (CDC). Approximately 2.8% of the population or 358,000 individuals in Illinois were estimated to have a hearing difficulty. Of those with a hearing difficulty, 38% were < 65 years of age. In addition to the resident LEP population, it is important to consider foreign visitors, illegal/undocumented immigrants, and immigrants/refugees.

The table below outlines potential needs/issues for individuals, groups, and/or populations from diverse cultures and/or with LEP as well as strategies/tactics that may assist in addressing their needs/issues. This list is not inclusive, and planners/responders should not assume that all the needs/issues are applicable to all individuals, groups, and/or populations within ethnic or cultural groups. Strategies/tactics should be tailored after assessing the specific needs of individuals or groups during the disaster/incident. In addition, there may be additional strategies/tactics that can be found in other sections of this plan that apply based on overlapping of the FAN/At-Risk Populations categories (e.g. Diverse Cultures/Language & Literacy and Age FAN category).

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
COMMUNICATION	• Limited English speaking or does not speak English • Cultural context of language used in messaging • Lack of trust in government and/or the source of information if family/friends unavailable to translate • Inaccurate, inconsistent, and unreliable information or messaging • Lack of familiarity with where to obtain accurate information • Difficulty communicating with written word related to reading comprehension,	• Language access procedures should be integrated directly into policies/plans. • All information/messages should be distributed in languages known to be spoken in the area of the disaster. The messages should be reviewed for any word choices that may create a cultural/dialect context conflict. Utilize translation services to convert written information/ messages into other languages. • All written information/messages should be distributed in multiple formats at an appropriate reading comprehension level and include the use of symbols/pictures and large font.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	literacy skills, education level, and/or visual impairments • Lack of access to spoken language translators • Lack of access to sign language interpreters • No family members available to translate • Cultural perceptions of planning for emergencies/disasters • Accents may interfere with communication	• Information that should be translated/interpreted includes but is not limited to: general incident, evacuation, shelter-in-place, location of shelters, transportation resources, facilities to obtain care or assistance, potential impact of secondary hazards, family reunification process, food and water safety, public health protection, emergency closures or detour notices, closure notices, community meetings, process to report damage, consumer protection issues, curfew and curfew related restrictions, and any other health/safety/security information. • Interpreters for spoken language and sign language should be accessed. • It is not recommended to use children as interpreters. • Maintain a resource list of in-person, telephone, and video interpreter services (e.g. Illinois Deaf and Hard of Hearing Commission, Illinois Superior Court Language Interpreter Registry, state master contract for interpretation through Multilingual Connections, FEMA's translation and interpretation services during Presidential declared disasters) • Engage existing Community Organization Information Networks (COIN), community/cultural leaders, and cultural brokers (individual, organization or group that advocates and helps link groups or persons of differing cultural backgrounds) to assist with information sharing and distribution. • Engage embassies/consulates to assist with information sharing/distribution and to identify additional needs.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Collaborate with state and national ethnic media sources to assist with information sharing and distribution. • Establish and maintain a crisis resource hotline that provides access to different languages to provide information on the incident, instructions on how to respond, locations of shelters, etc.
TRANSPORTATION	• Limited or lack of resources to self-evacuate, relocate, or travel to dispensing sites • Resistance to evacuate/relocate • Lack of awareness of: need to evacuate/relocate; transportation resource availability; resources to assist once relocated (cultural/language) • Cultural/religious restrictions • Additional resources required to evacuate and later return to home area • Lack of trust in government, law enforcement, or other agency issuing evacuation order, providing transportation, and arranging relocation	• Follow Communication strategies to assist with distributing information about transportation resources. • Provide transportation to assist with evacuating/ relocating/travel to dispensing sites, as well as return to home area after a disaster. • Work with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), forestry agencies, school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, and ambulance companies. • Coordinate with embassies/consulates to assist with transportation needed outside of the U.S. • Collaborate with cultural groups and community leaders to alleviate fears. • Provide information to all those being evacuated regarding the destination of the transportation vehicles. • Provide additional staff/responders as needed and requested to assist those with visual impairments with safely moving in unfamiliar area(s) and in/out of transportation vehicles.
SAFETY/SUPERVISION	• Assumption exists that the agency/ organization responsible for safety/supervision (e.g. au pair/nanny placement services, child care centers)	• Follow Communication strategies to assist with obtaining and distributing information. • Collaborate with the Illinois Department of Health and Human Services (IDHS) and Department of Children

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	speaks English and can easily assist with information sharing and distribution • Au pairs/nannies caring for children may not speak English or be able to locate parents of the children • Family composition may not align with traditional and legal definitions • Assistive services, agencies, and/or service animals may not be available for those who are HOH, deaf, have visual impairments, or are blind	and Family Services (DCFS) to obtain and distribute information to child care centers. • Identify and collaborate with au pair/nanny placement services (especially those utilizing au pairs from other countries) before the disaster to encourage parents to have a disaster plan; and emphasize the need during a disaster to obtain and distribute information. • Collaborate with families, social service agencies (e.g. DCFS, Illinois Department of Aging {IDOA}), law enforcement, and health care facilities as indicated and required to identify who is responsible for caring for children and adults who are unable to make their own medical decisions. • Provide additional staff/responders as needed and requested to assist those with visual or hearing impairments.
MEDICAL CARE	• Limited, inconsistent, or lack of access to care before a disaster • Family composition may not align with traditional and legal definitions and lead to difficulty with providing consent for medical care • Cultural conflicts with recommended care (e.g. vaccination or prophylaxis medications) • Lack of trust in government or entities providing medical care, prophylaxis, or vaccinations • Fear to seek care among undocumented immigrants	• Collaborate with families, social service agencies (e.g. DCFS, IDOA), law enforcement, and health care facilities as indicated and required to identify who is responsible for caring for children and adults who are unable to make their own medical decisions. • Collaborate with cultural groups, community leaders, and cultural brokers to alleviate fears, share and distribute information, and encourage use of medical resources for those who are undocumented and families with mixed status (legally in the U.S. and undocumented). • Collaborate with agencies such as the Illinois Primary Health Care Association (IPHCA) and Federal Qualified Health Centers (FQHC) to provide care during disasters

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Lack of awareness among undocumented immigrants about medical care opportunities • Lost or damaged hearing/visual aids	(e.g. vaccinations, mass prophylaxis) and to share and distribute information • Assist local health departments (LHD) with implementing their policies to provide medications during mass prophylaxis to undocumented immigrants. • Assist with obtaining hearing and visual aids • See *Attachment 6: Medical Conditions and Disabilities* for additional strategies and tactics.
SHELTERING	• Lack of awareness of shelter location • Lack of trust in shelter organizers • Fear related to safety, inability to communicate, and inability to maintain cultural traditions • Cultural and religious considerations related to food, gender, and pets/animals • Difficulty navigating in the shelter related to visual impairments	• Follow Communication strategies to assist with: distributing information about shelters; identifying and addressing needs/concerns when entering shelters; and sharing information with those within the shelters. • Collaborate with community leaders, cultural/religious leaders, and cultural brokers to identify and address barriers to shelter utilization. • Collaborate with shelter organizers to provide available resources to accommodate specific needs/issues that are identified during the intake process (as applicable and as possible). The American Red Cross (ARC) is able to identify cultural and religious needs during the intake process and collaborate with community agencies to adapt shelters to meet identified needs. In addition, they encourage individuals from various ethnic groups and those that have FAN to volunteer in the shelters. This process promotes trust of those needing to utilize shelters during disasters. • Provide interpreters (spoken and sign language) and translate signs within the shelter to accommodate the various languages spoken by those in the shelter.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Provide additional staff/responders as needed and requested to assist those with visual impairments. • Signage within the shelter should be in large print and a combination of written language and pictures. • Establish and communicate shelter rules with all those seeking shelter during the initial intake process (e.g. pets/animals, purpose of shelter, length of time shelter anticipated to be open, etc.). • Bring information about resources, disaster relief, and reimbursement to the shelter.
MAINTAINING INDEPENDENCE	• Less financial reserve to be able to maintain their independence for any length of time • Access to resources and disaster aid for undocumented immigrants • Cultural perceptions of planning for emergencies/disasters • Assistive services, agencies, and/or service animals may not be available to help maintain independence for those who are HOH, deaf, have visual impairments, or are blind.	• Follow Communication strategies to assist with identifying what is needed to help individuals, groups, and/or populations of diverse cultures or the LEP maintain their independence during and after the disaster. • Collaborate with responders and community agencies to provide the resources needed (during and after disasters), to those who are HOH, deaf, have visual impairments, or are blind to maintain their independence. • Collaborate with community leaders, cultural/religious leaders, and cultural brokers to identify needs and share/distribute information regarding available resources, especially to undocumented immigrants. • Provide food/water for low SES groups after a disaster, especially to those groups that receive aid before the disaster.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Assist in improving the resiliency of immigrants by working to help them stay connected to others of the same ethnicity/culture during and after a disaster. • Collaborate with agencies such as IDHS to provide social services and temporary funding to meet basic needs. • Link individuals with mental health resources that are culturally competent as needed and indicated. • Incorporate the following into the multi-agency resource center (MARC) process (this is a community meeting to link community members with available resources before disaster responders demobilize from the area): the utilization of interpreters (spoken and sign language), translation of written documents, use of large font on documents, and collaboration with community leaders, cultural/religious leaders, and cultural brokers to encourage community members to attend.
MASS FATALITY	• Cultural/religious considerations related to death rituals, cremation, autopsies, mass graves, etc. may conflict with legal obligations/investigative process • Collaboration with foreign embassies, or consulates may be needed	• Follow Communication strategies during mass fatality response that assists with identifying the cultural/religious considerations that exist and in explaining the legal obligations/investigative process. • Collaborate with community leaders, cultural/religious leaders, and cultural brokers to identify needs, share/ distribute information regarding the legal obligations/ investigative process and provide support to altering rituals based on the circumstances of the disaster. • Collaborate with cultural/religious/community leaders for guidance on disposition of remains and other cultural/religious considerations.

ATTACHMENT 2: DIVERSE CULTURES/LANGUAGE AND LITERACY FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Collaborate with embassies/consulates for assistance with identification of deceased, notification of next of kin, and transportation of remains to family. • Implement public messaging beyond the area of disaster (statewide/nationwide) to provide an avenue for distant friends/ family to contact authorities if concerned their family member(s) may have been in area of disaster or is missing. • Refer to the Illinois *Pandemic Influenza Preparedness and Response Plan: Fatality Management Annex* for additional information.

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

Economic disadvantage within this annex includes those who: have low, limited, and/or fixed income; live at or below the federal poverty level; have unstable or unsecure housing; live in public, government funded, government assisted, subsidized, low rent, and/or supportive services housing. Having an economic disadvantage before a disaster limits an individual or family's ability to respond during the disaster and comply with required actions (e.g. evacuation), or responders' recommendations and/or guidance (e.g. shelter in place). This lack of financial reserve and/or stable housing places the individual and their family at higher risk during and after a disaster. In addition, many times, those included in the Economic Disadvantage FAN category overlap with one or more other FAN categories such as having medical conditions and/or disabilities and/or having limited English proficiency (LEP). This only further hinders their ability to respond appropriately and protect themselves and their families during a disaster. According to the Centers for Disease Control and Prevention (CDC) Social Vulnerability Annex, just over 14% of the population in Illinois is below the poverty line with the two highest percentages of those living below the poverty level located in the Marion Region (most rural/least populated area) and EMS Region 11 (city of Chicago - most urban/most populated area) (CDC). Identification of high risk groups within communities or areas of the state prior to a disaster can facilitate/expedite the activation of resources to these areas during a disaster.

The table below outlines potential needs/issues for economic disadvantage individuals, groups and/or populations as well as strategies/ tactics that may assist in addressing their needs/issues. This list is not inclusive, and planners/responders should not assume that all the needs/issues are applicable to all individuals, groups, and/or populations that are economic disadvantage. Strategies/tactics should be tailored after assessing the specific needs of individuals or groups during the disaster/incident. In addition, there may be additional strategies/tactics that can be found in other sections of this plan that apply based on overlapping of the FAN/At-Risk Populations categories (e.g. Economic Disadvantage FAN category and Diverse Cultures/Language & Literacy FAN category). This annex and the strategies/tactics are not intended to nor capable of resolving the economic disadvantage that exists before a disaster. The goal is to identify those who may need additional resources and assistance during and after the response due to their pre-existing economic disadvantage.

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
COMMUNICATION	• Limited availability, unreliable, or no communication methods/tools • Limited English proficiency (LEP) • Lack of trust in government and/or the source of information • Inaccurate, inconsistent, delayed, and unreliable information or messaging	• Information/messaging should be sent through various and redundant methods (e.g. TV, radio, social media, text messaging, automatic phone calls). • Use alternate means of sharing messages (e.g. printed signs, existing electronic billboards, community broadcast systems, traffic alert signs, bullhorns, cell phone carriers' alert systems, commercial business' electronic signs, home monitored alarm/alert systems).

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Lack of familiarity regarding where to obtain accurate information • Difficulty communicating with written word related to reading comprehension, literacy skills, and/or education level	• Engage community center/agencies, faith-based organizations, existing Community Organization Information Networks (COIN), cultural leaders, and religious leaders to assist with information sharing and distribution. • Engage community resources that provide services to economic disadvantage groups (e.g. food pantries, soup kitchens, social service agencies) to share and distribute information as well as re-establish services as soon as possible after the disaster. • All written information/messages should be distributed in multiple formats at an appropriate reading comprehension level and include the use of symbols/pictures. • Information that should be provided includes but is not limited to: general incident, evacuation, shelter-in-place, location of shelters, transportation resources, facilities to obtain care or assistance, potential impact of secondary hazards, family reunification process, food and water safety, public health protection, emergency closures or detour notices, closure notices, community meetings, process to report damage, consumer protection issues, curfew and curfew related restrictions, and any other health/safety/security information. • During the MARC (community meeting to link community members with available resources before disaster responders demobilize from the area), collaborate with community leaders to distribute alerts about the meeting to community members so they can attend.

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
TRANSPORTATION	• Limited or lack of resources to self-evacuate, relocate, or travel to dispensing sites (e.g. do not drive, do not have a reliable vehicle, rely on public transportation or do not have money for gas, rely on friends/family for transportation) • Limited or lack of resources to return to their home area after evacuating/relocating • Resistance to evacuate/relocate • Lack of awareness of the need to evacuate/ relocate and transportation resource availability • Lack of trust in government, law enforcement, or other agency issuing evacuation order, providing transportation, and arranging relocation • Alternative or non-traditional transportation resource(s) needed due to medical and/or mobility issues	• Follow Communication strategies to assist with distributing information about transportation resources • Provide transportation to assist with evacuating/ relocating/traveling to dispensing sites as well as returning to home area after disaster. • Work with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), Illinois Emergency Management Agency (IEMA), National Disaster Medical Services (NDMS), Mutual Aid Box Alarm System (MABAS), forestry agencies, school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/ community centers/senior centers, and ambulance companies to assist. • Collaborate with community leaders to alleviate fears. • Provide information to all those being evacuated/relocated regarding the destination of the transportation vehicles. • Collaborate with mass/public transportation agencies to adjust/waive the cost for riders during disasters, especially during evacuations.
SAFETY/SUPERVISION	• Family composition may not align with traditional and legal definitions • Extended family sharing living quarters • Assistive services, agencies, and/or service animals may not be available for those who depend on such services. • Closures of child care centers/schools will likely prevent or limit parents from working	• Follow communication strategies to assist with obtaining and distributing information. • Collaborate with the Illinois Department of Education (schools), IDHS, and IL DCFS (for child care centers) to reopen schools and child care centers as soon as possible after a disaster and identify alternate locations as needed.

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• During evacuation/relocation of members of a community, utilize tracking systems (e.g. EMTrack as available) to assist with reunification. • If extended families that share living quarters need to be separated during a disaster, ensure parents/guardians are kept together with their children. • Communicate with Incident Command when individuals or groups are identified that require additional staff to provide care and/or safety/supervision.
MEDICAL CARE	• Limited, inconsistent, or lack of access to medical care before a disaster • Family composition may not align with traditional and legal definitions and lead to difficulty with providing consent for medical care • Economic conflicts with recommended care (e.g. vaccination or prophylaxis medications) • Lack of trust in government or entities providing medical care, prophylaxis, or vaccinations • Lack of stockpile of medications and treatments • Not compliant with recommended treatment regimens • May present or become more acutely ill quicker during a disaster due to unmanaged chronic medical conditions	• Collaborate with families, social service agencies (e.g. DCFS, Illinois Department of Aging {IDOA}), law enforcement, and health care facilities as indicated and required to identify who is responsible for caring for children and adults who are unable to make their own medical decisions. • Collaborate with the community leaders to alleviate fears, share and distribute information, and encourage use of medical resources. • Collaborate with agencies such as the Illinois Primary Health Care Association (IPHCA) and Federal Qualified Health Centers (FQHC) to provide care during disasters (e.g. vaccinations, mass prophylaxis) and to share and distribute information. • Collaborate with trusted health care providers (e.g. Parish Nurses) to assist with sharing and distributing information and bringing recommended treatments to isolated communities. • Assist local health departments (LHD) with implementing their policies to provide medications during mass prophylaxis.

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Establish a screening/triage process to identify those with chronic conditions and those with acute medical conditions and link them to the appropriate services/resources (hospital {for acutely ill only}, clinics, community health services, outpatient pharmacies, outpatient medical stations). • Collaborate with regional health care coordinating centers (RHCCs) and Regional Health Care Coalitions (HCC) to obtain available equipment/supplies to assist with providing medical care. • See *Attachment 6: Medical Conditions and Disabilities FAN Category* for additional strategies/tactics.
SHELTERING	• Lack of awareness of shelter location • Lack of trust in shelter organizers • Assistance with housing/sheltering will extend beyond the disaster • Extended family sharing living quarters presents challenges to provide housing for whole family in one location • Often live in disaster prone areas and limited resources to rebuild/repair own homes	• Follow communication strategies to assist with: distributing information about shelters; identifying and addressing needs/concerns when entering shelters; and sharing information with those within the shelters. • Bring information about resources, disaster relief and reimbursement to the shelter(s). • Establish the goals and limitations of shelter assistance at the time the service is being offered to ensure clear understanding and reasonable expectations (e.g. evacuation shelters are short term, disaster housing assistance will not solve housing issues that existed prior to the disaster). • Collaborate with faith-based community, non-governmental organizations and other groups that can provide assistance with rebuilding/repairing home after disasters. • The American Red Cross (ARC) has a process to collaborate with community agencies to adapt shelters to

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		meet identified needs as well as promote individuals from various ethnic groups and those that have FAN to volunteer. This process promotes trust in those needing to utilize shelters during disasters.
MAINTAINING INDEPENDENCE	• Less financial reserve to be able to maintain their independence for any significant period of time during the disaster event as well as the recovery phase • Difficulty planning for emergencies/ disasters when they encounter challenges on a day-to-day basis to secure adequate food and other basic needs • Limited to no stockpile of food, water, and/or medications • Assistive services and agencies may not be available to help maintain independence (e.g. closed food pantries during disasters)	• Follow communication strategies to assist with identifying what is needed to help the economic disadvantage maintain their independence during and after the disaster. • Collaborate with responders and community agencies to provide the resources needed to those who use them before disasters to maintain their independence during and after an event. • Provide food/water for those individuals and families that receive aid before the disaster. • Collaborate with agencies such as IDHS to provide social services and temporary funding to meet basic needs. • Link individuals with mental health resources as needed and indicated. • During the multi-agency resource center (MARC) (community meeting to link community members with available resources before disaster responders demobilize from the area), collaborate with community leaders and cultural/religious leaders to inform and encourage community members to attend.
MASS FATALITY	• Limited or lack of financial resources to cover funeral arrangements, etc., especially if more than one family member died in the disaster	• Follow communication strategies during mass fatality response to assist in identifying the cultural/religious considerations that exist and in explaining the legal obligations/investigative process.

ATTACHMENT 3: ECONOMIC DISADVANTAGE FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Cultural/religious considerations related to death rituals, cremation, autopsies, mass graves, etc. may conflict with legal obligations/investigative process	• Collaborate with community leaders and cultural/religious leaders to identify needs, share/distribute information regarding the legal obligations/investigative process and provide support to altering rituals based on the circumstances of the disaster. • Collaborate with cultural/religious/community leaders for guidance on disposition of remains and available financial assistance for death rituals. • Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Refer to the Illinois *Pandemic Influenza Preparedness and Response Plan: Fatality Management Annex* for additional information.

ATTACHMENT 4: INSTITUTIONALIZED SETTINGS/CONGREGATE CARE FAN/AT-RISK POPULATION

There are numerous residential facilities that exist in Illinois. Each type of facility offers specialized services to meet the unique needs of its clients. Most clients that reside in and utilize these types of facilities have a functional and access need such as a chronic medical, physical, or mental health condition. However, clients in these Illinois facilities fall under the scope of this annex regardless of any pre-existing conditions. Below is a list of the types of residential facilities within Illinois with a summary of the services they offer, as well as an example. Most of these facilities are regulated by one of the following state agencies: Illinois Department of Public Health (IDPH), Illinois Department of Human Services (IDHS), Illinois Department of Aging (IDOA), Illinois Department of Corrections (IDOC), Illinois Department of Juvenile Justice (IDJJ), Illinois Department of Children and Family Services (DCFS), or the Illinois Department of Healthcare and Family Services (IHFS). Note that DCFS provides oversight at any of the below facilities in which a child may be residing. The abbreviation for the agency that regulates the facility can be found bolded and in parentheses after the facility type. For more detailed information about each type of facility, please refer to the end of this attachment.

- Assisted living establishment: **(IDPH)** A home, building, residence, or any other place for three or more unrelated adults that provides single-occupancy living units with small kitchen appliances, sleeping accommodations, private toilet and washing facilities, and private or common bathing facilities. Intermittent health related services are available 24 hours a day. At least 80% of the residents are aged 55 years or older.
- Congregate care: Licensed or approved residential settings that provide 24-hour care for children in a group home or an institution. These settings may include a child care institution, a residential treatment facility, or a maternity home. Examples include: Long Term Care Under-22 (LTC U-22) **(IDHS)**; child group homes specializing in mental health, DCFS group residential home **(DCFS)**, and juvenile detention centers **(IDJJ)**.
- Detention and Correctional Facilities: Examples of these facilities include juvenile detention centers **(IDJJ)**, correctional facilities **(IDOC)**, prisons **(IDOC)**, and treatment and detention facilities (TDF) **(IDHS)**.
- Shared housing establishment: **(IDOA)** Publicly or privately-operated freestanding residence for 16 or fewer persons unrelated to the facility owners and/or managers. Shared housing provides the same services as assisted living. At least 80% of the residents are aged 55 years or older.
- Sheltered care facilities: **(IDHS and IDPH)** Residence that provides maintenance and personal care including food, shelter, and general supervision for an individual who is incapable of maintaining a residence or managing his own person. Routine nursing or health care is provided.
- Supportive living facilities (SLF): Residential settings that provide or coordinate personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services.
  - Intermediate care facilities for the developmentally disabled (ID/DD) **(IDHS, IDPH)**
  - State operating developmental centers (SODC) **(IDHS)**
  - Community independent living arrangements (CILA) **(IDHS)**
  - Long-term residential mental health care **(IDHS)**

- Long-term care facilities **(IDPH, IDHS, IDOA)**
- Residential treatment centers for addictions **(IDHS)**
- Hospice centers homes **(IDPH)**
- Specialized mental health rehabilitation facilities (SMHRF) **(IDHS)**

Within the hospital setting, there may be units or services that address the needs of FAN populations.

Each of the agencies that oversee these facilities has an intra-agency disaster plan that outlines how it will respond during a disaster. These plans should include components that address communication, transportation, safety/supervision, medical care, sheltering, maintaining independence, and mass fatality for the FAN/At-Risk Populations that are served by the agency. Outlining these processes here is beyond the scope of this annex. The role of IDPH and other health care agencies and responders is to assist and support these types of facilities in caring for their populations as requested within the scope that is outlined in the *Illinois Emergency Operations Plan (IEOP)* and the *IDPH ESF-8 Plan* (including but not limited to providing health and medical resources).

The other Attachments within this annex can assist IDPH, other health care agencies, and the agencies that oversee these facilities with addressing the needs of individuals that reside in the facilities or as these individuals integrate into the health and medical system. For example, if residents from a supportive care facility need to seek medical treatment at a hospital, alternate care site (ACS), or temporary medical treatment site (TMTS), the Attachments in this annex can help responders identify needs based on the individual (e.g. for an older adult with LEP that resides in a long-term care facility, access *Attachment 1: Age FAN Category* and *Attachment 2: Diverse Cultures/Language & Literacy FAN Category*).

Each of the agencies that oversee these facilities are integrated into the state emergency operations center (SEOC). Therefore, the SEOC liaisons for each agency, including IDPH, can communicate directly with each other to identify resource needs and availability to assist in meeting the needs of this FAN/At-Risk Population.

ATTACHMENT 4: INSTITUTIONALIZED SETTINGS/CONGREGATE CARE FAN/AT-RISK POPULATION

Definitions

Assisted Living Establishment: A home, building, residence, or any other place where sleeping accommodations are provided for at least three unrelated adults, at least 80% of whom are 55 years of age or older and where the following are provided consistent with the purposes of the Act:

1. Services consistent with a social model that is based on the premise that the resident's unit in assisted living and shared housing is his or her own home; community-based residential care for persons who need assistance with activities of daily living, including personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.
2. Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment, with the consent of the resident or resident's representative.
3. A physical environment that is a homelike setting that includes the following and such other elements as established by the Department: individual living units each of which shall accommodate small kitchen appliances and contain private bathing, washing, and toilet facilities, or private washing and toilet facilities with a common bathing room readily accessible to each resident. Units shall be maintained for single occupancy except in cases in which 2 residents choose to share a unit. Sufficient common space shall exist to permit individual and group activities.

Community Independent Living Arrangements: This is a living arrangement for adults (age 18 and older) in a group home, family home or apartment where 8 or fewer unrelated adults with developmental disabilities live under supervision of the community developmental services agency. Residents receive complete and individualized residential habilitation, personal support services, and supports under the direction of a community support team within the local agency.

Congregate Care: These are licensed or approved settings that include group homes, residential treatment facilities, psychiatric institutions, and emergency shelters. Placement into this type of facility may also be used for children who require short term supervision and structure.

Correctional Centers: The Illinois Department of Corrections operates and oversees adult correctional centers within our state as well as boot camps, work camps and adult transition centers. Each has a defined operational population capacity as well as an assigned security level (e.g. Medium Security Adult Male; Minimum Security Adult Female). The living units typically consist of housing units, receiving and orientation units, segregation units and a multi-bed health care unit. All facilities strive to provide a safe and humane environment for offenders, and offer access to program opportunities that are designed to assist inmates in bettering themselves and preparing for life in the community upon release. Women's Facilities provide a continuum of programs and services

to help female offenders reestablish and strengthen their relationship with their children and enhance their ability to grow within the family structure.

Hospice Center Homes: A hospice is a public agency or private organization, or a subdivision of either of those, that is primarily engaged in providing care to terminally ill individuals through a program of home care or inpatient care, or both home care and inpatient care, utilizing a medically directed interdisciplinary hospice care team of professionals or volunteers, or both professionals and volunteers. A hospice program may be licensed as a comprehensive hospice program or a volunteer hospice program. A Hospice Residence is a separately licensed home, apartment building, or similar building providing living quarters: that is owned or operated by a person licensed to operate as a comprehensive hospice; and at which hospice services are provided to facility residents.

Intermediate Care Facilities for the Developmentally Disabled: A facility that serves clients with developmental disabilities. Developmental disability is defined as a severe, chronic disability of a person which:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments
2. Is manifested before the person attains age 22
3. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
    a. self-care
    b. receptive and expressive language
    c. learning
    d. mobility
    e. self-direction
    f. capacity for independent living
    g. economic self-sufficiency
4. Reflects the person’s need for combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended durations and are individually planned and coordinated.

Juvenile Detention Centers: These facilities provide a safe and restricted environment for juveniles (age 13 - 20) who have been adjudicated and/or committed for a set period of time, detained on a short-term basis while awaiting completion of the court process or placement in a long-term care program. Health services are available and staffed during normal working hours. If a health emergency need arises after working hours, the Juvenile Detention Centers utilize the local hospital to provide any emergency health services required. Any specialized care that is required is facilitated by the facility by transport to the prescribed medical professional's office or clinic. These facilities also provide individualized programming to meet the needs of each youth, such as education and vocational training, substance abuse treatment programs, mental health services, medical services, leisure time activities, assessments, parenting group and family engagement programs.

ATTACHMENT 4: INSTITUTIONALIZED SETTINGS/CONGREGATE CARE FAN/AT-RISK POPULATION

Long-Term Care Facilities: "Facility" or "long-term care facility" means a private home, institution, building, residence, or any other place, whether operated for profit or not, or a county home for the infirm and chronically ill operated pursuant to Division 5-21 or 5-22 of the Counties Code, or any similar institution operated by a political subdivision of the State of Illinois, which provides, through its ownership or management, personal care, sheltered care or nursing for 3 or more persons, not related to the applicant or owner by blood or marriage. It includes skilled nursing facilities and intermediate care facilities as those terms are defined in Title XVIII and Title XIX of the federal Social Security Act. It also includes homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs. "Facility" does not include the following:

1. A home, institution, or other place operated by the federal government or agency thereof, or by the State of Illinois, other than homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs.
2. A hospital, sanitarium, or other institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation as organized facilities therefor, which is required to be licensed under the Hospital Licensing Act.
3. Any "facility for child care" as defined in the Child Care Act of 1969.
4. Any "Community Living Facility" as defined in the Community Living Facilities Licensing Act.
5. Any "community residential alternative" as defined in the Community Residential Alternatives Licensing Act.
6. Any nursing home or sanatorium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination. However, such nursing home or sanatorium shall comply with all local laws and rules relating to sanitation and safety.
7. Any facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act.
8. Any "Supportive Residence" licensed under the Supportive Residences Licensing Act.
9. Any "supportive living facility" in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01.
10. Any assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act, except only for purposes of the employment of persons in accordance with Section 3-206.01.
11. An Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act.
12. A facility licensed under the ID/DD Community Care Act.
13. A facility licensed under the Specialized Mental Health Rehabilitation Act of 2013.
14. A facility licensed under the MC/DD Act.
15. A medical foster home, as defined in 38 CFR 17.73, that is under the oversight of

Long-Term Residential Mental Health Care: The Mental Health Division operates nine psychiatric hospitals for adults. The hospitals providing mental health inpatient treatment for adults are located throughout the state and work closely with the community mental health agencies and community hospital psychiatric units in their region. The exception is Chester Mental Health Center, which provides a maximum-security treatment setting for individuals sent by the criminal courts or who are in need of more intensive behavior modification services.

Residential Treatment Centers for Addictions: These are licensed, accredited centers that provide adults and adolescents with short-term and long-term residential services. Short-term residential programs provide intensive but relatively brief treatment, typically based on a modified 12-step approach. These programs help to reduce the risk of relapse once a patient leaves the residential setting. Long-term residential treatment provides care 24 hours a day that includes a wide range of services and treatments, generally in a non-hospital setting.

Shared Housing Establishment: A publicly or privately operated free-standing residence for 16 or fewer persons, at least 80% of whom are 55 years of age or older and who are unrelated to the owners and one manager of the residence, where the following are provided:

1. Services consistent with a social model that is based on the premise that the resident's unit is his or her own home
2. Community-based residential care for persons who need assistance with activities of daily living, including housing and personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.
3. Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment, with the consent of the resident or the resident's representative.

Sheltered Care Facilities: A facility that provides maintenance and personal care. Maintenance is defined as food, shelter, and laundry services. Personal care is defined as assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual.
Specialized Mental Health Rehabilitation Facilities: A specialized mental health rehabilitation facility (SMHRF) that provides at least one of the following services: triage center; crisis stabilization; recovery and rehabilitation supports; or transitional living units for 3 or more persons. The facility shall provide a 24-hour program that provides intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. It includes facilities that meet the following criteria:

1. 100% of the consumer population of the facility has a diagnosis of serious mental illness.
2. No more than 15% of the consumer population of the facility is 65 years of age or older.

3. None of the consumers are non-ambulatory.
4. None of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability.
5. The facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding the effective date of the Act and qualifies as an institute for mental disease under the federal definition of the term.

<u>Supportive Living Facilities:</u> Affordable assisted living model that offers elderly (65 and older) or persons with physical disabilities (22 and older) home and community-based services as an alternative to nursing facility placement. Residents choose from the following menu of services that are provided by the facility:

1. Intermittent nursing care
2. Social/recreational programming
3. Health promotion and exercise programs
4. Medication oversight
5. Ancillary services
6. 24-hour response/security
7. Personal care
8. Laundry
9. Housekeeping
10. Maintenance
11. Meals and snacks

<u>State Operating Developmental Centers:</u> A facility that serves clients with developmental disabilities. Developmental disability is defined as a severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental and physical impairments
2. is manifested before the person attains age 22
3. results in substantial functional limitations in 3 or more of the following area of major life activity:
   a. self-care
   b. receptive and expressive language
   c. learning
   d. mobility
   e. self-direction
   f. capacity for independent living
   g. economic self-sufficiency

4. Reflects the person's need for combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended durations and are individually planned and coordinated.

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

The Isolation FAN/At-Risk Population category includes social isolation, temporary residents, cultural isolation, and geographic isolation. The following are some examples of individuals, groups, and/or populations within Illinois that may be experiencing one or more of these types of isolation before a disaster and therefore, may need additional or tailored assistance to improve equity in access to disaster services and resources.

- Social isolation: Homebound; homeless; individuals without extended family and/or that live alone; single parents; sole caregiver for someone with FAN; individuals who reside within correctional facilities/institutionalized/congregate care settings; individuals living in remote and/or rural areas with limited, inconsistent, or no access to media; low-income population; commune and/or individuals or groups living off the grid; victims of human trafficking/domestic violence.
- Temporary residents: Homeless; undocumented immigrants, seasonal or temporary populations, and those in temporary locations; seasonal tourists, residents, and workers (including migrant workers); individuals isolated by recreational activity (e.g., primitive campers or backpackers); campers and staff at residential summer camps; students, teachers, administrators, and employees at schools, universities, and boarding schools; visitors and/or students from other countries; individuals living in shelters (e.g. homeless, runaways, or domestic abuse); individuals displaced by a disaster; disaster relief volunteers; military personnel and their families; transportation workers (e.g. truckers, pilots, railroad engineers, etc.); low-income and/or those living below the poverty line; traveler and/or transient populations.
- Cultural isolation: Ethnic groups; religious communities (e.g., Amish, Mennonite); low-income and/or those living below the poverty line; seasonal migrant workers; commune and/or individuals or groups living off the grid; traveler and/or transient population.
- Geographic isolation: Individuals living in remote and/or rural areas with limited, inconsistent, or no access to media.

The table below outlines potential needs/issues for isolated individuals, groups and/or populations as well as strategies/tactics that may assist in addressing their needs/issues. This list is not inclusive, and planners/responders should not assume that all the needs/issues are applicable to all isolated individuals, groups, and/or populations. Strategies/tactics should be tailored after assessing the specific needs of individuals or groups during the disaster/incident. In addition, there may be additional strategies/tactics that can be found in other sections of this plan that apply based on overlapping of the FAN/At-Risk Populations categories (e.g. Cultural Isolation and Diverse Cultures/Language & Literacy FAN category).

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
COMMUNICATION	• Limited availability, unreliable, or no communication methods/tools • Limited English proficiency (LEP) or does not speak English • Cultural context of language used in messaging • Lack of trust in government and/or the source of information • Inaccurate, inconsistent, and unreliable information or messaging • Lack of familiarity with where to obtain accurate information • Inability to communicate or receive information due to effects of disaster; delays in receiving information • Physical and/or medical barriers to communicate • Follow hierarchal structure among cultural and/or religious groups • Difficulty identifying the location of individuals, groups, and/or populations to share information or send messages • Need to collaborate with multiple entities required (e.g. civilian/military, domestic agencies/ foreign embassies, or consulates)	• Information/messaging should be sent through various and redundant methods (e.g. TV, radio, social media, text messaging, automatic phone calls). • Information/messages should be distributed in languages known to be spoken in the area of the disaster. The messages should be reviewed for any word choices that may create a cultural/dialect context conflict. • Use alternate means of sharing messages (e.g. printed signs, existing electronic billboards, community broadcast systems, traffic alert signs, bullhorns, cell phone carriers' alert systems, commercial business' electronic signs, home monitored alarm/alert systems). • Engage faith-based organizations, existing Community Organization Information Networks (COIN), cultural leaders, and religious leaders to assist with information sharing and distribution. • Engage community resources that provide services to isolated groups (e.g. food pantries, soup kitchens, homeless agencies) to share and distribute information. • Engage embassies/consulates to assist with information sharing and distribution and to identify additional needs • Engage local law enforcement (LE), EMS, fire departments, universities, schools with international studies departments, forestry service, park services, and other agencies to share and distribute information.
TRANSPORTATION	• Limited or lack of resources to self-evacuate/relocate • Need to travel greater distances out of rural and/or isolated areas	• Follow Communication strategies to assist with distributing information about transportation resources.

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Resistance to evacuate/relocate • Alternative or non-traditional transportation resource(s) needed due to medical and/or mobility issues • Difficulty in identifying the location of individuals/groups/populations to identify transportation needs • Lack of awareness of: need to evacuate/ relocate; transportation resource availability; resources to assist once relocated (perceived or actual) • Collaboration with multiple entities required (e.g. civilian/military, domestic agencies/ foreign embassies, or consulates) • Group hierarchy and decision-making process among cultural and/or religious groups • Cultural/religious restrictions • Additional resources required to evacuate and later return to area • Lack of familiarity with area to know how to self-evacuate/relocate • Inability to evacuate/relocate due to effects of the disaster	• Provide transportation to assist with evacuating/relocating/ traveling to dispensing sites, as well as return to home area after a disaster. • Work with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), Illinois Emergency Management Agency (IEMA), National Disaster Medical Services (NDMS), Mutual Aid Box Alarm System (MABAS), forestry agencies, school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/ community centers/senior centers, and ambulance companies to assist. • Utilize the case management approach to managing transportation needs such as: various types of vehicles that may be needed; identifying appropriate locations to transport to that best fits the needs of the individual, group, and/or population; additional belongings, animals, vehicles, etc. that may need to accompany the individual, group and/or population; and need to assist with transportation back to home area after disaster. • Coordinate with embassies/consulates to assist with transportation needed outside of the U.S. • Coordinate within the hierarchy of cultural/religious groups and their leaders to help identify specific alternative transportation methods that may be needed. • Collaborate with responders and law enforcement for next steps if individuals/groups refuse to evacuate/relocate during mandatory evacuation orders.
SAFETY/SUPERVISION	• Difficult to identify and provide needed safety/supervision resources	• Follow Communication strategies to assist with obtaining information on caregiver needs.

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Collaboration with multiple entities required (e.g. Illinois Department of Corrections {IDOC}) • Cultural/religious considerations • Medical and/or cognitive considerations • Resistance to comply with safety or supervision measures • Additional resources required to address needs of individual with FAN and their caregiver • Group hierarchy and decision-making process among cultural and/or religious groups • Alternative processes required to assess needs	• If the primary caregiver is present with the individual or group, keep the caregiver with them if possible, especially parents with their children. • Implement a screening process at points of contact to identify those who may need assistance (either as an individual with FAN or the caregiver of an individual with FAN). • Implement a process to check on the status of and assist those identified FAN individuals/groups that are sheltering in place. • Assign appropriate staff, volunteers, or other responders to help those requesting or are in need of assistance (e.g. mental health agencies, home health agencies, faith-based organizations, advocacy groups, social services). • Coordinate with utility companies to ensure known individuals with FAN receive high priority for repairs to utility systems. • Link military families with identified needs to military services. • Coordinate within the hierarchy of cultural/religious groups and their leaders to help identify those needing assistance before, during, and after a disaster. • Staff should accompany individuals or groups from institutionalized settings/group living facilities, including detention centers, and maintain responsibility for these individuals per intra-agency protocols. • Communicate with Incident Command when individuals or groups are identified that require

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		additional staff to provide care and/or safety/supervision.
MEDICAL CARE	• Limited, inconsistent, or lack of access to care before disaster • Difficult to obtain medical history/medical records • Reliance on medical equipment and medications • Lack of stockpile of medications and treatments • Not compliant with recommended treatment regimens	• Collaborate with the community leaders to alleviate fears, share and distribute information, and encourage use of medical resources. • Collaborate with agencies such as the Illinois Primary Health Care Association (IPHCA) and Federal Qualified Health Centers (FQHC) to provide care during disasters (e.g. vaccinations, mass prophylaxis) and to share and distribute information. • Collaborate with trusted health care providers (e.g. Parish Nurses) to assist with sharing and distributing information and bringing recommended treatments to isolated communities. • Assist local health departments (LHD) with implementing their policies to provide medications during mass prophylaxis. • See *Attachment 6: Medical Conditions and Disabilities FAN Category* for strategies and tactics.
SHELTERING	• Resistance to utilizing shelters • Lack of awareness of shelter location(s) • Lack of trust in shelter organizers • Fear/anxiety • Cultural and religious considerations • Difficulty complying with shelter rules • Additional space requirements • Prefer to shelter in place rather than relocate to a disaster/evacuation shelter	• Follow Communication strategies to assist with: distributing information about shelters; identifying and addressing needs/concerns when entering shelters; and sharing information with those within the shelters. • Establish the goals and limitations of shelter assistance at the time the service is being offered to ensure clear understanding and reasonable expectations (e.g. evacuation shelters are short term, disaster housing assistance will not solve housing issues that existed prior to the disaster).

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Higher incidence of mental/behavioral health needs in homeless populations	• Collaborate with local health departments (LHDs) to establish medical and mental health surveillance systems as well as isolation precautions as indicated and applicable. • Collaborate with law enforcement and shelter organizers to ensure safety and security within shelters. • Collaborate with community leaders, advocacy groups, and cultural/religious leaders to identify and address barriers to shelter utilization. • Collaborate with shelter organizers (e.g. American Red Cross) to provide available resources to accommodate specific needs/issues if possible. • Identify and connect individuals or groups with community resources to provide additional long term sheltering as needed when the evacuation shelter closes • Assist those being monitored by the Illinois Department of Corrections (e.g. those on house arrest) with contacting the authorities to verify their presence in the shelter.
MAINTAINING INDEPENDENCE	• Resistant to the loss of any degree of independence • Difficult to assess what is needed to maintain independence	• Follow Communication strategies to assist with identifying what is needed to help isolated individuals, groups, and/or populations maintain their independence during and after the disaster. • Collaborate with responders and community agencies to provide the resources needed to help isolated individuals, groups, and/or populations maintain their independence during and after disasters. • Facilitate access to basic supplies and healthcare resources as available (e.g. deliver food, water, and/or

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		additional medication/supplies in order to shelter in place). • Link individuals with mental health resources as needed and indicated. • Collaborate with distant family, embassies/consulates, employers, and other sources to assist with addressing the needs of isolated individuals, groups, and/or populations. • Assist those being monitored by Department of Corrections (e.g. those on house arrest) with contacting the authorities to verify their location as applicable.
MASS FATALITY	• Delay in being reported as missing • Difficulty identifying remains • Difficulty locating next of kin • Cultural/religious considerations • Collaboration with multiple entities required (e.g. civilian/military, domestic agencies/ foreign embassies, or consulates)	• Collaborate with local law enforcement, cultural/religious/ community leaders, advocacy groups, home health agencies, food pantries/soup kitchens, and other groups to assist with identification of deceased and next of kin. • Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Collaborate with cultural/religious/community leaders for guidance on disposition of remains and other cultural/ religious considerations. • Collaborate with embassies/consulates for assistance with identification of deceased, notification of next of kin, and transportation of remains to family. • Implement public messaging beyond the area of disaster (statewide/nationwide) to provide an avenue for distant friends/family to contact authorities if concerned their family member may have been in the area of disaster or is missing.

ATTACHMENT 5: ISOLATION FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Refer to the Illinois *Pandemic Influenza Preparedness and Response Plan: Fatality Management Annex* for additional information.

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

Typically, medical issues and disabilities are categorized by whether the disability or issues causes a cognitive, physical, mental, or sensory impairment. However, within this annex, the Medical Conditions and Disabilities FAN Category is further divided into the following sub-categories: cognitive impairments, mobility impairments, chronic diseases/conditions, acute or temporary diseases/conditions, and dependency on technology, medications, durable medical equipment and/or electricity for medical diseases/conditions. Below are specific examples of conditions or types of individuals within each of the subcategories:

- Cognitive impairment: Behavioral health and/or emotional disturbances (e.g. mental illness, substance abuse, drug/alcohol dependency, severe depression, or other mental illness that leaves the individual unable to follow directions and/or display aggressive behavior); and developmental, intellectual, learning and/or speech or language impairments (e.g. autism, sub-average level of intellectual functioning with IQ<75, inability to understand and use language skills, reduced vocabulary, traumatic brain injuries).
- Mobility impairment: Physical impairment(s) that interfere with an individual's ability to move one or more of their extremities (e.g. amputated limb, cerebral palsy, unable to ambulate, individuals with a history of stroke with unilateral paralysis, paraplegic).
- Chronic diseases/conditions: Persistent illness, disease, or condition lasting for greater than one year (e.g. HIV/AIDS, kidney failure, chronic pain, visually impaired, blind or those who would be visually impaired without their glasses/contacts, hard of hearing or deaf, bariatric patients).
- Acute or temporary diseases/conditions: Illness, disease, or condition that may cause functional limitations, but the limitations are transient and for shorter duration (typically less than 6 months), e.g. fractured extremity(ies), recent surgeries such as orthopedic or cardiac, pregnancy, or infectious conditions (especially those related to the disaster i.e. pandemic influenza).
- Dependency on technology, medications, durable medical equipment (DME) and or electricity for medical diseases/conditions: Individuals that require medications, equipment, or other devices/services to manage their chronic diseases/conditions (e.g. oxygen dependent, renal dialysis, glucometer for diabetics, ventilator dependent, wheelchair bound).

There may be significant overlap between these five categories. For example, those with a cognitive impairment would also have a chronic condition and depend on medications to treat the condition. These defined categories are used, despite the overlap, to provide greater focus during planning so additional or tailored assistance during the response can be given to improve equity in access to disaster services and resources.

The table below outlines potential needs/issues for those individuals with medical conditions and disabilities as well as strategies/tactics that may assist in addressing their needs/issues. This list is not inclusive, and planners/responders should not assume that all the needs/issues are applicable to all individuals with medical conditions or disabilities. Strategies/tactics should be tailored after assessing the specific needs of individuals during the disaster/incident. In addition, there may be additional strategies/tactics that can be found in other sections of this plan that apply based on overlapping of the FAN/At-Risk Populations categories (e.g. Medical Conditions and Disabilities FAN category and Economic Disadvantage FAN category).

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
COMMUNICATION	• Physical, medical, and/or cognitive barriers to hearing/seeing, processing/comprehending, and responding to information and communications • Limited English proficiency (LEP) • Unable to or difficulty with providing information (e.g. personal information, medical information, family contact information) • Require additional time to share and process information	• Use alternate and redundant means of sharing information and communicating (e.g. large print, written and verbal, use of pen/paper, picture boards, communication devices, Braille). • Interpreters for spoken language and sign language should be used. • Tailor messages/information based on the needs of the individual. Simplified, short messages may prevent sensory overload and improve understanding. • Collaborate with primary caregiver if available to identify most effective way(s) to communicate with the individual. • All written information/messages should be distributed in multiple formats at an appropriate reading comprehension level and include the use of symbols/pictures, and large font. • Information that should be provided includes but is not limited to: general incident, evacuation, shelter-in-place, location of shelters, transportation resources, facilities to obtain care or assistance, potential impact of secondary hazards, family reunification process, food and water safety, public health protection, emergency closures or detour notices, closure notices, community meetings, process to report damage, consumer protection issues, curfew and curfew related restrictions, and any other health/safety/security information.

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
TRANSPORTATION	• Physical, medical, and/or cognitive barriers to self-evacuation, relocation, and travel to dispensing sites • Does not utilize mobility aids at home but will need devices in other locations • Alternative or non-traditional transportation resource(s) needed due to medical and/or mobility issues • Requires additional space in transportation vehicles to accommodate caregiver, equipment, devices, belongings, service animals, comfort animals • Requires additional time to process information, follow instructions, and respond • Additional resources required to evacuate and later return to home area • Additional resources required to transport to receive care (e.g. dialysis) • Resistance to evacuate or relocate	• Follow communication strategies to assist with distributing information about transportation resources. • Provide transportation to assist with evacuating/ relocating/ traveling to dispensing sites as well as returning to home area after a disaster. • Work with agencies such as public transportation agencies, Illinois Department of Transportation (IDOT), Illinois Emergency Management Agency (IEMA), National Disaster Medical Services (NDMS), Mutual Aid Box Alarm System (MABAS), forestry agencies, school bus companies, charter bus companies, companies with wheelchair accessible vans/cars/buses, churches/ community centers/senior centers, and ambulance companies to assist. • Provide information to all those being evacuated regarding the destination of transportation vehicles. • Transport smaller groups of people together to accommodate medical, isolation needs, and/or cognitive issues, especially those with sensory overload. • Provide additional staff/responders to assist with providing greater safety/supervision and support, as indicated and available during transport. • Implement a process to determine if the method of transport is appropriate for the individual (e.g. ability to use medical equipment during transport, inability to sit for long periods of time, presence of service animals, need for isolation for immunocompromised individuals).

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Implement safety and security measures during transport (e.g. ability to secure the individual in the vehicle, check for contraband). • Implement a process to screen/triage for medical issues that occur during transport and identify the appropriate care for those issues.
SAFETY/SUPERVISION	• Caregiver may be separated from the FAN individual • Assistive services, agencies, and/or service animals may not be available • Legal considerations such as power of attorney/decision making authority/ guardianship, and living wills as well as access to corresponding documentation	• Follow communication strategies to assist with obtaining and distributing information. • Keep caregiver with patient. • Collaborate with families, social services (e.g. IDOA, DCFS), schools, child care centers, health care facilities, long-term care facilities, and law enforcement to: provide documentation on power of attorney/decision making/guardianship and living wills; identify who is responsible for the care of an individual who is unable to make their own decisions; identify alternate caregivers if the parent/guardian is injured/ill or goes into labor and is unable to care for their other children. • Provide additional staff/responders as needed and requested to assist with care if the primary caregiver is unavailable (e.g. home health agencies, medical staffing agencies, disaster medical teams, staff from assisted living and long-term care facilities, schools with special education programs, child care centers). • Cohort individuals together as indicated and applicable to assist with staffing requirements.
MEDICAL CARE	• Individual does not have a stockpile of their medications or treatments	• Establish a screening/triage process to identify those with chronic conditions and those with acute medical and psychiatric conditions and link them to the

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Individual does not have their needed equipment, medications, and/or treatments with them • Caregiver or individual refuses recommended care/treatment (e.g. mass prophylaxis or vaccinations) • Recommended care (e.g. mass prophylaxis or vaccinations) is contraindicated • Individual is experiencing an exacerbation of their chronic illness/condition • Individual is experiencing an acute mental/behavioral health episode • Individual is experiencing withdrawal from drugs and/or alcohol • Specialized treatments for conditions/illnesses are dependent on external resources (e.g. dialysis, chemotherapy, physical therapy, prenatal care) • Pregnant woman goes into labor or develops pre-labor/perinatal complications	appropriate services/resources (hospitals {for acute medical or psychiatric conditions, or women in labor only}, clinics, community health services, outpatient pharmacies, outpatient medical stations, rehabilitation centers, drug/alcohol detox centers, mental health facilities). • Collaborate with medical supply companies, home health agencies, pharmacies, regional health care coordinating centers (RHCCs), Regional Health Care Coalitions (HCC), and/or state Strategic National Stockpile (SNS) coordinator to obtain additional equipment, medications, and treatments to assist with providing medical care. • Implement a process to track durable medical equipment (DME). • Collaborate within IDPH and with CDC as indicated if care recommendations are contraindicated due to other conditions to determine if alternative care options are available. • Provide education regarding risks/benefits for receiving recommended care to individuals refusing care. • Collaborate with agencies/groups to address mental/ behavioral health needs (e.g. American Red Cross, disaster mental health teams, comfort dog agencies, etc.), implement a screening process and conduct psychological first aid to link with resources. • Collaborate with agencies such as physical therapy centers, oncology centers, obstetric offices/clinics, and methadone clinics, to assist individuals with maintaining their treatment regimen.

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Coordinate with dialysis centers and hospitals to ensure individuals receive their dialysis treatments.
SHELTERING	• Required utilities (e.g. electricity) may not be available to allow individuals to shelter in place • Assistive services, agencies, and/or service animals may not be available to allow individuals to shelter in place • Additional space requirements due to equipment, service animals • Difficulty navigating in the shelter related to visual impairments or mobility aids. • Difficulty coping in the shelter due to sensory overload or other cognitive impairments • Difficulty completing intake process • Require more time to process information, follow instructions, and move around within the shelter environment • Traditional shelter bedding, food, bathroom facilities, and spacing may not accommodate the needs of those with FAN • Safety concerns within the shelter (e.g. contraband, acute mental/behavioral health condition(s), fall hazards)	• Follow communication strategies to assist with: distributing information about shelters; identifying and addressing needs/concerns when entering shelters; and sharing information with those within the shelters. • Establish rules, goals, and limitations of shelter assistance at the time the service is being offered to ensure clear understanding and reasonable expectations (e.g. evacuation shelters are short term, disaster housing assistance will not solve housing issues that existed prior to the disaster, no drugs/alcohol allowed). • Shelter set up for proper space allocation for FAN (100 square feet per person) with ADA compliant bathroom facilities, separate space for those with cognitive conditions and experience sensory overload, and refrigeration for medications. • Shelter organizers (e.g. American Red Cross) implement a screening process for: medical conditions; mental health conditions; medications, equipment, resource needs; primary caregiver; specialty diet requirements; isolation requirements; access to power/electricity needs. • Collaborate with shelter organizers to obtain additional medications, equipment, treatments, and other care resources for those within the shelter. • Ensure shelter organizers have a plan in place on how acute medical and mental health conditions will be addressed.

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
		• Provide additional staff/responders as needed and requested to assist with care if primary caregiver is unavailable (e.g. home health agencies, medical staffing agencies, disaster medical teams, staff from assisted living and long-term care facilities, schools with special education programs, child care centers).
MAINTAINING INDEPENDENCE	• Difficulty planning for emergencies/ disasters such as stockpiling medications due to expense • Assistive services and agencies may not be available to help maintain independence (e.g. home health services unavailable) • Required utilities (e.g. electricity) may not be available to allow individuals to shelter in place • Difficulty coping with a disruption in their routines	• Follow Communication strategies to assist with identifying what is needed to help maintain their independence during and after the disaster. • Implement a screening process to identify what is needed for the individual to remain independent. • Link individuals with mental health resources as needed and indicated. • Coordinate delivering food, water, medications, treatments, and equipment (including fuel if they have a generator) to the individual. • Collaborate with utility companies to give those individuals that require electricity a higher priority for re-establishing service. • Provide staff/responders as needed and requested to assist with care (e.g. home health agencies, medical staffing agencies, disaster medical teams). • Accommodate the routines/rituals of those with cognitive conditions, if possible.
MASS FATALITY	• May be more adversely affected (higher mortality rate) due to co-morbidities from chronic conditions (incident dependent) • Disposition of medical devices that were with the patient when they expired	• Follow Communication strategies during mass fatality response to assist in identifying the cultural/religious considerations that exist and in explaining the legal obligations/investigative process.

ATTACHMENT 6: MEDICAL CONDITIONS AND DISABILITIES FAN/AT-RISK POPULATION

RESPONSE CAPABILITY	POTENTIAL NEEDS/ISSUES	STRATEGIES/TACTICS
	• Infectious/communicable disease concerns for responders	• Collaborate with families regarding the disposition of any medical equipment, medications, and other belongings. • Request federal resources such as Disaster Mortuary Operational Response Teams (DMORT). • Refer to the Illinois *Pandemic Influenza Preparedness and Response Plan: Fatality Management Annex* for additional information.