



Emergency Preparedness for Children



The American Academy of Pediatric's Family Readiness Kit is available at www.aap.org/family/frk/frkit.htm.

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Introduction

The tsunami in Southeast Asia. Hurricane Katrina. The 911 terrorist attacks. These events have heightened our awareness of the devastating impact of natural and man-made disasters and raised questions about our capacity to anticipate crises, reduce their impact, respond quickly, and restore normalcy.

Emergency, or disaster management, is not a one-time activity, such as developing a written plan or initiating a rescue operation. It's a continuous process by which individuals, groups, and communities manage hazards so that their impacts are reduced or avoided altogether.

Historically, the responsibility for disaster management has been placed with police, fire, and emergency medical services at local, state, and federal levels. Today, organizations that provide public health and medical services also find themselves responsible for disaster management. Public health professionals, however, bring a different perspective to emergency preparedness: a focus on the well-being of communities, and expertise in the use of surveillance and risk reduction strategies.

This issue of *Northwest Bulletin* examines the interplay between public health and emergency preparedness, with an emphasis on children.

- Dr. Maxine Hayes, in her editorial, reminds us that successful planning for children involves close partnerships with schools, the pediatric community, and law enforcement.
- Dr. Susan Allan notes that public health professionals already have experience in emergency response, such as planning for an influenza outbreak or responding to a chemical spill. The challenge is to use what we know and to share what we know with other key players.
- The state reports highlight skills in expanding current technologies to deal with emergencies and incorporating emergency preparedness into public health training.

Emergency preparedness planning must reflect both the unique character of each Northwest state, and the special concerns and needs of children.

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NorthwestBulletin:
Family and Child Health

Transitions

This summer Michelle Bell, PhD, MSW, will retire. Dr. Bell is a founding member of the *Northwest Bulletin: Family and Child Health* (NWB), and a faculty member of the Maternal and Child Public Health Leadership Training (MCH) Program at the University of Washington. In an interview with the NWB, she reflects on the past two decades in MCH public health.

NWB: What changes have you seen in maternal and child health?



Michelle Bell: Access to prenatal and infant care for low-income women and children has improved, due mostly to expansion of coverage through Medicaid and the State Children's Health Insurance Program (CHIP). Adolescent pregnancy and childbearing has decreased in recent years, though the rates are still unacceptably high. Children with special health care needs now have a better chance of living into adolescence and adulthood due to new technologies and increased access to specialized health care services. Immunization rates for children have improved, thanks in large part to the tireless work by MCH programs and advocates.

NWB: What makes the Northwest region unique and how does that uniqueness affect public health practice?

Michelle Bell: The Northwest region is larger than other regions in the United States, and includes sparsely-populated rural or frontier areas, where delivery of health care services is very challenging. Geographical barriers, such as mountains and bodies of water, and long distances between population centers add to the challenge, as does the shortage of health care professionals in rural/frontier areas. State and local public health programs have to be creative in their use of resources to reach the intended populations.

NWB: What challenges do public health professionals face?

Michelle Bell: Public health professionals always have to do more with less, but with the record national budget deficit, we might see the lowest levels of funding for state and federal programs we've ever seen and greater competition for that funding. This means that MCH public health professionals will need to be vigilant in representing women's and children's interests, as illustrated in this issue on emergency preparedness for children.

Editorial

Emergency Preparedness: Spotlight on Children

by Maxine Hayes, MD, MPH

Recent natural disasters and events of terrorism and war have heightened society's awareness of the need for emergency preparedness. For decades, emergency planning has been the responsibility of local, state, and federal government agencies and certain non-governmental organizations such as the American Red Cross. A successful response to a disaster requires the interaction of personnel and resources from multiple agencies in an organized and coordinated manner according to a well-formulated, well-practiced plan. Although planning has increased lately, attention to the unique needs of children remains minimal or—in many cases—non-existent.

A successful response to a disaster requires the interaction of personnel and resources from multiple agencies in an organized and coordinated manner according to a well-formulated, well-practiced plan.

I am very pleased to see this edition of the *Northwest Bulletin: Family and Child Health* focus on emergency preparedness for children. As a pediatrician, I have long advocated for this. Recent events in America and around the world vividly remind us that as we prepare for emergencies, we should not forget children.

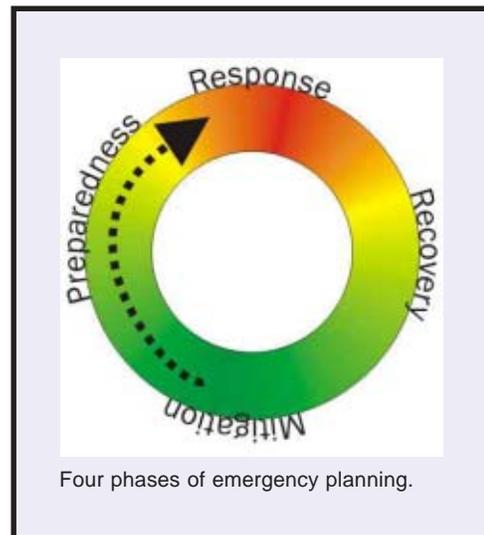
Of course, in emergencies government must play a big role, yet it is up to all of us to help our most vulnerable during times of crisis. For children, the first line of defense is always their families. After Hurricane Katrina hit the Gulf Coast, the American Academy of Pediatrics added pediatric disaster planning to its strategic priorities. Eventually, the academy will develop a national template focusing on the needs of children, with regional guidelines for implementing partnerships within local, state, and national agencies. I believe it is vital that health care providers with expertise in working with children, especially pediatricians, be included in readiness and response planning at all government levels.

Since natural and man-made disasters may occur anywhere and at anytime, we must ensure that, minimally, every family has a disaster readiness plan. All disasters are local and local communities must work with many partners to ensure every family has a plan. That means working with employers, schools, and churches who can reach families or

heads of household, with this message. Going to where people live, work, play, and pray will be key!

All disasters are local and local communities must work with many partners to ensure every family has a plan.

The Washington State Department of Health has worked closely with the Division of Emergency Management on a *Disaster Preparation Handbook*. It contains a wealth of information on simple steps that families can take to make sure they are ready before a disaster strikes. It can be downloaded or print copies can be ordered for businesses, churches or other organizations. There is also an excellent family guide for preparing for pandemic flu available on the Department of Health Web site.



Of course, preparing for emergencies takes more than just knowing what to do; it takes action. There are four phases to emergency planning: **mitigation and prevention, preparedness, rescue/response, and recovery**. Priorities during the rescue/response period for families with children are to assure that basic needs such as food, shelter, clean water, formula, and diapers are available.

Disaster plans should also:

- Educate first responders that children should not be separated from their parents unless unavoidable due to the parents' health.
- Educate families on the importance of developing contingency plans so their children can be identified and family members reunited, should they be separated during an emergency.

- Educate families about how to meet their children's special health care needs. Parents should include clearly labeled medications—with provider and pharmacy contact information—in emergency preparedness kits.
- Involve schools in all phases of disaster preparedness.
- Recognize the mental health needs of children in disasters.
- Assure the physical safety of children and families, monitor for sex offenders, and coordinate responses that cross state lines.
- Encourage communities to work with state government to adopt electronic health records. This is crucial for immunization histories and for care of children with special health care needs.
- Ensure that communication strategies reflect both sensitivity to and consideration of the multicultural and multilingual nature of our region and nation.

This is only a short list of some immediate actions planners should think about; I am sure there are others. I encourage pediatricians and others who work most closely with children to get involved in all four phases of planning and responding to crises. Our children are depending on it.

Maxine Hayes, MD, MPH, is the state health officer for the Washington State Department of Health, where she advises the governor and the secretary of health on issues ranging from emergency response to preventing childhood illness. She works closely with the medical community, local health departments, and community groups to give the public the latest scientific information on how to become and stay healthy, to prevent the spread of infectious diseases, and to protect the public's health. Dr. Hayes is also Clinical Professor of Pediatrics at the University of Washington, School of Medicine, and Affiliate Faculty, Maternal and Child Public Health Leadership Training Program, School of Public Health and Community Medicine at the University of Washington. She is the recipient of many awards and honors for her work in maternal and child health, including the American Medical Association's 2002 Dr. Nathan Davis Award; and is also a fellow of the American Academy of Pediatrics.



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Public Health Systems and Emergency Preparedness: Building Upon What We Know

by Susan Allan, MD, JD, MPH

Since the terrorist attacks of 2001, organizations that provide public health and medical services have seen themselves redefined as “emergency responders.” This has been a challenging transition. Many of our staff are still not clear about their roles in an emergency, and are trying to figure out the appropriate balance of “emergency preparedness” activities and “normal” work. A local health department director from Idaho told her staff not to expect things to get back to “normal,” that normal is just a setting on the clothes dryer. This is an important message. Even though we are too busy and “emergency preparedness” seems like one more demand, the people we serve expect us to be able to help them in emergencies. All public health staff who plan, coordinate, and deliver services to children and families need to figure out how to be prepared for an emergency.

Realistic Expectations for Preparedness

But what does it mean to be “prepared?” Many expectations are frankly unrealistic. No matter how prepared we are, we cannot make an emergency look like life as usual. But we can take measures to minimize harm to people and to the systems that support them. One of our most important activities in emergency preparedness is to set specific and realistic expectations and to communicate these expectations to our staff and to the people we serve. In an emergency, we will probably need to stop doing some things that we usually do, and will do other things in different ways. This is not a “failure” of preparedness, but rather it is a good response. Public health staff need to be told to expect these changes and to see them as successes. The goal is to make these changes in a manner that is planned and purposeful, not chaotic and reactive.

No matter how prepared we are, we cannot make an emergency look like life as usual. But we can take measures to minimize harm to people and to the systems that support them.

How do we identify those activities that are most useful, and balance them with our other responsibilities? Many found the emphasis on preparing for terrorist events, while ignoring other emergency needs, frustrating. More recently, however, emergency preparedness expectations have broadened to include natural disasters and pandemic diseases, with a shift towards “all-hazards preparedness.”



Family Preparedness Day in New Orleans, May 2006. FEMA brought together many organizations to present emergency preparedness information. Photo courtesy of FEMA.

While these expanded expectations might seem overwhelming, this is a more appropriate framework, because it allows each community to “get real”—to look at its own risks and resources. Emergency plans for Multnomah County, a multilingual urban area with a large local health department and many hospitals, should look very different from plans for Oregon’s Malheur or Wallowa Counties, with their handful of public health staff, one hospital, and vast areas of sparse population.

The Oregon state and local public health systems identified three emergency scenarios to focus our emergency planning on: a major earthquake, pandemic influenza, and a major chemical accident. Many other states are taking a similar approach and choosing emergency scenarios that make sense for them. These scenarios serve as useful guides for planning, but the plans are intended to be flexible so that they could apply to analogous emergencies. For example, an earthquake plan should also apply to tsunamis, floods, and volcanic eruptions. A pandemic influenza plan should apply to any major disease outbreak. And a chemical response plan should apply to most radiation events. Planning requires a constant tension between using the specific case to inform the plans or exercises, and the need to be flexible because we can’t predict what actually will happen.

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Build Upon Existing Emergency Response Systems in Public Health

We know a lot about emergency response because we already respond to emergencies of different types and sizes that affect children and families. State and local public health staff investigate outbreaks of illness from drinking water or food; or outbreaks of whooping cough, chickenpox or tuberculosis in schools, churches, or workplaces. We provide urgent vaccinations or antibiotics in response to a meningitis case or a pertussis outbreak; and manage shortages of influenza vaccine. Much of our work really is emergency preparedness or emergency response, but it hasn’t been recognized as such. We should build on what we already know how to do, not create new and separate systems for “the big one.”

Our emergency planning must take place within existing emergency planning frameworks established in each community and each state through its Office of Emergency Management, or comparable office or official. Public health and medical response plans can not operate in isolation; they need to be connected to the plans of such entities as law enforcement, fire department, and public works. Our plans also can benefit from the greater experience these emergency managers have with developing and implementing emergency plans. And each agency and organization needs to know and coordinate with others. As we saw in the failures of the response to Hurricane Katrina, coordination among responders is essential.

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Understand Established Emergency Response Tools

We in public health need to understand the procedures and vocabulary of Incident Management Systems (IMS). These aren’t magic rules, but they can help us work more effectively with other agencies, states, and partners that use IMS. Fundamentally, IMS is a management tool, providing a structure that allows common understanding of goals, responsibilities, and information flow.



Be Prepared to Help Your Neighbor

Our neighbor’s level of emergency preparedness may be as important as our own. In a major disaster, we would depend upon adjoining communities or states to provide extra staff and resources to help us. Similarly, we need to be prepared

to help these neighbors. So we are making efforts to ensure that we have communication systems, compatible plans, and basic familiarity with other states' systems and key personnel.



Take Care of Your Family

It is critical that our own families have basic supplies, and know what to do in an emergency and where to get reliable information. We've heard the advice about having three days' worth of water and food in our homes, a week's worth of extra medications, and so on. We should tell our families how to get authoritative information about what is going on in our communities in an emergency. In a very large emergency, it is likely that many of us would need to be self-reliant for a few days. Know where family members would go if they couldn't get home. Agree on how you would check in to make sure everyone is okay. For you to be ready to take on your own role as an emergency responder, you need to make sure your family is taken care of.



It is challenging to find the time to do emergency preparedness activities in addition to daily work. But it is clear that the public needs us to do both. We need to set appropriate and realistic expectations, and to direct efforts to those things that really will make a difference.

Susan Allan, MD, JD, MPH, is the public health director for the Oregon Department of Human Services. In this role she oversees the state's public health programs, works with county health administrators, and ensures delivery of consistent and high-quality public health services statewide.



Prior to assuming this post in March 2005, Dr. Allan spent most of her career in Arlington County, Virginia. She served as county health director in Arlington for seventeen years and was significantly involved with disaster preparedness and response. The 9/11 attack on the Pentagon (located in Arlington), a sniper attack, a West Nile virus outbreak, and the anthrax and SARS cases all occurred during her tenure as health director.

Dr. Allan holds doctoral degrees in law and medicine from Harvard University and a master's degree in public health from Johns Hopkins University. She is board certified in public health and general preventive medicine, and is a Fellow of the American College of Preventive Medicine.

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Oregon Trailblazing: The MCH Perspective in Emergency Preparedness Planning

by Patricia Westling, MSN

The incorporation of a maternal and child health (MCH) focus into the State of Oregon's Emergency Preparedness plans began in the spring of 2005. At that time, state public health officials were beginning to develop the *Health Chemical Response Plan* and each office within the public health section in the Office of Family Health was asked to assign a representative to participate in the emergency preparedness planning process. This approach was designed to ensure that a wide variety of perspectives would be heard and that the needs of as many populations as possible would be addressed.

The Office of Family Health representative brought experience in public health MCH nursing and consulted with the Perinatal and Child Regional Nurse team during plan development to maximize the effort. The result? An MCH focus has been incorporated into other public health emergency preparedness plans and a maternal and child health focus is considered in the majority of planning efforts. A full-time MCH staff member will soon be assigned to work in Oregon's emergency planning activities.

Preparing for an Influenza Pandemic: Guidelines for Children and Families

by John M. Neff, MD

Federal agencies are preparing for a possible influenza pandemic. At a summit held in April 2006, Washington State Governor Christine Gregoire and Secretary of Health Mary Selecky emphasized that this is the time to prepare, not panic. Through worldwide tracking of influenza, evidence of infection has been found in the wild bird population and in poultry. Over 200 cases of avian influenza in humans, some deadly, have been reported—but none have been identified in the United States.

The avian influenza virus must go through several changes before it crosses the barrier from birds to humans, and then on to a human pandemic. It is not known if or when this will happen. Based on historical experience, if sustained person-to-person transmission occurs, a worldwide outbreak might develop quickly. A local outbreak could last for about eight weeks.

Based on historical experience, if sustained person-to-person transmission occurs, a worldwide outbreak might develop quickly.

The Centers for Disease Control and Prevention (CDC) has cautioned that in the early stages of a human pandemic, schools and public transportation systems may be closed and public gatherings may be restricted to contain the epidemic. Vaccines or medicines may not be immediately available for prevention or treatment. Emergency rooms, medical facilities, and hospitals could be overcrowded and the demand for medical equipment and supplies, including respiratory support, might exceed capacity. Health care providers might be overwhelmed with patients.

Families—Planning Ahead

The best way to plan for pandemic flu is to be prepared at home. Children generally serve as reservoirs of infection so parents will be encouraged to keep children at home to prevent spreading the flu. Children with special needs, especially those with chronic respiratory conditions, will be vulnerable. They should be immunized and treated with medicines, if available, to prevent infections.

Families should coordinate medical plans with their health care providers, especially if a child is dependent on medications or medical technology. For example, parents of a child on a respirator or dialysis should consult with their care

Figure 1. CDC home care guidelines.

As much as possible, physically *separate* the patient with influenza from healthy persons living in the home.

All household members should carefully follow recommendations for *hand hygiene*, such as hand washing with soap and water or using an alcohol-based hand rub after contact with a patient with influenza or the environment in which he or she is receiving care.

Although no studies have assessed the use of masks at home to decrease the spread of infection, use of a *surgical or procedure mask* by the patient or caregiver during interactions may be beneficial.

Soiled dishes and eating utensils should be washed either in a dishwasher or by hand with warm water and soap. It is not necessary to separate eating utensils used by a patient with influenza from other household utensils.

Laundry may be washed in a standard washing machine with warm or cold water and detergent. It is not necessary to separate soiled linen and laundry used by a patient with influenza from other household laundry. Care should be used when handling soiled laundry to avoid self-contamination. Hand hygiene should be performed after handling soiled laundry.

Tissues used by the ill patient should be placed in a bag and disposed of with other household waste. Consider placing a bag at the bedside.

Environmental surfaces in the home should be cleaned using normal procedures.

providers on how to manage their child's health care at home to avoid the need to go to a medical facility. This also applies to parents whose children are dependent on medicines, such as those with seizures or intravenous nutrition. Advance planning can help everyone get through even the worst case scenario with as few bad outcomes as possible.

The best way to plan for pandemic flu is to be prepared at home.

Here is a partial list of steps to prepare for an influenza pandemic:

1. Stock up on food because grocery stores may be overrun with panicked customers. Purchase a two-week supply at minimum; six to eight weeks if possible. Select canned goods, frozen meat and vegetables, dried foods (used for camping trips), cereals, bread, peanut butter, power bars, pasta, rice, and corn meal. Think about how to get by with less and how to store non-perishables.
2. Store a supply of necessary medicines and special formulas.
3. Secure first aid supplies.
4. Collect games, books, and other fun activities to fill the day. Talk with teachers about materials and plans for learning at home.
5. Work out a plan with your physician on the health care needs of your child and how to telephone your physician's office for advice should a family member get influenza or some other illness.
6. Find out if your employer has a response plan and what arrangements you can make to stay home to take care of your child and family.
7. Follow CDC home care guidelines for caring for a sick person (Figure 1).

In summary **be prepared, not scared.**

John Neff, MD, a graduate of Harvard Medical School, is the director of the Center for Children with Special Needs at Children's Hospital and Regional Medical Center in Seattle, where he previously served as medical director. Dr. Neff is Professor of Pediatrics at the University of Washington School of Medicine.



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Resources and References

American Academy of Pediatrics. Resources for Pandemic Influenza.
www.aap.org/new/influenza-birdflu.htm

Public Health—Seattle & King County.
www.metrokc.gov/health/pandemicflu/index.htm

United States Department of Health and Human Services. One-Stop Access to U.S. Government Avian and Pandemic Flu Information.
www.pandemicflu.gov/

United States Department of Health and Human Services.
www.pandemicflu.gov/planguide/checklist.html
(Personal planning check list.)

United States Department of Health and Human Services. Pandemic Influenza Plan Supplement 5 Clinical Guidelines.
www.hhs.gov/pandemicflu/plan/sup5.html#box4



Healthy Mothers, Healthy Babies
Coalition of Washington State
is now

WithinReach of Washington State

The new name reflects the organization's growth over the past 18 years to include the health and well-being of the whole family.

www.hmhbwa.org/

Talking to Children about Disasters

by J. Christie Holmgren, APR

Children who have witnessed a disaster either directly or through the news media are likely to have an increased sense of vulnerability, fear, and anxiety. They need active support and guidance from the important adults in their lives.

Parents, teachers, and caregivers should watch for any unusual behaviors, including sleep problems, increased anxiety, depression, unexplained physical symptoms or social problems that may signal difficulty coping.

Recent research suggests parents talk with their children about disasters, but don't force the issue:

- Ask what they already know or understand.
- Encourage them to ask questions and provide clear and simple explanations that match their level of anxiety and ability to understand.
- Limit the amount of television viewing of disasters by younger children.
- When older children watch television coverage of a disaster, watch with them and discuss what's happening and how they feel about it.
- Consider sharing your own feelings about the event with your children and take the opportunity to model good coping behaviors.
- Provide reassurance about the steps being taken to keep children safe.
- Encourage children to tell their own stories of the event by talking or through art, music, journals, etc.
- Encourage their participation in activities to help the victims of the disaster.

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See resources on page 15.

State Reports

Alaska Report



The State of Emergency Preparedness for Children in Alaska

by Yvonne Goldsmith, MS

State agencies and local communities in Alaska are at various stages of developing emergency preparedness plans. Most of these plans do not address specific subpopulations such as children or seniors. The municipality of Anchorage—home to 42% of the state’s population—has developed an emergency preparedness plan that does address the needs of children. The Anchorage Office of Emergency Management prepared a *Comprehensive All-Hazard Child Care Facility Planning Guide* for child care providers. The guide covers 15 events that could occur in Anchorage and provides best response practices known to date. Each child care facility is encouraged to develop its own disaster plan based on the guide’s model disaster plan.

A Registry for Special Populations

In March 2006, Anchorage established a disaster registry to track certain vulnerable populations, such as seniors, children and adults with developmental or physical disabilities, and homebound/frail individuals, during emergency events. The database is maintained by the city’s Emergency Operations Center and shared with local fire stations. Services available to registrants include help in creating a home preparedness plan and, during an emergency, a home visit to check on the registrant or assist with evacuation.

Schools Gear Up in Anchorage

The Anchorage School District, which serves 40% of all children in the state, has similarly been proactive in emergency preparedness. Twenty-one middle and high schools are designated as emergency shelters. Each shelter has a temporary water and sewage system, a power generator, radio communications equipment, and a container stocked with emergency supplies. The containers can be moved to other locations using specially equipped trucks in case a shelter becomes unusable. Each school has an evacuation

plan and is capable of housing their students for up to several days as well as providing shelter to the general public.

Statewide Planning

The Alaska Department of Health and Social Services (DHHS), Division of Public Health, recently drafted a *Pandemic Influenza Response Plan*. The plan outlines specific state and federal agency responsibilities and operational procedures under different scenarios. For example, the operational plan for vaccine distribution and use lists priority groups to receive the vaccine during a pandemic.

The DHHS Division of Behavioral Health is responsible for behavioral health disaster response services. Its *Behavioral Health Emergency Response Plan* outlines best practices in response and recovery operations in various disaster situations, whether natural or man-made. For example, it establishes procedures for identifying and deploying resources in coordination with other state agencies and local Community Mental Health Centers. These centers are expected to provide initial response services and manage long term recovery efforts based on their capabilities. The state provides assistance and coordination services.

Yvonne Goldsmith, MS, tracks health indicators and engages in research on maternal, child, and family health for the Alaska Department of Health and Social Services, Division of Public Health. She also serves on the editorial board of the Northwest Bulletin.

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Alaska Department of Health and Social Services. Behavioral Health Emergency Response Plan. www.hss.state.ak.us/dbh/resources/publications.htm

Avian Pandemic Plan.

www.hss.state.ak.us/DPH/DPHPP/pandemicflu/default.htm

Municipality of Anchorage. Anchorage Emergency Operations Plan, Child Care Facility Planning Guide, Disaster Registry for Vulnerable Seniors.

www.muni.org/oem/index1.cfm

Idaho Report



2-1-1 Information and Referral System and Emergency Preparedness

by Patricia Williams

The Idaho CareLine is a statewide, toll-free telephone information and referral program of the Idaho Department of Health and Welfare (IDHW). The program was created in 1991 to satisfy the federal mandates of its original partners, the Maternal and Child Health and Infant Toddler Programs. The CareLine's "connecting people with services" concept has continually evolved to meet the changing needs of Idaho residents.

In July 2000 the Federal Communications Commission designated "2-1-1" as the telephone number for community information and referral services, recognizing that the human service arena is a complicated maze for families to navigate. Over the last six years 38 states have implemented 2-1-1 services to over half of the nation's population. In 2003 Idaho became the fourth state to offer 2-1-1 services through its CareLine.



Faced with a confusing array of agencies and help-lines, the 2-1-1 system—with its easy to remember phone number—helps callers identify volunteer opportunities and get information about critical health and human services. In the family and child health arena, these services range from prenatal care, immunizations, and adolescent pregnancy prevention to Medicaid resources, nutrition information, child care referrals, and more. In Idaho, 2-1-1 helps people "Get Help" and "Give Help." The "Get Help" component uses a centralized call center and a statewide Web-based resource database. The "Give Help" service is provided through a Web-based volunteer center sponsored by United Way of Treasure Valley (serving the greater Boise area.). The system is also a source of valuable feedback to public policy makers and non-profit leaders by providing information about the needs of communities around the state.

The Role of the 2-1-1 Idaho CareLine in Disaster Response

The 2004 and 2005 hurricane seasons in the Gulf Coast provide recent examples of how 2-1-1 call centers were used for assistance and emergency information. In Idaho the 2-1-1 system will also serve as an important disaster management tool. By limiting 9-1-1 phone lines to life-threatening, immediate-response calls, the 2-1-1 line will operate as the public information, volunteer placement, and donations management call center.

The 2-1-1 CareLine is designated in the IDHW *Health Emergency Communication Plan* as the public entry point for information and referral during a declared health emergency. Work in this arena and the staging of mock disaster training events have helped to:

- Identify and remedy capacity issues of the telephone system.
- Support development of Web-based resources and the capability to immediately double the call center size.
- Develop a cadre of trained volunteers to assist in the call center during an emergency.

A current planning focus is the development of key messages for special populations such as the homebound and children with special needs. The Idaho CareLine will continue to expand and work cooperatively with local service providers to address issues that affect communities, both during normal times and in disasters.

Patricia Williams—a 27-year veteran of the Idaho Department of Health and Welfare—has directed the Idaho CareLine for the last eight years and is responsible for coordinating the implementation of 2-1-1 services statewide. She currently chairs the Northwest Alliance of Information and Referral Systems.

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Allen, Kenn. 2004. Trial by Wind and Water: How 2-1-1 Played a Vital Role During the 2004 Florida Hurricanes. www.211.org

United Way of America (UWA) and the Alliance for Information and Referral Systems (AIRS). 2-1-1-Get Connected, Get Answers. www.211.org



A 21st Century Henry Street: Adding Emergency Preparedness to MCH Home Visits

by Patricia Westling, MSN

Maternal and child public health programs in Oregon usually include nurse home visiting to facilitate client interactions in familiar surroundings, and to identify and address health and safety issues in the client's immediate environment. Home visiting services have long been available to pregnant women, infants, and children from diverse racial and ethnic backgrounds who have risk factors such as inadequate housing, lack of insurance, physical or mental disabilities, limited education, chronic illness, and unemployment.



Picture of Lillian Wald, courtesy of the Jewish Women's Archive. www.jwa.org/feminism

Public health nursing was conceived in 1893 by Lillian Wald, founder of the renowned Henry Street Settlement House in New York's Lower East Side. Over the next several years the early public health nurses (PHNs) taught many families about disease prevention and health practices. And they were an invaluable resource during the 1918 influenza pandemic. But their work didn't stop with individual client services; they also collaborated with others to address community issues and provide optimal quality of life such as building playgrounds, implementing school lunch programs, expanding access to health care, and abolishing child labor—activities that were far outside the scope of usual nursing practice.

Public Health Nurses in the Era of Emergency Preparedness

Plans are underway to incorporate emergency preparedness education and assistance into Oregon's public health maternal and child health programs. PHNs will be trained in basic home preparedness, and information on individual and family preparedness will be included in home visiting and

case management. The goal is to help ensure that information reaches families who need it most.

Hurricane Katrina—which struck shortly after Oregon began this program—reinforced the vital need for individual preparedness. Although guidelines are available to help families prepare for emergencies, the list may seem overwhelming or unwieldy to young parents on limited budgets or with multiple burdens. However, with assistance from a trusted nurse working with the family in their home, plans can often be made to purchase one or two food or personal emergency supply items with each visit to the grocery store and to find a suitable storage location in the home.

The addition of emergency preparedness education to public health nursing will help to empower a vulnerable population and create a modern-day Henry Street Settlement.

Public health nurses who primarily focus on maternal and child health issues may initially find themselves out of their element working with state and local emergency preparedness planners. However, just as those from other disciplines are becoming involved in this effort, the PHNs bring a unique perspective to the planning process. And because one of the cornerstones of public health is community infrastructure, this type of collaboration serves broader purposes.

It's been said that Ms. Wald's movement created a "significant awakening on matters of social concern, particularly those affecting the protection of children throughout society in general—and a new sense of responsibility among men and women...." The addition of emergency preparedness education to public health nursing will help to empower a vulnerable population and create a modern-day Henry Street Settlement.

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Washington Report



Keeping Children Safe in Out-of-Home Settings

by Teresa Cooper, RN, MPH

Where will you be when the “big one” hits? Where will your children be? Most children spend much of their day away from their home and their parents. Infants and young children—an especially dependent population—may spend their days in licensed or unlicensed day care homes, child care centers, homes of relatives, or specialized preschools. Disaster planning and emergency preparedness must include children and the adults to whom they will look for help, guidance, and comfort. Washington State is working hard to prepare for emergencies that affect children.

Most children spend much of their day away from their home and their parents.

Child care providers and preschools

Regulations require that licensed child care centers prepare a disaster plan and review it at least annually. Child care health consulting, an important unregulated system of care, is available to child care/early learning providers in Washington. The consultants are usually public health nurses employed by local health departments or districts. They offer help in creating, reviewing, and practicing emergency plans and are a key source of information about health in group child care settings. Healthy Child Care Washington, a program of the State Department of Health (DOH), provides training to child care health consultants and includes emergency preparedness in its training manual. DOH also publishes a handy flip chart on disaster procedures for child care providers.

Local public health departments

Local public health professionals are leaders in helping ensure children's health and safety. With epidemics and outbreaks in the news, and the possibility of pandemic influenza, local health jurisdictions are using both old and new ways to educate and prepare the public. Snohomish Health District's Partners in Child Care Program offers classes and materials on emergencies and disasters for child

care providers. A particular strength of this program is the participation of environmental health specialists on the child care health consulting team. The Tacoma-Pierce County Health Department is organizing training sessions on pandemic flu planning for child care and preschool providers.

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Public education

Educational organizations are moving forward in preparedness planning as well. School nurses are likely first responders in health emergencies affecting school children; many are on the forefront of planning efforts. A school nurse in the Bethel School District in southeast Pierce County, for example, has spearheaded a planning committee on emergency preparedness with the school district and Pierce County government and has co-authored a book on emergency preparedness for schools. Educational Service District (ESD) 101 in Spokane features school emergency preparedness on its Web site. The Office of the Superintendent of Public Instruction, the state's education agency, also offers Web-based materials on preparing schools for pandemic flu. Teachers and administrators in the schools may need to be reminded of the effects a disaster could have on their settings, such as an order to close the school by the local health officer. Even when buildings are not closed, staff must be prepared to deal with high absentee rates among staff and students.

Resources for emergency planning abound, but a good plan is never finished. The care of children requires thoughtful planning and support before, during, and after an emergency.

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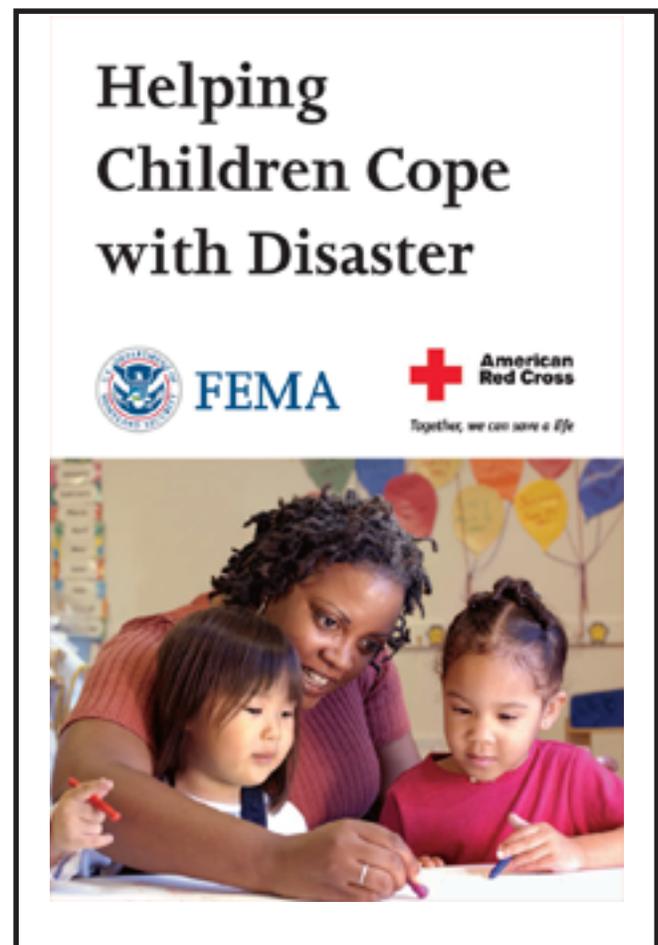
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