- [Shaylin] So with that, I
wanna introduce June Kailes,

who is sitting here to my right.

And June Kailes owns a disability
policy consulting practice

and is a pioneer, leader, and innovator

in healthcare, emergency
management, aging with disability,

stakeholder engagement, and hospitality.

The breadth and depth of her experience

in disability, accessibility,
and functional needs issues

are widely known,

as respected as a writer,
trainer, researcher,

policy analyst, subject
matter expert, and advocate.

June concentrates on replacing
the ambiguous aspects

of disability etiquette,
sensitivity, awareness,

and legal compliance with
maximum impact, practices,

and measurable skill sets.

June works with clients

to build critical disability
competencies and capabilities.

She translates the laws and regulations

into clear, actionable, detailed,

and sustainable building blocks,

and tools that close service gaps,

prevent civil rights violations,

and remove barriers,
inequities and disparities.

June uses the how, who,
what, where, when, and why

to get physical,
programmatic, communication,

and equipment access right.

June has received many honors and awards,

has delivered hundreds
of keynote addresses,

workshops, and seminars,

and has over 200 publications,

which you will learn, I'm
sure, about some of those

and how to access those in
this next hour together.

So with that, and without any further ado,

I introduce you all to June Kailes.

(attendees clapping)

- [June] The mic is on? Good?

Can you hear me? Any problems?

Let me know if it drifts
off or something happens.

So, well, it's a pleasure to be here.

That was a pretty complete
bio, so I won't restate it,

but just, I'm from California,
based in Los Angeles.

Closer.

I have to kiss the mic. Okay.

So I'm from L.A,, but
originally from New York,

and it's great to be here.

And it's great to follow Sadie,

'cause Sadie is a great person

that fits in tons of soundbites,

so I can just refer back to her soundbites

and you'll know what I'm speaking about.

So a little bit about my descriptor.

If you need to find me in the audience,

I'm probably one of only two
scooter users here today,

so I would be fairly easy to pick out,

in terms of high profile.

And the other thing you'll
probably wanna know about me

is I'm a speaker who sits down,

because actually when I stand and speak

I have to spend most
of my energy balancing,

and you don't want me to do that.

So that's why I tend to sit and speak.

So we're talking about FAST today,

and I kinda termed it differently.

I said the question is, "FAST: yes or no?"

Or are there other options to think about?

So Cyndi, do I have that right question?

Good, good.

So that's my contact
information and my email.

You can always find me.

If a burning question occurs
to you later, just email me.

And if you don't get an
answer, nag me. Email me again.

Sometimes I get buried in the
email avalanches, so don't...

Feel free to nag.

So these slides today are
available to you at this link.

So it's a quick link,
jik@jik.com/fast, all lowercase.

So you can get the slides,
minus many of the pictures,

because I just don't
want the copyright police

coming after me,

and I can't always
remember which ones I took

and which ones I stowed
somewhere during something.

So, but you'll get all the text,

so for ease of your
note-taking experience,

feel free to download those later.

So what I wanna cover
today is what is FAST,

past, present, and future,
and my recommendation,

because I can't help
but give you my opinion

about what I think in terms of FAST:

the name, the training
that occurs with it,

the focus, the roles,
how we look at success,

and what kind of due diligence
or decision making process

should you think about

in terms of thinking

about Functional Assessment Service Teams

as something that you may
want to adopt in some form,

or customize, tailor, or re-conceptualize.

So FAST basically is a process

by where a team delivers support

in disasters and emergencies
to people with disabilities

and others with access
and functional needs

through deployed members of government

and community of partners working together

and combining their skill sets

to provide services and support

that help people to maintain
their health, their safety,

and their independence.

So in terms of you all out there,

how many of you are from a state agency?

Okay, how many of you are from
a local government agency?

Lots.

And how many of you

are from a local
community-based organization?

Not so many. Maybe I see 6, 7, 8.

Okay, good to know.

So in terms of the history
of FAST, let's look at that.

This is what FAST is,

and the history is that...

Sadie reminded me that
Katrina occurred in 2005,

but the history of FAST is that,

and this probably does date me a bit,

but 30 years ago, like in the seventies

in California and beyond...

How many?
- [Offscreen] 50.

- [June] Oh, my...

(audience member speaking indistinctly)

- [June] Oh my, well, you know,

I've always had this math issue, (laughs)

so thank you.

Yeah. So back then...

No, no. Thank you.

Way before Katrina,

there was a group of us
advocates in California

that documented a very
deep and dramatic lack

of equal and inclusionary
emergency services

for people with disabilities.

So what we saw way back
then was discrimination.

People with disabilities

were turned away from shelters frequently.

Why?

Just because they were a
wheelchair user, or they were Deaf,

or they were a service animal
user, or they were blind.

It was very traumatic

in terms of what we saw and documented.

So while they were
registering at a shelter,

people were told sometimes
that they had to go elsewhere.

They had to go to this medical shelter,

or they had to go to a hospital

or some other kind of institution.

Why?

Because the common belief was

that people with disabilities were sick.

They needed medical care,

they needed protection and
supervision and special shelters,

or as we like to say, really
a medical model of health.

So

what looked acute and
vulnerable and fragile

to the untrained eye was
just living with disability

to those experienced
in disability services

and service systems.

So people with disability were confronted

with a lot of indiscriminate application

of the medical model,

the false belief that
people with disabilities

needed medical services and medical care.

And this implicit bias back
then, for several decades,

overburdened very scarce medical resources

that were actually needed

by people with acute medical needs.

The other thing that went on was that

many of us from the community,

community-based organizations,

volunteered to help at shelters,

and say, "We could help people.

We could help people get what they need."

And we were turned away. Why?

Because we lacked -

quote, "lacked the proper credentials,"

unquote.

So FAST -

Utter frustration.

I was on a plane, and I
thought about, what the hell,

what were we going to do?

And in 2007, I thought of and
pitched the concept of FAST

to the California Department
of Public Social Services,

which in the end contracted with me,

and we worked together on developing

the FAST concept,

plans, and a training course

that eventually in 2010

was approved by FEMA.

So the whole intent of FAST

was we could do better

and we could work smarter together

by building partnerships
with both government

and the community in terms of what...

The community being cities and counties,

and VOADs, primarily like
the American Red Cross.

The intent was to really...

to really blend

the competencies

and the skill sets of both government

and those in the community disability

service system,

and Independent Living Centers,

and develop teams that would be inclusive

of government and the community,

and especially, as Sadie says,

with and not for people with disabilities.

To really provide assistance

that people sometimes had

or were perceived to have complex

and urgent disability related needs.

The intent was to identify and remedy

and retool interventions

that reflected old stigmatizing biases,

stereotypes, and beliefs,

and indiscriminate and
widespread application

of the medical model.

So the concept also included

that these teams would understand

compliance

with civil rights laws and protections,

and have the skill sets
to actually implement

what was needed in terms
of physical access,

and equipment access, and
service access programs,

and communication access.

So determining and meeting needs,

and replacing things, like
what Sadie said so well,

went over in terms of have you ever,

medication issues, mobility aid issues,

supplies, personal assistance,

people who might need
assistance with daily living:

brushing, eating, grooming, toileting,

transferring, or communicating.

So the concept back then was team members

to work with shelter personnel

to identify and meet
essential functional needs

so that people could remain
as independent as possible

and maintain their health and their safety

and their independence,

and to really help to decrease the

impact of degraded or

gaps in critical personal support systems.

Now many of us with
disabilities are reminded,

particularly when we travel or we're

outside of our work or home environments,

that things are disruptive.

Things that are easy for us
with our customized environments

tend to degrade and degrade significantly

in emergencies and disasters.

So kind of addressing those gaps

and helping to meet those needs

so people can continue
to protect their health

and their safety.

So the concept was that
teams would work in shelters,

and would travel from one
shelter to another and back,

to help people to get what they need.

Basically, you're talking about a team

with trained eyes and ears.

The original intent was to form a team

that had a variety of skill sets

that could be mixed together,

'cause none of us are
experts in everything

whether we have a disability or not.

We all have different levels
and depths of expertise.

So the intent was to create a team

with a mixed combination

of these skill sets

and be able to really work well together.

So in California, well, California today,

according to the website,

and I don't know if it was back then,

but now they want a minimum
of two years experience

working with and/or assessing the needs

of people with access
and functional needs.

That's what their website says today.

Currently, they say a team is comprised

of two to eight members.

Back then, the concept was

that a team would be at least five people

with that combination,

a mix from government and the community.

But, so the original intent
was really combined skills.

Well, guess what?

It did not work out
that way, or it hasn't,

and I try and keep an
eye on what's going on

around the country with FAST.

And what I see is that today,

unlike the original intent

was California uses primarily

state teams that

that are supposed to consist of

members with this combined experience,

but that often has not been the case.

So at the end of my slide deck,

you'll have access to the
link for the California site,

and you can read more

about the way they promote FAST today.

But I see it as FAST, in California

and actually in many other areas,

is that FAST has morphed,

has changed into a government-centric

only team

versus this mixed makeup.

And why did that happen?

Well, I kind of feel embarrassed
about the whole thing.

Like why didn't I think this up back then?

Why didn't it occur to me
that this would happen?

And what happened was it was easier

and it took a whole lot less effort

to train and recruit and deploy

government workers only.

Why? Because the reimbursement
was already in place.

The insurance was already in place.

The liability issues
were already in place.

So this made...

Excuse me. I'm developing
allergies, I think.

What was hard was that the
community-based organizations

was really an unresolved barrier,

a big weakness in this whole concept,

because we had overlooked

the issue of expense reimbursement

the issue of insurance,

and the issue of liability issues.

So the expectation, the old expectation

was disability service staff
could volunteer their time

and not have to worry about
any of these other issues.

The reality is that

the term "charitable organizations"

is misleading.

Although the tax status is nonprofit,

this does not mean volunteers do the work.

Community-based organizations
have contractual,

payroll,

operating expenses, compliance issues,

and deliverable obligations.

So what we were confronted
with as barriers is

many could not cover,
although they wanted to help,

they wanted to participate,

many could not cover their
staff salaries, overtime,

without additional funding.

So the learning that needs to be applied

is that community-based organizations,

we need to think about working

in terms of payment and reimbursement,

and sorting out the details,

the what, why, where, when, and how.

That that's what was missing in the model

that needs to be addressed.

So this is a slide of a FAST person

and someone talking actually
to a Red Cross worker.

So government-only FAST

in California

may involve people with disabilities

who happen to be government employees

or have disability expertise,

but there was no assurance

that they bring to that
role lived experience,

that they bring to that role

the social model

versus the medical model

in terms of understanding the
details and the complexity

and the nuances of
living with a disability

and the understanding

of implementing civil rights protections.

So FAST around the country has evolved

different names, different versions,

and my observation, there's lots of

focus on the startup process,

the training, and the recruitment,

but much less

in terms of teams that really

get deployed in emergencies.

So remember, FAST was
conceived a long time ago.

2007. That's a long time ago.

So things have changed.

The recognition for disability
inclusion planning services

and training has evolved -

slowly, but has evolved.

And the models are shifting.
The resistance is weakening.

Outdated dogma is being challenged.

Acceptance and adoption is increasing.

And there are new dents and new ripples

in terms of things getting better.

There is now, there wasn't then,

an Office of Disability
Inclusion, an - ODIC,

Office of Disability
Inclusion and Coordination

at FEMA.

There is Disability Integration

at the American Red Cross,

and some of the government agencies now

also are focusing more on the role

of organizations in the community
in terms of emergencies.

So I'm gonna tell you a bit about

my recommendations for FAST in

terms of name and training.

But -

So let me just go through
what some of those are.

I think, you know, people often talk

about the California model of FAST,

but I always like to say in
a number of different arenas,

dogma needs to have a shelf life.

It's gotta have an expiration date.

We've gotta keep revising and retooling

and refining and refreshing what we do.

You could pick your word,

but one of my favorite quotes is,

"If we always do what we always did,

you'll always get what you always got,

and is that enough?"

In my opinion, no.

So the first thing I would do in

rethinking this whole concept is

I'd change the name.

I'd get rid of "assessment,"
call it "assistance."

I'd get rid of "service,"

because I just like "support" better.

And by the way, we could assess
'til we're blue in the face,

but without assistance, it's not enough.

And I would change "service" to "support,"

just because I think it's more
of a warm, encompassing term.

I would also, and this
is really important,

I would broaden the focus,

broaden the focus.

The shelter focus is just too narrow.

There are many places in this
country, believe it or not,

who've never opened a shelter, ever.

But there's still a whole
lot of need out there

beyond shelter.

So the FAST concept, I'm pleading with you

to think about it in a more
flexible, and customizable,

and even local way.

What can you do locally to

evolve the concept,

to make it work for you locally

as well as at the state level.

One of the things with state
teams that is a disadvantage

is that state people typically, commonly,

are not as familiar with local resources,

culture, norms, and demographics.

And this is just the slide of your typical

tangled maze service
system in a community.

It looks like a Star
Wars something or other.

It's just, you know,
a lot to sort through.

It's a lot to have to know.

And locally, you know,
we're much more advanced

in knowing it and working with it

than maybe a state team would be.

The other thing we need to do is expand

the concept of who are
our community partners.

We often just think of them

as community-based service organizations.

Well, the overarching thing
here in terms of the partners

is, you know, Craig Fugate,

who was one of the past
administrators of FEMA, used to say,

"It's really important that your staff and

your leaders look like the
flock that they're leading."

And with the demographic
shifts in our country,

aging population,

more culturally and
linguistically diverse people,

it really is important

that the partners need to look and be

of and by and with all these groups,

so they come to teams,
they come to support,

with understanding the diversity,

with the diversity of
perspectives to provide services.

So what do I mean by

by broaden - Who?

Well, first: businesses.

And how many of you have a

a Business Emergency Operation Council,

or BEOC in your community or in the state?

Anyone? Hands?

Not too many, three or four. Okay.

Well, what they are,
are in some communities

they conduct continuity
planning with each other,

and they form partnerships

to support preparing for, responding to,

and mitigating emergency risks.

So we need to think about
including them, where they exist,

as part of the team.

The other is our health partners,

and we don't think broadly enough

about those health entities.

The healthcare coalitions.

How many of you work with
a healthcare coalition?

Ah, more hands, like
maybe 20. That's good.

Community clinics, home health agencies,

managed care organizations,

infusion centers,

vendors of consumable medical supplies -

oxygen, pharmacy services.

And then there's the big store,
the big box store partners

that we often forget, and
all the logistic partners.

Who are the logistic partners?

Those are the UPS and the post office and

FedEx and Amazon,

and all these new evolving
air drop deliveries

or drone deliveries.

And then there's the
transportation providers.

And not only the school buses,

but, you know, the rental car places

and the Lyfts and the Ubers

and the airport shuttles
and the taxi services.

And then there's the
personal assistance services,

both public and private
caregiver providers.

And there's lodging, there's the realtors,

there's the Airbnbs,
the hotels, the motels,

the building managers, and the
utilities, power and water.

And again, schools, universities,

and all of the organizations
in the community

that work with people with disabilities,

aging, faith-based, and family services.

So the table, the partners,

you have to cast a wider net here.

Oops.

Hmm. Missing some slides here.

So partners -

Sadie talked about messaging and alerts

and force multiplying,
using the community partners

to get the messages out

in a way that is really
culturally appropriate

and customized.

And the example I like to give is

agencies that work with

people with intellectual disabilities.

Some of them are very, very skilled

in providing and reinforcing
easy-to-understand messages,

like using plain language, using pictures,

using repetition.

They're really good at this.

Something that's not very
intuitive to the rest of us.

So messaging is an
important role for partners,

as are life safety checks.

I'm wondering where those slides went.

Hmm. I think I have the
same problem as you, Sadie.

I'm kinda missing some
slides. I don't know.

The slide monster is doing
something to our slides.

Anyway, sorry about that. Whoops.

So life safety checks is another
community partner activity,

checking on people through text,

through phone calls, through email.

And the newest tech is

using automated systems

to just touch base with people and say,

"Hey, if you're okay, press yes.

If you're not okay, press no."

And we, because we know you,

'cause you're part of
the people we support,

will try and get in touch with you.

So using partners

who could check in with people,

particularly partners who know

the people they support,

who are at the highest risk
because they're isolated,

they don't have a lot of support systems,

they don't understand or
access alerts and warnings,

and they're transportation-dependent.

Another role is helping people

with their preparedness plans.

And this is something we
kind of give a lot of...

We undervalue it, and we underestimate

what it takes to do that
well and to do that right.

We don't think about how
difficult this is for some people

to think about how they're
gonna plan to get help.

It's scary for some people
'cause they're kind of in denial,

so you have to work
through the denial first

that things could be, that
there could be bad days,

and that

a helper list is something
that we should all have

so that we can help each
other, and know each other,

and be ready to support each other,

and live close enough to each other

so that we can be available.

And how do we put that
kind of system together

in a personal plan?

Part of the personal plan
is also evacuation planning,

and for people who don't
have transportation,

and even those who do

but whose car may not work in a disaster,

it's difficult to think about, you know,

how will I get out of here?

Who could I call? What would
be a fast way to leave?

So helping people think about
that, their support systems,

what they would take in
terms of grabbing and go,

what they need.

And it sounds so simple,
but it's really not.

I mean, it's certainly,

even for somebody with
a mobility disability,

you need to think through
labeling your equipment

in case you're separated.

You need to think through if
the equipment is demolished

or destroyed or damaged.

Who's the payer? What's the serial number?

Just kind of prepping all that.

And it takes work, takes time.

So helping people,

and also helping them with their

signing up for local alerts and warnings.

You know, we just think
that's a no-brainer.

A lot of people do not
know how to do that.

Other partner roles,

and The Partnership is
really good at this,

which is offering

technical expert support remotely,

you know, developing
teams that you can call

to help you problem solve with things

that may seem kind of
complex and complicated,

that you can call on a
team who knows this stuff,

who does it daily,

who could help you think through

what to do and how to do it.

So those are just some of the roles

that partners could play.

Some partners will offer
sign language interpreters,

and being able to contract with them

and knowing how that will
occur, when it will occur,

what it will cost, what the
reimbursement will be like,

offering assistance at points
of distribution centers.

You know, we sometimes
don't think through the fact

that I may not be able
to carry heavy water

back to where I'm going,

or people who need help
picking up what they need

and getting it back to
where they're going.

Just help at PODs, point of distribution,

with line management.

Some people cannot wait in line

because of heat tolerance,
cold tolerance, whatever,

so this is kind of a
semblance of a shorter line

for people who need
kind of an express lane

because of some relationship

to difficulty waiting in long lines.

And debris removal.

You should say,

"Well, June we got that
managed. The government

does that. We got all
these government contracts

to remove debris." Right?

Yes? Huh?

No. They don't cover removing debris

from from sidewalks - often.

And for people who are roaming
around their community,

they're really not able
to leap over fallen trees

with a single bound, you know?

It's a big issue, and that
sometimes is not addressed

very quickly or easily.

So these are just pictures

of trees blocking accessible pathways.

I couldn't find a good picture,

so this is my AI-generated
picture, I will confess.

It's not too bad.

The wheelchair's a little off,
but hey, it kind of works.

Yes? Yeah?

Telehealth.

Telehealth is a big
deal also in disasters,

and our health partners can be very

helpful in making that
a reality for people

who need some immediate
health kind of consultation,

and making them work
either over the phone,

or by FaceTime, by computer.

Again, telehealth.

How to get someone, remotely,
a healthcare provider?

Oh, now these slides got here,

and boy did this get mixed up.

Anyways, you'll have the slides

in terms of messaging
that we already went over.

Life safety checks, very,
very important service

for people with disabilities
who may need immediate help

with getting food or supplies
or equipment or power,

or being able to evacuate or
needing assistance evacuating.

Preparedness plans, we
went over some of that.

Technical expert teams.

Providing access to assistance centers

to access navigation or
case management services,

including assisting in
navigating the benefit maze.

And we all know how difficult that can be.

So also site surveys, you
know, it's often overlooked

until the last minute service,

and we like to try and plan ahead.

So use community partners

to do the safe surveys ahead of time,

so you know where the
best PODs are to open

that are already accessible,

or shelters, or areas
for disaster assistance,

or people with expertise

on knowing how to do the quick fixes

when things don't work out,

when just a little bit of
fix can improve access,

whether it's a ramp
over a high threshold or

ordering porta-potties

and portable accessible showers,

because the ones there
are totally inaccessible.

Some pictures of accessible

portable restrooms,

and having them available,
and knowing where to get them,

and having those contracts in place early.

So these are all things that
teams can work on locally

to help you force multiply
what you're doing,

to work with you as a partner.

So let's take a break here
for a moment in terms of,

I wanna ask you all to...

Oh wait, I forgot one. Training.

Training is something that

I forgot to mention,

and that is that the FAST
course, the California model,

it's a day and a half of training,

and, you know, people who get trained

years later are often not the
people who end up deploying.

So I always say that
there needs to be really

important just-in-time focus in training

so people are reminded through checklists

and field operation guides

of the essence of what
they need to be doing.

Because, you know, I always say

people, we're all affected by CRS.

CRS, you know what that is?

Can't remember stuff.
Can't remember stuff.

So this just-in-time training really helps

to combat CRS.

And we need to spend a whole lot more time

focusing on just-in-time training,

and not just long, two-day,
three-day training.

So I wanna ask you to take
a moment at your tables

and answer some of these questions

in terms of from your perspective,

from your roles, your responsibilities,

is there any value in this FAST concept?

If no, why not?

And if yes, what would the objective be?

What would the intent be? What could work?

And who will be the major partners

who have the needed resources?

So take just a few minutes

and discuss among yourselves
at your table, you know,

just make any sense at all

in terms of something you could implement

in some kind of flexible
and customizable way.

So if you're at a table of one,

just kind of switch over for a moment

to a table with other people,

and just kind of discuss
it among yourselves

for a few minutes.

I'll give you at least
five minutes to do this.

So measuring success in my book

would be who in the end
are we able to deploy,

and what is their impact, the
results of their employment?

How do we measure that?

For example, just-in-time training,

the real impact is people get reminded

of what their essential roles are,

and their essential roles
actually help people

to meet needs and protect
their lives and their safety.

So -

My recommendations to you
all is, as you look at this,

and by the way, I just wanna know,

in your group discussions,

tell me how many of you answered no,

this would not be a go, this is a no-go.

And it's good to be honest.
How many answered no?

Oh, come on.

No one? Really?

Well, maybe some of you can
confess to me in private later.

(laughing)

Okay, well,

I urge you to look at this carefully,

and look at stuff that
is below the surface.

Don't just say, "Oh, this
is a really good idea.

I think we'll do it."

You know, really kind of
do your homework here.

Look at what does it take to do this well.

do it right, in whatever
way you wanna formulate it.

Be thorough. Look at all your options.

If I had a contract to investigate FAST,

because frankly, you
know, I've observed a lot.

I have a lot of anecdotal stories to tell,

but I haven't done the
rigorous research on FAST,

so technically the
researchers would say to me,

"The jury is out on this FAST,"

in the way it was conceived
initially, originally.

So if I had a contract,

if I had a contract to investigate FAST

and this yes/no question,

what I would do, and
this is really important,

what I would do is

I would look for states and local areas

that have deployed,

have experience with
deploying people in teams,

versus the majority who are engaged

and focused on the start up activities,

the training, the
recruiting, on, you know...

That's process, but I
wanna know about outcome.

I wanna know about what happened.

I wanna know about how
many teams were deployed

and how do we measure success.

What happened?

How many people were actually

protected in terms of
being able to function

in either shelter-in-place or at a shelter

or successfully navigate a POD, whatever?

What are the measures out there,

and what does it take

to sustain the relationships?

And what works and what still needs work?

And how are locals and
states defining these teams?

And what is the mix?

And is there a mix of community
and government people?

And how often are these
lists or teams updated?

How current are they?

What's the training like?

And are there prerequisites
for the training,

either refresher trainings,
just-in-time training,

and how many of these partners

are participating in drills and exercises?

And the measure of success in that

is not just the participation,

but are they involved in the evaluation,

in the hot washes, in applying the lessons

so that there's an improvement process

so it's made real, it's applied.

So just, I mean, I have a
whole list of questions.

I can go on for at least
another hour, but I won't.

So, but just, in taking this seriously,

really ask the difficult questions.

Budget, measuring success, recruitment,

MOUs, payment, reimbursement.

And think creatively. Be flexible.

What's needed in your area?

And work at defining that with partners,

with the community.

Just some pictures here of a FAST vest

and a FAST logo.

You know, the logo is a wheelchair user

and interpreter hands,
question mark, and a cane user.

And again, FAST people

talking to a shelter manager

in the trenches there.

This was what the FAST ID looked like

after you got a background check.

In California, background checks
were fingerprint processed.

And lastly, resources. You
got the California link,

the way that current model is described,

those current state teams.

And the other resource I
would ask you to look at

is the role of health plans
in disasters and emergencies,

'cause it applies to many
different health entities,

and I think we often
are not inclusive enough

of all of our health partners

as part of our community partners.

Oh, so I think that's it.

I think we get lunch, and I
think I gave back how many?

Oh, but any burning questions?

And I don't wanna short
change you five minutes.

Okay, any questions?

Questions over there?

- [Audience Member] When you're
talking about recruiting,

speaking of recruiting,

I told Sadie a little while ago

when it comes to people who volunteer

or people who, you know, the disaster

could be happening to them,

we're talking about the people
that we're recruiting though,

we've gotta have a backup
plan for the recruits,

'cause sometimes they're
not gonna be available

because this disaster
has struck their family.

So are there two groups
maybe we should have,

where you have recruits
and then backup recruits?

How do you do that?

Maybe because like we
have an interpreter set up

to say yes, they'll be
at the disaster meeting,

and then they're not available
for some reason or another.

So you have like team A and then team B?

Would that work or...?

- [June] Well, interesting question.

In terms of the interpreters,

part of good contracting
is having backup contracts,

to never just have one contract.

You have several contracts.

But in terms of your community partners,

it's always good to have many partners,

because there will always be people

who cannot be part of a deployment

because they've been
significantly impacted themselves.

That's just part of disaster work.

We always have to plan for that.

You know, just like in
the disability world,

you've gotta have some
very heart-to-heart talks

with your personal assistant

if you're reliant on
somebody you hire for help,

because in an emergency they
may have family obligations,

and they're not gonna
be able to get to you.

And so backup plans,

your individual plans have
to account for that as well.

So just never relying on
one, but relying on many,

and recruiting many, not just one.

Any other questions?

Okay, I'll be around for
your confessions later

or any other questions.

So thank you.

(attendees clapping)