National Commission on Children and Disasters
February 2, 2010 Meeting

Minutes

Participants:

Ernest Allen, J.D.*
Michael Anderson, M.D., FAAP*
Merry Carlson, MPP*
Victoria Johnson, MS
Roberta Lavin, Ph.D., APRN, BC†
Hon. Sheila Leslie*
Bruce Lockwood, CEM*
Graydon "Gregg" Lord, MS, NREMT-P*
Nicole Lurie, M.D., MSPH†
Irwin Redlener, M.D., FAAP*
Christopher Revere, MPA
David Schonfeld, M.D., FAAP*
Mark K. Shriver, MPA*
Lawrence Tan, J.D., NREMT-P*

Invited Guest:

Sonya Hsieh, Department of Homeland Security

*Commission Member
† Full-time federal employee

The meeting was open to the public and held at the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), 7th Floor East Multi-Purpose Room, 901 D Street SW, Washington, DC, 20447. Approximately 55 members of the public attended; six presented oral statements.

<u>Proceedings of February 2, 2010</u>

CAPT Roberta Lavin, Designated Federal Officer to the Commission, called the meeting to order at 9:30 a.m. Emily Goodman of Abt Associates was designated record-keeper for the meeting. CAPT Lavin asked the Commissioners to introduce themselves.

CAPT Lavin introduced Vice Chairperson Dr. Michael Anderson, who provided an overview of the meeting's agenda. He said that the Commission is well aware of the effects of the disaster in Haiti, indicating that this situation would likely be addressed throughout the day. He also mentioned that the day before, a very successful Long-Term Recovery Workshop had been held in Washington, DC, the highlights of which would be discussed later in the morning, following a summary of the Commission's field visit to Iowa.

Discussion of Iowa Field Visit

Dr. Anderson asked Christopher Revere to summarize the Commission's January 6, 2010 field visit to Cedar Rapids (IA) to learn more about Iowa's recovery efforts since the floods and tornadoes in 2008. Those who travelled to Cedar Rapids included Commissioners Mark Shriver, Sheila Leslie, and Dr. David Schonfeld, and Commission

staff. They met with federal, state, local, and non-governmental representatives to discuss the recovery efforts and lessons learned from the recovery process. Mr. Revere highlighted several key findings from the trip. First, it was clear to the Commissioners that the recovery efforts were hindered by the absence of national, state, and local long-term disaster recovery plans, and that Iowans are looking to the federal government for guidance in developing these plans. Second, a central point of coordination for recovery is needed to ensure that necessary services are provided for children and families. Third, most federal disaster assistance programs are designed to assist with the immediate response to a disaster, and not long-term recovery. The Commission wants to review current programs to determine whether they can be modified to meet long-term recovery needs, or whether new programs are needed. Mr. Revere said that federal housing assistance programs illustrate this point—families have to move frequently because the assistance period keeps expiring. Fourth, recovery is not just a federal responsibility. As an example, Mr. Revere observed that there is a need for evacuee tracking and family reunification immediately after the disaster, before federal resources may be available.

In sum, Mr. Revere said that the Iowa field visit reinforced the need for a national recovery framework, with clear roles and responsibilities for all levels of government, so that state and local officials do not have to "negotiate" with the federal government after the disaster to implement the programs that are needed to meet children's needs. The field visit was also timely, given that the public comment period for the draft National Disaster Recovery Framework document will begin in February.

Dr. Schonfeld summarized findings from the Iowa trip regarding schools and mental health. He prefaced his comments by noting a general disconnect between school officials and mental health officials: school officials said they wanted more mental health support, but didn't know how to access mental health services, while at the same time mental health officials said they had trouble gaining access to the schools.

Dr. Schonfeld felt that officials in Iowa did an effective job at "cobbling together" local, state, and federal resources, but that in general they were hampered by the limitations and inflexibility of federal disaster assistance programs. As an example, the Federal Emergency Management Agency's (FEMA's) Crisis Counseling Program (CCP), which provides post-disaster funding for counseling and outreach, does not have a pre-disaster planning component. As a result, schools without a pre-existing relationship with a community mental health provider had difficulty using CCP funding.

Dr. Schonfeld suggested that a recurring theme of the field visit was that federal assistance programs did not address the state's actual unmet needs. He stressed that federal officials wanted to help, but were constrained by their agencies' regulations, policies and procedures, so that federal officials had to negotiate with state officials to develop a better "fit" between the federal programs and the needs of Iowa communities. Sometimes the negotiations resulted in services being reimbursed (e.g., relocating a school administration building), but in other instances the needed services were not reimbursed (e.g., there was no reimbursement for the costs of transporting evacuated children to schools in their home community).

Dr. Schonfeld highlighted three recommendations from Iowa school officials: (1) extend the CCP program beyond the current 18-month period and cover additional services (e.g., direct therapy); (2) provide pre-disaster training for school and mental health officials on how to help children recover from disasters; and (3) design child-specific CCP assessment forms.

Dr. Schonfeld noted some administrative and technical problems that Iowa experienced with federal disaster funding, including with CCP. A total of 16 grant applications (including extensions) had to be filed because application requirements were keyed to the date of the first presidential disaster declaration, as opposed to the end of the incident period that was extended due to subsequent tornadoes and floods that struck the state. As a result, there was a major disconnect between the budget for services intended for one phase of recovery and the time period it eventually needed to cover. He said there was confusion about what services would be covered, and about the way that some necessary services were not covered because they were deemed to be planning activities and not response activities (e.g., community presentations to children on how to prepare for future floods was deemed preparedness and not recovery-focused) or not responsive to funding guidelines (e.g., counseling staff were instructed not to assist students who witnessed a school staff member's murder because it was not related to the covered disaster that provided their support). He stated that the scope of services provided under CCP is too limited. He also mentioned that Iowa negotiated with FEMA for the creation of a child coordinator position within the state-level administration of the mental health recovery services, and suggested that this position could be institutionalized within the federal guidance and made a fixture in all state-level programs. In general, Dr. Schonfeld emphasized the importance of ensuring that services that are actually needed are funded, that there is adequate flexibility in programs and that unnecessary barriers to the delivery of services are not erected.

Dr. Schonfeld highlighted three recommendations regarding mental health services. First, for planning purposes FEMA should provide states with the standard conditions of all grant applications in advance of disasters. That is, states need to know what they will be reimbursed for. A consequence of not knowing this, Dr. Schonfeld said, was that service providers were hesitant to offer services, preferring to wait to clarify if their services would duplicate other services or otherwise be deemed ineligible for reimbursement – what some have referred to as the "race to be last" in providing services. Second, Dr. Schonfeld recommended linking application requirements to the end of the incident rather than the start. Third, CCP guidance should require substance abuse screening, which is currently optional.

Next, Ms. Leslie offered reflections on the Iowa trip. She thanked those from Iowa in attendance, noting their willingness to be candid about what worked and what did not following the disasters. She emphasized that the area around the nuclear power plant was the most prepared for the disaster because laws required detailed emergency plans and coordination between child-serving agencies and emergency management in these areas. Ms. Leslie said that the challenge was to replicate that type of planning in all other

geographic areas, although she acknowledged it would be difficult to motivate state and local officials to undertake these efforts if they had not experienced a disaster.
Ms. Leslie added that the field visit provided an opportunity to test some of the Interim Report recommendations. In particular, she said that conversations with state and local officials validated many of the child welfare recommendations. She said that an area for future exploration is how to improve relationships between state and local emergency planners and child-serving agencies.

Mr. Shriver invited David Miller, Administrator of the Iowa Department of Homeland Security, to offer comments on the Commission's field visit. Mr. Miller thanked the Commission for coming to Iowa, stating that it helped reinforce the importance of pre-disaster planning within the state. He then concurred with earlier comments Commissioners had made on the visit, in particular the need for increased pre-disaster planning, the importance of integrating children's needs into the plans, the need to replicate in other parts of the state the highly effective planning model in the area around the nuclear power plant (in particular, the requirement to develop an evacuation plan and a plan to reunite children with their families) and the need to link federal funding to the end, rather than the start, of the incident period.

Mr. Shriver asked Mr. Miller whether the Iowa legislature was considering expanding the planning requirements for areas around nuclear power plants to other parts of the state. Mr. Miller said that there had been some discussion amongst legislators and that it could be legislated or perhaps become an administrative rule. He indicated that Iowa is currently implementing the Emergency Management Accreditation Program (EMAP), which includes establishing standards for planning, and which he hopes will encourage Iowa counties to adopt those planning standards. He also said that the Rebuild Iowa Office recommended "smart planning," which includes the consideration of populations with special needs such as children and rebuilding to facilitate economic development. Mr. Shriver also asked whether steps were being taken to address problems caused by linking funding programs to the start, rather than end, of the incident. Mr. Miller said that he has spoken with the new FEMA Regional Director about this, and will have the National Emergency Management Association take up this issue. Mr. Shriver said that he would also raise this issue in a future meeting with Sen. Tom Harkin.

Referring to the hodgepodge of federal and state programs that are available after disasters, Mr. Miller said the current situation is like making "stone soup," in which a multitude of agencies offer specific assistance programs, in absence of a plan for how all the programs combined will meet the area's overall recovery needs. Mr. Miller is looking for a "recipe" for recovery, noting that adequate planning is essential for developing that recipe.

Dr. Irwin Redlener asked whether there were attempts during the flooding to ensure continuity of medical care for children. As Mr. Miller was not sure of the answer, Dr. Redlener asked whether Commission staff could follow up on this question.

Dr. Redlener then observed that in Iowa, as was the case in New Orleans, the federal government is sending a mixed message regarding recovery. Federal officials recognize that local officials are best positioned to creatively solve problems that the disaster caused, but at the same time, the federal government erects barriers to creative local problem-solving by providing funding streams in silos, with various funding and programmatic constraints. Dr. Redlener conceded that it would be very difficult to correct this problem, but he challenged the Commission to address the disconnect between the structure of resources the federal government provides to local communities and local communities' vision of how to provide the best care and services to their citizens.

Merry Carlson, based on her experience applying for federal disaster assistance in Alaska, agreed with Dr. Redlener, in particular noting that the process of applying for CCP funding—and determining what the allowable activities are—is unnecessarily complex. Dr. Schonfeld added that addressing the disconnect and better serving the needs of local communities requires a centralized authority in the Executive Branch that oversees disaster recovery and all the individual federal disaster assistance programs. Mr. Miller concurred, and added that both centralized coordination and a centralized authority are needed. Finally, Mr. Miller stressed the need for an improved damage assessment process, one that incorporates the total community need, rather than a series of assessments each focusing on a specific federal assistance program.

Discussion of Long-Term Disaster Recovery Workshop

Mr. Shriver asked Dr. Anderson to begin the discussion of the previous day's Long-Term Disaster Recovery Workshop by summarizing the break-out session on Children's Access to Primary Health Care.

Dr. Anderson felt that the Workshop was highly successful, and in particular thanked Mr. Ron Sims, Deputy Secretary at the U.S. Department of Housing and Urban Development, for his opening remarks at the Workshop. Dr. Anderson said that participants in the Primary Health Care breakout session focused on three Interim Report recommendations: (1) ensuring access to a "medical home," (2) accelerating development of a National Disaster Recovery Framework, and (3) expanding the pediatric capabilities of federal disaster response teams. He summarized the many barriers to achieving the "desired state," including funding, insurance and Medicaid gaps, limitations to the Stafford Act, the absence of electronic medical records, lack of training, shortages of health care professionals and information technology needs.

Dr. Anderson said that many recommendations emerged from the breakout session, including the need to: integrate children's needs throughout the National Disaster Recovery Framework; expand pre-disaster recovery planning at the local and state level; clarify command and control structures during recovery, and; designate for-profit health care facilities and practices as critical infrastructure for the purposes of Stafford Act funding.

Dr. Anderson asked Dr. Scott Needle, a pediatrician from the Gulf Coast region who participated in the Primary Health Care breakout session, to offer his reflections on the session. Dr. Needle reported that Hurricane Katrina destroyed his office in Bay St. Louis, Mississippi. After he and his family had evacuated the area, he contacted FEMA to see if he could use one of their trailers for his medical office. FEMA denied this request, because trailers could not be used by private businesses. Three months later he was able to establish a fully functioning office in a portable classroom trailer provided by a local community hospital. He was able to continue operating his practice in the trailer for six months, but was then forced to close it for financial reasons. He received no governmental assistance during this period. Later, he learned that HHS was offering grants to community health care centers, but not to individual practitioners. When he asked HHS officials why this was the case, he was told that they never heard from individual practitioners, implying that, as a result, there was no perceived need. Dr. Needle emphasized the importance of federal officials proactively engaging local stakeholders to ensure that federal assistance is aligned with the community's recovery needs.

Dr. Redlener thanked Dr. Needle for raising critically important points, and argued that the American Academy of Pediatrics needs to advocate for individual practitioners to ensure that their practices can quickly re-open following disasters. Dr. Redlener asked Dr. Steven Krug to comment on Dr. Needle's experience. Dr. Krug agreed with Dr. Redlener's comments, emphasizing that the recovery process must account for all primary care providers, including individual practitioners.

Mr. Shriver asked Dr. Schonfeld to summarize the breakout session on Provision of Mental Health Services to Children. The goal of the session was to determine the role of the federal government and its partners in support of the delivery of long-term disaster mental health services to children in congregate care facilities. Dr. Schonfeld emphasized that these services were for the social and emotional health for children impacted by disasters, rather than for treatment of mental illnesses. He said that the barriers to providing these services were similar to the barriers highlighted in the other breakout sessions, and included funding, training, and the lack of pre-disaster planning.

Of the many recommendations emerging from the breakout session, Dr. Schonfeld highlighted five, including the need to: (1) consider the family as the unit of service, rather than just the child; (2) ensure that the National Disaster Recovery Framework clearly defines "mental health recovery" for children and families and includes more than identification and referral for mental illnesses and trauma symptoms and syndromes; (3) clarify what federal disaster assistance will and will not pay for; (4) ensure a seamless transition of services during the response and recovery phases and from federally funded to state-funded programs; and (5) institutionalize the availability of interdisciplinary teams that can provide training and technical assistance to state and local school systems and other congregate care sites and mental health providers.

Ms. Leslie said that future efforts related to provision of mental health services need to recognize that the "mental health infrastructure" in schools is being diminished through

cuts in funding for mental health providers. Dr. Schonfeld agreed, and said that reauthorization of the No Child Left Behind Act provides an opportunity to address the general problem of the lack of school-based mental health services.

Dr. Redlener, noting the likelihood of reduced levels of discretionary spending in next year's budget, suggested that the Commission, as well as other national organizations and local communities, focus on how to use existing funding more efficiently, such as by identifying redundancies in existing programs or restructuring the methods of delivering services. Ernest Allen agreed with Dr. Redlener, indicating that recommendations need to consider fiscal realities, possible areas of overlap, and opportunities for greater efficiency. Dr. Schonfeld, referring back to his comments on the Iowa trip, said that efficiencies in the delivery of school-based mental health services could be attained by developing pre-disaster relationships between schools and mental health providers. Mr. Allen, responding to Dr. Schonfeld's remark that there will never be sufficient funding to provide all the necessary services, highlighted the need to prioritize spending to ensure that top-priority items receive funding.

Mr. Shriver asked Bruce Lockwood to summarize the breakout session on Barriers to Information Sharing and Data Collection. Mr. Lockwood said that the desired state is implementation of two Interim Report recommendations—development of a national evacuee tracking and family reunification system and review of current privacy policies to permit timely information sharing when it is clearly in the best interest of children. He said that the barriers to achieving the desired state identified prior to the Workshop included information confidentiality rules, restrictive policies of federal agencies, the lack of a universal Release of Information (ROI) form, and the lack of established and interoperable information collection systems. Breakout participants identified other barriers to standardized tracking, including a lack of clarity on: what the scope of the system is; who owns and operates the system; who can access the system; what information will be available; how information would be entered; how the system could be funded; and whether barriers are due to the privacy laws or agencies' interpretation of the laws. Mr. Lockwood also said that additional outreach is needed to highlight the need for evacuee tracking.

Recommendations emerging from the breakout session: the scope of the system should be limited, focused on the safety of children until reunification, incorporate data standards, and link existing systems rather than creating new ones; a federal agency or an advisory board should have authority for the system; access to the system should be based on triggers that consider privacy issues and that vary for different user groups; and outreach activities should be required, in particular for school systems and child care providers. Mr. Lockwood commented that different levels of data access could be depicted visually via a pyramid: FEMA, at the top of the pyramid, would require only aggregate data, while service providers in direct contact with children, at the bottom of the pyramid, would require access to substantial individual-level data. He also emphasized the importance of having an "information sharing platform" for facilitating information sharing, rather than a single tracking system. Mr. Lockwood also highlighted the critical need to collectively review privacy laws and regulations,

suggesting the federal government establish a "one-stop shop" for this issue that, in particular, addresses how laws and regulations apply in disaster situations.

Mr. Allen followed up Mr. Lockwood's comments by noting that, while breakout session participants emphasized the importance of tracking children after disasters, participants also emphasized the critical role of privacy laws. But, Mr. Allen said, privacy laws should not be a barrier to delivering needed services to children after disasters, and therefore some type of emergency exception to privacy laws is needed. Ultimately, he argued, the quality of service delivery to children depends on the quality of the information made available to service providers.

Commenting on Mr. Allen's observation that triggers need to be defined to invoke an emergency exception to the privacy laws, Mr. Lockwood said that state-level triggers are also needed, since the majority of disasters do not result in a Presidential disaster declaration. Ms. Carlson concurred with both Mr. Lockwood and Mr. Allen that effective information sharing is needed to deliver the broad spectrum of needed services to children and families.

Presentation by RADM Nicole Lurie

Mr. Shriver introduced RADM Nicole Lurie, Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Health and Human Services, and thanked her for appearing before the Commission.

Prior to taking questions from the Commissioners, RADM Lurie reviewed ASPR's priorities and recent accomplishments. She remarked that ASPR released the first-ever National Health Security Strategy (NHSS), a document that defines goals for protecting the American public during a health emergency. The NHSS focuses on the need for active collaboration and coordination, and defines roles and responsibilities for government and individual citizens.

Second, RADM Lurie said that ASPR had coordinated response efforts to H1N1, American Samoa and Haiti within the past seven months. Each response was a learning experience for ASPR regarding the needs of children and how to respond to those needs. For example, prior to the H1N1 crisis, the number of pediatric ventilators nationwide was not known. Now that number is known. RADM Lurie said that the American Samoa response highlighted the need for accurate data on the local population, in particular about children with health conditions and other special needs. RADM Lurie also pointed out that the pediatric capabilities of National Disaster Medical System (NDMS) teams are being improved, and that all teams responding to Haiti are pediatric-capable. She said that a challenge in the response to Haiti is coordinating with the United States Agency for International Development (USAID) and the Haitian government to ensure that as many pediatricians and other health care volunteers from the United States as possible are able to get to Haiti. This challenge in turn has focused attention on improving volunteer registries, such as the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

A third major focus of ASPR, RADM Lurie said, is medical countermeasures, and ASPR is currently engaged in an end-to-end review of these, including manufacturing, testing, and distribution processes.

RADM Lurie also highlighted two staffing changes within ASPR: a new Deputy Secretary for Policy will be starting on or around March 1st, and a Robert Wood Johnson Health Policy Fellow in RADM Lurie's office has been assigned to coordinate all children's issues within ASPR.

Following her opening comments, RADM Lurie invited questions and comments from the Commission. Dr. Schonfeld began the questioning by expressing concern about the lack of focus on the unique needs of children, and the lack of pediatric representation on panels and workshops funded by ASPR and addressing critical issues related to disaster preparedness.. He pointed out that the ASPR-funded Institute of Medicine (IOM) meeting did not include pediatric representation (despite requests prior to the meeting) and their final report on Crisis Standards of Care, issued in September 2009, did not adequately address the unique needs of children. RADM Lurie acknowledged that the report would have been stronger had it done so, noting that discussions are ongoing to continue and expand the study.

Mr. Shriver, saying that children have long suffered from benign neglect by the federal government, asked RADM Lurie if pediatric specialists and pediatricians were involved in planning and setting the agenda for the upcoming IOM meeting on medical countermeasures. RADM Lurie said that the agenda for that meeting is being reexamined, and that pediatric issues would be a focus of her opening remarks.

Mr. Shriver asked whether ASPR would be willing to establish a senior-level working group focusing on children issues, much like the one that FEMA Administrator Craig Fugate established at FEMA. RADM Lurie reiterated the staffing changes that she mentioned earlier in her remarks, and, in response to a follow-up question from Mr. Shriver, said that she and her new staff persons would be happy to meet monthly with the Commission.

Dr. Schonfeld emphasized that he is not questioning ASPR's intentions, but that he is disappointed with results to date. He hopes that children's needs will be a key focus of the upcoming IOM meeting, rather than just being included in RADM Lurie's opening remarks, and that the forthcoming IOM report will include creative solutions for addressing the unique needs of children rather than simply reiterating the problem. RADM Lurie shared Dr. Schonfeld's concerns, pointing out that substantial work is underway and that results can be expected in the near future. She asked for the Commission's help in formulating solutions to meet children's needs following disasters. RADM Lurie also said that "reasonable" progress has been made in the federal government's response teams and organizations.

Dr. Anderson agreed with RADM Lurie that progress has been made on improving response teams, noting in particular the hiring of a Deputy Chief Medical Officer for Pediatrics for the NDMS as a very positive step. He then asked RADM Lurie to elaborate further on the fact that over 1,000 pediatric specialists have volunteered to go to Haiti, and yet federal Disaster Medical Assistance Teams (DMAT) have only one pediatrician per team. RADM Lurie responded by indicating that ASPR has been trying to improve NDMS in a variety of ways. Responding to the crisis in Haiti has been challenging because of the need to coordinate with USAID and the Haitian government, which has asked the federal government to limit the number of volunteers coming to Haiti. She said that ASPR is working with USAID and the Haitian government on a system to rotate medical volunteers into Haiti over the next 2-3 years. RADM Lurie said that one area where the pediatric community in the United States could make a significant contribution is in formulating a strategy, in conjunction with USAID, to address the ongoing orthopedic and rehabilitation needs of children in Haiti. She noted that prior to the earthquake Haiti had no orthopedic or rehabilitation infrastructure.

Dr. Redlener also expressed frustration at a number of issues, including the overly complex process for deploying volunteers to Haiti, the slow pace at which volunteers were arriving in that country and the lack of focus on children's issues at IOM meetings. Dr. Redlener asked RADM Lurie if ASPR had ideas on how to speed the deployment of volunteers to Haiti. RADM Lurie said she shared Dr. Redlener's frustration with regard to Haiti, but emphasized that ASPR is working under a Mission Assignment from USAID, and that USAID has said that they want more non-governmental organization (NGO)-based teams, rather than federal teams, deployed to Haiti. As an example of USAID's focus on the NGO community, RADM Lurie said that USAID established an Aidmatrix website for NGOs and other volunteer organizations to register as medical volunteers for the Haiti relief efforts.

Mr. Lockwood described the staffing problems he encountered in his district when the first H1N1 vaccines were received. The majority of persons who had volunteered to administer vaccines were not willing to administer the vaccines to children, and yet the first shipment of vaccines was earmarked for children. Consequently, the detailed planning that his district conducted was not aligned with the subsequent ASPR guidance on vaccine distribution. He encouraged ASPR to emphasize in H1N1 after-action reports, as well as future guidance documents, the need for data-driven planning that incorporates local demographics. RADM Lurie agreed with Mr. Lockwood's suggestion, and encouraged local officials to participate in the H1N1 after-action report process.

Mr. Shriver thanked RADM Lurie for addressing the Commission.

Presentation on Lessons Learned Information Sharing Portal

Mr. Shriver introduced Sonya Hsieh from the U.S. Department of Homeland Security (DHS), who provided an overview of the DHS/FEMA Lessons Learned Information Sharing (LLIS) portal known as LLIS.gov.

Ms. Hsieh said that the portal's target audience is the emergency response and homeland security community. There are three main components to LLIS. The first is a document repository. LLIS includes over 800 after-action reports and 1,800 state and local emergency plans. Second, LLIS has an in-house research staff that has produced over 1,000 "original content" documents on lessons learned and innovative practices. Third, LLIS is a network and collaboration tool with over 53,000 members. Ms. Hsieh said that 89% of the members are state or local officials, 5% are federal officials, and 6% are from the private sector. All members are "vetted and validated," as all information on the portal is on a "need to know" basis. All members are encouraged to submit content to LLIS.

Ms. Hsieh said that information is organized into topic-specific pages where members can access information, share experiences, and discuss issues. As an example, she displayed for the Commission a LLIS.gov screen shot of the "Emergency Planning for Persons with Disabilities and Special Needs" topic area page. Members interested in a particular topic can sign up for "dispatches," which are emails from LLIS that highlight new content or reports for that topic.

Ms. Hsieh highlighted the "channel" feature of LLIS. With channels, members can create their own "mini LLIS." Each channel has an administrator, who controls access to the channel's document library and member forums. She noted that some channels are public while others are private. Finally, Ms. Hsieh mentioned that LLIS has formed partnerships with a number of offices within DHS, as well as with other federal agencies.

Dr. Anderson thanked Ms. Hsieh for her presentation. He asked her, if the Commission were to advocate for a pediatric disaster response channel within LLIS, who would administer the channel and vet content. Ms. Hsieh said that the channel's administrator, who is designated when LLIS creates the channel, controls access to the channel. If the channel is a "moderated" channel, as opposed to a "public" channel, then the administrator could control what is and is not posted. Dr. Anderson asked how often LLIS is used, such as the number of "hits" the site gets. Ms. Hsieh didn't have data on use, but said that use varies widely depending on current events, such as an upcoming national exercise.

Mr. Lockwood commented that he frequently uses LLIS.gov, but finds it difficult to locate children-specific content on the site. He recommended that LLIS.gov try to make this information easier to find and, in particular, avoid including content related to children only in a "special needs" category. Ms. Hsieh agreed, and said that LLIS would appreciate any assistance from the Commission on how to make children-specific content more accessible. In response to a question from Dr. Anderson, Ms. Hsieh said that LLIS has collaborated with NGOs.

Dr. Schonfeld, after thanking Ms. Hsieh for addressing the Commission, asked for further clarification on the LLIS document-vetting process and, specifically, whether LLIS would be amenable to having an outside group of experts vet documents related to children and disasters. Ms. Hsieh said that documents posted to LLIS are not ordinarily

vetted by outside subject-matter experts, but that LLIS has collaborated with organizations in this process. She added that documents posted to private channels can be vetted by the channel administrator. She also clarified that LLIS is not open to the general public, but rather only to persons who have registered with (and been vetted by) LLIS.

Ms. Carlson mentioned another DHS resource—the Homeland Security Information Network (HSIN) Connect—for posting documents and holding on-line discussions. She said that officials in Alaska use HSIN Connect frequently.

Mr. Revere, reminding the Commissioners that a recommendation needs to be made regarding a national clearinghouse on children and disasters, suggested that the Commission and staff meet with FEMA to discuss the specific requirements that the Commission has for a national clearinghouse, and then determine whether or not LLIS.gov could meet those requirements. He said that if the Commission were to recommend that a national clearinghouse be created, there are two choices—either recommend the creation of a new site, or recommend the expansion of one or more existing sites to meet the needs the Commission identifies. He added that LLIS cost $1.5 million to set up and costs $3-4 million per year to operate.

Gregg Lord felt that the Commission needed to agree on whether the goal is to have a publicly available site or a secure site that is open only to members. Dr. Schonfeld said he wanted a site that is accessible to the professionals without requiring pre-registration, although he added that content from such a public site should also be available within LLIS to LLIS members. He felt that LLIS has great potential, but is not the ideal type of site that he is hoping could be created. Mr. Lockwood also added that some content was appropriate for limited-access sites like LLIS, while other content should be accessible to the general public.

Dr. Redlener asked whether the American Academy of Pediatrics (AAP) could host the site, noting that their website has both information for the general public and limited-access information. He asked Ms. Cindy Pellegrini from AAP whether this was possible, and she said that they could if funding were available. Dr. Redlener felt that the AAP was the "natural home" for the clearinghouse site. Mr. Lockwood on the other hand felt that the clearinghouse should not be housed at a site that is tied to one specific discipline. Mr. Lord emphasized that, independent of whether the site is hosted at LLIS, AAP, or some other organization, LLIS was a great example of what an information sharing site could accomplish.

Mr. Lockwood asked whether LLIS has a policy in place to ensure that documents on the site are current, for example, removing a document that refers to out-of-date standards. Ms. Hsieh responded that LLIS staff do not proactively identify out-of-date documents, but that they do respond to members' comments and act accordingly.

Mr. Shriver thanked Ms. Hsieh for appearing before the Commission.

The meeting adjourned for lunch at 12:30 p.m. and reconvened at 1:30 p.m.

Public Comments

Following the lunch break, Dr. Anderson thanked Mr. Shriver for chairing the morning session, and then opened the public comment segment of the meeting by calling on Dr. Anna Miller.

Dr. Miller, chief orthopedic surgery resident at the Hospital for Specialty Surgery in New York City, recently returned from Haiti. She commented that she and her team were far better prepared to treat adults requiring orthopedic care than children, noting that the team had only considered adults in their planning activities. Upon arrival in Haiti, she observed that many children required amputations, which could have been avoided if teams had been on-scene earlier. Dr. Miller urged the Commission to consider the importance of rapidly deploying pediatric resources, including pediatric orthopedic surgeons, to disaster scenes.

Dr. Anderson thanked Dr. Miller for her testimony, noting that her service provided a wonderful example of volunteerism in the aftermath of a disaster. In response to a question from Dr. Anderson, Dr. Miller said that her hospital funded her team's trip to Haiti, with logistical support from a colleague in the Dominican Republic. Dr. Anderson commented that this illustrates the challenge of integrating medical specialists into the federal response to a disaster.

Next, Dr. Anderson called on Dr. Daniel Green, who represented the Pediatric Orthopaedic Society of North America (POSNA). Dr. Green said that there are approximately 600 pediatric orthopedic surgeons in the U.S., some of whom had responded to disasters such as the Oklahoma City bombing and Haiti. He said that POSNA is ready to assist the Commission to improve the disaster response for children, including helping form a Pediatric Rapid Response Medical Team. Dr. Anderson thanked Dr. Green for his testimony, and asked if POSNA had attempted to integrate their organization and resources into the federal medical response structure. Dr. Green said that it was unclear to his organization how to go about this.

Dr. Anderson then called on Nancy Beers, Director of Camp Noah and Disaster Services for Lutheran Social Service of Minnesota. Ms. Beers thanked the Commission for their work, and encouraged the Commissioners to be mindful of the role that non-profit organizations have had in responding to disasters and addressing the needs of children. She provided an overview of Camp Noah, a week-long disaster recovery day camp for children in kindergarten through 6th grade. Ms. Beers reported that Camp Noah served 800 children in Iowa following the recent flooding in that state. Dr. Schonfeld commented that the Commissioners had heard positive reports of Camp Noah during their trip to Iowa in January.

To answer Dr. Anderson's question on how Camp Noah was funded, Mark Peterson, President and Chief Executive Officer of Lutheran Social Service of Minnesota,

addressed the Commission. Mr. Peterson said that they rely on donations to support the camp. He said that the camp was established because his organization believed that the emotional needs of children were not being met following a series of floods in the 1990s. He said that, in addition to positively affecting the lives of children, the camp also provided training to volunteers in disaster response, and incorporated best practices for providing therapeutic services to children following a disaster. In response to two questions from Dr. Redlener, Mr. Peterson said that Camp Noah could be expanded nationally, and that his organization has proposed removing any religious content in future versions of the curriculum. Dr. Anderson then asked whether other camps for children have benefitted from lessons learned from Camp Noah. Mr. Peterson was not aware of any.

Next, Dr. Anderson introduced Dr. Henri Ford, who addressed the Commission via telephone. Dr. Ford, a pediatric trauma surgeon from Children's Hospital Los Angeles, recently returned from Haiti, where he was part of a DMAT Team. He said that, once a field hospital was established 72 hours after their arrival, his DMAT team treated over 2,000 patients, of which roughly 40% were children. Still, he felt significant opportunities to treat additional children, and treat others more effectively, had been missed. In particular, Dr. Ford cited three primary problems: (1) a lack of coordination of pediatric assets; (2) a lack of resources, supplies, equipment and medications to treat children; and (3) the lack of a coordinated approach to handle the large number of displaced children, in particular orphaned children. For example, the DMAT team had no pediatric ventilators, even though 50% of the population is under 15 years of age. Based on his experiences, Dr. Ford recommended establishing national pediatric disaster response teams; requiring hospitals to plan for pediatric disasters, to ensure sufficient supplies; and establishing protocols for tracking children transferred between hospitals and for communicating with parents.

Dr. Anderson thanked Dr. Ford for addressing the Commission and for his heroism in Haiti. Mr. Lord asked Dr. Ford whether he felt the situation would be any different with respect to coordination, assets, and tracking children if a similar disaster were to occur in the United States. Dr. Ford said he hoped it would, noting that hospitals in Los Angeles have engaged in regional training and coordination exercises to improve the response for children. Still, he said that the response to Haiti was not adequate. Mr. Lord added that he anticipates that similar resource gaps would occur if a similar disaster occurred in the United States. Dr. Anderson, echoing Dr. Ford's remarks, highlighted the large number of pediatric and other medical specialists that would like to be part of the federal response, relative to the small number that actually *are* part of the federal response.

Dr. Redlener commented that an official from the Haitian Ministry of Health had asked that medical care not be provided to children who would need intensive follow-up care after initial surgical procedures. He asked Dr. Ford whether this was an appropriate request, given the situation in Haiti. Dr. Ford said that this was unacceptable, and pointed out that the initial, delayed response greatly complicated aftercare. As a follow-up, Dr. Redlener asked what planning has occurred among U.S. agencies to ensure that adequate follow-up care will be provided in Haiti. Dr. Ford said that the current plan to

establish two DMAT teams, serving a 250- and a 350-bed facility respectively, is clearly inadequate.

After thanking Dr. Ford for his comments, Dr. Anderson called on Dr. Krug from Children's Memorial Hospital in Chicago, who is a member of the Commission's Pediatric Medical Care Subcommittee. After thanking the Commission for extending the focus of their discussions to disaster recovery, Dr. Krug commented that he had three colleagues in Haiti who would echo Dr. Ford's comments on the lack of coordination, especially regarding shortages of critical pediatric resources. Dr. Krug felt that a fundamental barrier to addressing the needs of children is that children are placed in the general "special populations" category. Doing so neglects the unique needs of children, and creates a situation where conference organizers (e.g., IOM) feel that if they have discussions on the needs of children then they also have to include a similar focus on all the other special populations. Dr. Krug argued that this often provides a convenient excuse for well-intentioned organizers not to include a substantial focus on the needs of children at conferences.

Dr. Anderson then asked whether there were any additional comments from the public. When none were offered, Dr. Anderson moved to the next agenda item.

Open Discussion

Dr. Anderson asked Mr. Revere to discuss future plans for an ad hoc report that Commission staff have been developing to measure the progress of federal agencies in implementing the Interim Report recommendations. Mr. Revere said that the six-month anniversary of the release of the Interim Report is approaching, and that Mr. Shriver and Commission staff felt that this date would be the best time to issue an ad hoc report from the Commission, particularly given the continuing interest that Congress has expressed in the Interim Report. To help prepare the report, Mr. Revere suggested that a letter signed by Mr. Shriver be sent to the various agencies and offices that have responsibility for implementing the Commission's recommendations, asking them to provide the Commission with an update on their progress implementing the recommendations, or on their plans to implement them. Responses would be available for the Commission to review and discuss at the Commission's March 23rd meeting. These discussions would inform next steps for finalizing the ad hoc report and implementation of the recommendations.

Mr. Revere asked the Commissioners for comments and suggestions on this plan. Dr. Anderson felt this was an excellent plan. Dr. Schonfeld asked for clarification on whether the goal was to issue a status report (i.e., a report on the extent to which the recommendations have been implemented) or a "report card" (i.e., the Commission issues a "grade" for each agency). Given the overall objective of measuring progress on implementing the recommendations, Mr. Revere asked CAPT Lavin to comment on time constraints for issuing a status report or report card. She said that the Final Report is due in October, meaning that the Final Report has to be completed on September 1st so that the clearance process can begin. As a result, she felt that an ad hoc progress report had to

be completed by June 1st. CAPT Lavin said that receipt of feedback from agencies would be expedited by sending requests through HHS via the controlled correspondence process.

Mr. Lockwood said that he was concerned about issuing a "report card" since this would need well-defined metrics. He felt that the Commission was not ready to define those metrics, and suggested that a status report would be a better option.

Dr. Redlener supported the report card approach, arguing that it was the best way to get the attention of the agencies and to communicate to the public that the Commission is not satisfied with the extent to which the recommendations have been implemented. He argued that a status report would simply enable agencies to identify steps they have taken, but not place those steps in the context of what steps need to be taken. He acknowledged that metrics would need to be developed and that this is not easy. Dr. Redlener said that the Children's Health Fund recently issued a report card on the various health care proposals being debated in Congress, which included well-defined metrics.

Dr. Schonfeld agreed on the need to hold agencies accountable. He felt it was best to frame the report as a "progress report." He said that progress can be measured in such a report, although not necessarily with a letter grade. He suggested determining the extent to which agencies have taken action on each individual item or recommendation. The Commission could then rate that progress as, say, adequate, needs improvement, etc.

CAPT Lavin interjected and reminded the Commission to be mindful of their charge, and that it did not include producing an evaluative report or report card. She did indicate, however, that the Commission can produce an ad hoc report that is either a status report or progress report.

Lawrence Tan suggested that an ad hoc report could focus on the actions taken following issuance of the Interim Report. Those actions, in turn, would be referenced in the Final Report as part of what Ms. Carlson termed a gap analysis. Mr. Revere commented that this process not only would be a status check on implementation, but also would help the Commission determine whether the recommendations required modification or further refinement. Dr. Schonfeld concurred with Mr. Revere on the need to learn from agencies how the Commission can help with implementation. He also suggested that the report be less evaluative in tone, and instead focus on what progress has occurred and what remains to be done. Ms. Carlson agreed, indicating that the report would summarize the situation when the Commission was formed, the current situation, and then what work remains. Dr. Redlener, on the other hand, again argued the need to be more forceful in articulating the lack of progress in some areas. Mr. Lord agreed with Dr. Redlener on the need to clearly identify what has improved and what hasn't.

Mr. Revere summarized by indicating that an ad hoc report would be the vehicle by which the Commission could articulate their findings about progress that has and has not been made on implementing the Commission's recommendations.

In response to a question from Mr. Lord, CAPT Lavin said that grades or other evaluative indicators could be put in the ad hoc report. Dr. Schonfeld recommended that an analysis of the response in Haiti, generalized to include implications for future similar disasters, not be included in that ad hoc report, but rather be the subject of a separate, rapidly produced report. CAPT Lavin said that the Commission can produce as many ad hoc reports as desired.

With no additional comments from Commissions on the ad hoc report, Dr. Anderson broached the topic of whether the Commission should undertake additional field visits, in light of the earlier and successful visits to Louisiana and Iowa. Dr. Anderson suggested the possibility of a field visit to Florida, in particular to the Miami area, to assess the impact of influx repatriated citizens due to the earthquake in Haiti. Such a trip could inform both a possible ad hoc report on Haiti and the Final Report, by examining lessons learned from handling the large number of patients and evacuees coming to that area from Haiti.

In response to a question from Victoria Johnson, Dr. Schonfeld said that the field visit should focus on the immediate response to the Haiti crisis, rather than on the long-term recovery. While expressing concern that any Commission findings or an ad hoc report on Haiti may not be produced soon enough to meet the public's desire for information on Haiti, he felt that a Florida field visit could both inform the Final Report and illustrate the extent of unmet needs for children in both Haiti and the U.S. CAPT Lavin said that, while the Commission must limit its focus to domestic issues, an ad hoc report could address problems that occurred after Haitian patients and evacuees were in the U.S. Dr. Schonfeld also said that the response in Florida could illustrate whether the U.S. had the capacity to serve large numbers of children. Mr. Lord concurred, indicating that the shortages in pediatric equipment highlighted by Dr. Ford during his public comments could easily occur in this country as well.

Mr. Lockwood said that the impacts on Florida social services systems should also be assessed. CAPT Lavin agreed, and said that the majority of persons evacuated from Haiti to Florida did not require medical care. In total, 20,000 persons from Haiti have arrived in the past three weeks, with the vast majority settling in Florida. She also said that a significant number of evacuated persons are orphans awaiting adoption in the U.S.

Dr. Schonfeld noted that the Commission has not yet addressed a situation in which a mass casualty incident caused a large number of children to become orphans, thus presenting yet another reason to undertake a field visit to Florida. Dr. Anderson asked Commission staff to assess the feasibility of a field visit and begin making preliminary contacts.

Dr. Anderson asked whether there were other suggestions for field visits. Dr. Redlener recommended that the Commission re-visit New Orleans to assess the progress that has been made during the year since the Commission's trip there.

Dr. Anderson then turned to Dr. Schonfeld for his thoughts on next steps for the Commission, given the tight timeline outlined earlier by CAPT Lavin. Dr. Schonfeld, noting that he is more concerned about the needs of children following disasters than he was when the Commission was formed, said that "I don't think our work is done." He asked the Commissioners for their suggestions for ensuring that focus remains on children and disasters (e.g., extending the duration of the Commission or transferring responsibility to another organization), arguing that "the Final Report should not be the final word."

In response to a question from Mr. Lockwood, CAPT Lavin said that under the current legislative mandate the Commission's work ends with submittal of the Final Report, except that Commissioners must be available for six months to answer questions from Congress or the White House. Mr. Tan felt that the Commission needed to proceed under the assumption that the current timeline would not change. Dr. Schonfeld concurred, but added that the Commission needs to determine now whether there is Congressional support for continuing the Commission's activities, either by the Commission or another entity.

Dr. Anderson, noting that the National Coalition on Children and Disasters originally advocated for the creation of the Commission, asked Mr. Revere if he knew the Coalition's position on a possible role for the Commission after October 1st. Mr. Revere replied that the Commission cannot advocate to Congress or the White House to continue the Commission, but that the Coalition can and, more importantly, is ready and willing to undertake those steps. He said that Commission staff meet regularly with Coalition members, and that he would discuss this issue at upcoming meetings.

Mr. Revere asked the Commissioners to consider whether the Commission's charge is sufficient to enable the Commission to accomplish its goals beyond just producing a Final Report, given what has been learned to date. Dr. Anderson asked Mr. Revere what his impressions were on how receptive Congress would be to expanding the scope of the Commission's charge. Mr. Revere responded that although staff frequently brief Congress on the Commission's activities and there is widespread interest in those activities, Congress had not explicitly asked Commission staff about a possible Commission role after October 1st. He felt this was a good time to raise this issue, however, with the start of the appropriations process. Mr. Revere emphasized that, while what the Commission will do after October 1st is unknown, the Commission is fully funded through October 1st to produce the Final Report.

Mr. Lord asked what the Commission would want to accomplish if the Commission were able to continue working after October 1st. Dr. Schonfeld said that he would want to continue monitoring progress in implementing the Commission's recommendation, and identify gaps in services and resources. He emphasized that there needs to be an ongoing presence to advocate for the needs of children in disasters, although the Commission does not necessarily have to be the entity to take on that role. Dr. Schonfeld felt that the Final Report must not only be produced on time, as required by the charter, but also point out that additional work remains to meet the needs of children during disasters. For example,

the Final Report could discuss possible roles for the Commission, or another similar organization or office, post-October 1st to help ensure that those needs are met. Dr. Schonfeld felt that the Commission needed to make a strong statement on how to ensure that work continues on advocating for children affected by disasters after October 1st.

Mr. Revere pointed out that the Commission needs to reach consensus on this issue quickly, given the October 1st deadline, although CAPT Lavin pointed out that, absent a special appropriation, the Commission would not have any funding after October 1st, because the federal budget is not typically finalized until several weeks or months after October 1st.

Dr. Anderson then opened a discussion of the goals and objectives of the next Commission meeting, which is scheduled for March 23rd. He suggested a more strategic agenda, focusing in particular on identifying a "home" that will take the lead in advocating for the Commission's recommendations and the needs of children affected by disasters. Mr. Lord agreed with Dr. Anderson, as did Mr. Revere, who commented that a number of strategic issues need to be on the agenda. These include the ad hoc report on progress regarding the Interim Report recommendations, as well as other issues that the Commission has not had time to address. Mr. Lord wondered whether one day was sufficient for this discussion, although Mr. Lockwood added that it was important for the subcommittees to meet on the 22nd as well. Mr. Revere said that staff would consult with the Commission Chair and the other Commissioners to develop a list of strategic items that need to be addressed in March, and then determine whether a single-day Commission meeting would be sufficient.

Dr. Anderson then asked for clarification on how the Commission wanted to address the problems children have experienced as a result of the earthquake in Haiti, including possibly producing an ad hoc report on that issue. Mr. Lockwood expressed concern that such a report might be beyond the scope of the Commission's charter. Dr. Schonfeld suggested that the Commission focus on the lessons learned from the response to Haiti that are generalizable to a large-scale incident occurring in the United States that involved thousands of children. Such a report, he argued, would help determine whether the United States was prepared for a similar disaster, particularly given the Commission's expertise regarding the needs of children. Mr. Lockwood was comfortable with that approach, compared to a report focusing just on Haiti. Mr. Lord argued that it was important to evaluate the nation's response to this disaster, particularly regarding shortages and lack of coordination of pediatric resources and equipment.

Ms. Johnson then listed the items that the Commission hoped to accomplish in the next 2-3 months, including a field visit to Florida, an ad hoc report on Haiti, an ad hoc report on progress implementing the Commission's Interim Report recommendations, and the on-going work of the subcommittees regarding the development of recommendations for the Final Report. The Commissioners agreed with Ms. Johnson that subcommittee conference calls should be held in February. Dr. Schonfeld felt that a Commission report on Haiti had to be completed within 3 to 4 weeks "in order to be relevant." In response to

a request from Ms. Johnson, Dr. Anderson and Mr. Lord offered to assist Commission staff with a draft of the Haiti report.

Dr. Anderson asked whether the Commissioners had any other business to discuss. When no other issues were raised, CAPT Lavin formally adjourned the meeting at 3:15 p.m.

Participant Affiliations:

Ernest Allen: National Center for Missing and Exploited Children
Dr. Michael Anderson: University Hospitals, Case Western Reserve University
Merry Carlson: Division of Homeland Security and Emergency Management, State of Alaska
Hon. Shelia Leslie: Nevada General Assembly, 2nd Judicial District Court
Bruce Lockwood: Bristol-Burlington Health District
Graydon "Gregg" Lord: Homeland Security Policy Institute, George Washington University
Dr. Irwin Redlener: National Center for Disaster Preparedness, Columbia University; The Children's Health Fund
Dr. David Schonfeld: National Center for School Crisis and Bereavement, Cincinnati Children's Medical Hospital Center
Hon. Mark K. Shriver: Save the Children
Lawrence Tan: Emergency Medical Services Division, New Castle County Department of Public Safety
CAPT Roberta Lavin: Administration for Children and Families, U.S. Department of Health and Human Services/United States Public Health Service
RADM Nicole Lurie: U.S. Department of Health and Human Services
Christopher Revere: National Commission on Children and Disasters
Victoria Johnson: National Commission on Children and Disasters
Sonya Hsieh: U.S. Department of Homeland Security

Commenter Affiliations

Dr. Anna Miller, Hospital for Special Surgery, New York (NY)
Dr. Daniel Green, Pediatric Orthopaedic Society of North America (POSNA) and Hospital for Special Surgery, New York (NY)
Nancy Beers, Lutheran Social Service of Minnesota
Mark Peterson, Lutheran Social Service of Minnesota
Dr. Henri Ford, Children's Hospital Los Angeles (CA)
Dr. Steven Krug, Children's Memorial Hospital, Chicago (IL)