NATIONAL COMMISSION ON CHILDREN AND DISASTERS
NOVEMBER 20-21, 2008 MEETING

MINUTES

Participant List

Dr. Michael Anderson*
Carol Apelt[+]
Joseph Becker
Benjamin Berkman
William "Greg" Burel[+]
Merry Carlson* (via teleconference)
CAPT Allen Dobbs
Dr. Alfred "Carl" Jurison[+]
Dr. Steven Krug
CAPT Roberta Lavin[+]
Dr. Brad Leissa[+]
Hon. Sheila Leslie*
David Lipin
Bruce Lockwood*
Graydon "Gregg" Lord*
RADM Boris Lushniak[+]
Mark Misczak[+]
Edward "Ned" Olney
Dr. Irwin Redlener*
Chris Revere
Dr. David Schonfeld*
Mark Shriver*
Dr. David Siegel[+]
Lawrence Tan*
Roy Winter

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The meeting was partially open to the public: a closed session was held from 8:30 a.m. – 10:30 a.m., and the remainder of the meeting was open to the public. The meeting was held at the Administration for Children and Families, 901 D Street SW, Washington, DC 20447. Approximately 20 members of the public attended: five presented oral statements to the Commission (Joseph Becker, Dr. Steven Krug, David Lipin, Ned Olney, and Roy Winter); none presented written statements.

Proceedings of November 20, 2008

CAPT Roberta Lavin, as Designated Federal Official to the Commission, opened the closed session of the meeting at 8:30am and welcomed the members, then introduced Commission Chairperson Mark Shriver. The closed session, where the Commission heard presentations from a panel of experts from the U.S. Department of Health and Human Services regarding issues surrounding medical countermeasures as they relate to children, concluded at 10:30 a.m. The remaining Commission proceedings were open to the public.

Panel: Disaster Case Management

A panel of experts on disaster case management was introduced: Mark Misczak, Federal Emergency Management Agency (FEMA); Carl Jurison, U.S. Department of Housing and Urban Development (HUD); and CAPT Lavin, U.S. Department of Health and Human Services.

Mr. Miczak opened his remarks with the observation that FEMA lacked the ability and authority to deliver disaster case management services prior to Katrina, instead working with non-governmental organizations (NGOs) to deliver such services on an ad hoc basis. Hurricane Katrina demonstrated to FEMA that those impacted by a major disaster may

need additional assistance getting back to their pre-disaster status. The international donations that poured into the U.S. following Katrina were used to fund Katrina Aid Today to help people displaced by the disaster, regardless of their post-Katrina location, to connect to social services available locally. FEMA found this to be a fairly successful model, engendering many discussions throughout the Federal Government and Congress, and ultimately resulting in the granting of disaster case management authority to FEMA by Congress.

As a result of this new authority, FEMA partnered with HUD to activate the Disaster Housing Assistance Program (DHAP) for Katrina evacuees. FEMA's request to HUD was that it help displaced families identify and secure sustainable housing; HUD then began delivering housing case management services in the gulf. A Louisiana-led disaster case management pilot was also established, through which the state receives money from FEMA to operate its own program, with oversight from FEMA.

Dr. David Schonfeld asked Mr. Misczak for FEMA's definition of case management, to ensure the Commission has an understanding of what the term encompasses for FEMA. Mr. Misczak responded that it did not mean the provision of direct services to families, but rather is a relationship between a case manager and client in which a recovery plan is developed. Case managers identify needed services in the community, provide referrals as necessary, and encourage clients to seek the services they need. Dr. Schonfeld inquired into the skill set FEMA requires to ensure that case managers are qualified to correctly assess and address client needs. Mr. Misczak acknowledged that FEMA lacks case management expertise and does not consider itself qualified to outline minimum requirements for case managers, hence FEMA's partnerships with the U.S. Department of Health and Human Services (HHS) and HUD. Mr. Misczak also noted that HUD provides case management for clients living in HUD housing, and that case managers hired by NGOs must demonstrate their qualifications to their employing NGO (i.e. Catholic Charities) prior to delivering case management services.

Dr. Carl Jurison began his comments by explaining that DHAP as activated for 2008's Hurricane Ike is a culmination of lessons learned over recent years by HUD and FEMA. DHAP-Ike provides monthly rental assistance, as well as housing security and utility deposits. All families participating in DHAP-Ike are required to participate in case management; if they choose not to participate in case management, they become ineligible for further HUD services. Once FEMA determines an individual's DHAP eligibility, HUD provides the services to which the individual is entitled under the program. In particular, HUD case managers reach out to the elderly and other special needs populations. Dr. Jurison explained how the DHAP program works.

Mr. Shriver asked Dr. Jurison to redirect his comments toward an overview of the program's case management component, to which Dr. Jurison noted that he works on DHAP operations and not case management. Mr. Misczak interjected to observe that the various case management partners (i.e. HUD, HHS, NGOs) do explore the various resources available to clients, and CAPT Lavin said that HUD case management involves job assistance and other non-housing services, in addition to its housing-focused efforts.

Dr. Irwin Redlener asked how many Louisiana families are currently in temporary housing. Mr. Misczak responded that about 3,000 families remain in trailers in the Gulf, most of them in Louisiana, and 15,000 families remain displaced (i.e. in temporary non-trailer housing). If families move out of trailers and into DHAP, they are enrolled into HUD's case management program. Dr. Redlener pointed out Mr. Misczak's figures equate to approximately 35,000 children who, given the temporary nature of their homes, lack access to reliable healthcare and other services. Dr. Jurison observed that a family is FEMA's responsibility until the family signs a disaster rental subsidy contract with HUD, at which time they become the responsibility of HUD. FEMA provides trailers, etc., to families under its care, but once a family signs the subsidy contract, HUD assumes responsibility for them and funds their services through HUD appropriations. Families cannot receive services from more than one entity at a time, thus the "handoff" from FEMA to HUD.

Lawrence Tan inquired as to what part of the case management process focuses on education and other services for children. Dr. Jurison responded that it is his understanding that HUD case managers address those needs. Furthermore, Mr. Misczak noted that case managers provide services for special needs cases, which include children.

Dr. Schonfeld asked why the case management process is so complex, and if there is data on the percentage of families which opt not to partake of case management services. The percentage was not known by those present, though it was suggested it might be researched. Mr. Misczak estimated 30 percent do not participate, but data on the reasons why are not known and not collected.

Dr. Redlener said that FEMA funding under the DHAP had not been transferred to NGOs in Louisiana for the provision of disaster case management services envisioned for Katrina, and asked whether FEMA's case management approach is a theoretical model. Mr. Misczak clarified that the 15,000 displaced families he mentioned are receiving HUD case management services through DHAP, and that the 3,000 remaining in trailers are eligible for aid from Katrina Aid Today, while Louisiana establishes its own grant-funded case management program. Dr. Redlener pressed his point that Catholic Charities still has not received Katrina-related funds and is struggling to provide services without the funding.

Mr. Misczak re-emphasized that prior to Katrina, FEMA had no authority to provide disaster case management services. Additionally, he noted that when Congress did provide the authority, it was not made retroactive, effectively prohibiting FEMA from going back to serve families impacted by Katrina. He said that, under the pilot funded with donations from the international community, FEMA identified a non-FEMA funding source that enabled them to add additional monies to Katrina Aid Today to bridge the services gap until FEMA could fund Louisiana in setting up its own disaster case management program. Mr. Misczak acknowledged that some processes might be slower than others, but that Federal agencies have regulations and processes with which they

must comply. Furthermore, he noted that many families across America need case management services, but FEMA case management must be disaster-related. There are challenges present when a population had a significant number of needs prior to a disaster, such as was present in Louisiana prior to Katrina. Mr. Misczak again stressed that FEMA is limited in what it can do for Katrina populations because of the realities on the ground and in statute.

CAPT Lavin opened her remarks by noting that when HHS' Administration for Children and Families (ACF) entered the disaster case management realm, one of the first relationships ACF established was with HUD, which has the greatest access to available resources. ACF's disaster case management program was instituted with five principles in mind (self-determination, self-sufficiency, federalism, flexibility and speed, and support to states) and with the goal of returning families to a state of self-sufficiency as quickly as possible, based on what the individual says s/he needs. ACF's model proposes to have case management teams on the ground almost immediately to begin filling in service gaps quickly and connect people to the services they need until the state can resume responsibility. The ACF model connects to services already available in the community, landing case managers within 72 hours of disaster so individuals with immediate needs have a place where they can receive services and support in the earliest days. This model uses a professional, experienced and capable case management team on the ground fast; it also sends out Public Health Service officers and others who can provide medical backup to support case management efforts in real time: doctors and nurses are available 24/7 to provide medical insight.

ACF's disaster case management model, piloted and now fully operational in Baton Rouge following Hurricane Gustav, tried to ensure that the most vulnerable populations were triaged first and given priority within the system. Because the disaster case management operation is collocated within the Joint Field Office (JFO), FEMA representatives can simply walk across the hall to the disaster case management team to discuss and transfer those individuals in need of more in-depth case management. ACF has a contract with Catholic Charities to provide disaster case management to Gustav-impacted Louisiana residents. Catholic Charities subcontracts with local agencies and NGOs to provide case management services as well, particularly for special needs populations (i.e. mental health, developmental disabilities). Additionally, AmeriCorps*VISTA members answered phones and handled referrals in the JFO.

ACF notes that 42 percent of the Gustav population assisted through this model are children, and that 4,600 clients are actively being served as of today's date. ACF's disaster case management program has only been funded for Gustav-related case management, but Ike-impacted families are being served too at the request of the Secretary of Health and Human Services, since it would be inhumane to turn them away. CAPT Lavin observed that at least half of the households impacted by a disaster do not need or want government assistance; case management is really for those who are unable to help themselves.

Mr. Shriver inquired as to the method for disaster case management services being used for Hurricane Ike-impacted Texas. Mr. Misczak responded that Texas requested a FEMA grant that would enable the state to operate its own program. Mr. Shriver observed that, because of the time necessary to request and receive FEMA grant funding, Ike victims have not yet received any case management services unless they have entered DHAP; Mr. Misczak noted that FEMA has referred approximately 30,000 families to HUD for services.

CAPT Lavin noted that ACF's program does not ask clients about their immigration status or other questions that might cause them to feel uncomfortable participating in the program. Potentially questionable families are referred to NGOs with the understanding that there are questions ACF does not intend to ask. CAPT Lavin also said that ACF had received a letter from Texas requesting its disaster case management services, but when FEMA offered grant money, the state chose this option. CAPT Lavin voiced her frustration that after three months Texas has yet to assist anyone, despite the fact that vulnerable populations need services. She supports development of a system to get case managers on the ground immediately, whether through ACF's existing program or some other means.

Dr. Schonfeld observed that while a state may lose track of children, its education system may have a record of a child's registration and know the child's location. He asked if there are alternative models FEMA is considering for keeping track of victims. Mr. Misczak said FEMA has explored numerous models. People referred to HUD's program are FEMA-eligible and funding is provided based on how many people FEMA estimates will be FEMA-eligible. Connecting to a state entity (such as an education system) or other system would be one small part of a broader approach. Currently, FEMA hosts town hall meetings and other outreach efforts to communicate what services and aid is available to impacted members of the community. Many NGOs, agencies and service providers attend these events to meet with families; Mr. Misczak emphasized that these outreach efforts are not solely housing-focused events. Dr. Schonfeld suggested that schools might help support the needs of impacted children and encouraged exploration of that as an option.

Mr. Misczak said the three case management pilots currently underway will offer findings on various approaches. FEMA hopes the Commission will provide input on the strongest components of the findings of each to ensure the best program possible. Bruce Lockwood asked whether FEMA is developing a metric as a result of the pilot findings. Mr. Misczak responded that an analysis will be conducted on each pilot once they are complete, but studies of the pilots will not begin until the latter part of 2009.

Dr. Schonfeld said that in some instances, families are relocated to another town or community because of available housing, though the family wants to return to its home town as quickly as possible. He asked whether case managers might have a conflict of interest in trying to facilitate reinstating families in their original communities. Dr. Jurison said there is no evidence that rebuilding is slowed or that other problems relating to reinstatement have arisen. He stressed that it is the family's responsibility to find

housing, not the case manager's or FEMA's, and that often housing simply is not available. Dr. Schonfeld countered that families may worry that if they leave their community temporarily to find housing elsewhere, there may be less incentive to rebuild the decimated area. Mr. Misczak said that could potentially occur, but that such a situation is not specifically a FEMA issue.

Dr. Redlener noted that DHAP-Ike ends March 2010, Federally supported Katrina housing programs end March 2009, and there is a need for more qualitative data on the scale of the issue. CAPT Lavin cautioned that whatever program is developed, it should not be based on what has happened in Louisiana because of the strong influence of parishes, a unique situation that does not exist in other states.

Dr. Redlener asked why three different Federal agencies must each have their own disaster case management programs. Mr. Misczak noted the value in testing different approaches, although CAPT Lavin observed that FEMA can use mission assignments to task disaster case management service delivery to a specific agency. Dr. Redlener encouraged the Federal Government to get organized and clear about where various responsibilities lie rather than agencies each doing comprehensive case management separately and with different definitions. CAPT Lavin noted that if the Federal Government (i.e. the President or the Secretary) made disaster case management a priority, then such organization would occur, but unfortunately the government has not made it such a priority.

Mr. Shriver requested recommendations from the panelists on ways to improve the Federal Government's ability to manage and deliver disaster case management services following an event. Mr. Misczak said that the emergent concern based on today's panel session is to make case management services available immediately to the impacted population irrespective of who delivers them. He noted that the Stafford Act requires FEMA to grow states' capabilities to respond to disasters, so FEMA must identify ways to accomplish both goals. He observed that the housing concerns in particular may be smoothed out.

Dr. Schonfeld observed that while the panel and the Commission discussed all these various bureaucratic aspects, no one is asking whether impacted children are healthy and whole. When making someone whole is discussed, it is in the context of the adults, with little consideration for the situation for the child. He noted that HUD Section 8 housing can be located in unsafe neighborhoods, and the choice of whether to accept housing in dangerous neighborhoods or lose all eligibility for Federally funded supports can be overwhelming to people who have just come through a traumatizing disaster. The needs of children can be lost or forgotten in the melee.

Mr. Misczak said FEMA is trying to balance a number of different considerations in disaster response structure, including but not limited to children's concerns. He said the input from today's meeting will be shared with FEMA's senior leadership, including the Commission's request for metrics. He cautioned that the choices made by a family can

have an effect on metrics intended to measure program success and these choices may make delivery of essential services more difficult.

Panel: Shelter Design

A panel of shelter design experts was introduced: Mark Misczak, FEMA; Joseph Becker, American Red Cross (ARC); Edward Olney, Save the Children; and Roy Winter, Church of the Brethren.

Mr. Misczak opened by noting that sheltering is defined under the National Response Framework (NRF). He said that FEMA's responsibility is to address issues where a state lacks sufficient sheltering capacity. Federal standards are based on the ARC's shelter standards. Pre-event, FEMA works with state partners to develop shelters and other relevant response capacities, and becomes involved in large events where existing shelters do not meet the need. FEMA attempts to minimize congregate sheltering situations (i.e. arenas) and locate people in smaller shelter facilities as quickly as possible; FEMA's National Disaster Housing Strategy outlines its efforts and standards relative to sheltering concerns.

Mr. Becker opened his remarks with the observation that ARC responds to about 200 disasters across the country on a daily basis, most very small that involve housing people in hotels rather than shelters. When large events occur, ARC's partners become critical to serving the need. It is these large-scale disasters when a high school gym or a church becomes a shelter. Mr. Becker outlined the three phases of disaster housing: phase one is immediate emergency sheltering, with a duration of days; phase two shifts to interim housing, such as hotels; phase three involves long term housing, with the goal of returning families to a state of normalcy. Sheltering in this country is designed to be short-term.

ARC does not declare facilities to be shelters; that responsibility rests with local emergency managers. Approximately 40,000 buildings nationwide are currently pre-designated to be ARC shelters in times of emergency. Once local emergency managers declare one of those facilities to be a shelter, ARC operates it, employing volunteers and trained staff. ARC volunteers receive background checks and are extensively trained prior to shelter deployment.

In regard to shelter admission, shelters' top priority is that anyone with need is admitted, and confidentiality of those admitted is maintained. When individuals first enter a shelter, they are triaged for medical and other needs, a process that has improved significantly in recent years. Furthermore, within the past two years, ARC has established a working relationship with law enforcement for the purpose of identifying sex offenders within the shelter population so that they can be relocated to more appropriate sheltering options.

Mr. Becker noted that Church of the Brethren partners with ARC to provide child care within shelters. He said that, following Hurricane Ike in Texas, every shelter had child care services available as well as a safe place for children to play and be with their families. Despite the shelter standards ARC has upheld for decades, Hurricane Katrina

taught ARC how to partner more effectively with local organizations for the delivery of services. Mr. Becker observed that ARC has been developing guidelines to ensure that standards of care are consistent regardless of who is operating a shelter (i.e. ARC, Volunteer Organizations Active in Disasters [VOADs], churches). These standards include sanitation ratios, personal space ratios, and many other considerations. The Board of the National VOAD is considering the adoption of mass care standards developed by ARC.

Mr. Becker said it would be extraordinary for the Federal Government to operate shelters. In the United States, shelter operation has long been the responsibility of volunteers through local partnerships with organizations (i.e. churches, schools) that agree to uphold ARC standards. While the U.S. must improve its sheltering standards, the primary concern to be examined is how to transition people out of shelters more quickly into permanent, affordable housing.

Mr. Becker outlined four areas that might be improved:

1. Pre-disaster networking. Improve integration of local resources into the disaster response.
2. Triage. Improvement is needed regarding the health triage of children entering shelters with their parents.
3. Mental health. ARC focuses on mental health, but connecting individuals with local mental health resources is lacking.
4. Preparedness. ARC invests much in encouraging community preparedness, particularly for kids (i.e. Masters of Disaster curriculum taught in schools), but further distribution mechanisms and reach is critical.

Mr. Becker observed that when situations needing improvement are identified, Americans turn first to the Federal Government. He suggests this reaction be recalibrated to examine the sector providing the service in question to identify whether clear standards and the resources to execute those standards are present.

Mr. Olney opened his remarks by noting his intention to offer Save the Children's experiences regarding the provision of shelter and protecting children internationally, as well as to put forward considerations toward the development of domestic sheltering standards. During 2008, Save the Children provided emergency life-saving assistance to over 2 million beneficiaries worldwide. In addition, Save the Children is the largest provider of assistance in West Darfur, managing camps for over 500,000 internally displaced. In Darfur, there are hundreds of international organizations working to protect and alleviate the suffering of millions of displaced. An international engagement, including the United Nations, military and police peacekeepers, diplomatic and human rights efforts, as well as enormous humanitarian efforts, have been ongoing since 2003. For such a large convergence, questions of prioritization, responsibilities and funding become critical. It is for large-scale crises that the Sphere standards were conceptualized.

Mr. Olney explained the Sphere Project as the approach the international community has taken toward emergency response, with sheltering as a subset. For decades, emergency response organizations including the United Nations, the Red Cross, NGOs and governments responded to emergency events in an ad hoc manner, which was highly dependent upon the experience of staff and the personal values and decisions applied in varying contexts. In 1997, the Sphere initiative was launched by a group of NGOs and the Red Cross, taking a more systematic approach. Sphere framed a Humanitarian Charter and identified minimum standards to be attained in disaster assistance in each of five key areas: water and sanitation; nutrition; food aid; shelter; and health services. The handbook, first published in 2000, contributed to an operational framework for accountability. Taken as a whole, the Sphere standards represent a consensus across a broad spectrum and reflect a continuing determination to ensure human rights. Since the first Sphere handbook was published, over 400 organizations and 80 countries have contributed to the development of the minimum standards.

The standards are based upon the principles that populations affected by disasters have the right to life with dignity, are qualitative in nature, and are meant to be universal and applicable in any operating environment. The cornerstone is the Humanitarian Charter, which is based upon the principles and provisions of humanitarian law, international human rights law, refugee law, and the code of conduct for the International Red Cross and NGOs in disaster relief.

The underpinning of emergency response standards is human rights and particularly the rights of children. Mr. Olney explained that the United Nations General Assembly adopted the Convention on the Rights of the Child and opened it for signature on November 20, 1989. It was ratified faster and by more governments than any other human rights instrument. Its basic premise is that children (all humans below the age of 18) are born with fundamental freedoms and the inherent rights of all humans. All member nations, except the U.S. and Somalia, have ratified it.

As an American organization that represents saving lives, alleviating suffering and protecting children in emergencies worldwide, it is not lost on the brutal regimes where Save the Children works that the U.S. has not ratified the Convention on the Rights of the Child.

Mr. Olney said that children have rights in emergencies and must be protected, not as a matter of privilege or charity but as a matter of fundamental human rights, and therefore should be seen within that context. Any support that the Commission may provide to linking international human rights law into the discussion on protecting children in emergencies in the United States would go far in raising the status of children and of respect for human dignity during emergencies, both here and abroad.

Mr. Olney said that, based on his decade of international experience, he wished to raise for Commission consideration a recommendation that general sheltering standards for local, state and federal authorities, as well as for NGOs, be established, and that they provide specific recommendations for the safeguarding of children in emergencies.

Mr. Olney noted that FEMA currently has responsibility for the provision of mass care and sheltering under Emergency Support Function (ESF) 6; FEMA's primary implementing partner in delivering sheltering services is ARC. The majority of U.S. shelters are open less than 72 hours and are operated by local jurisdictions, with longer-term management of mass care transitioning to FEMA and the ARC in large-scale disasters. Examples include:

- City of San Diego operated mass shelter at Qualcomm Stadium during initial phase of California Wildfires (Oct. 2007)
- City of Houston operated mass shelter at George R. Brown Convention Center in Houston following Hurricane Ike (Sept. 2008)

Mr. Olney offered the following recommendations for the development of general shelter standards:

- Apply to all ages and abilities
- Focus on ensuring human dignity
- Provide immediate life-saving support and protection
- Establish responsibilities for maintaining safety and protection of shelter inhabitants. When individuals and children must enter a shelter, they are no longer able to fulfill their own duty of care. For example, a child going to a toilet in his own home is not at risk, but by placing them in a mass shelter, they are at risk when they must use a portable toilet facility located in a poorly lit area well outside the shelter structure.
- Are based upon established global standards for sheltering and transitional housing (Sphere)
- Are created at the national level, then adopted and implemented at state and local levels. General shelter standards should be applied in every shelter in the U.S. and its territories.
- Monitoring procedures are established to ensure quality and determine adherence to general shelter standards; access to Federal and state funding should be denied for non-compliance by implementing agency
- Information (i.e. leaflets) provided in culturally appropriate languages to residents, the state and implementing agencies of shelter residents' rights (i.e. outlining what to expect and the grievance policies) and responsibilities (i.e. accompanying their own children to and from toilet facilities and reporting instances of observed noncompliance)

In a written statement submitted to the Commission prior to the meeting, Mr. Olney offered some specific recommendations for inclusion in the general shelter standards. Those recommendations are included in brackets below:

- [Temporary Housing Phase 1: Initial 24-48 Hours of Disaster: General Shelter Standards should include:

- Minimum numbers of toilets and showers, as well as standards for toilet placement, lighting and security/monitors at each, 24 hours per day
- Safe space (a clearly demarcated safe play area for children)
- Shelter layout and design standards (safe play area, surrounded by family cots/blankets, surrounded by single women's cots/blankets, surrounded by single men's cots/blankets, essentially forming concentric circles to help ensure children's safety and protection)
- Minimum standards for food, water, health and hygiene, access to medical care
- Counting of children and babies upon registration and documentation of their ages and special needs (currently, all individuals entering shelters are counted as individuals; there are few, if any, records of numbers of children present, ages, and special needs)
- Clear child reunification protocols for unaccompanied children and minors to facilitate family reunification
- Provision of basic essential hygiene needs (including size appropriate diapers) and an environmentally sound system for their disposal

- Temporary Housing Phase 2: Day 2 – Day 7 post-disaster: Implementers should strive to achieve the following:

    - In some applications, particularly rapid onset disasters, the effects of the emergency may prevent the full implementation of the general shelter standards during the initial 24-48 hours. During this phase, full implementation should be attained. (Example from the international response community: the Sphere standard is 15 liters of water per day per person. During the initial phase, they may only be able to provide 5 liters of water per day, but by day 7, they must provide 15 liters of water per day per person.)
    - Additional shower/bathing facilities with designated times for child bathing and family use; include appropriate monitoring by staff/security
    - Infrastructure to make certain single parents receive the support necessary to ensure the health and hygiene of their children
    - Establishment of diaper changing areas and a system to ensure environmentally sound practices for the disposal of diapers (Example: This issue was highlighted during Hurricane Ike: because no disposal system was established, many shelter managers complained that portable toilet facilities were clogged by non-biodegradable trash being thrown into the toilets, including diapers and feminine hygiene products.)
    - Establishment of private area for breastfeeding and access to nurses to provide support for nursing mothers

- Temporary Housing Phase 3: Day 7 – 1 Year Post-Disaster

    - To support human dignity and the preservation of family, transition from mass shelters to facilities that provide private space for families and

designated toilet facilities per family (for example family individual housing units such as tents, trailers, or hotel rooms, that contain individual family-designated toilet facilities). Families assume additional responsibility for cleaning living spaces and their own toilets.

- The number of people in one location should be minimized. Mass sheltering or large transitional housing sites amplify problems dramatically, putting children at greater risk.
- Orientation and placement of family individual housing units (tents, trailers, hotel rooms) in clusters of original community members, mirroring regular community structure, as opposed to lining them up in straight rows, military style. The cluster approach helps safeguard children within their local community cluster.
- Establishment of safe bathing facilities for children (Example: baby washing tents offer the opportunity for mothers to network, and receive critical health and safety information and individual assistance support)
- Green spaces and outdoor collective play spaces and playgrounds
- Sidewalks, safe walkways, posted speed limits, designated bus stops
- Establishment and enforcement of noise ordinances to facilitate regular sleeping habits
- Laundry facilities
- Access to schools, child care facilities and after-school programs, including transportation and emergency funding
- Establishment of a community meeting site for residents and facilitation of meetings to empower residents to identify and resolve issues, as well as the sharing of essential recovery information
- Programs to build bridges between longer-term shelter populations/transitional settlement populations and local communities to facilitate integration into the established community and decrease stress, animosity and tension.]

Mr. Olney said support from the Commission for the establishment of general shelter standards is essential, and it is his recommendation that FEMA convene its partners in a collaborative process to develop them. This may take considerable time and effort but is a path worth walking.

Gregg Lord asked why shelter standards need to be developed when international and ARC standards already exist. Mr. Becker noted that emulating Sphere is advantageous, but observed that Americans would not tolerate many of the standards present in the international approach. Thus a process for modification and stakeholder buy-in is needed.

Dr. Schonfeld noted that standards are not necessarily explicit (i.e. “baby supplies” vs. “formula quantities”). Mr. Becker said ARC has toolkits for shelter managers that get to that level of detail, and that ARC welcomes the Commission’s input on further strengthening its materials.

Roy Winter opened his presentation by noting that Church of the Brethren (COB) focuses on delivering services in the immediate aftermath of a disaster. COB works in partnership with ARC and FEMA to provide care where people are congregating. All volunteers are welcomed, screened, and trained. He observed that intensive training allows volunteers to provide many services and, conversely, that poorly trained volunteers can do a great deal of harm. COB keeps its caregivers very focused on their specific tasks, as distraction from those tasks can be harmful. Mr. Winter said COB has learned that having materials available for kids is not as important as having age-appropriate interaction with them. COB groups kids together based on age groups, focusing mainly on children aged 2-9 years; older kids need a different set of activities that create a therapeutic environment. Shelters that consider and plan for children run more smoothly than shelters that do not.

COB works to support the whole family and strengthen the family unit's ability to function in the shelter environment. Children are increasingly on emergency managers' minds, though not in their top 5 list of priorities.

Mr. Shriver asked if ARC reimburses local non-ARC shelters. Mr. Becker responded in the affirmative. Mr. Shriver observed that perhaps a carrot/stick approach might be that non-ARC organizations not receive reimbursement if they fail to meet a set of established standards. Mr. Becker said he could not recall a time when that kind of approach was employed, noting that issues of children not being taken care of more often arise in ARC-operated shelters than non-ARC community partner shelters who "smother their victims with love."

Dr. Schonfeld reemphasized that ARC standards are not explicit. If the standards are not explicit, he asked, then how does ARC ensure shelters really are prepared? Mr. Becker said that shelters often open within two hours of a disaster lacking many, if not most, of the supplies they will need. The supplies will arrive, but cannot be there at the very beginning. Dr. Schonfeld observed that Hurricane Ike was not a no-notice event, yet the shelters did not know how many children were in the community (although it knew how many animals). Mr. Becker said ARC shelter residents tend to be older and sicker than the general population, but CAPT Lavin noted that 42 percent of those being served through its Gustav disaster case management program in Louisiana are kids.

Mr. Misczak said most people will stay with friends or family rather than go to a congregate shelter, hence the older, sicker population which has fewer such options. ARC knows who is operating a shelter, but will not know the demographics of any given shelter except through the registration rolls, which are not distributed or reported at national levels.

Dr. Redlener observed that manual data recording is not reasonable in this day and age, and said information should be recorded electronically at intake, thus gathering the types of demographic information necessary to assess the needs of children and families in the shelter. CAPT Lavin said such a tool exists but shelter managers are not required to use it. Mr. Lockwood asked about the feasibility of bar coded wristlets, to which Mr. Becker responded that it was mainly a matter of funding: getting donors to buy IT systems and

other such infrastructure is very difficult, an unfortunate reality of the nonprofit world. Mr. Misczak added that FEMA has a free tracking system it has offered to states, but that states have declined to use it in favor of their own individual systems.

Dr. Schonfeld noted that standards specify minimum amounts of water for cooking, bathing, etc., but not minimum amounts of formula and other child supplies. Mr. Becker notes that ARC initial shelter opening kits include formula and diapers, but they are insufficient for serving the whole shelter since they are intended to cover immediate emergency needs only until local supply chains are established.

Dr. Anderson asked if volunteers are trained in pediatric needs. Mr. Becker said people who have anything more than minor medical needs are sent to special needs shelters that are run by hospitals and therefore equipped to address such medical needs.

Dr. Redlener observed that when sheltering extends for longer periods than anticipated, the responsibility for shelter residents' wellbeing becomes unclear. He asked where such responsibility lies. Mr. Becker responded that the shelter operator partners strategically within the community when it appears stays will extend longer than a few days; it is also the shelter manager's responsibility to liaise with community elements such as schools and mental health service providers to set up structures as needed. Mr. Misczak said FEMA's role at that stage is merely a support role, such as providing a temporary school facility, but it is the responsibility of the community to communicate their needs and readiness.

Mechanisms for increasing the focus and explicitness of planning for children were discussed. While most Federal agencies prefer to solve issues through policy rather than new law, that avenue requires organizational resolve and commitment to be successful.

Mr. Misczak noted that additional data on shelter populations is something desirable to a number of entities, and said that while it is not always readily available, FEMA can try to begin moving in that direction. Mr. Lockwood said that if the base documents used by FEMA to request response data included relevant demographic data fields, those would filter down through states and counties to the local level, increasing the likelihood that such data is reported.

Dr. Schonfeld suggested that guidance relating to human behavior in certain situations (i.e. gang development and other social behaviors) be developed to assist shelter operators and law enforcement. Mr. Becker noted that shelter security is a local decision, but Dr. Schonfeld pressed the point, observing that specific guidelines and recommendations would improve the current modes of service delivery and law enforcement.

Dr. Redlener said that mega disasters pose the most serious problems, given the large numbers of congregate shelters necessary for response, the significant numbers of displaced citizens, and the decimation of local infrastructure. He asked whether there are policies that differentiate between functioning in a mega disaster vs. a smaller scale

event. Mr. Misczak said FEMA implements a host state protocol, where people are relocated to other locations where damage and impact was less critical. In such situations, it will take an extended period of time before people return to their home communities. In these situations, states and local jurisdictions exert pressure, because states do not want citizens removed from their jurisdictions. States prefer to have their citizens in congregate shelters than removed to other areas outside their control, especially if it is to more permanent housing. Some communities will try to avoid opening a mega shelter, while other communities are quick to open mega shelters, which introduce a major social dynamic. But they open mega shelters because they feel it is the only option they have to keep their citizens in their community.

Additionally, ARC works through its local chapters. When an event is larger than a local chapter can handle, the nearby ARC chapters become involved to help provide services. For large events like Gustav or Ike, ARC brings in people on a national scale, though it is not optimal because those people do not know the local community.

Dr. Redlener suggested that such questions should be examined beforehand, ensuring information, protocols, relationships, etc., are established and in place before events to ensure that a disaster's impact on children is minimized. The larger the event, the less relevant the local infrastructure becomes in the equation because it will either be decimated or people will have been evacuated. The regional and national infrastructure is more relevant in large-scale situations.

Mr. Becker observed that removal from a community is not always the best option for the family because that community is where their support system resides. Mr. Becker added his support to that of Mr. Olney regarding development of a national shelter standard, but only if FEMA and the VOADs are involved. Mr. Misczak reiterated FEMA's openness to receiving recommendations from the Commission on child-related issues.

The possibility of evaluating and emulating international tracking systems was discussed. CAPT Lavin reminded all present that the tracking of people is subject to The Privacy Act and other confidentiality concerns.

Panel: Acute Medical Care

A panel of acute medical care experts was introduced: Dr. Steven Krug, Children's Memorial Hospital; David Lipin, San Francisco Bay Area Disaster Medical Assistance Team; and CAPT Allen Dobbs, MD, U.S. Department of Health and Human Services.

Dr. Krug opened his remarks with the observation that existing public safety systems are overtaxed daily, particularly urban systems: hospitals are overcrowded and the pediatric abilities of emergency department teams are uncertain. Emergency department care grew 26% but number of emergency departments decreased by 425 between 1993 and 2003. Most emergency departments do not require pediatric training for their clinical staff, and more evidence is needed to determine how to care for children in emergency departments. There is a pediatric emergency care experience gap: just 5-10 percent of emergency department patients are children, and most of those are not critical emergency

cases, which means there is not much opportunity for physicians to work with kids in emergencies.

Dr. Krug noted that most U.S. healthcare systems are design, staffed and equipped primarily for the care of adults, but children cannot medically be treated simply as little adults. He asked a critical question: can the U.S. create surge capacity to care for a large number of critically injured children?

To this point, he outlined ten recommendations to increase the United States' state of pediatric disaster readiness:

1. Invest in the capacity of the emergency and acute care foundation of the U.S. healthcare system, including EMS and trauma systems, emergency departments, hospitals and emergency care providers.
2. Promote the presence of consistent day-to-day pediatric emergency readiness as this will assist pediatric disaster readiness. Facilities, training, and pediatric care coordinators are key, and the Emergency Medical Services for Children organization should continue its leadership in this area.
3. Build upon existing systems/strengths in the U.S. acute care portfolio, including trauma centers, children's hospitals and academic medical centers.
4. Improve pediatric readiness and care capabilities of DMATs and the Medical Reserve Corps, including "bottom-up" and "top-down" processes.
5. Remove barriers to study, authorization and deployment of pediatric-specific therapies and countermeasures.
6. Establish national standards to assure child and family readiness of shelters and alternate care facilities.
7. Anticipate and meet the unique social and mental health needs of children as part of disaster response and recovery.
8. Consider primary care as a readiness asset and make maintenance of the medical home a priority for disaster recovery.
9. Require pediatric expertise in emergency and disaster planning at all levels.
10. Define pediatric-specific performance measures.

Pediatric involvement should be mandatory at all levels of disaster planning. Professional stakeholder organizations might be strategically partnered with to increase capacity, and existing assets can be more effectively leveraged.

Dr. Redlener observed that a plan for alternate care sites and providers for children is needed. Dr. Krug concurred, citing the lack of ventilators and pediatric supplies, but said the way to plan is to develop capacity and leverage existing resources to assist nonpediatric facilities in identifying how they would serve an influx of children.

Dr. Anderson asked what percent of the Institute of Medicine (IOM)'s 2006 recommendations have been implemented. Dr. Krug's response was that the implicit message accompanying IOM's recommendations was not to expect the Federal Government to embrace its recommendations. The grassroots approach to implementing

the recommendations is a more realistic expectation, and government should be encouraged to embrace the many committed organizations and individuals as it considers its next steps in this area.

Mr. Lipin began his comments by cautioning that, although he is an intermittent HHS employee, his remarks to the Commission are being delivered as a private citizen: HHS did not review or clear his points.

He said that when focusing on caring for children in disasters, what is really important is the care of the family unit. The best caretakers for children are parents within the established family unit. However, in disaster response, the response community does not focus on the family unit. The more stress put on the family, the more difficult it becomes for them to care for the child (i.e. a single mother with several kids, one of which is a special needs child requiring more of her attention). Services are not delivered to families as cohesive units.

Mr. Lipin introduced the topic of aeromedical evacuation, stating that regions evacuate when a pending disaster is identified (i.e. hurricanes). Much improvement has occurred in this area since Katrina, but there is further improvement needed, because the approach remains one of treating patients as individuals, again to the detriment of the family unit. Airlifting patients often divides children from parents/families because only patients are allowed on planes and caregivers are left behind. This traumatically impacts the child. In evacuations, it is often more difficult to find a pediatric bed than an adult bed, so it is more likely a child will be transported further away than an adult might be. In the U.S., large scale patient movement depends on the U.S. Department of Defense, whose process is burdensome and not designed for civilian populations. Their system relies on the principle that a patient can not be transported until there is a place for them to go. This causes the patient to have to remain in the danger theatre longer than they might otherwise be.

The National Disaster Medical System (NDMS) involves the provision of medical care at special needs shelters. DMATs are stocked with pediatric supplies as part of their response cache, but many shelters do not have pediatric-appropriate supplies. Mr. Lipin noted that making it FEMA's responsibility to provide these supplies may not be the answer because parents are familiar with the specific brands of supplies they usually purchase; thus, Mr. Lipin suggests that parents in shelters should be consulted regarding which supplies their shelter might stock.

Mr. Lipin said that medical/special needs shelters often lack appropriate supervision mechanisms for children in situations where their caregivers are patients, which can add to the child's trauma (similarly, the removal of pets from medical shelters is very traumatic for children because, once again, that pet is a part of the family unit).

Mr. Lipin touched on a few of the legal issues that can arise in medical/special needs shelters:

- It can be difficult to obtain reporting requirements and procedures (e.g. suspected abuse);
- It can also be difficult to report abuse due to a lack of communications or child supportive services;
- The ability to manage children who have been separated from their parents (e.g. aeromedical evacuation) can be undermined; and
- Registered sex offenders can gain admittance to shelters given shelters' "take all comers with need" approach, putting children (and adults) at severe risk.

Mr. Lipin offered several recommendations for the Commission's consideration:

- The Centers for Medicare and Medicaid (CMS) should create a national emergency healthcare program (e.g. emergency Medicaid) for out-patient services that aligns with its in-patient (NDMS) program to ensure patients' access to healthcare in emergencies is maintained.
- CMS should allow patients to maintain a 30-day supply of critical medications (currently health insurers generally do not allow patients to maintain a prescription medication buffer).
- Available healthcare professional are sometimes unable or unwilling to assist during disasters due to out-of-area licenses, lack of liability coverage, and pre-registration requirements. Therefore, HHS should develop a web-based system for designated healthcare entities to perform instant credentialing of out-of-area medical professionals. Additionally, HHS should offer Federal liability protection for licensed healthcare professionals working for a healthcare entity during a disaster.
- Because disasters often exacerbate other basic family and individual needs, the NDMS should expand to provide a more complete (though still basic) disaster health services solution, including mental health, social services, etc.
- FEMA should create a national evacuee tracking system that is accessible to all public and private entities involved with evacuation, with results viewable by evacuees and their families, to better facilitate reunification.
- NDMS should enhance its electronic medical records system to create a national disaster healthcare record system used by all healthcare entities that treat or transport patients during a disaster to ensure disparate healthcare entities can coordinate their activities and services.
- DOD should develop a "casualty evacuation" model for aeromedical evacuation, common across active military and national guard units, that provides rapid patient movement while relying on external entities to manage patient reception and disposition.

Dr. Anderson asked whether Mr. Lipin found it difficult for DMAT volunteers to collaborate with non-DMAT entities (i.e. hospitals), to which Mr. Lipin responded that he felt such relationships are underutilized. The Federal Government typically does not excel at the formation of such relationships at the local level. Dr. Anderson then inquired as to the baseline levels of training that novice DMAT nurses receive in the area of pediatrics. Following Mr. Lipin's assertion that there are no baseline levels of pediatric

training for DMAT nurses, Dr. Anderson voiced his support for a minimum training standard.

Dr. Anderson asked whether DMAT caches have enough supplies for pediatric needs. Mr. Lipin said that, initially, they do not, though they do receive what they need when the supply chain is established. Once DMATs are on the ground and meet up with their cache, they generally have what they need, although sometimes there are delays in getting the cache to DMAT teams, which can pose supply problems. He observed that there may be instances where a pediatric specialty DMAT team would be useful, but noted it would be more useful to increase pediatric capacity of non-pediatric medical professionals. Dr. Schonfeld said almost every population has children, so increasing pediatric capacity in DMATs would be desirable.

CAPT Dobbs opened his remarks with the observation that DMATs were originally formed as national teams with local capability, an approach that changed in 2001 when DMATs were transferred operationally to the newly created U.S. Department of Homeland Security, where they gradually became a Federal disaster response mechanism, a subtle but significant change. Following Hurricane Katrina, DMATs were operationally returned to HHS as a result of the Katrina lessons learned. CAPT Dobbs said DMATs were never intended to serve as or supplant local emergency response mechanisms.

CAPT Dobbs said the IOM report was correct in many aspects, as were many post-Katrina lessons learned literature. Until Katrina, DMTAs were supplied locally and lacked interoperability. However, in the past two years, DMATs have returned to a more standardized operational structure. DMATs were for a period viewed (and used) as a "one size fits all" approach, but today a more modular, scalable model is being utilized.

CAPT Dobbs said that things can be done right now to improve DMATs. He suggested that a pediatric structure be included. He noted that none of the pediatric issues mentioned in the 2006 IOM report Dr. Krug discussed earlier have been addressed in the DMAT structure yet, nor were they addressed in Hurricanes Ike and Gustav. HHS is currently reviewing DMAT cache stocks and evaluating where adjustments might be made, including pediatric concerns. CAPT Dobbs also said that age-appropriate medical skills are needed.

CAPT Dobbs outlined his recommendations for increasing DMAT pediatric capacities for response:

- A scaled and coordinated response that begins locally with local preparedness is ideal.
- Regional healthcare coordination groups that include pediatric capacity and expertise can establish communications and expectations regarding mutual aid (including transport).
- Interstate and national coordination should focus on pediatrics.

- Multimodal (rail, ground, air) pediatric critical and acute care transport standards (i.e. personnel, equipment, treatment) should be developed and usable across the spectrum of coordinated transport (local, state, private, DOD).
- A patient movement regulation outlining coordinated local, state and regional pediatric transportation and available bed capacity should be established.

CAPT Dobbs observed that pediatric critical care transport is a daily occurrence, and asked how that could be translated into a local/regional/national capability. How can the National Guard and DOD be successfully encouraged into updating their operations rules to ensure capability for pediatric, geriatric, and other special needs patients? CAPT Dobbs mentioned the presence of a national ambulance contract, and noted that new iterations of that contract will likely improve transport capacity. He said that surge capacity for large events should be made more robust in the area of pediatrics by non-pediatric providers. He suggested increasing healthcare regional coordinating groups, which would lend itself well to a more robust national capability, though scaling up would be needed.

CAPT Dobbs noted that the NDMS would like to standardize a training curriculum with public and private sector stakeholders that develops capacity for critical care teams to support other teams that may lack specific care expertise. Additionally, he said that pairing new regulations under development with pediatric components will allow for more effective transport of pediatric patients.

Dr. Anderson inquired whether there was a practical way to streamline the non-Federal pediatric resources available to the Federal Government in a response. CAPT Dobbs said that if a medical professional has been credentialed, the Federal system should not need to re-credential them. However, a national credentialing system evokes states' rights concerns.

Mr. Lord said that a perceived gap is that there is a disconnect within DMATs that fails to recognize already existing fundamental training processes. CAPT Dobbs said that NDMS envisions a DMAT as arriving, clinically apt, with local capabilities in place.

Dr. Schonfeld asked what role children's hospitals might play in regional care. CAPT Dobbs responded that surge response is critical, and that how pediatric hospitals work with NDMS to develop standards is important. In particular, a standard for a critical care pediatric transport team might be worth examining more acutely.

Dr. Krug observed that many of the standards being suggested have already been developed and just need to be tapped into and/or adopted.

Mr. Shriver closed the meeting for the day, noting the Commission would resume meeting at 8:30 am in the morning.

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Mr. Shriver welcomed all present to the second day of meeting then introduced Benjamin Berkman to facilitate a practical discussion of the previous day's sessions and next steps.

Mr. Berkman said that, following the October 2008 meeting, he identified some threshold questions and issues, outlined in the framework document distributed. He began the discussion with the following questions for consideration: what issues does the Commission want to consider; what research should be pursued; what expert panels and hearings should be scheduled; and ultimately, what outcomes does the Commission want to realize. Based on that the Commission's answers to those foundational questions, the Commission can then identify how it wishes to organize itself to accomplish those tasks.

Mr. Berkman walked through the framework document; issue areas he identified were medical countermeasures and acute medical care, case management and shelter design.

Disaster Case Management

During the discussion, Dr. Redlener suggested expansion of the case management issue parameters, as he believed them to be limited as written in Mr. Berkman's framework summary. He also voiced his hope that the Commission will develop an understanding of what types of personal information can be tracked (without violating Privacy Act and HIPPA laws) so that appropriate metrics can be incorporated into the agenda to be developed by the Commission. At the end of the day, he said, such metrics should specifically outline what needs to happen before, during and after disasters, including the necessary benchmarks and timeline.

Mr. Lord suggested looking at case management as a holistic concept and suggested identifying a common definition, with which CAPT Lavin concurred, observing that HUD, ACF, and FEMA each have their own definition. Dr. Schonfeld suggested starting with the ACF approach to disaster case management and working out from there, expanding to national mechanisms and considerations.

Louisiana

Mr. Shriver noted some Commissioners' desire to focus on the post-Katrina situation in Louisiana. Dr. Redlener stated his desire to do so, citing a recent Children's Health Fund review of children living in FEMA trailers, including Renaissance Village residents, which revealed significant medical problems in children that are double the usual CDC rates for underserved populations. He felt the Commission could help the plight of children in Louisiana through its ability to point national attention there.

Dr. Schonfeld said that a Commission visit to Louisiana for this purpose could provide an opportunity to showcase what could go wrong following a disaster, including what did gone wrong post-Katrina. Such a showcase could effectively spotlight the need that remains unaddressed in Louisiana, then enable the Commission to shift focus to improvements in the system. The Commission discussed the pros and cons of focusing its efforts on Louisiana, and debated levels of scope such focus might involve.

The Commission was reminded of the specificity of the statute to avoid redundancy with other efforts and findings that have already been made, and that its work must focus on areas not previously considered. To this end, Dr. Schonfeld suggested the Commission identify the ongoing persistent need present in Louisiana's low-income child populations, as well as the consequences resulting from inadequate addressing of those needs, including mental health.

Mr. Lord said he felt the Commission should use its position to "ring the bell" regarding the situation of low-income children in Louisiana, even if it means momentarily sidestepping away from the Commission's statutory mandate. Sheila Leslie concurred, observing additional political clout and public awareness of the Commission and its work may result.

The Commission achieved consensus that the Louisiana issues would be addressed with a circumscribed, macro approach. Mr. Berkman then asked what the Commission wants to accomplish by focusing on Louisiana in such a manner. Dr. Schonfeld suggested establishing a plan that would address the remaining issues. As part of such a plan, CAPT Lavin suggested reviewing the options that were available to the state but were never implemented, noting that those options included money for mental health that was never used and likely remains available. Dr. Schonfeld then gave voice to a fundamental question: if the state has decision-making authority but does not adequately serve its citizens, does the Federal government do nothing?

The Commission was not created as an investigative body, but rather as an advisory body to Congress with the responsibility for making broad policy recommendations. Mr. Lockwood concurred, but noted that the Commission would have recommendations as a result of looking into the Louisiana situation that could be carried forward at a macro level. It was then suggested the Commission consider amendments to existing laws to address the Commission's concerns rather than attempting to create a comprehensive legislative package for Congressional review, which may not be acted upon during the Commission's relatively short period of existence.

Dr. Schonfeld suggested focusing on the theme of case management, recovery and resiliency for the Louisiana trip.

Sheltering

A discussion of various methods for affecting change ensued, including a debate on the pros and cons of legislative versus policy approaches, Homeland Security Presidential Directives (HSPDs), and agency leadership adoption of child-friendly priorities. Merry Carlson suggested recommendations be linked to funding and grant guidance. CAPT Lavin said that when the need for an HSPD is identified, a working group at the White House is assembled to manage its development and shepherd it through the bureaucratic interagency process. Mr. Lord suggested that the Homeland Security Advisory Committee might be prevailed upon to pursue such an avenue, which could potentially shorten the usual HSPD development timeline.

A discussion ensued as to what extent the Commission wants to interface with community stakeholders, such as ARC or NVOAD (National Voluntary Organizations Active in Disasters). Mr. Lockwood noted that the Commission might offer input and advice to such bodies as they develop materials and plans, but should not be writing such materials and plans (i.e. national sheltering standards).

Mr. Berkman recapped the sheltering discussion, noting that the Commission could conduct a comprehensive survey of all sheltering guidance, toolkits, etc., and assemble a package of materials and information necessary for consideration as development of a national shelter standard is undertaken; this package would be shared with stakeholders in a collaborative development process. The Commission would consider whether an accountability structure (i.e., withholding Federal funding if national shelter standards are not upheld by shelters) is needed and what form such a structure might take.

Recovery

Mr. Tan noted the Commission's tendency to get down "into the weeds" rather than maintaining the macro perspective it must espouse in order to meet its statutory mandate effectively. The Commission should consider big picture policy changes, he said, but it is not the Commission's role to outline or specify how such policy changes should be implemented. Mr. Tan suggested that once the Commission is further along in its work, perhaps it might delve into such micro level concerns, but while still at the beginning of its work, maintaining a macro viewpoint is optimal.

CAPT Lavin noted that eventually a fundamental examination of the United States' approach to disaster assistance is needed. She asked why a family that owns real estate, for example, is eligible for more government assistance after a disaster than a low-income family with no financial or property resources at all.

Mr. Lockwood noted that schools are required to have response plans but not recovery or continuity of operations (COOP) plans. "Response happens" one way or another, he said, but recovery and COOP is often inadequately planned for, if planned for at all. How can sustainability be ensured so schools can stand back up after a disaster, thus enabling children to return quickly to at least this aspect of their normal pre-disaster lives? The Commission discussed school planning as an issue to spotlight in the future.

Subcommittees

The creation and structure of various subcommittee ideas were discussed, including possible subcommittees on resiliency, child care, and recovery. Dr. Redlener suggested developing a two-page rationale for a Recovery subcommittee before such a subcommittee is formed, which would provide a framework for so broad a topic. Dr. Redlener will work with Mr. Lockwood and Ms. Carlson to develop this rationale, then distribute it to subcommittee members for review and comment. Mr. Berkman also suggested phasing subcommittees in and out over time as topics command the Commission's attention, noting that all subcommittees do not have to be created right now. Dr. Schonfeld suggested inviting child care experts to speak to Commission before decision to create a subcommittee is made.

At the meeting's conclusion, the following subcommittees and participants had been identified and agreed upon:

- Acute medical care and countermeasures; Drs. Anderson, Redlener, Schonfeld
- Sheltering, starting with shelter design then moving on to long-term concerns – Mr. Lockwood
- Disaster case management, focusing on the overall system but acknowledging service provision concerns as well
- Mental health and community resiliency
- Recovery, taking a broad approach but also examining some of the smaller components, such as child care and school-related issues

Dr. Schonfeld suggested a separate workgroup that would work with stakeholders to develop shelter guidelines and review other materials for thoroughness in planning for and responding to the needs of children post-disaster.

Other Business

Dr. Redlener suggested a few items that might be brought before Congress as immediate recommendations, and was tasked by the Commission with drafting a brief white paper incorporating his suggestions for Commission consideration. The Commission also asked Dr. Schonfeld to draft a paper regarding medical countermeasures issues that could be shared with Congress immediately for consideration and action.

The Commission discussed potential locations, formats, and speakers for its next meeting. Commission staff will work with the members in the coming weeks to identify dates and location.

The meeting was adjourned at 1:30 p.m.