**National Commission on Children and Disasters**
**Field Visit: Miami, Florida**
**April 27, 2010**

**Participants on behalf of Commission:**
Dr. Michael Anderson, NCCD Vice-Chairperson
Dr. Irwin Redlener, Commissioner
Lawrence Tan, Commissioner
Vicki Johnson, Policy Director
Frank Valliere, Policy Specialist
Kim Fletcher, Abt Associates

**Participants on behalf of the Commission attended all sessions.*

**Morning Session: Discussion on Medical Coordination of Pediatric Patients from Haiti: Movement and Care**

**Invited participants:**
CAPT Patti Pettis, ASPR/HHS*
Jose Cintron, Region IV, NDMS/FCC Coordinator*
Elaine Kelley, Office of Refugee Resettlement, ACF/HHS*
COL Nick Lezama, USTRANSCOM*
John Cherry, Florida Division of Emergency Management
Mark O'Neill, State Department of Health
Hiram Ruiz, Department of Children and Families
Jeanne Eckes-Roper, Emergency Preparedness Director, Broward Health
Sherry Capers, Miami-Dade Emergency Management
Dr. Deise Granado-Villar, Chief Medical Officer, Miami Children's Hospital
John Wilgis, Florida Hospital Association

* Federal employee

*Updated June 24, 2010*

**Proceedings:**

Commissioner Dr. Michael Anderson welcomed and thanked the participants for their attendance. He expressed the Commission's hopes that today's field visit would present an opportunity for an open dialogue on issues that arose following the January 12, 2010 earthquake in Haiti. He explained that the Commission is charged with looking at domestic issues, and is therefore not here to examine the response in Haiti, but domestic issues that arose as a result of evacuees entering Florida.

Dr. Anderson noted that the day would be broken into two sessions: the morning session would focus on medical coordination issues and the afternoon session would focus on children without a status, school support, and any other issues the participants would like

to discuss. With the Commission's second report due to the President and Congress in October, the Commission would like to identify policy gaps as well as best practices. Commissioner Dr. Irwin Redlener added that the Commission is concerned about a disaster of this magnitude occurring domestically, and the implications it would have for children. The purpose of this meeting is to derive lessons learned from the experiences of those involved with response efforts in Florida. Dr. Anderson opened the floor to participants, asking that each person to walk the Commission describe their role in the response effort.

Captain Patti Pettis stated that the domestic mission was not adequately funded from the beginning. Following the event, the Department of State, which served as the lead agency of the federal response, provided funding and tasked USAID to direct the response in Haiti. However, there was little thought on how to support the repatriation mission and address the domestic issues that would arise. The current federal plan for repatriation was based on the 2006 Lebanon repatriation effort, which generally involved moving healthy people. The Haiti repatriation effort was more complicated because many people had medical needs and were homeless. CAPT Pettis stated that the response was reactionary, and Florida took the lead early on, doing an exemplary job. Eventually the federal government stepped in with the activation of NDMS, but it was a very disjointed effort from the beginning.[1]

Dr. Anderson asked why the federal government waited to activate NDMS. CAPT Pettis indicated that it was a lack of funding. She explained that the Administration for Children and Families (ACF) is in charge of repatriation and has a minimal budget for this task ($1 million total per year), which was quickly used up. Additionally, the general intent for NDMS is focused on service members, so the idea of evacuating civilians, including children, was never really planned for. There were limitations in transporting large numbers of pediatric patients. Dr. Anderson agreed that this was the original intent of NDMS, and asked whether NDMS is prepared to mature into an entity that can better serve children. CAPT Pettis stated that Dr. Kevin Yeskey, Director of Preparedness and Emergency Operations, ASPR, has made a commitment to developing response capabilities for children. They are currently looking to expand the scope of NDMS to include agreements with hospitals with pediatric bed space.

John Wilgis stated that one of the primary challenges was that while disaster response typically begins and ends locally, in this instance it was reversed. This was a federal mission, which Florida assisted. There were multiple federal agencies involved, including the Department of State, USAID, and HHS, but a lead agency was never identified. There was little coordination in the response. Dr. Redlener stated that USAID was the lead agency for the response; CAPT Pettis responded that USAID led operations in Haiti but had no role in the repatriation process in the U.S. Dr. Redlener acknowledged this, stating

[1] Jeanne Eckes noted after the meeting that "South Florida (Region VII) developed an ad hoc process for patient movement since there was no declared NDMS activation or DoD "official patient movement" with US TRANSCOM that worked well. The process became the model for the rest of the state and was shared with other states. This certainly was a best practice developed just in time."

that coordination was lacking in both international and domestic efforts. Many concerns remain about coordination for domestic events.

Commissioner Lawrence Tan stated that there is a need to reexamine NDMS for children, especially communications and coordination. Jeanne Eckes cited the need for modifications to the whole NDMS process, as it was never meant for pediatrics. She added that there is a lack of knowledge at the local level about the capacity and capabilities of NDMS.

Ms. Eckes stated that for this particular event, Department of State was the lead agency because it was an international event that involved repatriation of U.S. citizens. However, repatriation efforts normally involve healthy citizens, which was not the case with this event. The Department of State does not have a medical arm, and was thus hospital shopping the day after the earthquake. They called Ms. Eckes office, and were put in contact with the state Emergency Operations Center. This was the only call Ms. Eckes received asking about hospitals for use in the response, but she checked back to ensure that needs were being met. Ms. Eckes also agreed that coordination was a major issue.

Dr. Anderson stated that there seems to be a disconnect. NDMS is responsible for patient transportation; however NDMS does not have agreements with many pediatric facilities. He asked if there is a system in place for these two parts to work together. Ms. Eckes replied that she thinks there should be after this event. CAPT Pettis outlined the three components of NDMS, stating that the primary components are: 1) transportation, managed by Department of Defense (DoD), 2) Federal Coordinating Centers (FCCs), managed by the Veterans Administration (VA), and 3) deployment of health care personnel, which are civilian "intermittent federal employees" managed by ASPR. While there are two pediatric-specific Disaster Medical Assistance Teams (DMATs) under ASPR, pediatrics has not been a major focus of NDMS. CAPT Pettis stated that NDMS has never really been used to meet pediatric needs in disaster response, so while there are pediatric specialists on some teams, this is not a major component.

Mr. Wilgis stated that the bridge between transport and the receiving facilities is the Memorandums of Understanding (MOUs) among hospitals and NDMS, which allow for scalability beyond the VA system of hospitals. He added that Florida also has a state medical response system, which is mirrored on the federal system. Oftentimes, the same people that are involved in the federal system are involved in the state system, enabling the state to rapidly respond to an event before federal government becomes involved. Dr. Anderson stated that pediatric facilities and NDMS need to actively reach out to one another to establish this bridge. Children's hospitals the need to be more involved.

Dr. Deise Granado-Villar stated that partnership with the regular trauma network is crucial. She identified three priority needs for moving forward: medical coordination from the onset, guidelines for the immediate establishment of a disaster pediatric care site, and guidelines for determining who should be transported internationally for medical care.

Dr. Anderson stated that following the Haiti earthquake, more than 1,200 pediatric health care personnel volunteered to assist with medical needs in Haiti. He added that a system for pre-registering and vetting potential volunteers would be beneficial. Dr. Granado-Villar agreed, stating that a move in this direction has begun. The goal is to establish a database of people by specialty, with training or experience working in disaster situations, which could deploy when a disaster occurs.

Returning to the NDMS activation, Col Nick Lezama explained that while the medical response and definitive medical care components of NDMS were activated, he believed the patient movement component was not. DoD moved patients without funding or reimbursement. [Note: In a subsequent discussion with ASPR leadership, the Commission learned that all components of NDMS were activated at once, including patient movement, which facilitated reimbursement to DoD for patient transport.]Activation of this component sooner may have mitigated many coordination problems between DoD and HHS, however, a state must first make the request for assistance.. Additionally, before NDMS was activated, DoD was looking for hospitals on an ad hoc basis, largely relying on Florida to find appropriate hospitals to provide medical care. Once NDMS was activated, patients could be moved more equitably to Florida and Georgia. He suggested that the Commission should recommend an assessment of NDMS, especially the patient movement component and its role in international disaster response.

Dr. Redlener agreed that there needs to be clear differentiation on the issue of sending responders outside of the U.S. to respond, but the Commission must remain focused on what happened in the U.S. While less than 1,000 patients entered the U.S. medical system as a result of this disaster, it clearly stressed the system. If an event of this magnitude were to happen in the U.S., there could be thousands of children in need of medical attention. The Commission wants to gain a better understanding of the implications of this event for a major domestic event.

CAPT Pettis stated that the critical piece is funding. Some NDMS hospitals and the state of Arkansas have withdrawn from the system because of reimbursement issues. Florida and Georgia are currently experiencing these same reimbursement issues with this event. The other major issue is planning. CAPT Pettis stated that in her region, only one of the eight states has an approved repatriation plan.

John Cherry called for the immediate establishment of a unified command. For weeks after this event there was no plan, and NDMS activation looked like the most reasonable alternative at the time. From an emergency management perspective, Florida approached this event as if Haiti was a U.S. state. FEMA attempted to work with the state Emergency Operations Center, however they were told by USAID that they have no authority and were forced to stand down. The domestic impact of the event was significant because evacuees have severe injuries that will require long-term care. Also, other large-scale events going on in the state, such as the Superbowl, which stretched hospital bed space capacity and surge capabilities. NDMS activation was seen as the most reasonable approach to handling strain on the medical system and providing visibility to the

situation. Regarding visibility, Florida was receiving very little information on patients until flights were about to land. NDMS activation was needed to gain visibility.

Dr. Anderson stated that he appreciates the analogy of looking at the disaster as if Haiti were another state. Dr. Anderson asked COL Lezama if improvements in disaster transportation were still needed. COL. Lezama stated that the limited pediatric transport capability, the need for more training in pediatric transport, and the need for greater coordination between agencies all need to be addressed. He added that DoD is currently working with HHS to pre-identify DMAT personnel to work at airfields where patients are put onto aircraft, for the purpose of pre-hurricane evacuations. He would like to see this expanded to include pre-identifying pediatric transport civilian personnel that can be integrated onto DoD aircraft. While DoD would not be able to transport all children affected by a domestic disaster, they can certainly be part of the response. Dr. Redlener asked who has the authority to integrate civilian pediatric experts into military transport mechanisms. COL Lezama recommended the DMAT concept as the first step. DMAT personnel go through a vetting process and are federalized and trained. As an example, in May, 72 DMAT personnel will be trained to provide on-the-ground services and will be able to be integrated into ground facilities. In terms of expanding to those without training, that will be more problematic. Dr. Anderson agreed, stating that we would not want a doctor to become a liability in the field because of a lack of training.

Ms. Eckes stated that one of her biggest concerns was that some of her colleagues self-deployed to Haiti to assist in the medical response. The concern is having semi- or untrained professionals getting onto military aircraft and treating patients in austere conditions, potentially placing patients, the crew and themselves in danger. In addition to having personnel that can assist in a disaster response pre-identified, she suggested that these personnel must be trained as well. Dr. Anderson agreed that training is needed, but asserted that there are assets out there that do this every day. Ms. Eckes stated that these are the people that should be called on to assist.

Ms. Eckes stated that patients began arriving in Florida on January 13 via private ambulance from institutions like University of Miami that already had a footprint in Haiti. In these early days, patients in need of medical attention, regardless of nationality, were evacuated, leading to many immigration issues. Customs and Border Patrol had a difficult job determining the location and status of evacuees.

CAPT Pettis stated that NDMS has experience working in concert with DoD in domestic response, especially for hurricane evacuations. For example, after Hurricane Ike, patients were evacuated from Galveston to Arkansas and NDMS was doing triage in concert with DoD, but this was mostly for adult patients. They were able to move children, but this was generally within a small area. With recent downsizing and outsourcing of pediatric capabilities in DoD, the ability to address maternal and child health is limited.

Hiram Ruiz stated that there were three groups of people with medical needs coming into the state. There were those who came through the repatriation program itself. This is supported by a small program managed by the Office of Refugee Resettlement with an

annual budget of $1 million. They did not have a medical component identified, and little information was given as to whether there were any medical needs on repatriation flights until they landed.[2] The second group was foreign national medical evacuees on military flights and the third group was those who arrived by private means.

Mr. Wilgis stated that the opportunity here is to determine what needs to be done to fix the problems and fill the holes. While there are already a lot of mechanisms in place, it is a matter of breaking down the silos and increasing coordination. This was especially evident in the lack of interaction between federal agencies and between private NGOs and government entities. Additionally, triggers that activate the response effort need to be identified.

Dr. Redlener agreed that the silo issue is recurrent and intractable, and this begins with large number of committees in Congress that have jurisdiction over disaster response. He added that the Commission has a legal responsibility to report back to the President and Congress, and asked participants to think about what changes they would make within the federal government.

Dr. Granado-Villar stated that it is crucial that there is a seamless line of communication between all agencies. While this may be challenging, work on standardizing processes, both for disaster sites and receiving facilities, is beginning. This can help create a set of guidelines so everyone is on the same page. Credentialing of responders is also critical. As an example, a lack of credentialing responders in the Haiti response may have resulted in a number of amputations that were unnecessary.

Jose Cintron suggested that every time a Federal Coordinating Center is created, pediatric expertise must be involved. Ms. Eckes added that DMATs and other transport teams have to pre-identify personnel to focus on pediatric transport needs and train them appropriately. There also needs to be greater partnership between general hospitals and the NDMS system. During the response, Ms. Eckes was able to help connect all 53 hospitals in the region with the government agencies bringing patients into Florida. Under a typical NDMS response, NDMS would only transport patients to NDMS hospitals.

Dr. Anderson stated that children's hospitals would want to increase cooperation as well. But with the current fiscal climate, most of those involved with hospital finances would probably not be motivated by the current NDMS funding system. Ms. Eckes added that it always goes back to funding. While reimbursement at the rate of 110% of Medicare is helpful, this does not cover long-term care, rehabilitation facilities or transport, all of which need to be taken into account. Dr. Redlener stated that the Commission should

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[2] Hiram Ruiz noted after the meeting "While the repatriation program is normally the small program described above, in response to the Haiti crisis, it mushroomed overnight into a massive federal/state effort that led to the admission of more than 26,ooo repatriates (US citizens and their families) into Florida alone during a two-month period."

focus on this issue and create a strong, explicit recommendation on what is needed and what it will cost.

CAPT Pettis stated that a National Level Exercise is set for May 2011, and expressed concern that there is no focus on medical surge in the exercise. She has pushed for a medical surge component, and suggested the Commission should similarly request a pediatric focus in this exercise. This will bring attention to the issue and show areas where there are gaps. The intent of the exercise is to demonstrate vulnerabilities so they can be addressed. Dr. Redlener agreed, stating that regional planning groups tend not to focus on medical issues, often saying that it is too complicated. Mr. Tan stated that exercising is part of the Commission's Interim Report recommendations, and that this issue can be included here.

Vicki Johnson asked why the transportation component of NDMS was not activated. [Note: ASPR later confirmed that the patient transport component of NDMS was activated.] CAPT Pettis replied that DoD planes were not originally intended for medical evacuation. They were sent to Haiti with cargo, and then became "planes of opportunity" to assist in evacuating repatriates and those with medical needs. There were people coming off of the planes with obvious injuries, some of whom were transported in ambulances, while others departed on their own and came to hospitals later. The focus was entirely on response in Haiti, not triage of those arriving in the U.S. Dr. Redlener asked whether domestic consequences should have been included in Haiti response planning; all participants agreed that they should have. Mr. Wilgis stated that domestic planning was a key component that was missing. There needs to be an examination of how the system can morph to deal with international events that have a domestic impact, as well as how the situation would play out had this been a domestic event.

Mr. Tan stated that the Commission's Interim Report acknowledges that if day-to-day emergency medical capabilities are not adequate, surge capacity is not possible. Without adequate internal planning and capabilities for surge, an attempt to assist in an international event like this one will lead to the problems that were encountered (e.g., no lead federal agency, people trying to self-deploy). This is also evident in the response to domestic events, as was seen in the response to Hurricane Katrina. Self-deployment was a major issue during the Hurricane Katrina response. There is a need to show how this can be detrimental to response efforts. Dr. Redlener agreed, stating that in the Hurricane Katrina response, there were many questionable people administering medical care. He suggested that pre-credentialing medical responders would likely be a good way to address this; however, there won't be enough volunteers if we rely entirely on federal credentialing. CAPT Pettis stated that there is a credentialing system, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VIP). ESAR-VIP was created for this purpose, but the problem is that states are given money to implement this system in their own way and there is no national credentialing system that ties state systems together. Even states using the same vendor do not necessarily have interoperable systems. She suggested that there needs to be a real-time, electronic system that crosses state lines, so states can draw from pools of professionals credentialed in other states. Mr. Cintron stated that a national system, called Federal Medical Stations

(FMS) exists within Veterans Affairs, but this system does not have a pediatric component. Ms. Eckes asked whether this system communicates with ESAR-VIP systems in any way, to which Mr. Cintron replied it does not. Ms. Eckes added that pre-credentialing also provides an opportunity to help sustain response beyond the immediate response. While there may be many professionals that cannot assist in the immediate aftermath, these professionals will be needed in the intermediate and long-term phases as well. Dr. Anderson stated that the capabilities of ESAR-VIP systems vary widely between states, and while the goals of such a system are laudable, the execution has not been that effective.

Mr. Wilgis stated that another issue that should be focused on is the variation between state preparedness levels, which depends a lot on the level of threat each state faces. The problem is that a catastrophic disaster will cross state lines. He suggested that bonds need to be strengthened between federal, state and local agencies and private health care. Dr. Anderson agreed, stating that the Commission can help push out best practices, and positing that a state like Florida that responds to disasters a lot has become a well-oiled machine for response, which other states can learn from.

Dr. Anderson asked whether bridges to the pediatric community have been adequately built in Florida. Participants agreed that while work with the pediatric community in disaster response has begun, and this response demonstrated better engagement with the pediatric community, there is still much work to be done. Dr. Anderson added that the time is now; as the Haiti disaster wanes, the next major disaster is right around the corner.

Ms. Eckes stated that a total of 196 pediatric patients were seen in the region, and this was generally not a large number and the system did not become overwhelmed. She also suggested that the large majority (157) were transported by private, non-military aircraft, and engaging the private air ambulance community in disaster response is necessary. Mr. Wilgis added that in a domestic event, much of the transportation would occur on the ground, so this aspect of transporting pediatric patients needs to be addressed as well. Dr. Redlener agreed, stating that non-government transport and health care delivery is being marginalized, which will not work in a large disaster. It comes back to two primary issues, the needs for better overall coordination and funding to build a bridge to the private pediatric community.

Dr. Granado-Villar suggested the creation of a data bank of all private resources that can assist in disaster transportation. CAPT Pettis suggested engaging Business Executives for National Security in this effort.

Mr. Ruiz stated that this event has led to recent discussions at the federal level concerning mass migration. He suggested the Commission review this issue and its potential impact on children. He added that the whole process of providing long-term care needs to be examined, stating that the end of coverage under NDMS at 30 days does not take into account long-term needs. Mr. Wilgis agreed, stating that pushing long-term needs onto state Medicaid systems is a problem because many state systems are low on funding. Dr. Granado-Villar agreed that the assurance of continued care at discharge is crucial, and a

plan to assure continued medical care is needed. On mass migration, Ms. Eckes stated that Florida has a very robust plan, but this is still very lean on pediatrics. She added that the states need to address scenarios such as a child that dies in a state they are evacuated to. CAPT Pettis agreed that there is a big disconnect in this area, and reasserted the need for a single federal agency to take responsibility.

Mr. Cherry stated that the Emergency Management Assistance Compact (EMAC) is a mechanism in all 50 states that can help with coordination and identifying and credentialing professionals in different states. There is also a reimbursement mechanism under EMAC.

Mr. Cherry added that on the issue of children who are orphaned as the result of a disaster, court systems will be impacted. He asserted that this needs to be looked at on the national level. Elaine Kelley stated that she was involved with orphans that came in to the U.S. from Haiti, some of whom arrived on huge transports. Many of these were small children, very few of whom were escorted. There was little medical information available on the children that were coming in. She asserted the need to establish a process for the safe transport of children. Dr. Redlener stated that this issue is highly disconcerting. It is important that we find a way to ensure that these same problems do not recur. While this is a great challenge, non-stop feedback to government on how children's needs in disasters can be better met can help achieve this.

Dr. Anderson thanked the participants for their input, stating that this session has brought to light important pediatric issues. As the Commission is set to expire in October 2010, he asked participants to think about who can be the champion for these important issues when the Commission no longer exists. The session ended at 11:30.

**Afternoon Session: *'Discussion on Children without a Status: Coordination and Support' and 'Discussion on School Support for Repatriated Children and Adoptees from Haiti'***

**Invited Participants:**
Elaine Kelley, Office of Refugee Resettlement, ACF/HHS*
Hiram Ruiz, Department of Children and Families
Diane Sepielli, Homeless Education, Broward County Public Schools
Bill Sydnor, Broward County Public Schools
Linda Medvin, Broward County Public Schools
Laurel Thompson, Broward County Public Schools
Laura Chiarello, Miami-Dade County Public Schools
Jose Roza, Patient/Family Services, Miami Children's Hospital
Sherry Capers, Miami-Dade Emergency Management
Eileen Colon-Santiago, United States Conference of Catholic Bishops

* Federal employee

Commissioner Dr. Michael Anderson began the afternoon session by explaining that the Commission's charge is to look at domestic issues surrounding disaster preparedness, response, recovery and mitigation. The purpose of this session is to examine lessons learned by the south Florida school systems that can help inform the Commission on domestic issues in disasters as they pertain to children. He asked participants to provide information and recommendations that the Commission can bring to the President and Congress.

Linda Medvin stated that one of the primary issues was incorrect information. South Florida schools were expecting thousands of orphaned children with great need for assistance. Instead, many children were American citizens from families of higher socio-economic status in Haiti. Programs to meet essential needs were established, though in many cases, children's needs were higher level (like advanced placement classes), beyond what schools anticipated or could offer. Little information was distributed through official channels, with much being obtained through the news media. Dr. Redlener stated that this was the Department of State's expectation as well, though initial perception did not equal the reality.

Diane Sepielli stated that the Broward County public school system was fortunate to have a good McKinney-Vento homeless education program in place, which is not the case for every district. Of the more than 1,000 students that entered Broward County schools, more than 900 fit the definition of homeless under McKinney-Vento and were provided assistance. It is important to note that if a good plan is in place, the process can run very smoothly, as it did in Broward County. People from the school system convened immediately to ensure plans were in place to meet any needs that may arise. Dr. Anderson said that it appears the group came together in a triage-like manner. Ms. Sepielli stated that because of Florida's experience with hurricanes, disaster response has been practiced and information and guidelines for disaster response are already available.

Hiram Ruiz asserted the need for a continuum of communication and coordination throughout disaster response. He explained that there was much confusion early on. Though this has gotten better over time, it still remains. This was a huge crisis, and the focus was on getting people out of a desperate situation, but there was little attention to what would happen once people arrived in the US. Most people entered the U.S. through the repatriation program. These were American citizens who had lived in the U.S. at some point and were part of the middle class in Haiti. Immigration status continues to be the largest problem for those who are not repatriates, including family members of repatriated children. Many were admitted under B2 (tourist) visas. On January 16, Mr. Ruiz's office contacted DHS about problems associated with providing B2 visas to non-citizens, including the fact that many of these were being issued to Haitian parents of American children. Under a B2 visa, these parents are not entitled to any assistance nor are they able to work and support their children. These calls had no impact. Many of those admitted under B2 visas were living with patients in the hospital, having nowhere else to go. Even if they were granted humanitarian parole, it would take three months to

get a work authorization. Luckily, the Cuban/Haitian Entrant program was eventually utilized to provide some assistance. A lesson learned is that from the very beginning there has to be a plan for the short, intermediate and long-term support.

Dr. Laurel Thompson agreed that during the crisis, no one thought about long-term needs. In the school system, the expectation was that the children would need the majority of services, not the families. Now that the response has entered the intermediate phase, one problem has been that some evacuees are losing their host families. Also, in some cases, basic needs are still not being addressed and immigration continues to remain a huge issue.

Dr. Redlener explained that immigration issues are beyond the purview of the Commission, but the issue of a surge of children entering the school system is not. He asked if the thousands of children that entered the south Florida school systems were from another state, would the school systems be capable of absorbing them. Linda Medvin responded that the schools were able to absorb the children because of the large size of the districts and the ability to distribute children among schools. She added that inoculation issues will arise whenever children are entering a school system from a different location, because of issues like missing records and different inoculation needs between locales. Ms. Sepielli stated that under McKinney-Vento, inoculation is not a barrier to allowing children to enter the school system right away.

Dr. Redlener asked if there were other health issues that arose. Dr. Thompson stated that there is always a need to address mental health issues following a disaster. She added that in Broward County, there was discontent among parents of students already in the system about the possibility of new illness being introduced to their children by incoming students. The district was able to respond quickly to the need for physicals and vaccinations through the use of mobile units. She felt they learned and were able to increasingly respond to needs as the situation progressed.

Dr. Anderson stated that previous experience with disasters in Florida led to a relatively smooth response. He stated that the Commission would like to ensure other communities, especially those with less experience, are as prepared. Ms. Sepielli stated that having a good homeless education program is necessary to deal with these issues. If a school district receives federal funding, which most do, they are required to be in compliance with McKinney-Vento or could risk losing all federal funding. She added that schools were lucky that most of the incoming students arrived before the count for full-time equivalency students occurred, providing extra money for each student. Schools receive no additional money for students that enter the system after this count. The state also provided extra funding to provide for additional needs, like school supplies and clothing.

Dr. Redlener asked about the maximum surge capacity for south Florida schools. While they were unable to provide numbers, Laura Chiarello and Ms. Sepielli explained that Miami-Dade and Broward Counties are the 4$^{th}$ and 6$^{th}$ largest school districts in the nation respectively, so a surge of incoming students was manageable. Dr. Redlener asked if the U.S. Department of Education (DoEd) should conduct a national assessment of school

surge capacity. Ms. Thompson stated that school districts would already know their surge capacity and help place students that have been evacuated out-of-state. Ms. Chiarello added that it would be a family decision on where to move, not a government decision. Dr. Redlener said he understands this, but stressed that the Federal government plays a major role in evacuation, and asked whether the surge capacity of school systems should play into the formula for deciding where to evacuate people. Ms. Chiarello stated that they had anticipated an influx of 10,000 kids into the school system initially, which would have been difficult to handle. The backup plan was to convert a hospital building the district had purchased into a school if needed. CAPT Pettis stated that many evacuees will go to a place where they have family and ties. She added that during the Gulf hurricane evacuations, some states volunteered to host evacuees. She suggested that the idea of offering incentives like funding and support to states that can serve as host states should be examined.

Revisiting immigration issues, Elaine Kelley suggested that issues concerning immigration status do not just affect people entering the country; a disaster could strike a domestic area that already has a large immigrant and undocumented population. She provided southern California as an example of a place where there may be large numbers of U.S. citizen children with undocumented parents.

Ms. Sepielli stated that long-term recovery committees exist to bring many people from different areas of expertise together to the table. They are currently working to helping Haitian children affected by the disaster.

Returning to the topic of a large influx of children into the school systems, Dr. Thompson stated that because the county is so large and structured, and because of its location, they are used to influxes of new students, so this was not a major problem. As soon as the earthquake occurred, a group of about 30 people throughout the school system and the community came together to discuss possible issues that could arise and effective and efficient processes to deal with these issues. This occurred prior to the involvement of federal agencies, and focused on both assisting people in Haiti and preparing for an influx of evacuees into south Florida.

Mr. Tan stated that these are really good examples of how communities can ramp up efforts early. Expectations of who would be entering the community clearly did not match reality, noting that in an emergency response, it is important to obtain as much information as possible from the onset. There was a communications disconnect, where most information seemed to be coming form the news media instead of from official channels. From the Commission’s view, it seems that there should be a recommendation to improve the communications link, to be better prepared for disasters. Dr. Thompson agreed that there is a need for better communication between federal agencies, state and local entities, and the community. Dr. Redlener asked who should have the lead in coordinating communications efforts. Ms. Capers suggested that in this case, it should have been DoD, as they led transportation efforts, and that there should have been a list created as people were boarding flights. Ms. Eckes suggested HHS should take the lead on domestic efforts to communicate information on those on board evacuation vehicles.

Jose Roza suggested that a manifest of everyone boarding evacuation vehicles must be created and shared.

Returning to the bigger picture of communication, Mr. Ruiz stated that DHS never communicated with the public to provide information on incoming evacuees. Public perception was shaped by reports from the media, which turned out to be wrong and a huge distraction. This affected the ability to address what was really going on. There is a need for official sources to clearly communicate information to the public.

CAPT Pettis added that there needs to be communication between evacuating states and host states. As an example, Kentucky served as a host state for hurricane evacuees from the Gulf coast, and received people wearing FEMA wrist bands, but had no way to attain any information from these wrist bands. Ms. Eckes related this back to patient tracking, in which there are many robust systems but little interoperability between these systems.

Mr. Ruiz stated that in relation to unaccompanied minors, there was no real way to know how many children were unaccompanied that have remained in the state. In this event, the ORR system addressed the cases of U.S. nationals. In a domestic situation, this would not happen. There will still be a large number of unaccompanied minors. Custody issues could arise, and it is a complex process for the state to take children into care. Thought about how the foster care system can respond to large numbers of unaccompanied children is needed, as the current system could not expand that quickly. Ms. Sepielli stated the McKinney-Vento addresses this very well, as it deals with unaccompanied minors all the time. It states that if a student is living without a guardian, they are considered unaccompanied and are tracked by schools as such. Ms. Sepielli and Ms. Chiarello said they will pull the data and inform the Commission as to how many children in Broward and Miami-Dade county schools are designated unaccompanied. Ms. Eckes added that DCF workers were very creative in ensuring unaccompanied minors were identified and tracked, by creating the new label '*humanitarian hold.'* CAPT Pettis stated that the medical review board that was established in Haiti helped minimize the number of unaccompanied minors evacuated. In a domestic event, this should be accounted for at both embarkation and debarkation sites.

Ms. Kelly stated that any child with neither a legal status nor a parent or guardian in the U.S. is supposed to be taken into state care. Powers of attorney were not recognized as legal guardianship. Any child that was identified as an *unaccompanied alien child* was referred to ORR. ORR has children in custody and is providing consent for medical decisions.

Dr. Redlener returned to the issue of the capacity of schools to accept large numbers of children, asking what effect this has on schools in the long-term. Bill Sydnor stated that Broward schools are in a recessive period right now, so they are able to absorb a large influx of children. However, had this event occurred a few years ago, during a period of overcrowding, the system would have been really stressed. He added that the schools only identified school-aged children. But there has been a heavy reliance on the school

system to take into account the number of children that entered the state. A large number of children that are not school-aged are going unaccounted for.

Ms. Chiarello stated that housing is an important piece, as people may not return to their communities for a long period following a major disaster. There needs to be a way to allow incoming families to create a new home and be integrated into their new community.

Dr. Redlener stated that school surge capacity seems to be just one piece of community capacity to accept evacuees after a major disaster. He suggested a need for some assessment of the long-term capacity of communities to absorb people following a disaster. Dr. Anderson stated that a National Disaster Recovery Framework is currently being created to focus on long-term needs. Unfortunately, in the early version of this framework, children are not as well represented as they should be and the framework fails to identify a lead agency for recovery.

Ms. Chiarello stated that it is more than just the numbers, but the ability to meet specific needs, that plays into communities' capacity to absorb evacuees. Ms. Medvin added that there is also a large Haitian population in south Florida, who had special needs arising from the disaster as well. Wherever a disaster occurs, people already present in the community may be affected by it.

Returning to the discussion on communication, Ms. Medvin said that the numbers of expected evacuees were greatly exaggerated. Initially, they were told to expect 200,000 evacuees in Florida, with 45,000 in Miami-Dade and Broward Counties. Though the number of evacuees has not reached even this lower number nationally, these numbers have not been updated and are still noted by the media. Ms. Sepielli stated that they are being told there could be another large influx of children this summer. DoEd has asked them to continue tracking incoming children. CAPT Pettis stated that these numbers were based off of a mass migration scenario. She added that there is a need to continue to plan and have processes in place for improbable situations. Dr. Redlener agreed, stating that to be ready for unexpected events, there needs to be flexible, resilient structures in place.

CAPT Pettis stated that NDMS activation was recommended by Florida just days after the event, but HHS did not want to discuss this option because of a lack of funding. Many options for dealing with this crisis were considered, and NDMS was at the bottom of the list. This resulted in Florida saying that they could no longer accept evacuees and only then was NDMS to be considered.

Summarizing the participants input, Mr. Tan stated that the major lessons learned from this response include the need for reliable information, an assessment of communities' capability to handle an influx of children, the ability to track evacuees, a continuity of business plan for school districts, a long-term case management infrastructure that will support families that may be relocated for extended periods, and funding. He asked whether this was a reasonable summation.

Ms. Sepielli stated that the response to an influx of children and families is handled best at the local level. Communities know their capabilities and needs, and systems are already in place. She asserted that the creation of new levels of federal and state involvement would increase the barriers in response. While Dr. Redlener agreed that communities know their capabilities and needs best, he asserted that in a large disaster – like Hurricane Katrina, where close to 2 million people were evacuated – most evacuation efforts will be under the control of the federal government. The question is where will these people end up? The federal government needs to know the big picture of what capacities already exist to determine where they can send evacuees. Ms. Sepielli agreed with this, and added that those involved at the local level need to know who to contact at the state and federal level.

Mr. Sydnor stated that there needs to be a set of national standards on school district response to mass evacuation events. With this current response, each district responded differently. There should be a template of identified standards that allow for a range of actions, to ensure all districts are starting on the same page. Additionally, it is important to understand the needs of the community as a whole. Dr. Redlener stated that in a major domestic disaster, there would likely be a large number of families permanently displaced, so it is important to be prepared for this.

Ms. Medvin stated that when there is a large influx of people from outside the community, there is a need for sensitivity training that will provide information on issues such as cultural differences. Ms. Chiarello added that Miami-Dade County schools are conducting a paid workshop for school employees on acculturation and people in the community who can assist in this process. It is important to provide as much information as possible to school personnel to ensure the influx of new children and families into schools is a smooth process.

Dr. Redlener stated that in receiving communities, regardless of where people come from, there will always be the need for support from people that understand trauma. Sherry Capers stated that there has been attention to dealing with the medical and school perspectives, but not enough focus on working with local emergency management. She added that trauma will continue long term. Dr. Redlener agreed, citing a cohort study in New Orleans that is showing an increase in trauma over time. CAPT Pettis added that military health care costs have risen 50%, most of which is related to mental health issues, especially among children.

Ms. Johnson stated that the Commission's Interim Report includes a recommendation on disaster mental health and bereavement training for teachers. The Commission feels that this needs to be imbedded in accreditation. She asked participants how the Commission could advocate for the integration of disaster mental health into accreditation programs. Ms. Medvin stated that unless funding is provided, it will not gain traction. Additionally, if it is required for accreditation, it must come through the state. Dr. Redlener stated that the issue of funding seems to be central to most of what has been discussed. He recommended discussing funding as it pertains to every area in the Commission's purview at the next Commission meeting.

Ms. Capers stated that Florida is convening a state Unmet Needs Committee to help sustain care in any disaster. They are looking to universities to help develop a pool of resources to support in disasters. Ms. Chiarello suggested that all states should put a team together to address and these issues and train people.

Dr. Redlener stated that often training occurs immediately after an event and is not ongoing. He asked whether such "just in time" training is good enough. Ms. Sepielli stated that it is not; there needs to be training systems in place. Though every disaster will be unique, systems need to be in place, ongoing training needs to occur, and when disasters strike, the right people need to be convened to address the unique needs of the current situation.

Ms. Johnson stated that while funding is a primary concern, there is a need to think outside the box too. Ms. Sepielli stated that resources vary widely among school districts. Dr. Redlener agreed, stating that large school districts have very different needs and resources than smaller districts. Ms. Sepielli stated that it is important to ensure all districts know what they are supposed to be doing to address children's needs under the law. She also suggested that school districts need to create partnerships with community entities in advance of disasters. Ms. Medvin agreed, stating that in the current response, many community organizations stepped up to fill both anticipated and unanticipated needs. Dr. Redlener agreed that the south Florida community response to this disaster was remarkable.

To close the session, Dr. Redlener asked participants to provide their final thoughts on lessons learned from this response. Ms. Medvin stated that there is a need for accurate information, and a single agency to distribute and verify information. Mr. Sydnor stated that small school districts need to collaborate to build regional disaster response capacity. Eileen Colon-Santiago stated that there is a need for centralization in times of crisis. In this incident, command was diffused, which led to resources being wasted. Additionally, there needs to be a centralized funding source for disaster response. Ms. Capers stated that funding needs to be allocated for states and communities that receive evacuees. CAPT Pettis identified three major areas that need to be well-defined: funding, planning, and leadership. She also expressed concern with who would continue to push these issues after the Commission ends. Ms. Eckes stated that the various local, state and federal entities need to come together in disaster response. Additionally, in an international response like this one, a coordinated domestic response effort must be established as well. She also recommended that all disaster plans should be scalable. Mr. Roza stated that there is a need for a better assessment mechanism to identify evacuees. Each agency's role in the disaster response must be determined. Finally, the ability to address mental health issues should be planned for in advance. Ms. Sepielli stated that agencies and points of contact within agencies should be designated for information distribution, and there must be a better understanding of each agency's role in disaster response. She added that local communities are able to lead efforts in response as well; it does not all need to be commanded from the federal and state levels. Dr. Redlener stated that disasters

occur on a continuum, from small to mega-disasters. Consequently, the responsibility for response rests with entities ranging from the local to national levels.

Mr. Tan stated that he appreciates the comments and engagement of all of today's participants. Protection of our children is something that has been long overlooked. The Commission wants to raise this to a higher level, and the observations and concerns of those involved in local response efforts are important to achieving this.

Dr. Redlener concluded the meeting by stating that an extraordinary amount of talent exists in the south Florida community, as demonstrated by this response. Understanding what happened here, but also understanding what needs to happen nationally, is extremely important. He thanked participants for their input, and asked that they send anything else they think may assist the Commission's work to Vicki Johnson.