NATIONAL COMMISSION ON CHILDREN AND DISASTERS
JUNE 26, 2009 MEETING

MINUTES

Participants

Ernest Allen*
Dr. Michael Anderson*
Carol Apelt+
Merry Carlson* (via teleconference)
W. Craig Fugate+
Randall Gnatt
Jacqueline Haye
Victoria Johnson
CAPT Roberta Lavin+
Hon. Sheila Leslie*
Bruce Lockwood*
Dr. Joan Lombardi+
Graydon "Gregg" Lord*
Vinicia Mascarenhas
Dr. Irwin Redlener*
Christopher Revere
Dr. David Schonfeld*
Matthew Seney
Mark K. Shriver*
Lawrence Tan*

* Commission member
+ Full-time Federal employee

The meeting was open to the public and held at the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Multi-Purpose Room, 7th Floor West, 901 D Street SW, Washington, DC, 20447. Approximately 52 members of the public attended; two presented oral statements.

Proceedings of June 26, 2009

CAPT Roberta Lavin, Designated Federal Officer to the Commission, opened the meeting at 9:31 a.m. and welcomed the members. Ms. Carol Apelt was designated record keeper for the meeting. CAPT Lavin then introduced Commission Chairperson Mark Shriver.

Mr. Shriver welcomed the Commission members and those observing in the audience. He announced that a new charter reflecting the Commission's status as a statutory advisory committee was filed with Congress in May. He then said the purpose of this meeting was to review the subcommittees' recommendations before taking a final vote on their inclusion in the Commission's interim report to Congress at the Commission's September meeting.

Dr. Michael Anderson, Vice Chairperson, noted the productivity of the past eight months, as evidenced by the preliminary recommendations. He said the meeting the day prior with the National Academy of Sciences (NAS) represented an historic partnership between academia, government and practitioners. He thanked Commission staff for its support in the preparation of the preliminary recommendations and the NAS event.

National Academy of Sciences Workshop

Mr. Shriver invited Dr. David Schonfeld to share highlights from the NAS meeting. Dr. Schonfeld briefly summarized the speakers' contributions, beginning with Jack Harrald, NAS chair of the Disasters Roundtable, who spoke of the synergy to be achieved through

collaboration between the Commission and NAS. Mr. Shriver discussed the mandate for disaster preparedness, especially the "benign neglect" of children that occurs in traditional disaster preparation and response. Konstantine Buhler, founder, Always Ready Kids, discussed disaster preparedness from the youth perspective, noting that youth are aware and want to be prepared and part of the solution, and that a cultural shift is necessary to elevate the importance of preparedness. Gerard Jacobs, University of South Dakota, provided the practitioner's perspective, highlighting inadequate preparations for mental health in disasters and proposing to offer psychological first aid training for teachers, children and caregivers. Robert Pynoos, University of California, Los Angeles, said grief is an important component of a disaster's impact, and that disaster planning must tailor services to the different groups that may be at risk, e.g., children with Attention Deficit Hyperactivity Disorder or autism, children who are wheelchair-bound, etc. Little horizontal integration exists between disaster management policy and prevention policy, he said. Consultant Brian Flynn reviewed the policy context, suggesting that parity between behavioral, physical and mental health should be emphasized and questioning whether disaster-related behavioral/mental health services should be funded via an entitlement rather than grants. Robin Gurwitch, National Center for School Crisis and Bereavement, spotlighted the need to address bereavement and grief.

During the second panel on schools and security, Kathleen Henning, International Association of Emergency Managers, offered the emergency manager's perspective, noting the importance of integrating schools into local community disaster preparedness plans, providing child care not only during the stress-filled immediate disaster but long-term as well, and supporting reunification efforts. She recommended building strong physical school structures while avoiding placing them in flood plains, and providing grant-writing training to emergency managers. Destruction of schools in disasters is costly, and schools are valuable during the recovery process because they possess a number of physical and human resources. In addition, they often serve as a focal point for the community's healing process. Lori Peek, Colorado State University, suggested definitions of "recovery" and "resilience" for children, noting that children have different developmental needs that must be addressed to ensure recovery. She said teaching the "three Rs," the core principles of the education system, depends on how two additional Rs, resiliency and recovery, are addressed when crises occur. The Agency for Healthcare Research and Quality's Sally Phillips discussed the importance of social messaging in disseminating critical information to children and the community. MaryEllen Salamone discussed the disparity between children's needs and the resources available for meeting them after disaster. Most American children and youth who need mental health services, disaster-related or otherwise, do not receive them despite the nation's resources. Disaster plans must address more than a child's physical needs while being presented to children in a non-frightening manner. Encouraging volunteerism can help empower children and youth, enabling them to feel they have a role in preparing their families and communities.

Dr. Irwin Redlener noted that he saw the "grants versus entitlements" issue as germane to the Commission's work. He said the Department of Education's program on school staff preparedness is limited and has minimal participation. He said it would be advantageous to help schools become more adept at seeking grants, but he also encouraged moving toward an entitlement approach. Additionally, Dr. Redlener did not recommend adding "resilience" and "recovery" to the "three Rs," since other important items such as parenting could easily be added

too. Dr. Schonfeld agreed that this would not be a recommendation of the Commission but responded that the "three Rs plus two" concept was a way of looking at the education of the whole child, i.e., all of the topics necessary for children to become well-rounded individuals.

Dr. Schonfeld concluded his report by outlining the unifying themes that became evident during the NAS workshop:

1. Include all stakeholders, especially children, in planning and implementation.
2. Integrate mental health and safety aspects at the community level.
3. Plan ahead for multiple unexpected events.
4. Identify available physical and human resources prior to a disaster event.
5. Provide interagency coordination before disasters.
6. Identify champions to spearhead programs at every level to make emergency preparedness a routine responsibility of schools.
7. The foundation for community resiliency often forms around a unifying entity (i.e., church, football, market) prior to a disaster.

Dr. Schonfeld suggested the Commission develop strategies to integrate these unifying themes into the Commission's work. Mr. Shriver recognized the work that the National Coalition on Children and Disasters has done in these areas and requested its input on strategy development be solicited.

Pediatric Medical Care Subcommittee

Dr. Anderson, chair of the Pediatric Medical Care Subcommittee, delivered the first subcommittee report. He reviewed the subcommittee's statement of purpose: "the subcommittee on Pediatric Medical Care will explore ways to improve the current system for providing acute medical care to children in disasters, including improvements to the current processes for developing, stockpiling, and distributing medical countermeasures for children in a disaster and ensuring an effective emergency medical response system for children with sufficient pediatric-specific surge capacity." Dr. Anderson then reviewed the subcommittee's draft recommendations, here summarized:

> Providing high quality medical care of children in disasters requires several key elements:
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> 1) Competency-based training in basic and advanced pediatric medical care for a wide spectrum of personnel.
> 2) Include pediatric experts in all disaster planning initiatives so the unique medical needs of children can be ideally prepared for.
> 3) Children represent over 20% of the population and simply including their needs in "special populations" is inadequate. The federal government should remove children from inclusion simply in special populations and instead find avenues and programs that more fully assess and support pediatric needs in disasters.
>
> 1. HHS should form a standing advisory body, including federal partners and external experts, to advise the Secretary of HHS on issues pertaining specifically to pediatric emergency medical countermeasures.

A. Assemble and study available data on therapies used as medical countermeasures in the pediatric population for high risk chemical, nuclear, radiological, and biological threats.
B. Develop consensus-driven recommendations on the emergency use of these medications where adequate evidence exists to pre-authorize the use of specific medical countermeasures.
C. Where there is insufficient evidence to support the requirements for formal pre-authorization, the advisory body will convene to develop a proposed research agenda (with funding mechanism) and approve interim treatment guidelines where possible.
D. HHS must also work toward rapid and efficient distribution of these treatment guidelines and approvals into the field, stockpiles, caches etc.

2. Policies in the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Strategy and Implementation Planning should ensure children receive parity in the development and acquisition of medical countermeasures. All PHEMCE working groups should include pediatric representation.

3. Congress should appropriate funding for the development, acquisition and stockpiling of medical countermeasures specifically for children.

4. HHS, in collaboration with the Department of Homeland Security (DHS), should develop guidance on the deployment and safe and effective administration of medications to children during an emergency. The Centers for Disease Control and Prevention (CDC)'s Cities Readiness Initiative should develop guidance and exercise tools to help jurisdictions develop the capability to deliver medications to children from Points of Distribution (PODs) during an emergency.

5. HHS or another appropriate entity should develop and maintain a national clearinghouse for data, protocols and tools related to children and disasters.

6. A Pediatric Education Task Force should establish core competencies and a standard, modular pediatric disaster medicine training curriculum that could be utilized across a spectrum of professions from basic training of non-medical emergency responders to advanced training for Federal and state Disaster Medical Assistance Team (DMAT) members, hospital-based health care providers, and Medical Reserve Corps volunteers. Key elements of standardized curriculum and training programs would include the development of:

A. User-friendly patient care guidelines for children based on scenarios including chemical, biological, radiological and nuclear incidents
B. Pediatric-specific severity criteria and treatment guidelines, including guidance on pediatric preparations (i.e. oral suspensions) and dosages for medications administered to children
C. Clinical practice guidelines, based on available evidence, for the triage, treatment and transport of acutely ill and injured children at all levels of care that can be used across the spectrum of coordinated multi-modal transport (local, state, private, and Federal)
D. Guidance for emergency medical services (EMS), hospitals, emergency management, fire and law enforcement on how to incorporate pediatric-related objectives into routine drills and exercises that would test responders' competencies in the delivery of pediatric care, evacuation, and triage

7. Federally-funded medical response teams must expand their capability to respond to emergencies that may involve pediatric injuries and casualties through the comprehensive integration of pediatric-specific training, guidance, and exercises.

8. Congress should authorize and appropriate funding for a formal, regionalized pediatric system of care to respond to public health emergencies.

9. Local, regional and national disaster response plans should fully integrate trauma systems, children's hospitals, and other institutions with pediatric critical care and pediatric medical and surgical sub-specialty care capabilities.

10. To best prepare for public health emergencies and disasters involving children, all acute care hospitals (i.e. facilities with a 24/7 emergency department) should be prepared to provide emergency care for acutely ill or injured children.

11. With input from pediatric emergency, trauma and critical care experts and children's advocates, state and Federal programs should adopt pediatric-specific performance measures and benchmarks to guide planning efforts and pediatric readiness.

12. Disaster plans should recognize, promote and integrate the medical home (a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective) as a vital resource for children and families in disaster planning, mitigation, response and recovery.

13. HHS/Department of Transportation (DOT) or another appropriate agency should adopt standardized, pediatric-specific equipment requirements for first response and emergency medical response vehicles, based on level of certification/licensure of the personnel staffing that response vehicle, as a requirement for eligibility for reimbursement by the Centers for Medicare and Medicaid.

14. Congress should expand the Emergency Medical Services for Children program and appropriate $37.5 million per year for the next five years, as recommended in the 2006 Institute of Medicine report *Emergency Care for Children: Growing Pains.*

15. The National Association of State Emergency Medical Service Officials should collaborate with appropriate organizations and state agencies to develop and standardize pediatric performance metrics and training guidelines for the licensing/certification of all first responder and pre-hospital care provider organizations.

16. All medical protocols should include provisions for pediatric medical countermeasures consistent with jurisdictional rules and regulations.

17. EMS multi-casualty incident supply caches should include caches of pediatrics supplies and medications and be readily accessible

18. HHS/DOT or another appropriate agency should require that EMS care protocols have pediatric-specific considerations, with input from local pediatric care experts.

Commission Executive Director Christopher Revere suggested amending recommendation 1.D to incorporate HHS cooperation with local and state planners, as the Federal government shares these responsibilities with same. Dr. Redlener noted that the advisory committee (recommendation 1) should report to the HHS Secretary and have the authority to oversee issues department-wide.

Mr. Shriver asked how the HHS Secretary makes decisions regarding medical countermeasure recommendations for children. Dr. Redlener responded that it was a complex process involving the Food and Drug Administration, the National Institutes of Health and the CDC, among others. Given the complexity of the process, the advisory committee suggested in recommendation 1 might therefore review the result of the interagency process before final submission to the HHS

Secretary for review. CAPT Lavin said it may not be possible to elevate the advisory committee to such a role, since the PHEMCE process follows specific legislation. Dr. Redlener responded that the subcommittee envisions a pediatric body to advise the Secretary once PHEMCE completes its process. Mr. Revere noted that there is interest within the Assistant Secretary for Preparedness and Response in getting pediatric representation on PHEMCE, but Dr. Redlener advocated broadening the advisory committee's focus beyond pediatric medical concerns.

Dr. Schonfeld suggested amending recommendation 1.C to exclude approval since a lack of funding might preclude implementation. After a brief discussion of funding points made in later recommendations, Dr. Anderson agreed that language regarding funding could be added to recommendation 1.

Dr. Anderson said the subcommittee believes that current pediatric disaster medical training is inadequate to effectively meet children's needs in a disaster. He averred that the establishment of a national clearinghouse for data, protocols and tools related to children and disasters (recommendation 5) would ensure a continuing focus on children after this Commission terminates. Dr. Schonfeld questioned the federal management requirement of the clearinghouse, surmising a national nongovernmental organization might also suffice. Mr. Shriver asked if it would be advisable to combine the clearinghouse recommendation with the earlier advisory body recommendation. Dr. Schonfeld noted that doing so might saddle too much responsibility on a single entity, thus slowing down the process. Dr. Redlener suggested making a broad recommendation for the entities and their purposes, but stopping short of prescribing implementation. Mr. Ernest Allen noted that the roles of the advisory body and the clearinghouse may be different, with the possibility that the latter might not need to be a government agency. At Mr. Shriver's request, Dr. Anderson tabled further discussion of recommendation 5.

Mr. Graydon Lord suggested an edit to recommendation 6.C to note that the likelihood of identifying standard pediatric triage guidelines is low because there is a limited evidence base from research on which to develop these guidelines. Dr. Anderson agreed to consider language such as "where practical or possible." Dr. Schonfeld suggested adding a reference to mental health, to ensure parallel recommendations.

Mr. Lord voiced a concern that the phrase "federally funded medical response team" might inadvertently omit other relevant entities to which the standard should apply. Dr. Anderson agreed to revise the language. Dr. Redlener raised the question of whether Department of Defense (DOD) assets have been fully explored, e.g., deployability and pediatric expertise. Mr. Shriver agreed it would be valuable to invite DOD to discuss its capabilities with the Commission so that they can be considered within the broader context of the Commission's work. Mr. Lord suggested approaching the Department of Veterans Affairs as well.

Dr. Anderson said there is discussion about potentially revising Federal strike team formation and deployment, resulting in recommendation 7.F.

Dr. Anderson said children will be better served if the nation's regional response capability is strengthened. Fewer than 10% of U.S. hospitals have adopted the standards outlined in recommendation 10.A. Dr. Redlener concurred, noting that pediatric needs cannot be isolated,

and that the healthcare system as a whole must be improved before chronic shortfalls for kids can be rectified. Mr. Revere noted that HHS funding already exists for regionalization efforts and noted the Commission, along with relevant Federal agencies, is exploring how to emphasize pediatric needs in grant guidance for 2010-2011. Dr. Redlener asked that staff collect and organize the data supporting all of the Commission's recommendations. CAPT Lavin confirmed that background information and citations will be documented for each recommendation in the interim report.

After reviewing recommendation 13, Dr. Anderson observed that standards for EMS equipment do not seem to be available. Mr. Lord said such standards exist, but enforcement of those standards is inconsistent and often hampered by insufficient funding and/or oversight. Because there is no national standard, state and local governmental and nongovernmental providers have not expended the resources necessary to achieve the standards. He suggested tying providers' funding disbursement under CMS to meeting the standards. Mr. Bruce Lockwood clarified that most providers meet some of the standards but not all. Dr. Anderson agreed to Dr. Schonfeld's suggestion to modify grant guidance overall to incorporate EMS concerns. Mr. Lawrence Tan suggested the stimulus package might be expanded to include EMS personnel, since it already includes law enforcement and first responders. To effectively treat pediatric patients, EMS vehicles not only require pediatric protocols and equipment, but must also be staffed with knowledgeable operators.

Dr. Anderson noted that two sections, disaster victim critical care transport and volunteers, liability and credentialing, are not offering recommendations at this time because more examination and discussion is necessary.

Mr. Lockwood made a motion to move the Pediatric Medical Care Subcommittee's recommendations forward. The motion was seconded by Dr. Schonfeld and passed with no dissenting votes.

Remarks by Dr. Joan Lombardi, ACF

Mr. Shriver introduced Dr. Joan Lombardi, ACF's new Deputy Assistant Secretary for Policy and HHS Interdepartmental Liaison for Early Childhood Development, inviting her to share a few words.

Dr. Lombardi noted that she had been an ACF employee previously, including when the Oklahoma City bombing occurred. She said that the nation has come a long way since then, and the Commission's recommendations will be critical in continuing to move the ball forward. She said she has prior experience working on international preparedness issues involving young children, and her work at ACF will require her to focus on that demographic as well. Dr. Lombardi thanked the Commission, noting ACF's commitment to working with the Commission, and underscoring her intention to help to promulgate its recommendations.

Mr. Shriver said it will be important to ensure the Commission's recommendations are in fact implemented, and do not just gather dust on a shelf. Dr. Lombardi noted that the child care community was not prepared for the Oklahoma City disaster. Mr. Shriver said the subcommittee

examining child care will report later in the meeting, but noted that the neglect of children's needs after Hurricane Katrina has already been acknowledged in meetings on Capitol Hill. Dr. Schonfeld observed that child care is not as supported, standardized or regulated as other industries, so disseminating information about child care strategies in the interim report may be difficult. Dr. Lombardi responded that mechanisms exist within the child care community for sharing information, and that ACF is ready to proactively support all efforts.

Evacuation, Transportation and Housing Subcommittee

Mr. Lockwood, chair of the Evacuation, Transportation and Housing Subcommittee, presented the subcommittee's report. Mr. Lockwood indicated that the subcommittee's work has focused on the subject of mass care shelters in order to prepare for the 2009 hurricane season, but is now broadening. He said the subcommittee has been working with the American Red Cross (ARC) and the National Voluntary Organizations Active in Disaster (NVOAD) to develop a pilot guidance document to establish children-specific standards and indicators for shelters. It is an "annex" to the ARC guide for shelter managers that will be piloted during the 2009 hurricane season. The Commission looks forward to receiving feedback from the shelters that implement the standards this year and will improve the document after re-evaluating it. He introduced ARC's Trevor Riggen, seated in the audience, and thanked him for his work helping to develop the annex. Mr. Lockwood explained that there is an ongoing discussion regarding how much of the annex can be made mandatory. There may be sections that are impossible to include in the first moments of a disaster, but the subcommittee is considering the possibility of establishing timelines for the provision of various supplies and components once feedback from the pilot is received. Mr. Shriver also thanked Mr. Riggen and Joe Becker of ARC for their work with the Commission.

Mr. Lockwood reviewed the standards and related action steps contained in the annex. He clarified that the annex recommends the co-location of pet shelters near emergency/disaster shelters because pets are beneficial for the mental wellbeing of children, noting that pets cannot be sheltered within emergency/disaster shelters for people.

Dr. Schonfeld expressed concern that the annex does not seek to make infant formula immediately available upon a shelter's opening; it should be included in a stockpile. Mr. Lockwood explained that infant formula is a difficult item to keep in stockpiles because it is perishable. He noted that some personal responsibility must be expected of families, since a shelter may not be able to provide the complete range of supplies its residents require. Dr. Schonfeld asked if sufficient infant supplies could be on hand to support babies for 1-2 days until more adequate supplies can be obtained. CAPT Lavin reminded the Commission that a shelter is often immediately established even if adequate supplies are not immediately available. Needed supplies, such as perishable items that cannot be stockpiled, can be quickly gathered once shelter doors open. The subcommittee is also working to identify key supply items for children that could be kept in caches by the Federal Emergency Management Agency (FEMA) and transmitted as needed on request of state governments. FEMA is already working with ARC, the American Academy of Pediatrics, Save the Children and others to finalize a list of supplies that should be included in caches and to determine items that are more appropriate to administer via pre-purchase agreements. Dr. Schonfeld later cautioned the group to look beyond hurricane

season when developing a list of age-appropriate perishable and nonperishable supplies for children. Mr. Lockwood wrapped up the discussion on the sheltering guidelines, noting that the subcommittee's recommendation is that the Commission support a pilot test of the annex in 2009. He mentioned that the longer-term goal is to incorporate the contents of the sheltering annex into the body of the ARC shelter guide rather than keeping it separate as a stand-alone chapter on pediatric concerns. In developing the standards document, the subcommittee involved not only ARC, but several of its major partners as well. Mr. Riggen noted that ARC shared the annex with all ARC shelter managers approximately three weeks prior to the meeting, in preparation for the 2009 hurricane season. Mr. Lord noted that, once the standards are finalized, FEMA should be the primary disseminating agency.

Mr. Lockwood continued by reviewing the subcommittee's remaining preliminary recommendations and action steps, starting with the subcommittee's statement of purpose: "The Evacuation, Transportation and Housing Subcommittee will recommend minimum standards for the care of children during evacuation, transportation and housing at any phase of a disaster. The subcommittee will seek ways to encourage greater responsibility and accountability for the development and maintenance of standards that ensure the safety and accessibility for children, regardless of whether the services are provided by government or non-governmental organizations. To achieve this goal, the subcommittee will investigate approaches, both internationally and domestically, to identify best practices and address existing gaps. The subcommittee will facilitate collaboration of subject matter experts and stakeholders to address the identified issues by thoughtfully integrating the needs of children in these environments."

Mr. Lockwood discussed the overall organization of the document, re-emphasizing that the sheltering section became the primary focus due to the proximity of the 2009 hurricane season, and that further exploration for several of the other sections is needed. The subcommittee's first recommendation was: "Develop and implement standards and indicators for emergency/disaster shelters that are specific to meeting the unique needs of all children, including those with special needs."

Mr. Shriver inquired about efforts to employ technology in shelters. Mr. Lord suggested identifying technology as a cross-cutting issue, with a recommendation to explore technology and the attendant cost required to enable shelters to quickly share data. Shelters currently operate in terms of counting individuals in beds at midnight, which does not account for those who only use the shelter during the day for meals and other services. Also, better demographic data would detail the variable needs of different populations.

Dr. Redlener said there are issues in delivering health care to children in shelters. Confusion exists regarding roles and responsibilities, medical care information-sharing, etc. Mr. Riggen said ARC, while not a medical care provider, does provide basic first aid and referrals. In addition, temporary infirmaries may be possible in future due to an agreement ARC developed with the Medical Reserve Corps to work in shelters. He emphasized that local level partnerships will be important. Dr. Redlener suggested a recommendation that formal agreements be created to explicitly define how medical care services will be delivered in shelters. Mr. Lockwood observed that a key question would be whether a time-based threshold for implementation could be identified, especially for shelters or safe havens that open for a limited number of hours. Dr.

Schonfeld suggested the shelter manager might coordinate the health care, similar to the co-location of pet shelters. CAPT Lavin reminded the Commission that ARC is not the only provider of shelters. Other local or smaller faith-based shelter operators are unlikely to be able meet a requirement mandating that they establish a stand-alone infirmary and have prior agreements in place with outside medical care groups to provide medical services. Accordingly, she said the medical care coordination responsibility should not be placed on shelter operators. Dr. Redlener offered an alternate view, envisioning a role for the Federal government to provide/pay for medical care in shelters that are open for more than 12 hours. Mr. Lockwood noted that Connecticut requires that EMS personnel be present at shelters, no matter how long they are open. Dr. Anderson suggested that the Pediatric Medical Care and Evacuation, Transportation and Housing Subcommittees jointly work to clarify this issue in collaboration with ARC.

Ms. Merry Carlson reminded the Commission that it must think more broadly than hurricanes or large-scale, large-state circumstances. The goal is to change the way people focus on the issues, one example of which would be having kids be a part of the problem-solving occurring on the ground. The goal is to create a way of thinking that puts children at the forefront of shelter managers' considerations and planning. The approach must be holistic, not hurricane-specific. Mr. Lockwood concurred, sharing his hope that a church that establishes a shelter for its members would look to the shelter documents for guidance. The Commission must be sensitive that shutting down church shelters because of noncompliance would mean a resultant burden on other shelter providers.

Mr. Lockwood then read the recommendation on national planning: "Federal preparedness and response guidance documents, including the National Response Framework, the Target Capabilities List, and the Universal Task List, must incorporate specific guidance on how states and localities can plan for and respond to the needs of children during a disaster. Also, grant guidance for Federal disaster grants must incorporate and prioritize considerations for children." This recommendation requires Federal disaster grants to place children as a high priority. Mr. Lockwood said children must become involved in any nationally mandated exercises.

Mr. Lockwood next mentioned a consideration that has been tabled for the Commission's continued review: "DHS/FEMA must provide information in real time on their websites regarding the potential impact of a disaster, so disaster-relief organizations are better able to estimate the likely demand." Mr. Lockwood noted that there is a significant push for real-time information that would aid disaster relief organizations in their preparations before an event, but more input on this topic is needed for the subcommittee to make a recommendation.

Mr. Lockwood reviewed the child care recommendation, noting that sheltering considerations currently deal only with providing respite child care while parents remain present in the shelter: "Administrative and regulatory agencies for child care are strongly encouraged to develop statewide child care all-hazards plans in coordination with state and local emergency managers. State licensing bodies are encouraged to require child care providers to have comprehensive all-hazards plans that, at a minimum, incorporate specific capabilities such as shelter-in-place, evacuation, relocation, family reunification, training, continuity of service and accommodation of children with special needs. Child care providers' (center-based and home-based) plans must

be developed in coordination with local and state emergency operations plans." The subcommittee's recommendation is intended to address families' longer-term child care needs.

After a short discussion regarding the use of "licensed/unlicensed," Dr. Schonfeld questioned the expectation that home-based child care providers would collaborate with the state office of emergency management. The Commission considered a suggestion from Jeanne-Aimee DeMarrais of Save the Children to address licensed centers first.

Mr. Lockwood reported that a recommendation for family reunification and tracking was tabled while the subcommittee continues to consider it. There is a medical component to it, which will require further investigation with partner groups. The topics of evacuation and transportation were also tabled while the subcommittee identifies additional partners. Housing also requires further exploration. Mr. Revere observed that the breadth of topics to be considered by the Evacuation, Transportation and Housing subcommittee is complex. Housing issues are being shared with the Human Services Recovery Subcommittee, which is considering longer term housing concerns. Input has been received from organizations like Habitat for Humanity, and several considerations identified have been examined by the subcommittee. A meeting with the Department of Housing and Urban Development is scheduled to discuss persistent housing issues, with the goal of developing logical, practical recommendations.

Dr. Redlener observed that some issues transcend one subcommittee or another, and should be approached as general, overarching Commission recommendations. He asked that staff track such topics and compile them in a more broadly written part of the Commission's report. Additional topics include recovery, child care, and the collection and provision of information/data sharing.

Mr. Lord made a motion to move the Evacuation, Transportation and Housing Subcommittee's recommendations forward. The motion was seconded by Dr. Anderson and passed with no dissenting votes.

The meeting adjourned for lunch at 11:56 a.m. and reconvened at 1:03 p.m.

Remarks by W. Craig Fugate, FEMA

Mr. Shriver welcomed new FEMA Administrator, W. Craig Fugate, and Tracy Wareing, Counselor to Department of Homeland Security Secretary Janet Napolitano. He lauded Administrator Fugate's exemplary work for the state of Florida and a recent quote in the *Washington Post* regarding kids and disaster response, where he remarked "Kids are not little adults."

Administrator Fugate said his experience as a paramedic taught him that different treatment and handling needs are required in a crisis, a resonant point when considering disaster preparedness. According to Administrator Fugate, when planning for a disaster, a community should identify the complete demographic composition present within it, and then include the needs of the entire population as a whole in an integrated plan. He said that adding different annexes for different subpopulations as afterthoughts to the original plan weakens the overall planning effort because

stressed emergency management personnel will not be able to effectively incorporate every addendum in times of crisis. Children are present in every community and should be planned for accordingly. Discussing which infrastructures must be reinstituted first after a disaster, Administrator Fugate said standing schools back up is critical because children can better handle stress when they are able to resume their routines. FEMA is not trying to get schools back to *normal*, but rather to get children back into a familiar environment and give a community a visible sign that things are getting back to normal. He said that a school bus driving through a neighborhood and bringing kids to school is a powerful image connoting progress on the road to recovery.

Mr. Shriver described the Commission's subcommittee structure and the morning's proceedings. Because some subcommittees are considering child care issues, he asked Administrator Fugate to speak to the importance of child care.

Administrator Fugate observed that there are two pieces to the child care issue: preparedness and recovery. How should child care be addressed as a planning issue, and where can funding be found to help child care centers resume operations after an emergency? He said a strong case can be made for nonprofit child care providers to be eligible for reimbursement funding post-disaster. If day care centers cannot get back online, he asked, what resources can be leveraged within schools that are being brought back online? He noted that even opening preschools doesn't address the needs of the youngest children and their parents. Does the Stafford Act present options? If not, what approaches could states take, particularly outside of preschool? FEMA considers such questions from the perspective of the grant-making process. He said the other issue concerns whether child care facilities have disaster plans and are prepared to activate them.

Dr. Redlener commented that it is important to give parents room to reorganize their lives, and the Commission has the ability to recommend legislative changes that could provide that leeway. The Commission would like to work with FEMA to identify statutory revisions that would enable FEMA to pursue Administrator Fugate's stated goals for child care.

Administrator Fugate observed that the child care industry is not particularly resilient, comparing it to a cottage industry that is dependent on a limited personnel pool and is not part of a larger system like schools and hospitals. He asked, what constitutes rebuilding for the child care industry? FEMA coordinates the rebuilding process after a disaster, but does not facilitate resiliency. He encouraged the Commission to determine where, at the Federal level, the expertise can be found to facilitate resiliency in the child care industry.

Dr. Redlener suggested some resiliency might be created through training and exposure. Alternately, innovative day care surge capacity planning methods could be identified, especially if corporate/business communities could be engaged to consider how they could be involved.

Administrator Fugate invited the Commission to share its views with FEMA on an ongoing basis rather than waiting until formal recommendations are submitted to Congress and the White House later this year.

Dr. Anderson asked how the needs of children are being met in relation to FEMA's contracts for tent camps during the 2009 hurricane season. Administrator Fugate responded that a generic adult model was used in that scenario, but requested input from the Commission on what it would like to see happen in future approaches. He noted that building a base camp is one thing, but it is quite another to build an immediate-need shelter.

Mr. Lockwood asked if FEMA is reviewing matters of interpretation (i.e., internal policy vs. statute). Administrator Fugate replied that FEMA is reviewing the Stafford Act, Part 44 of the Code of Federal Regulations (CFR), and FEMA policies to determine the source of some restrictive rules. He is trying to shift the agency toward an outcome-based approach to thinking through disaster response, and noted that much of FEMA's policy is not in line with Congressional intent. Mr. Lockwood suggested that FEMA review eligibility for funding as part of this process. Administrator Fugate requested a list of items the Commission would like FEMA to review.

Dr. Schonfeld asked about long-term recovery considerations. Administrator Fugate noted that, if schools and housing are not online within a reasonable period, middle class families with transferable job skills will relocate to more promising communities rather than risk their children's futures. Families without children may be willing to risk an adverse environment, but if the tax base is not restored within five years, the community, schools, etc., cannot be restored by FEMA. In such instances, other areas of government must address the core issues that are impeding the community's ability to recover.

Dr. Schonfeld asked whether the idea is to develop FEMA's expertise to address those core areas or to identify another appropriate entity for that responsibility. Administrator Fugate responded that "who" is not important as long as it happens. FEMA's responsibility is in coordinating the team responding to a disaster. Administrator Fugate said he could envision a similarly coordinated team for the recovery phase. If the community remains focused on re-establishing the tax base, then careful thought regarding the steps needed to ensure that the population does not leave is necessary: child care, job training, job creation, and a wide array of other services and current community considerations must be part of that recovery planning process. For example, in the current transitional economy, he asked, where should job training be targeted (e.g., jobs that are being eliminated vs. growth sector jobs)? Such considerations are beyond FEMA's scope and mission. He asked where the center of gravity is to have the Federal family come together. He said the Department of Agriculture has rural programs nationwide but is not involved in disaster planning. There are other mechanisms that could be used to aid in recovery besides FEMA programs and Stafford Act funding streams, such as putting money in the Community Development Block Grant program to distribute resources. Appropriating additional funding to the Stafford Act generally is not the answer because the Act's scope is limited, he said. If local and state governments must determine for themselves where to adjust Federal programs to meet their needs, it will not get done.

Dr. Schonfeld said the Commission has struggled with the fact that no specific agency is responsible for long-term recovery, and asked where that responsibility might be housed. Administrator Fugate answered that some states are better prepared than others and some therefore need additional supports. A fundamental challenge is how to leverage the system to

meet states' multi-level preparedness needs. Perhaps another Federal agency is better situated to deliver direct services and expertise to build long-term capability in the community. Those relationships (i.e., Federal-state) should be identified and mapped out beforehand, not after a disaster occurs. With regard to funding, states differ. Some prefer a reimbursement model, while others want funding up front.

Dr. Redlener inquired about the status of the draft National Disaster Recovery Strategy. Administrator Fugate responded that it is not ready. FEMA is trying to resume a forward-looking outlook, rather than the past-dominated perspective it has struggled with since Katrina, which drained attention from what must happen to prepare for the next event. He acknowledged the need to absorb past lessons learned, but asserted that FEMA cannot be consumed by that effort at the expense of future planning.

Mr. Allen alluded to Administrator Fugate's belief in having a single plan, but shared the Commission's sense that planning and plans overall have been inadequate relative to the needs of children. The Commission's recommendations are fraught with items addressing the inadequacy of plans, he said, because the needs, demands and challenges for children are all different from those of healthy adults. He asked how FEMA thinks about children. Administrator Fugate said he wants to integrate planning for children directly into the core plans rather than having specialized plans or annexes for children. He plans to steer FEMA toward viewing children as a core component of the community.

Mr. Lockwood asked for the Administrator's thoughts on medical countermeasures for children. Administrator Fugate responded that pediatric medical countermeasures should be incorporated into the base plan, e.g., including children in the plan's medical section. Another challenge is that many grant programs give little attention to the pediatric community in planning. For example, current plans for biological disasters (equipment, chemicals, etc.) are not suited to pediatric physiology. Teaching pediatric chemical response and treatment is not done well and should be incorporated into grant guidance. Administrator Fugate offered another example: autoinjectors contain adult doses, but do not provide guidelines for dosing children. Paramedics will not have the luxury of making adjustments on the fly in the event of a radiological or biological mass attack.

Mr. Lord noted that the subcommittees are honing in on grant guidance opportunities. Medical issues with pre-hospital care are a challenge because of the many entities that focus on EMS matters. There is, however, an effort to reach some level of standardization relative to first responders' equipment. The medical countermeasures issue is tied to Food and Drug Administration and Stafford Act limitations. This is a considerable gap, Mr. Lord observed.

Mr. Shriver thanked Administrator Fugate for speaking with the Commission. Administrator Fugate said that DHS leadership is sensitive to the Commission's concern for children, and as the new Administrator, he has an eye on a variety of cross-cutting issues. He voiced the goal of elevating children's issues across all DHS departments, not just FEMA.

Human Services Recovery Subcommittee

Dr. Redlener, chair of the Human Services Recovery Subcommittee, gave the subcommittee's report, beginning with a review of overriding issues identified by the subcommittee, summarized here:

> Failures of recovery planning and preparedness, exacerbated by the absence of effective support programs, leave the most vulnerable child populations in persistent jeopardy. For example, Louisiana families post-Katrina continue to live with chronic uncertainty and lack resources to provide adequately for the multiple needs of their children.
>
> Challenges of "recovery planning" include insufficient planning resources/leadership, ill-defined recovery goals, lack of coordination among relevant agencies in the aftermath of disasters, long-term sustainability of disaster case management programs and the wide-range of unpredictable conditions that are possible in post-disaster scenarios. Recovery capacity is greatly affected by local conditions, state-based priorities and other economic and political factors.
>
> The guiding principle for child-friendly disaster recovery must be clear**:** appreciating the opportunity to create self-sufficiency for families and a "new and improved normalcy" for all children, especially those who are socially/economically disadvantaged, and not just recreating the inadequate conditions of the pre-disaster community.
>
> In developing recovery strategies, specific attention must focus on five essential domains that are ensured when children are sheltered for more than seven days: disaster case management; housing; health, mental health and oral health care; school and supervised after-school activities; and child care.

Dr. Redlener reviewed the preliminary general recovery recommendations, requesting feedback on recommendation 1 regarding the NRF and an ambitious deadline (December 31, 2009). Those recommendations are summarized below:

> 1. The Federal government must accelerate development of the NRF with an explicit emphasis on restoring self-sufficiency for children and families. The Commission recommends the NRF be ready for public comment by December 31, 2009.
>
> 2. Recovery strategies, roles, and responsibilities must be emphasized as critical components of federal, state and local disaster plans, including systems responsible for the education, care and welfare of children. The guiding principles would govern the request for and provision of federal disaster funding. In addition, the federal government must develop guidelines to ensure that the needs of children are appropriately incorporated into required recovery strategies.
>
> 3. The President shall establish a permanent coordinating council within the White House to develop a unified, collaborative disaster planning, response and recovery structure for children, including assigning lead agency status to agencies with responsibility for children as part of its core mission, i.e. HHS, the Department of Education, and community development, such as the Department of Housing and Urban Development.
>
> 4. The coordinating council shall also include advisory representation from state and local government partners, as well as nonprofit and private sector partners with relevant jurisdiction over the recovery needs of children.
>
> 5. DHS/FEMA shall create an office with sufficient policy expertise dedicated to serving children affected by disasters. The office must possess extensive experience developing

> and leading national policy efforts, have a demonstrated track record in interagency collaboration, and be dedicated to serving the needs of children and families affected by disasters. The head of this office will report directly to the FEMA Administrator and have authority to cross-cut FEMA Directorates to ensure that the needs of children are instilled throughout the agency. The office would also be responsible for creating interagency partnerships with relevant federal, state and local entities with the jurisdiction for and expertise in working with children and families to shape preparedness, response and recovery efforts across FEMA and to determine the most efficient and effective ways to direct DHS/FEMA funding toward the provision of assistance and services to children.

Dr. Schonfeld suggested the Commission should become familiar with the NRF process and current established timeframes before stipulating a deadline, and that the Commission could partner in the process now rather than awaiting Presidential approval. Dr. Redlener said the Commission might ask FEMA to consider and incorporate the Commission's recommendations by year-end.

Mr. Allen observed that Administrator Fugate was unambiguous that the NRF is currently under active development, and establishing a deadline just two months after the Commission's recommendations are submitted to the President and Congress may not be reasonable. Mr. Shriver invited DHS' Ms. Wareing to comment. She reiterated that the NRF is a priority, but still needs work. She said December 31, 2009, might be an aggressive deadline, but it does not mean that the idea cannot be suggested. If the Commission is able to collaborate with FEMA as requested, it could be feasible to consider a year-end date.

CAPT Lavin expressed concern that sending any information to FEMA prior to submission of the interim final report to the President and Congress in October would be problematic because the Commission lacks authority to submit recommendations directly to Federal agencies. Mr. Revere reminded the Commission that the preliminary recommendations are a matter of public record and may be used by FEMA at its discretion. The Commissioners agreed to retain the recommendation of a December 31, 2009, deadline for the National Disaster Recovery Strategy. Mr. Lord said the deadline means only that the Strategy should be ready for a period of public comment at that time, after which the revision process would continue.

Dr. Redlener asked staff to combine recommendations 1 and 2. He said the permanent coordinating council outlined in recommendation 3 would be located within the White House. Mr. Shriver wondered if such a recommendation might effectively institutionalize the work of the Commission in the Executive Branch. Mr. Allen asked whether the council could be seen as an alternative proposal to the HHS advisory body suggested earlier by the Pediatric Medical Care subcommittee. Dr. Redlener clarified that the HHS advisory body is HHS-specific, while the White House body would ensure that all agencies work together. The latter would not focus on implementation or operational details, but instead ensure avoidance of duplication, filling of gaps, conflict resolution, etc.

Dr. Schonfeld observed that, with agencies focused on the details and a White House body focused on the big picture, a disconnect between various policies might occur. A brief discussion ensued regarding the structure and reporting relationships for the council. The discussion regarding recommendations 3 and 5 was shelved until the Commission's September meeting.

Dr. Redlener reviewed the disaster case management recommendations:

1. FEMA must review best practices and make a decision to support a single disaster case management program no later than December 31, 2009. The disaster case management program must be holistic in scope, flexible and sensitive to cultural and economic differences in communities, placing a priority on serving the needs of families with children.

2. The disaster case management program must be led by a single Federal agency to coordinate, among all relevant agencies and organizations, disaster case management and ensure there is a) adequate understanding of the health and human services needs of children and involvement of voluntary agencies that provide disaster case management, and b) access to funding that supports all aspects of disaster case management, including direct services.

3. The program must be made available to all states to allow for the development of disaster case management capacity prior to a disaster. Funding must be provided to states for infrastructure and capacity-building to support a disaster case management program in advance of a disaster.

4. Develop a national contract to ensure rapid deployment of case managers, funding, and transition to service providers in the local community. The contractor also would pre-identify state and local subcontracting agencies and pre-roster disaster case managers from professional organizations that can provide surge capacity following a disaster.

5. Development of a consistent set of comprehensive program evaluation tools that regularly measure and monitor success based upon tangible positive outcomes for families (especially those most in need), rather than case managers simply making referrals. The program evaluation will also include guidelines for assessing and monitoring recovery milestones for children.

6. Ensure that all individuals in a declared disaster area are eligible to receive case management services.

7. DHS/FEMA, with assistance from the Department of Justice, shall review current privacy laws to determine the extent to which Federal, state and local agencies and eligible non-governmental organizations engaged in supporting children affected by disasters, may be permitted to share information in a disaster situation that would otherwise be protected by privacy laws under normal circumstances

Dr. Redlener noted that recommendations 4, 5, and 7 could be combined. With reference to recommendation 6, Mr. Lockwood said disasters are traditionally declared based on county boundaries and noted that the Commission does not want to unintentionally pronounce that individuals within an entire county should necessarily receive case management services if their area has not actually been affected. It was noted that Commission staff would modify the language to address Mr. Lockwood's concern.

Dr. Redlener gave an overview of the recommendations for health and mental health services:

1. Federal funds and reimbursement to the states must be made available to support health and mental health programs that provide comprehensive assessment and on-going services (to include pediatric physical health, mental and behavioral

health and oral health) for all children facing significant challenges during the recovery from a major disaster.

- The model of care must be consistent with the concept of the "medical home" consisting of preventive care, health education, timely diagnosis and treatment of acute illness, management of chronic conditions, coordination of specialty care needs, and availability of urgent and emergent response.
- Each child shall be assigned to a "medical home provider," providing care and assessment consistent with the model as described above.
- Comprehensive medical records, preferably on an electronic health record system, shall be maintained for every child receiving care under this program.
- Access to medications, specialty health care services and other special needs must be ensured.
- Case managers must ensure that transportation for scheduled and urgent health care appointments are available and timely.

2. In order to restore medical homes damaged or destroyed by a disaster, primary care practices must be eligible for federal assistance under the Stafford Act.

Dr. Schonfeld asked Commission staff to add recommendation 2's notation regarding medical homes to a growing list of entities that are eligible for services.

Dr. Redlener reviewed the subcommittee's academic recovery recommendations:

1. The Department of Education, DHS, and HHS must coordinate and collaborate to ensure that education and related services develop a recovery plan to provide immediate educational access by enrolling and placing disaster-affected children in educational and related services.

- It is essential that comprehensive educational and related services (academic, social, health, and mental health services) be provided to affected children during recovery from major disaster;
- The academic, related and ancillary services must be at least of the same scope as the free, appropriate public education provided to all children and youth;
- Deliberate speed in providing recovery education and related services must include relaxing legal requirements as appropriate, such as the requirement to submit immunization and medical records before student enrollment, during disaster declarations and recovery

2. Department of Education, DHS, and HHS must coordinate and develop software and hardware for a deployable emergency school enrollment system, with self-contained, fully-functional networks capable of enrolling students throughout the United States. The system will enable school officials to identify and enroll affected students in educational services, to provide a school and teacher assignment, and to assign transportation, meals, supplies, uniforms, and identification for special services while creating a comprehensive data system of children and youth displaced by disaster.

3. The Department of Education must collaborate and coordinate with HHS and HUD to ensure that families, children, youth, and school personnel receive emergency recovery-related services including mental health counseling, disaster, crisis and bereavement counseling, and after-school services.

Dr. Redlener reviewed the subcommittee's child care recovery recommendations:

1. Include licensed child care as an “essential service” under the Stafford Act to ensure funding and support for recovery of the child care infrastructure, either through amendments to existing DHS/FEMA regulations or the Act.

2. DHS/FEMA must work with other Federal agencies to address the provision of child care in the NRF as a human service activity under applicable Emergency Support Functions.

3. FEMA must issue “disaster-specific guidance” clarifying that certain child care services are eligible for reimbursement under Category B of the Public Assistance Program. The policy memorandum would formalize that child care is considered an “emergency protective measure” under Category B allowing eligible applicants (State agencies, local governments, and certain non-profit, private organizations) located in a state with an emergency or a major disaster declaration, to apply for reimbursement for child care services provided to evacuees through the Child Care and Development Fund (CCDF) program.

4. FEMA must issue policy guidance to coordinating and regional offices to clarify that temporary child care assistance provided by state and/or local governments to disaster victims throughout the recovery period following an emergency (e.g., period of time for which disaster victims receive FEMA-funded housing) is eligible for FEMA funds.

5. Reauthorization of the Child Care and Development Block Grant program must include a requirement that state child care plans include guidelines for recovery after a disaster and include the development of temporary/emergency child care operating standards.

6. Creation of a Child Care and Development Block Grant emergency fund to provide supplemental assistance to states that receive evacuated families from another state.

Mr. Shriver invited Ms. Wareing to comment on terminology used for different providers in recommendation 1. She doubted that the Stafford Act’s public works component allows for the support of private, sometimes for-profit, child care facilities. Mr. Revere said staff would work with Ms. Wareing to develop language to capture the Commission’s intent that all providers would be affected.

Mr. Lockwood asked whether the Commission could broaden recommendation 1, i.e., not limiting revisions exclusively to the Act if local options are better. Mr. Shriver concurred, observing that the subject arose in a recent conversation with DHS Secretary Napolitano. Staff will edit the language accordingly.

Mr. Shriver noted that the Child Care and Development Block Grant program is under reauthorization, which may provide an opportunity to include disaster recovery planning within its grant guidance.

Dr. Redlener reviewed the subcommittee’s housing recommendations:

1. Recovery plans must focus on transitioning from emergency housing to temporary housing to permanent housing quickly and seamlessly. When possible, transitional housing must serve as a foundation for a permanent, long-term housing solution.

2. Families with school-aged children must be prioritized for permanent housing to expedite children's return to school and access to a medical home.

3. Priority for expedited housing placement must be further delineated for families with children having special health or educational needs.

4. Create a permanent mechanism for the private sector (both non-profit and for-profit) to assist in HUD's and FEMA's development of disaster response and recovery strategies.

5. DHS/FEMA must evaluate the rental repair pilot program authorized by the Post Katrina Emergency Management Act and, if shown to be effective, consider establishing a permanent rental repair program authorizing the use of the Disaster Relief Fund through a corresponding amendment to the Stafford Act.

Dr. Redlener asked staff to combine recommendations 2 and 3 and delete recommendation 4. Mr. Shriver noted that additional housing recommendations would be forthcoming from the Evacuation, Transportation and Housing Subcommittee.

Dr. Redlener reviewed the subcommittee's mental health recommendations:

1. Enhance the research agenda for disaster mental and behavioral health of children and families by convening a working group to review the research portfolios of federal research funders across government to identify gaps in knowledge, areas of recent progress, and priorities for research in disaster mental and behavioral health programs for evaluation, early intervention, treatment for disaster-related problems, and dissemination of training in disaster mental and behavioral health interventions for children.

2. Provide adequate funding for disaster pediatric mental and behavioral health training for professionals and paraprofessionals, including psychological first aid, brief cognitive-behavioral interventions, social support interventions, and bereavement counseling and support.

3. DHS/FEMA and HHS must collaboratively develop and fund a national strategy to promote psychological resilience of individuals, families, and communities, including the integration, dissemination, and ongoing evaluation of psychological first aid.

Minor edits were made in recommendation 2 to incorporate a training component previously discussed. Mr. Lord requested a notation recognizing that the Commission will likely face global issues related to resiliency after the interim final report is submitted to the President and Congress. The Commission should connect with DOD to explore questions of community resiliency.

Mr. Lockwood made a motion to move the Human Services Recovery Subcommittee's recommendations forward. The motion was seconded by Ms. Leslie and passed with no dissenting votes.

Education, Child Welfare and Juvenile Justice Subcommittee

Ms. Leslie, chair of the Education, Child Welfare and Juvenile Justice Subcommittee, delivered the subcommittee's report. She said that, because the subcommittee is new, it has fewer

recommendations prepared. The subcommittee revised its name to include "Child Welfare" to fully recognize the focus on child welfare as well as education and juvenile justice. The group noted that although states have child welfare plans, they often do not know whether those plans actually work because of a lack of training and exercising. Ms. Leslie observed that there is no Federal law requiring disaster planning for schools and juvenile justice systems, and the structure of disaster planning by emergency management planners and schools, child welfare and juvenile justice systems are not aligned. Many districts say they have a written plan, but have not coordinated with local emergency planning managers or first responders.

Ms. Leslie gave an overview of the school emergency planning recommendations:

> 1. State departments of education must ensure all schools and school districts develop, implement and communicate comprehensive, multi-hazard school emergency management plans that address all four phases of emergency management planning (mitigation, preparedness, response, and recovery). The plans will be developed through collaboration among public, private and parochial schools, local government, local public health, law enforcement, local emergency managers, first responders, hospitals, healthcare providers, child welfare systems, mental health agencies, education agencies, parents/caregivers, children, and other community stakeholders.
>
> 2. DHS/FEMA and the Department of Education must encourage joint training and exercises involving teachers, school personnel, parents, children and other stakeholders along with first responders in exercises that test school disaster plans as part of comprehensive state and local emergency plans.
>
> 3. Metrics and performance measures must be developed and implemented by states, with guidance from the Department of Education, to help schools assess progress in implementing and exercising school emergency management plans, and providing after action reports in the event the plan is utilized.

Mr. Lockwood suggested minor language changes to reflect the subcommittee's intent to cover all hazards and all schools. Ms. Leslie invited input about where the responsibility for ensuring that all schools have plans might rest. Consensus supported the subcommittee's designation of state education agencies. Mr. Lockwood observed that the Departments of Justice and Education collaborate on subjects such as school shootings and suggested similar interagency cooperation might be employed for disaster planning.

Ms. Leslie reviewed recommendations about mental health services provision in schools, noting that the Commission might eliminate recommendation 3 as duplicative to other subcommittees' recommendations:

> 1. Pre-service training. Post-secondary schools of education must include basic training in the areas of crisis, bereavement, and trauma-related support services as part of mandatory curricula for all students. This training must be added as accreditation and/or licensure requirements for teachers and relevant school personnel.
>
> 2. In-service training. Basic training in the areas of crisis, bereavement, and trauma-related support services must be required professional development for teachers and relevant school personnel.

3. Investigate the necessity and feasibility of creating an on-line clearinghouse to inform teachers and school personnel about training materials available to them in the areas of crisis, bereavement, and trauma-related support services.

4. Ensure that the FEMA/SAMHSA Crisis Counseling Assistance and Training Program is used to support school based mental health training of school staff (including teachers and school mental health staff) so that crisis counseling services may be delivered in schools immediately after a disaster. Child mental health professionals must have an advisory role to the FEMA/SAMSHA Crisis Counseling Assistance and Training Program on an ongoing basis regarding the use of these funds as well as the development of training materials and program guidelines.

5. Require that state disaster mental health plans incorporate school-based services.

Mr. Lockwood encouraged the Commission to ensure the Department of Education's Readiness and Emergency Management for Schools (REMs) program remains visible and viable. It is an excellent program, he said, but under-funded and underutilized. Dr. Schonfeld added that, while it should receive additional funding, it might also assume the responsibility to disseminate information to schools so that more know about the REMs program. Currently, schools must contact a clearinghouse to obtain REMs information.

Ms. Leslie gave an overview of two child welfare recommendations:

1. HHS, in collaboration with DHS/FEMA, must provide technical assistance to assist states in developing comprehensive child welfare emergency management plans that address all four phases of emergency management planning.

2. The plans must be developed in coordination with state and local emergency managers, along with other key stakeholders, and integrated into state and local emergency operations plans, training and exercises.

She observed that the child welfare system by definition connotes a personal disaster for families. The 2006 Family Services Improvement Act requires that states have disaster recovery plans, however it is unclear how effective and comprehensive these plans are in actuality. Ms. Leslie said the subcommittee agreed it must merge the idea of having a plan with the concept that it be meaningfully and professionally evaluated for effectiveness.

Ms. Leslie also addressed the subcommittee's recommendations on juvenile justice topics:

1. Reauthorization of the Juvenile Justice and Delinquency Prevention Act must include an amendment to require the development of disaster plans, supported by federal funds for technical assistance at the state and local level.

2. The plans must address all four phases of emergency management and be developed in coordination with state and local emergency managers, along with other key stakeholders, and integrated into state and local emergency operations plans, and be utilized in training and exercises.

3. A model/template disaster plan for state juvenile justice systems must be developed by the Department of Justice, in coordination with agencies with emergency management expertise, and distributed to the states.

4. Ensure/require that private residential treatment facilities have disaster plans in place.

5. Juvenile court systems must have comprehensive emergency plans in place that, at minimum, address procedures for continuity of operations, including processing cases and holding hearings, in the wake of a disaster.

Ms. Leslie said there is no Federal requirement that juvenile justice/court systems have disaster plans. The Juvenile Justice and Delinquency Prevention Act is currently under reauthorization, and Commission members may wish to consider contacting Senator Leahy's office to see if such a requirement might be included. Mr. Shriver asked whether juvenile correctional facilities have plans. Mr. Allen confirmed that some, but not all, do. CAPT Lavin added that some states have emergency planning requirements for juvenile corrections facilities. Ms. Leslie acknowledged the point, noting that a subcommittee representative of those facilities indicated that implementation often falls short.

Ms. Leslie said the subcommittee identified other issues warranting further examination, e.g., pandemics, which are broader than the subcommittee's scope but which would affect the institutions within the subcommittee's purview. She mentioned that pandemic flu should be addressed by the Commission, especially considering the likelihood of the return of H1N1 next flu season. Ms. Leslie reported that the subcommittee wants to look further into the issue of emotional trauma for incarcerated youth and options for homeless/runaway youth, who often receive little attention in disaster planning.

Dr. Schonfeld made a motion to move the Education, Child Welfare and Juvenile Justice Subcommittee's recommendations forward. The motion was seconded by Mr. Tan and passed with no dissenting votes. Dr. Redlener was in absentia at the time of the vote.

Public Comments

Mr. Shriver opened the floor for public comment at 3:05 p.m.

Ms. Elizabeth Blake, representing the National Coalition on Children and Disasters, expressed its satisfaction with the "massive talent" and "deep level of engagement and progress made" by the Commission. She said the Coalition looks forward to continuing its level of engagement, given its expanded expertise and ability to approach Congress. As a Federal entity, the Commission is prohibited from lobbying activities. The Coalition, however, has had meetings on Capitol Hill and has created subcommittees to align with those of the Commission. Ms. Blake invited the audience to attend a July 15 meeting at Habitat for Humanity to discuss strategies for ensuring enactment of the Commission's recommendations. Mr. Shriver thanked Ms. Blake and shared his appreciation for the Coalition's continuing efforts and support of the Commission.

Mr. Peter Sternberg of Skokie, Illinois, read comments on his own behalf; his written comments are on file with the Commission. He advocated designating a government authority to compel the integration of fire, police, public health, hospitals and schools before an event in order for the system as a whole to perform maximally during an event, with the least residual damage to all. Dr. Schonfeld confirmed receipt of earlier materials submitted by Mr. Sternberg, and invited him

to continue to provide input to the Commission. Of particular interest would be his perspective on AHRQ's CD-ROM tool on pediatric decontamination.

No further remarks were offered. Mr. Shriver closed the public comment period at 3:20 p.m.

Other Business

Mr. Shriver announced the launch of the Commission's new Web site, www.childrenanddisaster.acf.hhs.gov, and expressed his appreciation to the Commission's Communications team, Vinicia Mascarenhas and Matthew Seney, for their efforts in its development. He also thanked Alba Sierra, ACF, for her assistance for same.

Mr. Allen inquired about the Commission's plan, if any, regarding a Stafford Act revision effort. Mr. Shriver noted that several matters raised by Administrator Fugate would be pursued. He suggested that the Commissioners reconvene with staff via remote participatory means to develop revisions that Mr. Revere could share with Administrator Fugate and/or Ms. Wareing before the Commission's September meeting. Mr. Revere said staff will continue to review questions regarding the Stafford Act and relevant sections of the CFR. He noted the importance of identifying which bucket each of the Commission's recommendations fall under (policy, regulatory or legislative).

Mr. Revere indicated that staff will continue to review any documents provided by stakeholders or found in the public domain, particularly relative to questions of interpretation of the Stafford Act. He said while it may be optimal to seek legislative change rather than policy or regulatory change, some items may be quickly incorporated by FEMA without pursuing a legislative route. It will be important to determine into which category suggested changes fall, and to collaborate with FEMA's legal counsel when appropriate.

Mr. Shriver invited all Commissioners to provide input, preferably by July 6, regarding areas staff should review, and suggested avoiding the assumption that issues have already been identified. He asked Mr. Revere to send a reminder regarding Commissioners' submissions.

Mr. Shriver called for a motion to adjourn the meeting, which was made by Mr. Lockwood; Dr. Schonfeld seconded. The meeting was adjourned at 3:26 p.m.

Participant Affiliations:

Ernie Allen: National Center for Missing and Exploited Children
Dr. Michael Anderson: University Hospitals, Case Western Reserve University
Carol Apelt: Administration for Children and Families, U.S. Department of Health and Human Services
Merry Carlson: Division of Homeland Security and Emergency Management, State of Alaska
W. Craig Fugate: Federal emergency Management Agency, U.S. Department of Homeland Security
Randall Gnatt, National Commission on Children and Disasters
Jacqueline Haye, National Commission on Children and Disasters
Victoria Johnson, National Commission on Children and Disasters

CAPT Roberta Lavin: Administration for Children and Families, U.S. Department of Health and Human Services/United States Public Health Service
Hon. Sheila Leslie: Nevada General Assembly; 2nd Judicial District Court
Bruce Lockwood: Bristol-Burlington Health District
Dr. Joan Lombardi: Administration for Children and Families, U.S. Department of Health and Human Services
Graydon "Gregg" Lord: Homeland Security Policy Institute, George Washington University
Vinicia Mascarenhas, National Commission on Children and Disasters
Dr. Irwin Redlener: National Center for Disaster Preparedness, Columbia University; The Children's Health Fund
Christopher Revere: National Commission on Children and Disasters
Dr. David Schonfeld: National Center for School Crisis and Bereavement, Cincinnati Children's Medical Hospital Center
Matthew Seney, National Commission on Children and Disasters
Mark K. Shriver: Save the Children
Lawrence Tan: Emergency Medical Services Division, New Castle County Department of Public Safety

Commenter Affiliations:

Liz Blake: National Coalition on Children and Disasters; Habitat for Humanity International
Peter Sternberg: Skokie, IL