NATIONAL COMMISSION ON CHILDREN AND DISASTERS
FEBRUARY 27, 2009 MEETING

MINUTES

Participants

Ernest Allen*
Dr. Michael Anderson*
Carol Apelt+
Merry Carlson* (via teleconference)
CAPT Roberta Lavin+
Sheila Leslie*
Bruce Lockwood*
Vinicia Mascarenhas
Dr. Irwin Redlener*
Christopher Revere
Mark 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, 200 Independence Avenue SW, Room 705A, Washington, DC, 20201. Approximately 40 members of the public attended: none presented oral or written statements, though some questions were entertained by the Commission.

Proceedings of February 27, 2009

CAPT Roberta Lavin, as Designated Federal Official to the Commission, opened the meeting at 8:34 a.m. and welcomed the members. Carol Apelt was designated record keeper for the meeting. CAPT Lavin then introduced Commission Chairperson Mark Shriver.

Mr. Shriver welcomed the Commission and those observing in the audience. He invited comments from the audience, noting his prerogative as Chairperson in reserving the right to guide or conclude discussion as he deemed appropriate.

Mr. Shriver asked Vice Chairperson Dr. Michael Anderson and Commission member Dr. Irwin Redlener, serving as co-chairs of the Pediatric and Medical Care Subcommittee, to give the first subcommittee report, summarizing the discussion from February 26.

Dr. Redlener opened by observing that the subcommittee meeting covered a wide range of categories: structure (i.e. training, roles and responsibilities), regulatory issues (i.e. pre-authorization of medical countermeasures for pediatric use, off-label use), and acute medical care needs (amassing information and consensus on proper dosage and delivery methods for children). He noted that the idea of a disaster preparedness, response and recovery clearinghouse of reliable information and data was discussed in detail. Dr. Anderson said there are a number of resources available to the pediatric and broader medical community but one central home for such resources and information does not currently exist. Another topic explored by the subcommittee was the potential development of national minimum training standards for pediatric care during disasters.

Dr. Anderson noted that children's hospitals, school nurses, the Federal government and others inadvertently create silos, hindering the overall stakeholder communities' ability to share and benefit from the full complement of information available. The subcommittee discussed the importance of identifying methods for streamlining data-sharing and eliminating those silos to make response more efficient and universal.

Dr. Anderson presented the subcommittee's recommendations for further review and discussion:

- Support the development of a White House Office of Children's Affairs for oversight of Federal programs and regulations relating to children's issues, including disaster preparedness, response and recovery
- Develop National Clearinghouse for Children and Disasters
    - Central repository for data, protocols, tools
    - Broad range of issues—medical care, sheltering, case management
    - Oversight body for peer review and standardization
- Develop national standards for care of children in disasters, tying compliance with funding
    - Medical competencies of health care workers
    - Triage tools
    - Equipment requirements
    - Transport protocols
- Streamline the process for enrollment of pediatric professionals into state and Federal disaster networks
- Require pediatric expertise to be part of all regional, state and national disaster planning
- Develop more formal network support for children's hospitals such that transfer and interagency support of children's needs in disasters are streamlined; develop avenues where pediatric professionals can be more involved in local and national disaster planning and response
- Require pediatric expertise and training for all Federal disaster relief teams (Disaster Medical Assistance Teams, etc.)
- Convene expert panel on disaster use of off-label drug use and other countermeasures, summarize priorities and implement appropriate changes to Federal regulations

Dr. Redlener underscored the subcommittee's interest in exploring the idea of an information clearinghouse. Such a clearinghouse would involve peer review to ensure confidence that its materials are legitimate and the result of expert consensus.

Christopher Revere, Executive Director of the Commission, said one of the Commission's charges is to consider the creation of such a clearinghouse. There is support from the pediatric and emergency management communities for the idea. He suggested a subcommittee or working group might be created specifically to consider the

creation of a clearinghouse, since such a resource would focus on a range of topics that extend beyond issues of pediatric medical care.

Dr. Redlener said the subcommittee is exploring the mechanisms that Federal agencies operate under which constrain pre-authorization of emergency medical countermeasures for children, as well as other constraints that could delay preparation in the field. Off-label use in disasters, where a drug might be useful responding to the needs of adults but cannot be used in a similar fashion on children, is of concern to the subcommittee.

Dr. Redlener read into the record a comment from an external source, reproduced below as written in the email; the complete email is on file with the Commission.

> …It is much worse than that when you take into account the new EUA (emergency use authorization) from FDA. In essence, the entire SNS stockpile of cipro and doxy can no longer be released in a disaster until the FDA signs an EUA after the incident occurs (because the drugs are not formally indicated). Worse, the EUA requires that patients be given informed consent about the drugs and that the sheets of information on the drugs will not be approved by the FDA until after the incident occurs… Bear in my mind that we have only 48 hours to mass prophylaxis an entire population. The approval process is expected to take several hours (4-8). The forms will then have to be distributed by email and then printed by the millions. Finally, the FDA EUA will not include the drugs stockpiled by the states which were purchased with Federal monies under Federal deliverables.
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> …The FDA refuses to allow us to crush cipro for children as they said it does not taste good, so only doxy can be crushed. Bear in mind there is no suspension held in the SNS. They also will not allow us dispense powder in mixing bottles to the families, we must premix the drugs. The importance of that is that once you mix the suspension it only lasts ten days, so now the families have to come back every 10 days for their 60 days course of anthrax prophylaxis….

Dr. Redlener observed that the United States is improving its ability to respond to disasters from a pediatric point of view. Serious thought regarding mega-disasters remains to be undertaken, however. Consideration should be given to how differentiation between "everyday" disasters and mega-disasters is made. Dr. Redlener said the subcommittee suggests convening a discussion involving the Commission, the American Academy of Pediatrics (AAP), the Food and Drug Administration (FDA) and other relevant organizations to develop a strategy and report back findings at the next public Commission meeting, regarding suggestions to improve the pre-authorization of emergency medical countermeasures for children and development of medical countermeasures specifically for children.

Dr. Anderson said that medical drug use should be streamlined based on medical expertise. The AAP developed recommendations along these lines, but with new leadership at FDA, the Commission should consider how best to move such recommendations forward for review and consideration. Mr. Revere emphasized involving other stakeholders (such as the Office of the Assistant Secretary for

Preparedness and Response at the U.S. Department of Health and Human Services [HHS]) to develop consensus regarding AAP's recommendations. Ms. Cindy Pelligrini of AAP confirmed AAP's support of the points Drs. Anderson and Redlener made in their subcommittee report.

CAPT Allen Dobbs noted that Homeland Security Presidential Directive 21 directs Federal agencies to review the national disaster strategy for the National Disaster Medical System (NDMS); the revised strategy is due in 2010. He said the points of the Commission's discussion should be shared with the team developing that strategy. Sally Phillips, from HHS's Agency for Healthcare Research and Quality, concurred. Mr. Revere encouraged the subcommittee to continue engaging stakeholders to ensure all perspectives are heard and considered. Mr. Shriver noted that if it is difficult for groups working on this issue to get information from Federal agencies, then it is the job of the Commission to determine the reasons behind such difficulties.

Natalie Love of the Congressional Research Service advised the Commission that discussions with Congress regarding changes to the Stafford Act are ongoing. She asked whether the subcommittee discusses what systems might be used in the case of catastrophic events. Dr. Redlener responded that certain actions are taken either because evidence exists to support their effectiveness or, in the absence of evidence, because there is consensus opinion from the expert field. Ms. Love noted that one challenge has been defining "catastrophic event." She also said the question of whether having one Federal point of command is most effective is under exploration.

Dr. Redlener suggested that a mega-disaster is a catastrophic event that overwhelms existing response systems, involving potential societal breakdown. Ms. Love responded that different kinds of disasters require different kinds of responses, thus a single national approach will be ineffective. The subcommittee will consider these points.

Bruce Lockwood, chair of the Sheltering and Mass Care Subcommittee, delivered the subcommittee's report. He said that national shelter standards, including the care of children, are being developed by the American Red Cross and will be considered by the National Volunteer Organizations Active in Disasters (NVOAD) Board in May. The subcommittee will be working to provide input on its content. The subcommittee agrees on the need for national shelter standards in disasters, but it is still considering where such a standard would be housed (for example, within FEMA) and how it would be applied to shelters that are run by local and state emergency managers, not by the American Red Cross.

A question was raised during the subcommittee discussion regarding the definition of "child" within the guidelines. Children are typically defined as "under 18" however, education requirements in the shelter extend up to the age of 25. Another point was raised as to whether guidelines should be developed for the first 72 hours of shelter operation, followed by a more extensive set of guidelines for situations where the shelter is open beyond 72 hours. The subcommittee also discussed how technology will play a role in shelter design and operations, including technology for a clearinghouse to enable survey

of a number of databases (i.e. sex offender registries), counting of children based upon their age, and the design of a shelter layout that includes safe areas for children . One challenge to effective delivery of services to shelter populations is that some populations do not wish to provide identification or credentials to perceived authority figures (i.e. illegal immigrants).

Another identified definition need surrounded the term “child care.” To some, the term connotes a day care center, while in reality disaster child care may be more accurately described as “respite care” designed to give parents/guardians/caregivers a break from the children.

During the American Red Cross (ARC) shelter assessment phase, the needs of individual shelters can be identified and addressed. The subcommittee suggested that a package of relevant pediatric and child-specific supplies might be created by the state to enable shelters to access a cache of supplies for pediatric needs.

Mr. Lockwood presented the subcommittee’s recommendation for further review and discussion:

- The Commission is actively working with the American Red Cross, FEMA, state and local national associations and NGOs to develop a detailed set of guidelines for emergency shelter design that appropriately incorporate the unique needs of all children, including children with special needs and challenges. Once these guidelines have been developed, the Commission recommends that FEMA implement an appropriate structure to encourage these guidelines as part of comprehensive national shelter standards.

Mr. Revere noted the subcommittee discussed changing “enforcement” in the draft recommendation be revised to “encouragement” so that it is less harsh. Mr. Lockwood supported this because requiring it significantly impacts the “mom and pop” shelters that appear in the immediate aftermath of an event. The question of defining tiers of sheltering was discussed, with the possibility that “enforcement” language might be employed relative to higher tiers, while “encouragement” is reserved for “mom and pop” shelters.

ARC shelter assessment teams include representatives from the U.S. Department of Health and Human Services, the Administration for Children and Families (ACF), the Administration on Aging, the Centers for Disease Control and Prevention, and the Federal Emergency Management Agency (FEMA). FEMA issues a mission assignment, triggering the assembly of a shelter assessment team to review a variety of different shelter concerns. CAPT Lavin said that Hurricane Gustav and Ike shelter assessments specifically included reviewing the needs of children in the shelters visited. A new assessment tool is under development at FEMA, with input from ACF as a result of lessons learned during the response and aftermath of Hurricanes Gustav and Ike.

Mr. Lockwood said that the subcommittee had agreed to digest the information discussed and heard during its meeting and expects to offer additional recommendations in future. Mr. Revere noted that the subcommittee examined international and domestic shelter standards, and has additional input it wishes to offer ARC to ensure children, partnered and single parents, and expectant mothers are effectively planned for and taken care of. It was noted that many shelters struggle to achieve full compliance with the requirements of the Americans with Disabilities Act. Conversations were suggested among stakeholders to develop guidelines for children with disabilities.

The NVOAD and ARC shelter guidelines are being revised to reflect better organization, similar to the standards outlined by the Sphere Project; FEMA is participating in the subcommittee discussions and developing its own guidelines around sheltering. ARC guidelines would only apply shelters that ARC operates; non-ARC states would not be subject to them. The subcommittee may opt to recommend, once the guidelines are final, national adoption by FEMA. It was noted that initially shelters are operated by local governments, and usually transition to ARC, essentially making shelters the responsibility of different authorities as time passes.

CAPT Lavin noted that there is a lack of standard definitions across the emergency management community, underscoring the subcommittee's suggestion that definitions be developed. Dr. Redlener suggested that shelters receiving Federal support could be held to standards, while non-Federal shelters could be encouraged to adopt standards, thus avoiding the possibility of discouraging needed pop-up shelters.

Mr. Lockwood said that caches of supplies can take as long as 96 hours to arrive at shelters after states request them. Imposing standards on Federally funded shelters that must be met earlier than that 96-hour window could put shelters in a situation where they cannot feasibly meet the standard (and thus incur penalties).

Mr. Lockwood asked how one meets the needs of children while simultaneously identifying ways to meet the overall response supply needs. He noted that he is encouraged by the states' leadership in this area. Mr. Shriver suggested proceeding in a manner similar to how the requirements regarding pets were implemented. Mr. Lockwood cautioned that the cost requirements of standards must accompany the recommendation of their national adoption.

Lawrence Tan observed that as these issues are considered, responsibilities rest not only with the Federal government but with states too: the Federal government must wait for states to request assistance. If states do not request it, Federal agencies cannot intervene.

Ernest Allen noted that legislative action may be necessary, in addition to the adoption of a national standard, because legal barriers exist that prevent agencies from sharing information about evacuees. Current technology, including networking of disparate entities, is almost absent in the emergency response arena. Building upon Mr. Allen's observation, CAPT Lavin noted that systems and technologies exist but are cost-

prohibitive. She suggested that grant guidance might be a useful tool in addressing issues of technology.

CAPT Dobbs said that the Centers for Disease Control and Prevention and the Strategic National Stockpile have Federal Medical Shelters. He noted that the number of children using FMCs is generally small but in a catastrophic event would increase. He said the need for special needs shelters is greater than for general population shelters, and suggested the subcommittee consider urging the development of guidelines for children in FMCs. Mr. Lockwood observed that this is a cross-cutting issue encompassing the work of both the Shelter and Pediatric Medical Care subcommittees.

Mr. Shriver, chair of the Disaster Case Management (DCM) Subcommittee, asked Mr. Revere to give the subcommittee report. Mr. Revere noted that DCM is a particular concern that has emerged in the Commission's consciousness. The subcommittee is attempting to identify ways governments and communities can work more efficiently together in this area. DCM addresses the question of longer term recovery. Services must be delivered quickly and on an equal access basis, although particularly to citizens who are most in need of it (i.e. low income populations, families with children, individuals with medical concerns).

Mr. Revere reported that three Commissioners and CAPT Lavin visited Baton Rouge, Louisiana, in January 2009 to view and discuss post-Katrina efforts to help people recover. During this visit, the Louisiana Family Recovery Corps offered several recommendations for moving forward:

- A definition of DCM should be established. A holistic definition sensitive to economic, health and social considerations is of interest to the Commission.

- Substantial funding has been targeted to recovery, but accountability for results is lacking. Performance and positive outcomes must be measured in meaningful ways.

- Long term recovery is not possible without financial assistance because of burden it imposes on the state.

- The reluctance and/or inability of Federal agencies to share information on families is problematic. Local assistance agencies must search for families individually, and although families may be ineligible for Federal assistance does not mean they may not have needs that local response agencies could address.

- Resources should be pooled to better assess and respond to targeted needs.

The subcommittee explored whether performance measures should be built into Federal recovery grants. Prequalification of organizations with a proven track record for effectiveness might be advantageous, thus enabling faster distribution of funds and, by extension, faster ground response.

The subcommittee discussed structural issues and roles of federal, state and local partners in meeting the long-term recovery needs of children. The subcommittee questioned who holds ultimate responsibility for the oversight of DCM, and asked whether there should be a central recovery authority.

The subcommittee deemed that recovery planning should be more prevalent in the states. States should not develop their recovery strategies on an ad hoc basis, but rather have them thoughtfully prepared and ready for activation. The subcommittee asked how funding mechanisms might be rendered more responsive to the needs of children. Should those funds be available as long as the need is present? Currently, timelines appear arbitrary regarding when response fund availability ends.

The subcommittee posited that no recovery strategy or disaster case management programs will be effective unless all participants are aligned: Federal, state and local levels must all be incorporated and on the same page.

Mr. Revere presented the subcommittee's recommendations for further consideration and discussion:

- The Commission recommends that the Federal government develop and adopt a standard definition of "disaster case management" across all relevant agencies. Disaster case management shall be holistic in scope and sensitive to cultural and economic differences.

- The Commission recommends that recovery strategies for children be included in planning documents for disasters. Such requirements should be encouraged and supported at the state and local level through Federal disaster funding mechanisms (e.g. grant guidance).

Dr. Redlener observed that recovery as a concept is generally physically defined (i.e. rebuilding schools or hospitals) and is not usually incorporated relative to human recovery. He suggested that the Commission might redefine what is meant when "recovery" is discussed: necessary but modest investment in health and human impact is vital. Dr. Redlener offered the suggestion that a White House Office on Children's Affairs might be created to oversee concerns such as this to ensure children's needs are met. He also suggested the DCM subcommittee might broaden its focus to a more expansive examination of children and recovery. CAPT Lavin countered that DCM is not only a recovery mechanism, and identification of it as such omits it from the equally critical preparation and response phases. Dr. Jeffrey Upperman suggested using the term "community resilience" rather than recovery. Additionally, Daniel Fagbuyi suggested the Commission might define children's recovery as "new normalcy" since things won't go back to where they were before.

Another member of the audience noted that one challenge with "building better" is that the Stafford Act does not allow for such an approach. The Stafford Act enables only a

return to where things were before the event occurred. Dr. Redlener responded that the Commission plans to review existing laws and regulations, and recommend changes as necessary to remove barriers to the most effective response possible.

Andrew Garrett cautioned that we as a nation should avoid assumptions that because we are Americans we cannot adopt what other nations have developed. Materials in use elsewhere in the world should be considered for incorporation into our own processes.

An audience member commented that when recovery is discussed, longevity is not considered. Louisiana children are still traumatized by Hurricane Katrina but it is difficult to continue tackling such ongoing issues when the funding expires. Mr. Shriver noted the concern, mentioning that Save the Children and the Children's Health Fund have been working independently in those areas. The time period for which FEMA is responsible, as well as who assumes responsibility once that period ends, remains unclear. Dr. Redlener noted that detailed recovery plans should be in place before disasters to ensure communities are resilient and ready to respond. Dr. Redlener noted the difference between "recovery" and "recovered."

Mr. Lockwood noted that recovery has never been included in any response grants, and that the focus must shift to how communities stand back up. The majority of deliverables are dictated by the grant guidance, and Mr. Lockwood suggested issues surrounding recovery be included. There is a current shift toward reducing those dollars, but focusing on restoring communities should be an emergent priority.

Regarding the suggestion of a White House Office of Children's Affairs, Mr. Allen observed that the United States has a long history of creating positions that are more symbolic than substantive. The substantive role of such an office, including operational structure and legal authority to coordinate and compel agency actions, should be clearly identified to ensure true effectiveness. CAPT Lavin noted that Mr. Allen's suggestions appear similar in scope to the Homeland Security Council.

Christine Calpin inquired why a new White House office must be created rather than incorporating such responsibility within the existing Domestic Policy Council. Mr. Revere noted that the Domestic Policy Council has reached out to the Commission for a briefing on the Commission's work. Such an option will be explored.

Mr. Lockwood motioned that the recommendations presented at the meeting be moved forward for further exploration and research. Sheila Leslie seconded the motion, which was adopted.

Mr. Revere said that a major milestone for the Commission this year is completing the Commission's interim report to Congress, due in October 2009. He suggested the full Commission begin meeting on a quarterly basis starting in June. In the meantime, the subcommittees will meet more frequently to continue focusing on their topics, as will the research team. At the Commission's September meeting, a draft of the interim report to Congress will be available for members' review and deliberation. CDR Stephanie

Bardack is currently working on a literature review, distilling the universe of material into a format the Commission can employ. Mr. Revere encouraged members of the audience to share documents, reports, and research with the Commission to ensure it can be included in the body of research. The Commission's ultimate goal is to issue recommendations that are thorough and workable.

Mr. Revere reported that the Commission staff has been busy, as there is much interest on Capitol Hill and in the community regarding the Commission's work: Senators Kennedy and Landrieu have requested meetings, and the House Committee on Transportation and Infrastructure has registered interest. One goal is to ensure that the needs of children are front-of-mind with Congressional policy makers, and the Commission can be a valuable resource to Congress in that regard. Meetings with the new leadership at the U.S. Department of Health and Human Services have occurred as well, although without a Secretary the Department is hindered in its ability to implement changes. Mr. Revere also reported that a meeting is scheduled with Melody Barnes of the White House Domestic Policy Council, and Vice President Biden's office was notified of the Commission's work. U.S. Department of Homeland Security Secretary Janet Napolitano has been actively realigning her Department's efforts to meet the needs of families, and Commission staff is attempting to schedule a meeting with Homeland Security leadership to discuss issues of children that fall under their jurisdiction.

Mr. Shriver transitioned to a discussion about the future work for the Commission. Mr. Allen suggested addressing the inadequacies of the Stafford Act, inquiring how and where such a process might be undertaken. Mr. Shriver observed that since Congress is currently reviewing changes to the Stafford Act, perhaps the Congressional Research Service could assist the Commission in its research. Mr. Lockwood suggested a panel of experts or a subcommittee to address the Commission's Stafford Act analysis.

In response to an inquiry about how to review disaster housing situations, Mr. Revere suggested that the research team be allowed to complete their review, enabling staff to make a more informed recommendation to Commissioners regarding which subcommittee might address housing issues. Mr. Revere also noted the role of schools with regard to children's health, mental health, preparedness and response. He suggested that the realm of education might be the next big focus of the Commission.

CAPT Dobbs suggested the Commission study efforts around community resiliency and risk mitigation strategies.

Naya McMillan announced the formation of a federal advisory committee, the Federal Education and Training Interagency Group (FETIG), that consists of the U.S. Departments of Transportation, Health and Human Services, Defense, Homeland Security and Veterans Affairs. The FETIG will provide a consensus document on public health and medical emergency preparedness education and training to assist in the drafting of the National Health Security Strategy every four years beginning in 2009.

Dr. Monteic Sizer suggested the Commission include consideration of resettlement issues in its agenda.

Mr. Revere introduced Commission staff: Carol Apelt, deputy director; Vinicia Mascarenhas, communications director; Victoria Johnson, policy director; Jacqueline Haye, executive assistant.

Mr. Shriver closed by noting that the Commission is charged with not duplicating the work of others. Rather, the Commission will leverage information from existing entities and resources to ensure children are adequately taken care of and considered is the focus. He encouraged communication from the public and invited constructive criticism.

The meeting was adjourned 11:48 a.m.

Participant Affiliations:

Ernest Allen: National Center for Missing and Exploited Children
Dr. Michael Anderson: University Hospitals, Case Western Reserve University
Carol Apelt: National Commission on Children and Disasters
Merry Carlson: Division of Homeland Security and Emergency Management, State of Alaska
CAPT Roberta Lavin: Administration for Children and Families, U.S. Department of Health and Human Services/United States Public Health Service
Sheila Leslie: Nevada State Assembly Member, District 27
Bruce Lockwood: Public Health Emergency Response Coordinator, Bristol-Burlington Health District
Vinicia Mascarenhas: National Commission on Children and Disasters
Dr. Irwin Redlener: Mailman School of Public Health, Columbia University/The Children's Health Fund
Christopher Revere: National Commission on Children and Disasters
Mark Shriver: Save the Children
Lawrence Tan: Emergency Medical Services Division, New Castle County Department of Public Safety

Commenter Affiliations:

Christine Calpin, human services consultant
CAPT Allen Dobbs III, National Disaster Medical System, U.S. Department of Health and Human Services
Dr. Andrew Garrett, National Center for Disaster Preparedness, Columbia University
Natalie Love, Congressional Research Service
Naya McMillan, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
Cindy Pelligrini, American Academy of Pediatrics
Sally Phillips, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
Dr. Monteic Sizer, Louisiana Family Recovery Corps
Dr. Jeffrey Upperman, Children's Hospital of Los Angeles