



NATIONAL COMMISSION
ON
CHILDREN AND DISASTERS

2010 REPORT TO THE PRESIDENT AND CONGRESS
OCTOBER 2010



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Foreword

Mr. President and Members of Congress:

The National Commission on Children and Disasters is pleased to submit for your consideration our 2010 Report to the President and Congress.

The Commission is an independent, bipartisan body established by Congress and the President to identify gaps in disaster preparedness, response, and recovery for children and make recommendations to close the gaps. As required under the Kids in Disasters Well-being, Safety, and Health Act of 2007, the Commission delivered an Interim Report to you on October 14, 2009. This 2010 Report to the President and Congress builds on our previous findings and recommendations.

One year ago, the Commission offered a sobering assessment of the national state of disaster and emergency preparedness for children. As expected, we found serious deficiencies in each functional area, where children were more often an afterthought than a priority.

For the past year, we have worked extensively with the Administration, Congress, and non-Federal partners to close these gaps by focusing existing programs and capabilities more intently on children. A number of recommendations in the Interim Report were implemented. The Federal Emergency Management Agency (FEMA) created an intra-agency working group to serve as a focal point for policy on children and disasters that has been actively addressing issues raised by the Commission. More recently, the Department of Health and Human Services (HHS) created its own intra-agency working group that began meeting in May of this year. The Commission has been a driving force in fostering stronger inter-agency collaboration among FEMA, HHS, the Department of Education, and the Department of Justice to address the disaster needs of children. Important progress was made to provide a safer environment and age-appropriate supplies for children in mass care shelters, and we achieved a heightened recognition of child care as an essential disaster service in the community.

Despite signs of progress and cooperation, our work is far from finished. Disasters are inevitable and growing in frequency. In the two years since the Commission's inception, our Nation has witnessed severe disasters: devastating 100-year floods in the Midwest, a major earthquake and tsunami in American Samoa, the public health emergency caused by the H1N1 influenza pandemic, the cataclysmic earthquake in Haiti, and the unprecedented oil disaster in the Gulf of Mexico. On a smaller but nevertheless important scale, communities around the Nation face emergencies every day.

Each new disaster presents distinct challenges. However, we can anticipate the needs of children and, therefore, we can and must prepare to meet those needs. The capability of systems to meet the needs of children in times of disaster will remain inadequate until we as a Nation first achieve an optimal level of emergency readiness for children on a daily basis.

Children represent nearly 25 percent of our population. Consider that on any given weekday, 67 million children are in schools and child care, a time when children are most vulnerable because they are away from their families. Yet, only a handful of States require basic school evacuation and family reunification plans. In addition, just 25 percent of emergency medical services (EMS) agencies and 6 percent of hospital emergency departments have the supplies and equipment to treat children. The Strategic National Stockpile, intended to provide the public with medicine and medical supplies in the event of a public health emergency, is woefully under-stocked with medical countermeasures for children.

This already fragile state of readiness deteriorates quickly when disaster strikes. Programs and practices for managing disasters are fragmented and unaccountable to children; instead they are designed primarily to help able-bodied adults. Children are categorized as an “at-risk,” “special needs,” or “vulnerable” population, a well-intended consideration that inadvertently creates a perverse benign neglect of children, in which they receive less attention in disaster planning and management rather than more.

We do not suggest that our Nation is completely unprepared for assisting children affected by disaster. Existing capabilities can and should be built on to integrate children into preparedness, planning, response, and recovery. In our final analysis, meeting the needs of children in disaster planning and management is a national responsibility lacking not only sufficient funding, but also a pervasive concern, a sustained will to act, and a unifying force.

The Commission respectfully calls on the President to develop and present to Congress a National Strategy on Children and Disasters. Under the imprimatur of the President, the strategy would sound an unequivocal call to action for Federal, State, territorial, tribal, and local levels of government; private sector industry; non-governmental agencies; faith-based partners; academia; communities; families; and individuals to engage one another around a cohesive set of meaningful national goals and priorities to remedy the years of benign neglect of children.

We recognize the unprecedented challenges facing all levels of government and their non-governmental partners. In these difficult times, however, sufficient attention and resources must be dedicated to safeguarding our Nation's 74 million children before, during, and after disaster, a goal the Commission believes it shares with most Americans.

We present the 2010 Report to the President and Congress having made a careful, conscious effort to provide recommendations that are practical and achievable and can make a lasting difference. We are grateful for the opportunity to contribute to such a challenging and important endeavor.

Respectfully submitted,



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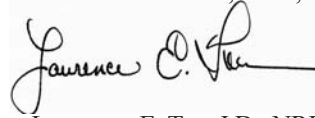
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Abbreviations

ACF	Administration for Children and Families (HHS)
AHPP	Alternative Housing Pilot Program (FEMA)
AHRQ	Agency for Healthcare Research and Quality (HHS)
ALS	Advanced Life Support
ANSI	American National Standards Institute
ARC	American Red Cross
ASPR	Office of the Assistant Secretary for Preparedness and Response (HHS)
BARDA	Biomedical Advanced Research and Development Authority
BLS	Basic Life Support
CB	Children’s Bureau (ACF)
CCB	Child Care Bureau (ACF)
CCDBG	Child Care and Development Block Grant
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CFSIA	Child and Family Services Improvement Act
CHIP	Children’s Health Insurance Program
CIP	Court Improvement Program
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
CPT	Current Procedural Terminology
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DoD	Department of Defense
DOJ	Department of Justice
DOT	Department of Transportation
ED	Department of Education
ESC	Enterprise Senior Council
EHCY	Education for Homeless Children and Youth Program
EMS	Emergency medical services

EMSC	Emergency Medical Services for Children
EPA	Environmental Protection Agency
ESF	Emergency Support Function
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency (DHS)
FERPA	Family Educational Rights and Privacy Act
FETIG	Federal Education and Training Interagency Group
FICEMS	Federal Interagency Committee on Emergency Medical Services
FY	Fiscal Year
GAO	Government Accountability Office
HERA	Hurricane Education Recovery Act
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration (HHS)
HSGP	Homeland Security Grant Program
HUD	Department of Housing and Urban Development
IAA	Interagency agreement
IOM	Institute of Medicine
ISP	Immediate Services Program
LEA	Local Education Agency
MCM	Medical countermeasure
NCCD	National Commission on Children and Disasters
NCDMPH	National Center for Disaster Medicine and Public Health
NCJFCJ	National Council of Juvenile and Family Court Judges
NDHTF	National Disaster Housing Task Force
NDMS	National Disaster Medical System
NDRF	National Disaster Recovery Framework

NHSS	National Health Security Strategy
NIH	National Institutes of Health (HHS)
NLE	National Level Exercise
NMETS	National Mass Evacuation Tracking System
NRC	National Resource Center (EMSC)
NRF	National Response Framework
NVOAD	National Voluntary Organizations Active in Disaster
OASIS	Organization for the Advancement of Structured Information Standards
OFRD	United States Public Health Service Office of Force Readiness and Development
OHS	Office of Head Start (HHS)
OJJDP	Office of Juvenile Justice and Delinquency Prevention (DOJ)
PEHSU	Pediatric Environmental Health Specialty Unit
PHEMCE	Public Health Emergency Medical Countermeasures Enterprise
PII	Personally identifiable information
PKEMRA	Post Katrina Emergency Management Reform Act of 2006
PL	Public Law
PTSD	Post-traumatic stress disorder
QRIS	Quality Rating and Improvement Systems
REMS	Readiness and Emergency Management for Schools
RSF	Recovery Support Function
RSP	Regular Services Program
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SBA	Small Business Administration
SEA	State Education Agency
SERV	School Emergency Response to Violence
SNS	Strategic National Stockpile
USTRANSCOM	United States Transportation Command (DoD)

Background

The National Commission on Children and Disasters (“the Commission”) was established pursuant to the Kids in Disasters Well-being, Safety, and Health Act of 2007 as provided in Division G, Title VI of the Consolidated Appropriations Act of 2008.¹ The Commission’s status as an independent Federal Advisory Committee was clarified in Division A, Section 157 (b) of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009.²

The Commission was instructed to conduct a comprehensive study to independently examine and assess the needs of children (0-18 years of age) in relation to the preparation for, response to, and recovery from all hazards, including major disasters and emergencies, by building upon the evaluations of other entities and avoiding unnecessary duplication by reviewing the findings, conclusions, and recommendations of these entities. In addition to this report, the Commission submitted an Interim Report³ in October 2009.

The Commission reports specific findings, conclusions, and recommendations relating to: 1) child physical health, mental health, and trauma; 2) child care in all settings; 3) child welfare; 4) elementary and secondary education; 5) sheltering, temporary housing, and affordable housing; 6) transportation; 7) juvenile justice; 8) evacuation; and 9) relevant activities in emergency management. The Commission also provides specific recommendations on the need for planning and establishing a national resource center on children and disasters, and reports on the coordination of resources and services, administrative actions, policies, regulations, and legislative changes as the Commission considers appropriate.⁴

The Commission is bipartisan, consisting of 10 members appointed by President George W. Bush and Congressional leaders. Commission members represent a variety of disciplines, including pediatrics, State and local emergency management, emergency medical services, non-governmental organizations dedicated to children, and State elected office. The Commission organized four subcommittees comprising Commissioners and Federal and non-Federal representatives: 1) Education, Child Welfare, and Juvenile Justice; 2) Evacuation, Transportation, and Housing; 3) Human Services Recovery; and 4) Pediatric Medical Care. The Commission met publicly on a quarterly basis and subcommittees met monthly to address their focus areas.

1 Public Law (P.L.) 110-161 (2008).

2 P.L. 110-329 (2009).

3 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

4 P.L. 110-161 (2008).

Executive Summary

The President and Congress charged the National Commission on Children and Disasters with carrying out the first-ever comprehensive review of Federal disaster-related laws, regulations, programs, and policies to assess their responsiveness to the needs of children and make recommendations to close critical gaps.

In this Executive Summary, the Commission assembles all the recommendations in this report. As is customary for a Federal advisory body such as the Commission, the recommendations are primarily directed toward the President, Federal agencies, and Congress. However, in order to achieve a coordinated national strategy on children and disasters at all levels of government—including Federal, State, tribal, territorial, and local—the Commission urges non-Federal executive and legislative branches of government to consider and apply the recommendations, as appropriate.

To assist Congress, Federal agencies, and non-Federal partners in quickly identifying recommendations most relevant to them, the Commission provides an index organized by the agency, group, or individual charged with implementing the recommendation (see Appendix B: Index to Recommendations and Responsible Entities).

1. Disaster Management and Recovery

Recommendation 1.1: Distinguish and comprehensively integrate the needs of children across all inter- and intra-governmental disaster management activities and operations.

- *The President should develop a National Strategy for Children and Disasters.*
- *The Executive Branch, Congress, and non-Federal partners should prioritize children separately from “at-risk” population categories.*
- *The Executive Branch at all levels of government should establish and maintain permanent focal points of coordination for children and disasters, supported by sufficient authority, funding, and policy expertise. FEMA should establish Children’s Integration Specialists at the regional level.*
- *The Executive Branch and non-Federal partners should incorporate children as a distinct priority in base disaster planning documents and relevant grant programs.*
- *The Executive Branch and non-Federal partners should incorporate education, child care, juvenile justice, and child welfare systems into disaster planning, training, and exercises.*
- *The Executive Branch and non-Federal partners should incorporate children as a distinct priority in relevant target capabilities, preparedness training, and exercises, with specific target outcomes and performance measures.*
- *The Executive Branch and Congress should institute accountability and progress monitoring measures to track implementation of Commission recommendations and capability improvements.*

Recommendation 1.2: The President should accelerate the development and implementation of the National Disaster Recovery Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing, and human services recovery needs of children.

Recommendation 1.3: DHS/FEMA should ensure that information required for timely and effective delivery of recovery services to children and families is collected and shared with appropriate entities.

- *Government agencies and non-governmental organizations should collect information on children and families necessary to identify and support their immediate and long-term recovery needs.*
- *DHS/FEMA should expand information sharing with appropriate government agencies and non-governmental organizations to enable the delivery of recovery services.*
- *DHS/FEMA should pre-identify and credential additional local and out-of-State voluntary and non-governmental organizations and networks that provide disaster assistance to children and families.*

Recommendation 1.4: DHS/FEMA should establish interagency agreements to provide disaster preparedness funding, technical assistance, training, and other resources to State and local child serving systems and child congregate care facilities.

2. Mental Health

Recommendation 2.1: HHS should lead efforts to integrate mental and behavioral health for children into public health, medical, and other relevant disaster management activities.

- *Congress should direct HHS to lead the development of a disaster mental and behavioral health Concept of Operations (CONOPS) to formalize disaster mental and behavioral health as a core component of disaster preparedness, response, and recovery efforts.*

Recommendation 2.2: HHS should enhance the research agenda for children's disaster mental and behavioral health, including psychological first aid, cognitive-behavioral interventions, social support interventions, bereavement counseling and support, and programs intended to enhance children's resilience in the aftermath of a disaster.

- *HHS should convene a working group of children's disaster mental health and pediatric experts to review the research portfolios of relevant agencies, identify gaps in knowledge, and recommend a national research agenda across the full spectrum of disaster mental health for children and families.*

Recommendation 2.3: Federal agencies and non-Federal partners should enhance pre-disaster preparedness and just-in-time training in pediatric disaster mental and behavioral health, including psychological first aid, bereavement support, and brief supportive interventions, for mental health professionals and individuals, such as teachers, who work with children.

Recommendation 2.4: DHS/FEMA and SAMHSA should strengthen the Crisis Counseling Assistance and Training Program (CCP) to better meet the mental health needs of children and families.

- *Simplify the Immediate Services Program (ISP) grant application to minimize the burden on communities affected by a disaster and facilitate the rapid allocation of funding and initiation of services.*
- *Establish the position of Children’s Disaster Mental Health Coordinator within State-level CCPs.*
- *Formally modify the CCP model to indicate and promote “enhanced services” where the mental health impact is unlikely to be adequately addressed by “typical” CCP services.*
- *Include bereavement support and education within services typically provided under the CCP.*

Recommendation 2.5: Congress should establish a single, flexible grant funding mechanism to specifically support the delivery of mental health treatment services that address the full spectrum of behavioral health needs of children including treatment of disaster-related adjustment difficulties, psychiatric disorders, and substance abuse.

3. Child Physical Health and Trauma

Recommendation 3.1: Congress, HHS, and DHS/FEMA should ensure availability of and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats.

- *Provide funding and grant guidance for the development, acquisition, and stockpiling of MCM specifically for children for inclusion in the Strategic National Stockpile (SNS) and all other federally funded caches, including those funded by DHS/FEMA.*
 - *Amend the Emergency Use Authorization to allow the FDA, at the direction of the HHS Secretary, to authorize pediatric indications of MCM for emergency use before an emergency is known or imminent.*
 - *Form a standing advisory body of Federal partners and external experts to advise the HHS Secretary and provide expert consensus on issues pertaining specifically to pediatric emergency MCM.*
 - *Within the HHS Biomedical Advanced Research and Development Authority, designate a pediatric leader and establish a pediatric and obstetric working group to conduct gap analyses and make research recommendations.*
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- *Include pediatric expertise on the HHS Enterprise Governance Board or its successor and all relevant committees and working groups addressing issues pertaining to MCM.*
 - *Establish a partnership between the proposed MCM Development Leader and key pediatric stakeholders both within and outside government.*

Recommendation 3.2: HHS and DoD should enhance the pediatric capabilities of their disaster medical response teams through the integration of pediatric-specific training, guidance, exercises, supplies, and personnel.

- *HHS should develop pediatric capabilities within each National Disaster Medical System (NDMS) region.*
- *HHS should establish a “reserve pool” of pediatric health care workers to assist in NDMS disaster response.*
- *HHS and DoD should establish a Pediatric Health Care Coordinator on each disaster medical response team and develop strategies to recruit and retain team members with pediatric medical expertise.*

Recommendation 3.3: HHS should ensure that health professionals who may treat children during a disaster have adequate pediatric disaster clinical training.

- *The President should direct the Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response (FETIG) to prioritize the development of pediatric core competencies, core curricula, training, and research.*
- *The FETIG should support the formation of a Pediatric Disaster Clinical Education and Training Working Group to establish core clinical competencies and a standard, modular pediatric disaster health care education and training curriculum.*

Recommendation 3.4: The Executive Branch and Congress should provide resources for a formal regionalized pediatric system of care to support pediatric surge capacity during and after disasters.

- *HHS should include pediatric surge capacity as a “Required Funding Capability” in the Hospital Preparedness Program.*
- *States and hospital accrediting bodies should ensure all hospital emergency departments stand ready to care for ill or injured children through the adoption of emergency preparedness guidelines jointly developed by the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association.*

Recommendation 3.5: Prioritize the recovery of pediatric health and mental health care delivery systems in disaster-affected areas.

- *Congress should establish sufficient funding mechanisms to support restoration and continuity of for-profit and non-profit health and mental health services to children.*

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- *The Executive Branch should recognize and support pediatric health and mental health care delivery systems as a planning imperative in the development and implementation of the National Health Security Strategy and National Disaster Recovery Framework.*
 - *HHS should create Medicaid and Children's Health Insurance Program incentive payments for providers in disaster areas.*
 - *The American Medical Association should adopt a new code or code modifier to the Current Procedural Terminology to reflect disaster medical care in order to facilitate tracking of these services and as a means for enhanced reimbursement from public and private payers.*

Recommendation 3.6: EPA should engage State and local health officials and non-governmental experts to develop and promote national guidance and best practices on re-occupancy of homes, schools, child care, and other child congregate care facilities in disaster-impacted areas.

- *EPA and HHS should expand research on pediatric environmental health risks associated with disasters.*

4. Emergency Medical Services and Pediatric Transport

Recommendation 4.1: The President and Congress should clearly designate and appropriately resource a lead Federal agency for emergency medical services (EMS) with primary responsibility for the coordination of grant programs, research, policy, and standards development and implementation.

- *Establish a dedicated Federal grant program under a designated lead Federal agency for pre-hospital EMS disaster preparedness, including pediatric equipment and training.*

Recommendation 4.2: Improve the capability of emergency medical services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.

- *Congress should provide full funding to the Emergency Medical Services for Children (EMSC) program to ensure all States and territories meet targets and achieve progress in the EMSC performance measures for grantees, and to support development of a research portfolio.*
- *As an eligibility guideline for Centers for Medicare & Medicaid Services reimbursement, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for Basic Life Support and Advanced Life Support vehicles.*
- *HHS and DHS should establish stronger pediatric EMS performance measures within relevant Federal emergency preparedness grant programs.*
- *HHS should address the findings of the EMSC 2009 Gap Analysis of EMS Related Research.*

Recommendation 4.3: HHS should develop a national strategy to improve Federal pediatric emergency transport and patient care capabilities for disasters.

- *Conduct a national review of existing capabilities among relevant government agencies and the private sector for emergency medical transport of children.*

5. Disaster Case Management

Recommendation 5.1: Disaster case management programs should be appropriately resourced and should provide consistent holistic services that achieve tangible, positive outcomes for children and families affected by the disaster.

- *The Executive Branch and Congress should provide sufficient funds to build, support, and deploy a disaster case management system with nationwide capacity.*
- *DHS/FEMA should clarify the transition from Federal to State-led disaster case management programs.*
- *Government agencies and non-governmental organizations should develop voluntary consensus standards on the essential elements and methods of disaster case management, including pre-credentialing of case managers and training that includes focused attention to the needs of children and families.*

6. Child Care and Early Education

Recommendation 6.1: Congress and HHS should improve disaster preparedness capabilities for child care.

- *Congress and HHS should require States to include disaster planning, training, and exercise requirements within the scope of their minimum health and safety standards for child care licensure or registration.*
- *Congress should provide HHS the authority to require States to develop statewide child care disaster plans in coordination with State and local emergency managers, public health, State child care administrators and regulatory agencies, and child care resource and referral agencies.*

Recommendation 6.2: Congress and Federal agencies should improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.

- *DHS/FEMA should revise its Public Assistance regulations to codify child care as an essential service.*
- *Congress should codify child care as an “essential service of a governmental nature” in the Stafford Act.*
- *Federal agencies should incorporate child care as an essential service in the National Response Framework, the National Disaster Recovery Framework, the National Disaster Housing Concept of Operations, and Disaster Housing Practitioners’ Guide.*

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- *Congress should authorize a grant funding mechanism, such as an emergency contingency fund, to repair or rebuild private, for-profit child care facilities, support the establishment of temporary child care, and reimburse States for subsidizing child care services to disaster-affected families.*

Recommendation 6.3: HHS should require disaster preparedness capabilities for Head Start Centers and basic disaster mental health training for staff.

7. Elementary and Secondary Education

Recommendation 7.1: Congress and Federal agencies should improve the preparedness of schools and school districts by providing additional support to States.

- *Congress and ED should award disaster preparedness grants to State education agencies to oversee, coordinate, and improve disaster planning, training, and exercises statewide and ensure that all districts within the State meet certain baseline criteria.*
- *DHS/FEMA should partner with ED to provide funding and other resources to support disaster preparedness efforts of State and local education agencies, including collaborative planning, training, and exercises with emergency management officials.*

Recommendation 7.2: Congress and ED should enhance the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster.

- *Congress and ED should award funds to States to implement and evaluate training and professional development programs in basic skills in providing support to grieving students and students in crisis, and establish statewide requirements related to teacher certification and recertification.*

Recommendation 7.3: Ensure that school systems recovering from disasters are provided immediate resources to reopen and restore the learning environment in a timely manner and provide support for displaced students and their host schools.

- *Congress should create a permanent funding mechanism to support recovery for schools and students.*
- *Congress should establish an emergency contingency fund within the Education for Homeless Children and Youth program and expeditiously provide grants to school districts serving an influx of displaced children.*
- *Congress and ED should support the immediate provision of expert technical assistance and consultation regarding services and interventions to address disaster mental health needs of students and school personnel.*
- *DHS/FEMA, ED, and other Federal agencies should clarify, consolidate, and publicize information related to the recovery programs, assistance, and services (e.g., transportation to schools) currently available to school systems through the Stafford Act and other Federal sources.*

8. Child Welfare and Juvenile Justice

Recommendation 8.1: Ensure that State and local child welfare agencies adequately prepare for disasters.

- *Congress should request a national assessment of child welfare disaster planning to determine if significant advances have been made since passage of the Child and Family Services Improvement Act of 2006 (CFSIA).*
- *HHS should develop detailed disaster planning criteria by regulation or other formal policy guidance to supplement the basic procedures mandated in CFSIA.*
- *Within each ACF regional office, child welfare staff and the region's emergency management specialist should collaboratively review and evaluate the State child welfare disaster plans required by CFSIA and assist States in developing comprehensive plans and meeting their statutory obligations.*
- *DHS/FEMA and HHS should provide funding, guidance, and technical assistance to child welfare agencies and encourage collaboration with emergency management, courts, and other key stakeholders.*

Recommendation 8.2: Ensure that State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children adequately prepare for disasters.

- *Congress should require State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children to have comprehensive disaster plans in place.*
- *DHS/FEMA and DOJ should support disaster planning for State and local juvenile justice agencies and residential treatment, correctional, and detention facilities that house children by providing funding, technical assistance, and training.*

Recommendation 8.3: HHS and DOJ should ensure that juvenile, dependency, and other courts hearing matters involving children adequately prepare for disasters.

- *HHS should include disaster preparedness as a component of the Court Improvement Program for dependency courts.*
- *DOJ should include disaster preparedness as a component of the proposed National Juvenile Delinquency Court Improvement Program.*
- *DOJ and the National Council of Juvenile and Family Court Judges should incorporate disaster preparedness into the Model Courts program.*

9. Sheltering Standards, Services, and Supplies

Recommendation 9.1: Government agencies and non-governmental organizations should provide a safe and secure mass care shelter environment for children, including access to essential services and supplies.

- *Implement national standards and indicators for mass care shelters that are specific and responsive to children.*
- *Integrate essential age-appropriate shelter supplies for infants and children into shelter planning and fund the addition of child-specific supplies to caches for immediate deployment to support shelter operations.*
- *Implement common standards and training, including standards for criminal background checks, to mitigate risks unique to children in shelters such as child abduction and sex offenders.*

10. Housing

Recommendation 10.1: Prioritize the needs of families with children, especially families with children who have disabilities or chronic health, mental health, or educational needs, within disaster housing assistance programs.

- *Government agencies and non-governmental organizations should ensure that families with children in disaster housing, especially community sites, have access to needed services and are provided safe and healthy living environments.*
- *Congress should authorize DHS/FEMA to reimburse State and local governments for providing wrap-around services to children and families in community sites.*
- *DHS/FEMA should develop clear written guidance around emergency transportation planning and reimbursement for State and local governments that addresses the recovery needs of children and families.*
- *Government agencies and non-governmental organizations should identify and promote innovative programs to expedite the transition into permanent housing for families with children.*

11. Evacuation

Recommendation 11.1: Congress and Federal agencies should provide sufficient funding to develop and deploy a national information sharing capability to quickly and effectively reunite displaced children with their families, guardians, and caregivers when separated by a disaster.

- *DHS should lead the development of a nationwide information technology capability to collect, share, and search data from any patient and evacuee tracking or family reunification system.*
- *DHS should support the development of voluntary consensus-driven standards for data collection and data sharing through a joint Federal, non-Federal, and private sector process.*
- *Government agencies should ensure the collection of appropriate data on evacuated children, particularly unaccompanied minors.*

Recommendation 11.2: Disaster plans at all levels of government must specifically address the evacuation and transportation needs of children with disabilities and chronic health needs, in coordination with child congregate care facilities such as schools, child care, and health care facilities.

1. Disaster Management and Recovery

Recommendation 1.1: Distinguish and comprehensively integrate the needs of children across all inter- and intra-governmental disaster management activities and operations.

Recommendation 1.2: The President should accelerate the development and implementation of the National Disaster Recovery Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing, and human services recovery needs of children.

Recommendation 1.3: DHS/FEMA should ensure that information required for timely and effective delivery of recovery services to children and families is collected and shared with appropriate entities.

Recommendation 1.4: DHS/FEMA should establish interagency agreements to provide disaster preparedness funding, technical assistance, training, and other resources to State and local child serving systems and child congregate care facilities.

1. Disaster Management and Recovery

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- *The President should develop a National Strategy for Children and Disasters.*
- *The Executive Branch, Congress, and non-Federal partners should prioritize children separately from “at-risk” population categories.*
- *The Executive Branch at all levels of government should establish and maintain permanent focal points of coordination for children and disasters, supported by sufficient authority, funding, and policy expertise. FEMA should establish Children’s Integration Specialists at the regional level.*
- *The Executive Branch and non-Federal partners should incorporate children as a distinct priority in base disaster planning documents and relevant grant programs.*
- *The Executive Branch and non-Federal partners should incorporate education, child care, juvenile justice, and child welfare systems into disaster planning, training, and exercises.*
- *The Executive Branch and non-Federal partners should incorporate children as a distinct priority in relevant target capabilities, preparedness training, and exercises, with specific target outcomes and performance measures.*
- *The Executive Branch and Congress should institute accountability and progress monitoring measures to track implementation of Commission recommendations and capability improvements.*

Children under the age of 18 comprise nearly 25 percent of the U. S. population, or 74 million Americans.^{5,6} Given the significant number of children in our Nation, the Commission recommends that the unique needs of children must be more thoroughly integrated into planning and made a clear and distinct priority in all disaster management activities.

The Nation’s ability to prepare for, respond to, and recover from disaster—especially in regard to children—can neither depend on a single level or agency of government, nor be approached on a piecemeal basis. Disaster management is a shared responsibility, based on each team member doing what it does best and leveraging the expertise and strengths of others. Capabilities, policies, and programs currently are fragmented and need clearly stated desired outcomes, priorities, and resources for children, across and among all levels of government.

5 U.S. Census Bureau, “USA QuickFacts from the US Census Bureau,” <http://quickfacts.census.gov/qfd/states/00000.html>.

6 U.S. Census Bureau, “Interim State Population Projections, 2005,” <http://www.census.gov/population/www/projections/files/PressTab5.xls>.

The lack of clear priorities and sufficient resources for children and families in times of disaster primarily is related to the lack of a national strategy. In the May 2010 Progress Report on Children and Disasters, the Commission, while recognizing marginal pockets of improvement, called for the President to develop, in coordination with Federal and non-Federal stakeholders, a National Strategy for Children and Disasters.⁷ This strategy would provide a platform for the development of short- and long-term goals, objectives, and capabilities to more cohesively address gaps in disaster preparedness, response, and recovery for children. The Commission stands by its previous recommendation that the Administration must provide leadership and a charge of urgency and innovation to move the Nation forward in addressing the critical needs of children in disasters.

Children’s Unique Needs in Disasters

Children are not simply small adults. Throughout this report, the Commission notes children’s unique vulnerabilities in disasters that must be addressed in disaster management activities and policies. For example:

- Children may experience long-lasting effects such as academic failure, post-traumatic stress disorder, depression, anxiety, bereavement, and other behavioral problems such as delinquency and substance abuse.
- Children are more susceptible to chemical, biological, radiological, and nuclear threats and require different medications, dosages, and delivery systems than adults.
- During disasters, young children may not be able escape danger, identify themselves, and make critical decisions.
- Children are dependent on adults for care, shelter, transportation, and protection from predators.
- Children are often away from parents, in the care of schools, child care providers, Head Start or other child congregate care environments, which must be prepared to ensure children’s safety.
- Children must be expeditiously reunified with their legal guardians if separated from them during a disaster.
- Children in disaster shelters require age-appropriate supplies such as diapers, cribs, baby formula, and food.

7 National Commission on Children and Disasters, “Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals,” (Washington, DC: NCCD, May 11, 2010), 2, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

A major impediment to the prioritization of children lies in the inclusion of children as a group within population categories labeled “at-risk,” “vulnerable,” or “special needs.” The Department of Health and Human Services (HHS) recognizes children as “at-risk” along with 10 other populations.⁸ While well intentioned, the advent of these categories has resulted in diluting, rather than concentrating, a specific and necessary focus on children, and has led to plans in which children are addressed in annexes, if at all.

The Commission recommends that the Executive Branch, Congress, and non-Federal partners reconsider laws and policies, such as the 2006 Pandemic and All-Hazards Preparedness Act,⁹ that group children into broad “at-risk” population categories. Children typically have unique needs in all types of emergencies and disasters, and many of these needs can be anticipated; thus, disaster management agencies should place a specific and sustained focus on children in their daily and disaster response activities. For example, when children were disproportionately affected by the 2009 H1N1 pandemic, the Centers for Disease Control and Prevention (CDC) recognized the need to treat children as a distinct part of the general population and in response created a Children’s Health Team with representation in the CDC’s Emergency Operations Center. The team was instrumental in bringing attention to the needs of children and the necessity for offering national-level guidance to families, schools, and child care providers concerning personal precautions, the H1N1 vaccine, and school closures. Organizations with similar experiences during their disaster relief efforts, such as the American Red Cross, agree that children need to be considered as a distinct population in disaster planning, rather than as part of a larger “at-risk” or “special needs” categories.¹⁰

The Commission recommended in its Interim Report that the White House assume “a central leadership and coordinating role” to advise the President, the Executive Branch, and non-Federal partners on the need to make children a disaster planning imperative and to foster integration of children across national security and domestic policy-making priorities.¹¹ The Commission recommends that the President implement this recommendation, with a corollary that the President also create a permanent focal point of responsibility and accountability for coordinating children’s disaster needs across the Federal Government and with non-Federal officials. At the regional level, the Federal Emergency Management Agency (FEMA) should establish Children’s Integration Specialists, who can coordinate with other Federal regional staff, such as the HHS Administration for Children and Families, and with state and local partners. Similarly, State and local governments could assign the duty of intra- and inter-agency coordination of children’s disaster needs to the immediate office of the executive, for example led by a cabinet member from the public health office, social services department, or emergency preparedness agency.

8 Office of the Assistant Secretary for Preparedness and Response, “At Risk Individuals, Behavioral Health, and Human Services Coordination,” <http://www.phe.gov/Preparedness/planning/abc/Pages/default.aspx>.

9 Public Law (P.L.) 109-417 (2006).

10 Trevor Riggen, American Red Cross, Testimony of Trevor Riggen before the U.S. House of Representatives, Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings and Emergency Management, Washington, DC, October 20, 2009, 2, <http://transportation.house.gov/Media/file/Economic%20Development/20091020/Riggen%20Testimony.pdf>.

11 National Commission on Children and Disasters, Interim Report, (Washington, DC: NCCD, October 14, 2009), 3, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

The Commission also recommends that Executive branch leaders at all levels of government create a centralized focal point to identify and fix gaps in disaster policies and programs for children and families (see Appendix C: Model Executive Order or Resolution Creating a “Cabinet on Children and Disasters and Children and Disasters Advisory Council”). Relevant government agencies also may create such a mechanism. In August 2009, FEMA formed a Children’s Working Group to “create a lasting, positive change, at every level of government” by ensuring that the needs of children are incorporated into all disaster preparedness, response, and recovery efforts. The Working Group reports to the FEMA Administrator and a counselor to the Homeland Security Secretary and is composed of representatives from the Department of Homeland Security (DHS) and FEMA, including the Office of the Administrator, key Program Directorates, the Regional Operations Office, Specialty Areas, and Supporting Offices, as well as subject matter experts and FEMA staff who participate on Commission subcommittees.¹² In addition, the Working Group is assisting in the development of disaster planning activities for children with partner agencies, specifically HHS, the Department of Justice (DOJ), and the Department of Education (ED), and with non-governmental partners.

In March 2010, HHS also formed a Children’s Working Group co-chaired by the Assistant Secretary for Preparedness and Response and the Assistant Secretary for Administration of Children and Families. HHS’ working group will assess current capabilities to address children in disaster planning activities and seek to facilitate coordination across the agency. To expedite progress, the Commission urges the HHS working group to synchronize priority areas with critical gaps the Commission has identified, such as coordinated disaster planning for children, development of pediatric medical countermeasures, and delivery of disaster mental and behavioral health services to children.

The creation of advisory bodies is an important means to place a focus on children and families; however, these entities are currently ad hoc in nature and may be eliminated following a change in Administration. Therefore, the Commission urges these advisory bodies be permanently established by statute and replicated across Federal and non-Federal agencies, reporting directly to top-level leadership, with sufficient authority, funding, staffing, and policy expertise to effectively expedite the implementation of the Commission’s recommendations and other related activities.

The Commission also recommended that the Executive Branch and non-Federal partners incorporate children as a distinct priority throughout base disaster planning documents and relevant grant programs. In response to these recommendations, Administrator Fugate directed FEMA staff to review base planning guidance and work to ensure that the needs of

12 National Commission on Children and Disasters, “Meeting Minutes of the November 10, 2009 Public Meeting,” (Washington, DC: NCCD, November 10, 2009), 2, http://www.childrenanddisasters.acf.hhs.gov/minutes/20091110_MinutesV02.pdf.

children are a core consideration in disaster planning.¹³ Also, the FEMA Children's Working Group is collaborating with the agency's National Preparedness Directorate to incorporate children's needs into FEMA's disaster planning documents, including the Comprehensive Planning Guide 101 and the National Response Framework.¹⁴

Making children a priority will have important implications at all levels of government for training, equipment, supplies, and exercises, since priorities drive investment and resource allocation decisions. Not enough attention has been paid nor resources devoted to improving Federal and especially non-Federal disaster capabilities for children. The bedrock of the Nation's disaster planning and management system lies at the State and local levels. First responders to any disaster are not likely to be FEMA, HHS, or other Federal entities. If requested at all, Federal support may not arrive for several hours or days after the disaster.

States and localities supported by Federal emergency preparedness grants should develop disaster capabilities that meet the needs of children. However, a disproportionately small amount of the total Federal funds appropriated for State and local disaster management is specifically allocated to support development of capabilities to assist children. DHS worked closely with the Commission to develop and release a Supplemental Resource regarding children in disasters within its FY 2010 Homeland Security Grant Program guidance.¹⁵ The guidance provides States with specific examples of eligible uses of funding to benefit children, such as supplies, planning, and training; however, the guidance does not require States to expend grant funds to address the needs of children.

The Commission recommends that specific emergency preparedness capabilities for children be developed and integrated into existing capabilities that are supported by Federal emergency preparedness grants. States and jurisdictions would then have greater means to develop disaster capabilities that meet the needs of children. Grantees should assess their performance in meeting the needs of children during exercises and drills, and include performance evaluations in their After Action Reports and improvement and corrective action plans. Based on briefings with national organizations representing State and local governments and knowledge derived from field visits, the Commission developed a list of basic disaster capabilities for consideration by elected officials and emergency managers (Appendix D).

The Commission also recommends that congregate care settings, such as schools, child care, juvenile justice, and child welfare facilities, along with local child serving agencies be included in planning, training, and exercises. Likewise, State child serving government agencies should be incorporated into State-level efforts. The Government Accountability

13 Craig Fugate, Testimony of Craig Fugate before the U.S. Senate, Committee on Homeland Security and Governmental Affairs, Subcommittee on Disaster Recovery, Washington, DC, December 10, 2009, 3, http://hsgac.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=bba3b475-bd7e-4138-9cdf-3ed88c17f73e.

14 National Commission on Children and Disasters, "Meeting Minutes of the November 10, 2009 Public Meeting," 2.

15 Department of Homeland Security, *Fiscal Year 2010 Homeland Security Grant Program Supplemental Resource: Children in Disasters Guidance*, (Washington, DC: DHS, June 2009), 1, http://www.fema.gov/pdf/government/grant/2010/fy10_hsgp_children.pdf.

Office (GAO) asserted that children would be better protected if State and local disaster plans incorporated child welfare, education, and other agencies that serve children.¹⁶ The Commission believes that integrating these State and local agencies and facilities in State and local planning efforts is essential to ensure that States and communities are prepared to address the needs of children.

The Commission recommended in its Interim Report that children's needs be addressed in relevant target capabilities, preparedness training, and exercises, with specific target outcomes and performance measures.¹⁷ FEMA intends to integrate children's issues into the 2011 National Level Exercise (NLE).¹⁸ The concept for the NLE is a major earthquake within the New Madrid seismic zone impacting eight Midwest States.¹⁹ Among the overarching exercise objectives are evacuation and shelter-in-place, mass care (sheltering, feeding, and related services), medical surge, and long-term recovery.²⁰ Since no single jurisdiction or response discipline will be capable of handling an event of this magnitude, the Commission recommends that the NLE test the capabilities of cooperative efforts among jurisdictions and pre-event mutual aid agreements to address children's needs, especially in the context of additional health and mental health care for children and evacuation of unaccompanied children across State lines. The earthquake in Haiti demonstrated the need to ensure capabilities around quickly reuniting unaccompanied children with their families and accommodating a potential surge of orphans resulting from a mass casualty event.²¹ Echoing earlier concerns regarding serious gaps in preparedness, the Commission also recommends that exercises test capabilities and training around more common and realistic events faced by State and local responders, rather than just catastrophic events.

Finally, in order to institute accountability and track national progress toward implementation of the Commission's recommendations and the improvement of capabilities for children, Congress should require the Administration to prepare and submit an annual report on children and disasters to appropriate Congressional committees. Additionally, the Commission recommends that the Executive Branch require relevant agencies to incorporate measurable goals into their multi-year strategic plans and an evaluation framework to monitor performance and impact of investments related to children and disasters, particularly with regard to grant programs.

16 U.S. Government Accountability Office, *Gulf Coast Hurricanes: Lessons Learned for Protecting and Educating Children*, GAO-06-680R, (Washington, DC: GAO, 2006), 2, <http://www.gao.gov/new.items/d06680r.pdf>.

17 National Commission on Children and Disasters, Interim Report, 3.

18 Federal Emergency Management Agency, "FEMA National Advisory Council Meeting," (Washington, DC: DHS, February 10, 2010), 5, http://www.fema.gov/pdf/about/nac/feb10_11_exec.pdf.

19 Craig Fugate, Statement of Craig Fugate before the U.S. House of Representatives, House Committee on Transportation and Infrastructure, Subcommittee of Economic Development, Public Buildings and Emergency Management, "Post Katrina – What It Takes to Cut Bureaucracy and Assure a More Rapid Response After a Catastrophic Disaster," Washington, DC, July 27, 2009, 6, http://www.fema.gov/pdf/about/testimony/072709_fugate.pdf.

20 Office of the Assistant Secretary for Preparedness and Response, "TE&LL Calendar of Events," Training, Exercises and Lessons Learned Newsletter, August 2010, 1-6.

21 National Commission on Children and Disasters, "Summary Report: Field Visit, Miami, Florida," (Washington, DC; NCCD, 2010), 2, http://www.childrenanddisasters.acf.hhs.gov/Summary_FLFieldVisit_FINAL.pdf.

Recommendation 1.2: The President should accelerate the development and implementation of the National Disaster Recovery Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing, and human services recovery needs of children.

As supported by the findings of a 2009 GAO report on recovery efforts following Hurricane Katrina,²² key to any recovery effort is the prompt restoration of critical services for children and families, including housing, health and mental health, education, child care and nutrition services, and safe recreation areas, which are discussed in greater detail later in this report. In the Interim Report, the Commission recommended the prompt development of a National Disaster Recovery Strategy that specifically addresses the needs of children in long-term recovery from disasters.

The Commission's field visit to Iowa, to gather findings and lessons learned from the long-term recovery efforts of Iowa's 2008 floods and tornados, also underscored the need for improved long-term recovery planning. In particular, it was clear to the Commission that the recovery efforts in Iowa were hindered by the absence of a pre-existing national, State, or local long-term disaster recovery plan. Other key findings from the field visit included the critical need for a central point of coordination at the Federal and non-Federal level for recovery programs and services, specifically for children and families, and the pressing need for Federal disaster assistance programs designed to support long-term recovery of children and families.

The Post-Katrina Emergency Management Reform Act of 2006²³ requires the development of a "National Disaster Recovery Strategy"²⁴ to coordinate long-term recovery resources following major disasters. This strategy document, now named the National Disaster Recovery Framework (NDRF), is designed to be a companion document to the National Response Framework. The Commission and Congress have urged the Administration to accelerate the development of this document. A Long-Term Disaster Recovery Working Group was formed in 2009, and a first draft of the NDRF was released on February 5, 2010.²⁵

22 U.S. Government Accountability Office, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, GAO-09-561, (Washington, DC: GAO, 2009), <http://www.gao.gov/new.items/d09561.pdf>.

23 P.L. 109-295; 120 Stat. 1394 (2006).

24 This document and any subsequent guidance and tools are part of the developing National Disaster Recovery Strategy. Federal Emergency Management Agency, *National Disaster Recovery Framework: Draft*, ed. U.S. Department of Homeland Security (Washington, DC: DHS, February 5, 2010), 4, http://www.fema.gov/pdf/recoveryframework/omb_ndrf.pdf.

25 Federal Emergency Management Agency, "FEMA Releases Draft National Disaster Recovery Framework, Press Release No. HQ 10-012," <http://www.fema.gov/news/newsrelease.fema?id=50366>.

The Commission provided comments on the draft, based in part on its findings from the Iowa field visit and a field visit in Louisiana in January 2009.²⁶ Among other suggestions, the Commission cited a need for: 1) the appointment of a Federal Disaster Recovery Coordinator who reports directly to the President; 2) an office residing in the White House or a Federal agency to help build recovery capacity across the country; 3) the incorporation of school and child care recovery as a major theme and element in the framework; and 4) leadership and operational guidance on how States and communities can reestablish for-profit and nonprofit health care practices. In addition, the Commission commented that the NDRF should recognize the need for Federal agencies to: proactively educate States about available resources; assist in holistic long-term needs assessments for children and families; reduce the burden of paperwork; create greater flexibility in grant guidance, reimbursements, and regulations; and help identify ways to address unmet needs in States and localities.

In addition, the Working Group intends to develop an NDRF Annex with Recovery Support Functions (RSFs),²⁷ which are critical to specifying the roles and responsibilities of Federal and non-Federal partners and fostering new interagency collaborations. The Commission urges that the RSFs be developed in collaboration with State, tribal, and local jurisdictions, especially those with recent long-term recovery experiences and lessons learned. These jurisdictions will inform Federal agencies where there are significant gaps in funding, resources, and coordination that require new capabilities and capacities at the Federal level. Also, States and localities may have recovery planning models and best practices that could be shared nationally throughout this effort. For example, Iowa established a Rebuild Iowa Office to coordinate State-wide disaster recovery efforts and provide a centralized entity to address issues such as housing, public health and health care, infrastructure, economic and workforce development, education, and hazard mitigation.²⁸

The NDRF and a report to the President were scheduled to be delivered by June 1, 2010. At the time of this report's publication, finalization of the documents is on hold due to Federal response and recovery efforts following the oil spill disaster in the Gulf of Mexico. The Commission urges the Administration and Congress to move swiftly to provide necessary additional authority and funding to undertake new recovery responsibilities, particularly as they relate to children and families. The Commission also recommends that the Administration and Congress ensure that disaster recovery assistance programs for children and families are more responsive to the needs identified by States and communities who will receive the assistance.

26 National Commission on Children and Disasters, "Comments: National Disaster Recovery Framework," (Washington, DC: NCCD, February 26, 2010), 1-5, http://www.childrenanddisasters.acf.hhs.gov/20100224_NCCD_NDRFCommentsV04FINAL.pdf.

27 Similar to Emergency Support Functions in the NRF, RSFs would outline categories of governmental and non-governmental recovery resources and provide strategic objectives for their use.

28 Rebuild Iowa Office, "Welcome to the Rebuild Iowa Office Web site," <http://www.rio.iowa.gov/>.

Recommendation 1.3: DHS/FEMA should ensure that information required for timely and effective delivery of recovery services to children and families is collected and shared with appropriate entities.

- Government agencies and non-governmental organizations should collect information on children and families necessary to identify and support their immediate and long-term recovery needs.
- DHS/FEMA should expand information sharing with appropriate government agencies and non-governmental organizations to enable the delivery of recovery services.
- DHS/FEMA should pre-identify and credential additional local and out-of-State voluntary and non-governmental organizations and networks that provide disaster assistance to children and families.

A major barrier to the timely and adequate provision of services for children and families after a disaster is the limited collection and sharing of information on disaster survivors among government agencies and organizations providing disaster relief and service delivery. The Children's Health Fund, in its report on disaster case management following the Gulf Coast hurricanes, reported that FEMA's inability to share client-level data, based upon regulations and policies derived from FEMA's interpretation of the Privacy Act,²⁹ resulted in information being given to HHS for case management work that was insufficient for providing health and human services to individuals and families.³⁰ More recently, during its January 2010 Iowa field visit, the Commission learned of instances where insufficient or uncoordinated sharing of information impeded the delivery of services to children and families. For example, following the spring 2008 floods in Iowa, the administrator of the State-level Crisis Counseling Assistance and Training Program (CCP) was denied basic information from FEMA, including the addresses of affected homes, despite CCP being a FEMA-funded program. According to the administrator, outreach efforts would have been much more efficient had they been given access to this information.³¹ Iowa officials also indicated that the inability to share information between the various agencies and organizations providing case management services presented difficulties for both case managers and clients.³²

Information collection and sharing can: 1) provide more complete identification of the unique needs of children and families; 2) create a more accurate composite picture of the needs of children and families within the communities affected by the disaster; and 3) ensure that children and families are offered and provided continuous services during the entire recovery process.

29 P.L. 93-579; 5 U.S.C. § 552a (1974).

30 Children's Health Fund, *Reforming Disaster Case Management: National Lessons from Louisiana*, (New York, NY: CHF, December 2009), 15, http://www.childrenshealthfund.org/sites/default/files/Disaster%20Case%20Management%20Roundtable%20Report%20and%20Recommendations_Finaldraft.pdf.

31 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," (Washington, DC: NCCD, 2010), 3-4, http://www.childrenanddisasters.acf.hhs.gov/20100106_IowaFieldVisit_MinutesV03FINAL.pdf.

32 *Ibid.*, 20-21.

For the purpose of providing more comprehensive data on children to FEMA and its Federal and non-Federal partners, the Commission recommends that FEMA collect information, in the disaster recovery assistance intake process, identifying the ages of children in an applicant's household and any health, mental health, physical, nutritional, and educational needs. In the current process, FEMA collects information for the purpose of determining eligibility for FEMA-specific assistance. FEMA does not request specific information on children and only requires the applicant to indicate the number and type of dependents in the applicant's household.

The Commission also recommends that FEMA pre-identify and credential additional local and out-of-State voluntary and non-governmental organizations and networks that provide disaster assistance to children and families to enable the organizations to obtain access to the information they need to provide recovery assistance.³³ FEMA had, until recently, shared limited information with specific voluntary and non-governmental organizations for the purpose of preventing the duplication of monetary benefits to survivors. FEMA modified its information sharing policies and procedures to enable sharing of information with government agencies and members of the National Voluntary Organizations Active in Disaster (NVOAD) or members of FEMA or State-recognized Long Term Recovery Committees.³⁴ Other local and out-of-State voluntary and non-governmental organizations would benefit from access to information that helps them identify survivors in need.

Although FEMA often plays a key role in information collection and sharing, in many cases, FEMA will not have information on survivor children and families for weeks or months after a disaster.³⁵ Therefore, the collection and dissemination of data among State, tribal, local, and non-governmental agencies is also critical since the initial response in any event will be handled by local and State agencies.

Finally, the Commission determined that, in some instances, schools can be a useful source for providing immediate information on children and families following a disaster. Upon request of the Commission, ED clarified earlier information-sharing guidance to schools under the Family Educational Rights and Privacy Act³⁶ that was issued in response to questions surrounding the H1N1 influenza pandemic. The updated guidance³⁷ assists school officials in determining what information may be shared and with whom in response to natural and man-made disasters.

33 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals," 3-4.

34 National Commission on Children and Disasters, "Meeting Minutes of the Human Services Recovery Subcommittee," (Washington, DC: NCCD, March 23, 2010), 2, http://www.childrenanddisasters.acf.hhs.gov/NCCD%20Subcommittees/20100322_HSRSubcommitteeReport.pdf.

35 Individuals are given 60 days to register for assistance from FEMA following a disaster. *Ibid.*, 2.

36 20 U.S.C. § 1232g (1974).

37 U.S. Department of Education, "Family Educational Rights and Privacy Act (FERPA) and the Disclosure of Student Information Related to Emergencies and Disasters,"

(Washington, DC: ED, June 2010), <http://www2.ed.gov/policy/gen/guid/fpco/pdf/ferpa-disaster-guidance.pdf>.

The Commission recognizes that the privacy of children and families' personal information must be protected when personally identifiable information is being collected and released to agencies and organizations delivering recovery services in the aftermath of a disaster. The Commission urges Federal, State, tribal, and local agencies to be cognizant of privacy laws and relevant disaster and emergency waivers, and to have pre-disaster information-sharing agreements and policies in place.

Recommendation 1.4: DHS/FEMA should establish interagency agreements to provide disaster preparedness funding, technical assistance, training, and other resources to State and local child serving systems and child congregate care facilities.

State and local child serving systems and child congregate care facilities must be adequately prepared to protect children in disasters. Children spend a significant amount of time under the care or custody of these various systems and facilities, which include schools,³⁸ child care and early education,³⁹ child welfare, and juvenile justice.⁴⁰ However, as identified in other chapters of this report, gaps in disaster preparedness are prevalent in these settings.

Federal agencies such as the DOJ Office of Juvenile Justice and Delinquency Prevention (OJJDP), ED, and the Administration of Children and Families' Child Care Bureau (CCB) and Children's Bureau (CB) provide some assistance to support the disaster preparedness efforts of their State and local partners. However, these Federal agencies lack the funds and disaster planning expertise to substantially support the disaster preparedness efforts of their State and local partners.

The Commission recommends that DHS/FEMA, as the primary Federal agency charged with enhancing our Nation's disaster preparedness,⁴¹ play a leading role in supporting and improving disaster preparedness of State and local child serving systems and child congregate care facilities. DHS/FEMA should establish interagency agreements (IAAs) with OJJDP, ED, CCB, and CB. The IAAs would specify formal commitments of each agency to

38 Public elementary and secondary schools were expected to have record attendance in fall 2009, with 49.8 million students enrolling. Private elementary and secondary school attendance should reach 5.8 million students. National Center for Education Statistics, "Fast Facts," <http://www.nces.ed.gov/fastfacts/display.asp?id=372>.

39 The number of children under the age of 6 in some type of child care situation each week exceeds 12 million. National Association of Child Care Resource & Referral Agencies, *Child Care in America: 2009 Fact Sheets*, (Arlington, VA: NACCRRRA, April 2009), 3, <http://www.naccrra.org/docs/policy/state-fact-sheet-2009.pdf>.

40 In 2007, more than 1.6 million delinquency cases were processed nationwide resulting in 149,000 youth being placed out of their home. Charles Puzzanchera, Benjamin Adams, and Melissa Sickmund, *Juvenile Court Statistics 2006-2007*, ed. National Center for Juvenile Justice (Pittsburgh, PA: NCJJ, 2010), 9, 50, <http://www.ncjservehttp.org/ncjjwebsite/pdf/jcsreports/jcs2007.pdf>.

41 One of DHS' core missions is to "enhance the ability of State, territory, local, and tribal governments to prevent, protect against, respond to, and recover from terrorist attacks and other disasters." U.S. Department of Homeland Security, *Homeland Security Grant Programs Overview*, (Washington, DC: DHS, December 8, 2009), 2, <http://www.dhs.gov/xlibrary/assets/grant-program-overview-fy2010.pdf>.

provide funding, expertise, and other resources to support innovative, collaborative programs to improve disaster preparedness capabilities of State and local child serving systems and child congregate care facilities. The IAAs would also facilitate increased inter-agency and inter-governmental planning and coordination, including joint training and exercises involving emergency management officials and officials from child serving systems at the State and local level.

2. Mental Health

Recommendation 2.1: HHS should lead efforts to integrate mental and behavioral health for children into public health, medical, and other relevant disaster management activities.

Recommendation 2.2: HHS should enhance the research agenda for children's disaster mental and behavioral health, including psychological first aid, cognitive-behavioral interventions, social support interventions, bereavement counseling and support, and programs intended to enhance children's resilience in the aftermath of a disaster.

Recommendation 2.3: Federal agencies and non-Federal partners should enhance pre-disaster preparedness and just-in-time training in pediatric disaster mental and behavioral health, including psychological first aid, bereavement support, and brief supportive interventions, for mental health professionals and individuals, such as teachers, who work with children.

Recommendation 2.4: DHS/FEMA and SAMHSA should strengthen the Crisis Counseling Assistance and Training Program (CCP) to better meet the mental health needs of children and families.

Recommendation 2.5: Congress should establish a single, flexible grant funding mechanism to specifically support the delivery of mental health treatment services that address the full spectrum of behavioral health needs of children including treatment of disaster-related adjustment difficulties, psychiatric disorders, and substance abuse.

2. Mental Health

Recommendation 2.1: HHS should lead efforts to integrate mental and behavioral health for children into public health, medical, and other relevant disaster management activities.

- Congress should direct HHS to lead the development of a disaster mental and behavioral health Concept of Operations (CONOPS) to formalize disaster mental and behavioral health as a core component of disaster preparedness, response, and recovery efforts.

Children are particularly vulnerable to the mental health impact of disasters and lack the experience, skills, and resources to independently meet their mental and behavioral health needs.⁴² Mental and behavioral health effects are of specific concern in children of all ages due to the likelihood of lasting reactions.⁴³ Studies show that following disasters many children experience academic failure, post-traumatic stress disorder (PTSD), depression, anxiety, bereavement, and other behavioral problems such as delinquency and substance abuse.^{44, 45, 46} A report by the National Center for Disaster Preparedness on the impact of the 2010 Gulf of Mexico oil spill disaster on children and families estimated that over 19 percent of the pediatric population in coastal Louisiana and Mississippi experienced emotional or behavioral distress related to the oil spill.⁴⁷ However, as indicated in the Commission's Interim Report, the mental health effects of disasters are typically overlooked in disaster management and often are not considered until well after an event when it is too late to affect optimal response or recovery efforts.⁴⁸ A greater focus on the disaster mental and behavioral health needs of children is necessary throughout Federal, State, and local preparedness activities, including planning, training, and exercises, and response and recovery efforts.

42 David Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children?: Implications From September 11th," *Pediatrics* 113, no. 5 (2004): 1400, <http://pediatrics.aappublications.org/cgi/reprint/113/5/1400>.

43 Annette M. LaGreca, Wendy K. Silverman, Eric M. Vernberg, and Michael C. Roberts (eds.), *Helping Children Cope with Disasters and Terrorism*, (Washington, DC: American Psychological Association Press, 2002), 327-357.

44 John Pane, Daniel F. McCaffrey, Nidhi Kalra, and Annie J. Zhou, "Effects of Student Displacement in Louisiana During the First Academic Year After the Hurricanes of 2005," *Journal of Education for Students Placed at Risk (JESPAR)* 13, no. 2 (2008):168-211, http://www.rand.org/pubs/reprints/2008/RAND_RP1379.pdf.

45 Ann S. Masten and Joy D. Osofsky (Eds.), "Disasters and Their Impact on Child Development [Special Section]," *Child Development*, 81, no. 4 (2010): 1029-1286, <http://onlinelibrary.wiley.com/doi/10.1111/cdev.2010.81.issue-4/issuetoc>.

46 Annette M. LaGreca, Wendy K. Silverman, Eric M. Vernberg, and Michael C. Roberts (eds.), *Helping Children Cope with Disasters and Terrorism*, 11-33.

47 David Abramson, Irwin Redlener, Tasha Stehling-Ariza, Jonathan Sury, Akilah Banister, and Yoon Soo Park, *Impact on Children and Families of the Deepwater Horizon Oil Spill: Preliminary Findings of the Coastal Population Impact Study*, Research Brief 2010-8, ed. National Center for Disaster Preparedness, Columbia University Mailman School of Public Health (New York, NY, August 3, 2010), 4, 7, http://www.ncdp.mailman.columbia.edu/files/NCDP_Oil_Impact_Report.pdf.

48 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 9, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

The Commission recommends that Congress direct the Department of Health and Human Services (HHS) to develop a disaster mental health Concept of Operations (CONOPS) to formalize disaster mental and behavioral health as a core component of disaster preparedness, response, and recovery efforts. The CONOPS would establish a national disaster mental health strategy and identify goals and activities necessary for building local, State, and Federal disaster mental and behavioral health capabilities for children and families in disaster preparedness, response, and recovery. The CONOPS would also outline the coordination of Federal and non-Federal disaster mental health capabilities and programs for children and families. Both the Commission, in its Interim Report, and the National Biodefense Science Board have previously recommended that HHS develop a disaster mental health CONOPS. HHS, in response to the Commission's request for information on progress in implementing its Interim Report recommendations, reported that the development of a disaster mental health CONOPS requires the designation of a lead agency with requisite authority and funding.⁴⁹

Recommendation 2.2: HHS should enhance the research agenda for children's disaster mental and behavioral health, including psychological first aid, cognitive-behavioral interventions, social support interventions, bereavement counseling and support, and programs intended to enhance children's resilience in the aftermath of a disaster.

- *HHS should convene a working group of children's disaster mental health and pediatric experts to review the research portfolios of relevant agencies, identify gaps in knowledge, and recommend a national research agenda across the full spectrum of disaster mental health for children and families.*

Although research has repeatedly documented the adverse impact of trauma and loss on children, little research exists evaluating the effectiveness of services and interventions to address these impacts.⁵⁰ As noted in the Commission's Interim Report, evidence suggests that some commonly used interventions, such as critical incident stress debriefing or management, are not effective and may instead be damaging, especially when used with children.^{51, 52} Even less research has been conducted regarding the effectiveness of services and interventions for grieving children or those experiencing adjustment problems related to other stressors prevalent in the aftermath of a disaster. A new, expanded national agenda for disaster mental health research is necessary to prioritize and facilitate exploration of the full spectrum of mental health services for children and families.

49 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals," (Washington, DC: NCCD, May 11, 2010), 5, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

50 Disaster Mental Health Subcommittee, *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. U.S. Department of Health and Human Services (Washington, DC: HHS, 2008), 8-10.

51 *Ibid.*, 9.

52 George Foltin, David Schonfeld, and Michael Shannon, *Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians*, AHRQ Publication Number 06(07)-0056, ed. Agency for Healthcare Research and Quality (Rockville, MD: AHRQ, 2006), 279, <http://www.ahrq.gov/research/pedprep/pedresource.pdf>.

The Commission recommends that a working group of children’s disaster mental health and pediatric experts be convened to review the research portfolios of relevant agencies that fund Federal research. The working group would identify gaps in knowledge, areas of recent progress, and priorities for research. The goal is to ensure that the full spectrum of disaster mental and behavioral health is addressed within this research portfolio, including, but not limited to, psychological first aid, cognitive-behavioral interventions (including those that can be delivered to children in schools and other group settings), social support interventions, bereavement counseling and support, and programs intended to enhance children’s resilience in the aftermath of disaster.

A priority of this effort should be to support research that further defines resilience and evaluates the effectiveness of resilience programs and support services for children and communities recovering from disasters. “Resilience and Sustainability” is identified as one of nine core principles of recovery in the draft National Disaster Recovery Framework, which links resilience building efforts with the capacity of communities to recover from future disasters.⁵³ However, little is known about the characteristics that make children and communities resilient or the effectiveness of various programs that purport to build or enhance resilience.

The National Institutes of Health (NIH) expressed support for the establishment of the proposed working group. NIH also indicated that an opportunity to conduct an annual review of research on children’s disaster and mental health research may be available via the Behavioral and Social Science Consortium. The Commission recommends that NIH vigorously pursue these opportunities in partnership with the Substance Abuse & Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the HHS Assistant Secretary for Preparedness and Response (ASPR), and, as appropriate, the Federal Emergency Management Agency (FEMA).

Recommendation 2.3: Federal agencies and non-Federal partners should enhance pre-disaster preparedness and just-in-time training in pediatric disaster mental and behavioral health, including psychological first aid, bereavement support, and brief supportive interventions, for mental health professionals and individuals, such as teachers, who work with children.

As a result of limited access to formal mental health services and treatment following a disaster, communities depend on persons who are not mental health professionals but who routinely interact with children—such as teachers and school staff, first responders, health care professionals, child care and early education providers, child welfare and juvenile justice professionals, and members of the faith-based community—to provide basic support services and brief interventions. As indicated in the Commission’s Interim Report, these individuals must have basic knowledge of how to recognize signs of distress, assist children in adjusting and coping, and identify children who require more advanced care.⁵⁴

53 Federal Emergency Management Agency, *National Disaster Recovery Framework Draft*, (Washington, DC: FEMA, February 5, 2010), 13, http://www.fema.gov/pdf/recoveryframework/omb_ndrf.pdf.

54 National Commission on Children and Disasters, *Interim Report*, 11.

The Commission continues to recommend that professionals and others who work with children receive basic training in a range of disaster mental and behavioral health issues, to include psychological first aid, cognitive-behavioral interventions, social support interventions, and bereavement counseling and support. Mental health professionals, including those working in schools and other child congregate care settings, must also receive adequate training related to disaster mental health care for children.

Optimally, training for mental health professionals and other individuals who work with children should be provided prior to an event, since supportive services should begin during the disaster or in the immediate aftermath. Finding adequate time and resources for staff to receive training in the immediate aftermath of a disaster is difficult. Staff, who may be affected by the disaster themselves, will likely have to attend to a range of increased demands in adverse conditions. At the Commission's January 2010 field visit to Iowa, school officials expressed the need for pre-event training for school and mental health officials.⁵⁵

The Commission's Progress Report notes that, through the Crisis Counseling Assistance and Training Program (CCP), personnel at schools and faith-based organizations have received just-in-time training after disasters on providing support to children and families.⁵⁶ While these efforts are important, the Commission urges HHS, FEMA, the Department of Education, and the Department of Justice to expand efforts to provide pediatric disaster mental and behavioral health training, both before and after disasters, to a larger consortium of professionals and other individuals who work with children.

55 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," (Washington, DC: NCCD, 2010), 5, http://www.childrenanddisasters.acf.hhs.gov/20100106_IowaFieldVisit_MinutesV03FINAL.pdf.

56 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals," 5.

Recommendation 2.4: DHS/FEMA and SAMHSA should strengthen the Crisis Counseling Assistance and Training Program (CCP) to better meet the mental health needs of children and families.

- *Simplify the Immediate Services Program (ISP) grant application to minimize the burden on communities affected by a disaster and facilitate the rapid allocation of funding and initiation of services.*
- *Establish the position of Children’s Disaster Mental Health Coordinator within State-level CCPs.*
- *Formally modify the CCP model to indicate and promote “enhanced services” where the mental health impact is unlikely to be adequately addressed by “typical” CCP services.*
- *Include bereavement support and education within services typically provided under the CCP.*

CCP is a post-disaster grant program administered by FEMA and SAMHSA and awarded to State mental health agencies or other local or private mental health organizations. CCP provides Federal funding to help States relieve mental health problems caused or aggravated by major disasters through the provision of “professional counseling services.”^{57,58} The current CCP model is designed to address the short-term mental health needs of children and adults affected by disasters by supporting services focusing on individual and group counseling, education and referrals, and training of lay-person or “paraprofessional” counselors.⁵⁹ CCP does not provide mental health treatment or substance abuse services.⁶⁰

CCP should be strengthened to better meet the needs of children, families, and communities affected by disasters. Several States have encountered challenges applying for CCP funding, implementing programs, and assisting people who need more intensive services than those traditionally provided through CCP.^{61, 62}

57 Federal Emergency Management Agency, *Federal Emergency Management Agency Crisis Counseling Assistance and Training Program Guide*, ed. Federal Emergency Management Agency and Substance Abuse & Mental Health Services Administration (Washington, DC: FEMA, 2009), 9,

http://download.ncadi.samhsa.gov/ken/pdf/cmhs/CCP_Program_Guidance_ver1.1.pdf.

58 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA’s Crisis Counseling Program Needs Improvements*, GAO-08-22, (Washington, DC: GAO, 2008), 10, <http://www.gao.gov/new.items/d0822.pdf>.

59 Substance Abuse & Mental Health Services Administration, “Emergency Mental Health and Traumatic Stress: An Overview of the Crisis Counseling Assistance and Training Program,” http://mentalhealth.samhsa.gov/cmhs/emergencyservices/ccp_pg01.asp.

60 Ibid.

61 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA’s Crisis Counseling Program Needs Improvements*, 20.

62 National Commission on Children and Disasters, “Summary Report: Field Visit, Cedar Rapids, Iowa,” (Washington, DC: NCCD, 2010), 2-3, http://www.childrenanddisasters.acf.hhs.gov/20100106_IowaFieldVisit_Summary.pdf.

The Commission recommends that FEMA and SAMHSA simplify the CCP application process. To receive CCP funding from FEMA following a Presidentially declared disaster, States must first apply for an immediate grant and, if there is a continuing need, a longer-term grant.⁶³ The Immediate Services Program (ISP) grant funds CCP services for up to 60 days following a disaster declaration, while the Regular Services Program (RSP) grant can help States meet service needs for an additional nine months.⁶⁴ To apply for the ISP grant, States must, within 14 days of the disaster declaration, submit a formula-based needs assessment documenting the inadequacy of their available resources and presenting a plan for service delivery.⁶⁵ States with a continuing need for CCP services must submit an additional application for an RSP within 60 days of the declaration.⁶⁶ In 2008, the Government Accountability Office (GAO) chronicled the experiences of six States in obtaining and using CCP grants to respond to either 9/11 or Hurricane Katrina and found that all six States encountered difficulties in collecting information required for their ISP applications within established deadlines and in preparing parts of their ISP applications.⁶⁷ Officials indicated to GAO “that the amount of information required for their applications was difficult to collect because of the scope of the disasters and the necessity for responding on other fronts, such as ensuring the safety of patients and personnel at State-run mental health facilities.”⁶⁸ Several State officials also noted that in the immediate aftermath of a catastrophic disaster, preliminary damage assessments, the location of people in need of services, and other information required for the ISP application is not always available or reliable.⁶⁹ Although Federal agency officials reported to GAO that changes were implemented in 2007 to decrease information requirements in the ISP and RSP applications, revise the needs assessment formula, and clarify the applications and corresponding guidance,⁷⁰ Iowa officials reported many of the same challenges in applying for and implementing their State CCP program in response to a series of tornadoes and floods in 2008.⁷¹

The Commission recommends that FEMA and SAMHSA, with input from States, simplify the ISP application so that it can be easily completed in the aftermath of a disaster. In addition, States may benefit by developing a generic plan for the ISP phase of their program prior to an event, so that it can be pre-approved by FEMA and SAMHSA. In this manner, funds could be immediately allocated based on a pre-identified formula using certain measurable benchmarks related to the damage and the affected population. This would reduce the

63 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA’s Crisis Counseling Program Needs Improvements*, 10.

64 If a State documents the need for additional services, FEMA may extend an RSP grant for an additional 90 days or, in the case of a catastrophic disaster, an even longer period. *Ibid.*, 11.

65 *Ibid.*, 10-11.

66 *Ibid.*, 10-11.

67 *Ibid.*, 20.

68 *Ibid.*, 20.

69 *Ibid.*, 20.

70 *Ibid.*, 22.

71 As a result of the cascading nature of the events in Iowa, the Iowa Department of Human Services had to complete 16 grant applications to implement their CCP program, Project Recovery Iowa. In discussions with the Commission, Iowa officials reported difficulty using the needs assessment tool to estimate resource requirements and budgetary needs for ISP services within the 14 days allotted. Iowa officials indicated that this difficulty contributed to underestimating the needs of their citizens. National Commission on Children and Disasters, “Summary Report: Field Visit, Cedar Rapids, Iowa,” 2-3.

burden on affected States and communities and promote the immediate allocation of funding and initiation of services. If States find that there is a continuing need for services past the initial 60 day phase supported by the ISP, they would then still apply for the additional longer-term RSP grant, at which time they would have a more informed idea of the particular needs of their population and program modifications needed to better address those needs.

Any CCP needs assessment or funding formula should include the presence of population groups, such as children, who are at increased risk for psychological distress. Officials in State programs reviewed by the GAO expressed concern that the CCP application's needs assessment formula did not capture data on the percentage of children and other particularly vulnerable groups in the affected population, which they considered to be critical in assessing communities' mental health needs.⁷²

To further ensure that the needs of children are not overlooked, the Commission recommends that State-level CCP programs establish a Children's Mental Health Coordinator position. After a request from the State-level program in Iowa and much negotiation, this position was created and funded within Project Recovery Iowa to provide specific support and oversight of the services offered to children and to ensure that developmentally-appropriate training and materials were provided to crisis counselors.⁷³ This position also helped to ensure that a focus was placed on children in the service delivery model and that their unique needs and sensitivities were taken into account.⁷⁴ FEMA and SAMHSA should support the institutionalization of this position in other State programs by incorporating the position into guidance and automatically funding it, without a State having to negotiate for its creation.

With regard to the scope of services provided under the CCP, the Commission recommends a formal enhancement of the current CCP model to better serve children and families with mental health impacts that are more serious than what CCP was designed to address. The scope of CCP's services does not include "long term, formal mental health services such as medications, office-based therapy, diagnostic services, psychiatric treatment, or substance abuse treatment."⁷⁵ Rather, CCP services are designed to be delivered in familiar community settings by teams of non-mental health providers from the community (paraprofessionals), who are trained by mental health professionals with specialized mental health or counseling training.⁷⁶ Children and families in need of treatment are intended to be referred to existing service systems.⁷⁷

72 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements*, 21.

73 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," 7-8.

74 *Ibid.*, 7-8.

75 Substance Abuse & Mental Health Services Administration (SAMHSA), "Emergency Mental Health and Traumatic Stress: An Overview of the Crisis Counseling Assistance and Training Program."

76 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements*, 11.

77 Ramya Sundararaman, Sarah A. Lister, and Erin D. Williams, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, RL33738, ed. Congressional Research Service (Washington, DC: The Library of Congress, 2006), 2-3.

Although CCP provides referrals for treatment services, children and families often have limited access to traditional mental health providers due to a chronic shortage of mental health providers,⁷⁸ and limited insurance coverage in connection with mental health and substance abuse services.⁷⁹ Mississippi officials implementing the State-level CCP after Hurricane Katrina reported to the GAO that they wanted to serve as many people as possible because fewer providers were available to accept referrals.⁸⁰ According to New York, Louisiana, and Mississippi officials who spoke with the GAO, CCP clients could have benefited from improved crisis counseling beyond the CCP model whether or not they displayed symptoms indicating the need for referrals.⁸¹

In response to requests from New York, Louisiana, and Mississippi to allow their CCPs to offer enhanced services, FEMA and SAMHSA permitted the development of pilot programs offering enhanced crisis counseling services “consistent with the non-clinical, short-term focus of the CCP model.”^{82, 83} New York’s enhanced services after 9/11 were provided by mental health professionals based on cognitive behavioral approaches and included up to 12 counseling sessions to help individuals referred for enhanced services develop skills to cope with anxiety, depression, or other symptoms of post-disaster stress.⁸⁴ In Louisiana and Mississippi, individuals who were referred for enhanced services following Hurricane Katrina were provided services by mental health professionals in a single “stand-alone” session.⁸⁵ However, if needed, clients could obtain additional enhanced sessions or referrals for mental health and substance abuse treatment services.⁸⁶

The Commission urges FEMA and SAMHSA to formally modify the current CCP model to include the provision of “enhanced services” in large-scale disasters where the mental health impact is unlikely to be adequately addressed by “typical” CCP services. In February 2008, the GAO recommended that FEMA and SAMHSA expeditiously “determine what

78 U.S. Government Accountability Office, *Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them*, GAO-09-563, (Washington, DC: GAO, 2009), 7, <http://www.gao.gov/new.items/d09563.pdf>.

79 Ramya Sundararaman and C. Stephen Redhead, *Mental Health Parity: Federal and State Action and Economic Impact*, RL31657, ed. Congressional Research Service (Washington, DC: The Library of Congress, 2008), 1.

80 U.S. Government Accountability Office, *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA’s Crisis Counseling Program Needs Improvements*, 28.

81 *Ibid.*

82 *Ibid.*

83 SAMHSA’s “six operating principles are (1) disaster-trained clinical professionals are a key component of specialized crisis counseling teams; (2) an active outreach must be maintained; (3) appropriate assessment and referral techniques will be utilized; (4) specialized techniques must be appropriate to the short-term, temporary nature of CCP and phases of disaster recovery; (5) specialized techniques must focus on immediate practical needs and priorities of survivors; and (6) training, supervision, and oversight are critical to successful implementation and operation.” *Ibid.*, 29.

84 *Ibid.*

85 *Ibid.*

86 *Ibid.*

types of [enhanced] crisis counseling services should be formally incorporated into CCP and make necessary revisions to program policy.”⁸⁷ In response, FEMA and SAMHSA officials indicated they intended to consider incorporating certain types of enhanced services into the CCP model.⁸⁸ However, no form of enhanced services has yet been codified or communicated to communities as a program enhancement that can be made available after a disaster.

Without enhanced services being formally incorporated into the CCP model, some States or communities may lack knowledge of the potential availability of enhanced services and therefore may not request or plan to provide them. Institutionalizing the availability of enhanced services by formally incorporating them into the CCP model for disasters where the mental health impact is unlikely to be adequately addressed by “typical” CCP services would enable any State to more effectively prepare prior to a disaster, develop their CCP proposals, and provide their populations with needed counseling services.

Finally, while the CCP does provide a means to address bereavement support, the services reflect a focus on trauma treatment. Reliance on a professional network that has an exclusive trauma focus to provide technical assistance, support, and just-in-time training has resulted in limited attention to bereavement support outside the context of addressing trauma syndromes or symptoms. The inclusion of broader bereavement subject matter expertise is a critical gap, and more conscious and thoughtful attention to bereavement support within outreach, education, and counseling services delivered through the CCP would be an important step toward addressing broader disaster mental health needs of children and families.

Recommendation 2.5: Congress should establish a single, flexible grant funding mechanism to specifically support the delivery of mental health treatment services that address the full spectrum of behavioral health needs of children including treatment of disaster-related adjustment difficulties, psychiatric disorders, and substance abuse.

Despite the existence of CCP and other Federal assistance programs, the Commission remains concerned that the mental health needs of many children and families affected by disasters will go unmet. As the Congressional Research Service noted in a 2006 report: “Survivors of a disaster often need a range of mental health services that go beyond those provided for by CCP, which only provides referral to mental health services.”⁸⁹ Without additional assistance to address barriers to mental health treatment for children, which commonly preexist disasters and preclude surge capacity thereafter, many children will be unable to access the treatment they need.

87 Ibid., 33.

88 Ibid., 34.

89 Ramya Sundararaman, Sarah A. Lister, and Erin D. Williams, *Gulf Coast Hurricanes: Addressing Survivors’ Mental Health and Substance Abuse Treatment Needs*, 13.

As previously noted, children often go without needed mental health services on a daily basis due to a chronic shortage of pediatric mental health professionals⁹⁰ and limited insurance reimbursement for these services.⁹¹ This gap worsens following disasters because of increased demand, limited surge capacity among providers, limited transportation, and other competing family recovery needs.^{92,93} Resources must be provided to ensure that children have access to immediate and long-term mental health interventions following disasters in order to address disaster-caused mental health issues, as well as pre-existing mental health conditions exacerbated by the disaster.

The Commission recommends that Congress authorize and provide appropriations to support a single, flexible grant funding mechanism with the specific purpose of addressing barriers to mental health treatment services for children following disasters. Congress may choose to modify and adequately appropriate funds through an existing grant program such as SAMHSA Emergency Response Grants or authorize a new grant program for use after Presidentially declared disasters.⁹⁴

Adequate funding should be targeted to States and communities in need, for the specific purpose of supporting disaster mental health treatment services immediately following a Presidentially declared disaster and throughout long-term recovery efforts. After catastrophic disasters such as Hurricane Katrina and 9/11, a variety of different established programs, such as block grants and other ad hoc grants, have provided pools of funding to States from which funds could be used to support mental health services. However, States recovering from disasters face many competing priorities and may not choose to expend funds on mental health services, which often do not receive attention equivalent to that given to other health needs.

Funding should be used to support the full range of mental health and substance abuse treatment services that are not covered by the CCP, including the treatment of disaster-

90 Jane Koppelman, *The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment*, ed. National Health Policy Forum (Washington, DC: NHPF, 2004), 3-5, http://www.nhpf.org/library/issue-briefs/IB801_ChildMHPProvider_10-26-04.pdf.

91 American Academy of Pediatrics, *Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration*, (Elk Grove Village, IL: AAP, 2009), 2-5, <http://practice.aap.org/content.aspx?aid=2775>.

92 David Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children?: Implications From September 11th," 1400.

93 U.S. Government Accountability Office, *Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them*, 12.

94 Under SERG, SAMHSA has authority to award noncompetitive grants from its discretionary funding to fund emergency mental health and substance abuse treatment services not permitted under CCP, whether or not there has been a major disaster declaration. Although Congress provided funding for the response to Hurricanes Katrina and Rita through several supplemental appropriations, SAMHSA did not receive any supplemental funding. Accordingly, SERG grants totaling only \$600,000 were split among Alabama, Louisiana, Mississippi, and Texas. Ramya Sundararaman, Sarah A. Lister, and Erin D. Williams, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, 6.

related adjustment difficulties such as bereavement; psychiatric disorders such as PTSD and acute trauma syndromes, depression, and anxiety; substance abuse; and psychotropic medication expenses. Funds should also support the anticipated increase in mental health services after a disaster that may be required for children with mental health problems that predated the disaster.

Furthermore, the funding mechanism must provide sufficient flexibility to address other barriers that prevent access to services such as a lack of mental health providers and transportation. For example, State and local governments must have the ability to use grant funds to hire additional mental health providers and train mental health providers in disaster mental health for children.

3. Child Physical Health and Trauma

Recommendation 3.1: Congress, HHS, and DHS/FEMA should ensure availability of and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats.

Recommendation 3.2: HHS and DoD should enhance the pediatric capabilities of their disaster medical response teams through the integration of pediatric-specific training, guidance, exercises, supplies, and personnel.

Recommendation 3.3: HHS should ensure that health professionals who may treat children during a disaster have adequate pediatric disaster clinical training.

Recommendation 3.4: The Executive Branch and Congress should provide resources for a formal regionalized pediatric system of care to support pediatric surge capacity during and after disasters.

Recommendation 3.5: Prioritize the recovery of pediatric health and mental health care delivery systems in disaster-affected areas.

Recommendation 3.6: EPA should engage State and local health officials and non-governmental experts to develop and promote national guidance and best practices on re-occupancy of homes, schools, child care, and other child congregate care facilities in disaster-impacted areas.

3. Child Physical Health and Trauma

Recommendation 3.1: Congress, HHS, and DHS/FEMA should ensure availability of and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats.

- *Provide funding and grant guidance for the development, acquisition, and stockpiling of MCM specifically for children for inclusion in the Strategic National Stockpile (SNS) and all other federally funded caches, including those funded by DHS/FEMA.*
- *Amend the Emergency Use Authorization to allow the FDA, at the direction of the HHS Secretary, to authorize pediatric indications of MCM for emergency use before an emergency is known or imminent.*
- *Form a standing advisory body of Federal partners and external experts to advise the HHS Secretary and provide expert consensus on issues pertaining specifically to pediatric emergency MCM.*
- *Within the HHS Biomedical Advanced Research and Development Authority, designate a pediatric leader and establish a pediatric and obstetric working group to conduct gap analyses and make research recommendations.*
- *Include pediatric expertise on the HHS Enterprise Governance Board or its successor and all relevant committees and working groups addressing issues pertaining to MCM.*
- *Establish a partnership between the proposed MCM Development Leader and key pediatric stakeholders both within and outside government.*

Children are subject to higher levels of exposure and harm following chemical and biological incidents.⁹⁵ Children inhale more air and consume more water on a per-weight basis than adults.⁹⁶ Therefore, if a chemical, biological, radiological, nuclear, or explosive agent enters into the environment, children are more vulnerable than adults to the agent's adverse effects. Although these considerations should warrant greater attention to children during emergencies, the quantity of pediatric medical countermeasures (MCM)⁹⁷ in the Strategic National Stockpile (SNS)⁹⁸ is very limited. While the SNS maintains MCM for adults for high-threat agents, comparable pediatric indications and countermeasures for

95 American Academy of Pediatrics, Committee on Environmental Health and Committee on Infectious Diseases, "Chemical-Biological Terrorism and Its Impact on Children," *Pediatrics* 118, no. 3 (2006): 1271, <http://pediatrics.aappublications.org/cgi/content/full/118/3/1267>.

96 U.S. Environmental Protection Agency, *Child-Specific Exposure Factors Handbook (Final Report) 2008*, (Washington, DC: EPA, 2008), xxi, <http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid=199243>.

97 MCM refer to drugs, biological products, or devices that treat, identify, or prevent harm due to chemical, biological, radiological, nuclear, and explosive agents.

98 The SNS "has large quantities of medicine and medical supplies to protect the American public if there is a public health emergency severe enough to cause local supplies to run out. Once Federal and local authorities agree that the SNS is needed, medicines will be delivered to any State in the U.S. within 12 hours. Each State has plans to receive and distribute SNS medicine and medical supplies to local health departments as quickly as possible." Centers for Disease Control and Prevention, "Strategic National Stockpile (SNS)," <http://www.bt.cdc.gov/stockpile>.

children are largely unavailable or have not been approved by the Food and Drug Administration (FDA).⁹⁹ It is critical that the Federal Government take all steps necessary to remedy fully and quickly these gaps in coverage for children currently present within the SNS, in addition to ensuring that MCM developed and approved in the future have pediatric indications, dosages, and formulations.

A summary report of a February 2010 workshop sponsored by the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE)¹⁰⁰ reemphasized the need for certain populations, especially children, to have immediate access to MCM.¹⁰¹ The workshop report discusses how incentives to develop pediatric MCM¹⁰² are impeded by the obstacles involved in conducting clinical trials of MCM on children.¹⁰³ Although procurement contracts issued by the Biomedical Advanced Research and Development Authority (BARDA) for chemical, biological, radiological, and nuclear threats contain options to extend label indications to pediatric populations, the incentive is unsuitable since the participation of children in controlled trials is virtually impossible.^{104,105}

In December 2009, in the aftermath of the H1N1 pandemic, the Department of Health and Human Services (HHS) Secretary directed the Office of the Assistant Secretary for Preparedness and Response (ASPR) to lead a thorough review of its entire MCM system and

99 U.S. Department of Health and Human Services, National Institutes of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development, Center for Research for Mothers and Children, Obstetric and Pediatric Pharmacology Branch, "Meeting Minutes, BPCA Biodefense Meeting," (Rockville, MD: NIH, September 8-9, 2008), <http://bpca.nichd.nih.gov/collaborativeefforts/upload/Biodefense-09-08.pdf>.

100 PHEMCE is the inter-agency body responsible for coordinating the research, development, regulation, procurement, stockpiling, and deployment of MCM. U.S. Department of Health and Human Services, "Project BioShield," <https://www.medicalcountermeasures.gov/BARDA/bioshield/bioshield.aspx>.

101 Theresa Wizemann, Clare Stroud, and Bruce Altevogt, *Innovative Strategies to Enhance Products from Discovery Through Approval*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2010), 24, http://books.nap.edu/openbook.php?record_id=12856&page=R1.

102 Under Section 505A of the Food and Drug Administration Modernization Act of 1997 (i.e., the "Pediatric Rule"), FDA can request pediatric testing from investigators and manufacturers of a product. The reward for such testing is a 6-month period of marketing exclusivity to develop patents and intellectual property related to the product. U.S. Department of Health and Human Services, Food and Drug Administration, "Frequently Asked Questions on Pediatric Exclusivity (505A), the Pediatric Rule, and Their Interaction," <http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/ucm077915.htm>.

103 Theresa Wizemann, Clare Stroud, and Bruce Altevogt, *Innovative Strategies to Enhance Products from Discovery Through Approval*, 40-41.

104 U.S. Department of Health and Human Services, Memorandum to the National Commission on Children and Disasters: *Response to the National Commission on Children and Disasters Interim Report*, March 18, 2010, 17, Washington, DC.

105 FDA reported to the Commission that "exposure [of children] to toxic substances for the purpose of a controlled trial is not ethical, and so the FDA must utilize data from sources other than the gold standard randomized, controlled, clinical trial. In addition, pediatric patients are not capable of providing legal informed consent, and cannot volunteer for studies, especially if there is not direct benefit to the subject. Pediatric product development is challenging and unique, and requires a rational approach that leverages existing data to obtain sufficient evidence of safety and effectiveness in the pediatric population." *Ibid.*, 21.

make recommendations.¹⁰⁶ The Public Health Emergency Medical Countermeasures Enterprise Review, released in August 2010, recognizes the need to enhance the development and regulatory review of MCM for vulnerable populations, including children and pregnant women, as part of a broader effort to improve MCM regulatory science, domestic manufacturing capacity, coordination and collaboration, and financial incentives.¹⁰⁷ While the review does not specify in greater detail the significant gaps that currently exist in our Nation's portfolio of MCM for children, the Commission supports several of the recommendations in the review because they provide promising opportunities to address the disparate challenges that are unique to children, through new mechanisms and investments.

The review appropriately recommends that HHS identify a senior leader for the MCM enterprise (MCM Development Leader). The Commission recommends that there be a partnership between this leader and key pediatric stakeholders both within and outside government. This partnership should include the Commission, but in addition, key non-governmental organizations, such as the American Academy of Pediatrics. Furthermore, HHS reported to the Commission that it has identified research and development needs and regulatory issues surrounding pediatric MCM, yet funding is not available to address these gaps. This information should be coordinated with the MCM Development Leader and shared with the BARDA senior leadership council.

The review proposes the creation of an independent strategic investment entity for MCM innovation and development. Pediatric MCM should be a priority and therefore it is vital for this entity to have pediatric expertise. The review also calls for a reassessment of how liability protection is offered to the parties involved in MCM development, testing, manufacturing and administration. The Commission concurs, as liability concerns are perceived to be a significant barrier to pediatric labeling and the application of MCM to children.

The review recommends that the FDA be resourced with enhanced capability and capacity to work proactively with industry sponsors and researchers in targeted areas in the hope that this activity might help to expedite the development of MCM. In addition, the Commission recommends that one of the targeted regulatory science enhancement initiatives for the FDA be pediatric labeling and formulations for existing MCM in the SNS.

The review refers to the FDA's role in the Emergency Use Authorization (EUA) process but does not appear to acknowledge that the EUA (or a modified EUA mechanism) might be a useful tool in creating more timely solutions to emerging or perceived threats—and particularly so for children. Recognizing that the development of FDA-approved MCM for

106 Secretary Kathleen Sebelius, "Address to the American Medical Association Third National Congress on Health System Readiness," (Washington, DC: AMA, December 1, 2009), 3, <http://www.newfluwiki2.com/upload/sebeliusdec1speech.pdf>.

107 U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response, *The Public Health Emergency Medical Countermeasures Enterprise Review: Transforming the Enterprise to Meet Long-Range National Needs*, (Washington, DC: HHS, August 2010).

children may take several years, the Commission recommends that Congress amend the EUA statute to permit the FDA, at the direction of the HHS Secretary, to authorize pediatric indications of MCM for emergency use before an emergency is known or imminent. The Project BioShield Act of 2004¹⁰⁸ established the EUA, which permits FDA to approve “the emergency use of drugs, devices, and medical products (including diagnostics) that were not previously approved, cleared, or licensed by FDA” and “the off-label use of approved products in certain well-defined emergency situations.”^{109, 110} Despite this mechanism, FDA lacks authority to authorize MCM prior to a declaration of an emergency, which prevents the stockpiling of pediatric MCM in the SNS for ready availability, which places children at an unacceptable risk. Pediatric indications should be authorized when sufficient data exist regarding the pediatric dose and administration of the MCM, and when expert consensus advises that it is prudent to stockpile the MCM for pediatric use during an emergency.

In its Interim Report, the Commission recommended that the HHS Secretary establish an advisory committee of Federal and external partners to provide expert consensus opinion on issues pertaining specifically to pediatric MCM.¹¹¹ The advisory committee could review existing data and information on MCM and provide rationale and consensus-based recommendations for use with children during an emergency, ideally before an emergency occurs. The 2006 Pandemic and All-Hazards Preparedness Act¹¹² specifically gives the HHS Secretary the authority to establish a working group of experts to “obtain advice regarding supporting and facilitating advanced research and development related to qualified countermeasures and qualified pandemic or epidemic products that are likely to be safe and effective with respect to children, [etc.].” HHS suggested to the Commission that the advisory committee be established as a standing committee within the NBSB, which has a broad scope beyond children. The Commission believes this approach is insufficient and urges Congress and the HHS Secretary to establish this advisory committee as a separate entity solely dedicated to children.

Finally, the Commission recommends that ASPR designate a pediatric leader within BARDA, supported by a pediatric and obstetric working group, to conduct gap analyses on MCM for children and pregnant women, make research recommendations and provide input to Federal procurement contracts for MCM. Also, as recommended in the Interim Report, existing committees and working groups must include pediatric experts to ensure children

108 Public Law (P.L.) 108-276 (2004).

109 Stuart Nightingale, Joanna Prasher, and Stewart Simonson, *Emergency Use Authorization (EUA) to Enable Use of Needed Products in Civilian and Military Emergencies*, ed. Centers for Disease Control and Prevention (Atlanta, GA: CDC, 2007), 1046, <http://www.ncbi.nlm.nih.gov/pubmed/18214177>.

110 The 2009 H1N1 outbreak provided examples of the use of EUAs. EUAs were used to approve the use of Tamiflu and/or Relenza on children under 1 year of age. EUAs were also issued for use of certain personal protective equipment during the H1N1 outbreak. Centers for Disease Control and Prevention, “Termination of the Emergency Use Authorization of Medical Products and Devices,” <http://www.cdc.gov/h1n1flu/eua/>.

111 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 15, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

112 P.L. 109-417 (2006).

are represented when MCM are being prioritized for development and procurement.¹¹³ HHS reported that the PHEMCE includes pediatric subject matter experts on all of its inter-agency activities, such as Requirements Working Groups and Integrated Program Teams. The Commission acknowledges these positive actions and recommends that pediatric leadership also be included on PHEMCE's Enterprise Governance Board, which is proposed to be replaced by the Enterprise Senior Council (ESC). The ESC will include senior leaders of PHEMCE "to oversee and serve as the decision forum for MCM development policy and implementation."¹¹⁴ Appropriate pediatric leadership would ensure that pediatric MCM needs are consistently considered throughout the entire MCM development process.

Recommendation 3.2: HHS and DoD should enhance the pediatric capabilities of their disaster medical response teams through the integration of pediatric-specific training, guidance, exercises, supplies, and personnel.

- *HHS should develop pediatric capabilities within each National Disaster Medical System (NDMS) region.*
- *HHS should establish a "reserve pool" of pediatric health care workers to assist in NDMS disaster response.*
- *HHS and DoD should establish a Pediatric Health Care Coordinator on each disaster medical response team and develop strategies to recruit and retain team members with pediatric medical expertise.*

The National Disaster Medical System (NDMS) is the Federal Government's primary system to augment disaster medical care in response to major emergencies and disasters. NDMS has three components: 1) medical response to a disaster area by trained and credentialed individuals, supplies, and equipment that compose teams, including Disaster Medical Assistance Teams (DMATs);¹¹⁵ 2) patient movement from a disaster site to participating health care facilities; and 3) definitive medical care at participating hospitals.¹¹⁶ NDMS has responded to domestic and international emergencies and disasters, including Hurricane Katrina and the 2010 earthquake in Haiti.

113 National Commission on Children and Disasters, *Interim Report*, 16.

114 U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response, *The Public Health Emergency Medical Countermeasures Enterprise Review: Transforming the Enterprise to Meet Long-Range National Needs*, 16.

115 DMAT is "a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event." Office of the Assistant Secretary for Preparedness and Response, "Disaster Medical Assistance Team (DMAT)," <http://www.phe.gov/Preparedness/responders/ndms/teams/Pages/dmat.aspx>.

116 Office of the Assistant Secretary for Preparedness and Response, "National Disaster Medical System," <http://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx>.

As highlighted in the Commission's Interim Report, NDMS' pediatric capabilities are limited, even though children constitute a substantial percentage of DMAT patients.¹¹⁷ For example, only two of the 53 DMATs are Pediatric Specialty Teams¹¹⁸ and less than 6 percent of NDMS clinical practitioners have subspecialty training in pediatrics.¹¹⁹ Findings from the Commission's April 2010 field visit to Florida to examine the domestic impact from the Federal response to the Haiti earthquake highlighted the need to supplement DMATs with pediatric specialty health care providers, expand NDMS' hospital network to include more pediatric health care facilities, and improve Federal capability to transport pediatric patients.¹²⁰

In its Interim Report, the Commission made specific recommendations for improving NDMS' pediatric capabilities, including: adding core competencies on treatment and care of children to NDMS national credentialing standards; providing pediatric education and training to all DMAT members; equipping DMATs with appropriate pediatric supplies and equipment prior to deployments; establishing protocols for delivering care; and developing new pediatric "strike teams" for responding to disasters in which large numbers of children are injured.¹²¹

In response to the Interim Report recommendations, NDMS hired a Deputy Chief Medical Officer for Pediatric Care. Also, ASPR plans to address the recommendations by: 1) developing a reserve pool of qualified professionals who have the credentials and competence to provide a service, but cannot commit to "full-time" NDMS membership¹²²; 2) initiating a cache development program to define a cache standard for pediatrics; and 3) developing objectives and guidelines for a standard pediatric training curriculum for NDMS response teams.¹²³ The Commission recommends HHS develop a detailed plan for accomplishing these objectives.

117 Katherine A. Gnauck, Kevin E. Nufer, Jonathon M. LaValley, Cameron S. Crandall, Frances W. Craig, and Gina B. Wilson-Ramirez, "Do Pediatric and Adult Disaster Victims Differ? A Descriptive Analysis of Clinical Encounters from Four Natural Disaster DMAT Deployments," *Prehospital and Disaster Medicine* 22, no. 1 (2007): 67, http://pdm.medicine.wisc.edu/Volume_22/issue_1/nufer.pdf.

118 PSTs are specialty DMATs, composed of "individuals specifically trained in the care of children and pediatric-specific equipment, supplies, and pharmaceuticals." Debra Weiner, Shannon Manzi, Mark Waltzman, Michele Morin, Anne Meginniss, and Gary Fleisher, "FEMA's Organized Response with a Pediatric Subspecialty Team: The National Disaster Medical System Response: A Pediatric Perspective," *Pediatrics* 117, no.5 (2006): S406, <http://pediatrics.aappublications.org/cgi/reprint/117/5/S2/S405>.

119 Nicole Lurie, Testimony of Nicole Lurie before the U.S. Senate, Committee on Homeland Security and Governmental Affairs, Ad Hoc Subcommittee on Disaster Recovery, "Children and Disasters: The Role of HHS in Evacuation Planning and Mental Health Recovery," Washington, DC, August 4, 2009, http://hsgac.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=aa8241f6-6f0e-41a5-87c3-07c9a58ecbfa.

120 National Commission on Children and Disasters, "Summary Report: Field Visit, Miami, Florida," (Washington, DC: NCCD, 2010), 2, http://www.childrenanddisasters.acf.hhs.gov/Summary_FLFieldVisit_FINAL.pdf.

121 National Commission on Children and Disasters, *Interim Report*, 18-19.

122 NDMS uses individuals with specific expertise in medical or public health services, emergency management, forensic sciences, and other related fields. These individuals must meet prerequisite training requirements applicable to their positions before being eligible to participate on an NDMS team and be available for interstate deployment. If accepted, individuals become intermittent Federal employees, compensated when deployed on an NDMS mission. Office of the Assistant Secretary for Preparedness and Response, "Recruitment Information: National Disaster Medical System," <http://www.phe.gov/Preparedness/responders/ndms/teams/Pages/recruitment.aspx>.

123 U.S. Department of Health and Human Services, Memorandum to the National Commission on Children and Disasters: *Response to the National Commission on Children and Disasters Interim Report*, 27-28.

The Commission recommends that NDMS form a pre-credentialed reserve pool of pediatric professionals to supplement DMATs. DMATs often do not have members with expertise in key pediatric specialties, such as individuals who provide surgical, intensive care, nursing, or neonatology services. Difficulty in recruiting pediatric health care providers to DMATs is often due to the significant time commitment for travel, training, and exercises. As an alternative to recruiting pediatric specialists as full-time DMAT members, a reserve pool of pediatric specialists could provide individuals to supplement a DMAT if there is a high demand during an emergency for their particular expertise. For example, many health care workers—including more than 1,200 pediatricians and children’s hospital personnel¹²⁴—spontaneously volunteered to work in Haiti after the 2010 earthquake. Despite their good intentions, many of these professionals could not participate because they had not been previously trained and credentialed by emergency response organizations. NDMS would identify reserve pool members before a disaster to ensure they receive proper credentials, liability coverage, and basic disaster training. NDMS is working with pediatric organizations such as the National Association of Children’s Hospitals and Related Institutions and the American Academy of Pediatrics to encourage membership in DMATs and reserve pools. The NDMS should assess the current state of its network and work with stakeholder groups to further expand participation by pediatric centers. This would serve to increase the available bed capacity—and particularly critical care beds—and awareness and management of that limited resource.

The Commission also recommended that a Pediatric Health Care Coordinator be designated on each federally funded medical response team,¹²⁵ with responsibility for developing strategies for enhancing pediatric medical expertise within the team. In response, the U.S. Public Health Service’s Office of Force Readiness and Deployment (OFRD), which oversees U.S. Commission Corps teams¹²⁶ that deploy in response to public health emergencies, established Pediatric Health Care Coordinators.¹²⁷ OFRD also committed to evaluating the feasibility of expanding its Readiness and Response Program to include rostered Pediatric Strike Teams within existing resources and funding. However, OFRD noted that funding is not provided in the Fiscal Year (FY) 2011 budget request for OFRD pediatric teams or pediatric-specific field training or exercises. The Commission recommends that Congress appropriate funds to support these activities and that HHS include funds in the FY 2012 budget request. Furthermore, the Commission urges HHS and other Federal agencies, particularly the Department of Defense (DoD), to establish and appropriately resource Pediatric Health Care Coordinators on their medical response teams.

124 National Commission on Children and Disasters, personal communication with the American Academy of Pediatrics, July 15, 2010.

125 Federally funded medical response teams include DMATs, Public Health Service Commissioned Corps teams, DoD teams, and Medical Reserve Corps teams.

126 OFRD’s teams include Rapid Deployment Force Teams and Mental Health Teams, as well as recently developed Services Access Teams, which are specifically designed to assist those affected by a disaster, including children and youth, by connecting them with local service providers. United States Public Health Service, “Office of Force Readiness and Deployment,” <http://ccrf.hhs.gov/ccrf/>.

127 U.S. Department of Health and Human Services, Memorandum to the National Commission on Children and Disasters: *Response to the National Commission on Children and Disasters Interim Report*, 27.

Recommendation 3.3: HHS should ensure that health professionals who may treat children during a disaster have adequate pediatric disaster clinical training.

- *The President should direct the Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response (FETIG) to prioritize the development of pediatric core competencies, core curricula, training, and research.*
- *The FETIG should support the formation of a Pediatric Disaster Clinical Education and Training Working Group to establish core clinical competencies and a standard, modular pediatric disaster health care education and training curriculum.*

Health professionals, whether responding to a disaster scene or treating survivors in a hospital, must have appropriate training to provide needed medical care to children. Children are a significant portion of the population and are as likely as adults, if not more likely, to sustain serious injuries during disasters. In 2009 and 2010, Federal disaster response teams were deployed to disaster sites in American Samoa and Haiti, where children constitute approximately 40 percent of the population. In Haiti, children sustained serious crushing injuries, in many cases requiring amputations.¹²⁸

Emergency managers and health professionals should plan and train for an anticipated number of pediatric survivors requiring medical care after a disaster based on the demographics of their community. Pediatric training provided to emergency medical responders varies in content and quality primarily due to the absence of national standards for pediatric disaster education and training.¹²⁹ As noted previously, few DMAT members have formal subspecialty training in pediatrics.¹³⁰ Also, the National Guard Bureau staff reported that there is very limited pediatric training for emergency responders who are not already pediatric specialists.¹³¹

128 Daniel Green, "Public Comment at the National Commission on Children and Disasters Public Meeting, February 2, 2010," 4-6, http://www.childrenanddisasters.acf.hhs.gov/20100202_PublicComment_DGreen.pdf.

129 Elizabeth Ablah, Annie M. Tinius, and Kurt Konda, "Pediatric Emergency Preparedness Training: Are We on a Path toward National Dissemination?," *The Journal of Trauma* 67, no. 2 (2009): S156.

130 While 68 percent of the clinical practitioners comprising DMATs have pediatric-specific training, only 5.6 percent have formal subspecialty training in pediatrics (e.g., pediatricians, pediatric nurse practitioners, pediatric emergency medicine, and pediatric critical care), and 47 percent have formal training specific to pregnant women. "Pediatric-specific training" refers to boarded or licensed providers who have received formalized training in pediatric care as well as training for other age groups (e.g., Emergency Medicine and Family Medicine). "Subspecialty training in pediatrics" refers to physicians and nurse practitioners who have received formalized training limited to pediatrics. Allen Dobbs, Chief Medical Officer, NDMS, personal communication to Christopher Revere, August 19, 2009.

131 MAJ Julie Carpenter, Medical Operations Officer, National Guard Bureau, personal communication to Commissioner Michael Anderson, July 23, 2010.

The Commission recommends that the President direct the Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response (FETIG)¹³² to address these deficiencies. As part of this effort, the Commission recommends that FETIG, working through the National Center for Disaster Medicine and Public Health (NCDMPH), should prioritize the development of pediatric core competencies, core curricula, training, and research in the NCDMPH's work plan. The Commission recommends that all Federal agencies represented on the FETIG, particularly HHS as the coordinating agency for Emergency Support Function (ESF) #8,¹³³ provide the resources necessary to support the mission and continuation of the FETIG.

To complete this work, the FETIG should support the formation of a Pediatric Disaster Clinical Education and Training Working Group with appropriate pediatric subject matter experts to complete this work. The Commission's Interim Report recommended forming this working group to: establish detailed core competencies and skill sets for different types of responders and health care professionals; develop a national training curriculum based on those core competencies; review existing training materials; provide guidance on how to incorporate children into exercises and drills; and build continuing education requirements into licensing and re-certification processes.¹³⁴

The importance of training is reflected in the HHS 2009 National Health Security Strategy (NHSS), which outlines actions for ensuring the Nation's health in the event of a major disaster or incident. One of NHSS' 10 strategic objectives is to "develop and maintain the workforce needed for national health security."¹³⁵ The lack of training and certification standards is noted as one obstacle to achieving this objective.¹³⁶ A companion NHSS Implementation Guide outlines specific activities to be accomplished in 2010, including prioritizing areas of investment and developing workforce competencies.¹³⁷ The Commission recommends that HHS explicitly address the needs of children in its efforts to expand workforce training and development.

132 FETIG is an advisory group with representatives from Federal agencies, academia, and the private sector that coordinates public health, medical disaster preparedness, and response core curricula, training standards, and education for use by Federal agencies and non-governmental organizations. Office of the Assistant Secretary for Preparedness and Response, *Charter for the Federal Education and Training Interagency Group*, (Washington, DC: HHS, March 13, 2008), 1-3.

133 ESF #8, Public Health and Medical Services, coordinates all Federal assistance in support of State, local, tribal, and regional response to public health and medical disasters, incidents requiring a coordinated Federal public health or medical response, and developing public health or medical emergencies. U.S. Department of Homeland Security, Federal Emergency Management Agency, "National Response Framework, Emergency Support Function #8 – Public Health and Medical Services Annex," <http://www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf>.

134 National Commission on Children and Disasters, *Interim Report*, 19-20.

135 U.S. Department of Health and Human Services, *National Health Security Strategy of the United States of America*, (Washington, DC: HHS, 2009), 8, <http://www.phe.gov/Preparedness/planning/authority/nhss/strategy/Documents/nhss-final.pdf>.

136 *Ibid.*, 9.

137 U.S. Department of Health and Human Services, *Interim Implementation Guide for the National Health Security Strategy of the United States of America*, (Washington, DC: HHS, 2009), 4, <http://www.phe.gov/Preparedness/planning/authority/nhss/implementationguide/Documents/iig-final.pdf>.

Recommendation 3.4: The Executive Branch and Congress should provide resources for a formal regionalized pediatric system of care to support pediatric surge capacity during and after disasters.

- *HHS should include pediatric surge capacity as a “Required Funding Capability” in the Hospital Preparedness Program.*
- *States and hospital accrediting bodies should ensure all hospital emergency departments stand ready to care for ill or injured children through the adoption of emergency preparedness guidelines jointly developed by the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association.*¹³⁸

A mass casualty event or major public health emergency involving children will rapidly overwhelm local health care response capabilities. Communities must develop pediatric medical surge plans that focus on incorporating and sharing local, regional, State, and Federal resources. Regionalization of emergency care was one of the key recommendations of the 2006 Institute of Medicine (IOM)’s Committee on the Future of Emergency Care.¹³⁹ Formal regionalized pediatric systems have been associated with improvements in daily patient outcomes as well as medical surge capacity during disaster response and long-term recovery.^{140,141}

In September 2009, Federal, State, and local policymakers and stakeholders assessed progress made since the IOM’s 2006 report during a two-day workshop on regionalizing emergency care sponsored by the Emergency Care Coordination Center.¹⁴² Representatives from key Federal agencies offered comments on opportunities and challenges going forward, including the need for: data-driven approaches to measuring effectiveness and designing systems; a Congressional action plan for advancing regionalization; the establishment of roles, responsibilities, and priorities of a lead Federal agency; and consistency across all regional emergency medical services (EMS) systems.

138 American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association, “Joint Policy Statement: Guidelines for Care in the Emergency Department,” *Pediatrics* 124, no. 4 (2009): 1233-43, <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/4/1233.pdf>.

139 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Emergency Care for Children: Growing Pains. Executive Summary*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2007), 4, http://www.nap.edu/nap-cgi/report.cgi?record_id=11655&type=pdfxsum.

140 Monica E. Kleinman, “Regionalization of Critical Care: Not Just for Kids,” *Critical Care Medicine* 37, no. 7 (2009): 2149-2154.

141 Murray Pollack, Steven Alexander, Nancy Clarke, Urs Ruttiman, Helen Tesselaar, and Antoinet Bachulis, “Improved Outcomes from Tertiary Center Pediatric Intensive Care: A Statewide Comparison of Tertiary and Non-tertiary Care Facilities,” *Critical Care Medicine* 19, no. 2 (1991): 150-159.

142 ASPR’s ECCC was established to promote and support Federal programs that will enhance emergency care and its delivery systems; to advance regional partnerships; and to support State, local, and regional preparedness and response capability. Office of the Assistant Secretary for Preparedness and Response, “ECCC Frequently Asked Questions,” <http://www.phe.gov/Preparedness/planning/eccc/Pages/faqs.aspx>.

In light of the ongoing challenges, the Commission recommends that the Executive Branch and Congress invest greater resources to assist health care systems in regionalization, compliance with the national emergency care guidelines for children, and development of pediatric medical surge capacity for disasters. The 2009 American Recovery and Reinvestment Act¹⁴³ allocated funds for comparative effectiveness research, providing an opportunity to bolster research on regionalized systems of pediatric care. Additional funding for demonstration projects on regionalization was authorized in the 2010 Patient Protection and Affordable Care Act.¹⁴⁴ The scope of this authorization includes at least four projects that will design, implement, and evaluate innovative regional emergency medical care systems. An explicit requirement is that all grantees address “pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children, and adolescents.”¹⁴⁵ Given the potential of these projects to advance regional systems of care for children, the Commission recommends that Congress appropriate funds for this initiative.

While regional pediatric systems of care rely on the participation of the Nation’s 250 children’s hospitals,¹⁴⁶ other hospitals also must be prepared to provide appropriate care for children. As noted in the Commission’s Interim Report, up to 50 percent of disaster survivors will be “walk-ins,” arriving at hospital emergency departments through means other than EMS.¹⁴⁷ However, most hospitals are not adequately prepared to treat critically ill children. Only 6 percent of hospital emergency departments have inventories of pediatric equipment and supplies that meet national guidelines.¹⁴⁸

To support hospital preparedness regionalization efforts, the Commission recommends that the HHS Hospital Preparedness Program (HPP) include pediatric surge capacity as a “Required Funding Capability.”¹⁴⁹ Furthermore, to increase awareness of funding eligibility for pediatric initiatives, children should be specifically referenced throughout future HPP grant guidance, rather than grouped within a subset of “at-risk populations.” HPP should highlight and share pediatric funded activities and best practices with hospitals and eligible health care systems. HHS reported that several States used program funding to develop pediatric specific initiatives including regionalized pediatric response, evacuation plans, improved risk communications, improved training, pediatric stockpiles, and pediatric strike teams.¹⁵⁰

143 P.L. 111-5 (2009).

144 P.L. 111-148 (2010).

145 P.L. 111-148, Sec. 1204.

146 National Association of Children’s Hospitals and Related Institutions (NACHRI), “History of Children’s Hospitals,”

<http://www.childrenshospitals.net/AM/Template.cfm?Section=+History+of+Children%E2%80%99s+Hospitals&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=12693>.

147 Agency for Healthcare Research and Quality, “Preparation by General Health Care Facilities for a Surge of Critically Ill Children,” U.S. Department of Health and Human Services, <http://www.ahrq.gov/prep/pedhospital/pedhospital6.htm>.

148 American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association, “Joint Policy Statement: Guidelines for Care in the Emergency Department,” 1234.

149 Office of the Assistant Secretary for Preparedness and Response, “Hospital Preparedness Program,” <http://www.phe.gov/preparedness/planning/hpp/pages/default.aspx>.

150 U.S. Department of Health and Human Services, Memorandum to the National Commission on Children and Disasters: Response to the National Commission on Children and Disasters Interim Report, March 18, 2010, 8, Washington, DC.

Notwithstanding the need for greater Federal support, State health care licensing bodies and the Joint Commission on Accreditation of Healthcare Organizations must be the primary drivers in promoting health care system regionalization and adoption of standards and emergency preparedness recommendations.¹⁵¹

Recommendation 3.5: Prioritize the recovery of pediatric health and mental health care delivery systems in disaster-affected areas.

- *Congress should establish sufficient funding mechanisms to support restoration and continuity of for-profit and non-profit health and mental health services to children.*
- *The Executive Branch should recognize and support pediatric health and mental health care delivery systems as a planning imperative in the development and implementation of the National Health Security Strategy and National Disaster Recovery Framework.*
- *HHS should create Medicaid and Children’s Health Insurance Program incentive payments for providers in disaster areas.*
- *The American Medical Association should adopt a new code or code modifier to the Current Procedural Terminology to reflect disaster medical care in order to facilitate tracking of these services and as a means for enhanced reimbursement from public and private payers.*

Health and mental health care providers face significant challenges in restoring their operations in a timely manner post-disaster, which hinders the consistent provision of care to children and families during disaster recovery. Therefore, Federal, State, and local disaster recovery planning must consider existing resource gaps for the recovery of health and mental health care practices after disasters. The Robert T. Stafford Disaster Relief and Emergency Assistance Act (“Stafford Act”)¹⁵² provides funds for repairs to public or nonprofit medical facilities. However, approximately 85 percent of pediatric treatment in the United States occurs in privately-owned medical practices.¹⁵³ Although the Small Business Administration makes loans to support rebuilding and provide operating capital for private, for-profit businesses, many practices affected by major disasters may lack the means to qualify for or repay such loans since health care practices often experience a decline in patients and variations in health insurance reimbursements. After Hurricanes Katrina and Rita, it took nearly two years for many physicians in the New Orleans area to treat a volume of patients sufficient to sustain their practices.¹⁵⁴

151 The Joint Commission, “About the Joint Commission,” <http://www.jointcommission.org/AboutUs/>.

152 P.L. 93-288, as amended, 42 U.S.C. 5121-5207 (1988).

153 Suk-fong Tank, *Profile of Pediatric Visits*, ed. American Academy of Pediatrics (Elk Grove, IL: AAP, 2007), 2, <http://practice.aap.org/public/ProfileOfPediatricVisits.pdf>.

154 Gary Peck, Testimony of Gary Peck before the U.S. Senate, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, “Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns,” Washington, DC, August 1, 2007, 4, <http://www.aap.org/advocacy/washing/Testimonies-Statements-Petitions/08-01-07-NOLA-Providers-Testimony.pdf>.

The Commission recommends that Congress establish sufficient funding mechanisms to support restoration and continuity of for-profit and nonprofit health and mental health services to children following a disaster. The National Health Security Strategy recognizes the importance of restoring access to health services following a disaster. The Strategy states that pre-event planning is fundamental to resuming service delivery in areas affected by a disaster. Such planning should address: behavioral health services for both the affected community and responders; the provision of medical services throughout the recovery period; and the rebuilding and restoration of health care delivery mechanisms, including the health care infrastructure.¹⁵⁵

In the Interim Report, the Commission recommended the development of a National Disaster Recovery Strategy which, among several provisions, would include:

- Continuous access to the full spectrum of pediatric medical services, including a medical home,¹⁵⁶ pediatric specialty services, and children’s hospitals;
- Federal disaster assistance grants for all medical facilities damaged or destroyed by a disaster, such as primary medical, dental, and mental health care practices and clinics; and
- Access to appropriate crisis, bereavement, and mental health services.¹⁵⁷

In addition, the Commission recommends that the National Health Security Strategy and the National Disaster Recovery Framework and Recovery Support Functions prioritize and support the continuity and restoration of health and mental health practices in jurisdictions affected by disasters. In addition, Federal, State, and local recovery planning must involve primary and mental health care providers at the community level.

The Commission further recommends that the Centers for Medicare & Medicaid Services create Medicaid and Children’s Health Insurance Program (CHIP) incentive payments for providers in areas impacted by disasters. Following Hurricane Katrina, the Federal Government provided a 10 percent increase in Medicare reimbursements to physicians in New Orleans after designating Orleans Parish a health professional shortage area.¹⁵⁸ However, pediatricians did not benefit from this assistance since eligible children are insured under Medicaid, not Medicare.¹⁵⁹

155 U.S. Department of Health and Human Services, *National Health Security Strategy of the United States of America*, 15.

156 A “medical home” is defined as a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Stephen E. Edwards, “Foreword,” *Pediatrics: Supplement: The Medical Home* 113, no. 5 (2004): 1471.

157 National Commission on Children and Disasters, *Interim Report*, 6.

158 Louisiana Department of Health and Hospitals, “News Release: Orleans Parish Declared as Health Professional Shortage Area,” <http://www.dhh.louisiana.gov/news.asp?ID=1&Detail=857&Arch=2006#>.

159 Gary Peck, “Post-Katrina Health Care in the New Orleans Region: Progress and Continuing Concerns,” 6.

Finally, the Commission recommends the creation of a unique code or code modifier to the Current Procedural Terminology (CPT)¹⁶⁰ to report professional services provided in a declared disaster area to public and private health insurance providers. This would allow the appropriate documentation and tracking of such services in the aftermath of a disaster. Insurers may also choose to compensate health care providers with higher insurance reimbursement for services provided to disaster-affected individuals. The Commission is currently collaborating with the American Academy of Pediatrics to propose a new CPT code for “disaster-related care” to the American Medical Association’s CPT Editorial Panel in 2010.¹⁶¹

Recommendation 3.6: EPA should engage State and local health officials and non-governmental experts to develop and promote national guidance and best practices on re-occupancy of homes, schools, child care, and other child congregate care facilities in disaster-impacted areas.

- *EPA and HHS should expand research on pediatric environmental health risks associated with disasters.*

Children may suffer serious health and wellness consequences after disasters due to environmental exposure to and inhalation of particulate matter containing asbestos, lead, cement dust, and mold.¹⁶² Following 9/11, 52.8 percent of 3,184 children enrolled in the World Trade Center Health Registry displayed a new or worsened respiratory symptom and 5.7 percent received a new diagnosis of asthma.¹⁶³ More recently, a report by the National Center for Disaster Preparedness on the impact of the 2010 Gulf of Mexico oil spill disaster on children and families estimated that over 40 percent of the population living within 10 miles of the coast had experienced some direct exposure to the oil spill, and that households with children were 1.4 times more likely to report oil spill exposure than households without children.¹⁶⁴

160 CPT is “the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.” CPT® is registered trademark of the American Medical Association. American Medical Association, “About CPT,” <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.shtml>.

161 CPT is “maintained by the CPT Editorial Panel, which meets three times a year to discuss issues associated with new and emerging technologies as well as difficulties encountered with procedures and services and their relation to CPT codes.” Ibid.

162 Philip Landrigan, Paul Liroy, George Thurston, Gertrud Berkowitz, L.C. Chen, Steven Chillrud, Stephen Gavett, Panos Georgopoulos, Alison Geyh, Stephen Levin, Frederica Perera, Stephen Rappaport, Christopher Small, and the NIEHS World Trade Center Working Group, “Health and Environmental Consequences of the World Trade Center Disaster,” *Environmental Health Perspectives* 112, no. 6 (2004): 738, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1241968/pdf/ehp0112-000731.pdf>.

163 Pauline Thomas, Robert Brackbill, Lisa Thalji, Laura DiGrande, Sharon Campolucci, Lorna Thorpe, and Kelly Henning, “Respiratory and Other Health Effects Reported in Children Exposed to the World Trade Center Disaster of 11 September 2001,” *Environmental Health Perspectives* 116, no. 10 (2008): 1386, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569099/pdf/ehp-116-1383.pdf>.

164 David Abramson, Irwin Redlener, Tasha Stehling-Ariza, Jonathan Sury, Akilah Banister, and Yoon Soo Park, *Impact on Children and Families of the Deepwater Horizon Oil Spill: Preliminary Findings of the Coastal Population Impact Study*, Research Brief 2010-8, ed. National Center for Disaster Preparedness, Columbia University Mailman School of Public Health (New York, NY, August 3, 2010), 4, 7, http://www.ncdp.mailman.columbia.edu/files/NCDP_Oil_Impact_Report.pdf.

The Commission recommends that the Environmental Protection Agency (EPA), in collaboration with its network of Pediatric Environmental Health Specialty Units (PEHSU)¹⁶⁵ and other pediatric experts, develop national guidance and best practices for families, caregivers, health care providers, and responsible parties to determine when it is safe for children to re-enter or re-occupy a home, school, child care facility, or other facility affected by a disaster. EPA should partner with HHS and other Federal agencies to expand existing guidance with information specific to children, including *Planning Guidance for Protection and Recovery Following Radiological Dispersal Device (RDD) and Improvised Nuclear Device (IND) Incidents*,¹⁶⁶ *Draft Planning Guidance for Recovery Following Biological Incidents*,¹⁶⁷ and The White House Office of Science and Technology Policy's draft *Clean-up Decision-Making Guidance for Chemical Incidents*, which is under development by an interagency working group.

The Commission also recommends additional research to expand the evidence base on environmental health risks to children associated with disasters. In 1997, EPA and HHS partnered with other Federal agencies to establish the President's Task Force on Environmental Health Risks and Safety Risks to Children.¹⁶⁸ Among the Task Force's accomplishments were the development of the National Children's Study, the Federal Strategy Targeting Lead Paint Hazards, and the Healthy School Environments Assessment Tool to examine environmental threats to children's health.¹⁶⁹ The authority for the Task Force expired in 2005, and efforts are underway to reestablish the Task Force in 2010. The Commission recommends that the Task Force prioritize research efforts on environmental health risks of children associated with disasters.¹⁷⁰

165 PEHSUs are a network of pediatric environmental health specialists who provide information and outreach concerning protection of children's health from environmental hazards. PEHSUs conduct academic research, partner with local medical practices, and provide free clinical consultations of environmental exposures. Jerome Paulson, Catherine Karr, James Seltzer, Debra Cherry, Perry Sheffield, Enrique Cifuentes, Irena Buka, and Robert Amler, "Development of the Pediatric Environmental Health Specialty Unit Network in North America," *American Journal of Pediatric Health* 99, no. S3 (2009): S511-512, <http://ajph.aphapublications.org/cgi/reprint/99/S3/S511>.

166 Federal Emergency Management Agency, "Planning Guidance for Protection and Recovery Following Radiological Dispersal Device (RDD) and Improvised Nuclear Device (IND) Incidents," *Federal Register* 73, no. 149 (2008): 45032, http://www.fema.gov/good_guidance/download/10260.

167 U.S. Department of Homeland Security and U.S. Environmental Protection Agency, *Draft – Planning Guidance for Recovery Following Biological Incidents*, (Washington, DC: DHS, 2009), 1, <http://www.trivalleycares.org/comments/DHSDraftGuidance.pdf>.

168 Peter Grevatt, Testimony of Peter Grevatt before the U.S. Senate, Committee on Environment and Public Works, Washington, DC, March 17, 2010, 4, http://epw.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=1e09573e-707b-4e69-95cb-f4d80898b9c3.

169 U.S. Government Accountability Office, *Environmental Health: High-Level Strategy and Leadership Needed to Continue Progress toward Protecting Children from Environmental Threats*, GAO 10-205, (Washington, DC: GAO, 2010), 41-42, <http://www.gao.gov/new.items/d10205.pdf>.

170 National Commission on Children and Disasters, "Meeting Minutes of the Pediatric Medical Care Subcommittee," (Washington, DC: NCCD, March 22, 2010), 2, http://www.childrenanddisasters.acf.hhs.gov/NCCD%20Subcommittees/20100323_PMCSubcommitteeReport.pdf.

4. Emergency Medical Services and Pediatric Transport

Recommendation 4.1: The President and Congress should clearly designate and appropriately resource a lead Federal agency for emergency medical services (EMS) with primary responsibility for the coordination of grant programs, research, policy, and standards development and implementation.

Recommendation 4.2: Improve the capability of emergency medical services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.

Recommendation 4.3: HHS should develop a national strategy to improve Federal pediatric emergency transport and patient care capabilities for disasters.

4. Emergency Medical Services and Pediatric Transport

Recommendation 4.1: The President and Congress should clearly designate and appropriately resource a lead Federal agency for emergency medical services (EMS)¹⁷¹ with primary responsibility for the coordination of grant programs, research, policy, and standards development and implementation.

- *Establish a dedicated Federal grant program under a designated lead Federal agency for pre-hospital EMS disaster preparedness, including pediatric equipment and training.*

As stated in the National Health Security Strategy, emergency medical services (EMS) is an integral part of our Nation's emergency services system, alongside police, fire, and emergency management.¹⁷² Numerous Federal programs and entities provide some form of support or policy-making for EMS. These entities include the Federal Interagency Committee on Emergency Medical Services (FICEMS);¹⁷³ the National Highway Traffic Safety Administration's Office of EMS¹⁷⁴ and National EMS Advisory Council;¹⁷⁵ the Health Resources and Services Administration's (HRSA) Emergency Medical Services for Children (EMSC) program;¹⁷⁶ and the Department of Health and Human Services' (HHS) Assistant Secretary for Preparedness and Response's Emergency Care Coordination Center,¹⁷⁷ among others. FICEMS was primarily established to ensure coordination among the Federal agencies and entities involved with State, local, tribal, or regional emergency medical services and 9-1-1 systems.¹⁷⁸ However, FICEMS does not have program management and budgetary authority to provide disaster preparedness grants to EMS providers and ensure accountability for meeting National performance measures.

171 EMS is a system of public and private agencies and organizations providing treatment and transportation of patients to available emergency medical care.

172 U.S. Department of Health and Human Services, *National Health Security Strategy of the United States of America*, (Washington, DC: HHS, December 2009), 1, <http://www.phe.gov/Preparedness/planning/authority/nhss/strategy/Documents/nhss-final.pdf>.

173 FICEMS was established in 2005 to: ensure coordination among Federal agencies; identify the needs of State, local, tribal, and regional EMS systems; recommend programs, including grant programs; help establish priorities; and advise and make recommendations regarding the implementation of State EMS programs. Public Law (P.L.) 109-59, 119 Stat. 1933, (2005), <http://ems.gov/pdf/ficems-bill.pdf>.

174 The Office of EMS provides support to FICEMS in coordination with HHS and the Department of Homeland Security (DHS) and manages the EMS.gov Web site. National Highway Traffic Safety Administration, "The History of EMS at NHTSA," <http://www.ems.gov/other/history.html>.

175 The National EMS Advisory Council was established in April 2007 "as a nationally recognized council of EMS representatives and consumers to provide advice and recommendations regarding EMS to NHTSA." National Highway Traffic Safety Administration, "NEMSAC," <http://www.ems.gov/nemsac/index.html>.

176 Emergency Medical Services for Children National Resource Center, "EMSC: An Historical Perspective," Children's National Medical Center, http://www.childrensnational.org/files/PDF/EMSC/EMSC_An_Historical_Perspective.pdf.

177 ECCCC was established to promote and support Federal programs that enhance emergency care and its delivery systems. Office of the Assistant Secretary for Preparedness and Response, "Emergency Care Coordination Center," <http://www.phe.gov/Preparedness/planning/eccc/Pages/default.aspx>.

178 P.L. 109-59, 119 Stat. 1933 (2005).

In 2006, the Institute of Medicine (IOM) reported that “[t]he scattered nature of Federal responsibility for emergency care makes it difficult for the public to identify a clear point of contact, limits the visibility necessary to secure and maintain funding, and creates overlaps and gaps in program funding.”¹⁷⁹ Accordingly, IOM recommended that Congress establish a lead agency that has “primary programmatic responsibility for the full continuum of emergency medical services and emergency and trauma care for adults and children,” including pre-hospital care and medical-related disaster preparedness.¹⁸⁰ The Commission finds that Federal agency leadership and oversight for pre-hospital EMS is still unclear and supports IOM’s recommendation that Congress clearly designate and appropriately resource a lead Federal agency for EMS.

The Commission also recommends that Congress establish a dedicated Federal grant program to improve EMS disaster preparedness and response. The National EMS Advisory Council released a position statement in June 2009 stating: “Providing core funding specifically for EMS, regardless of delivery model, to ensure surge capacity and response to public health emergencies and natural or man-made disasters is an essential public interest.”¹⁸¹ Unlike other first responder entities, including emergency management agencies, law enforcement, fire departments, public health departments and hospitals, the majority of EMS systems in the Nation do not receive Federal grant support for disaster preparedness and response.¹⁸² In addition, the American Recovery and Reinvestment Act of 2009¹⁸³ did not authorize funds for EMS organizations. Grants are necessary to support State-level coordination and disaster planning, field-level staffing, pediatric supply and equipment needs, pediatric-specific training and exercises, and, in general, the expansion of pediatric surge capacity for disasters. A lead Federal agency is also necessary to ensure existing emergency preparedness grant programs establish pediatric EMS performance measures.

179 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Emergency Care for Children: Growing Pains*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2007), 6-7, http://books.nap.edu/catalog.php?record_id=11655.

180 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Hospital-Based Emergency Care: At the Breaking Point*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2007), 368, http://www.nap.edu/openbook.php?record_id=11621.

181 National EMS Advisory Council, Position Statement adopted June 3, 2009, http://www.ems.gov/pdf/NEMSAC_PositionStatement_HealthcareReform.pdf.

182 National Association of State Emergency Medical Services Officials, *State EMS Office Involvement in Domestic Preparedness Efforts: NASEMSO 2008 Addendum*, (Falls Church, VA: NASEMSO, 2008), 5, <http://www.nasemso.org/Projects/DomesticPreparedness/documents/08DPAddendumReport-2.pdf>.

183 P.L.111-5 (2009).

Recommendation 4.2: Improve the capability of emergency medical services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.

- *Congress should provide full funding to the Emergency Medical Services for Children (EMSC) program to ensure all States and territories meet targets and achieve progress in the EMSC performance measures for grantees, and to support development of a research portfolio.*
- *As an eligibility guideline for Centers for Medicare & Medicaid Services reimbursement, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for Basic Life Support and Advanced Life Support vehicles.¹⁸⁴*
- *HHS and DHS should establish stronger pediatric EMS performance measures within relevant Federal emergency preparedness grant programs.*
- *HHS should address the findings of the EMSC 2009 Gap Analysis of EMS Related Research.¹⁸⁵*

As noted in the Commission's Interim Report, the IOM reported in 2006 that on a daily basis a great disparity exists across the Nation in the quality of adult and pediatric emergency care, which is exacerbated by disasters.¹⁸⁶ EMS requirements regarding coordination among first responders, equipment standards, and emergency care training vary widely across localities, regions, and States.¹⁸⁷ IOM identified specific challenges to pre-hospital pediatric care including: the lack of essential pediatric equipment on ambulances; gaps in Food and Drug Administration (FDA) approved medical countermeasures for children; a lack of pediatric inter-facility transfer agreements among hospitals; and a lack of pediatric training requirements for pre-hospital emergency medical technicians.¹⁸⁸ A 2009 IOM workshop convened to examine progress in improving emergency care since the previous report found that, despite some new Federal programs and initiatives, many of these gaps still exist.¹⁸⁹

184 American College of Surgeons Committee on Trauma, American College of Emergency Physicians, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee – Emergency Medical Services for Children Partnership for Children Stakeholder Group, and American Academy of Pediatrics, *Equipment for Ambulances*, (Washington, DC: Children's National Medical Center, 2009): 2-5, http://www.childrensnational.org/files/PDF/EMSC/PubRes/Equipment_for_ambulances_FINAL.pdf.

185 Emergency Medical Services for Children National Resource Center, Children's National Medical Center, *Gap Analysis of EMS Related Research: Report to the Federal Interagency Committee on EMS*, (Washington, DC: EMSC, 2009), http://www.childrensnational.org/files/PDF/EMSC/NationalActivities/Gap_Analysis_of_EMS_Related_Research.pdf.

186 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Emergency Care for Children: Growing Pains*, 1-2.

187 *Ibid.*, 6.

188 *Ibid.*, 2.

189 Institute of Medicine, *The National Emergency Care Enterprise: Advancing Care Through Collaboration: Workshop Summary*, (Washington, DC: National Academies Press, 2009), http://books.nap.edu/catalog.php?record_id=12713.

The Interim Report included a recommendation to increase funding for the EMSC program¹⁹⁰ within HHS.¹⁹¹ The Commission concurs with the IOM recommendation that the EMSC be funded at \$37.5 million per year for five years.¹⁹² Additional funds will help States meet the EMSC's pediatric-specific performance measures, including: pediatric equipment on ambulances; interfacility transfer guidelines and agreements to expedite pediatric transfer; pediatric education requirements for pre-hospital providers; and online, offline, or written pediatric medical direction¹⁹³ for pre-hospital providers.^{194,195} These funds can support: the establishment and maintenance of a full-time EMSC administrator in every State and territory; research to build an evidence base for the development of standardized pre-hospital pediatric disaster care practices and protocols; and the evaluation of each State's performance in providing EMS services to children, which provides incentives for progress and public transparency in the use of the funds.

There are other existing mechanisms of Federal support for EMS providers that can be directed to support EMS disaster preparedness. For example, the Centers for Medicare & Medicaid Services (CMS) provides reimbursement for medical services to EMS providers.¹⁹⁶ The Commission recommends that CMS, as a condition for reimbursement, require first responder and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies, in accordance with the national guidelines for equipment for basic life support (BLS) and advanced life support (ALS) vehicles.¹⁹⁷ In 2007, only 16 percent of BLS units and 18 percent of ALS units reported meeting EMSC performance measures for essential pediatric equipment and supplies as outlined in the national guidelines.¹⁹⁸ States and territories, which are responsible for the licensing and regulation of patient transport vehicles, also should require BLS and ALS units to meet the national guidelines.

190 The EMSC Program, administered by HRSA, "provides States grant money to help develop and institutionalize emergency medical services for critically ill and injured children" by enhancing existing EMS systems' pediatric capability. Emergency Medical Services for Children National Resource Center, "EMSC: An Historical Perspective."

191 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 26, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

192 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Emergency Care for Children: Growing Pains*, 14.

193 Medical direction protocols allow a paramedic or Emergency Medical Technician (EMT) to contact a physician from the field via radio or other means to obtain instructions on further care for a patient.

194 Emergency Medical Services for Children National Resource Center, *EMSC Performance Measures: 2009-2010 "Final" Edition*, (Washington, DC: Children's National Medical Center, October 1, 2009), 14-92, http://www.childrensnational.org/files/PDF/EMSC/ForGrantees/PM_Implementation_Manual_V2009.pdf.

195 The full list of EMSC performance measures is available on HRSA's Web site. Emergency Medical Services for Children, "Performance Measures," Health Resources and Services Administration, <http://bolivia.hrsa.gov/emsc/PerformanceMeasures.aspx>.

196 Centers for Medicare & Medicaid Services, "Ambulance Services Center," <https://www.cms.gov/center/ambulance.asp>.

197 American College of Surgeons Committee on Trauma, American College of Emergency Physicians, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee – Emergency Medical Services for Children Partnership for Children Stakeholder Group, and American Academy of Pediatrics, *Equipment for Ambulances*, 2-5.

198 Diana Fendya, Sally Snow, and Tasmeen Singh Weik, "Using System Change as a Method of Performance / Quality Improvement for Emergency and Trauma Care of Severely Injured Children: Pediatric System Performance Improvement," *Journal of Trauma Nursing* 17, no. 1 (2010): 32.

In addition, the Commission recommends that Federal emergency preparedness grant programs establish stronger pediatric EMS performance measures. The Hospital Preparedness Program within the HHS Office of the Assistant Secretary for Preparedness and Response should hold hospital grantees accountable for acquiring recommended pediatric equipment and supplies and establishing interfacility transport guidelines and agreements for children, in alignment with the EMSC's performance measures. According to a 2003 survey, only 6 percent of hospital emergency departments carry essential pediatric equipment¹⁹⁹ and only 14 percent of hospitals have interfacility transport guidelines containing all the subcomponents recommended by EMSC.²⁰⁰ Interfacility agreements and guidelines are necessary to ensure hospitals are prepared to quickly and effectively move patients to appropriate definitive care, which is essential for hospitals that lack the capability to care for pediatric trauma patients.²⁰¹

Also, the Department of Homeland Security (DHS) should establish stronger pediatric EMS accountability measures within the DHS Homeland Security Grant Program (HSGP) in alignment with the EMSC's performance measures. State grantees should adequately support EMS providers and the regionalization of EMS assets to enhance both pediatric and adult medical surge capacity during disasters. As cited in the HSGP FY 2010 guidance, DHS requires State and local grantees to include EMS in all State and urban area homeland security plans.²⁰² The HSGP guidance also suggests that these plans include the needs of infants and children as well as individuals with disabilities.²⁰³ However, the HSGP grants enable States to establish their own priorities and accountability measures for meeting these requirements, and DHS does not promote or monitor the provision of funding to EMS providers.²⁰⁴ State and local emergency management agencies must have stronger requirements and incentives to work closely with State EMSC program coordinators to improve EMS and meet disaster preparedness goals.

Finally, the Commission recommends that HHS provide funds to address the research gaps identified in the EMSC National Resource Center's (NRC) *Gap Analysis of EMS Related Research*.²⁰⁵ The NRC analysis concludes further research in EMS disaster preparedness for both adults and children is needed in the areas of education and training of disaster and EMS personnel; systems efficacy for surge capacity, staffing, and strategies to minimize

199 Marianne Gausche-Hill, Charles Schmitz, and Roger Lewis, "Pediatric Preparedness of US Emergency Departments: A 2003 Survey," *Pediatrics* 120, no. 6 (2007): 1230, <http://pediatrics.aappublications.org/cgi/reprint/120/6/1229>.

200 Diana Fendya, Sally Snow, and Tasmeen Singh Weik, "Using System Change as a Method of Performance / Quality Improvement for Emergency and Trauma Care of Severely Injured Children: Pediatric System Performance Improvement," 32.

201 *Ibid.*, 29.

202 U.S. Department of Homeland Security, *Fiscal Year 2010 Homeland Security Grant Program: Guidance and Application Kit*, (Washington, DC: DHS, 2009), 10, http://www.fema.gov/pdf/government/grant/2010/fy10_hsgp_kit.pdf.

203 *Ibid.*, 10-11.

204 State grantees do not need to provide direct funding to EMS providers if they can "demonstrate that related target capabilities have been met or identify more significant priorities." *Ibid.*, 11.

205 Emergency Medical Services for Children National Resource Center, Children's National Medical Center, *Gap Analysis of EMS Related Research: Report to the Federal Interagency Committee on EMS*.

parent-child separation; and outcomes of patients being treated and released by EMS personnel. The analysis also indicates a need to develop a unique structure of research that is specific for disasters or mass casualty events.²⁰⁶ The Commission agrees with the importance of this finding and recommends a specific emphasis be placed on pediatric needs.

Furthermore, the Commission concurs with the 2006 IOM recommendation that the HHS Secretary examine the gaps and opportunities in emergency and trauma care research to outline the organizational structure, priorities, and funding for future research efforts.²⁰⁷ The Commission recommends that the HHS Secretary provide funds to support an initiative that identifies new strategies for creating research networks, assimilating emergency care researchers into grant review processes, and developing a pediatric clinical research center or institute.²⁰⁸

Recommendation 4.3: HHS should develop a national strategy to improve Federal pediatric emergency transport and patient care capabilities for disasters.

- *Conduct a national review of existing capabilities among relevant government agencies²⁰⁹ and the private sector for emergency medical transport of children.*

When State and local emergency medical response capabilities are overwhelmed, the National Disaster Medical System (NDMS)²¹⁰ and other Federal assets may be deployed to provide medical support upon request. As discussed in Chapter 3, one component of NDMS is patient transport. Specifically, NDMS partners with the Department of Defense's (DoD) U.S. Transportation Command (USTRANSCOM) to coordinate and execute patient evacuation and transport from a disaster site to receiving points for definitive care within the U.S.²¹¹

Although USTRANSCOM is called on to evacuate and transport patients of all ages from disaster sites, DoD reported to the Commission that it has limited ability to provide medical care and transport for children. DoD's deployable teams are primarily trained and equipped to support military forces.²¹² In addition, DoD's capacity for patient transport in general is limited by the availability of medical aircraft and trained aeromedical personnel.²¹³

206 Ibid., 15-16.

207 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Emergency Care for Children: Growing Pains*, 314.

208 Ibid., 314.

209 For example, the Department of Defense, DHS, and the Coast Guard.

210 NDMS was originally designed to support the medical care and transport of military and civilian casualties from a war abroad, but has never been used for this purpose; its mission today includes post-disaster medical support for civilians. Crystal Franco, Eric Toner, Richard Waldhorn, Thomas Inglesby, and Tara O'Toole, "The National Disaster Medical System: Past, Present, and Suggestions for the Future," *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 4, no. 5 (2007): 319, http://www.upmc-biosecurity.org/website/resources/publications/2007_orig-articles/2007_article_pdfs/2007-12-04-natldisastermedsys-tempastpresfut.pdf.

211 Ibid., 322.

212 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals," (Washington, DC: NCCD, May 11, 2010), 7, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

213 Crystal Franco, Eric Toner, Richard Waldhorn, Thomas Inglesby, and Tara O'Toole, "The National Disaster Medical System: Past, Present, and Suggestions for the Future," 322-323.

NDMS and DoD are not the only entities activated to provide support for medical care and patient transport during disasters. The Coast Guard and State National Guard units may also be activated during emergencies for medical response.^{214,215} Also, FEMA manages a National Ambulance Contract to provide ground ambulances, air ambulances, and paratransit vehicles to any location in the country within 24 hours of activation.²¹⁶ In addition, many health care organizations and hospitals have their own private patient transport assets or vendor agreements.²¹⁷

The Commission recommends that HHS, as the coordinator and primary agency in charge of Emergency Support Function (ESF) #8,²¹⁸ develop a national strategy to ensure a baseline capability to provide appropriate emergency care and transport of children during disasters. A national strategy is necessary to improve coordination during large-scale medical evacuation and transportation of children to appropriate definitive care during disaster response.²¹⁹

To inform a national strategy, the Commission recommends that HHS conduct an assessment to determine Federal and non-Federal pediatric medical transport capacities. The assessment would examine local, regional and national pediatric patient transport capabilities, including necessary equipment and training to provide emergency care to children. The assessment should provide a gap analysis that compares the supply of available pediatric-capable assets with demand under all hazards scenarios in different regions of the country. In addition, the review should outline: the organizational structures of medical transport units; the State or regional differences in EMS requirements; the estimated number of EMS units; the resource capacities of EMS teams; and the skill

214 During Hurricane Katrina, the Coast Guard assisted with the evacuation of 9,462 patients and medical personnel from hospitals and nursing homes. Federal Emergency Management Agency, “The First Year After Hurricane Katrina: What the Federal Government Did,” http://www.dhs.gov/xfoia/archives/gc_1157649340100.shtm.

215 Senate Committee on Homeland Security and Governmental Affairs, *Hurricane Katrina: A Nation Still Unprepared*, S. Rpt. 109-322, (Washington, DC: GPO, 2006), 414, <http://www.gpoaccess.gov/serialset/creports/katrinanation.html>.

216 U.S. Department of Transportation, “FEMA Awards EMSC/AMR Disaster Response Contract,” <http://www.dotcr.ost.dot.gov/Documents/Emergency/artikel-8759400.htm>.

217 Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Future of Emergency Care: Emergency Medical Services at the Crossroads*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2007), 58, http://books.nap.edu/openbook.php?record_id=11629.

218 ESF #8, Public Health and Medical Services, coordinates all Federal assistance in support of State, local, tribal, and regional response to public health and medical disasters, incidents requiring a coordinated Federal public health or medical response, and developing public health or medical emergencies. U.S. Department of Homeland Security, Federal Emergency Management Agency, “National Response Framework, Emergency Support Function #8 – Public Health and Medical Services Annex,” <http://www.fema.gov/pdf/emergency/nrf/nrf-esf-08.pdf>.

219 For example, more than 4,000 patients were evacuated through the New Orleans airport and some patients were placed on Air Force aircraft; however, more than half were placed on National Guard and private aircraft and thus were not logged and tracked as NDMS patients. Senate Committee on Homeland Security and Governmental Affairs, *Hurricane Katrina: A Nation Still Unprepared*, 414.

capabilities of medical transport personnel. The assessment should also include private air ambulance assets, as many injured children evacuated from Haiti to Florida after the 2010 Haiti earthquake were transported via private air ambulances outside the NDMS system.^{220, 221}

The Commission's recommendation builds on a 2008 report issued by the National Biodefense Science Board, which recommended that NDMS develop "a standard patient movement concept of operations" that explicitly addresses the needs and management of at-risk individuals, including children and pregnant women, as well as an "accounting/tracking system that can properly register the true capacity of non-overlapping NDMS medical personnel who can be deployed for an event."²²²

220 Ian Urbina, "Paperwork Hinders Airlifts of Ill Haitian Children," *New York Times*, February 8, 2010, <http://www.nytimes.com/2010/02/09/world/americas/09airlift.html>.

221 Enrique Ginzburg, William O'Neill, Pascal Goldschmidt-Clermont, Eduardo de Marchena, Daniel Pust, and Barth Green, "Rapid Medical Relief - Project Medishare and the Haitian Earthquake," *The New England Journal of Medicine* 362, no. 10 (2010): 1-3, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1002026>.

222 National Biodefense Science Board, *Strategic Improvements To The National Disaster Medical System (NDMS): Report From The Disaster Medicine Working Group NDMS Assessment Panel*, (Washington, DC: HHS, September 2008), 5.

5. Disaster Case Management

Recommendation 5.1: Disaster case management programs should be appropriately resourced and should provide consistent holistic services that achieve tangible, positive outcomes for children and families affected by the disaster.

5. Disaster Case Management

Recommendation 5.1: Disaster case management programs should be appropriately resourced and should provide consistent holistic services that achieve tangible, positive outcomes for children and families affected by the disaster.

- *The Executive Branch and Congress should provide sufficient funds to build, support, and deploy a disaster case management system with nationwide capacity.*
- *DHS/FEMA should clarify the transition from Federal to State-led disaster case management programs.*
- *Government agencies and non-governmental organizations should develop voluntary consensus standards on the essential elements and methods of disaster case management, including pre-credentialing of case managers and training that includes focused attention to the needs of children and families.*

Children and families often require disaster case management²²³ services to help them regain self-sufficiency and address problems that a disaster has caused or exacerbated. Hurricanes Katrina and Rita demonstrated that in large-scale disasters the demand for disaster case management services may overwhelm the resources of voluntary, faith-based, and State and local organizations.²²⁴

In its Interim Report, the Commission concurred with the Government Accountability Office (GAO)²²⁵ and recommended that the Federal Emergency Management Agency (FEMA) establish a single Federal disaster case management program by the end of 2009.²²⁶ More specifically, the Commission recommended that this program: be led by a single Federal agency; be holistic, flexible, and sensitive to cultural, linguistic, and economic differences in communities; place a priority on serving the needs of families and children; ensure that case managers are rapidly deployed to affected areas; be adequately funded to support infrastructure, capacity building, and all aspects of disaster case management service

223 Disaster case management has been defined as “the process of organizing and providing a timely, coordinated approach to assess disaster-related needs including health care, mental health, and human services needs that were caused or exacerbated by the event and may adversely impact an individual’s recovery if not addressed. The purpose of disaster case management is to rapidly return individuals and families who have survived a disaster to a state of self-sufficiency.” Roberta Lavin and Sylvia Menifee, *Disaster Case Management: Implementation Guide*, (Washington, DC: Administration for Children and Families, 2009), 6-7, http://www.acf.hhs.gov/ohsepr/dcm/docs/Draft_DCM_ImplementationGuide.pdf.

224 Following Hurricanes Katrina and Rita, donations from foreign countries enabled FEMA to fund the Katrina Aid Today consortium. The Post Katrina Emergency Management Reform Act, passed in October 2006, amended the Stafford Act to grant the President the authority to provide financial assistance for case management services to survivors of major disasters. Public Law (P.L.) 109-295, title VI, §689f, codified at 42 U.S.C. §5189d (2006); U.S. Government Accountability Office, *Disaster Assistance: Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims*, GAO-10-278T, (Washington, DC: GAO, 2009), 1, <http://www.gao.gov/new.items/d10278t.pdf>.

225 U.S. Government Accountability Office, *Disaster Assistance: Greater Coordination and an Evaluation of Programs’ Outcomes Could Improve Disaster Case Management*, GAO-09-561, (Washington, DC: GAO, 2009), 34, <http://www.gao.gov/new.items/d09561.pdf>.

226 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 31-32, http://www.childrenanddisasters.acf.hhs.gov/20091014_5081R_partII.pdf.

delivery; and include a comprehensive evaluation component that measures and monitors outcomes, especially in regard to children.

FEMA and the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) signed an interagency agreement (IAA) in December 2009 to allow the implementation of ACF's disaster case management program.²²⁷ Under this IAA, following a Presidential disaster declaration and a FEMA-approved request from the affected State(s) for disaster case management services, ACF can initiate the deployment of disaster case management teams within 72 hours of notification from FEMA. Disaster case management teams will remain deployed for 30 to 180 days, after which FEMA and ACF will coordinate the transfer of all remaining clients to the State lead agency, enabling the continued coordination of services.

The Commission recommends that the Executive Branch and Congress provide sufficient adequate funds to build, support, and deploy a disaster case management program with nationwide capacity. The Commission is concerned that the Federal Government has not adequately funded development of the ACF Program. For Fiscal Year (FY) 2009, HHS requested, but Congress did not approve, \$10 million to build the program's capacity (e.g., training and credentialing of personnel, planning assistance to States) and develop a comprehensive case management database for training and recovery planning. In FY 2010, Congress approved just \$2 million for disaster case management, and for FY 2011 the President requested \$2 million. Meanwhile, FEMA indicates that it does not have authority to support funding for pre-event training or direct services to families through a disaster case management program.

The GAO review of Federal disaster case management programs also found gaps that "adversely affected" the delivery of case management services to some families and illuminated the need for greater coordination and program evaluation.^{228, 229} These gaps include interruptions in funding and service delivery, as program responsibility transferred from one agency to another, and delays in starting new State-level programs. Ultimately, children and families deserve a smooth, uninterrupted transition from agency to agency and from short- to long-term recovery. The Commission seeks clarity from FEMA regarding how it will address the transition of survivors' cases to a State-run disaster case management program, including contingency plans to continue Federal disaster case management services if a State is unprepared to provide such services to its survivors.

227 FEMA News Release HQ-09-145, "FEMA and Department of Health and Human Services' Administration for Children and Families Improve Disaster Case Management through Interagency Agreement," <http://www.fema.gov/news/newsrelease.fema?id=50037>.

228 U.S. Government Accountability Office, *Disaster Assistance: Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims*, 7-9.

229 U.S. Government Accountability Office, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, 13-14.

Not all disasters will involve disaster case management assistance from the Federal or State Government; local non-governmental agencies will often be assisting survivors in certain circumstances. Therefore, the National Volunteer Organizations Active in Disasters (NVOAD) collaborated with the Council on Accreditation²³⁰ to develop disaster case management guidelines to provide their members with a standardized set of policies and practices in the delivery of services to meet long-term recovery needs. However, these guidelines may deviate from the parameters of the ACF case management program. For example, under the NVOAD guidelines, disaster case managers may be employees or volunteers, based on their life experience, skills, education, and training as determined by the voluntary organization. Alternatively, the ACF model uses case managers who have a bachelor's degree in a health care-related or human services field.²³¹

The Commission recognizes the unique service delivery challenges associated with disasters, especially in addressing the long-term recovery needs of families with children, and that all case management programs may not implement identical service delivery models. The Commission recommends that Federal, State, and non-governmental partners develop voluntary consensus standards on the essential elements and methods of disaster case management and case manager training, through research and evaluation, to reconcile philosophical differences. Furthermore, the Commission recommends that case managers be pre-credentialed and provided specialized disaster training to advocate for the full range of necessary health, mental health, and other social services assistance for families with children.

230 Council on Accreditation, "Case Management," http://www.coacanadastandards.org/standards.php?navView=private§ion_id=21.

231 In the ACF model, paraprofessionals or volunteers are designated as case manager assistants or client navigators. Roberta Lavin and Sylvia Menifee, *Disaster Case Management: Implementation Guide*, 68.

6. Child Care and Early Education

Recommendation 6.1: Congress and HHS should improve disaster preparedness capabilities for child care.

Recommendation 6.2: Congress and Federal agencies should improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.

Recommendation 6.3: HHS should require disaster preparedness capabilities for Head Start Centers and basic disaster mental health training for staff.

6. Child Care and Early Education

Recommendation 6.1: Congress and HHS should improve disaster preparedness capabilities for child care.

- *Congress and HHS should require States to include disaster planning, training, and exercise requirements within the scope of their minimum health and safety standards for child care licensure or registration.*
- *Congress should provide HHS the authority to require States to develop statewide child care disaster plans in coordination with State and local emergency managers, public health, State child care administrators and regulatory agencies, and child care resource and referral agencies.*

Child care providers must be prepared to provide a safe and secure environment for children during and after a disaster. Over 12 million children under the age of six are in child care every week.²³² However, according to a 2010 report by Save the Children, only 14 States²³³ have laws or regulations requiring licensed child care providers to develop written disaster plans for addressing general evacuation processes, reunification efforts, and accommodation of children with special needs.²³⁴

The Commission recommended in its Interim Report that disaster preparedness for child care be ensured through two measures: requiring States to include disaster planning in their minimum health and safety standards for child care licensure or registration; and developing statewide child care disaster plans with State and local emergency managers and other agencies involved in child care.²³⁵ State plans should include guidelines for the continuation of child care services in the aftermath of a disaster, including the provision of emergency and temporary child care services and temporary operating standards. At a minimum, provider plans should include provisions for evacuation and relocation, shelter-in-place or lock-down procedures, communication and reunification with families, continuity of operations, accommodation of persons with disabilities and chronic medical conditions, staff and volunteer training, and practice drills.²³⁶ These plans should also be coordinated with local emergency management and included in overall local planning efforts.²³⁷

232 This includes children in child care centers, family child care homes, and the homes of friends and relatives. National Association of Child Care Resource & Referral Agencies, *Child Care in America: 2009 Fact Sheets*, (Arlington, VA: NACCRRRA, April 2009), 3, <http://www.naccrra.org/docs/policy/state-fact-sheet-2009.pdf>.

233 The word “States” includes the District of Columbia, which is one of the 14 “States” meeting the named criteria.

234 Save the Children, *A National Report Card on Protecting Children During Disasters*, (Westport, CT: Save the Children, 2010), 4, <http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/2010-Disaster-Report.pdf>.

235 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 35, http://www.childrenanddisasters.acf.hhs.gov/20091014_5081R_partII.pdf.

236 Save the Children and the National Association of Child Care Resource and Referral Agencies have developed disaster preparedness standards for child care, including guidance for State regulatory practices and child care providers, which include these recommended provisions. National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), http://www.naccrra.org/disaster/docs/Disaster_Report.pdf.

237 The lack of coordination and communication with emergency management was evident in Iowa, where only child care providers in communities near nuclear power plants coordinated planning with local emergency managers, and that was only because it is required for nuclear preparedness planning. Outside of those areas, there was less communication between child care providers and emergency management officials. National Commission on Children and Disasters, “Summary Report: Field Visit, Cedar Rapids, Iowa,” (Washington, DC: NCCD, 2010), 5-6, http://www.childrenanddisasters.acf.hhs.gov/20100106_lowaFieldVisit_Summary.pdf.

The Commission recommends that Congress and the Child Care Bureau (CCB) within the Department of Health and Human Services' (HHS) Administration for Children and Families implement disaster preparedness requirements by statute and regulation. Currently, CCB encourages, but does not require, disaster planning among its Child Care Development Block Grant (CCDBG)²³⁸ grantees (States, tribes, and territories), and the child care provider community. However, CCDBG requires States to certify that they have child care licensing requirements and to establish baseline health and safety standards for child care providers supported by CCDBG. CCB should require States to include disaster planning as part of the State's baseline health and safety standards for child care providers supported by CCDBG funds. Furthermore, Congress should amend the CCDBG Act to embed these basic disaster planning requirements in statute. The amendments would require States to develop statewide child care disaster plans in coordination with State and local emergency managers, public health, State child care administrators and regulatory agencies, and child care resource and referral agencies, as well as require States to incorporate minimum disaster preparedness requirements for child care providers within the scope of the State's licensing or regulatory regime.

Currently, ACF and Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA) are collaborating to provide guidance to states on developing statewide comprehensive child care disaster plans. In Chapter 1 of this report, the Commission recommends that ACF and DHS/FEMA establish a formal interagency agreement to pool resources to make funding, technical assistance, and training available to further support child care preparedness efforts.

Incorporating disaster preparedness in quality rating systems for child care providers may provide another effective mechanism for promoting provider preparedness, especially among providers who may be exempt from certain licensure and regulatory requirements.²³⁹ In recent years, several States have adopted Quality Rating and Improvement Systems (QRIS) designed to assess and improve the quality of child care for children.²⁴⁰ The Commission urges States to incorporate elements of emergency preparedness into their rating systems.

238 CCDBG provides formula grants to States, territories, and tribes to help low-income families obtain child care services

239 For instance, in some States, home-based providers and providers serving a small number of children may be exempt from the State's licensing or regulatory scheme.

240 QRIS aim to make "child-care quality transparent to child-care providers, parents, and policymakers." RAND Corporation, "Child-Care Quality Rating and Improvement Systems: What Can We Learn from Early Adopters?," (Santa Monica, CA: RAND Corporation, 2008), 1, http://www.rand.org/pubs/research_briefs/2008/RAND_RB9377.pdf.

Recommendation 6.2: Congress and Federal agencies should improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.

- *DHS/FEMA should revise its Public Assistance regulations to codify child care as an essential service.*
- *Congress should codify child care as an “essential service of a governmental nature” in the Stafford Act.*
- *Federal agencies should incorporate child care as an essential service in the National Response Framework, the National Disaster Recovery Framework, the National Disaster Housing Concept of Operations, and Disaster Housing Practitioners’ Guide.*
- *Congress should authorize a grant funding mechanism, such as an emergency contingency fund, to repair or rebuild private, for-profit child care facilities, support the establishment of temporary child care, and reimburse States for subsidizing child care services to disaster-affected families.*

Child care services must be restored as quickly as possible following a disaster to provide children with a safe environment and sense of routine while parents make efforts to rebuild their lives. During a field visit to Iowa in January 2010, the Commission discovered that, where child care was not available, children were typically kept at home, sometimes playing in debris or other unsafe conditions.²⁴¹ If a community does not have access to quality child care after a disaster, parents may not be able to work, placing further economic stress on the family and the community.²⁴² Following large-scale events, child care services may recover slowly or may not be restored to full capacity. Following Hurricane Katrina in 2005, only 65 percent of the child care centers in the Greater New Orleans area had reopened as of December 2009.²⁴³

In its *Interim Report*, the Commission presented recommendations designed to help restore child care capacity immediately following and during the recovery from a disaster.²⁴⁴ Specifically, the Commission recommended that the provision of child care be designated as an essential service in disaster preparedness, response, and recovery across all levels of government. The Commission also recommended that reimbursement provided under the Stafford Act be expanded to support 1) disaster child care services for affected families, 2) the establishment of emergency and temporary child care, and 3) the rebuilding of damaged child care facilities, regardless of whether providers operate as private businesses or nonprofits.

241 National Commission on Children and Disasters, “Summary Report: Field Visit, Cedar Rapids, Iowa,” 6.

242 National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, 9.

243 Senator Mary Landrieu, Opening Statement of Chairman Landrieu before the U.S. Senate, Committee on Homeland Security and Governmental Affairs, Ad Hoc Subcommittee on Disaster Recovery, “Children and Disasters: A Progress Report on Addressing Needs,” Washington, DC, December 10, 2009, 2, http://hsgac.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_id=bba3b475-bd7e-4138-9cdf-3ed88c17f73e.

244 National Commission on Children and Disasters, *Interim Report*, 37.

In response to the Commission’s recommendations, FEMA revised its Public Assistance policy to permit reimbursement to State and local governments for the provision of emergency child care services that coincide with the emergency sheltering period in the immediate aftermath of a disaster.²⁴⁵ FEMA also clarified, as a statement of policy, that child care is an “essential service of a governmental nature,” meaning that nonprofit child care providers may be eligible for FEMA assistance to repair damaged facilities if they do not qualify for Small Business Administration (SBA) disaster loans or if the SBA approves a loan for less than the amount required to repair the damage.²⁴⁶ FEMA recently published guidance clarifying these policies²⁴⁷ and HHS will be assisting FEMA in distributing the guidance to child care administrators in States and Territories.²⁴⁸ The Commission recommends that FEMA revise its Public Assistance regulations to codify these statements of policy. In addition, the Commission recommends that child care be codified as an “essential service of a governmental nature” in the Stafford Act.

Although FEMA’s policy of reimbursing State and local governments for emergency child care services during emergency sheltering operations should benefit families, an emergency sheltering period typically lasts a few days.²⁴⁹ Families recovering from disasters may need additional assistance to help cover the costs associated with quality child care once they leave the shelter. As detailed in the Interim Report, after Hurricane Katrina, Mississippi provided 60-day emergency child care certificates to displaced families in need of child care assistance, many of whom otherwise would not have been eligible for benefits due to residency, income, or work requirements.^{250,251} Mississippi served 2,700 displaced children at an approximate cost of \$1.65 million with the expectation that it could be reimbursed, but absorbed the expense as there was no mechanism in place for Federal reimbursement. Mississippi was denied reimbursement from FEMA and was not eligible to receive additional CCDBG funding.²⁵² Currently, no mechanism provides services or assistance to affected families with needs beyond the sheltering period. Neither is there a means to provide targeted support to States to assist them in meeting additional child care needs resulting from an influx of displaced families.

245 Eligible child care costs may include, but are not limited to labor, facility costs, supplies, and commodities. U.S. Department of Homeland Security, *FEMA Disaster Assistance Fact Sheet 9580.107: Public Assistance for Child Care Services*, ed. Federal Emergency Management Agency (Washington, DC: FEMA, March 2010), 1, http://www.fema.gov/pdf/government/grant/pa/9580_107.pdf.

246 *Ibid.*, 1-2.

247 *Ibid.*, 1-2.

248 National Commission on Children and Disasters, “Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps To Achieve Commission Goals,” (Washington, DC: NCCD, May 11, 2010), 11, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

249 National Commission on Children and Disasters, “Meeting Minutes of the November 10, 2009 Public Meeting,” (Washington, DC: NCCD, November 10, 2009), 4-5, http://www.childrenanddisasters.acf.hhs.gov/minutes/20091110_MinutesV02.pdf.

250 National Commission on Children and Disasters, Interim Report, 37.

251 Administration for Children and Families, “ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance,” (Washington, DC: HHS, 2007), 1.

252 CCDBG awards are allocated to States based on formulae required by statute. The program lacks the authority to target funds to States affected by a disaster. *Ibid.*, 1-3.

Additional measures are also needed to support the rebuilding of child care infrastructure. Restoration of child care services as quickly as possible is essential for children to resume a safe and normal routine and for parents to resume working. Although FEMA clarified that reimbursement for repairs may be available for nonprofit child care providers who fail to qualify for SBA assistance, the majority of child care providers are private businesses, and the Stafford Act does not provide reimbursement for the cost of rebuilding private, for-profit facilities. Furthermore, many child care providers typically do not qualify for SBA disaster loan assistance and lack the independent resources to rebuild and reopen after a disaster. Following the series of hurricanes affecting the Gulf Coast (Hurricanes Katrina, Rita, Ike, and Gustav), only 46 percent of the child care providers who applied for SBA loans and completed the review process were approved.²⁵³ The Commission heard similar accounts when meeting with child care officials in Iowa, where it was reported that many child care providers could not demonstrate the requisite ability to repay an SBA loan as many were just breaking even before the flooding.²⁵⁴

The Commission recognizes the challenges associated with amending the Stafford Act to provide reimbursement for damages to private businesses, including essential services such as child care. In order to address the gap in available disaster assistance for for-profit child care and the other aforementioned gaps in providing child care services and assistance for families recovering from disasters, the Commission recommends that Congress authorize the establishment of an emergency child care contingency fund.

After a disaster, the contingency fund would provide reimbursement to State, tribal, territorial, and local governments to support the following:

- **Restoration of Child Care Infrastructure:** An emergency child care contingency fund would provide much-needed grants to help rebuild private for-profit child care centers that fail to qualify for other Federal assistance, in order to help restore affected communities' capacity to provide quality child care services.
- **Temporary Child Care Services:** FEMA has committed to reimburse State and local governments for emergency child care services that coincide with the sheltering period in the immediate aftermath of a disaster. However, additional support may be required to bridge the gap between the end of the sheltering period and the time when community providers are able to reopen in order to ensure access to quality child care services and continuity of care.
- **Assistance to Affected Families for Child Care Services:** An emergency child care contingency fund would assist governments in meeting additional child care needs resulting from an influx of displaced families from other affected communities, by allowing States to subsidize child care services for affected families without depleting CCDBG funds that are already committed to providing needed child care services to working low-income families.

253 Senator Mary Landrieu, Opening Statement of Chairman Landrieu before the U.S. Senate, "Children and Disasters: A Progress Report on Addressing Needs," 2.

254 National Commission on Children and Disasters, "Summary Report: Field Visit, Cedar Rapids, Iowa," 6

Finally, the Commission continues to recommend that child care be incorporated as an essential service in the National Response Framework (NRF), the National Disaster Recovery Framework (NDRF),²⁵⁵ the National Disaster Housing Concept of Operations (CONOPS), and Disaster Housing Practitioners' Guide. FEMA is in the process of updating the NRF, tentatively scheduled for release in 2011, and has committed to incorporating children's needs into this revision.²⁵⁶ The NDRF, the National Disaster Housing CONOPS, and the Disaster Housing Practitioners' Guide were not finalized at the time of this report's publication.

Recommendation 6.3: HHS should require disaster preparedness capabilities for Head Start Centers and basic disaster mental health training for staff.

The Head Start program has provided educational, health, nutritional, social, and other services to preschool-age children and their families since its inception in 1965, serving more than 27 million enrolled children.²⁵⁷ Administered by the HHS Office of Head Start (OHS), the program awards grants to local public agencies, nonprofit and for-profit organizations, tribes, and school systems to operate Head Start centers at the local level.²⁵⁸ In FY 2009, more than 900,000 children were enrolled in 49,200 Head Start classrooms.²⁵⁹

In the 2007 reauthorization of the Head Start Act,²⁶⁰ Congress required OHS to conduct an evaluation of the emergency preparedness of Head Start and Early Head Start programs and to make recommendations on how Head Start could improve its readiness for disasters.²⁶¹ In accordance with the Act, OHS conducted a survey of Head Start centers nationwide to determine the centers' policies and plans for large-scale disasters.²⁶² OHS also developed and published a comprehensive guidance document, the Head Start Emergency Preparedness Manual, which provides technical assistance to Head Start program

255 National Commission on Children and Disasters, "Comments: National Disaster Recovery Framework," (Washington, DC: NCCD, February 26, 2010), 1, http://www.childrenanddisasters.acf.hhs.gov/20100224_NCCD_NDRFCommentsV04FINAL.pdf.

256 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps To Achieve Commission Goals," 11.

257 Office of Head Start, "Head Start Program Fact Sheet," Administration for Children and Families, U.S. Department of Human Services," <http://www.acf.hhs.gov/programs/ohs/about/fy2010.html>.

258 Ibid.

259 Ibid.

260 Public Law (P.L.) 110-134.

261 "Improving Head Start for School Readiness Act of 2007," <http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Act>.

262 Office of Head Start, *Head Start Emergency Preparedness Survey*, ed. U.S. Department of Human Services (Washington, DC: HHS, December 15, 2009), 1, <http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Fiscal/Program%20Management/Risk%20Management/ACF-PI-HS-09-09-A1.pdf>.

administrators and staff with respect to the creation and implementation of emergency preparedness plans.²⁶³ As of the time of this report's publication, OHS had not submitted recommendations for improving Head Start preparedness to Congress as required by the Act.

OHS is revising regulations, including its mandatory performance standards for Head Start Centers. The Commission recommends that the OHS' revised performance standards for Head Start centers incorporate emergency preparedness requirements, including:

- An all-hazards emergency preparedness plan developed in collaboration with emergency management officials, reviewed and updated regularly, and shared with parents and the community, and that includes:
 - o Plans for evacuating and relocating children and staff;
 - o Plans for shelter-in-place and lock-down;
 - o Plans to accommodate children with disabilities and chronic medical needs;
 - o Plans for reunifying children and families or caregivers;
 - o Roles and responsibilities of staff;
 - o Emergency contact information for children and families, staff and volunteers, and key local, State and Federal partners, including emergency management; and
 - o Plans for communicating with families, caregivers, and community members before, during, and after emergencies.
- Regular training for all staff members on the emergency preparedness plan, policies, and procedures, and basic disaster mental health support.
- Drills for evacuation, shelter-in-place, and lock-down.
- Plans for providing mental and behavioral health support to children after an emergency or other crisis.

It is critical that young children affected by disasters receive adequate mental and behavioral health support. Disasters expose young children to emotional trauma, which can have profound negative effects on child development.^{264,265} As noted in other chapters of this

263 Administration for Children and Families, *Head Start Emergency Preparedness Manual*, ed. U.S. Department of Health and Human Services (Washington, DC: HHS, 2009), <http://headstartresourcecenter.org/assets/files/EPrep%20Manual%20v22.pdf>.

264 National Child Traumatic Stress Network, "Understanding Child Traumatic Stress," U.S. Department of Health and Human Services, http://www.ncatsnet.org/ncats/nav.do?pid=ctr_aud_prnt_under#q13.

265 Alan M. Delamater and E. Brooks Applegate, "Childhood Development and Post-Traumatic Stress Disorder After Hurricane Exposure," *Traumatology* 5, no. 3 (Miami, FL: Sage Publications, 1999): 20-27, <http://www.fsu.edu/~trauma/a3v5i3.html>.

report, the chronic shortage of pediatric mental health professionals coupled with limited insurance reimbursement for mental and behavioral health services greatly diminishes the capability to provide necessary mental health care to young children after a disaster. Individuals who routinely interact with children, such as early education providers, should be trained to provide basic support to promote adjustment and recovery, and identify children who require more advanced care.

The Commission recommends that Head Start's revised performance standards incorporate basic disaster mental health training requirements within existing training requirements for Head Start staff. Head Start Centers are already required to employ or consult with a mental health professional. The Commission recommends that the mental health professional should also be trained in disaster mental health issues and interventions and have a leadership role in the development and implementation of a disaster mental health training program for staff.

Training for staff should include: instruction on the impact of trauma and bereavement on children; likely reactions; strategies for providing psychological first aid, brief supportive services, and bereavement support; and indications for referral for additional mental health services. Training would not only prove useful to Head Start staff in the aftermath of disasters, but also on a day-to-day basis as children enrolled in Head Start programs face higher than average stress levels and exposure to various types of trauma.²⁶⁶

266 Jane Knitzer and Jill Lefkowitz, *Helping the Most Vulnerable Infants, Toddlers, and Their Families*, ed. National Center for Children in Poverty, Columbia University Mailman School of Public Health (New York, NY: NCCP, January 2006), 13-15, http://www.nccp.org/publications/pub_669.html.

7. Elementary and Secondary Education

Recommendation 7.1: Congress and Federal agencies should improve the preparedness of schools and school districts by providing additional support to States.

Recommendation 7.2: Congress and ED should enhance the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster.

Recommendation 7.3: Ensure that school systems recovering from disasters are provided immediate resources to reopen and restore the learning environment in a timely manner and provide support for displaced students and their host schools.

7. Elementary and Secondary Education

Recommendation 7.1: Congress and Federal agencies should improve the preparedness of schools and school districts by providing additional support to States.

- *Congress and ED should award disaster preparedness grants to State education agencies to oversee, coordinate, and improve disaster planning, training, and exercises statewide and ensure that all districts within the State meet certain baseline criteria.*
- *DHS/FEMA should partner with ED to provide funding and other resources to support disaster preparedness efforts of State and local education agencies, including collaborative planning, training, and exercises with emergency management officials.*

In their lifetimes, children may spend more than 2,340 days in elementary and secondary schools,²⁶⁷ making it imperative that schools and school districts are prepared to protect children's safety and manage the complicated, multifaceted issues that arise when disaster strikes. Over 49 million students attended approximately 99,000 public elementary and secondary schools in 13,900 school districts in 2009, with an additional 5.8 million students enrolled in 33,700 private schools.^{268,269} Although many schools and school districts have developed emergency management plans, many plans and preparedness activities are not aligned with Federally-recommended practices.²⁷⁰ For example, a 2007 Government Accountability Office (GAO) survey of a sample of public school districts revealed that approximately 56 percent had no plans in place for continuing student education if schools are closed for an extended period, and many of their plans did not include accommodations for students with special needs.²⁷¹

The Commission recommends that additional Federal and State support is needed to improve the preparedness of schools and school districts and ensure that children are properly protected before, during, and after disasters. Sixty-two percent of school officials from surveyed school districts reported challenges to implementing emergency management programs, including insufficient equipment, training, and staff with emergency planning

267 This total is based on an average of 180 days per year, for 13 years. National Center for Education Statistics, "Average length of school year and average length of school day, based on selected characteristics," http://nces.ed.gov/surveys/pss/tables/table_15.asp.

268 National Center for Education Statistics, "Fast Facts," <http://www.nces.ed.gov/fastfacts/display.asp?id=372>.

269 Ibid.

270 The Departments of Education (ED), Homeland Security (DHS), and Health and Human Services (HHS) have collaborated and developed recommended practices to assist in preparing for emergencies that can be applied to school districts. For a list of selected recommended practices, see Table 2. U.S. Government Accountability Office, *Emergency Management: Status of School Districts' Planning and Preparedness*, GAO-07-821T, (Washington, DC: GAO, 2007), 11, <http://www.gao.gov/new.items/d07821t.pdf>.

271 Ibid., 15.

expertise.²⁷² While most school districts practice their emergency management plans annually within the school community, the GAO estimates that “over one-quarter of school districts with emergency management plans have never trained with first responders and over two-thirds of school districts do not regularly (i.e., at least once a year) train with community partners on how to implement their school plans.”²⁷³ During the Commission’s January 2010 field visit to Iowa, school officials in that State noted that school officials are not required by State law to collaboratively plan with emergency management officials, which results in differing levels of coordination in each county and school district.²⁷⁴

The U.S. Department of Education (ED) Office of Safe and Drug-Free Schools manages the Readiness and Emergency Management for Schools (REMS) program as a means to deliver grant funding directly to school districts for preparedness and emergency management initiatives and to provide technical assistance to districts. REMS provides discretionary, competitive grants to an estimated 150 school districts per year, with an average award of \$253,000.²⁷⁵ REMS requires grantees to develop comprehensive emergency management plans addressing all hazards, provide training for school personnel, and coordinate efforts with State or local homeland security plans. As the Commission noted in its Interim Report, REMS should receive continued support since it is a mechanism that can yield model programs and test various cost- and time-effective approaches to improving school preparedness. However, since 2003, the REMS program distributed 815 grants to Local Education Agencies (LEAs), serving a small proportion of the 14,200 public school districts nationwide.²⁷⁶

In its Interim Report, the Commission initially recommended the expansion of REMS toward the goal of establishing a school disaster preparedness program with appropriate funding to support a dedicated and sustained funding stream to all State Education Agencies (SEAs).²⁷⁷ The Commission envisioned SEAs taking a leadership role in improving, overseeing, and coordinating disaster preparedness throughout the State. States would provide funding, training, guidance, and technical assistance to LEAs to support a consistent level of preparedness statewide. In response to queries from the Commission, ED indicated that it would consider ways to adapt REMS to meet the desired role for SEAs, but noted that the

272 U.S. Government Accountability Office, *Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance*, GAO-07-609, (Washington, DC: GAO, 2007), 6, <http://www.gao.gov/new.items/d07609.pdf>.

273 *Ibid.*, 21.

274 National Commission on Children and Disasters, “Minutes: Field Visit, Cedar Rapids, Iowa,” (Washington, DC: NCCD, 2010), 3, http://www.childrenanddisasters.acf.hhs.gov/20100106_IowaFieldVisit_MinutesV03FINAL.pdf.

275 Readiness and Emergency Management for Schools Technical Assistance Center, “REMS Grant Application,” U.S. Department of Education, http://rems.ed.gov/index.php?page=REMS_Grant_Application.

276 Readiness and Emergency Management for Schools Technical Assistance Center, “REMS Grantees,” U.S. Department of Education, http://rems.ed.gov/index.php?page=REMS_Grantees.

277 SEAs include tribal nations and territories. National Commission on Children and Disasters, Interim Report, (Washington, DC: NCCD, October 14, 2009), 41, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

current level of resources would be insufficient to provide sustained funding to all SEAs. In addition, ED reported that new investments in elementary and secondary education should be consistent with the goals and direction of the Administration.

The Commission maintains that the Nation's students deserve to attend well-prepared schools. However, in recognition of the current fiscal environment and trend toward competitive funding to award innovation—as exemplified in the Administration's Race to the Top initiative and blueprint for reauthorizing the Elementary and Secondary Education Act—the Commission recommends that competitive disaster preparedness grants be awarded to States through the REMS program as an initial step toward developing innovative models designed to ensure a higher level of school preparedness statewide.

A competitive grant program would award funds to SEAs to develop statewide disaster preparedness initiatives. These initiatives could establish preparedness criteria for schools and school districts within the State that build on the REMS model, identify and propose solutions to correct deficiencies, and provide training, guidance, technical assistance, and funding to LEAs. In this manner, REMS funds could reach more school districts and establish greater accountability, efficiency, and consistency within States.

An overarching goal for the program could be the development of best practices and statewide models that could be shared with and adopted by other States. A more specific goal of this program could be to encourage collaboration between education and emergency management officials in preparedness efforts, including planning, training, and exercises throughout the State.

In Chapter 1 of this report, the Commission recommends that ED and the Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA) establish a formal interagency agreement to pool resources to make funding, technical assistance, training, and other resources available to support the disaster preparedness efforts of State and local education agencies and schools. Although school districts are currently eligible to receive certain DHS emergency preparedness funds, few States provide DHS funding to school districts.²⁷⁸ An interagency program could ensure that DHS preparedness funds reach schools and would promote collaborative planning, training, and exercises between education and emergency management officials at the State and local levels.

278 U.S. Government Accountability Office, *Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance*, 14-15.

Recommendation 7.2: Congress and ED should enhance the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster.

- Congress and ED should award funds to States to implement and evaluate training and professional development programs in basic skills in providing support to grieving students and students in crisis and establish statewide requirements related to teacher certification and recertification.

Teachers, school administrators, and other school personnel should be trained to understand the impact of trauma and loss on learning, and to provide basic supportive services that will help students adjust to a disaster and its aftermath and will promote academic achievement. Children can experience post-traumatic stress disorder, bereavement, and other behavioral problems, such as increased aggression or delinquency, after disasters.²⁷⁹ Common effects of crises on students include: school absenteeism; school behavior problems, such as aggressive or unlawful behavior; academic failure; and exacerbation of preexisting educational problems.²⁸⁰ On average, displaced students in Louisiana public schools in the year following Hurricane Katrina performed worse in all subjects and grades compared to other students, and experienced a variety of problems related to attendance, mental health, behavior, and academic performance.²⁸¹ Without sufficient training, educators may not be aware that a student is having difficulty adjusting or coping, and as a result, the student's behaviors, learning patterns, or social interactions may be misinterpreted or mislabeled.²⁸²

As noted in the Commission's Interim Report, teachers and school administrators receive little if any training around how to support children in the aftermath of a disaster to promote adjustment and academic achievement.²⁸³ During the Commission's January 2010 field visit to Iowa, school officials reported that they were unprepared to recognize the warning signs of depression, bereavement, or other behavioral and emotional issues in students following a disaster.²⁸⁴ Following Hurricanes Katrina and Rita, school personnel revealed that the greatest barriers to helping students following the storms were not being aware of the mental health programs they should use and the shortage of trained staff to implement these programs.²⁸⁵

279 John F. Pane, Daniel F. McCaffrey, Nidhi Kalra, and Annie J. Zhou, "Effects of Student Displacement in Louisiana During the First Academic Year After the Hurricanes of 2005," *Journal of Education for Students Placed at Risk (JESPAR)* 13(2), (2008):168-211, http://www.rand.org/pubs/reprints/2008/RAND_RP1379.pdf.

280 National Child Traumatic Stress Network, "The Effects of Trauma on Schools and Learning," http://www.nctsnet.org/nccts/nav.do?pid=ctr_aud_schl_effects.

281 John F. Pane, Daniel F. McCaffrey, Nidhi Kalra, and Annie J. Zhou, "Effects of Student Displacement in Louisiana During the First Academic Year After the Hurricanes of 2005," 168-211.

282 Jenny Curtin, *Creating Trauma-Sensitive Schools: Reducing the Impact of Trauma as a Barrier to Student Learning*, ed. International Society for Traumatic Stress Studies (Deerfield, IL: ISTSS, 2008), 1, http://www.istss.org/source/stresspoints/index.cfm?fuseaction=Newsletter.showThisIssue&Issue_ID=80&Article_ID=1353.

283 National Commission on Children and Disasters, *Interim Report*, 11.

284 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," 5.

285 Lisa H. Jaycox, Lindsey K. Morse, Terri Tanielian, and Bradley D. Stein, *How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery*, (Santa Monica, CA: RAND, 2006), 9-10, http://www.rand.org/pubs/technical_reports/2006/RAND_TR413.pdf.

The Commission recommends that funds be awarded to States to implement training and professional development programs for teachers and school personnel that impart basic skills in providing support to affected students, and to establish statewide training requirements tied to professional certification and recertification. The Commission believes that the most effective way to ensure that teachers and other school personnel receive the basic training necessary to effectively teach and support children in crisis is to include such training at the pre-service level as a condition of certification/licensure and at the in-service level as a condition of recertification/license renewal. However, requirements for new teacher certification and professional development fall predominately within the purview of the States and ED lacks the authority to require disaster mental health training. The Commission recommends that ED support a competitive grant program to incentivize the implementation of State disaster mental health training programs, including requirements for teacher certification and professional development. Grantees would be expected to pilot and evaluate training materials and methods to develop an evidence base and best practices that could serve as models for other States to adopt.

Model training tools should be developed at the national level and made available free to all States, whether or not the State is awarded funds, for the use of schools of education and professional organizations. Training for teachers and school personnel on how to support children following a disaster should impart basic skills and knowledge in the following areas: the impact of trauma and bereavement on children and their learning; likely reactions; strategies for providing psychological first aid, brief supportive services, and bereavement support; and indications for referral for additional mental health services.

Recommendation 7.3: Ensure that school systems recovering from disasters are provided immediate resources to reopen and restore the learning environment in a timely manner and provide support for displaced students and their host schools.

- *Congress should create a permanent funding mechanism to support recovery for schools and students.*
- *Congress should establish an emergency contingency fund within the Education for Homeless Children and Youth program and expeditiously provide grants to school districts serving an influx of displaced children.*
- *Congress and ED should support the immediate provision of expert technical assistance and consultation regarding services and interventions to address disaster mental health needs of students and school personnel.*
- *DHS/FEMA, ED, and other Federal agencies should clarify, consolidate, and publicize information related to the recovery programs, assistance, and services (e.g., transportation to schools) currently available to school systems through the Stafford Act and other Federal sources.*

In the aftermath of a disaster, school systems must reopen and return to their normal routines quickly in order to mitigate the traumatic effects of the event on students.²⁸⁶ Seven months after Hurricane Katrina, only 20 out of 130 schools in the New Orleans Public School system had reopened, with most buildings requiring decontamination due to environmental hazards following the hurricane.²⁸⁷ Schools that were able to reopen faced overcrowded classrooms, a reduction of teaching staff, and a lack of school books, computers, teaching supplies, and musical and sports equipment.²⁸⁸

Under the Stafford Act, public and certain nonprofit private schools are eligible to receive funding for the repair or replacement of buildings and their contents, including furnishings and equipment, the temporary relocation of classrooms, debris removal assistance, and emergency work to ensure access to the building and communication systems.²⁸⁹ However, to support the recovery of students and restore a normal learning environment, affected schools need a variety of assistance and services beyond repairing buildings and replacing contents as provided through the Stafford Act.

Following Hurricanes Katrina and Rita, there was a disparity between the assistance FEMA provided and the needs of students, families, and communities affected by the storms.²⁹⁰

286 Ibid., 6.

287 Representative George Miller, *Democratic Proposals to Open and Rebuild Gulf Coast Schools and Colleges*, (Washington, DC: U.S. House of Representatives, April 2006), 3, <http://edlabor.house.gov/publications/katrinareport.pdf>.

288 Ibid., 3-4.

289 Richard Apling, Paul Irwin, Ann Lordeman, Rebecca Skinner, and David Smole, "Education and Training Issues Related to Major Disasters," ed. Congressional Research Services (Washington, DC: CRS, November 4, 2005), 3, <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA441993&Location=U2&doc=GetTRDoc.pdf>.

290 Representative George Miller, *Democratic Proposals to Open and Rebuild Gulf Coast Schools and Colleges*, 9.

In light of this gap and in response to Hurricanes Katrina and Rita, Congress passed the Hurricane Education Recovery Act (HERA), a one-time emergency grant for the 2005-2006 school year providing funds for many important services to help restart school operations in impacted areas in addition to providing instructional support for displaced students and their host schools.²⁹¹

Under HERA's Immediate Aid to Restart School Operations program, funding was issued to SEAs in Gulf States impacted by the storm through ED for the purchase of equipment, supplies, books, and other services necessary to reopen schools and restore learning environments, such as hiring additional staff for psychological, social, behavioral, nursing, and counseling services for students and staff, and supporting expenses incurred to recruit teachers and other school personnel. HERA also established the Emergency Impact Aid Program, which supported instructional opportunities and support services for displaced students and offset the costs incurred by host schools for educating the 372,000²⁹² students displaced as a result of Hurricanes Katrina and Rita. At the time, no mechanism was in place to support these kinds of recovery programs for affected communities or receiving districts and States, and the Act was not signed into law until three months after the storms,²⁹³ forcing schools and school districts to await the needed assistance. Currently, there is no permanent source of funding in place should such a disaster occur again, as HERA provided a one-time authorization.

The Commission recommends that Congress authorize a permanent funding mechanism to ensure that school systems recovering from disasters have access to assistance and services needed to reopen and restore the learning environment in a timely manner and provide support for displaced students and the schools that host them. In 2010, Senator Landrieu of Louisiana introduced the Child Safety, Care, and Education Continuity Act, which would reauthorize some of the programs that expired under HERA in addition to new measures that strive to provide the services necessary to schools and students for a timely recovery following a disaster.²⁹⁴ As Louisiana's State Superintendent of Education testified at a hearing held by the U.S. Senate Ad Hoc Subcommittee on Disaster Recovery: "State[s], districts, schools, and even, more importantly, students and their families, need to know that there is a permanent and instantaneous funding source in place if their lives are disrupted by tragedy ... If a permanent fund were to be established, it would accelerate financial support to receiving districts and states and would provide instantaneous funding to help educators and support displaced students who are in great need of high-quality services."²⁹⁵

291 Public Law (P.L.) 109-148, "Hurricane Education Recovery Act of 2005," CFDA 84.938, <http://www2.ed.gov/policy/elsec/guid/secletter/051230Bill.pdf>.

292 Ibid.

293 The law was signed on December 30, 2005. U.S. Department of Education, "Frequently Asked Questions, Emergency Impact Aid for Displaced Students," <http://www.hurricanehelpforschools.gov/proginfo/faq-impact.pdf>.

294 Government Printing Office, Bill S.2898, "Child Safety, Care and Education Continuity Act of 2010," http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s2898is.txt.pdf.

295 Paul Pastorek, Testimony of Paul Pastorek before the U.S. Senate Ad Hoc Subcommittee on Disaster Recovery, Washington, DC, December 10, 2009, 2-3,

http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=4e18d245-5b8d-46a8-a75a-9d6bf606d1ba.

Another mechanism through which the Federal Government can support the educational needs of children displaced by disaster is the Education for Homeless Children and Youth (EHCY) program, under the McKinney-Vento Act.²⁹⁶ Most students displaced by a disaster may be considered “homeless” under the Act’s definition.²⁹⁷ Funds provided to school districts through the EHCY program may be used to support displaced children and youth through outreach and identification, enrollment assistance, transportation assistance, school records transfers, immunization referrals, tutoring, counseling, school supplies, assessment, case management, professional development for educators, and referrals for community services. However, the current statutory formula for allocating EHCY dollars does not provide a mechanism for immediately providing assistance in times of disaster.²⁹⁸ Moreover, only 11 percent of all school districts receive EHCY funding.²⁹⁹

The Commission recommends that Congress authorize the creation of an EHCY emergency contingency fund, from which grants to cover needed educational support services could be expeditiously targeted to school districts serving an influx of displaced children. There have been two supplemental McKinney-Vento appropriations in response to recent disasters: one in response to the 2005 Gulf Coast hurricanes and the other in response to the 2008 Midwest floods and Hurricane Ike. In both instances, appropriations arrived well after the disasters.³⁰⁰ Authorization for a permanent contingency fund would provide a mechanism for

296 P.L. 107-110; 42 U.S.C. §11431 et. seq (2001). Title X, Part C of the No Child Left Behind Act.

297 Section 725 of the McKinney-Vento Act defines “homeless children and youth” as individuals who lack a fixed, regular, and adequate nighttime residence, including children and youth who: share the housing of other persons due to loss of housing, economic hardship, or a similar reason; live in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; live in emergency or transitional shelters; live in abandoned in hospitals; await foster care placement; have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; live in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and are migratory children (as defined in section 1309 of the Elementary and Secondary Education Act of 1965, as amended). P.L. 100-77 (1987), <http://www2.ed.gov/policy/elsec/leg/esea02/pg116.html#sec725>.

298 EHCY funds are allocated to SEAs based on annual poverty data and do not reach school districts until the following academic year. U.S. Department of Education, “Education for Homeless Children and Youths Grants for State and Local Activities,” <http://www2.ed.gov/programs/homeless/index.html>; U.S. Department of Education, “Improving Basic Programs Operated by Local Educational Agencies (Title I, Part A),” <http://www2.ed.gov/programs/titleiparta/index.html>.

299 National Center for Homeless Education, *Education for Homeless Children and Youth Program, Data Collection Summary*, (Washington, DC: U.S. Department of Education, June 2010), 3, <http://center.serve.org/nche/>.

300 Section 106 of the Department of Defense Appropriations Act for 2006, released on December 30, 2005, provided assistance for homeless youth following the hurricanes in the Gulf Coast in accordance with Section 723 of the McKinney-Vento Homeless Assistance Act. P.L. 109-148, 119 Statute 2797 (2005).

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ148.pdf. Additionally, the Consolidated Appropriations Act of 2009, released September 30, 2008, provided an additional \$15 million to remain available through September 2009 for LEAs whose homeless student enrollment had increased due to “hurricanes, floods, or other natural disasters occurring during 2008 for which the President declared a major disaster under title IV of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974.” P.L. 110-329, 122 Statute 3595 (2009), http://www.usace.army.mil/CECW/Documents/cecwm/cra/pl_110-329.pdf.

supporting needed services for displaced students in an expeditious manner. School districts in Texas that received an influx of students following Hurricane Katrina testified that the presence of a strong McKinney-Vento program was critical in enabling schools to manage new students, including seamlessly integrating students with and without educational records into their systems, particularly students residing in shelters and motels.³⁰¹

In addition, a crucial aspect of restoring a normal learning environment following a disaster involves ensuring that students and school personnel receive mental and behavioral health support to mitigate the disaster's affects on academic achievement. Following a disaster, schools should be provided technical assistance and consultation by subject matter experts on developing a recovery plan to promote student adjustment. The Project School Emergency Response to Violence (SERV) program provides these and other mental-health related services for schools following a traumatic or violent event such as a school shooting or suicide; however, Presidentially declared disasters are not eligible events.³⁰²

The Commission recommends that Congress and ED provide sufficient funds to support the immediate provision of expert technical assistance and consultation regarding services and interventions to address disaster mental health needs of students and school personnel, including bereavement, reactions to trauma, and other adjustment difficulties that are likely after a disaster. Such consultation and technical assistance should be proactively offered (but not required) at no cost to the school and with no requirement for application. Additional services should include just-in-time training on bereavement support, psychological first aid, brief supportive services, and guidelines on referral for mental health services; provision of guidance materials; information on other resources, services, and potential funding opportunities to address longer-term or ongoing needs; and linkage to relevant professional organizations, agencies, and programs. ED should establish agreements with entities that focus on providing mental health consultation services to schools and have the capability to deliver such services in a timely manner.

Finally, the Commission recommends that FEMA, ED, and other Federal agencies should clarify, consolidate, and publicize information related to the recovery programs, assistance, and services currently available to school systems through the Stafford Act and other Federal

301 National Center for Homeless Education, *In Their Own Words: Schools and Students Overcoming Adversity*, ed. U.S. Department of Education (Washington, DC: ED, 2007), <http://center.serve.org/nche/downloads/itow.pdf>.

302 Office of Safe and Drug Free Schools, "Project School Emergency Response to Violence (SERV) Frequency Asked Questions," <http://www2.ed.gov/programs/dvppserv/faq.html#event>.

sources.³⁰³ Without comprehensive information on available programs and reimbursable expenses, school systems may be unable to take advantage of useful recovery resources. For example, FEMA should clarify its ability to provide reimbursement for school transportation expenses. FEMA's ability to cover such expenses is not documented in guidance or communicated clearly through Regional Offices to affected States or communities. During the Commission's January 2010 field visit to Iowa, school officials were informed by a FEMA official that FEMA can, in certain instances, reimburse school districts for additional costs associated with transporting displaced students to their schools of origin. However, school and emergency management officials were previously unaware of this, and thus failed to request such reimbursement from FEMA.³⁰⁴

303 The National Disaster Recovery Framework should state the importance of providing this information to school systems.

304 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," 4.

8. Child Welfare and Juvenile Justice

Recommendation 8.1: Ensure that State and local child welfare agencies adequately prepare for disasters.

Recommendation 8.2: Ensure that State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children adequately prepare for disasters.

Recommendation 8.3: HHS and DOJ should ensure that juvenile, dependency, and other courts hearing matters involving children adequately prepare for disasters.

8. Child Welfare and Juvenile Justice

Recommendation 8.1: Ensure that State and local child welfare agencies adequately prepare for disasters.

- Congress should request a national assessment of child welfare disaster planning to determine if significant advances have been made since passage of the Child and Family Services Improvement Act of 2006 (CFSIA).
- HHS should develop detailed disaster planning criteria by regulation or other formal policy guidance to supplement the basic procedures mandated in CFSIA.
- Within each ACF regional office, child welfare staff and the region's emergency management specialist should collaboratively review and evaluate the State child welfare disaster plans required by CFSIA and assist States in developing comprehensive plans and meeting their statutory obligations.
- DHS/FEMA and HHS should provide funding, guidance, and technical assistance to child welfare agencies and encourage collaboration with emergency management, courts, and other key stakeholders.

Hurricanes Katrina and Rita severely disrupted child welfare services, including forcing the evacuation of children in Louisiana's foster care system to 19 different States.³⁰⁵ The Government Accountability Office (GAO) subsequently conducted a survey of national foster care disaster planning to evaluate State planning capacity, and found that only three States had comprehensive child welfare plans that addressed all nine components of disaster planning identified by the GAO.³⁰⁶ Twenty States and the District of Columbia indicated that they had written child welfare disaster plans, but the quality of these plans varied widely, including the extent to which the plans include identification of dispersed children. Two months later, Congress passed the Child and Family Services Improvement Act (CFSIA),³⁰⁷ which included certain basic minimum disaster planning requirements for State child welfare agencies and required States to submit plans to the Department of Health and Human Services (HHS) Administration for Children and Families (ACF) by September 28, 2007. The law required State child welfare agencies to have procedures in place to respond to a disaster, "in accordance with criteria established by the [HHS] Secretary which should include how a State would:

- a. Identify, locate, and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster;

305 U.S. Government Accountability Office, *Child Welfare: Federal Action Needed to Ensure States Have Plans to Safeguard Children in the Child Welfare System Displaced by Disasters*, GAO-06-944, (Washington, DC: GAO, 2006), 1, <http://www.gao.gov/new.items/d06944.pdf>.

306 The survey covered all 50 States, the District of Columbia, and Puerto Rico. The nine State plan components, as specified in the 2006 GAO report, are: identify children who may be dispersed; identify caseworkers who may be dispersed; continue services to children who may be dispersed; preserve essential case information; coordinate services within the State; coordinate services outside the State; place children from other States; provide in-home family services; and identify new child welfare cases. *Ibid.*, 20.

307 Public Law (P.L.) 109-288; 120 Stat. 1233 (2006).

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- b. Respond to new child welfare cases in areas adversely affected by a disaster and provide services;
 - c. Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster;
 - d. Preserve essential program records; and
 - e. Coordinate services and share information with other States.³⁰⁸

Additional measures may be required to ensure that child welfare agencies are adequately prepared for disasters, as many States still have not engaged in comprehensive planning efforts. Although the Children's Bureau (CB) within ACF published an updated guidance document in 2007, detailed planning criteria to supplement the basic broad areas enumerated in the Act have not been issued in regulation by the HHS Secretary. A 2008 review of State child welfare plans by the National Council of Juvenile and Family Court Judges (NCJFCJ) found that State plans often contained only general statements addressing the five broad areas of planning required by the CFSIA. The plans reviewed also generally did not include directives concerning how information would be shared with the courts that make vital decisions affecting the lives of children and families in the child welfare system.³⁰⁹

The Commission recommends that Congress request a national assessment of child welfare disaster planning to determine if significant advances have been made since passage of the CFSIA. CB should conduct this assessment, or as an alternative, Congress may direct the GAO to follow up on its 2006 report.³¹⁰

Also, the Commission recommends that Congress require ACF and CB to develop a plan to ensure that all States prepare for disasters in a manner that is consistent with the intent of Congress as expressed in CFSIA. First, CB should develop detailed disaster planning criteria in a regulation or other formal policy guidance to supplement the basic procedures mandated in CFSIA.³¹¹ This would establish clear standards to help guide States' planning efforts and enable HHS to improve enforcement of the law by conducting a more exacting review to determine whether States are meeting their statutory obligations.

The Commission also recommends that the emergency management specialist in each ACF regional office participate in reviewing and evaluating the State child welfare disaster plans required by CFSIA, and in assisting States in developing comprehensive plans and meeting their statutory obligations. HHS, in its response to the Commission's request for information

308 P.L. 109-288; 120 Stat. 1233 (2006).

309 Lisa Portune and Sophia I. Gatowski, *Ensuring the Unique Needs of Dependency Courts are Met in Disaster Planning Efforts: Dependency Court Planning Templates for Continuity of Operations Plans*, (Reno, NV: National Council of Juvenile and Family Court Judges and American Bar Association, 2008), 67, <http://www.ncjfcj.org/images/stories/dept/ppcd/pdf/katrina%20a%20brief%20final.pdf>.

310 United States Government Accountability Office, *Child Welfare: Federal Action Needed to Ensure States Have Plans to Safeguard Children in the Child Welfare System Displaced by Disasters*, GAO-06-944, 1.

311 Although CB published an updated guidance document in 2007, no additional specific planning criteria were promulgated in regulation by the HHS Secretary.

on progress in implementing the Commission's Interim Report recommendations, reported that ACF regional office liaisons review these plans and can offer support to States in developing revisions or, if necessary, refer them to the Children's Bureau Training and Technical Assistance Network. It is important that individuals with emergency management and child welfare expertise participate in the review of State plans and provide technical assistance to States as needed.

Finally, State and local child welfare agencies should be encouraged by CB, in collaboration with the Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA), to prepare in ways beyond the minimal requirements enumerated in CFSIA, by:

- Conducting regular staff training and exercises of the plan.
- Coordinating with emergency management in formulating child welfare plans, and in integrating child welfare planning and exercises with other local and State planning and exercises.
- Collaborating with courts and other key stakeholders within the child welfare arena in planning and exercises.
- Developing a plan to provide additional services to address the emotional impact of disasters on children in the child welfare system.
- Requiring emergency planning for foster families, kinship care providers, and residential and group care facilities.
- Implementing the State plan at the local levels and integrating local plans into the State plan.

To encourage such State and local child welfare disaster planning efforts, in Chapter 1 of this report the Commission recommends that DHS/FEMA and ACF form a formal interagency partnership to pool resources to make funding, technical assistance, and other support available. Such resources should be used to support comprehensive and innovative preparedness initiatives; develop best practices; and facilitate collaborative planning, training, and exercises at the State and local level between child welfare and emergency management officials.

Recommendation 8.2: Ensure that State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children adequately prepare for disasters.

- Congress should require State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children to have comprehensive disaster plans in place.
- DHS/FEMA and DOJ should support disaster planning for State and local juvenile justice agencies and residential treatment, correctional, and detention facilities that house children, by providing funding, technical assistance, and training.

In 2007, more than 1.6 million delinquency cases were processed nationwide resulting in 149,000 youth being placed out of their home.³¹² In August 2005, prior to the arrival of Hurricanes Katrina and Rita, approximately 16,000 children were under the care or supervision of the juvenile justice systems in the impacted Gulf Coast States.³¹³ The experiences of some of these children demonstrate the importance of effectively implementing coordinated system-wide juvenile justice disaster plans.^{314,315} For example, while State-run juvenile facilities in New Orleans safely evacuated youth to Baton Rouge in advance of Hurricane Katrina, the last-minute evacuation of a city-run juvenile facility to the predominately adult-populated Orleans Parish Prison left some children trapped for days without food, water, or medical care.³¹⁶

A 2006 report funded by the Department of Justice (DOJ) Office of Juvenile Justice and Delinquency Protection (OJJDP) emphasized the importance of multi-agency collaborations in disaster planning, including involving Federal, State, and local agencies and community-based organizations.³¹⁷ The report noted that detention and correctional facilities that had undertaken these efforts were better positioned following Hurricanes Katrina and Rita to make the difficult decisions that affected the safety of youth under their care.³¹⁸

312 Charles Puzzanchera, Benjamin Adams, and Melissa Sickmund, *Juvenile Court Statistics 2006-2007*, ed. National Center for Juvenile Justice (Pittsburgh, PA: NCJJ, 2010), 9, 50, <http://www.ncjservehttp.org/ncjjwebsite/pdf/jcsreports/jcs2007.pdf>.

313 Susan James Andrews and Susan Yeres, *An Assessment of the Impact of Hurricanes Katrina and Rita on the Juvenile Justice System*, ed. Office of Juvenile Justice and Delinquency Prevention (Washington, DC: OJJDP, 2006), 3, <http://gemini.gmu.edu/ebct/Events/Katrina%20final%20report.pdf>.

314 *Ibid.*, 7.

315 Juvenile Justice Project of Louisiana (JJPL), *Treated Like Trash: Juvenile Detention in New Orleans Before, During, and After Hurricane Katrina*, (New Orleans, LA: JJPL, 2006), 10-11, http://www.jjpl.org/PDF/treated_like_trash.pdf.

316 *Ibid.*, 5.

317 Susan James Andrews and Susan Yeres, *An Assessment of the Impact of Hurricanes Katrina and Rita on the Juvenile Justice System*, 4.

318 *Ibid.*, 3.

The Commission recommends that all State and local juvenile justice agencies and facilities—including all residential treatment, correctional, and detention facilities that house children, as well as private facilities that manage youth treatment programs—have comprehensive disaster plans in place. Although a baseline level of disaster planning is required for State child welfare agencies, Federal law does not require juvenile justice systems to develop and implement disaster plans. While a Federal requirement is advisable, the Commission is currently working with OJJDP on incentives for action.

The overarching goal of juvenile justice disaster planning must be to protect the physical safety and emotional well-being of children in the State’s care before, during, and after a disaster. Critical services must be maintained (e.g., education, health, mental health, substance abuse, probation, and case processing) for all children in the system, whether in care or under supervision. Plans should be coordinated with other jurisdictions and entities within the juvenile system, including courts and probation services, and with key external stakeholders such as emergency management officials and community-based organizations. State juvenile justice agencies should oversee and coordinate system-wide disaster planning and certify that all local agencies and facilities that house juveniles within the State adequately prepare for disasters.

To help inform the development of juvenile justice disaster planning, the Commission recommended in its Interim Report that OJJDP conduct an assessment of disaster preparedness among State and local juvenile justice systems.³¹⁹ OJJDP subsequently requested disaster plans from the State agencies that receive its formula grant funds. Fifteen grantees responded and OJJDP found that the submitted plans were predominantly intended for basic continuity of operations, rather than comprehensive disaster preparedness, response and recovery.³²⁰

The Commission also recommended in its Interim Report that OJJDP form a working group with the mission of improving juvenile justice disaster preparedness nationwide.³²¹ OJJDP established the Justice Working Group on Children and Disasters, whose initial goal is to create a document with guiding principles to assist juvenile justice facilities in developing disaster plans.³²²

319 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 49-50, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

320 National Commission on Children and Disasters, “Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps To Achieve Commission Goals,” (Washington, DC: NCCD, May 11, 2010), 14, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

321 National Commission on Children and Disasters, *Interim Report*, 50.

322 The Working Group includes members from relevant Federal, State, and local agencies and non-governmental entities with expertise in managing and providing services within juvenile justice systems and the courts, as well as members with disaster management experience. The document is scheduled to be released in January 2011.

The Commission supports these initial steps, but believes that substantially more support—beyond the development and dissemination of a guidance document for facilities—is needed to adequately assist State and local agencies and facilities in preparing for disasters. Specifically, the Commission recommends OJJDP lead an effort to:

- Identify common gaps and shortcomings, as well as best practices, in State juvenile justice disaster planning.
- Develop a technical assistance and training program – that covers the full spectrum of disaster planning and management, including basic disaster preparedness and disaster mental health training for staff at juvenile justice facilities—and make it available to States.
- Support State and local juvenile justice systems in developing or updating disaster plans in coordination with State emergency management and key stakeholders including juvenile courts, residential treatment facilities, and correctional and detention facilities that house juveniles via court-ordered placements and social services agencies.

To help accomplish these objectives, OJJDP should consider creating a demonstration program that awards disaster planning grants to States through a competitive process. This approach could support and highlight successful planning models in specific States, which would in turn facilitate the development of best practices, and provide models to assist other States in improving their disaster plans.

In recognition of OJJDP’s limited resources and disaster management expertise, the Commission, in Chapter 1 of this report, recommends that DHS/FEMA and DOJ form a formal interagency partnership. This partnership would pool resources to make funding, technical assistance, and other support available to enhance the disaster preparedness, response, and recovery efforts of State and local juvenile justice systems and facilities. This collaboration would help OJJDP accomplish the objectives outlined above and promote collaborative planning, training, and exercises at the State and local level.

Ultimately, the Commission recommends that Congress enact a requirement for comprehensive disaster planning among juvenile justice facilities and agencies throughout the Nation. To the extent practicable, legislation would incorporate the guiding principles for effective disaster planning developed by the Justice Working Group on Children and Disasters. As part of this requirement, Congress should appropriate adequate funding to support Federal and non-Federal planning and other preparedness activities.

Recommendation 8.3: HHS and DOJ should ensure that juvenile, dependency, and other courts hearing matters involving children adequately prepare for disasters.

- *HHS should include disaster preparedness as a component of the Court Improvement Program for dependency courts.*
- *DOJ should include disaster preparedness as a component of the proposed National Juvenile Delinquency Court Improvement Program.*
- *DOJ and the National Council of Juvenile and Family Court Judges should incorporate disaster preparedness into the Model Courts program.*

Hurricanes Katrina and Rita demonstrated that courts with primary responsibility for cases involving children and youth need comprehensive disaster plans.^{323,324} In some areas of the Gulf, critical decisions involving the release, confinement, or movement of youth could not be made because judges could not be contacted, and backup plans were not in place.³²⁵ Decision making was further disrupted as some courts lost all their records, including backup records that were kept on-site.³²⁶ Courts, child welfare and juvenile justice professionals, and advocates lacked a systematic means to share information or coordinate essential activities. Courts and agencies struggled to locate children and foster and biological families, provide critical services and supports, and ensure appropriate oversight of cases. More recently, the Commission learned during its field visit to Iowa that during Iowa's 2008 floods and tornadoes, the Juvenile Court in Cedar Rapids lost all of its court records, necessitating a lengthy and arduous attempt at reconstructing the files from multiple sources.³²⁷

The Commission recommends that juvenile, dependency, and other courts hearing matters involving children must develop comprehensive plans that facilitate communication, coordination, and oversight of dependency and delinquency cases in times of disaster. In developing these plans, courts should collaborate with child welfare agencies, juvenile justice agencies and facilities, social workers, attorneys and other child advocates, volunteers, emergency management officials, and other community and professional stakeholders. In addition, since courts hearing cases involving children and youth are part of a larger court system, it is critical that planning efforts also be coordinated with the broader court system. Once the plans are developed, the courts should conduct regular disaster exercises involving these stakeholders.

323 Lisa Portune and Sophia Gatowski, *Ensuring the Unique Needs of Dependency Courts are Met in Disaster Planning Efforts: Dependency Court Planning Templates for Continuity of Operations Plans*, 2.

324 Victor E. Flango (ed.), *Emergency Preparedness in Dependency Courts: Ten Questions That Courts Serving Abused and Neglected Children Must Address*, (Williamsburg, VA: National Center for State Courts): Chapter 1, <http://www.icmeducation.org/katrina/chapter1.html>.

325 Susan Andrews and Susan Yeres, *An Assessment of the Impact of Hurricanes Katrina and Rita on the Juvenile Justice System*, 11.

326 Ibid.

327 National Commission on Children and Disasters, "Minutes: Field Visit, Cedar Rapids, Iowa," (Washington, DC: NCCD, 2010), 10, http://www.childrenanddisasters.acf.hhs.gov/20100106_IowaFieldVisit_MinutesV03FINAL.pdf.

Toward the goal of ensuring that juvenile and dependency courts have comprehensive disaster plans, the Commission recommends that CB clarify that funds from their Court Improvement Program (CIP) can be used by dependency courts and child welfare agencies to engage in collaborative disaster planning activities. The funds could improve the handling of cases and care for children who are in or may enter the child welfare system in times of disaster. All States receive CIP funding to conduct a variety of activities that promote system improvements within dependency courts and child welfare systems. These activities include creating and enhancing formal relationships between the courts and child welfare agencies. Responding to an appeal from the Commission to focus greater attention on disaster planning and collaborations among dependency courts and child welfare systems, CB indicated to its grantees that collaboration between dependency courts and child welfare systems in disaster planning constitutes the “meaningful and ongoing collaboration” that the CIP requires.³²⁸ However, more formal clarification, such as an addition to the program instruction should be issued to grantees.

The Fiscal Year 2011 budget request for OJJDP includes funding for a proposed National Juvenile Delinquency Court Improvement Program. If the program is approved by Congress, OJJDP should similarly include in the program instruction that collaborative disaster planning activities undertaken by delinquency courts and juvenile justice agencies and facilities also constitute eligible uses of program funds. In addition, OJJDP and CB should explore other possible ways to improve disaster preparedness in juvenile delinquency and dependency courts, and encourage collaborative disaster planning between courts and juvenile justice and child welfare agencies.

Finally, the Commission recommends that disaster preparedness be incorporated into the NCJFCJ’s Model Courts Program, an OJJDP-funded program that seeks to improve outcomes for abused and neglected children and their families by funding innovative court programs. The Commission believes that through the Model Courts program, OJJDP and NCJFCJ can lead the way in disaster preparedness for courts by raising awareness and developing best practices for other courts around the Nation to emulate.

328 Emily Cooke, Special Assistant for Court Improvement, Children's Bureau, Administration for Children and Families, Email Message to Court Improvement Program Coordinators, February 19, 2010.

9. Sheltering Standards, Services, and Supplies

Recommendation 9.1: Government agencies and non-governmental organizations should provide a safe and secure mass care shelter environment for children, including access to essential services and supplies.

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- *Implement national standards and indicators for mass care shelters that are specific and responsive to children.*
- *Integrate essential age-appropriate shelter supplies for infants and children into shelter planning and fund the addition of child-specific supplies to caches for immediate deployment to support shelter operations.*
- *Implement common standards and training, including standards for criminal background checks, to mitigate risks unique to children in shelters such as child abduction and sex offenders.*

During disasters, children and families must be assured a safe and secure shelter environment. Shelters are operated by the American Red Cross (ARC), other National Voluntary Organizations Active in Disaster (NVOAD) member organizations, faith-based organizations, and State and local governments under agreed upon standards and protocols. While the Federal Emergency Management Agency (FEMA) does not operate shelters or have the authority to enforce shelter standards, FEMA does provide guidance and reimbursement for eligible sheltering expenses under the Stafford Act.

In its Interim Report, the Commission determined that a more comprehensive body of information was needed to inform emergency planners, shelter managers, and staff about the needs of children in critical areas related to shelter design, supplies, and safety.³²⁹ The ARC worked with the Commission, FEMA, and other partners to develop guidance for shelter managers and staff. The guidance document, *Standards and Indicators for Disaster Shelter Care for Children*,³³⁰ was distributed to ARC chapters and adopted by the NVOAD Mass Care Committee in 2009.^{331,332}

Disaster shelters that opened during the September 2009 floods in Georgia demonstrated an increased awareness of the need to have child-appropriate supplies and expertise on hand.³³³ The spring 2010 flooding in Nashville, TN provided another opportunity to test the standards and indicators. Following visits to ARC shelters, the Commission noted that some

329 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 53, http://www.childrenanddisasters.acf.hhs.gov/20091014_5081R_partII.pdf.

330 *Ibid.*, 70.

331 American Red Cross, Testimony of Trevor Rikken, American Red Cross before the U.S. House of Representatives, Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings and Emergency Management, (Washington, DC: ARC, October 20, 2009), 4, <http://www.redcross.org/www-files/Documents/GovernmentRelations/09Oct20RikkenTestimony.pdf>.

332 National Commission on Children and Disasters, "Meeting Minutes of the Evacuation, Transportation, and Housing Subcommittee," (Washington, DC: NCCD, May 10, 2010), 4, http://www.childrenanddisasters.acf.hhs.gov/NCCD%20Subcommittees/20100510_ETHSubcommitteeReportFINAL.pdf.

333 American Red Cross, "Testimony of Trevor Rikken," 4.

revisions to the standards were needed, particularly to address the need for folding, portable cribs and playpens in shelters.³³⁴ An updated version of *Standards and Indicators for Disaster Shelter Care for Children* is included in Appendix E.

The Commission also collaborated with ARC, FEMA, the American Academy of Pediatrics, and Save the Children to develop a list of age-appropriate shelter supplies for infants and toddlers (Appendix F). The document provides guidance to shelter managers and staff on essential shelter supplies for children (e.g., formula, diapers, and baby food). FEMA incorporated the shelter supply list into preparedness grants guidance and other internal planning documents and indicated that the supplies are cost-reimbursable.³³⁵ In addition, FEMA identified the best methods for Federal responders to rapidly distribute these items to an affected area if requested.³³⁶ Such actions include entering into purchasing agreements with vendors to have these supplies ready for express shipment in the event of an incident.³³⁷ FEMA used the document as a guide for procuring supplies for evacuees waiting to depart Port Au Prince Airport following the 2010 earthquake in Haiti.³³⁸

Currently, elements of both guidance documents are being considered for incorporation into other shelter planning and assessment tools developed by FEMA, the Department of Health and Human Services (HHS), ARC, and other Federal and non-Federal partners. In addition, FEMA has a Pre-Scripted Statement of Work with the HHS Administration for Children and Families to conduct human services shelter assessments. The assessments were modified to include components of the shelter standards and indicators guidance, and the assessment teams will provide assistance to shelter operators in meeting the needs of children.

A corollary concern is the collection of information on the number of children in shelters, which normally is not available because most shelter registration forms do not include age categories. Additionally, shelter operators generally use a “midnight head count on pillows” method to count individuals, which does not consider age or people who use shelter

334 Commissioner Bruce Lockwood visited two shelters that were established in response to the flooding and observed that one had three infants, but no cribs, indicating that the standards do not address the need for child-specific beds. ARC also noted that this incident demonstrated a need for local chapters to have agreements in place with local vendors to obtain necessary supplies in case shipping issues arise, which occurred when the local FedEx facility flooded. National Commission on Children and Disasters, “Meeting Minutes of the Evacuation, Transportation, and Housing Subcommittee,” 4.

335 U.S. Department of Homeland Security, *Fiscal Year 2010 Homeland Security Grant Program Supplemental Resource: Children in Disasters Guidance*, (Washington, DC: DHS, June 2009), 2, http://www.fema.gov/pdf/government/grant/2010/fy10_hsgp_children.pdf.

336 National Commission on Children and Disasters, “Meeting Minutes of the November 10, 2009 Public Meeting,” (Washington, DC: NCCD, November 10, 2009), 4-5, http://www.childrenanddisasters.acf.hhs.gov/minutes/20091110_MinutesV02.pdf.

337 National Commission on Children and Disasters, Evacuation, Transportation, and Housing Subcommittee, Conference Call, March 11, 2010.

338 Federal Emergency Management Agency, Memorandum to the National Commission on Children and Disasters: *Response to the National Commission on Children and Disasters Interim Report*, March 19, 2010, 19, Washington, DC.

services but do not reside in shelters overnight. Data collection on children and families in shelters would improve shelter resource management and delivery of necessary services to shelter populations. In response to the Commission's concerns about the lack of data collection on children in shelters, FEMA's National Shelter System will be modified to capture information on the number of children within specific age brackets,³³⁹ thus greatly improving the system's ability to support the needs of children and families. These age breakouts are anticipated to be included in all shelter guidance documents under development.

The safety and security of children in shelters is of paramount concern to the Commission. The Interim Report therefore included a recommendation that protocols be established that will ensure children are protected against the threat of neglect, abduction, and sex offenders.³⁴⁰ At a minimum, all shelter workers should be trained to identify and address suspicious and inappropriate activity. Available resources include the National Resource Center for Child Protective Services' curriculum and trainer's guide *Preventing Child Abuse and Neglect in Disaster Emergency Shelters*.³⁴¹ FEMA also is developing health and safety educational materials for parents and families to better safeguard their children in a shelter environment. Safety and security may also be enhanced by conducting appropriate criminal history background checks on all shelter workers. Most NVOAD members have systems in place for performing background checks on their volunteers, but there are no consistent policies or guidelines. The Commission urges the NVOAD to develop points of consensus and cooperative standards for performing background checks, particularly for volunteers who provide care to children in shelters.

339 National Commission on Children and Disasters, "Progress Report on Children and Disasters: U.S. Agencies Take Modest Steps to Achieve Commission Goals," (Washington, DC: NCCD, May 11, 2010), 15, http://www.childrenanddisasters.acf.hhs.gov/20100511_NCCD_Progress_Report_FINAL.pdf.

340 National Commission on Children and Disasters, *Interim Report*, 53.

341 National Resource Center for Child Protective Services, "Preventing Child Abuse and Neglect in Disaster Emergency Shelters," http://www.nrccps.org/resources/disaster_emergency_shelters.php.

10. Housing

Recommendation 10.1: Prioritize the needs of families with children, especially families with children who have disabilities or chronic health, mental health, or educational needs, within disaster housing assistance programs.

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Recommendation 10.1: Prioritize the needs of families with children, especially families with children who have disabilities or chronic health, mental health, or educational needs, within disaster housing assistance programs.

- *Government agencies and non-governmental organizations should ensure that families with children in disaster housing, especially community sites, have access to needed services and are provided safe and healthy living environments.*
- *Congress should authorize DHS/FEMA to reimburse State and local governments for providing wrap-around services to children and families in community sites.*
- *DHS/FEMA should develop clear written guidance around emergency transportation planning and reimbursement for State and local governments that addresses the recovery needs of children and families.*
- *Government agencies and non-governmental organizations should identify and promote innovative programs to expedite the transition into permanent housing for families with children.*

The Federal Government and its State and local partners must address the unique housing and community needs of families with children in planning and throughout the continuum of disaster housing assistance, from emergency sheltering to interim housing to permanent housing.³⁴² Interim and permanent housing options must provide families with children access to stable, affordable, and safe housing in close proximity to schools, child care, and health and social services, which are critical for a family's recovery following a disaster. To minimize harmful disruptions to children's lives, the transition from interim to permanent housing also must be prompt and seamless.

Children may suffer emotional stress from having to move to unfamiliar locations or when they are disconnected from their traditional support networks.³⁴³ Following a move that results in a change in schools, children commonly require between four and six months for academic recovery.³⁴⁴ Children displaced following Hurricane Katrina moved an average of three times per child.³⁴⁵ A study of displaced students attending Louisiana Public Schools during the first academic year following the hurricane found that negative achievement

342 Interim housing is defined as the intermediate period of housing assistance that covers the gap between sheltering and the return of disaster survivors to permanent housing. Generally, this period may span from the day after the disaster is declared through up to 18 months. Long-term housing is defined as safe, sanitary, and secure housing that can be sustained without continued disaster-related assistance. Federal Emergency Management Agency, "Glossary/Acronyms," <http://www.fema.gov/emergency/disasterhousing/glossary.shtm>.

343 Lori Peek, "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience - An Introduction," *Children, Youth and Environment* 18, no. 1 (2008): 4-7.

344 Laurene M. Heyback and Patricia Nix-Hodes, "Reducing Mobility: Good for Kids, Good for Schools," *The Beam: The Newsletter for the National Association for the Education of Homeless Children and Youth* 9, no. 1 (1999): 5.

345 Anne Westbrook Lauten and Kimberly Leitz, "A Look at the Standards Gap: Comparing Child Protection Responses in the Aftermath of Hurricane Katrina and the Indian Ocean Tsunami," *Children, Youth and Environments* 18, no. 1 (2008): 187.

effects were correlated with the number of schools attended and were most significant among children who were displaced for the remainder of the academic year.³⁴⁶

The Commission urges State and local governments to prioritize families with children, especially families with children who have disabilities or chronic health, mental health, or educational needs, for disaster housing that meets their housing and community needs. Although the Stafford Act prevents the prioritization of any population for Federal assistance,³⁴⁷ according to the National Disaster Housing Strategy³⁴⁸ (the “Strategy”), State and local governments, through State-led housing task forces or other mechanisms, “will determine the priorities for placement of individuals and households.”³⁴⁹ However, the Strategy only suggests that State and local governments consider medical needs, accessibility requirements, and court restrictions when determining “which populations have precedence to ensure that everyone is housed to best suit their individual needs.”³⁵⁰

The Commission continues to recommend that individuals with subject-matter expertise related to children and programs to address children’s needs be included on the National Disaster Housing Task Force (NDHTF),³⁵¹ State-led housing task forces, and all related working groups. Representation on State-led housing task forces is especially critical since, as mentioned above, State-led task forces may identify populations for priority occupancy.³⁵²

In the *Interim Report*, the Commission recommended that the NDHTF integrate the needs of families with children throughout the Strategy’s Implementation Plan and other related efforts. The Implementation Plan was released in March 2010 and includes an objective and

346 John Pane, Daniel F. McCaffrey, Nidhi Kalra, and Annie J. Zhou, “Effects of Student Displacement in Louisiana During the First Academic Year After the Hurricanes of 2005,” *Journal of Education for Students Placed at Risk (JESPAR)* 13, no. 2 (2008): 55, http://www.rand.org/pubs/reprints/2008/RAND_RP1379.pdf.

347 Section 308 of the Stafford Act contains a mandate to ensure that “the distribution of supplies, the processing of applications, and other relief and assistance activities shall be accomplished in an equitable and impartial manner, without discrimination on the grounds of race, color, religion, nationality, sex, age, disability, English proficiency, or economic status.” Public Law (P.L.) 93-288, 42 U.S.C. 5151.

348 The Post-Katrina Emergency Management Reform Act (PKEMRA) required the Federal Emergency Management Agency (FEMA), in coordination with other Federal, State, local, and tribal governments and non-governmental organizations, to develop the Strategy. Released in January 2009, the Strategy describes how the Nation currently provides housing to disaster survivors and presents a new direction for disaster housing to better meet the needs of survivors.

349 Federal Emergency Management Agency, *National Disaster Housing Strategy Annex 4: Disaster Housing Community Site Operations*, (Washington, DC: FEMA, 2009), 112, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHSAnnex4.pdf>.

350 *Ibid.*, 112.

351 The Strategy called for the formation of the NDHTF “to provide a full-time, multi-agency focus on disaster housing related issues, to elevate the significance of disaster housing preparedness in all jurisdictions, and to oversee implementation of the Strategy.” The NDHTF, comprised of representatives from 15 Federal agencies, leads disaster housing contingency planning and preparedness efforts and advises the FEMA Administrator. Federal Emergency Management Agency, *National Disaster Housing Strategy Implementation Plan*, (Washington, DC: FEMA, March 2010), 1, http://www.fema.gov/pdf/emergency/disasterhousing/ndhs_implementation_plan.pdf.

352 Federal Emergency Management Agency, *National Disaster Housing Strategy Annex 4: Disaster Housing Community Site Operations*, 112.

corresponding tasks related to the needs of children, which were assigned to the NDHTF and the Department of Health and Human Services (HHS) as lead and coordinating entities.³⁵³ The Implementation Plan also indicates that the identification of wrap-around services³⁵⁴ necessary to meet the needs of children and families will be included in the National Disaster Housing Concept of Operations and Disaster Housing Practitioner's Guide³⁵⁵ currently being developed by the NDHTF.³⁵⁶ The Commission recommends that both documents clearly state that access, proximity, and transportation to educational institutions, child care, health and mental health care, child welfare, safe recreational sites, and essential social services must be primary considerations during the process of locating suitable housing options for families with children or designing a community site.

The Commission remains concerned about the delivery of wrap-around services for children and families placed in community sites. Following a large-scale disaster, available resources for interim housing may be insufficient to meet demand, prompting the development of community sites as an "option of last resort."³⁵⁷ After Hurricane Katrina, children experienced challenging living conditions due to overcrowded neighborhoods, unsafe communities, and isolation from other housing sites.³⁵⁸ Although some social services, including early childhood education and after-school programs, employment services, and transit for persons with disabilities, were offered on-site in the largest community site, Renaissance Village,³⁵⁹ it was likely the only site where this occurred.³⁶⁰ To address problems with the conditions in community sites, the Post-Katrina Emergency Management Reform Act

353 Federal Emergency Management Agency, *National Disaster Housing Strategy Implementation Plan*, 14.

354 As stated in FEMA's National Disaster Housing Strategy, wrap-around services "encompass a variety of human and social support that may be required to accompany temporary housing community sites during a disaster, such as health care, schools and daycare, security, social services, maintenance and repair, public transportation, and employment counseling." Federal Emergency Management Agency, *National Disaster Housing Strategy*, (Washington, DC: FEMA, January 16, 2009), 52, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHSCore.pdf>. The Commission also uses the term to refer to access to mental health and child care services and safe play areas for children.

355 The purpose of the CONOPS is to describe "specific roles and responsibilities and the actions each player must take to execute effective disaster housing operations across all levels of government, non-governmental organizations, and the private sector." *Ibid.*, 89.

356 The CONOPS and the Practitioners' Guide were to be completed within ten months following release of the Strategy. However, the deadline was subsequently changed to June 1, 2010, to coincide with the release of President Obama's long-term recovery framework. With the recovery framework on hold, the CONOPS and the Practitioners' Guide are not yet approved.

357 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 58, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

358 Shane Townsend and Nathalie Dajko, *Rapid Assessments of Temporary Housing Camps for Hurricane-Displaced Children and Families*, ed. Save the Children (Westport, CT: Save the Children, 2006), 3, http://www.savethechildren.org/publications/reports/katrina-assessment_final-0706.pdf.

359 Renaissance Village was located about 15 miles north of Baton Rouge (LA) and had a peak population of more than 500 families. Service providers included Head Start and Early Head Start. U.S. Government Accountability Office, *Disaster Assistance: Federal Efforts to Assist Group Site Residents with Employment, Services for Families with Children, and Transportation*, GAO-09-81, (Washington, DC: GAO, 2008), 39, <http://www.gao.gov/new.items/d0981.pdf>.

360 *Ibid.*, 4.

(PKEMRA) required the development of a plan for the operation of community sites, including access to public services, site management, security, and site density.³⁶¹

In an Annex to the Strategy entitled “Disaster Housing Community Site Operations,” the Federal Emergency Management Agency (FEMA) provides “a framework for Federal, State, territory, tribal, and local governments to plan every step of the community site operations process.”³⁶² FEMA acknowledges that “it is essential that access to educational institutions, places of employment, and essential social services is considered during the process of planning and designing a community site.”³⁶³ However, FEMA also acknowledges that locating a community near established wrap-around services and infrastructure may not be feasible. FEMA notes that, in those cases, additional services and infrastructure, such as child care and playgrounds, are often requested, but maintains that the Agency lacks the authority under the Stafford Act to provide these and other wrap-around services to children and families in community sites.³⁶⁴

The Commission urges State and local governments to ensure that access to wrap-around services is provided to community site residents. In addition, the Commission recommends that Congress authorize FEMA to reimburse State and local governments for reasonable expenses related to ensuring access to these services, whether in the form of transportation to nearby services or temporary augmentations to the community sites that permit the services to be delivered on-site.

Furthermore, the Commission echoes the Government Accountability Office (GAO) 2008 recommendation that FEMA develop clear written guidance around emergency transportation planning and reimbursement for State and local governments.³⁶⁵ Following Hurricane Katrina, the GAO identified only one Federal program that exclusively served community site residents, and only two community sites received services through the program.³⁶⁶ Routes were limited to FEMA-defined “essential services”—specifically banks, grocery stores, and pharmacies—while transport to other human and medical services was not provided. FEMA officials indicated to the Commission that although no specific written policy addressing reimbursement for emergency transportation costs exists, FEMA may cover certain additional transportation expenses under the public assistance program. States and local jurisdictions must have a clearer indication from FEMA of the type and scope of transportation assistance eligible for reimbursement following a disaster.

361 P.L. 109-295; 120 Stat. 1394.

362 Federal Emergency Management Agency, *National Disaster Housing Strategy Annex 4: Disaster Housing Community Site Operations*, 99.

363 *Ibid.*, 109.

364 *Ibid.*, 110.

365 U.S. Government Accountability Office, *Emergency Transit Assistance: Federal Funding for Recent Disasters, and Options for the Future*, GAO-08-243, (Washington, DC: GAO, 2008), 6-7, <http://www.gao.gov/new.items/d08243.pdf>.

366 U.S. Government Accountability Office, *Disaster Assistance: Federal Efforts to Assist Group Site Residents with Employment, Services for Families with Children, and Transportation*, 4-5.

Finally, the Commission recommends that the NDHTF continue to identify and promote innovative disaster housing solutions that accelerate the transition to permanent housing for families with children. One example of an innovative solution is FEMA's Alternative Housing Pilot Program (AHPP), which FEMA identifies as a key component of the National Disaster Housing Strategy.³⁶⁷ The most recognized initiatives under AHPP are the cottage programs, known as Mississippi Cottages in Mississippi³⁶⁸ and Katrina Cottages in Louisiana.³⁶⁹ The purpose of the programs is to develop and produce safer and more comfortable temporary housing units with the option of allowing units to be converted from temporary to permanent.^{370, 371} The cottages are designed to be larger and more durable than FEMA trailers and to provide a more comfortable living space.^{372, 373} In addition, they can be easily incorporated as a permanent part of a community, as has recently occurred in Ocean Springs, MS.³⁷⁴

In a statement to the House Homeland Security Committee in a July 2009 public hearing, FEMA Administrator Craig Fugate noted that Katrina-type cottages could significantly accelerate a small community's recovery following a disaster.³⁷⁵ He encouraged communities to develop strategies that integrate alternative housing solutions, such as the Katrina-type cottages, into their communities, as opposed to considering cottages an alternative to temporary housing.³⁷⁶

367 Federal Emergency Management Agency, "Alternative Housing Pilot Program," <http://www.fema.gov/about/programs/ahpp/index.shtm>.

368 At the program's height in Mississippi, 2,900 cottages were occupied. Mississippi's goal was to permanently install and transfer ownership of 1,200 cottages to individuals for location on individual sites by May 2010, and subsequently dispose of all cottages at transitional sites and demobilize all cottages that were not to be sold. The Mississippi Emergency Management Agency offered 250 of these cottages at auction to the public on June 4, 2010. Mississippi Emergency Management Agency, "Mississippi Alternative Housing," <http://www.msccottage.org/>.

369 In Louisiana, 119 of these Katrina Cottages had been completed in December 2009, with another 230 still to be built. While many of these are to be used as rental housing, the others will be sold to qualified buyers through a program overseen by the Louisiana Recovery Authority. Bill Barrow, "Katrina Cottage Financing Not Going to Waste, Louisiana Recovery Authority Reports," December 8, 2009, http://www.nola.com/hurricane/index.ssf/2009/12/katrina_cottage_financing_not.html.

370 Mississippi Emergency Management Agency, "Mississippi Alternative Housing."

371 Louisiana Recovery Authority, "\$74 Million for Louisiana Cottages on the Way."

372 Mississippi Emergency Management Agency, "Mississippi Alternative Housing."

373 Louisiana Recovery Authority, "\$74 Million for Louisiana Cottages on the Way." The Mississippi Cottages employ a variety of designs for small-scale, quality-built homes that provide strong resistance to storms. Other design features which are improvements over FEMA trailers include air-conditioned attics, EnergyStar heating, ventilating, and air conditioning (HVAC) systems, moisture and mold resistant materials, and a front porch. Cottages also reflect Gulf Coast design styles. Federal Emergency Management Agency, "Fact Sheet Awards - Selected Grant Awards For Alternative Housing Pilot Project," http://www.fema.gov/media/fact_sheets/ahpp_awards.shtm.

374 Mississippi Renewal Forum, "Getting to the Future First: Lessons from America in Mississippi's Storm Recovery?," <http://www.mississippirenewal.com/#>.

375 Craig Fugate, Testimony of Craig Fugate before the U.S. House of Representatives, Committee on Homeland Security, "FEMA Housing: An Examination of Current Problems and Innovative Solutions," Serial No. 111-27, Washington, DC, July 8, 2009, 11, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_house_hearings&docid=f:52955.pdf.

376 Ibid., 11-12.

11. Evacuation

Recommendation 11.1: Congress and Federal agencies should provide sufficient funding to develop and deploy a national information sharing capability to quickly and effectively reunite displaced children with their families, guardians, and caregivers when separated by a disaster.

Recommendation 11.2: Disaster plans at all levels of government must specifically address the evacuation and transportation needs of children with disabilities and chronic health needs, in coordination with child congregate care facilities such as schools, child care, and health care facilities.

11. Evacuation

Recommendation 11.1: Congress and Federal agencies should provide sufficient funding to develop and deploy a national information sharing capability to quickly and effectively reunite displaced children with their families, guardians, and caregivers when separated by a disaster.

- *DHS should lead the development of a nationwide information technology capability to collect, share, and search data from any patient and evacuee tracking or family reunification system.*
- *DHS should support the development of voluntary consensus-driven standards for data collection and data sharing through a joint Federal, non-Federal, and private sector process.*
- *Government agencies should ensure the collection of appropriate data on evacuated children, particularly unaccompanied minors.*

Families may become separated during the chaos of a disaster, especially when it necessitates evacuation. A no-notice disaster occurring while children are in schools, after-school programs, and child care facilities increases the likelihood that children will be separated from parents and guardians. Hurricanes Katrina and Rita demonstrated the consequences of a large-scale evacuation, as more than 5,000 children became separated from their families.³⁷⁷ More than 34,000 calls were placed to a special hotline that the National Center for Missing and Exploited Children established after the storms and it took 6 months for the last child to be reunited with their family.³⁷⁸ The longer a child is separated from parents and loved ones, the more he or she is at risk for physical injuries, abuse, abduction, and emotional trauma.³⁷⁹

The inability to track the movement and location of evacuated persons was a major factor delaying family reunification after Hurricanes Katrina and Rita.³⁸⁰ Limitations in tracking patients evacuated on various Federal, State, and private-sector aircraft were also identified.³⁸¹ In subsequent years, a number of States have developed or purchased systems for tracking

377 Sarita Chung and Michael Shannon, "Reuniting Children with Their Families During Disasters: A Proposed Plan for Greater Success," *American Journal of Disaster Medicine* 2, no. 3 (2007): 114.

378 *Ibid.*, 114.

379 Mark A. Brandenburg, Sue M. Watkins, Karin L. Brandenburg, and Christoph Schieche, "Operation Child-ID: Reuniting Children with Their Legal Guardians after Hurricane Katrina," *Disasters* 31, no. 3 (2007): 277-87.

380 Daniel D. Broughton, Ernest E. Allen, Robert E. Hannemann, and Joshua E. Petrikin, "Getting 5000 Families Back Together: Reuniting Fractured Families after a Disaster: The Role of the National Center for Missing & Exploited Children," *Pediatrics* 117, no. 5 (2006): S442-5, <http://pediatrics.aappublications.org/cgi/reprint/117/5/S2/S442>.

381 During Hurricane Katrina, the National Disaster Medical System (NDMS) was activated to provide patient transport and help facilitate hospital evacuations. More than 4,000 patients were evacuated through the New Orleans airport, and some patients were placed on Air Force aircraft; however, more than half of the patients were placed on National Guard and private aircraft. Only those patients who were evacuated on the Air Force aircraft were entered into the NDMS patient movement-tracking system. Thus, accurate data on all transported patients were not available. Senate Committee on Homeland Security and Governmental Affairs, S. Rpt. 109-322 – *Hurricane Katrina: A Nation Still Unprepared*, (Washington, DC: GPO, 2006), 414, <http://www.gpoaccess.gov/serialset/creports/katrinanation.html>.

evacuees.³⁸² States also have the option of using the National Mass Evacuation Tracking System (NMETS), a State-based system developed and released by the Federal Emergency Management Agency (FEMA) on June 1, 2010. NMETS is offered in three versions: a manual paper-based system, a low-tech computer database and an advanced technology system.³⁸³ State-based systems, however, have limited ability to track people who cross State lines, especially if the information is stored and used within the person's originating State only and interstate agreements to share information are not in place. After Hurricane Katrina, evacuated households, many of which relocated out of State, moved an average of 3.5 times over a 6-month period.³⁸⁴

In addition to evacuee tracking systems, tools were developed within the public and private sectors to reunite family and friends displaced by disasters. Congress authorized the creation of the National Emergency Child Locator Center³⁸⁵ and the National Emergency Family Registry and Locator System³⁸⁶ within the Post-Katrina Emergency Management Reform Act.³⁸⁷ Other prominent reunification tools have been created by the American Red Cross, Google, and the National Library of Medicine.³⁸⁸

The development of these various evacuee tracking systems and family reunification tools is encouraging; however, the absence of an overarching information technology capability that allows these systems to share data on displaced persons nationally remains a significant gap. The Commission recommends that Congress and relevant Federal agencies, including the Department of Homeland Security (DHS), the Department of Health and Human Services (HHS), and the Department of Defense (DoD) provide the necessary funding to develop a national information sharing capability that addresses the significant challenge of quickly and effectively reuniting displaced children with their families, guardians, and

382 See, for example: Texas Department of State Health Services, "Medical Special Needs Toolkit," http://www.dshs.state.tx.us/comp/comp/msn/Tab_J_SNETS_Sheltering.pdf; State of Louisiana, Department of Social Services, "DSS Offers First Look at Hurricane Evacuee-Tracking System," <http://dss.louisiana.gov/assets/docs/searchable/pressReleases/2008/05/evacueetracking5-30-.pdf>.

383 Waddy Gonzalez, *National Mass Evacuation System (NMETS)*, Presentation to the Evacuation, Transportation, and Housing Subcommittee, November 9, 2009.

384 David Abramson and Richard Garfield, *On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis*, ed. National Center for Disaster Preparedness, Columbia University Mailman School of Public Health (New York, NY, 2006), 3, http://www.ncdp.mailman.columbia.edu/files/On%20the%20Edge%20L-CAFH%20Final%20Report_Columbia%20University.pdf.

385 National Center for Missing & Exploited Children, "Natural Disasters: Is your family prepared?," http://www.missingkids.com/missingkids/servlet/PageServlet?LanguageCountry=en_US&PageId=3252.

386 Federal Emergency Management Agency, "National Emergency Family Registry and Locator System," http://www.fema.gov/media/fact_sheets/nefrls.shtm.

387 Public Law (P.L.) 109-295; 120 Stat. 1394 (2006).

388 See, for example: American Red Cross, "Safe and Well," <https://safeandwell.communityos.org/cms/>; Google, "Person Finder: Haiti Earthquake," <http://haiticrisis.appspot.com/>; Google, "Person Finder: Chile Earthquake," <http://chilepersonfinder.appspot.com/>; U.S. National Library of Medicine, "Lost Person Finder (LPF)," <http://archive.nlm.nih.gov/proj/lpf.php>.

caregivers when separated by a disaster. The Commission recognizes that the development of the infrastructure for a national information sharing capability with appropriate standards, guidelines, and protocols would require significant funding over multiple years, but believes this investment is necessary and supports current efforts to address this significant gap.

The Commission recommends that DHS, as the Federal coordinating agency for Mass Evacuation,³⁸⁹ lead the development of a nationwide information technology capability to collect, share, and search data from any patient and evacuee tracking or family reunification system. HHS and DoD should also have a major role in developing this capability, as they utilize a patient tracking system for patients evacuated by the HHS National Disaster Medical System.³⁹⁰

In its *Interim Report*, the Commission examined the Agency for Healthcare Research and Quality's (AHRQ) *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*.³⁹¹ According to the AHRQ report, the system would provide the capability to link existing Federal, State, tribal, local, community, and private systems that track the location and health status of patients and evacuees at health care facilities, disaster shelters, and other locations where patients and evacuees gather during an evacuation.³⁹² Since the Interim Report, efforts to advance the creation of this system have progressed.³⁹³ DoD and AHRQ drafted a statement of work (SOW) reflecting Federal requirements, which establishes a task-oriented approach allowing for incremental creation of the system as funds become available. A multi-agency memorandum of understanding³⁹⁴ is being finalized to establish policy for the national system, perform legal and regulatory reviews, examine existing tracking and regulating systems, and complete the SOW with Federal, State, tribal, local, and private industry representatives. In the next phase, the DoD project will look to bring together an interagency Executive Oversight Committee and one or more working groups to address the issues surrounding the creation of this platform. Additionally, the DHS Science & Technology Directorate awarded a contract to address the creation of Extensible Markup Language (XML)-based standards that will enable the exchange of information between legacy systems, through a "system of systems" approach.³⁹⁵

389 U.S. Department of Homeland Security, Federal Emergency Management Agency, "National Response Framework, Mass Evacuation Incident Annex," 1, http://www.fema.gov/pdf/emergency/nrf/nrf_massevacuationincidentannex.pdf

390 Ibid., 17.

391 National Commission on Children and Disasters, *Interim Report*, (Washington, DC: NCCD, October 14, 2009), 64, http://www.childrenanddisasters.acf.hhs.gov/20091014_508IR_partII.pdf.

392 Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*, AHRQ Publication Number 09-0039-EF, ed. Agency for Healthcare Research and Quality (Rockville, MD: AHRQ, 2009), 2-3, <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

393 National Commission on Children and Disasters, personal communication with Christy Music (DoD) and Sally Phillips (AHRQ), July 2, 2010.

394 DoD proposes to co-lead this next phase of the initiative with the Department of Health and Human Services (HHS), DHS, and FEMA, and will ask stakeholder Departments and non-governmental organizations, such as the Department of Transportation, the Department of Justice, the Department of Veterans Affairs, and ARC, to participate.

395 This contract led to work with the Organization for the Advancement of Structured Information Standards (OASIS) to establish patient tracking standards, which may later be expanded to tracking non-patient evacuees.

The Commission supports the objectives of the AHRQ recommendations and is encouraged by the recent progress on this initiative.

The Commission recommends that DHS direct an accrediting body, such as the American National Standards Institute (ANSI),³⁹⁶ to convene a panel of interested public and private parties to address the collection and sharing of information on evacuees. Federal, State, local, and private-sector entities would identify existing voluntary consensus standards or help accelerate their development should no suitable standards be identified.³⁹⁷ Common standards and protocols on privacy policies are needed to address the disclosure, access, activation, use, and storage of information on evacuees, as well as “a threshold level of confidentiality” that stakeholders agree to meet.³⁹⁸

Challenges and concerns regarding national data collection and sharing arose during discussions at the Commission’s February 2010 Long-Term Disaster Recovery Workshop.³⁹⁹ Participants questioned what information should be collected; who should have access to this information and how it can be used; and how this system will balance the critical need to share personally identifiable information (PII) while adhering to privacy and confidentiality laws and regulations, such as the Privacy Act,⁴⁰⁰ the Health Insurance

396 ANSI is a private, nonprofit organization that administers and coordinates the U.S. voluntary standards and conformity assessment system. ANSI collaborates with stakeholders from both industry and government to identify consensus-based solutions to national and global priorities. American National Standards Institute, “About ANSI Overview,” http://www.ansi.org/about_ansi/overview/overview.aspx?menuid=1.

397 For example, the National Commission on Terrorist Attacks Upon the United States requested ANSI to “develop a consensus on a ‘National Standard for Preparedness’ for the private sector.” National Commission on Terrorist Attacks Upon the United States, *The 9/11 Commission Report*, (New York, NY: July 2004), 398, <http://govinfo.library.unt.edu/911/report/911Report.pdf>. Based on ANSI’s recommendations, in June 2010 DHS adopted three existing standards for the Voluntary Private Sector Preparedness Accreditation and Certification Program, “a partnership between DHS and the private sector that enables private entities to receive emergency preparedness certification from a DHS accreditation system created in coordination with the private sector.” US Department of Homeland Security, “Secretary Napolitano Announces New Standards for Private Sector Preparedness,” http://www.dhs.gov/ynews/releases/pr_1276616888003.shtm.

398 A potential model for developing a national information sharing capability and standards is the *National Juvenile Information Sharing (JIS) Initiative*, which identified three components to successful and effective information sharing: effective multi-system collaborations, agreement on privacy and confidentiality practices, and the use of appropriate technology. Office of Juvenile Justice and Delinquency, *Guidelines for Juvenile Information Sharing*, (Washington, DC: OJJDP, October 2006), 15, <http://www.ncjrs.gov/pdffiles1/ojjdp/215786.pdf>.

399 National Commission on Children and Disasters, “Long Term Recovery Workshop: Report of Findings,” (Washington, DC: NCCD, 2010), 17-22, http://www.childrenanddisasters.acf.hhs.gov/20100201_WorkshopReportV04_FINAL_8F09.pdf.

400 The Privacy Act states that disclosure of protected health information can only occur with written consent of the individual. Although the Act enumerates a number of exemptions from the “written consent” requirement, it is unclear whether any exemption would apply to the disclosure of personal information pertaining to evacuees and their whereabouts. However, the Privacy Act’s “routine use” exemption allows for the sharing of information when compatible with the purposes for which it was collected. P.L. 93-579; 5 U.S.C. § 552a (1974). <http://www.justice.gov/archive/oip/privstat.htm>.

Portability and Accountability Act (HIPAA) Privacy Rule,⁴⁰¹ and the Family Educational Rights and Privacy Act (FERPA).⁴⁰² Questions remain about whether sharing PII during an emergency for the purpose of evacuee tracking is explicitly prohibited by privacy laws or limited by interpretations of laws. The Commission recognizes the importance of ensuring privacy and confidentiality of personal information, and in certain cases, strengthened privacy regulations are needed during disasters to protect children. Yet, information such as the location of unaccompanied minors can speed family reunification and should be shared with appropriate agencies and organizations when it is clearly in the best interest of a child.

The Commission recommends that evacuee tracking systems utilized by all levels of government collect appropriate data on evacuated children, particularly unaccompanied minors. A 2006 White House report called on DHS and the Department of Transportation to evaluate State and local evacuation plans and singled out unaccompanied minors as one subgroup that must be addressed in those plans.⁴⁰³ In response to suggestions from the Commission during NMETS development, FEMA improved NMETS's ability to track children by adding an "unaccompanied minor" check box and additional information fields to each of the versions of NMETS.⁴⁰⁴ Simultaneously, processes and procedures must be in place to allow youth, parents, and legal guardians to review information that is collected about them and that may be disclosed, and allow them to approve or amend their information.⁴⁰⁵

401 Under the HIPAA Privacy Rule, the disclosure of protected health information can only occur with written consent of the individual, unless the routine use exemption applies. P.L. 104-191, 101 Stat. 1936 (1996).

402 Guidance released in 2010 states that "FERPA permits school officials to disclose, without consent, education records, or personally identifiable information from education records, to appropriate parties in connection with an emergency, if knowledge of that information is necessary to protect the health or safety of the student or other individuals." U.S. Department of Education, *Family Educational Rights and Privacy Act (FERPA) and the Disclosure of Student Information Related to Emergencies and Disasters*, (Washington, DC: ED, June 2010), 4, <http://www2.ed.gov/policy/gen/guid/fpco/pdf/ferpa-disaster-guidance.pdf>.

403 The White House, *The Federal Response to Hurricane Katrina: Lessons Learned*, (Washington, DC: The White House, February 2006), 100, <http://library.stmarytx.edu/acadlib/edocs/katrinawh.pdf>.

404 When this box is checked on the electronic version, a message appears in red text indicating that the unaccompanied minor should be escorted to the proper authorities in compliance with State evacuation procedures. Also added to NMETS were fields allowing input of information to describe an unaccompanied minor (e.g., eye color, hair color, and other distinguishing features) and indicate the name of the agency or individual who has taken the minor into custody. FEMA is also exploring development of an unaccompanied minors registry which would serve as a central repository for registering unaccompanied minors located during a disaster. This system would assist States to uniformly register unaccompanied minors, search data fields, and reunite families more quickly.

405 Office of Juvenile Justice and Delinquency Prevention, *Guidelines for Juvenile Information Sharing*, 16.

Recommendation 11.2: Disaster plans at all levels of government must specifically address the evacuation and transportation needs of children with disabilities and chronic health needs, in coordination with child congregate care facilities such as schools, child care, and health care facilities.

Following Hurricanes Katrina and Rita, a 2006 Government Accountability Office report on the evacuation of vulnerable populations due to disasters found increased efforts in some States and localities to address the evacuation needs of “transportation-disadvantaged” populations, including persons with disabilities, but also found that many disaster plans were still lacking in this area.⁴⁰⁶ Results from a 2007 University of Kansas survey of 30 FEMA-declared disaster sites found that 57 percent of county emergency managers did not know how many persons with mobility limitations lived within their jurisdiction.⁴⁰⁷ While attention to the unique needs of children in disaster planning is increasing, more attention is necessary on evacuation planning for children with disabilities and chronic health needs.⁴⁰⁸

The Commission recommends that DHS/FEMA and relevant Federal and non-Federal agencies fully address the needs of children with disabilities and chronic health needs in evacuation and transportation plans. A 2009 report from the National Council on Disability stressed that evacuating persons with disabilities is more time- and resource-intensive compared to persons without disabilities; therefore, local pre-event evacuation planning is crucial.⁴⁰⁹ Planning that addresses the evacuation of populations with disabilities or chronic health needs must also consider children’s unique developmental characteristics and dependency needs, such as: the need to keep children with their guardians, family members and/or caregivers; medication, medical equipment, and service animals; and appropriate messaging and risk communication about how to evacuate and the risks of not evacuating. Individuals and families with disabilities and chronic health needs must be included in the emergency planning process, alongside emergency management agencies, State and local education agencies, transportation providers, and non-governmental organizations.⁴¹⁰ In addition, many children

406 U.S. Government Accountability Office, *Preliminary Observations on the Evacuation of Vulnerable Populations due to Hurricanes and Other Disasters*, GAO-06-790T, (Washington, DC: GAO, 2006), 9, <http://www.gao.gov/new.items/d06790t.pdf>.

407 Michael H. Fox, Glen W. White, Catherine Rooney, and Jennifer L. Rowland, “Disaster Preparedness and Response for Persons with Mobility Impairments,” *Journal of Disability Policy Studies* 17, no. 4 (2007): 204.

408 Lori Peek and Laura M. Stough, “Children With Disabilities in the Context of Disaster: A Social Vulnerability Perspective,” *Child Development* 81, no. 4 (2010): 1260.

409 National Council on Disability, *Effective Emergency Management: Making Improvements for Communities and People with Disabilities*, (Washington, DC: NCD, August 12, 2009), 77, http://www.ncd.gov/newsroom/publications/2009/pdf/NCD_EmergencyManagement.pdf.

410 Federal Highway Administration, *Evacuating Populations With Special Needs*, ed. U.S. Department of Transportation (Washington, DC: DOT, April 2009), 17-28, <http://ops.fhwa.dot.gov/publications/fhwahop09022/fhwahop09022.pdf>.

spend a significant amount of time in schools and child care, and some reside in group homes or juvenile justice facilities; therefore, planning for the evacuation of children with disabilities and chronic health needs should be required for these child congregate care settings and conducted in coordination with emergency managers.^{411, 412}

Transportation assets, particularly vehicles with accessible features for children with disabilities, must also be identified and organized in advance of a disaster.^{413, 414} School buses and public transportation have been suggested as possible resources for mass evacuation during a disaster.⁴¹⁵ A report by the Western Transportation Institute found that 92 percent of total possible passenger seats within 24 Gulf Coast counties and parishes were on school buses.⁴¹⁶ However, school buses are not always air-conditioned, and most lack wheelchair tie-downs and spaces for accommodating wheelchairs.⁴¹⁷ The report recommended that additional research be conducted on identifying and providing transportation for children following a disaster, with an emphasis on multi-agency planning, especially with child care facilities, schools, hospitals, emergency management agencies, and law enforcement agencies.⁴¹⁸

According to the U.S. Department of Education, more than 6.6 million children ages three to 21 have a diagnosed disability, representing 13.4 percent of total public school enrollment.⁴¹⁹ FEMA's Comprehensive Planning Guide 301 includes specific guidance for

411 Yet 25 States do not require all licensed child care facilities to have evacuation plans, 33 States do not require all licensed child care facilities to have evacuation plans that account for children with special needs, and 10 States and the District of Columbia do not require schools to have a written evacuation plan that accounts for multiple hazards. Save the Children, *A National Report Card on Protecting Children During Disasters*, (Westport, CT: Save the Children, 2010), 4, <http://www.savethechildren.org/atf/ct/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/2010-Disaster-Report.pdf>.

412 For additional information and recommendations on managing the needs of children with chronic health conditions in child care and schools, including emergency planning recommendations, see: Elaine A. Donoghue and Colleen A. Kraft, *Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide*, ed. American Academy of Pediatrics (Elk Grove Village, IL: AAP, 2009), https://www.nfaap.org/netforum/eweb/dynamicpage.aspx?site=nf.aap.org&webcode=aapbks_productdetail&key=BAD2FE33-C4E2-447F-9936-9DA8978B08D7.

413 National Council on Disability, *Effective Emergency Management: Making Improvements for Communities and People with Disabilities*, 77.

414 Federal Emergency Management Agency and Department of Homeland Security Office for Civil Rights and Civil Liberties, *Comprehensive Preparedness Guide (CPG) 301: Interim Emergency Management Planning Guide for Special Needs Populations*, Version 1.0, (Washington, DC: DHS, August 15, 2008), 5, <http://www.fema.gov/pdf/media/2008/301.pdf>.

415 Jaydeep Chaudhari, Janelle Booth, Zhirui Ye, David Kack, and Benedict Posadas, *Evacuation Preparedness of Public Transportation and School Buses in Rural Coastal Communities of the North Gulf Region*, (Bozeman, MT: Western Transportation Institute, April 15, 2010), http://www.westerntransportationinstitute.org/download.ashx?file=documents/reports/4W2643_Final_Report.pdf.

416 *Ibid.*, 15.

417 *Ibid.*, ix.

418 *Ibid.*, 32-33.

419 National Center for Education Statistics, *Digest of Education Statistics: 2009*, ed. U.S. Department of Education (Washington, DC: ED, April 2010), 84, http://nces.ed.gov/programs/digest/d09/tables/dt09_050.asp?referrer=report.

planning for the evacuation of schools and addressing the unique needs of students with disabilities.⁴²⁰ The guide suggests that school-based plans should ensure the participation of students and staff with disabilities in the event of an evacuation, lockdown, or shelter-in-place. In addition, it recommends that all school-based plans address a wide variety of disabilities, including visual, hearing, mobility, cognitive, and emotional.⁴²¹ These plans must ensure that evacuation vehicles and evacuation sites are accessible to students and staff with disabilities, and address reunification of students with their families and guardians after evacuation.⁴²² Pursuant to the Individuals with Disabilities Education Act, schools are required to provide transportation that accommodates students with disabilities.⁴²³ As part of the Individualized Education Plans (IEP) mandated for students with disabilities, schools should include plans for evacuating and providing appropriate transportation for these students.⁴²⁴ A planning tool from the National Fire Protection Association includes a checklist addressing issues regarding safe evacuation of students with disabilities that can be included with each student's IEP.⁴²⁵

420 Federal Emergency Management Agency and Department of Homeland Security Office for Civil Rights and Civil Liberties, *Comprehensive Preparedness Guide (CPG) 301: Interim Emergency Management Planning Guide for Special Needs Populations, Version 1.0*, 32-33.

421 Ibid., 32.

422 Ibid., 42-44.

423 P.L. 108-446 (2004).

424 National Fire Protection Association, *Personal Emergency Evacuation Planning Tool for School Students with Disabilities*, (Quincy, MA: NFPA, July 2007), 3, <http://www.nfpa.org/assets/files/PDF/Fact%20sheets/EvacStudentDisabilities.pdf>.

425 Ibid., 9-13.

Appendix

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Appendix A. Study Approach

The Commission was charged with conducting “a comprehensive study to examine and assess the needs of children as they relate to preparation for, response to, and recovery from all hazards, building on the evaluations of other entities and avoiding unnecessary duplication by reviewing the findings, conclusions, and recommendations of these entities.”⁴²⁶ Four main components comprised the Commission’s approach to conducting this study.

First, Commission staff and contractors searched academic databases and government and non-governmental Web sites to identify existing research, reports, policy positions, guidelines, and recommendations and identified gaps in the professional literature related to children and disasters. Relevant documents, including abstracts where available, were entered into an EndNote® X2 database, which serves as the Commission’s library.

Second, Commissioners and staff conducted three field visits to gather insights, lessons learned, and best practices from State and local jurisdictions affected by disasters. The first was held in Baton Rouge, LA, in January 2009 to discuss lessons learned from Hurricanes Katrina and Rita and discuss strategies to improve disaster case management services. The second was held in Cedar Rapids, IA, in January 2010 to discuss long-term recovery efforts in Iowa following the major floods and tornados during the summer of 2008. The third field visit was held in Miami, FL, in April 2010 to gather information about emergency response coordination and the resulting domestic impact from the Federal Government’s response to the 2010 earthquake in Haiti.

The Commission also extensively solicited and reviewed input from stakeholders and subject matter experts (Appendix H: Stakeholder Outreach). This outreach effort involved the following:

- The Commission formed four subcommittees comprising more than 50 subject matter experts.
- In April 2009 the Commission sent letters to 73 non-governmental stakeholder organizations requesting information, research articles, reports, and policy recommendations.
- The Commission co-sponsored the Disasters Roundtable Workshop on Children and Youth in Disasters with The National Academies in June 2009.
- The Commission convened a Long-Term Disaster Recovery Workshop in February 2010 with more than 120 governmental and non-governmental participants.
- Each public Commission meeting included a public comment period.

426 Public Law (P.L.) 110-161, Section 604 (2008).

Also, Commissioners and staff held numerous meetings with Federal, State, and local agencies and non-governmental organizations.

Minutes of all public Commission meetings, in-person subcommittee meetings, workshops, and field visits are available on the Commission's Web site.⁴²⁷ Also available at the Web site are the Commission's Interim Report and the Progress Report on implementation of the Interim Report recommendations.

427 <http://www.childrenanddisasters.acf.hhs.gov>

Appendix B: Index to Recommendations and Responsible Entities

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
1. Disaster Management and Recovery					
1.1: Distinguish and comprehensively integrate the needs of children across all inter- and intra-governmental disaster management activities and operations.	X	X	ALL	X	X
• <i>The President should develop a National Strategy for Children and Disasters.</i>	X				
• <i>The Executive Branch, Congress, and non-Federal partners should prioritize children separately from “at-risk” population categories.</i>	X	X	ALL	X	X
• <i>The Executive Branch at all levels of government should establish and maintain permanent focal points of coordination for children and disasters, supported by sufficient authority, funding, and policy expertise. FEMA should establish Children’s Integration Specialists at the regional level.</i>	X		ALL	X	
• <i>The Executive Branch and non-Federal partners should incorporate children as a distinct priority in base disaster planning documents and relevant grant programs.</i>	X		ALL	X	
• <i>The Executive Branch and non-Federal partners should incorporate education, child care, juvenile justice, and child welfare systems into disaster planning, training, and exercises.</i>	X		DHS/FEMA HHS ED DOJ	X	

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> The Executive Branch and non-Federal partners should incorporate children as a distinct priority in relevant target capabilities, preparedness training, and exercises, with specific target outcomes and performance measures. 	X		ALL	X	
<ul style="list-style-type: none"> The Executive Branch and Congress should institute accountability and progress monitoring measures to track implementation of Commission recommendations and capability improvements. 	X	X	ALL	X	
<p>1.2: The President should accelerate the development and implementation of the National Disaster Recovery Framework with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing, and human services recovery needs of children.</p>	X				
<p>1.3: DHS/FEMA should ensure that information required for timely and effective delivery of recovery services to children and families is collected and shared with appropriate entities.</p>			ALL	X	X
<ul style="list-style-type: none"> Government agencies and non-governmental organizations should collect information on children and families necessary to identify and support their immediate and long-term recovery needs. 			ALL	X	X
<ul style="list-style-type: none"> DHS/FEMA should expand information sharing with appropriate government agencies and non-governmental organizations to enable the delivery of recovery services. 			DHS/FEMA		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> DHS/FEMA should pre-identify and credential additional local and out-of-State voluntary and non-governmental organizations and networks that provide disaster assistance to children and families. 			DHS/FEMA		
<p>1.4: DHS/FEMA should establish interagency agreements to provide disaster preparedness funding, technical assistance, training, and other resources to State and local child serving systems and child congregate care facilities.</p>			DHS/FEMA HHS ED DOJ		
2. Mental Health					
<p>2.1: HHS should lead efforts to integrate mental and behavioral health for children into public health, medical, and other relevant disaster management activities.</p>		X	ALL	X	
<ul style="list-style-type: none"> Congress should direct HHS to lead the development of a disaster mental and behavioral health Concept of Operations (CONOPS) to formalize disaster mental and behavioral health as a core component of disaster preparedness, response, and recovery efforts. 		X	HHS		
<p>2.2: HHS should enhance the research agenda for children’s disaster mental and behavioral health, including psychological first aid, cognitive-behavioral interventions, social support interventions, bereavement counseling and support, and programs intended to enhance children’s resilience in the aftermath of a disaster.</p>			HHS		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> HHS should convene a working group of children’s disaster mental health and pediatric experts to review the research portfolios of relevant agencies, identify gaps in knowledge, and recommend a national research agenda across the full spectrum of disaster mental health for children and families. 			HHS		
<p>2.3: Federal agencies and non-Federal partners should enhance pre-disaster preparedness and just-in-time training in pediatric disaster mental and behavioral health, including psychological first aid, bereavement support, and brief supportive interventions, for mental health professionals and individuals, such as teachers, who work with children.</p>			DHS/FEMA HHS ED DOJ	X	X
<p>2.4: DHS/FEMA and SAMHSA should strengthen the Crisis Counseling Assistance and Training Program (CCP) to better meet the mental health needs of children and families.</p>			DHS/FEMA HHS		
<ul style="list-style-type: none"> Simplify the Immediate Services Program (ISP) grant application to minimize the burden on communities affected by a disaster and facilitate the rapid allocation of funding and initiation of services. 			DHS/FEMA HHS		
<ul style="list-style-type: none"> Establish the position of Children’s Disaster Mental Health Coordinator within State-level CCPs. 			DHS/FEMA HHS	X	
<ul style="list-style-type: none"> Formally modify the CCP model to indicate and promote “enhanced services” where the mental health impact is unlikely to be adequately addressed by “typical” CCP services. 			DHS/FEMA HHS		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> • Include bereavement support and education within services typically provided under the CCP. 			DHS/FEMA HHS		
<p>2.5 Congress should establish a single, flexible grant funding mechanism to specifically support the delivery of mental health treatment services that address the full spectrum of behavioral health needs of children including treatment of disaster-related adjustment difficulties, psychiatric disorders, and substance abuse.</p>		X			
3. Child Physical Health					
<p>3.1: Congress, HHS and DHS/FEMA should ensure availability and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats.</p>		X	DHS/FEMA HHS		
<ul style="list-style-type: none"> • Provide funding and grant guidance for the development, acquisition, and stockpiling of MCM specifically for children for inclusion in the Strategic National Stockpile (SNS) and all other federally funded caches, including those funded by DHS/FEMA. 		X	HHS		
<ul style="list-style-type: none"> • Amend the Emergency Use Authorization to allow the FDA, at the direction of the HHS Secretary, to authorize pediatric indications of MCM for emergency use before an emergency is known or imminent. 		X			
<ul style="list-style-type: none"> • Form a standing advisory body of Federal partners and external experts to advise the HHS Secretary and provide expert consensus on issues pertaining specifically to pediatric emergency MCM. 			HHS		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> • Within the HHS Biomedical Advanced Research and Development Authority, designate a pediatric leader and establish a pediatric and obstetric working group to conduct gap analyses and make research recommendations. 			HHS		
<ul style="list-style-type: none"> • Include pediatric expertise on the HHS Enterprise Governance Board or its successor and all relevant committees and working groups addressing issues pertaining to MCM. 			HHS		
<ul style="list-style-type: none"> • Establish a partnership between the proposed MCM Development Leader and key pediatric stakeholders both within and outside government. 			HHS		
<p>3.2: HHS and DoD should enhance the pediatric capabilities of their disaster medical response teams through the integration of pediatric-specific training, guidance, exercises, supplies, and personnel.</p>		X	HHS DoD		
<ul style="list-style-type: none"> • HHS should develop pediatric capabilities within each National Disaster Medical System (NDMS) region. 			HHS		
<ul style="list-style-type: none"> • HHS should establish a “reserve pool” of pediatric health care workers to assist in NDMS disaster response. 			HHS		
<ul style="list-style-type: none"> • HHS and DoD should establish a Pediatric Health Care Coordinator on each disaster medical response team and develop strategies to recruit and retain team members with pediatric medical expertise. 			HHS DoD		
<p>3.3: HHS should ensure that health professionals who may treat children during a disaster have adequate pediatric disaster clinical training.</p>			HHS DoD	X	X

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> The President should direct the Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response (FETIG) to prioritize the development of pediatric core competencies, core curricula, training, and research. 	X				
<ul style="list-style-type: none"> The FETIG should support the formation of a Pediatric Disaster Clinical Education and Training Working Group to establish core clinical competencies and a standard, modular pediatric disaster health care education and training curriculum. 			HHS DoD		
<p>3.4: The Executive Branch and Congress should provide resources for a formal regionalized pediatric system of care to support pediatric surge capacity during and after disasters.</p>	X	X	HHS		
<ul style="list-style-type: none"> HHS should include pediatric surge capacity as a “Required Funding Capability” in the Hospital Preparedness Program. 			HHS		
<ul style="list-style-type: none"> States and hospital accrediting bodies should ensure all hospital emergency departments stand ready to care for ill or injured children through the adoption of emergency preparedness guidelines jointly developed by the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association. 				X	X

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
3.5: Prioritize the recovery of pediatric health and mental health care delivery systems in disaster-affected areas.	X	X	DHS/FEMA HHS SBA	X	
<ul style="list-style-type: none"> • Congress should establish sufficient funding mechanisms to support restoration and continuity of for-profit and non-profit health and mental health services to children. 		X			
<ul style="list-style-type: none"> • The Executive Branch should recognize and support pediatric health and mental health care delivery systems as a planning imperative in the development and implementation of the National Health Security Strategy and National Disaster Recovery Framework. 	X		DHS/FEMA HHS SBA		
<ul style="list-style-type: none"> • HHS should create Medicaid and Children's Health Insurance Program incentive payments for providers in disaster areas. 			HHS		
<ul style="list-style-type: none"> • The American Medical Association should adopt a new code or code modifier to the Current Procedural Terminology to reflect disaster medical care in order to facilitate tracking of these services and as a means for enhanced reimbursement from public and private payers. 					X

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
3.6: EPA should engage State and local health officials and non-governmental experts to develop and promote national guidance and best practices on re-occupancy of homes, schools, child care, and other child congregate care facilities in disaster-impacted areas.			EPA		
• EPA and HHS should expand research on pediatric environmental health risks associated with disasters.			EPA HHS		
4. Emergency Medical Services and Pediatric Transport					
4.1: The President and Congress should clearly designate and appropriately resource a lead Federal agency for emergency medical services (EMS) with primary responsibility for the coordination of grant programs, research, policy, and standards development and implementation.	X	X			
• Establish a dedicated Federal grant program under a designated lead Federal agency for pre-hospital EMS disaster preparedness, including pediatric equipment and training.		X			
4.2: Improve the capability of emergency medical services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.			DHS HHS DOT	X	X
• Congress should provide full funding to the Emergency Medical Services for Children (EMSC) program to ensure all States and territories meet targets and achieve progress in the EMSC performance measures for grantees, and to support development of a research portfolio.		X			

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> As an eligibility guideline for Centers for Medicare & Medicaid Services reimbursement, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for Basic Life Support and Advanced Life Support vehicles. 			HHS		
<ul style="list-style-type: none"> HHS and DHS should establish stronger pediatric EMS performance measures within relevant Federal emergency preparedness grant programs. 			HHS DHS		
<ul style="list-style-type: none"> HHS should address the findings of the EMSC 2009 Gap Analysis of EMS Related Research. 			HHS		
4.3: HHS should develop a national strategy to improve Federal pediatric emergency transport and patient care capabilities for disasters.			HHS		
<ul style="list-style-type: none"> Conduct a national review of existing capabilities among relevant government agencies and the private sector for emergency medical transport of children. 			HHS		
5. Disaster Case Management					
5.1: Disaster case management programs should be appropriately resourced and should provide consistent holistic services that achieve tangible, positive outcomes for children and families affected by the disaster.	X	X	HHS DHS/FEMA	X	X
<ul style="list-style-type: none"> The Executive Branch and Congress should provide sufficient funds to build, support, and deploy a disaster case management system with nationwide capacity. 	X	X	HHS DHS/FEMA		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> DHS/FEMA should clarify the transition from Federal to State-led disaster case management programs. 			DHS/FEMA		
<ul style="list-style-type: none"> Government agencies and non-governmental organizations should develop voluntary consensus standards on the essential elements and methods of disaster case management, including pre-credentialing of case managers and training that includes focused attention to the needs of children and families. 			HHS DHS/FEMA	X	X
6. Child Care and Early Education					
6.1: Congress and HHS should improve disaster preparedness capabilities for child care.		X	HHS	X	
<ul style="list-style-type: none"> Congress and HHS should require States to include disaster planning, training, and exercise requirements within the scope of their minimum health and safety standards for child care licensure or registration. 		X	HHS		
<ul style="list-style-type: none"> Congress should provide HHS the authority to require States to develop statewide child care disaster plans in coordination with State and local emergency managers, public health, State child care administrators and regulatory agencies, and child care resource and referral agencies. 		X	HHS		
6.2: Congress and Federal agencies should improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.		X	DHS/FEMA HHS SBA		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> DHS/FEMA should revise its Public Assistance regulations to codify child care as an essential service. 			DHS/FEMA		
<ul style="list-style-type: none"> Congress should codify child care as an “essential service of a governmental nature” in the Stafford Act. 		X			
<ul style="list-style-type: none"> Federal agencies should incorporate child care as an essential service in the National Response Framework, the National Disaster Recovery Framework, the National Disaster Housing Concept of Operations, and Disaster Housing Practitioners’ Guide. 			DHS/FEMA HHS SBA		
<ul style="list-style-type: none"> Congress should authorize a grant funding mechanism, such as an emergency contingency fund, to repair or rebuild private, for-profit child care facilities, support the establishment of temporary child care, and reimburse States for subsidizing child care services to disaster-affected families. 		X			
<p>6.3: HHS should require disaster preparedness capabilities for Head Start Centers and basic disaster mental health training for staff.</p>			HHS		
7. Elementary and Secondary Education					
<p>7.1: Congress and Federal agencies should improve the preparedness of schools and school districts by providing additional support to States.</p>		X	DHS/FEMA ED		
<ul style="list-style-type: none"> Congress and ED should award disaster preparedness grants to State education agencies to oversee, coordinate, and improve disaster planning, training, and exercises statewide and ensure that all districts within the State meet certain baseline criteria. 		X	ED		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> DHS/FEMA should partner with ED to provide funding and other resources to support disaster preparedness efforts of State and local education agencies, including collaborative planning, training, and exercises with emergency management officials. 			DHS/FEMA ED		
<p>7.2: Congress and ED should enhance the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster.</p>		X	ED		
<ul style="list-style-type: none"> Congress and ED should award funds to States to implement and evaluate training and professional development programs in basic skills in providing support to grieving students and students in crisis and establish statewide requirements related to teacher certification and recertification. 		X	ED		
<p>7.3: Ensure that school systems recovering from disasters are provided immediate resources to reopen and restore the learning environment in a timely manner and provide support for displaced students and their host schools.</p>		X	DHS/FEMA ED		
<ul style="list-style-type: none"> Congress should create a permanent funding mechanism to support recovery for schools and students. 		X			
<ul style="list-style-type: none"> Congress should establish an emergency contingency fund within the Education for Homeless Children and Youth program and expeditiously provide grants to school districts serving an influx of displaced children. 		X			

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> • Congress and ED should support the immediate provision of expert technical assistance and consultation regarding services and interventions to address disaster mental health needs of students and school personnel. 		X	ED		
<ul style="list-style-type: none"> • DHS/FEMA, ED, and other Federal agencies should clarify, consolidate, and publicize information related to the recovery programs, assistance, and services (e.g., transportation to schools) currently available to school systems through the Stafford Act and other Federal sources. 			DHS/FEMA ED		
8. Child Welfare and Juvenile Justice					
8.1: Ensure that State and local child welfare agencies adequately prepare for disasters.		X	HHS DHS/FEMA	X	
<ul style="list-style-type: none"> • Congress should request a national assessment of child welfare disaster planning to determine if significant advances have been made since passage of the Child and Family Services Improvement Act of 2006 (CFSIA). 		X	HHS		
<ul style="list-style-type: none"> • HHS should develop detailed disaster planning criteria by regulation or other formal policy guidance to supplement the basic procedures mandated in CFSIA. 			HHS		
<ul style="list-style-type: none"> • Within each ACF regional office, child welfare staff and the region's emergency management specialist should collaboratively review and evaluate the State child welfare disaster plans required by CFSIA and assist States in developing comprehensive plans and meeting their statutory obligations. 			HHS		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> DHS/FEMA and HHS should provide funding, guidance, and technical assistance to child welfare agencies and encourage collaboration with emergency management, courts, and other key stakeholders. 			DHS/FEMA HHS		
8.2: Ensure that State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children adequately prepare for disasters.		X	DHS/FEMA DOJ	X	X
<ul style="list-style-type: none"> Congress should require State and local juvenile justice agencies and all residential treatment, correctional, and detention facilities that house children to have comprehensive disaster plans in place. 		X			
<ul style="list-style-type: none"> DHS/FEMA and DOJ should support disaster planning for State and local juvenile justice agencies and residential treatment, correctional, and detention facilities that house children by providing funding, technical assistance, and training. 			DHS/FEMA DOJ		
8.3: HHS and DOJ should ensure that juvenile, dependency, and other courts hearing matters involving children adequately prepare for disasters.			HHS DOJ	X	X
<ul style="list-style-type: none"> HHS should include disaster preparedness as a component of the Court Improvement Program for dependency courts. 			HHS		
<ul style="list-style-type: none"> DOJ should include disaster preparedness as a component of the proposed National Juvenile Delinquency Court Improvement Program. 			DOJ		
<ul style="list-style-type: none"> DOJ and the National Council of Juvenile and Family Court Judges should incorporate disaster preparedness into the Model Courts program. 			DOJ		X

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories and Localities	Non-Governmental Entities
9. Sheltering Standards, Services, and Supplies					
9.1: Government agencies and non-governmental organizations should provide a safe and secure mass care shelter environment for children, including access to essential services and supplies.			DHS/FEMA HHS	X	X
• <i>Implement national standards and indicators for mass care shelters that are specific and responsive to children.</i>			DHS/FEMA	X	X
• <i>Integrate essential age-appropriate shelter supplies for infants and children into shelter planning and fund the addition of child-specific supplies to caches for immediate deployment to support shelter operations.</i>			DHS/FEMA	X	X
• <i>Implement common standards and training, including standards for criminal background checks, to mitigate risks unique to children in shelters such as child abduction and sex offenders.</i>			DHS/FEMA	X	X
10. Housing					
10.1: Prioritize the needs of families with children, especially families with children who have disabilities or chronic health, mental health, or educational needs, within disaster housing assistance programs.			DHS/FEMA HUD HHS	X	X
• <i>Government agencies and non-governmental organizations should ensure that families with children in disaster housing, especially community sites, have access to needed services and are provided safe and healthy living environments.</i>			DHS/FEMA HUD HHS	X	X

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> • Congress should authorize DHS/FEMA to reimburse State and local governments for providing wrap-around services to children and families in community sites. 		X			
<ul style="list-style-type: none"> • DHS/FEMA should develop clear written guidance around emergency transportation planning and reimbursement for State and local governments that addresses the recovery needs of children and families. 			DHS/FEMA		
<ul style="list-style-type: none"> • Government agencies and non-governmental organizations should identify and promote innovative programs to expedite the transition into permanent housing for families with children. 			DHS/FEMA HUD	X	X
11. Evacuation					
<p>11.1 Congress and Federal agencies should provide sufficient funding to develop and deploy a national information sharing capability to quickly and effectively reunite displaced children with their families, guardians, and caregivers when separated by a disaster.</p>		X	DHS HHS DoD		
<ul style="list-style-type: none"> • DHS should lead the development of a nationwide information technology capability to collect, share, and search data from any patient and evacuee tracking or family reunification system. 			DHS		
<ul style="list-style-type: none"> • DHS should support the development of voluntary consensus-driven standards for data collection and data sharing through a joint Federal, non-Federal, and private sector process. 			DHS		

	President	Congress	Relevant Federal Agencies	States, Tribes, Territories, and Localities	Non-Governmental Entities
<ul style="list-style-type: none"> Government agencies should ensure the collection of appropriate data on evacuated children, particularly unaccompanied minors. 			DHS/FEMA HHS DoD		
<p>11.2: Disaster plans at all levels of government must specifically address the evacuation and transportation needs of children with disabilities and chronic health needs, in coordination with child congregate care facilities such as schools, child care, and health care facilities.</p>			DHS/FEMA	X	

Appendix C: Model Executive Order or Resolution Creating a “Cabinet on Children and Disasters and Children and Disasters Advisory Council”

WHEREAS, the citizens of [jurisdiction] are entitled to an expectation of effective preparedness, protection and leadership before, during, and after any domestic emergency or disaster; and

WHEREAS, children under 18 years old are more than [number] percent of the population in [jurisdiction] and have unique needs that must be addressed in emergency and disaster planning and management; and

WHEREAS, it is the responsibility of [jurisdiction] to marshal available resources to determine how best to prepare for, respond to and recover from an emergency or disaster for all citizens, including children; and

WHEREAS, the establishment of the [Executive branch leader’s] Cabinet on Children and Disasters and the Children and Disasters Advisory Council will serve to strengthen emergency and disaster preparedness, response and recovery with respect to children.

NOW, THEREFORE, I, [name], [Executive branch leader] of [jurisdiction], by virtue of the authority vested in me by the [jurisdiction or law], do hereby establish the [Executive branch leader’s] **Cabinet on Children and Disasters** and the **Children and Disasters Advisory Council**.

1. [Executive branch leader’s] Cabinet on Children and Disasters.

- a. **Purpose.** The purpose of the [Executive branch leader’s] Cabinet on Children and Disasters (hereinafter “Cabinet”) is to ensure that the [jurisdiction] appropriately supports the safety and security of children, including children with disabilities, before, during and after emergencies and disasters, including earthquakes, tornadoes, fires, floods, hurricanes, and acts of terrorism. It further shall be the purpose of the Cabinet to ensure that executive departments and agencies continually:
 - i) identify and address gaps in emergency and disaster preparedness, mitigation, response, and recovery for children; and
 - ii) facilitate cooperation and coordination among federal, state, local, and tribal governments and private organizations and individuals in the implementation of emergency and disaster preparedness plans as they relate to children.
- b. **Responsibilities.** The Cabinet shall advise the [Executive branch leader] on matters related to children and disasters including the direction of resources to develop and implement the [jurisdiction’s] Children and Disasters Strategy. In coordinating the [jurisdiction’s] children and disaster multi-agency planning, the Cabinet shall facilitate the analysis of administrative, fiscal, statutory and regulatory policies and practices and conduct a gap analysis and risk assessment of current practices.

The Cabinet shall not be responsible for day-to-day operations of the departments, agencies, commissions, and offices with a disaster preparedness and/or response purview or regulatory function. In addition, members of the Cabinet shall report to the [Executive branch leader's Chief of Staff or equivalent] for any and all accountabilities related to the [jurisdiction's] Children and Disaster Strategy.

- c. **Composition and Appointments.** The Cabinet shall consist of the following officials and individuals [from equivalent or applicable offices]:
- (1) Secretary of Human Services.
 - (2) Director of Emergency Management.
 - (3) Secretary of Public Health.
 - (4) Secretary of the Budget.
 - (5) Secretary of Education.
 - (6) Secretary of Environmental Protection.
 - (7) Director of Juvenile Justice Services.
 - (8) General Counsel.
 - (9) Secretary of General Services.
 - (10) Secretary of Legislative Affairs.
 - (11) Secretary of Planning and Policy.
 - (12) Chief Law Enforcement Officer.
 - (13) Additional members as appointed by the [Executive branch leader].
- d. **Chair.** The [individual responsible for public health, human services or emergency management] shall chair the Cabinet, convene and preside at its meetings, determine its agenda, direct its work, and, as appropriate to particular subject matters, establish and direct subgroups of the Cabinet.
- e. **Reporting.** The Cabinet shall submit to the [Executive branch leader] each year beginning one year after the date of this [Executive Order or Resolution] a report that describes:
- (1) findings and recommendations of the Cabinet for advancing the purpose and responsibilities set forth in section 1;
 - (2) the achievements of the Cabinet in implementing the purpose and responsibilities set forth in section 1; and
 - (3) the best practices among federal, state, local, and tribal governments and private organizations and individuals for emergency preparedness planning with respect to children.

2. Children and Disasters Advisory Council.

- a. **Composition and Appointment.** The Disasters Advisory Council (hereinafter referred to as “Advisory Council”) shall consist of stakeholder experts recommended by the Cabinet and appointed by the [Executive branch leader]. The [Executive branch leader] shall appoint the Chair of the Advisory Council.
- b. **Purpose and Responsibilities:** The Advisory Council shall advise the Cabinet on matters relating to preparedness and planning for children in the event of a major domestic disaster.
- c. **Terms.** All Advisory Council members shall serve at the pleasure of the [Executive branch leader].
- d. **Compensation.** Members of the Advisory Council shall serve without compensation for their services except that such members may be reimbursed the necessary and actual expenses incurred in attending meetings of the Advisory Council and in the performance of their duties in accordance with established policy.

3. Relationship with Other Agencies. All agencies under the [Executive branch leader’s] jurisdiction shall cooperate with and provide assistance and support to the Cabinet and the Advisory Council. Policy and process experts from the [jurisdiction] shall be available to the Cabinet to aid its mission.

4. Effective Date. This [Executive Order or Resolution] shall take effect immediately.

5. Termination Date. This [Executive Order or Resolution] shall remain in effect unless revised or rescinded.

Appendix D. Children and Disasters: the Role of State and Local Governments in Protecting This Vulnerable Population

Children under the age of 18 comprise about 25 percent of our population and have unique needs when an emergency or disaster strikes.

The National Commission on Children and Disasters is a bipartisan, independent body authorized by Congress to examine children's needs as they relate to preparation for, response to, and recovery from all hazards, including major disasters and emergencies. The Commission reports its findings and recommendations to the President and Congress.

Children require specific recognition, planning, and coordination between Federal, State, tribal, and local governments, and their non-governmental disaster-relief partners. The Commission developed a framework of essential elements for State and local governments to consider when addressing children in their emergency plans.

- Determine the demographics of your child population (age 0-18), including children with disabilities and special health care needs.
- Identify places children will most likely be when under supervised care (school, pre-school, child care, summer camps, group homes, juvenile justice facilities).
- Include needs of children in disaster training, exercises, and equipment purchases.
- Evaluate performance in meeting needs of children during exercises/drills and in after-action reports.
- Designate a focal point of responsibility for coordinating children's needs.
- Design an evacuation plan that provides transportation for children with their families and caregivers, especially children with disabilities.
- Include child tracking and family reunification procedures in disaster plans.
- Provide safe, accessible shelter environments for children and families, including essential age-appropriate supplies and care for medically-dependent children.
- Develop capability of emergency personnel to provide effective pre-hospital pediatric transport and medical care (training and supplies).
- Develop capability of hospital emergency departments to provide effective care for children (training and supplies).
- Provide basic psychological first aid training for emergency personnel to assist children.

-
- Support disaster plans, training, and drills for child congregate care providers that include evacuation, reunification, and addressing children with disabilities or chronic health needs.
 - Plan for establishing emergency child care.
 - Identify resources in county and surrounding counties to address a surge in children's needs, especially health and mental health needs.
 - Develop a long-term disaster recovery plan that addresses the needs of children and families (housing, schools, child care, health, and mental health).

Appendix E. Standards and Indicators for Disaster Shelter Care for Children

Updated June 2010

Purpose

To provide guidance to shelter managers and staff that ensures children have a safe, secure environment during and after a disaster—including appropriate support and access to essential resources.

Standards and Indicators for All Shelters

- Under most circumstances, a parent, guardian, or caregiver is expected to be the primary resource for his or her children, ages 18 and younger.
- In cases where parents or guardians are not with their children, local law enforcement personnel and local child protective/child welfare services must be contacted to assist with reunification.
- Children are sheltered together with their families or caregivers.
- Every effort is made to designate an area for families away from the general shelter population.
- Family areas should have direct access to bathrooms.
- Parents, guardians, and caregivers are notified that they are expected to accompany their children when they use the bathrooms.
- Every effort is made to set aside space for family interaction:
 - This space is free from outside news sources, thereby reducing a child’s repeated exposure to coverage of the disaster.
 - If age-appropriate toys are available, they will be in this space, with play supervised by parents, guardians, or caregivers.
- Shared environmental surfaces in shelters that are frequently touched by children’s hands or other body parts should be cleaned and disinfected on a regular basis. High-contact areas may include diaper changing surfaces, communal toys, sinks, toilets, doorknobs, and floors. These surfaces should be cleaned daily with a 1:10 bleach solution or a commercial equivalent disinfectant based on the manufacturer’s cleaning instructions. Local health department authorities may be consulted for further infection control guidance.
- When children exhibit signs of illness, staff will refer children to on-site or local health services personnel for evaluation and will obtain consent from a parent, guardian, or caretaker whenever possible.

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- When children exhibit signs of emotional stress, staff will refer children to on-site or local disaster mental health personnel and will obtain consent from a parent, guardian, or caretaker whenever possible.
 - Children in the shelters come in all ages and with unique needs. Age-appropriate and nutritious food (including baby formula and baby food) and snacks are available as soon as possible after needs are identified.
 - Diapers are available for infants and children as soon as possible after needs are identified. General guidelines suggest that infants and toddlers need up to 12 diapers a day.
 - Age-appropriate bedding, including folding, portable cribs or playpens are also available.
 - A safe space for breastfeeding women is provided so they may have privacy and a sense of security and support. (This can include a curtained-off area or providing blankets for privacy.)
 - Basins and supplies for bathing infants are provided as soon as possible after needs are identified.

Standards and Indicators for Temporary Respite Care for Children

Temporary respite care for children provides temporary relief for children, parents, guardians, or caregivers. It is a secure, supervised, and supportive play experience for children in a disaster recovery center, assistance center, shelter, or other service delivery site. When placing their child or children in this area, parents, guardians, or caregivers are required to stay on-site in the disaster recovery center, assistance center, or shelter or designate a person to be responsible for their child or children, who shall also be required to stay on-site.

In cases where temporary respite care for children is provided in a disaster recovery center, assistance center, shelter, or other service delivery site, the following standards and indicators shall apply:

- Temporary respite care for children is provided in a safe, secure environment following a disaster.
- Temporary respite care for children is responsive and equitable. Location, hours of operation, and other information about temporary respite care for children is provided and easy for parents, guardians, and caregivers to understand.
- All local, State and Federal laws, regulations, and codes that relate to temporary respite care for children are followed.
- The temporary respite care for children area is free from significant physical hazards and/or architectural barriers and remains fully accessible to all children.

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- The temporary respite care for children area has enclosures or dividers to protect children and ensure that children are supervised in a secure environment.
 - The temporary respite care for children area is placed close to restrooms and a drinking water source; hand washing and or hand sanitizer stations are available in the temporary respite care for children area.
 - Procedures are in place to sign children in and out of the temporary respite care for children area and to ensure children are released only to the parent(s), guardian(s), caregiver(s), or designee(s) listed on the registration form.
 - All documents--such as attendance records and registration forms (which include identifying information and parent, guardian, or caregiver names and contact information); information about allergies and other special needs; and injury and/or incident report forms--are provided, maintained, and available to staff at all times.
 - Toys and materials in the temporary respite area are safe and age-appropriate.
 - Prior to working in the temporary respite care for children area, all shelter staff members must receive training and orientation. In addition, such staff must successfully complete a criminal and sexual offender background check. Spontaneous volunteers are not permitted. When inside the temporary respite area, staff shall visibly display proper credentials above the waist at all times.
 - When children are present, at least two adults are to be present at all times. No child should be left alone with one adult who is not the parent, guardian, or caregiver.
 - All staff members must be 18 years of age or older. Supervision of the temporary respite care for children area is provided by a staff person at least 21 years of age.
 - An evacuation plan will be developed with a designated meeting place outside the center. The evacuation plan will be posted and communicated to parent(s), caregiver(s), and guardian(s) when registering their child.
 - The child-to-staff ratio is appropriate to the space available and to the ages and needs of the children in the temporary respite care for children area at any time.

Appendix F. Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities

Updated June 2010

This document was facilitated by the National Commission on Children and Disasters with guidance from subject matter experts in emergency management and pediatric care. The document identifies basic supplies necessary to sustain and support 10 infants and children up to 3 years of age for a 24-hour period. The guidance is scalable to accommodate 10 or more children over a longer period of time.

The National Commission on Children and Disasters recommends State and local jurisdictions provide caches of supplies to support the care of children in mass care shelters and emergency congregate care facilities for a minimum of 72 hours. The amount of supplies cached in an area should be based upon the potential number of children up to 3 years of age that could be populating the local shelters and facilities for a minimum of 72 hours, as determined by an assessment of current demographic data for the jurisdiction.

Depending on the nature of the event, a 24-72 hour supply of essential child-specific supplies should be on site prior to the opening of a shelter or facility. In situations where this is not possible, supplies should still be available for immediate delivery to the shelter, when children are sheltered, within 3 hours (for example, through local vendor agreements, supply caches, interagency mutual aid, etc.).

Such a level of preparedness is critical due to the high vulnerability of this population.

(Guidance begins on next page.)

Recommended Perishable Supplies for Immediate Delivery Within 3 Hours		
Quantity	Description	Comment
40 Jars	Baby food - Stage 2 (jar size is 3.5 - 4 oz.)	Combination of vegetables, fruits, cereals, meats
1 Box (16oz)	Cereal - single grain cereal preferred e.g., rice, barley, oatmeal)	Rice, barley, oatmeal, or a combination of these grains
See Note	Diaper wipes -- fragrance free (hypoallergenic)	Minimum of 200 wipes
40	Diapers - Size 1 (up to 14 lbs.)	Initial supply should include one package of each size diaper, with no less than 40 count of each size.
40	Diapers - Size 2 (12 - 18 lbs.)	
40	Diapers - Size 3 (16 - 28 lbs.)	
40	Diapers - Size 4 (22 - 37 lbs.)	
40	Diapers - Size 5 (27 lbs. +)	
40	Pull Ups 4T - 5T (38 lbs. +)	
320 oz.	Formula, milk-based, ready to feed (already mixed with water) ++	Breastfeeding is the best nutritional option for children and should be strongly encouraged.
64 oz.	Formula, hypoallergenic-hydrolyzed protein, ready to feed (already mixed with water) ++	
64 oz.	Formula, soy-based, ready to feed (already mixed with water) ++	
1 Quart	Oral electrolyte solution for children, ready-to-use, unflavored - Dispensed by medical/health authority in shelter ++	Do not use sports drinks. The exact amount to be given, and for how long, should be determined by an appropriate medical authority (doctor or nurse) and based on the degree of dehydration. To be used in the event that an infant or child experiences vomiting or diarrhea.
See Note	Nutritional supplement drinks for kids/children, ready-to-drink - Dispensed by medical/health authority in shelter	** Not for infants under 12 months of age ** Requirement is a total of 0 40-12 fl. oz. per day; in no larger than 8 oz. bottles.

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

Non-Perishable Supplies & Equipment		
Quantity	Description	Comment
25	Infant feeding bottles (plastic only) ++	4 - 6 oz. size preferred (to address lack of refrigeration)
30	Infant feeding spoons ++	Specifically designed for feeding infants with a soft tip and small width. Can be used for younger children as well.
50	Nipples for baby bottles (non-latex standard) ++	2 per bottle
25	Diaper rash ointment (petroleum jelly, or zinc-oxide based)	Small bottles or tubes
100 pads	Disposable changing pads	At least 13x18 in size. Quantity is based on 8-10 diaper changes per infant per day
10	Infant bathing basin	Thick plastic non-foldable basin. Basin should be at least 12" x10" x 4".
See Note	Infant wash, hypoallergenic	Either bottle(s) of baby wash (minimum 100 oz.), which can be "dosed out" in a disposable cup (1/8 cup per day per child) or 1 travel size (2 oz.) bottle to last ~48 hrs per child.
10	Wash cloths	Terry cloth/cotton - at least one per child to last the 72 hr period
10	Towels (for drying after bathing)	Terry cloth/cotton - at least one per child to last the 72 hr period
2 sets	Infant hat and booties ++	Issued by medical/health authority in shelter
10	Lightweight blankets (to avoid suffocation risk)	Should be hypoallergenic, (e.g., cotton, cotton flannel, or polyester fleece)
5	Folding, portable cribs or playpens	To provide safe sleeping environments for infants up to 12 months of age
2	Toddler potty seat	That can be placed on the seat of an adult toilet, with handles for support. One each should be located in both a Men's and Women's restroom
1 pack	Electrical receptacle covers	Minimum 30 (Note: Prioritize covering outlets in areas where children and families congregate (family sleeping area, children's areas, etc.)

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

Other Recommended Perishable Supplies		
Quantity	Description	Comment
40	Baby food – stage 1 (jar size ~ 2.5 oz)	Combination of vegetables, fruits, cereals, meats
40	Baby food - stage 3 (jar size ~ 6 oz)	Combination of vegetables, fruits, cereals, meats
40	Diapers - preemie size (up to 6 lbs.)	As needed for shelter population
	Healthy snacks that are safe to eat and do not pose a choking hazard (intended for children 2 years and older)	Should be low sugar, low sodium: yogurt, applesauce, fruit dices (soft) (e.g., peaches, pears, bananas), veggie dices (soft) (e.g., carrots), 100% real fruit bite-sized snacks, real fruit bars (soft), low sugar/whole grain breakfast cereals and/or cereal bars, crackers (e.g., whole grain, "oyster"/mini)

Other Recommended Non-Perishable Supplies and Equipment		
Quantity	Description	Comment
10	Sip cups (support for toddlers) ++	

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

Supplemental Information	
Description	Supplemental Notes
Formula	<p>Use of a powdered formula is at the discretion of the jurisdiction or shelter operator. If using powdered formula, preparation of the formula should be conducted by appropriately trained food preparation workers. Water used should be from an identified potable water source (bottled water should be used if there is any concern about the quality of tap or well water).</p> <p>Hypoallergenic hydrolyzed formula can be provided in powdered form—(1) 400 gram can—but only if potable water is accessible.</p>
Infant feeding bottles and nipples	<p>Each time nutritional fluids, formula and/or other infant feeding measures (including breast milk in a bottle) are distributed by trained, designated shelter staff and/or medical professionals, clean, sterilized bottles and nipples must be used. Note: After use, bottles are to be returned to the designated location for appropriate sterilization (and/or disposal). Bottle feeding for infants and children is a 24/7 operation and considerations must be in place to provide bottle feeding as needed. (On average, infants eat at minimum 5-8 times daily.)</p> <p>Note to staff: Sterilizing and cleaning</p> <p>Sterilize bottles and nipples before you use them for the first time by putting them in boiling water for 5 minutes. Nipples and bottles should be cleaned and sterilized before each feeding. If disposable bottles and nipples are not available and more durable bottles and nipples will be re-used, they must be fully sterilized before each feeding. To the greatest extent possible bottles and nipples should be used by only one child.</p> <p>In the event parents want to use their own bottles and nipples, shelter staff should provide support for cleaning these items between feedings. Such support includes access to appropriate facilities for cleaning (not public restrooms).</p>

Supplemental Information	
Description	Supplemental Notes
Note regarding all feeding implements for infants/children	<p>There is a specific concern with cleaning and sanitizing of all feeding implements associated with infants and children (infant feeding bottles/nipples, spoons, sip cups, etc). These items will require additional attention by food preparation staff to ensure they are sanitary as a means of reducing foodborne illness. Medical/health staff should be consulted on best means of raising awareness among shelter residents and enlisting their support for these extra sanitary measures.</p> <p>Feeding implements such as spoons and sip cups should be cleaned using hot soapy water provided potable water is available. When the item is being cleaned to give to another child the item must be sterilized.</p>
For the following items: infant bathing basin, lightweight blankets, diaper rash ointment, wash cloths, and towels	Consider pre-packaging the listed items together and providing one package to each family with children. Note: additional blankets and towels will be necessary for families with more than one child.

Appendix G. Subcommittee Members and Other Contributors

The Commission greatly appreciates the assistance of the following Federal agencies in providing helpful guidance and information used in the preparation of this report:

Corporation for National and Community Service

Department of Defense

Department of Education

Department of Health and Human Services

Department of Homeland Security

Department of Housing and Urban Development

Department of Justice

Environmental Protection Agency

National Council on Disability

National Guard Bureau

U.S. Access Board

The Commission also thanks the following individuals who participated on Subcommittees:

Human Services Recovery Subcommittee

Commissioners

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David Schonfeld, Vice-Chair

Merry Carlson

Sheila Leslie

Mark Shriver

Federal Representatives

Sarah Field, Department of Health and Human Services

Katherine Fox, Department of Homeland Security

Non-Federal Representatives

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Robin Gurwitch, National Center for Child Traumatic Stress

Cheryl Peterson, American Nurses Association

Augustina Reyes, University of Houston

Monteic Sizer, Louisiana Family Recovery Corps

Linda Smith, National Association of Child Care Resource & Referral Agencies

Giovanni Taylor-Peace, Habitat for Humanity

Evacuation, Transportation, and Housing Subcommittee

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Lawrence Tan, Vice-Chair

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Graydon "Gregg" Lord

Michael Anderson

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Andrew Garrett, Department of Health and Human Services

Martin Gould, National Council on Disability

Marsha Mazz, U.S. Access Board

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Jeanne Aimee DeMarrais, Save the Children

Kathleen Henning, International Association of Emergency Managers

David Lurie, National Association of County & City Health Officials

Richard Muth, National Emergency Management Association

Trevor Riggen, American Red Cross

Paul Schwartz, Department of Homeland Security, RET

Donna Swartz, Southern Baptist Disaster Ministries

Pediatric Medical Care Subcommittee

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Steve Krug, Children’s Memorial Hospital, Chicago

Sharon Mace, American College of Emergency Physicians

Jerry Paulson, Mid-Atlantic Center for Children's Health and the Environment

Cindy Pellegrini, American Academy of Pediatrics

Shirley Schantz, National Association of School Nurses

Jeffrey Upperman, Childrens Hospital Los Angeles

Education, Child Welfare, and Juvenile Justice Subcommittee

Commissioners:

Sheila Leslie, Chair

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Kathi Grasso, Department of Justice

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Kay Aaby, National Association of County & City Health Officials

Pat Cooper, Early Childhood and Family Learning Foundation

Patrick Chaulk, Annie E. Casey Foundation

Howard Davidson, American Bar Association Center on Children and the Law

Barbara Duffield, National Association for the Education of Homeless Children and Youth

Vincent Giordano, formerly of the New York Academy of Medicine, Office of School Health Programs

Gina S. Kahn, Hampden-Wilbraham Regional School District (MA)

Ned Loughran, Council of Juvenile Correctional Administrators

Pegi McEvoy, Seattle Public Schools

Michael Nash, National Council of Juvenile and Family Court Judges

MaryEllen Salamone, Families of September 11th

Carole Shauffer, Youth Law Center

Lisa Soronen, National School Boards Association

Gregory A. Thomas, National Center for Disaster Preparedness

Marleen Wong, LAUSD/RAND/UCLA Trauma Services Adaptation Center for Schools and Communities

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Sally Phillips, Agency for Healthcare Research and Quality

Olivia Sparer, Department of Health and Human Services

Cheryl Vincent, Department of Health and Human Services

Tracy Wareing, Department of Homeland Security

Appendix H. Stakeholder Outreach

The National Commission on Children and Disasters requested information, reports, research findings, and policy recommendations from the following non-governmental organizations:

American Academy of Family Physicians
American Academy of Pediatrics†*§^
American Association of School Administrators
American Association on Health and Disability^
American Bar Association Center on Children and the Law†*
American College of Emergency Physicians†*^
American College of Nurse-Midwives
American Federation of Teachers*^
American Institutes for Research^
American Medical Association
American Nurses Association†^
American Public Health Association
American Red Cross†*^
America's Promise
Amnesty International^
Annie E. Casey Foundation†
Association of Maternal and Child Health Programs*^§
Association of State and Territorial Health Officials§
Association of the Schools of Public Health, Centers for Public Health Preparedness
Association of Women's Health, Obstetric and Neonatal Nurses
Brethren Disaster Ministries, Children's Disaster Services†^
Catholic Charities USA†
Center for Education Reform
Center for Health and Homeland Security, University of Maryland^
Center for Rebuilding Sustainable Communities after Disasters^
Children and Family Futures
Children's Defense Fund
Children's Hospital Los Angeles^
Children in Disasters Project, Rainbow Center for Global Child Health^
Children's National Medical Center^

Children's Research Center^
Church World Service
Cincinnati Children's Hospital Medical Center^
CityMatch
Coalition for Global School Safety
Congressional Research Service^§
Council of Juvenile Correctional Administrators†
Council of State Governments
CYJ Enterprises, LLC^
Early Childhood and Family Learning Foundation†
Education Commission of the States
Emergency Management Assistance Compact Advisory Group§
Episcopal Diocese of Louisiana†
Families of September 11th †
Feeding America*
First Star
Food Research and Action Center§^
Habitat for Humanity*^
Health Care Centers in Schools†
Health Sciences Center, Louisiana State University^
Home Safety Council
Information Sciences Institute, University of Southern California^
Institute of Women's Policy Research
International Association of Chiefs of Police
International Association of Emergency Managers†*^
International Association of Emergency Medical Services Chiefs
International Association of Fire Chiefs*
International City/County Management Association
KidSafety of America^
LAUSD/RAND/UCLA Trauma Services Adaptation Center for Schools and Communities†
Louisiana Family Recovery Corps†*^
Lutheran Social Services of Minnesota^
March of Dimes

Mississippi Coast Interfaith Disaster Task Force
National Alliance for Hispanic Health^
National Assembly on School-Based Health Care*
National Association for the Education of Homeless Children and Youth†*
National Association of Child Care Resource & Referral Agencies†*
National Association of Children's Hospitals
National Association of Children's Hospitals and Related Institutions†^
National Association of Counties§
National Association of County & City Health Officials†*§
National Association of Emergency Medical Technicians*
National Association of Pediatric Nurse Practitioners†*^
National Association of School Nurses†^
National Association of School Psychologists^
National Association of State Boards of Education
National Association of State EMS Officials§
National Center for Child Traumatic Stress†
National Center for Disaster Preparedness, Columbia University†
National Center for Homeless Education^
National Center for Missing and Exploited Children†*^
National Center for School Crisis and Bereavement*
National Child Traumatic Stress Network
National Coalition on Children and Disasters§
National Conference of State Legislatures§
National Council of Juvenile and Family Court Judges†^
National Education Association*
National Emergency Management Association†*§
National Emergency Medical Services Association
National Governor's Association§
National Homeland Security Consortium§
National League of Cities*§
National School Boards Association†*^
National Voluntary Organizations Active in Disaster†
Nemours, Alfred I. duPont Hospital for Children^
Philips Healthcare^

Planning and Learning Technologies, Inc.^
Poverty & Race Research Action Council
Project K.I.D., Inc*
Ready Communities Partnership
Ready Moms Alliance*
Rebuilding Together
Salvation Army
Save the Children†§^
Society for Research in Child Development§
Southern Baptist Disaster Ministries†^
Stafford Act Consultants^
The Arc and United Cerebral Palsy Disability Policy Collaboration^
The Children's Health Fund†^
Total Community Action, Inc.^
Trust for America's Health*^
United States Breastfeeding Committee§
University of Southern California^
U.S. Conference of Mayors
White Ribbon Alliance for Safe Motherhood*^
Youth Law Center†
ZERO TO THREE^

† Provided representation to one of the Commission's four subcommittees

* Provided a formal response to the Commission's April 1, 2009 outreach letter

^ Registered for the Commission's February 2010 Long-Term Disaster Recovery Workshop

§ Held an in-person meeting with the Commission

Appendix I. Commissioner Biographies

Ernest E. Allen, J.D.

Appointed to the Commission by Senate Minority Leader Mitch McConnell, Mr. Allen is Co-Founder, President and CEO of the National Center for Missing and Exploited Children (NCMEC). He guided NCMEC's role in the recovery of 151,000 children, with NCMEC's recovery rate climbing from 62 percent in 1990 to 97 percent today. Mr. Allen also built a global missing children's network that includes 17 nations. He came to NCMEC after serving as Chief Administrative Officer of Jefferson County, Director of Public Health and Safety for the City of Louisville, KY, and Director of the Louisville-Jefferson County Crime Commission. He is a graduate of the Louis D. Brandeis School of Law.

Michael R. Anderson, M.D., FAAP Vice-Chairperson

Appointed to the Commission by President George W. Bush, Dr. Anderson is Vice President and Associate Chief Medical Officer at University Hospitals and Associate Professor of Pediatric Critical Care at Rainbow Babies & Children's Hospital in Cleveland, OH. As a pediatric specialist, Dr. Anderson has been active at the local, State, and national level in pediatric disaster readiness and response. Currently he is pooling the talent of Ohio's six children's hospitals to form a disaster response team to serve as a State and Federal asset in the wake of future disasters. His research and clinical interests include national physician workforce, pediatric critical care transport, and national health policy issues for children.

Merry Carlson, MPP

Appointed to the Commission by Senate Minority Leader Mitch McConnell, Ms. Carlson is the Preparedness Manager for the Division of Homeland Security and Emergency Management for the State of Alaska. She is the deputy State Coordinating Officer and was previously the State Individual Assistance Officer and chaired the Alaska Disaster Housing Task Force. Ms. Carlson has served as Alaska's Suicide Prevention Council Coordinator, and as Director of Health for the North Slope Borough in Barrow, AK, where she both provided direct service and administered 17 programs in physical and behavioral health. She also held roles in Barrow's Local Emergency Planning Committee and Emergency Operations Center.

Honorable Sheila Leslie

Appointed to the Commission by Senate Majority Leader Harry Reid, Ms. Leslie is a Member of the Nevada General Assembly and the Specialty Courts Coordinator for the 2nd Judicial District Court, running the criminal, family, and juvenile drug courts and the State's first mental health court. Ms. Leslie has worked on behalf of Nevada children, youth, and families for more than 25 years. She served as Executive Director of the Children's Cabinet, where she created innovative, award-winning programs including Family Preservation, the Child Care Resource Council, Homeless Youth Advocacy, Parent Education Network, and Nevada's first comprehensive Adolescent Health Care program. She was also founding director of the Food Bank of Northern Nevada. As owner of a small consulting business, Ms. Leslie provided comprehensive consulting services through contracts with public and private nonprofit human service organizations, specializing in developing and implementing public/private partnerships addressing the needs of children and their families.

Bruce A. Lockwood, CEM

Appointed to the Commission by Speaker Nancy Pelosi, Mr. Lockwood is the Public Health Emergency Response Coordinator for the Bristol-Burlington Health District in Connecticut. Mr. Lockwood has 28 years experience in emergency management, emergency medical services and public safety, with extensive planning at the local, regional, and State levels for children's needs in disaster situations. He served as the Canton Schools All Hazard Planning Chair and as a member of the Governor's Prevention Partnership School Safety Portal Committee and the Child Safety and Crisis Response, State of Connecticut, Daycare and Child Care Subcommittee; he also served on the Connecticut Public Health Emergency Preparedness Advisory Committee.

Graydon "Gregg" Lord, MS, NREMT-P

Appointed to the Commission by President George W. Bush, Chief Lord is Associate Director of the Grants & Training Division and Senior Policy Analyst at the Office of Homeland Security at George Washington University Medical Center. His career in public safety and emergency management has encompassed roles in rural and urban jurisdictions. He became a paramedic in the early 1980s, subsequently achieving promotion to EMS Operations Chief of the second largest EMS system in New England at Worcester Emergency Medical Services. Chief Lord lectures nationally and internationally on emergency and disaster systems management, leadership, and operations. He is an adjunct faculty member for various institutions and agencies, including the Institute for International Disaster Emergency Medicine, Texas A&M University, U.S. Department of Justice and the Copenhagen Fire Department. Prior to his role at George Washington University Medical Center, Chief Lord served as Division Chief of Emergency Medical Services for Cherokee County Fire Department in Cherokee County, GA.

Irwin Redlener, M.D., FAAP

Appointed to the Commission by Speaker Nancy Pelosi, Dr. Redlener is President and co-founder of The Children's Health Fund and is Director of the National Center for Disaster Preparedness at Columbia University's Mailman School of Public Health. Dr. Redlener worked extensively in the Gulf region following Hurricane Katrina, where he helped establish ongoing medical and public health programs, as well as a research program providing insights regarding the impact of disaster trauma on children and families. Dr. Redlener speaks and writes widely about challenges regarding large-scale disaster recovery. He also organized medical response teams in the immediate aftermath of the World Trade Center attacks in 2001 and has national and international disaster management leadership experience. Dr. Redlener served as Director of Grants and Medical Director of USA for Africa and Hands Across America. He also developed one of the country's largest health care programs for homeless children and their families. Currently, Dr. Redlener is developing clinical and public health programs in response to the Deepwater Horizon oil disaster.

David J. Schonfeld, M.D., FAAP

Appointed to the Commission by House Minority Leader John Boehner, Dr. Schonfeld, FAAP, is a developmental-behavioral pediatrician and the Thelma and Jack Rubinstein Professor of Pediatrics at Cincinnati Children's Hospital Medical Center, where he directs the National Center for School Crisis and Bereavement and the Division of Developmental and Behavioral Pediatrics. Dr. Schonfeld is a member of the Disaster Mental Health Subcommittee of the National Biodefense Science Board Federal Advisory Committee and the American Academy of Pediatrics Disaster Preparedness Advisory Council; he is also a Past President of the Society for Developmental and Behavioral Pediatrics. For more than two decades, he has provided consultation and training on school crisis and pediatric bereavement in the aftermath of a number of school crises (e.g., school shootings) and disasters within the United States and abroad, including flooding from Hurricane Katrina in New Orleans and Hurricane Ike in Galveston and the 2008 earthquake in Sichuan, China. He coordinated the training of school crisis teams for New York City Public Schools after 9/11. Dr. Schonfeld is actively engaged in school-based research involving children's understanding of and adjustment to serious illness and death and school-based interventions to promote adjustment and risk prevention.

Honorable Mark K. Shriver, MPA
Chairperson

Appointed to the Commission by Senate Majority Leader Harry Reid, Mr. Shriver is Senior Vice President for U.S. Programs at Save the Children. Before joining Save the Children, Mr. Shriver served as a Member of the Maryland House of Delegates. Among his many leadership roles as an elected official, he served as Maryland's first-ever Chair of the Joint Committee on Children, Youth and Families, where he spearheaded an early childhood education initiative resulting in more than 37 million new dollars for early education. Before being elected, Mr. Shriver created and served as Executive Director of the innovative Choice Program, a public/private partnership serving at-risk youth through intensive community-based counseling and job training services. The Choice Program has expanded to include The Choice Jobs Program and The Choice Middle School Program, and has been replicated nationwide. Mr. Shriver has served on a number of boards and commissions, including the Campaign for Tobacco-Free Kids, the FEMA National Advisory Commission, the Cal Ripken, Sr., Foundation, and the Living Proof Project. He was a member of the Maryland Governor's Juvenile Justice Advisory Council and the Governor's Task Force on Alternative Sanctions to Incarceration.

Lawrence E. Tan, J.D., NREMT-P

Appointed to the Commission by House Minority Leader John Boehner, Mr. Tan is Chief of Emergency Medical Services at the New Castle County, DE, Department of Public Safety. He started his career as a volunteer firefighter/EMT during high school. He has served as a paramedic, EMS Lieutenant, Emergency Services Assistant Manager, Assistant Chief and Deputy Chief during his 28 years service with New Castle County, DE. Mr. Tan's assignments have included commander of both the Administrative and Operations components of the service, in addition to a special Homeland Operations detail within the Office of the County Executive. Mr. Tan was a member of the National Faculty for the Counter Narcotics and Terrorism Operations Medical Support Program conducted by the Department of Health and Human Services, Department of Homeland Security Federal Protective Service, and United States Park Police. He also serves on the Federal Inter-agency Board for Equipment Standardization and Interoperability as a member of the Health and Medical Responder subgroup, and serves on the executive committee of the FEMA Region III Regional Advisory Council. Mr. Tan is a graduate of the Widener University School of Law and has been admitted to practice law in Pennsylvania, New Jersey, and the United States District Court of New Jersey.

Appendix J. Commission and Project Staff

Commission Staff

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