

**FOCUSING ON CHILDREN AND DISASTERS:
EVACUATION PLANNING AND MENTAL
HEALTH RECOVERY**

HEARING

BEFORE THE

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

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FOCUSING ON CHILDREN AND DISASTERS: EVACUATION PLANNING AND MENTAL HEALTH RECOVERY

TUESDAY, AUGUST 4, 2009

U.S. SENATE,
AD HOC SUBCOMMITTEE ON DISASTER RECOVERY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:04 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Mary L. Landrieu, Chairman of the Subcommittee, presiding.

Present: Senator Landrieu.

OPENING STATEMENT OF SENATOR LANDRIEU

Senator LANDRIEU. Good morning, I would like to call the hearing to order this morning of the Subcommittee on Disaster Recovery, which I am proud and happy to Chair. I thank the staff for helping prepare this hearing for this morning.

Today's hearing is entitled, "Focusing on Children and Disasters: Evacuation Planning and Mental Health Recovery." The Subcommittee's objective today is to evaluate the very special needs of children during the preparedness, response, and recovery phases of disaster and the extent to which our current planning and programs either meet or fail to meet these special needs.

We are focusing on children and their needs for several reasons. First, children in most families are the focal point, and parents who cannot find an available school, a day care center, or access to health care for their children may be forced to relocate after a disaster or, worse in some ways, be forced to stay out of the workforce when they are actually badly needed to help rebuild their communities, starting with their own homes, businesses, and places of worship.

According to the Bureau of Labor Statistics, about half the Nation's families include children, and 90 percent of those families include a parent that is a member of the workforce. So getting your workforce back to work after a disaster is one of our primary goals. That will be very difficult if we are not doing our best to provide them help and support with proper placement during those daylight hours for their children, either in schools or day care, and provide the mental health counseling that children need and families need to sustain themselves.

So we must be mindful of the fact that people cannot return to work or begin rebuilding until they locate a safe and productive environment for their children. These parents, I may remind everyone, are the nurses, the doctors, the first responders, the police officers, the grocery store owners, the gas station operators, the electric line repairmen, and the citizens who play an important role in the community's return. That means the provision of child care and reopening of schools must be a top priority.

I would like to show a chart of the number of day care centers that were operating.¹ In August 2005, the purple line shows how many day care centers were open, and then, of course, you can see the dramatic falloff over time.

The second reason we are focusing on children here today is that children are a vulnerable population with unique needs that require special planning to address, but in my view, they have not received the same level of attention that some other populations, whether it be the adult homeless or the disabled or the elderly generally. A broader goal of this hearing is to encourage the Nation to consider the mental well-being of the community as a key indicator of recovery, every bit as important as the restoration of infrastructure, housing, and the return of the economic tax base.

I would like to take a moment to commend the *Washington Times* for their particularly insightful articles, actually published the last couple of days—it was a coincidence that they were running these in line with our hearing—and I want to quote from one of the articles that was published on August 3. It says, “Almost 4 years after the massive hurricanes inundated much of New Orleans that killed about 1,800 people, millions of words have been written about the devastating physical damage to the city and hundreds of millions of dollars have been spent on fitful efforts at reconstruction. But almost nothing is said and relatively little has been spent on the more silent wreckage, the health of New Orleans residents who were pushed over the edge by the terror and turmoil of the storm and have been unable to recover emotionally or mentally.” And when I say New Orleans, I mean the greater New Orleans area, and in large measure, you could almost substitute the Gulf Coast for New Orleans.

Local response plans must be provided for evacuation, sheltering, and continued care of children from facilities where they are likely to be clustered at the time of the disaster or call for evacuation, either at day care centers, schools, and hospitals, including the neonatal wards and maternity wards. Katrina showed us the impact of failing to include the nursing home sector in our evacuation plans and we must ensure in the future that facilities which house other vulnerable members of our society are included fully in these planning processes.

Save the Children issued a report last month called “The Disaster Decade,” indicating, shockingly, that only seven States currently require schools and day care centers to develop comprehensive evacuation and reunification plans. Those States are Alabama, Arkansas, Hawaii, New Hampshire, Maryland, Massachusetts, and Vermont.

¹ The chart referred to by Senator Landrieu appears in the Appendix on page 95.

Local emergency managers and facility owners can do more to expand planning efforts. States with planning gaps may consider requiring these facilities to develop plans, as some States have already done, and obviously the Federal Government has a role to play.

Another concern raised by the report is the fact that child care is not eligible for funding under the Stafford Act as an essential service. I would like to ask and plan to ask our FEMA Director, Craig Fugate, who is here, to address this in his testimony, and I understand that he will.

In addition to schools and day care centers, we will also consider newborn infants and mothers who may be in hospital wards when disasters strike. According to HHS, an average of 36 babies are born each day in New York City, and in Los Angeles, the daily average is 416. If an evacuation was called in any of those cities, you can understand the difficulties of moving that kind of population, if necessary.

The Senate version of the Homeland Security Appropriations bill for fiscal year 2010 includes an amendment I offered encouraging DHS to conduct mass evacuation planning with States, local governments, and nonprofits, including monitoring, tracking, and continued care for neonatal and obstetric patients. Woman's Hospital will be testifying on the second panel. They executed this function for the State during the response to Hurricanes Katrina, Rita, and Gustav, and they have a great deal to share.

I am going to summarize the rest of my statement for the record because I am anxious to get on to the panel, but let me just say a few more things.

After the hurricanes, the demand for mental health services spiked due to increased trauma, depression, and substance abuse. That was combined with the loss of inpatient beds and mental health professionals which created a severe gap that strained medical workers and facilities, host communities, and first responders.

The LSU Department of Psychiatry screened 12,000 children in schools in Louisiana during the 2005 and 2006 school year. Some of the results of that study are startling. Eighteen percent of them had a family member who was killed in the hurricane. Forty-nine percent of them met the threshold for mental health referral. One year later, the rate was lower, but it was still 30 percent. Twenty-eight percent of displaced children in Louisiana are still suffering from depression or anxiety.

The suicide and attempted suicide rates for adults are also startling. I am going to include those in the record, but some are reporting that the suicide rates are three times higher than the national average. [National Average of Adults: 25-64: 14.88 per 100,000, New Orleans, Louisiana Pre-Katrina: 9 per 100,000, and New Orleans, Louisiana Post-Katrina: 27 per 100,000]. I was struck not only by the number of suicides, but also the number of suicide attempts. It was something like, if I remember, 116 people had committed suicide in 1 year, but 750 had attempted suicide.

The Crisis Counseling Assistance and Training Program is jointly administered by FEMA and SAMHSA. It is intended to counsel disaster survivors and teach them coping skills. We obviously need to do a great deal more.

There is a chart that shows the number of Federal programs that are available,¹ to support mental health and substance abuse services for disaster survivors. Basically this is a list of all the different programs offered through the Federal Government, grant programs, etc., for this purpose. There are 21 different Federal programs, and three of the 21—Medicaid, SCHIP, and Head Start—have income eligibility requirements that limit their ability to provide services in a seamless way after a disaster. But they are stovepiped, and there is no sort of comprehensive community delivery system, in my view, in place right now to cover the extraordinary needs after a catastrophic disaster that affects a community the way it did the greater New Orleans area and across large swaths of the Gulf Coast.

The Consolidated Appropriations Act of 2008 established the National Commission on Children and Disasters to conduct a comprehensive study and examine children's needs. Mr. Shriver and Dr. Redlener are both members of the Commission, and we are pleased to have them with us today to talk about their recommendations in their testimony later.

I would like to conclude with a quote from Chris Rose, who was a columnist for the *Times Picayune* that probably wrote more extensively on a daily basis about this issue than any person in the country. He gave the commencement address at Ursuline Academy a year after the storm, my alma mater high school that has been in New Orleans for 275 years. "My daughter was asked to write about her experiences over the past year when she came back to New Orleans, and this is what she wrote. 'There was a hurricane. Some people died. Some of them were kids.' My daughter was six when she wrote that. It just doesn't strike me as what you would wish for your child to write in her first grade journal, but there it is. You, all of us, are marked by life, by what happens. Like it or not, this storm and circumstances have marked you."

I think this is a good place to start this hearing because these are real consequences and lessons from the terrible catastrophe that happened. We are still struggling with how to respond better, how to plan better, and how to recover, and the needs of children are of primary interest to me, and particularly the mental and emotional needs of the community at large as we seek to build a better and stronger community.

So with that, let me submit the rest of my statement to the record.¹

I would like to introduce the first panel. We have Craig Fugate, Administrator of FEMA, who has been on the job now for about 2 months and is already making some very positive changes.

We have Rear Admiral Nicole Lurie, the Assistant Secretary for Preparedness, U.S. Public Health, Department of Health and Human Services. We are happy to have you, Admiral.

And Cynthia Bascetta, Director of Health Care, U.S. Government Accountability Office. They have issued a recent report, and we are interested in hearing about that report relative to the subject.

¹ The chart appears in the Appendix on page 91.

¹ The prepared statement of Senator Landrieu appears in the Appendix on page 29.

I will introduce the second panel at the appointed time, but Mr. Fugate, let us begin with you, and thank you for being here this morning.

TESTIMONY OF HON. CRAIG FUGATE,¹ ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. FUGATE. Well, good morning, Chairman Landrieu. I have submitted my written testimony. I would ask that be entered into the record and then I have some opening remarks, if that is OK with you.

Senator LANDRIEU. That is fine. Thank you.

Mr. FUGATE. As a paramedic, one of the things that I was taught early on in dealing with medical emergencies was that children are not small adults. That may seem like, duh, but it points out that not only are the pharmacological needs of children different, how you would treat certain conditions, it goes to the whole aspect that an adult, you just don't size down to a child and get the same outcome. You really have to focus on children. Their brain development, their mental capabilities, and their physiology are vastly different from adults. And so your treatment approach has to be geared towards a child, not merely taking what you would normally do for an adult and make it smaller.

And I think that is one of the challenges we have when we look at planning. Historically, when we look at communities and we write planning documents, my observation, and I have been doing this for a while, is we tend to write plans for us, the adults, people that have a high school education. They speak English, or they have more education. They have a car. They drive. They have resources. And they can pretty well take care of much of their needs. And so we tend to write a plan for that population.

Then we will go back and go, well, now we have this other group. They have different challenges. We need to write a plan for those. So we will come up with a second plan, and a third plan, and a fourth plan. And that has been our approach.

We are going to try something different. Based on the concerns that have been raised by the Commission on Children and Disasters and the GAO reports and the issues you have raised, we decided to take a different approach in FEMA, and instead of writing our plan for the adults and then try to figure out how we deal with everything else, let us write plans that actually reflect the communities we live in. They have children. There are people with disabilities. There are frail elderly. But let us quit putting all these populations in a special box that we will get to after we get the plan written and let us do this from the beginning.

So we are going to start with children. As you point out, there are cross-cutting issues, not only when we talk about disasters, but just in the daily delivery of service programs, that oftentimes we do not take advantage of when disaster strikes. There are many things that, I think if we looked at children up front, at the beginning, across all the areas, and we are starting internally with FEMA. But we also want to look at and work with our partners,

¹The prepared statement of Mr. Fugate appears in the Appendix on page 35.

because again, as we continue this journey, as I have completed my second month and look forward to completing my third, I hope, is FEMA is not the team. FEMA is part of a team.

I think we have to do a better partnership with our Federal partners where they have the expertise in how these programs need to be delivered, the needs that we are going to face, particularly when it is talking about in this hearing, children, both from their physical needs as well as dealing with emotional and mental support so that we reduce that trauma.

We know that historically in disasters, that in high stress and the events that children face, the quicker we are able to get to a sense of providing routine, to intervene early, the better the long-term outcome is for those children. Well, that means you cannot just look at what FEMA may be able to bring or fund, but look at how do we take existing programs that are already every day in a community and leverage that, and particularly when we look to our Federal partners, their expertise in helping us design programs that achieve a change in outcome, not just merely look at an administration of a grant program and hope we get where we need to go, but really get our partners to drive that process of how we need to structure and put together these programs so we effect real change.

So we have put together and have worked with Secretary Napolitano to form within FEMA a working group whose sole focus is to make sure that throughout FEMA, we are addressing children issues, from preparedness grants, training, exercising, all the way through our response and recovery activities.

And again, we continue to work on these issues, everything from, some of the issues we ran into with unaccompanied children, all right, working with the Center for Missing and Exploited Children to establish a child locator center, working with some of our programs like Citizen Corps, where we have the Community Emergency Response Team that now has programs designed for teenagers to become involved in that. Also working and looking at how we incorporate this across with our State and local partners.

The day care centers particularly are a challenge, because in a hurricane, these are going to be part of the overall—they are closed down as children are reunited with their parents before evacuation orders are issued. But an earthquake would happen during those time frames. We have seen other incidents that have occurred when children are in school, and we know that if people don't have good family communication plans and they don't know what those day care centers and schools are doing, it can cause a lot of trauma and stress to families as they try to reunite after a disaster.

So with that, I will conclude my opening remarks and look forward to the questions, ma'am.

Senator LANDRIEU. Thank you. Admiral Lurie.

**TESTIMONY OF REAR ADMIRAL NICOLE LURIE, M.D., M.S.P.H.,¹
 ASSISTANT SECRETARY FOR PREPAREDNESS, U.S. PUBLIC
 HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND
 HUMAN SERVICES**

Admiral LURIE. Good morning, Madam Chairman, and thank you, first, for your continued interest in and support of the issues that we are here to talk about today.

As we are coming up on the anniversary of Hurricane Katrina and reflect on it, it has been a really good time for us again to reflect on both the strengths and the gaps that remain in our National Emergency Preparedness, Response, and Recovery efforts.

We all know that throughout this, and as you have pointed out and Mr. Fugate has, that children and their families are often the most impacted and bear the most long-lasting scars of this. And let me say, first, having now spent a lot of time in New Orleans, my heart goes out to all of those who continue to suffer through all of this.

What I want to do is talk to you today briefly about HHS's efforts in the last 4 years to address particularly the needs of children, with the focus, as you requested, on evacuation, particularly of neonates and obstetrical patients, as well as mental health.

We all know that preparedness is a critical part of what we do. We are completely in sync with Mr. Fugate about the need to plan for the entire community, and a community it is, and communities are different and we need to plan to their needs. For that reason, my office has now more than 30 Regional Emergency Coordinators who are actually on the ground in communities, sort of the eyes and ears to really know how to plan exactly for those needs. We know that, in the long run, this preparedness and planning promotes resilience and enables communities to cope with the emergencies that come upon them. So building community resilience is a really important part of what we do.

By way of example, one of the important programs that we have gotten underway over the past couple years are partnerships to really look across the population spectrum, as we just heard about, and to integrate really at the front end all of the groups that might be considered in the vulnerable category, because when you add them all up, there are an awful lot of the population that is vulnerable, but kids and pediatric populations often very much rise to the top of the list.

Other kinds of programs that we have developed in response to this include training curricula for school crisis teams, disaster communication messaging, and a lot of work to develop programs in emotional first aid to early on address those emotional and mental health needs of children. And it is important, as we just heard, to do that at a developmentally appropriate level, and that means across the whole age range of kids as well as adults.

The National Child Traumatic Stress Network has been really instrumental in this regard and launched the Psychological First Aid Field Operations Guide immediately after the hurricane. We are really proud of the fact that those materials have now been picked up and adapted throughout the country.

¹ The prepared statement of Admiral Lurie appears in the Appendix on page 41.

On the response side per se, obviously, during an emergency, it is critical to support the State efforts to provide quick and competent assistance to everybody, children being no exception. The National Disaster Medical System (NDMS), otherwise, I think NDMS is the primary Federal program that supports patient care and transfer during this evacuation of patients. It has both pediatric and obstetric capacity, and I think since the storms has really worked very hard to upgrade its training, its material, and its transportation capacity in this regard. So this ranges from specialized equipment to transport teams who are really specially trained and capable, and to be sure that all of our teams now have those special capabilities involved in them.

In addition, as I think the Pediatric Disaster Coalition was formed by advocates in Planning Region VI, which includes New Orleans and the Gulf Coast, and its goals have also been focused on not only getting people out, but then identifying the appropriate receiving facilities for these children and their families and anyone else, and being sure that everybody knows about them, and that planning is integrated into community operations plans at every level.

Mental health needs can't be separated from the rest of other children's response needs, and how we respond early on is going to really impact the mental health of children and their families going forward. The Crisis Counseling Assistance Program, as is an example of collaboration between HHS and FEMA, as this is administered by the Substance Abuse and Mental Health Administration, and has crisis counselors routinely working at all of the places where children congregate.

As a complement, the National Child Traumatic Stress Network also has a cadre of rapid response teams that can be mobilized nationally, regionally, or locally after a Presidential directive.

Recovery is really complex, and I think as we all appreciate, it has been really sort of under-attended-to until the storm, and for this reason we are very excited about the new directions that FEMA is taking and are looking forward to working on the children's discovery efforts that have just been described.

HHS also started its own recovery coordination efforts and now has Recovery Coordinators identified in each district and a concept of operations that integrates many of these stovepiped programs, particularly within the HHS family, and we are continuing to work on building that out.

I think that we have made a great deal of progress in addressing the needs of children in disasters in the last 4 years. We also have a long way to go, and I think we would be the first to tell you that.

As we look forward to the future, we have a lot of planning and preparedness efforts underway. There is terrific research that has gotten started over the last 4 years. The challenge now is to take what we learned from that research and translate it into practice and best practices that are going to help communities all over the country and on the ground.

We are committed to the highest level of planning, response, and assistance for recovery for children in emergency events. We are most appreciative of the important work that the National Committee on Children and Disasters has done to highlight these im-

portant efforts. I also want to call out the work of the National Bio-defense Science Board, which had a work group focused very specifically and make recommendations for us on the important needs and mental health needs of children and their families going forward, and we are now moving forward to integrate a number of those efforts, and I think during the Q and A, I will probably have an opportunity to tell you more about those things. So thank you very much.

Senator LANDRIEU. Thank you. Ms. Bascetta.

TESTIMONY OF CYNTHIA A. BASCETTA,¹ DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. BASCETTA. Madam Chairman, thank you for inviting me to testify today about our recent report on barriers to mental health services for children in greater New Orleans, and to update you on our recommendations to FEMA in its efforts to support States faced with the mental health consequences of catastrophic disasters. My remarks will be a reminder of why ASPR and FEMA's commitment to children is so very important.

As the psychological trauma experienced by so many children in the aftermath of Hurricane Katrina increased the incidence of depression, PTSD, risk-taking behavior, and other potentially long-lasting behavioral and emotional effects. It is well known that children who grow up in poverty may be at even greater risk of developing mental health disorders, and in New Orleans, the slow pace of recovery and the recurring threat of hurricanes may further exacerbate their trauma.

Against this backdrop, we found persistent barriers to providing and obtaining mental health services, although Federal grants are helping to address them. Lack of mental health providers was identified as the No. 1 barrier to providing services. HRSA's designation of the parishes in the greater New Orleans area as Mental Health Professional Shortage Areas underscored this barrier, and State data showed a large decrease in the number of psychiatrists and clinical social workers who received Medicaid and CHIP reimbursement. To help address this shortage, funding from HRSA and CMS provided incentives to almost 90 mental health professionals who either relocated to or decided to stay in New Orleans.

The second most frequently identified barrier was sustainability of funding. We found that although most of the Federal grants we identified existed before Hurricane Katrina, the hurricane-related programs have been a key source of support for mental health services for children. Much of this funding is temporary and it is too early to know whether sustainability can be achieved by these programs.

We also reported on barriers to obtaining services for children and the top three were a lack of transportation, competing family priorities, and concern about stigma. Officials told us that funding from several programs had been used to provide children with transportation to mental health services, although none of the programs were designed solely for that purpose. Examples include

¹ The prepared statement of Ms. Bascetta appears in the Appendix on page 57.

Medicaid, the Community Mental Health Services Block Grant, and the Social Services Block Grant, as well as SAMHSA funding.

Similarly, block grants and disaster housing assistance program funds were used to help families struggling with housing, unemployment, and other expenses. There was also Federal support for case management and referral services designed to help families locate and obtain mental health services for their children, although we found a lack of continuous and reliable funding for case management.

Stigma, as well as transportation and competing family priorities, was addressed by the use of Federal funds to support services delivered in schools. During the 2007–2008 school year, nine school-based health centers were operating and at least four more were in the planning stages. The advantages of the school settings are that, first, it is not obvious that students are receiving mental health services; second, the transportation problem is solved; and third, the financial burden on the family is reduced because parents don't have to take time off from work and the services are offered at low or no cost.

Stigma can also be reduced by media campaigns, including the one run by FEMA and SAMHSA's Crisis Counseling Program (CCP). We made recommendations to FEMA in February 2008 to improve this program by revising its reimbursement policy to pay for indirect costs, as it does for other post-disaster response grant programs, and by determining what types of expanded crisis counseling services should be incorporated into CCP. Expanded services would provide more intensive services, especially in the aftermath of a disaster, when provider availability can be limited. And FEMA and SAMHSA have allowed the States to develop pilot programs along these lines.

The Department concurred with our recommendations, but has not yet implemented them. FEMA also recently concurred with additional recommendations we made to expedite and improve the effectiveness of its case management services. Taking these actions expeditiously before the next disaster would improve services for children and their families as well as for all adults.

That concludes my remarks.

Senator LANDRIEU. Thank you very much.

I would like to call attention, before I get into the questions, to two charts that I think are very telling.¹ The first is to my left, your right, and you will see the green lines or bars are mental health resources in New Orleans in August 2005. So starting from the left, emergency rooms in New Orleans, 9; psychiatric beds in New Orleans, 350; psychiatric beds in greater New Orleans, 668; and then physicians in New Orleans, 617; psychiatrists in New Orleans is the next bar, 196; and number of New Orleans doctors participating in Medicaid, 400.

Now, when you go to the orange, which is 2 years after the storm—you would think you would be well on your way to recovery 2 years after the storm. We are going into the fourth year. But 2 years after, in 2007, instead of having 350 psychiatric beds, we had

¹The charts submitted by Senator Landrieu appears in the Appendix on page 93 and 95 respectively.

77. Instead of 617 physicians in New Orleans, we had 140. Instead of 196 psychiatrists, we had 22. And instead of 400 doctors participating in Medicaid, we had 100.

Now, just this one chart shows that there is something terribly wrong with the system of support at either the local, the State or the Federal level, for shoring up the core of mental health stability in a community. It is one thing when you don't have access to mental health because of lack of funding. If you don't have the professionals to deliver the services, you could just start with this chart and work backwards from there. You don't have enough physical beds. You don't have enough professionals, etc. This is 2 years after the storm, when you would think that people would be really trying to return after a catastrophe. This isn't 4 years. This is 2 years.

And the trauma that occurs in a community struggling with limited services—I want to call your attention to this next chart I would like you to put up.¹ This is the child care center situation as of August 2007, and there are a couple of pretty startling graphs here. Again, this is 2 years after the storm. Hundreds of thousands of people have fled to Houston and Atlanta. They are trying to get back. A year has passed. Their neighborhood has finally been cleared of debris. They are coming back to try to build their life, and this is what they find 2 years after the storm.

The blue graph is the number of child care centers in the greater New Orleans area that were open before Hurricane Katrina, 275. The green is the marker of August 2007, is 100. In Jefferson Parish, that wasn't as affected, it was 197, and then it was, I think, down to 170.

But this is interesting, very interesting to me. In St. Bernard, which is the small little bars on the side, St. Bernard was a parish of 67,000 people that was virtually completely destroyed. Only five homes survived in the whole entire parish. Before the storm, there were 26 day care centers in St. Bernard Parish, a very tight-knit, middle-class, working-class community. Two years later, after all of our combined efforts, which obviously weren't enough, they only had 2 day care centers open—two in a parish that was completely destroyed.

Now, if we are asking parents to return and rebuild their communities, how is it possible for parents to do that if they only have 2 day care centers in the whole parish? What do they do? Do they strap their children on their backs while they gut their homes? Or do they bring their children in and let them sit while the parents gut their homes and they can play in the dirt and the nails? I am not understanding how we think that the system that we have is appropriate in any way, shape, or form.

So I could show you the statistics 4 years out from the storm, but this really grabbed me when I saw that after 2 years of all of our efforts, there were 2 day care centers open in St. Bernard Parish.

Mr. Fugate, how is FEMA working to provide safe places for children, whether it is schools or day care opportunities, while parents are struggling to rebuild their communities after a catastrophic disaster, and what would some of your comments be about what you have heard this morning?

¹ The chart referred to by Senator Landrieu appears in the Appendix on page 95.

Mr. FUGATE. Chairwoman, Mark Shriver, who currently chairs the National Commission on Children and Disasters, I think he was probably one of my first meetings after I was sworn in, and laid out the concerns and issues, many of which you have laid out, and asked the same question. What is FEMA going to do about it?

The easy answer would have been to put another box in there and say, we will write a plan for children and that will satisfy everybody's concerns. However, I didn't think that was going to do real change. And so as we talked with Mark and we talked with members of the Commission and we had an opportunity to go to one of the Commission meetings, I kept asking, we have historically looked at special populations as special as an afterthought, and I said, let us try something different. And maybe it is just semantics, but I have got to try this.

Why don't we write plans for the community and quit writing plans for just one part of the community, the people that can pretty well take care of themselves, and really look at what are the needs of the community. And as you point out, my experiences in the 2004 hurricanes, one of the first things we really pushed hard to do was to get things like the pre-K and schools open, and there were several reasons for that.

One is we recognized the stress to children going and that we did not have the resiliency in the mental health community because they were impacted like the rest of the facilities. All three hospitals in Charlotte County were shut down. And we knew that if we could get schools open, we could bring counselors to the schools and start working with children. It wasn't that we wanted schools back to normal. We just wanted to get them open to get children back into an environment that would get them into a routine that would both get them a chance to start dealing with this, but also give their parents a chance to deal with what had happened with their children somewhere safe.

The challenge has always been when you get into day care that it depends upon States and localities, but that can be a quasi-state function, local function, or a private investor-owned, and the Stafford Act, again, historically has been looking at what government's responsibilities have been when you look at reimbursement and programs.

So we are working with the Commission, and their report, we are saying, we don't have time for the report. We need to—as soon as you guys have identified this, how do we go back in FEMA and look at the Stafford Act, look at grants, look at program guidance, look at training, to start encouraging and recognizing that children from in the home—again, you cannot just do one for all children. You have to really look at them developmentally from infants up through a certain age and different grades. How do we change what we have been doing so that if disaster strikes in the future, we are addressing these issues?

Senator LANDRIEU. OK, and I appreciate that comprehensive look and I think it is important. That brings me to your other point when you said FEMA is a partner in this effort. Yes, I do believe that FEMA is a partner, but I would say that FEMA is the leader. FEMA should be the experts on disaster with your other Federal

partners. FEMA should be the driver. FEMA should be the motivator, the communicator.

I mean, I look at FEMA and Homeland Security as not being the only entity that responds after a disaster, but being the lead entity that helps to coordinate and manage your other Federal partners, gives guidance to your State and local partners, provides technical assistance and support to the private sector. But I wouldn't just say that FEMA is just any old partner. FEMA is the lead.

Two, when we talk about day care centers, part of this is, you are right, some of them are nonprofit. And some of them are for-profit. But a good plan that would make sure that Head Start teachers and early childhood education teachers and counselors are part of that first responder team coming back from rebuilding, loans from the Small Business Administration to make sure that these day care centers can get the loans they need.

And think about how difficult it is for a for-profit day care center operator under our current laws and current requirements to get a \$200,000 loan to reopen a day care center. Any bank or even under any regular system would look at her and say, why are you opening a day care center? There are no children in your parish. And she says, "Well, we will never have children in my parish unless I open and provide a space for them." But she is not—or he is not, whoever is running the center—is not deemed creditworthy, or their business plan is "not viable."

Well, that is true on its face, but that is where the Federal Government has to step up and say, under normal circumstances, you wouldn't lend this person \$200,000 to open a day care center where there are no children. But under this plan, under a disaster response plan, we are going to require you, basically, to lend the money at a lower interest rate and extend out the repayment, or if you don't get a day care center back in this parish, you are not going to have a parish back because there have got to be safe places for children in order for parents to return.

And I would submit another thing that is all interconnected, and I think, Mr. Fugate, you have hit the nail on the head. But when we are trying to encourage doctors to come back, we have lost many doctors, we think of them as doctors. We don't think of them as parents. Most of them are probably parents with children. They can't come back if there is not a day care center or a school for their children.

So all of our efforts to rebuild our community are really spinning our wheels if that plan, as you said, Mr. Fugate, doesn't have at its essence rebuilding safe places for children, which represent not only a special population, but a central population to the families that we need to rebuild, I guess is my point. And I just think that has really been overlooked.

They said there has been a vote that has been called, and unfortunately, because I am here by myself, I am going to need to probably call a brief recess and come back. But if the witnesses could remain on hand, I am going to go vote and then we will reconvene. I have a few more questions for the panelists, and then we will move probably right at 11 o'clock or a little bit after to our second panel.

Thank you, and the Subcommittee will stand in recess.

[Recess.]

Senator LANDRIEU. Thank you all for your patience. Our meeting will now resume.

I have just a couple of questions, and because of the time, I am going to submit the rest of them in writing. But let me just ask again, Mr. Fugate, you have heard the GAO recommendations for FEMA to modify program rules to allow reimbursement of indirect costs and consider expanded services when it comes to mental health counseling. How did you receive this recommendation and what are your plans to implement it, and if not, what will you do as an alternative?

Mr. FUGATE. Senator, we received them favorably, and this is prior to my arrival. We have been working with HHS to go through the implementation. We are, I believe, getting to the point of finalizing those and then sending those back out for final comment so we can go forward. Again, but we did receive these recommendations favorably. We are working to achieve that, and those are things that are still in process.

But I think it goes back to earlier when I said we are part of the team. On behalf of the Secretary and the President, my job is to coordinate all the Federal family when a governor requests and receives disaster assistance. But part of that is recognizing that subject matter expertise in existing programs have to be part of that response, and that is what I was referring to as we are part of that team, is I don't think FEMA has done a good job of understanding and working with our partner agencies to leverage all their programs and we have defaulted oftentimes to merely the Stafford Act, which may be appropriate in some cases but may not be the most effective way and doesn't build upon the existing expertise in programs that are already in a community.

And that is again why we are going to use this Children's Working Group to step back from our traditional, what I call the FEMA-centric approach that is always focused on the Stafford Act, and really look at what all the Federal family has and do a better job of leveraging those resources as a team so that we know where the expertise is, where core competencies exist, and again, with HHS and the programs they have dealing with mental health issues, particularly designed for children.

Then how do we leverage the Stafford Act so that we are, again, as you show these charts, not having the locals and the State have to go through and figure out who has got what, but we can present a program that focuses on outcomes, and in this case, particularly focus on the outcomes from children as the Federal family, working under that authority that the President has vested in FEMA, to support a governor and those local jurisdictions.

Senator LANDRIEU. Well, I agree with that, and I think your analysis that it has been a FEMA-centric approach and it needs to change to where FEMA is the lead of the team, marshaling the other forces, coordinating, being the link and designing the programs, not necessarily assuming responsibility to deliver them all, but to have them delivered through partnerships.

One more question and then I have a few others. In November 2005, I led the effort, along with Senator Kennedy and Senator Enzi—and without the support of these two Senators, I have to say

publicly, it never would have happened. But Senator Kennedy and Senator Enzi led a one-time unprecedented effort to establish basically a plan for the 300,000 children that had been displaced from the storm in the week of August 29, which is approaching soon, to try to find them a school somewhere in America where they could start school on a Monday, the following Monday, because children that are out of school for 2 or 3 weeks sometimes have to skip a whole year. And under their extraordinary leadership, this plan was implemented and basically provided vouchers for up to 300,000 children to attend school for that year. And as a result, the Katrina Class graduated, many of them.

This was one time, though. Mr. Fugate, are you going to recommend a continuation of this approach, and if so, how, and if not, what plan is going to be put in place the next time a catastrophic disaster happens?

Mr. FUGATE. Well, again, that is some of the issues we want to raise with our Children's Working Group. In Florida, our experience was that as many of the families—I think when we looked at the FEMA registration, we ended up with about 25,000 families that had come to Florida. They weren't part of any directed evacuation, either through churches or family associations or just coming to Florida. We were able to make decisions in the State of Florida pretty matter-of-factly that any of these folks that had children that were school-aged that wanted to go to school would enroll. We did that through our State Department of Education.

And again, we did this across the board, realizing that at some point, we would have to look at how we would come back to our Federal partner agencies that provided funding and get funding. We didn't want to take money away from the State of Louisiana, but we did recognize that many of these would be additional burdens for our local taxing authorities and how we do that.

And I think that is one of the things that we want to come back and go over, what is the best mechanism, so if a State has children coming into their State, or a jurisdiction has children coming in from outside of where the taxing base was at, how do we provide that assistance without——

Senator LANDRIEU. Well, I would suggest, respectfully suggest to you, look at this program that seemed to work amazingly well. And again, it was a very simple voucher program, up to \$7,500 as I recall worth of the cost of a Catholic school tuition, whether children left a private school to go to public or public school to private or Catholic school, because you have to have a program that snaps into place within the first week of the disaster, if it is a catastrophic disaster and it is obvious after a few days of analysis that there are no schools to come back to. You have got to have a button you press and this program operates.

Right now, as I understand it, although Senator Kennedy and Senator Enzi put this in place for Hurricanes Katrina and Rita, it was one time and it is not in place today. So if another catastrophic disaster happens this summer and either Texas or Mississippi or Alabama is hit and hundreds of thousands of children are displaced, as they were after Hurricane Katrina, we have to start all over again and get an Act of Congress to give people a back-up plan in the event that their school is destroyed.

So I only raise this to say that while we have done a lot of talk and we have had some actions, there are so many other steps that need to be taken.

One more question to GAO. The GAO recently released another report, as you mentioned, on disaster case management programs. Case managers are meant to help their clients find job training, permanent housing, relief supplies, access to critical services. Particularly after a disaster, case managers can be extremely helpful in trying to make sense of things, trying to identify the programs that are still operating and out there and making them real for clients.

What in your study could you share with us about the need for case managers? Did we have enough on the ground? How did the case management program work generally? I think you testified to this. Could you elaborate just a moment?

Ms. BASCETTA. Yes, I can. Overall, because of the chart that you showed with the multiplicity of funding streams, case management is really important. It is very difficult for families, especially low-income families or families under stress, to try to figure out how they themselves can put together the package of services that they need to stabilize and to regain their self-sufficiency.

We had two major findings. One was, as we found in the mental health area, there was a significant lack of case management providers and also limited referral services. This links back to the fact that if there aren't enough providers in the area, there is nobody to refer people to.

The other major concern was sustainability of funding and breaks in funding. There was one situation in which a Federal program was about to make a handoff to the State. The State program wasn't up and running yet. So there was about a 2-month gap in case management services when families were unable to access anything at all.

Senator LANDRIEU. Access anything whatsoever.

Ms. BASCETTA. That is correct.

Senator LANDRIEU. And I also understand that Catholic Charities, which is a very reputable and large and capable nonprofit, stepped forward to provide case management. But under the current law, they were not allowed to recoup indirect costs. So as a result, they were basically losing money as a nonprofit trying to deliver services for the Federal and State Government. Is that your understanding?

Ms. BASCETTA. I am not sure I have the details of the situation you are describing. I do know that Catholic Charities had dropped out as a provider of crisis counseling services because they weren't able to recoup their indirect costs, and this was part of the reason—part of the basis for our recommendation to expedite that reimbursement under FEMA's rules.

Senator LANDRIEU. OK. Thank you all very much. I am going to ask the second panel to come forward. I really appreciate your participation this morning and look forward to continuing to work with you.

As the second panel comes forward, just to save time, let me begin to introduce them.

Our first witness will be Mark Shriver, who served as the First Chair of the National Commission on Children and Disasters since July 2008. The Commission authorized under the Consolidated Appropriations Act of 2008 is tasked with the duty to conduct a comprehensive study that examines children's needs as they relate to all hazards and evaluate existing laws, regulations, and policies and programs relevant to the needs of children during and after a disaster. He is also Vice President and Managing Director of U.S. Programs for Save the Children. He served as a member of the Maryland House of Delegates and is not new to this subject. We are pleased and honored to have Mr. Shriver with us today.

Dr. Redlener also serves on the National Commission on Children and Disasters. Dr. Redlener is the President and Co-Founder of the Children's Health Fund, which works to educate the general public about the needs and barriers to health care. I want to say on a personal note, he really stepped up after Hurricanes Katrina and Rita, working through Senator Clinton's office at the time, to give tremendous support and encouragement to us along the Gulf Coast and we are grateful, Doctor, for your help and support.

And finally, Teri Fontenot, President and Chief Executive Officer of Woman's Hospital in Baton Rouge. Ms. Fontenot assumed this position in 1996 after serving as a Health Care Finance Operations Executive in Louisiana and Florida. She chairs the Louisiana Hospital Association Malpractice and General Liability Trust and is leading one of the finest hospitals, in my view, in Louisiana, with expertise in birthing and maternity for 8,500 mothers and children every year and is the designated hospital in Louisiana to coordinate disaster response for neonates, which is a very special group of infants that we need to focus our attention on, during a disaster.

But let us start, Mr. Shriver, with you. Thank you very much.

TESTIMONY OF MARK SHRIVER,¹ VICE PRESIDENT AND MANAGING DIRECTOR OF U.S. PROGRAMS, SAVE THE CHILDREN, AND CHAIRPERSON, NATIONAL COMMISSION ON CHILDREN AND DISASTERS

Mr. SHRIVER. Thank you very much, Madam Chairman, for hosting this hearing and for your interest in this issue. I have submitted a longer report, and frankly, you said most of the things that I was interested in saying and points to try to get across.

Just for the record, I am Mark Shriver, Vice President and Managing Director for Save the Children's U.S. Programs, and Chair the National Commission on Children and Disasters. I just want to summarize, Madam Chairman, and just say a couple of quick facts.

The bottom line is that children are 25 percent of the population, yet this Federal Government and State governments and really all across the board, we have spent more time and energy and money focused on the needs of pets in disaster planning response than we have on kids. That is 25 percent of the population has received less time and focus and resources than pets, and I think that for this country in this situation, that is absolutely outrageous.

Kids, as we all know and as you have eloquently said, Madam Chairman, are lumped in under at-risk, vulnerable, or special

¹The prepared statement of Mr. Shriver appears in the Appendix on page 67.

needs populations, and as Mr. Fugate just said, I think what he is proposing to do at FEMA through the efforts over there are really an exciting first step in the right direction, to try to address children's needs in a comprehensive and an effective manner rather than just creating window dressing, as he already has said.

A little background on the Commission, Madam Chairman. We had our first meeting last year. Our interim report is due in October of this year. Our final report is due to Congress and the President in 2010. We have had a field hearing in Baton Rouge where Dr. Redlener joined me down there, as well. We have engaged a large community of entities to gather information and try to assess where there are gaps in the services, and those folks are not just Federal Government, State, and local government, but nonprofits, as well.

I do just want to comment again that what Administrator Fugate has started at FEMA is very exciting from the Commission's perspective and from Save the Children's perspective and I just want to say a couple of quick words on child care.

You have already had the Save the Children report up there, but the issue is critically important, not just from a kids' perspective, which obviously is, I think, paramount, but the fact is that following a disaster, if you don't have child care facilities, you have a loss of economic opportunity, as you have already eloquently stated it. Save the Children's Disaster Decade Report, which is up there, shows that only seven States meet the basic requirements for licensed child care providers to have basic written emergency plans in place addressing evacuation, reunification, and accommodating children with special needs. Seven States in this country have the basic minimums in place. That, too, I think is absolutely outrageous and should be addressed through—can be addressed through Federal legislation, and some of the steps that we are proposing are in my written statement, Madam Chairman, but I will just highlight a couple of them.

Mr. Fugate talked about the Stafford Act and the importance of creating child care or saying that child care can be deemed an essential service. Clearly, we are very supportive of this concept. We think that funding is necessary for the establishment of temporary emergency child care and recovery of child care infrastructure.

The Child Care Development Block Grants are being authorized, Madam Chairman, as—and we would propose that during that reauthorization—that State child care plans include guidelines for recovering temporary emergency child care operating standards after a disaster, that be made a requirement, and that States also are required to have child care providers have comprehensive all-hazard plans that incorporate specific capabilities such as shelter in place, evacuation, relocation, family reunification, staff training, continuity of services, and accommodation of children with special needs. The Federal Government has the ability to put these requirements in the Child Care Development Block Grant reauthorization and we encourage you to look into that, Madam Chairman.

I know time is of the essence, so I will just wrap up by saying that a lot of the ideas that you and your staff have been working on and mentioning today are critically important, and I would only encourage you, as the Chair of this Commission and as a member

of the nonprofit community, to follow up, to follow up, and to follow up again. If you don't hold everyone's feet to the fire, kids, because they don't vote, and particularly poor kids, are not actively engaged in the political process. You are their voice, and if you do not stand up and your staff doesn't follow up diligently with all levels of the government, they will, unfortunately, suffer from benign neglect, which is what David Paulison told me has been the modus operandi in the past, and that benign neglect, I don't think, is the way that this country should be acting for poor children and especially vulnerable poor children across the country.

So thank you, Madam Chairman.

Senator LANDRIEU. Thank you, Mr. Shriver. I appreciate it.

And I want to note for the record that Administrator Fugate has stayed for the second panel and I would like that to be noted. It is important to me that he didn't testify and leave, but he is staying to hear these comments and I appreciate it. Thank you, Mr. Fugate.

Doctor Redlener.

TESTIMONY OF IRWIN REDLENER, M.D., PROFESSOR,¹ CLINICAL POPULATION AND FAMILY HEALTH, AND DIRECTOR, NATIONAL CENTER FOR DISASTER PREPAREDNESS, MAILMAN SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY, AND PRESIDENT, CHILDREN'S HEALTH FUND

Dr. REDLENER. Thanks, Madam Chairman, and again, I just want to echo our great appreciation for you holding these hearings and learning more about this terribly difficult problem that we are facing.

So I am a pediatrician, as you noted. I am President of the Children's Health Fund, but I am also Director of the National Center for Disaster Preparedness at Columbia University, and I have the honor of serving on the National Commission and chair there the Subcommittee on Human Services Recovery.

By way of background, shortly after Hurricane Katrina, and working with local officials, we dispatched seven of Children's Health Fund's fully contained mobile pediatric clinics and professional teams to the Gulf to provide acute medical and mental health care for survivors and evacuees, and eventually those became permanent programs which are still there in the Gulf, in Mississippi and Louisiana, affiliated with LSU, Tulane, and other institutions. But to date, for the record, we have seen over 60,000 health and mental health encounters in children.

In addition to that, the National Center, my Center, has conducted long-term periodic interviews with a cohort of 1,000 families, and I just want to summarize a couple of the key points out of many that I think are germane to our discussions today. This comes from our clinical information and our studies.

So more than three in five parents have felt now, over time, that their general situation currently is either uncertain or significantly worse than it was before Hurricane Katrina.

Second, approximately a third of displaced children are at least one year older than appropriate for their grade level in school.

¹ The prepared statement of Dr. Redlener appears in the Appendix on page 71.

Third, according to interviewed parents, more than two-thirds of children displaced by the hurricanes are experiencing emotional or behavioral problems as we speak, and in a study last fall of our program in Baton Rouge, 41 percent of children were found to have iron deficiency anemia, a third had impaired hearing or vision, and 55 percent were reported to have behavior or learning difficulties.

And as far as the overall situation for children is concerned, and to give some sense of scale, I believe that the number of disaster-related excessively vulnerable children right now, 4 years after Hurricane Katrina's landfall, is unacceptably high, with some 17,000, at the minimum, to, in my opinion, over 30,000 children still in limbo and still at substantial risk. In fact, many children who are now developing chronic emotional problems or who are failing in school will not easily recover. We are undermining not just their current well-being, but their future potential, as well.

In my opinion, the overall management of the recovery process from the hurricanes in the Gulf, while less visible than the images seen around the world of people waiting on their rooftops for rescue, has been more mishandled than the initial response to the disaster. The extraordinary failures of recovery and the persistence of trauma and profound disruption to children have been far more insidious and invisible than the acute situation.

Unfortunately, the failures of recovery have lost the attention of the media, for the most part, the public, and, I am sorry to say, perhaps many in government, as well.

The basic concept of long-term recovery is fraught with confusion and lack of leadership on every level. There is a lack of clarity of what we even mean by the term recovery. That is, are we talking about rebuilding physical environment or working to help families reestablish conditions of normal life as rapidly as possible?

Although a National Disaster Recovery Strategy was mandated under the Post-Katrina Emergency Management Reform Act of 2006, that strategy has yet to appear. That said, I believe that under new and highly motivated and capable leadership now at DHS and FEMA and HHS, we are hopeful that we may soon see the emergence of this critical road map.

Until very recently, there has been no apparent recognition that the needs of children must be understood and absorbed in all aspects of disaster response, planning, mitigation, and recovery, and we think this is changing, as well, as Mr. Shriver was just pointing out.

But perhaps most egregious of all, there is a growing sense, and I consider it a monumental misunderstanding, that recovery from large-scale disasters is a local problem to be solved and managed by States and local jurisdictions. But the destruction at the level we saw in the Gulf post-Hurricanes Katrina and Rita and the flooding of New Orleans was and remains a national problem. The well-being of the affected States is highly material to the well-being, the economy, and indeed the security of the United States.

So I want to just conclude with a few general recommendations, and then a couple of points just to emphasize what Mr. Shriver was saying about children. So in general—I have dozens of these, but let me just hit three of them.

Senator LANDRIEU. That is OK. Take another minute or two. We appreciate it.

Dr. REDLENER. So, first of all, the National Disaster Recovery Strategy must be completed as rapidly as possible, and preferably, were I you, I would ask for that by the end of this calendar year. There is absolutely no reason why that needs to be delayed any more than that, and if we don't have that, we are going to be still flailing around and trying to understand who is doing what for whom in the issue of long-term recovery.

Second, I would strongly recommend a high-level directorate reporting to the President that needs to be established to oversee and coordinate all relevant Federal assets and agencies with respect to long-term recovery. I mean rebuilding, and I also mean revitalizing, sustaining, and protecting the needs of children and families during this terrible, difficult transition.

Third, recovery must be seen as responding at every level to these human services needs during the recovery transition, and we would like to see how this National Recovery Strategy actually addresses them.

And then some of the other issues around children which represent, to me, the most dangerous problem that we are facing right now, because as I said before, the problems will not be sometimes at all reversible. Children that lose a year or two in school cannot be recaptured in terms of their academic success. Emotional problems rooted in 4 years of trauma—and by the way, we think it will take another 2 years to get everybody housed, if, in fact, we have housing available—those children, we ignore at their peril and our peril.

So I have been thrilled to be on the National Commission with Mr. Shriver and here are a couple of things I would just point out.

The National Recovery Strategy, when it develops, should have an explicit emphasis on safeguarding the health, mental health, and academic success of displaced children. This addresses the point you raised before. It cannot be ad hoc. It has to be part of our basic understanding about how we deal with recovery for this disaster and anything else that happens in the future. It may be a storm in the Gulf. It could be terrorism in New York. It could be an earthquake in San Francisco. We don't want to be redoing this and we need that road map.

Second, the Federal Government must assure a robust, uniform, and accountable case management program for every child displaced by a major disaster. I don't have time to go into it, but I had to medicate myself in order just to absorb the complexity and dysfunctionality of what our country called case management in the aftermath of this disaster. It is shameful.

And third, I would say that the health, dental, and mental health services for every displaced child should be assured and funded under a "medical home" comprehensive care model. And again, this is because somebody has got to take responsibility for not permitting children to fall through the cracks. They can't afford the delays and the interruptions in their safety net.

So I think I am going to leave it at that and would be happy to respond to any questions. But again, our profound gratitude to you, Senator, for taking and keeping the leadership on this vital issue.

Senator LANDRIEU. Thank you, Doctor Redlener. Ms. Fontenot.

TESTIMONY OF TERI FONTENOT,¹ PRESIDENT AND CHIEF EXECUTIVE OFFICER, WOMAN'S HOSPITAL, BATON ROUGE, LOUISIANA

Ms. FONTENOT. Madam Chairman, it is a privilege to come before you today to describe our hospital's response to the evacuation and care of critically ill patients in the horrific aftermath of Hurricane Katrina, our preparations for Hurricanes Rita, Gustav, and Ike, the important lessons learned, and our recommendations for emergency management and medical treatment of neonates.

Woman's Hospital is 70 miles northwest of New Orleans and a 2-hour drive from the Gulf Coast. Hospitals are usually a place of refuge rather than a complex evacuation site, so the need to evacuate one or a whole city of hospitals had not been considered. But in the catastrophe of Hurricane Katrina, Woman's Hospital did just that, by evacuating 122 infants from flooded hospitals in New Orleans in 4 days.

Working with our heroic colleagues in New Orleans under unfathomable conditions, not one transferred baby or mother died. Unquestionably, this remarkable achievement was the result of dedication and hard work by thousands of people, not because of carefully crafted and effective planning.

In fact, the chaos was overwhelming. Blackhawk helicopters brought men, women, and children day and night to our hospital. We received, stabilized, and transferred many patients to other facilities. But the most critically ill infants and women remained at Woman's Hospital. For a month after Hurricane Katrina, we cared for twice the usual number of critically ill infants and delivered 150 babies from the affected areas. For several days, there were 125 infants in our 82-bassinet neonatal intensive care unit. We also received and provided care for over 1,100 other patients and worked with area churches to provide shelters for 110 newly delivered mothers and families because they were rejected at government-run and Red Cross shelters.

What began as a rescue became a response to their overwhelming needs beyond medical care. This feat was successful because of our incredibly dedicated staff and expansion to our neonatal intensive care unit that was completed just weeks before Hurricane Katrina, and a drill held early in 2005 that yielded valuable information about needed equipment and processes. Fortunately, the rescue was adequate, but coordinated planning by all agencies involved could have vastly improved the response.

Hurricane Rita came 3 weeks after Hurricane Katrina. For Hurricane Rita and each storm since that time, neonates and high-risk obstetrical patients were evacuated to Woman's Hospital from hospitals before the storm, a key lesson learned.

In early 2006, providers of obstetrical and neonatal services throughout Louisiana convened and produced a plan for emergency management of neonates. We also contacted neighboring States to discuss evacuation, especially if Baton Rouge became the disaster

¹The prepared statement of Ms. Fontenot with an attachment appears in the Appendix on page 77.

site, since no other hospital in our State has the capacity to take our large number of NICU patients. We took part in research with Tulane University to study the effects of the stress of the storms on maternal and infant outcomes, and we are the officially designated provider for infants in Louisiana's Medical Institution Evacuation Plan. In short, we are committed to anything and everything that will prevent the chaos of Hurricane Katrina.

Hospitals in Louisiana have strengthened their infrastructure and plan to shelter in place, with the notable exception of especially fragile patients, such as ill newborns. Those hospitals still depend on us to transport and care for their patients.

Woman's Hospital's performance after Hurricane Katrina and the three hurricanes since that have threatened the Louisiana coast demonstrate that an expert organization with adequate capacity is critical for the emergency management of certain populations of fragile patients. The expert hospital is the coordinator of care and has capacity to care for displaced infants. Named Operation Smart Move, it is an initiative to ensure that infants and mothers throughout the Gulf Coast have a safe place, as well as a network of care and services to mitigate the devastating stress and overwhelming anxiety of recovery.

A remarkable opportunity exists to further implement these concepts as we build a replacement hospital. Surge capability was included in the original design, but was removed due to the high interest rates on tax-exempt debt and deep Medicaid cuts to hospitals. Building stand-by and surge capacity is now unaffordable for us and most hospitals, even though the hospitals in Louisiana have counted on us three times in less than 4 years to fulfill this need. Financial support for the capital and stand-by costs for hospitals to be ready at all times is critical for proper disaster preparedness.

The relocation of our hospital to a new campus will provide a unique learning opportunity. Representatives from hospitals like Woman's from across the Nation will participate in a real-time evacuation drill as our NICU is moved from one campus to another.

Another recommendation is the amendment of the Stafford Act so that private organizations will qualify for reimbursement of costs associated with evacuation. Many private organizations assist or replace governmental agencies before, during, and after disasters, yet are prohibited from directly receiving FEMA funds.

Your concern about the impact of disasters on children is appropriate and important. On behalf of the staff of Woman's Hospital, we are honored to share our experience and knowledge to improve the response and care of our most vulnerable citizens.

I will close with a special thank you for your ongoing support of Woman's Hospital, Operation Smart Move, and the opportunity to speak today, and I look forward to answering any questions. Thank you.

Senator LANDRIEU. Thank you very much, Ms. Fontenot. We appreciate your leadership. You continue to make this Senator very proud of the work that you are doing.

We will only have one question for each of you because of our time limitations. Let me, Ms. Fontenot, start with you, if you could

just restate two points for the record. One, despite the fact that your hospital did such extraordinary work in the storm, could you say again for the record what the current law allows you to get in terms of reimbursement? I understand that you are a private facility, so therefore while the government depended on you to help in so many ways, that you are not in line for any reimbursement. Could you explain that just a moment?

Ms. FONTENOT. My understanding is because we are not a governmental agency, that we are not able to receive funds directly from FEMA, that we have to have a contract with the State for any type of service that we provide and it goes through the State as the fiscal intermediary.

Senator LANDRIEU. And could you talk a minute about the surge capacity issue, because as we debate the health care bill and how we may reshape the health care delivery system for the country, I think this would be important. So again, if you could just comment about the lack of surge capacity.

Ms. FONTENOT. Thank you. Most hospitals are faced with cuts because of inadequate reimbursement, and particularly Medicaid, which, of course, that is the primary payer for children and particularly infants. Sixty percent of the babies in our NICU are covered by Medicaid. Half of the deliveries in our hospital are covered by Medicaid, and two-thirds are covered in our State by Medicaid.

So whenever there are Medicaid cuts, as there have been announced just this week in Louisiana, and, of course, that is being repeated around the country, hospitals are not able to provide the financial support for additional beds to be on stand-by, or equipment or supplies or planning or any of those things. Any reimbursement they receive has to go directly for the core medical services, and that is taking care of those babies that are in the hospital that day without being able to have anything on the side, so to speak, so that we can be surge hospitals, or expert hospitals, for that matter, because it is very expensive to have the planning and the drills and that sort of thing.

Senator LANDRIEU. Thank you very much.

Mr. Shriver, let me ask you if you could sum up, besides the excellent recommendation that a strategy be enacted by the end of the year and a requirement put down to receive that strategy, and that the Child Block Grants not be reinstated without the requirement that States step up to at least have evacuation, reunification, special needs, and written procedures for disaster planning, are there one or two other specific suggestions that you would like to mention that you think from your study and review should be really at the top of our list to address in the next few weeks and months?

Mr. SHRIVER. Well, I think, as Dr. Redlener mentioned, coming up with the national framework for recovery is critically important. I think, honestly, Senator, if you look at the Child Care Development Block Grant and can put those requirements in there, you come up with a recovery framework in the next 5½ months and you have all child care facilities in this country looking at the issue of reunification, an evacuation plan, making sure that children with special needs, that their needs are incorporated into their planning and that is tied in with the local emergency management

community, I would consider that a hugely successful 5½ months. I think that would be fantastic.

I think the issue that Administrator Fugate talked about regarding the Stafford Act and having those child care facilities be reimbursed, I know there are some intricacies involved in that, but I think if you can address that issue and come up with recommendations and funding for that, I think that would be hugely successful. And I think, frankly, if you could have another hearing to make sure that we are all doing what we are supposed to be doing, that would make the next 5½ months be very successful.

Administrator Fugate, to his credit, at the first meeting we had said about halfway through it, what do you need, and we rattled off a couple of the recommendations we had put here, and he and the Secretary are working aggressively on that and he has set up meetings every 30 days to gauge progress or lack thereof.

So if you and this Subcommittee could look at and have another hearing and hold our feet to the fire and the Executive Branch's feet to the fire, that would make the next 5½ to 6 months highly successful, as well.

Senator LANDRIEU. Thank you very much.

Doctor, you said that the case management—I think you would say—I am putting these words in your mouth—you would hardly call it case management. It was not really managing much of anything, so fragmented and unable to deliver in a timely, appropriate way. When we think about creating a new kind of system, I read in some of GAO's and RAND's recommendations that part of the delivery system might be done through the schools after they reopen through school-based counseling services. Do you want to comment on that? Should there be opportunities community-wide, and what is it about school-based counseling that you think is particularly desirable?

Dr. REDLENER. Well, first of all, we have to have a system that makes sure that every child who is school-age is in school and kids that are preschool-age are in appropriate day care facilities and that there are after-school programs. So the school and the related institutions, can become the basis of stability for lots of families, and especially lots of children. So from that point of view, if we could have services emanating out of that model, so every child is in school, every child has a family, and it is possible to think about a system that would mandate not only the kids being in school, but that appropriate safety net programs and assistance for the families be generated by that relationship, as well.

And I want to say one other word about the case management issues. There were lots and lots of very good people doing case management in the Gulf who still are—Catholic Charities, the other organizations that are down there that are governmental and non-governmental. The problem is it is so fragmented and disorganized and competing case management programs that many families are just slipping through the cracks.

So I just want to clarify that lots of good work was done. It is just that far too many—in fact, we don't even know how many children—getting the numbers that I cited, 17,000 to 30,000, was one of the most difficult challenges I have had in research in 20 years

because there isn't a single agency that feels itself as responsible for tracking these families who have been displaced.

So if we start with that, we have an inability to even figure out how many or where they are. We begged them—this is FEMA and the State—to make sure that no families were discharged from those horrendous trailer parks before we knew who they were and where they were going so we could provide services to them. But all sorts of bureaucratic snafus between the Federal Government, the State Government, and then the private agencies delivering services yielded, first, that one of the largest case management programs never got implemented, not one dime out of the original \$33 million was spent, I guess, until very recently, and second, we couldn't track families. We have no idea where they are. I don't know where all those kids are that you cited that were part of the evacuees.

I would challenge the Federal Government to try to figure out, where are they? How many are in Houston or in Mobile, Alabama, and so forth, and how many are still struggling, in limbo, in displacement conditions that are really hurting these children and their opportunity for success.

Senator LANDRIEU. OK. Thank you so much.

I would like to just close with a couple of comments. One, the Louisiana Family Recovery Corps, I understand, delivered some very good work.

Dr. REDLENER. They did.

Senator LANDRIEU. Unfortunately, their contract was not able to be renewed and I hope that they can be called in for comments as we try to come up with a better system.

And my final comment is, from my own personal experience, not only in my own family experience recovering from the disaster—as you all know, I am one of nine siblings and four of my brothers and sisters lost their homes and their children were displaced, so watching it up close and personal within my own family, and then expanding that out to our own neighborhood, Broadmoor, which was destroyed, and then out to the community, I have concluded one thing that I know without reading one report, that schools became the center of life when those neighborhoods were struggling to come back. Whether it was Saint Dominic's or Holy Cross or Wilson Public School that is getting ready to open, or Lusher that opened, it became the only stable place, building, in a neighborhood that is completely destroyed.

And the government at its own peril fails to recognize the importance of these schools. They brought stability to the life of parents that otherwise had no stability. They needed to turn from just schools to community centers that provide counseling and medical support, particularly when your hospitals are closed. Getting your schools open, getting children back in touch with their teachers, which is a familiar face at that moment, is very significant to children that have had such trauma.

It is just—I can't overestimate and overstate how important this is, and the Federal Government that doesn't recognize the importance of schools, be they public, private, Catholic, or independent, and the ability of schools to be sort of step-in-the-gap until the rest of the community comes back, I think is kind of the model that I

envision. And the celebration of joy, that when a school would open in a neighborhood, what it meant to that community cannot be overestimated.

So I would like to end with that. We have a great deal of challenge before us. The Subcommittee record will stay open for 15 days. Please, anyone can submit information for the record, and we will, Mr. Shriver, take you up on your strong recommendation to hold people accountable for the outcomes that we have discussed today.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 11:43 a.m., the Subcommittee was adjourned.]

APPENDIX

Opening Statement of Chairman Landrieu

Subcommittee on Disaster Recovery

Focusing on Children and Disasters: Evacuation Planning & Mental Health Recovery

August 4, 2009

Good morning and thank you all for being here today for this hearing of the Subcommittee on Disaster Recovery.

Today's hearing is entitled "Focusing on Children in Disasters." The committee's objective today is to evaluate the special needs of children during the preparedness, response, and recovery phases of disasters and the extent to which current planning and programs address those needs. We are focusing on children for several reasons.

First, children are the focal point of families, and parents who cannot find an open school or day care center or access health care for their children may be forced to relocate or stay home from work to address these gaps. According to the Bureau of Labor Statistics, about half of the nation's families include children, and out of those 35.2 million families with children, 90% of them include a parent that's a member of the workforce. 62% of all married couples with children live in households where both parents work.

So we must be mindful of the fact that people cannot return to work or begin rebuilding until they locate a safe and productive environment for their children. These parents may be nurses, doctors, first responders, grocery store owners, gas station operators, electric line repairmen, or other citizens who play an important role in the community's return. That means that provision of child care and reopening of schools must be top priorities after a disaster so parents can be free to go back to work and start rebuilding. As this chart indicates, 394 of the 469 schools that existed before the hurricanes have reopened since then along with 326 of the 498 day care centers.

The second reason we are focusing on children here today is that children are a vulnerable population with unique needs that require specialized planning to address, but in my view, they have not received the same level of attention since the 2005 hurricanes as those of the elderly and disabled.

Thirdly, children are disproportionately affected by disasters in comparison to adults when it comes to mental health, and the patchwork of federal programs now available is difficult if not impossible to navigate due to the complexity and variety of eligibility requirements.

A broader goal of this hearing is to encourage the nation to consider the mental well-being of a community as a key indicator of recovery, every bit as important as the restoration of infrastructure and housing and the return of the economy and tax base.

There is a wealth of field work and policy research that has been conducted recently on the needs of children in disasters. This hearing will help the Subcommittee to evaluate those proposals and recommend improvements to current programs and planning.

Evacuation Planning

Local response plans must provide for the evacuation, sheltering, and continued care of children from the facilities where they are likely to be clustered – day care centers, schools, and hospitals among them. Katrina showed us the impact of failing to include the nursing home sector in our evacuation plans, and we must ensure that facilities which house other vulnerable members of our society are included in the planning process and that they take responsibility for their role in community preparedness.

Save the Children issued a report last month called "The Disaster Decade" indicating that only 7

states require schools and day care centers to develop comprehensive evacuation and reunification plans. They are Alabama, Arkansas, Hawaii, New Hampshire, Maryland, Massachusetts, and Vermont.

Local emergency managers and facility owners can do more to expand planning efforts, states with planning gaps may consider requiring these facilities to develop plans as some states have already done, and federal officials may consider linking grant awards for these facilities to planning requirements.

Another concern raised by the report is the fact that child care is not eligible for funding under the Stafford Act as an essential service. I would like to ask the FEMA Administrator to specifically address this issue in his testimony.

In addition to schools and day care centers, we will also consider newborn infants and mothers who may be in hospital wards when disaster strikes.

According to HHS, an average of 56 babies are born each day in New York City, and in Los Angeles the daily average is 416.

The Senate version of the Homeland Security Appropriations bill for Fiscal Year 2010 includes an amendment that I offered encouraging DHS to conduct mass evacuation planning with states, local governments, and nonprofits and include monitoring, tracking, and continued care for neonatal and obstetric patients. I would like for Administrator Fugate to address ways he believes we can expand, require, or incentivize this type of planning.

Woman's Hospital in Baton Rouge executed this function for the State of Louisiana during the response to Katrina and Rita, and again last year during the Gustav response. Woman's is under permanent contract to the State, and has offered its concept of operations as a useful model for others in need of creating a response system to handle pregnant women and newborn babies during an emergency. Ms. Fontenot will be testifying on behalf of the hospital and sharing her experiences and recommendations on this subject.

Mental Health Recovery

The second major theme of our hearing is mental health. Children suffer higher rates of depression, post-traumatic stress disorder, and behavioral problems following a disaster. I chaired a hearing on the Gulf Coast's post-hurricane mental health crisis on October 31, 2007, where Dr. Howard Osofsky from LSU and Dr. Ron Kessler from Harvard each described their research findings on disaster-affected children, and Dr. Redlener and Ms. Bascetta will provide this committee with additional findings today from their own research in this area.

After the hurricanes, the demand for mental health services spiked due to increased trauma, depression, and substance abuse. That was combined with a loss of inpatient beds and workforce capacity, which created a severe gap that strained medical workers and facilities, host communities, and first responders.

LSU's Department of Psychiatry screened 12,000 children in schools during the 2005-06 school year. 18% of them had a family member who was killed in the hurricane. 49% of them met the threshold for a mental health referral. One year later, the referral rate was lower, but it was still 30%. According to Dr. Redlener's research, 28% of displaced children in Louisiana are still suffering from depression or anxiety and 33% still exhibit behavioral problems.

GAO's research in this area indicates that many of the children affected by the World Trade Center attacks in 2001 did not come forward for treatment for more than a year after the event. These figures are important, because they not only indicate the wide-scale prevalence of mental health problems among children after disasters, but the fact that these problems can persist for years

and may not manifest themselves right away.

The Crisis Counseling Assistance and Training Program (CCP) is jointly administered by FEMA and SAMHSA, and it is intended to counsel survivors and teach them coping skills during the immediate aftermath of an event, with a limit on the number of counseling sessions available and duration of the program. So it is inadequate to address mental health problems that are persistent or late in presenting themselves. We need to take the long view of mental health recovery from disasters.

In addition to its short duration, the program has funding restrictions that have created problems for providers. Catholic Charities Archdiocese of New Orleans walked away from its agreement to execute CCP services for the State of Louisiana because FEMA determined certain costs to be ineligible for reimbursement under the program's rules. We will hear from Ms. Bascetta about GAO's recommendations for reforming the CCP program and get reactions from FEMA and HHS to those recommendations, most of which were published in a report that was released in February 2008 called "Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements." Ms. Bascetta will also testify about a report that GAO issued last month that I requested along with Senator Lieberman entitled "Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them."

Lack of mental health providers was cited by the majority of GAO's survey respondents for this second report as the greatest barrier to providing mental health services for children, whereas transportation, stigmatization, and financial problems were among the barriers to accessing these services.

The report emphasizes an approach to mental health service delivery that I would like for all of this hearing's participants to focus on today, which is the model of school-based counseling. Save the Children and RAND have also done research on optimal vehicles for delivering these services and arrived at a similar conclusion.

Schools that require psychological assessments can help to remove the stigma attached to mental health treatment and create an environment where students perceive counseling as common, healthy and normal. Providers in schools can help parents save money on treatment costs and avoid having to leave work to drive their children to the point of service. School counselors also represent an existing workforce that can be trained in advance of disasters to treat their effects and remain after surge response programs are closed out for children who may not experience problems until a year or two after the event.

I mentioned HHS programs that support mental health recovery, and there are many that have helped Gulf Coast states to restore facilities, retain health care professionals, and recruit additional ones to prevent further workforce losses. There are however, so many HHS programs that can potentially support mental health service delivery that I worry about the varying rules between them and the bureaucratic burden that separate applications must place upon the program's users in the disaster area.

The first chart I would like to call your attention to is a list of 21 different federal programs that have provided support for mental health recovery in the Greater New Orleans area. The second chart came from GAO and indicates the wide variation in program rules for each of these programs. 3 of the 21 programs – Medicaid, SCHIP, and Head Start – have income eligibility requirements that limit their ability to provide services. This mass collection of programs seems vulnerable to stove piping and does not seem to reflect an outcome-oriented approach linked to measurements of patient progress or health care capacity. I would like to hear from Dr. Lurie how HHS brings this patchwork of programs together in a strategic goal-oriented way.

The New Orleans region has been designated by HRSA as a Health Professional Shortage Area (HPSA) since the hurricanes 4 years ago, and while the region has received funding to address the problem, they have not been able to pull themselves out of this category. It seems to me that this should be a shared goal of HHS and the state, and I would like to know how HHS could proactively pursue this goal.

National Commission on Children and Disasters

The Consolidated Appropriations Act of 2008 established the National Commission on Children and Disasters to conduct a comprehensive study that examines children's needs in relation to all hazards and evaluate the impact of current laws, regulations, and policies on children before and after a disaster. Mr. Shriver and Dr. Redlener are both members of the Commission and will talk about its work and recommendations in addition to their other testimony.

Conclusion – Chris Rose Speech to Ursuline Academy

I would like to conclude with a quote from a speech that was delivered by a journalist named Chris Rose, who chronicled his experiences after Katrina for the Times Picayune in New Orleans. He delivered this speech on the night of May 13th, 2006 to the graduating class of my own alma mater, Ursuline Academy.

“You are survivors. The Katrina Kids. The Children of the Storm... The water, it came to your school. The gasoline, chemicals, sewage, and blood came to your doorstep. It settled into the ground of this courtyard where we now gather... My daughter was asked to write about her experiences over the past year when she came back to school in New Orleans in January, and this is what she wrote: ‘There was a Hurricane. Some people died. Some of them were kids.’ My daughter was six when she wrote that. It just doesn’t strike me as what you would wish for your child to write in her first grade journal, but there it is. You – all of us – are marked for life by what happened here... Like it or not, this storm, these circumstances, have marked you. My belief is that your generation and those who come after you in this town will be extraordinarily resilient. That is a good quality to carry with you. You have seen and have suffered loss... One more thing, and this is important: Be kind to your parents. I will tell you something that they cannot or will not tell you, and it is this: They are consumed right now with a world of worry and doubt that is crushing in its weight. Maybe you can see this at home or maybe they are good at hiding it from you because that’s what parents do – spend most of our lives trying to shield our children from pain. They won’t tell you this, so I will: They’re scared. They’re terrified. We’re all terrified. Everything we know and love is at risk. So be kind to them. It’s like we’re all in a big boat right now, paddling for our lives, and we’ve got to be together of one mind to get through this. So get in the boat and grab a paddle and get ready for the ride of your lives.”

I think this quote helps to capture the acute impact and resulting despair that disasters can cause for children and their parents. But the passage also alludes to the ability of the human spirit to rebound and triumph over tragedy given the proper outlook and support. We must provide strategic leadership and resources to move our children out of harm’s way before disaster strikes, get them quickly back into school and day care after a disaster has passed, and invest in community-based support networks to promote their long-term mental health.

Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery

Ad Hoc Subcommittee on Disaster Recovery

Tuesday, August 4, 2009

10:00 AM

Dirksen Senate Office Building, room 342

Opening Statement

Senator Robert F. Bennett

Thank you all for coming to brief our panel. I am especially pleased that the distinguished group before us has such a depth of knowledge and experience dealing with disasters and specifically looking at the effects they have on one of the most vulnerable segments of the population: our children. As a new member of this Committee I welcome the chance to work on these important issues.

In my home state of Utah we have seen severe weather storms, tornadoes, forest fires and floods in recent decades. The Wasatch mountain range, which looks over 80% of Utah's population, sits on an active fault line, experiences small earthquakes frequently and is estimated to be overdue for an earthquake above the 7.5 magnitude level on the Richter scale. As a Utahn, I am aware that the occurrence of a major earthquake is not a question of if, but when. And like every Senator, I am keenly aware of the unique challenges each of our states face in responding to such disasters.

There are particular aspects of Utah's population which are directly relevant to today's hearing. Utah has the most children per family of any other state in the union by a large margin (2.2 children per family), when compared with the national average of 1.86 children per family. Utah has the highest percentage of its total population under age 5 of any state at 10 percent. Utah has the lowest median age in the nation, at 28.7. And finally, Utah is the fastest growing state, with 2.7 percent growth between July 2007 and July 2008. All of these statistics point to the fact that Utah has a proportionally larger part of its population that is especially susceptible to the adverse conditions that follow natural and man-made disasters.

As noted by many experts, including some of the panelists before us today, children are especially susceptible during a disaster. There are many aspects of disaster response which need further attention and development ranging from increased surge capacities to critical care transportation and long-term mental recovery through consistent case management. I am especially interested in evacuation and emergency planning, immediate post-disaster special needs responses, and medical and mental support services that are geared towards children and vulnerable populations.

Additionally, because we have seen many instances where a major disconnect exists between the state and local responders and the federal government response, I think it is important to work with organizations such as the Federal Emergency Management Agency, the Department of Health and Human Services and the National Guard to increase cooperation and communications before disasters strike. I plan to work closely with the FEMA regional office, the governor's office and the Utah National Guard to take a deeper look at Utah's preparedness for disaster response and what can be done from a federal level to improve it.

I hope to hear from our experts today on these and other important issues and how we can work to improve the situation of children in disaster areas.

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STATEMENT OF

HONORABLE CRAIG FUGATE
FEDERAL EMERGENCY MANAGEMENT AGENCY
U. S. DEPARTMENT OF HOMELAND SECURITY

BEFORE THE

SUBCOMMITTEE ON DISASTER RECOVERY
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL
AFFAIRS

UNITED STATES SENATE

“Focus on Children in Disasters: Evacuation Planning and Mental Health
Recovery”

Tuesday, August 4, 2009

Introduction

Good morning Chairman Landrieu, Ranking Member Graham and other distinguished members of the Subcommittee. It is a privilege to appear before you today on behalf of FEMA and the Department of Homeland Security, and I appreciate your interest in and continued support of the emergency management community. I appreciate that you have invited me to testify in this hearing, as I firmly believe that we, as a Nation, must do more to effectively meet the critical needs of all special needs populations, including children, who are affected by disasters.

Historically, the U.S. has approached disaster planning by focusing heavily on the needs of what many refer to as the general population, and has not devoted sufficient advance attention to those who may have special needs and thus require specific and immediate attention in a crisis. As a result, our special needs response actions are too often developed and executed on the fly, unnecessarily creating the potential for confusion and, in the worst cases, failure to meet the needs of children and other vulnerable members of the population.

Madam Chairwoman, FEMA is working hard to change this reactive approach. It is time for special needs populations, be they children or any other segment of our communities who have traditionally been underserved, to be more fully and consistently integrated into preparedness and planning efforts at every level of government. Children are a part of every community. We must understand and address their needs from the outset, recognizing that they are not simply small adults. We must avoid putting planning considerations specific to children in a separate box, and build instead disaster response and recovery plans that account for the fact that children make-up a significant percentage of the population. As FEMA Administrator, one of my top goals is to institutionalize this approach within our Agency, and I am pleased FEMA's dedicated staff has laid a solid planning foundation from which to work.

Even before I arrived in Washington, FEMA was reaching out to states, localities and tribes to ensure that our own basic planning efforts effectively incorporated the needs of children and other special populations. I will not only continue those efforts, but will further build upon and reinforce our national initiatives to improve how we address the critical needs of children in our plans for disaster preparedness, response and recovery.

Past and Ongoing Efforts To Address The Needs Of Children in Disaster Planning

While there is more that we, as a Nation, can do, FEMA has not been idle. We have built a strong network of both public and private organizations that will help unify and strengthen our combined capabilities. For instance, FEMA has worked with the National Center for Missing and Exploited Children to establish the National Emergency Child Locator Center. This Center, which was required as part of the Post Katrina Emergency Management Reform Act of 2006, helps local and tribal governments and law enforcement agencies track and locate children who have become separated from their parents or guardians as a result of a presidentially declared emergency or major disaster. The Center is operated out of the National Center for Missing and Exploited Children's facilities, with support from FEMA.

FEMA's grassroots Citizen Corps program has also been involved in improving community preparedness efforts related to children. Working through State and local Citizen Corps Councils, civic and government leaders are coming together to strengthen community preparedness by developing emergency operations plans and outreach strategies that better address the broader range of community needs, including the needs of children in disasters. In addition, FEMA has provided emergency planning assistance to states and communities, including recommendations on how to incorporate the needs of children into their planning efforts.

Training development and delivery for children, other special needs populations and citizen preparedness have been and will continue to be FEMA priorities. The Department has supported the development of a variety of course curricula, including:

- **Emergency Planning for Special Needs Communities**

The goal of the "Emergency Planning for Special Needs Communities" course is to introduce a strategic universal functional planning approach to initiate special needs planning. This approach will emphasize the role of emergency management and provide examples of best practices, lessons identified, tools, resources, and other support aids. The course material includes discussions on the emergency planning process to support special needs populations. It uses the National Response Framework's (NRF) definition of special needs populations, which is "populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to:

- Maintaining independence
- Communication
- Transportation
- Supervision
- Medical care

- **Teen Community Emergency Response Team, Train-the-Trainer**

Developed in partnership with Eastern Michigan University, this program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others following an event when professional responders are not immediately available on scene. Teen CERT training applies the CERT model to high school students and campuses. The Teen CERT Train-the-Trainer Course prepares instructors to deliver the CERT training to high school students and to work with school administrators to establish and maintain the training.

- **FEMA for Kids**

The FEMA for Kids website, <http://www.fema.gov/kids/>, features disaster related games, quizzes, stories, photos, cartoons and provides children with the opportunity to earn a Disaster

Action Kid certification. The site also offers information on preparing for disasters and coping with the aftermath, including guidance on how to create a supply kit and disaster plan, as well as specific information on Citizen Corps. The site offers access to an email server which regularly provides disaster news and information. Kids are also able to get information about ongoing disasters all over the country via an interactive map. Specific information is provided on preparing for and reacting to hurricanes, tornadoes, earthquakes, volcanoes, floods, tsunamis, thunderstorms, wildfires, winter storms, and acts of terrorism.

Additionally, our Emergency Management Institute provides a variety of training opportunities, including:

- **Emergency Planning and Special Needs Populations field course (G197)** This 2-1/2 day course is intended to offer those with responsibilities for providing emergency planning or care for seniors, people with disabilities, and/or special needs groups with the skills and knowledge they will need to prepare for, respond to, and recover from emergency situations. The target audience includes emergency managers, senior first response personnel, special needs coordinators, human services organization personnel, facility planners, community-based organizational personnel, advocacy group personnel, elected officials, public health personnel, and Voluntary Organizations Active in Disaster (VOAD) personnel.
- **Special Needs Planning Considerations for Emergency Management independent study course (IS-197.EM)** This course is designed for emergency management and first responder personnel to enable them to better understand the special needs population and teach them how to partner with persons with special needs as well as their support providers and organizations.

FEMA has also partnered with the American Red Cross to develop a Handbook called “Helping Children Cope with Disaster” to assist in educating parents and other child care providers on issues unique to children in disasters. And we have developed “Go-Kits” that will be distributed to all ten of our regions to assist States with the evacuation and sheltering needs of children during a catastrophic event.

In December 2007, Congress created a bipartisan National Commission on Children and Disasters (the “Commission”) to assess the needs of children as they relate to disaster preparedness, response, and recovery. The Commission is evaluating existing laws, regulations, policies, and programs that affect children in disaster situations, and has been charged with submitting a report to the President and Congress on its specific findings, conclusions, and recommendations. An Interim Report is expected this fall, followed by a Final Report in 2010. Mr. Mark Shriver, Managing Director for the internationally recognized non-profit organization Save the Children, serves as chair of the Commission and has also served on FEMA’s National Advisory Council since 2007.

While we are eagerly awaiting the Commission’s findings and look forward to working with this Committee and Congress in implementing its recommendations, FEMA will not wait to move forward with new and innovative approaches to help protect children during disasters. Nor will

we simply rest on the progress our Agency has already made to improve emergency planning efforts that incorporate the needs of children. FEMA is meeting regularly with the Commission and planning to find ways to integrate Commission recommendations as they are available and consensus is reached.

Moving Forward: New Approaches For Protecting the Needs of Children

In addition to its work on the Commission, Save the Children also recently issued a report calling for immediate federal action to better protect our community's children in times of disaster. The report makes several recommendations, including the establishment of an Office for Children's Advocacy at FEMA. I am pleased to announce that in response to this report and as a result of ongoing discussions with the Commission, FEMA is creating a Children's Working Group.

The purpose of the working group is to create a centralized platform – across all of FEMA's directorates – to ensure that the needs of children are incorporated into all of our disaster preparedness, response, and recovery efforts. Representatives from virtually all aspects of the agency will serve on the working group, which will be chaired by a senior member of the FEMA leadership team. The group will not only serve to create a common operating picture across FEMA, it will also improve our capacity to work collaboratively across the Federal government and with State and local partners in support of children's needs. This new team will advocate for children's issues at every stage of the planning process, rather than having the special needs of our most precious community members addressed as an afterthought.

More specifically, the Children's Working Group will focus on the following key areas:

- Child-specific guidance for evacuation, sheltering, and relocation;
- Tracking and reunification of families;
- Coordinated case management support;
- Enhanced preparedness for child care centers and schools as well as for children in child welfare and juvenile justice systems;
- Enhanced national planning, including incorporation of children into national planning scenarios and exercises;
- Incorporation of children's needs into grant guidance;
- Improved recovery coordination across the Federal government and with State, tribal and local partners in support of children's education, health and housing;
- Consideration as to how the Federal family can help ensure child care centers are able to rebuild and restore services more quickly following a disaster; and
- Increased public awareness efforts to educate families and protect children during disasters.

In short, the establishment of the Children's Working Group will provide an immediate forum for promoting the needs of children across the agency. It will allow us to move forward quickly in evaluating the recommendations of both the National Commission on Children and Disasters and non-governmental groups such as Save the Children.

It is our intent that the Children's Working Group will help identify and facilitate how best to integrate the special needs of children into all of our planning efforts without isolating children's issues from community issues at large.

This working group represents a new way of tackling and focusing on this issue, one that is aimed at integrating children's planning throughout the agency, coordinating among the federal family, and across the Nation. We are optimistic that this approach will create real, lasting change when it comes to our planning for, and treatment of, children's needs during disasters.

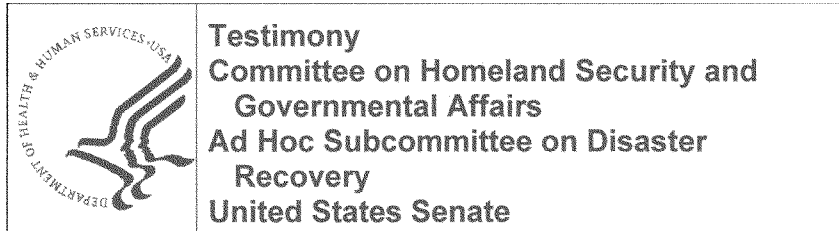
Conclusion

FEMA and the Department of Homeland Security are committed to advancing our Nation's preparedness by emphasizing the disaster needs of our Nation's most vulnerable citizens. Our efforts must begin with personal preparedness – a process of individual thinking and consideration of basic steps that each of us, and our families, must take to help prevent and prepare for the next disaster. We must focus on community preparedness, rather than merely just creating plans and guidance. Every citizen has a role to play in community preparedness.

In times of crisis, government plays a critical role in coordinating response and recovery efforts, especially in protecting and providing for the most vulnerable members of our population. The needs of children and other special needs members of our communities cannot simply fall to secondary planning considerations, but must be one of the central focuses of our planning, response and recovery.

While we have made significant strides toward this goal, we believe that even greater progress is within reach, thanks to our new Children's Working Group, valuable input from our partners and stakeholders, and the continued support of this Committee and Congress.

Thank you, Madam Chairwoman and members of the Committee, for allowing me to testify today. I am happy to answer any questions you may have.



**Children and Disasters: The Role of HHS
in Evacuation Planning and Mental
Health Recovery**

Statement of

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Assistant Secretary for Preparedness and Response

RADM, U.S. Public Health Service

U.S. Department of Health and Human Services



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Good morning Madam Chairwoman Landrieu, Ranking Member Graham, and other distinguished Members of the Ad Hoc Subcommittee on Disaster Recovery. It is a privilege to appear before you today on behalf of the Department of Health and Human Services (HHS). I am Dr. Nicole Lurie, the HHS Assistant Secretary for Preparedness and Response. My office is also known as ASPR.

I want to begin by expressing my appreciation for your interest in, and continued support of, emergency preparedness, response, and recovery efforts at HHS, specifically as they relate to children, and the efforts of the men and women who support that undertaking at every level of government, and within the private and volunteer sectors.

You are no doubt aware that emergency preparedness and response is a challenging and highly complex arena, encompassing Federal, State, tribal and local governments along with voluntary agencies and private sector partners. Although I will focus my remarks on HHS activities, I readily acknowledge that each of these partners plays a critical role in meeting the unique needs of children in disasters.

The Department of Health and Human Services is committed to the highest level of response for children before, during, and after emergency events, and continues to focus on integrating pediatric issues into the public health and

medical response to natural and human-caused emergencies and disasters, including pandemic influenza.

As part of this commitment, HHS has initiated programs and policies on a number of fronts to ensure that children receive the highest level of response before, during and after an incident. HHS recognizes that the needs of children are different when planning for disasters. Children require different skills and resources to treat their injuries and illnesses because they are far more than just "small adults." They can get sicker faster, but they can also heal quicker. Determining the most beneficial treatment for children during an emergency situation requires a different set of criteria than those used for adults.

The Department of Health and Human Services serves as the lead for Emergency Support Function 8, Public Health and Medical Services, under the National Response Framework. This provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, incidents requiring a coordinated Federal response, or during a developing health and medical emergency.

Under ESF 8, HHS serves as the lead Federal partner in ensuring that the nation is maintaining appropriate levels of medical surge capacity, which is a critical element of our national, State, and local resiliency. HHS manages the Strategic National Stockpile, the Medical Reserve Corps, the National Disaster Medical

System, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, and other critical medical and public health resources that can be activated during catastrophic events. I'd like to take a few moments to let you know about some of the initiatives addressing the needs of children that are happening at the Department.

The National Disaster Medical System, otherwise known as NDMS, is the primary Federal program that supports care and transfer during evacuation of patients. NDMS is a component of ASPR comprised of over 1500 volunteer hospitals and over 6,000 intermittent Federal employees assigned to approximately 90 general disaster and specialty teams geographically dispersed across the United States. The overall purpose of NDMS is to establish a single integrated national medical response capability for assisting State and local authorities with the medical impacts of major peacetime disasters and to provide support to the military. NDMS is working to enhance its pediatric capability in several ways.

Data on current NDMS clinical practitioners show that 68% have pediatric-specific training, 5.6% have specific subspecialty training in pediatrics, and 47% have formalized training specific to pregnant women. Although the approach of NDMS in fielding targeted personnel capabilities is to deploy activated NDMS clinicians who have broad-based training related to all age and at-risk groups, we still recognize that more specialized skill sets can be quite valuable. Since

children and pregnant women can be a particularly vulnerable population, NDMS is developing pediatric modules within the Disaster Medical Assistance Team (DMAT) structure. Not only will these professionals be able to support Federal missions, but the intent is for them to enhance State and local support networks. To achieve this goal, we will be holding a call this week with pediatric physicians and obstetricians to seek input on what NDMS can develop within the DMAT structure. To complement this effort, NDMS has recently conducted a review and upgrade of medical material in the NDMS response supplies to ensure that appropriate pediatric equipment and supplies are available to our response teams when they deploy.

In addition to clinical care, patient transportation is a key NDMS activity. NDMS has completed Phase 1 of the development of critical care transport team capability. Phase 1 has provided on-the-ground critical care support capability for mass patient evacuation and is capable of deploying to support the Department of Defense, including its National Guard Bureau, efforts to evacuate critical care patients. Each of these teams has clinical expertise and formal training in pediatric and obstetrical emergency care. Phase 2 of this program, tentatively scheduled for completion in the Spring of 2010, includes the further development and fielding of existing air-evacuation qualified critical care transport teams that will provide direct patient care during transport of critical care patients on multiple platforms, including fixed-wing and rotary-wing air, rail, and ground transport. Pediatric-specific critical care transport teams are planned

as well as fielding air-evacuation qualified teams that have formal pediatric-specific training.

In response to the challenges faced by pediatric specialty facilities and their transport services, the Pediatric Disaster Coalition was formed by advocates in HHS Federal Planning Region VI. This region includes the States of Texas, Arkansas, Louisiana, Oklahoma and New Mexico. This planning group consists of subject matter experts from free-standing children's hospitals, facilities with dedicated pediatric/neonatal units, pediatric specialty transport organizations, local and State public health, and Federal partners. The Coalition's goals include incorporating the use of civilian air and ground medical resources in State contracts and Mutual Aid Agreement to ensure prompt and coordinated evacuation of specialty patients. Other goals include identifying appropriate receiving facilities to assume care of the evacuated patients, disseminating information to stakeholders responsible for pediatric and neonatal evacuation planning, and integrating recommendations into hospital, local, and State emergency operations plans.

The Coalition has met to address lessons learned from hurricanes Katrina and Rita, where several pediatric transport teams participated. Based on its research, actual incidents, and exercises, they concluded that the requirements for transportation resources exceed the local availability to evacuate pediatric facilities to similar facilities. Because of the small percentage of usage of

hospital facilities by children versus adults, a more regionalized approach must be considered for children to significantly increase pediatric capacity during a disaster.

Transportation of pediatric and neonatal patients is a labor, training, and equipment intensive process and many challenges remain. The Department recognizes that there is a need for development of planning guidance for healthcare facilities as well as for local, State, regional, and Federal jurisdictions. While the National Response Framework mandates that States are responsible for determining patient evacuation requirements, Federal support can be requested when State capacity cannot support the evacuation requirements. Federal assets include ambulances from the DHS-funded FEMA National Ambulance Contract, administered by HHS. This contract provides for a neonatal specific typed rotary wing helicopter, and a neonatal specific typed fixed wing aircraft, both of these aircraft for neonatal transport were deployed during the 2008 hurricane season.

The Department continues to press forward on issues related to children on a number of other fronts. We are working hard to ensure that there are no gaps as we enter a season of hurricanes and H1N1. Let me highlight a few of these activities:

On June 17, ASPR and the National Biodefense Science Board hosted an all-day meeting of national experts and stakeholders to discuss pediatric issues in emergency response to inform planning for an ASPR sponsored Conference on Pediatric Preparedness and Response in Public Health Emergencies and Disasters to be held later this month. Participants provided information regarding concerns and approaches for medical response and medical countermeasures and other products for use in pediatric populations related to public health threats such as H1N1 influenza.

Also, this month the CDC is hosting a stakeholder meeting for Primary Care Providers, including obstetricians, to identify ways to reduce surge on hospitals and integrate providers into community planning.

In September, the CDC is leading a stakeholder meeting to address pediatric surge capabilities during disaster responses, such as H1N1 influenza. Expected outcomes are to reduce surge on hospitals through H1N1 Pandemic Influenza planning templates for various sizes of Pediatric Primary Care Offices and to identify operational best practices for concerns such as infection control, and optimizing resources. Other expected outcomes are integrating non pediatricians into pediatric care and identifying and developing education materials aimed at increasing coordination and communication between pediatric healthcare providers and public health.

In addition, CDC collaborated with HRSA to develop a National Newborn Screening Contingency Plan. As a result of the Newborn Screening Saves Lives Act of 2008, CDC, HRSA, and State departments of health (DOH) developed a national newborn screening contingency plan for use by a State, region, or consortia of States in the event of a public health emergency. The plan specifically addresses contingency planning, preparedness, and response activities around specimen collection, shipment, and processing, results reporting, confirmation, treatment and management resources, and education.

The Department's Hospital Preparedness Program has funded three partnership projects focused primarily on ensuring medical surge and appropriate care for pediatric populations, including surge emphasis on neonates and pregnant women. A project at Children's Hospital Los Angeles organized an issue identification and consensus conference on pediatric evacuation and reunification. The conferences covered topics including transportation, Pediatric Psychosocial Support, Clinical Issues, Non-Medical Issues, Technology and Tracking, and Communications/Information and Regulatory Issues. A report will be published in the August *Journal of Trauma* (Supplement).

Today's hearing is focused primarily on public health and medical services, including mental health. However, I would be remiss not to mention that HHS is also a support agency of Emergency Support Function 6, which encompasses mass care, emergency assistance, housing, and human services. During

disasters, the Administration for Children and Families (ACF) gathers information about child care centers and Head Start centers which serve infant and toddler aged children. ACF maintains contact with state human services and emergency management agencies to determine if there are any other issues that affect children. ACF has conducted shelter assessments revealing unmet human services needs for children, particularly a lack of and/or inappropriate child care in some shelters. ACF also has developed a disaster case management model with FEMA. Finally, ACF provides operational support to the National Commission on Children and Disasters. I believe you will be hearing more about the important work of the Commission on the second panel.

Although there are many other examples of Departmental activities focused on children, let me spend my remaining time on the issue of children's mental health and disaster recovery. The Department is focused on promoting the emotional recovery of children and their families affected by disasters and emergency events. Federal response entities such as the National Disaster Medical System and the Public Health Service have mental health professionals on their response teams, including professionals with expertise in working with children. Supplemental grant programs and on-going HHS disaster response and recovery efforts place an emphasis on meeting the needs of children, one of our most vulnerable populations in times of crisis and emergency.

An example of such efforts is the Crisis Counseling Assistance and Training Program, or CCP. This program is funded by the Federal Emergency Management Agency and is administered through an interagency agreement by HHS's Substance Abuse and Mental Health Services Administration (otherwise known as SAMHSA). Crisis counseling programs employ an outreach model and a strengths-based approach to help disaster survivors access personal coping mechanisms and identify community resources. The CCP targets at-risk groups, including children and their caregivers, for services. Crisis counselors routinely work in schools, libraries, community centers, health fair events, and other places children congregate, such as boys' and girls' clubs, to facilitate the psychological resilience of children following an emergency event and encourage the recovery process.

Other HHS programs focus on the mental health needs of children who have experienced a traumatic event such as a disaster. The most direct example is The National Child Traumatic Stress Initiative, funded by a Congressional appropriation through SAMHSA. This initiative funds a network of grantees called the National Child Traumatic Stress Network. This Network develops mental health resources and interventions for traumatized children, their families, and their communities in the wake of natural and man-made disasters. Network members across the country collaborate to develop best-practice approaches supported by empirical evidence, so that clinicians and emergency responders can be confident in the efficacy of methods employed to assist children.

Members also work directly with caregivers, teachers and professionals involved with children. In this way they enhance the ability of caregivers and community members to anticipate and address concerns of young people in their own communities who have experienced an emergency event.

To enhance acute disaster response, the Network maintains a Rapid Response Program that provides two trained Disaster Liaisons at each of the 51 funded Network Centers across the country. The Rapid Response Program can be mobilized nationally, regionally, and locally after a Presidential disaster declaration or catastrophic event. Rapid responders work closely with the Crisis Counseling Program, Federal partners, State disaster coordinators, and voluntary disaster response organizations.

Through Network funded grantees, and in partnership with the Veteran Administration's National Center for Post Traumatic Stress Disorder and the National Center for Child Traumatic Stress, the Department launched the Psychological First Aid Field Operations Guide immediately after Hurricane Katrina in 2005. This manual serves as a training guide for professionals and paraprofessionals to provide emotional support to those impacted by disasters. Psychological First Aid adaptations have been developed for schools, volunteers, and faith-based disaster responders. As of 2009, there have been over 50,000 downloads of the guide, and an additional 10,000 hard copies have been

distributed. Network staff have provided over 200 Psychological First Aid trainings around the country, training well over 5,000 disaster responders. A number of current Network centers serve children in hurricane affected areas of the Gulf Coast. Grantees include Louisiana State University and Mercy Family Center, both in New Orleans. The Network's Houston grantee, DePelchin Children's Center, has also been actively involved since Hurricane Katrina in providing direct services and disaster-related training. Over 20 Network grantees from across the country have deployed clinical staff to the Gulf Coast, provided operational support to centers that were impacted by the hurricanes, and supported children evacuated to receiving centers in their States since Hurricane Katrina and subsequent storms impacted the region. We know we have a great deal to learn from the Gulf Coast States. In order to further examine and improve our response and recovery efforts, the Network's Terrorism and Disaster Center has developed and is now pilot testing a new approach for assessing and strengthening community resilience in the Gulf region.

Other Network resources related to children's mental health include training for school-based cognitive behavioral interventions and an on-line speaker series focusing on the impact of terrorism and disasters on children. Speaker presentations are archived and may be accessed for free through the Network's online learning center.

The CDC Public Health Emergency Preparedness (PHEP) cooperative agreement is another HHS program that has sponsored a number of preparedness and mental health activities for children. This program has funded projects such as: a six-hour training curriculum for school crisis teams, an Education/Mental Health Disaster Readiness Committee that addresses issues of mental health preparedness and response in schools, and a disaster communications guidebook for community use that addresses mental health messaging. Another example of efforts supported by the PHEP program is the development of innovative brochures on “emotional first aid” for children. These pocket-size pamphlets addressed mental health needs of children by developmental level and provided quick tips for assisting them after a disaster.

In addition to these activities, the Department’s Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) has funded several research grants, largely at Tulane University, to look at the effects of a massive natural disaster, such as Hurricane Katrina, on displaced New Orleans residents. Pilot work has been done that would allow a longer-term study to be conducted on the continuing social and economic effects of this population over the coming years. Questions address concerns about disaster experiences where complete recovery may not happen, as well as identifying individuals for whom the disaster may have been a life-altering experience for the better.

The Department is working in an ongoing manner to analyze and improve disaster behavioral health preparedness and response for children. To support these efforts the National Biodefense Science Board, based on input from its Disaster Mental Health Subcommittee, completed a set of recommendations pertaining to disaster behavioral health. These recommendations include a focus on ensuring that children's needs are appropriately addressed following a disaster through developmentally and culturally-informed intervention, research, education, and training. Every relevant Federal department has provided an analysis of how the recommendations are currently being addressed and what must be done to further their implementation.

As part of these efforts, HHS has established the Office for At-Risk Individuals, Behavioral Health, and Human Services Coordination within ASPR to ensure that ASPR, along with the rest of the Department, is developing policies and capabilities for emergency planning, response, and recovery activities that are fully inclusive of the needs of children, including mental health needs, and also to ensure that efforts across the department remain coordinated.

In summary, I would like to thank you again for providing the opportunity for me to talk with you today about the Department's many efforts to address the needs of children in disasters and public health emergencies. We have made significant strides in addressing the needs of our youngest citizens and we anticipate continuing this momentum in the future.

Thank you, Madam Chairwoman. We look forward to working with the Subcommittee as we continue to improve our preparedness and recovery for our Nation's children.

I would be happy to answer any questions.

United States Government Accountability Office

GAO

Testimony
Before the Ad Hoc Subcommittee on
Disaster Recovery, Committee on
Homeland Security and Governmental
Affairs, U.S. Senate

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HURRICANE KATRINA

Barriers to Mental Health
Services for Children
Persist in Greater New
Orleans, Although Federal
Grants Are Helping to
Address Them

Statement of Cynthia A. Bascetta
Director, Health Care



GAO-09-935T

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the protection of children during disaster recovery and to provide highlights of our July 2009 report entitled *Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them*.¹ The greater New Orleans area has yet to fully recover from the effects of Hurricane Katrina, which made landfall on August 29, 2005. One issue of concern in the recovery is the availability of mental health services for children.² In our report, we estimated that in 2008 about 187,000 children were living in the greater New Orleans area—which we defined as Jefferson, Orleans, Plaquemines, and St. Bernard parishes.³

Many children in the greater New Orleans area experienced psychological trauma as a result of Hurricane Katrina and its aftermath, and studies have shown that such trauma can have long-lasting behavioral, psychological, and emotional effects on children. Poor children in this area may also be at additional risk, because studies have also shown that children who grow up in poverty are at risk for the development of mental health disorders.⁴ In 2007 the poverty rate for each of the four parishes in the greater New Orleans area was higher than the national average, and in Orleans and St. Bernard parishes, the rate was at least twice the national average. Experts have found increases in the incidence of depression, post-traumatic stress disorder symptoms, risk-taking behavior, and somatic and psychosomatic conditions in children who experienced the effects of Hurricane Katrina. In addition, children in greater New Orleans

¹GAO, *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, D.C.: July 13, 2009).

²For the purposes of this statement, such services include inpatient and outpatient counseling or mental health treatment; related ancillary services like transportation, translation, and case management; mental health education and prevention services; and substance abuse prevention and treatment services.

³For details regarding the computation of our estimate, see GAO-09-563, app. I.

⁴See GAO, *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, D.C.: Feb. 29, 2008); V. Murali and F. Oyebode, "Poverty, Social Inequality and Mental Health," *Advances in Psychiatric Treatment*, vol. 10 (2004), 216-224; and K.A.S. Wickrama et al., "Family Antecedents and Consequences of Trajectories of Depressive Symptoms from Adolescence to Young Adulthood: A Life Course Investigation," *Journal of Health and Social Behavior*, vol. 49, no. 4 (2008), 468-483.

may continue to experience psychological trauma because of the slow recovery of stable housing and other factors, such as the recurring threat of hurricanes. Data collected by Louisiana State University (LSU) Health Sciences Center researchers indicate that of the area children they screened in January 2008, 30 percent met the threshold for a possible mental health referral. Although this was a decrease from the 49 percent level during the 2005-06 school year screening, the rate of decline was slower than experts had expected.

Experts have previously identified barriers both to providing and to obtaining mental health services for children.⁵ Barriers to providing services are those that affect the ability of health care organizations to provide services, such as a lack of providers; and barriers to obtaining services are those that affect the ability of families to gain access to services, such as concerns regarding the stigma often associated with mental health services for children. The devastation to the health care system in greater New Orleans caused by Hurricane Katrina may have exacerbated such barriers.

Multiple federal agencies support the provision of mental health and related services for children in the greater New Orleans area through various programs. These agencies include the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration (SAMHSA) and the Departments of Education and Justice. For example, since Hurricane Katrina, the federal government has directed over \$400 million toward restoring health services, including mental health services for children, in Louisiana and the greater New Orleans area. Other federal funding not targeted to Hurricane Katrina recovery, available through several grant programs, also supports the delivery of children's mental health services in the area. These programs provide funding through annual formula grants—noncompetitive awards based on a predetermined formula—to Louisiana and through various discretionary grants to state and local agencies and nongovernmental organizations.⁶

⁵See, for example, the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (Rockville, Md., 2003).

⁶See GAO-09-563, appendixes II and III, for detailed information on selected federal programs that support mental health and related services for children.

My statement today is based on our July 2009 report, in which we (1) identified barriers to providing and barriers to obtaining mental health services for children in the greater New Orleans area, and (2) described how federal programs, including grant programs, address barriers to providing and to obtaining mental health services for children.

To do this work, we developed and used a structured interview and a written data collection instrument to gather views on barriers from 18 state and local stakeholder organizations selected on the basis of experts' referrals and the organizations' roles in children's mental health. The representatives of the 18 organizations we interviewed were asked, as a group, to identify the three greatest barriers to providing and to obtaining mental health services for children in the greater New Orleans area. Because the 18 organizations were not selected by random sample, their views cannot be generalized to all organizations or individuals working in the field of children's mental health services in the greater New Orleans area. To learn how federal programs address these barriers, we reviewed documents from and interviewed federal, state, and local officials involved in providing mental health services to children. Our work included a site visit to greater New Orleans. We conducted our work from April 2008 through June 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product. A detailed explanation of our methodology is included in our July 2009 report.

Barriers to Mental Health Services for Children Persist, Although Federal Grants Are Helping to Address Them

Stakeholder organizations most frequently identified a lack of mental health providers and sustainability of funding as barriers to providing mental health services to children in the greater New Orleans area, and they most frequently identified a lack of transportation, competing family priorities, and concern regarding stigma as barriers to families' obtaining mental health services for children. A range of federal programs are helping to address these barriers, but much of the funding they provide is temporary.

Lack of Providers Was Most Frequently Identified Barrier to Providing Children's Mental Health Services, and Lack of Transportation Was Most Frequently Identified Barrier to Obtaining Services

Among the 18 stakeholder organizations that participated in our structured interviews, the most frequently identified barrier to providing mental health services was a lack of providers. (See table 1.) Fifteen of the 18 organizations identified a lack of mental health providers—including challenges recruiting and retaining child psychiatrists, psychologists, and nurses—as a barrier to providing services. In addition, 13 of the 18 organizations identified sustainability of funding, including difficulty securing reliable funding sources and limitations on reimbursement for services, as a barrier to providing services.

Table 1: Most Frequently Identified Barriers to Providing Mental Health Services for Children in the Greater New Orleans Area

| Barrier | Number of organizations identifying barrier |
|--|---|
| Lack of mental health providers | 15 |
| Sustainability of funding | 13 |
| Availability of referral services | 5 |
| Lack of coordination between mental health providers or other providers serving children | 3 |
| Availability of physical space for programs | 2 |

Source: GAO.

Note: Data are from analysis of structured interview data collected from September through November 2008. Each of 18 stakeholder organizations was interviewed and asked to identify the three greatest barriers to providing mental health services for children. In some cases, organizations offered fewer than three barriers. Barriers named by only 1 organization were omitted from this table.

With regard to families' ability to obtain services for their children, 12 of the 18 organizations identified lack of transportation as a barrier.⁷ (See table 2.) In addition, 11 of the 18 organizations identified competing family priorities—such as housing problems, unemployment, and financial concerns—as a barrier to obtaining services. An equal number identified concern regarding the stigma associated with receiving mental health services as a barrier.

⁷For information on transportation services to hurricane victims, see GAO, *Disaster Assistance: Federal Efforts to Assist Group Site Residents with Employment, Services for Families with Children, and Transportation*, GAO-09-81 (Washington, D.C.: Dec. 11, 2008).

Table 2: Most Frequently Identified Barriers to Obtaining Mental Health Services for Children in the Greater New Orleans Area

| Barrier | Number of organizations identifying barrier |
|--|---|
| Lack of transportation | 12 |
| Competing family priorities | 11 |
| Concern regarding stigma | 11 |
| Lack of available services | 8 |
| Not knowing where to go to obtain services | 3 |
| Lack of health insurance | 2 |

Source: GAO

Note: Data are from analysis of structured interview data collected from September through November 2008. Each of 18 stakeholder organizations was interviewed and asked to identify the three greatest barriers to obtaining mental health services for children. Barriers named by only 1 organization were omitted from this table.

Federal Programs Address Barriers by Supporting State and Local Efforts to Hire Providers; Assist Families; and Deliver Care through School-Based Health Centers

A range of federal programs address barriers to mental health services for children in the greater New Orleans area by supporting various state and local efforts—including hiring providers, assisting families, and utilizing schools as delivery sites—but much of the funding is temporary. Several federal programs support state and local efforts to hire or train mental health providers. For example, as of May 2008, CMS's Professional Workforce Supply Grant, created with the intent to recruit and retain health professionals in the greater New Orleans area, was used to provide financial incentives to 82 mental health providers who agreed to either take a new position or continue in a position in the area and to serve for at least 3 years. This funding will be available through September 2009. In addition, a few federal programs support training of children's mental health providers. For example, SAMHSA's National Child Traumatic Stress Initiative awarded two grants in October 2008 to providers in the greater New Orleans area to provide training on, implement, and evaluate trauma-focused treatment for children.

Funding from several HHS programs has been used to transport children to mental health services. For example, Louisiana designated \$150,000 in its fiscal year 2009 state plan for SAMHSA's Community Mental Health Services Block Grant for transportation for children in the greater New Orleans area, and funding from ACF's 2006 Supplemental Social Services

Block Grant (SSBG) has also been used to supply transportation to mental health appointments for children.⁸

Federal programs also provide funding that is used to alleviate conditions that create competing family priorities—including dealing with housing problems, unemployment, and financial concerns—to help families more easily obtain children's mental health services. Federal programs address competing priorities, in part, by providing case management, information, and referral services,⁹ which can help families identify and obtain services such as health care, housing assistance, and employment assistance. For example, officials from a local organization that received funding from ACF's Head Start told us that the program had provided families with information and referrals for mental health services. Some federal programs also address competing family priorities by providing direct financial assistance, which may help alleviate family stress and make it easier for families to devote resources and effort to obtaining mental health services for their children.

Although most of the federal programs we identified were not established as a direct result of Hurricane Katrina, the programs that are hurricane-related have been an important source of support for mental health services for children in greater New Orleans. However, much of this funding is temporary and does not fully address the sustainability barrier. For example, funds from three hurricane-related grant programs—CMS's Primary Care Access and Stabilization Grant (PCASG), its Professional

⁸SSBG supplemental funds were appropriated to ACF for allocation to states for expenses related to the 2005 hurricanes under the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006, Pub. L. No. 109-148, div. B, title I, ch. 6, 119 Stat. 2680, 2768 (2005). Additional SSBG supplemental funding was allocated to Louisiana in January 2009 and is available through September 2009 from an appropriation made by the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Pub. L. No. 110-329, div. B, title I, ch. 7, 122 Stat. 3574, 3594-95 (2008).

⁹For more information on case management services provided after Hurricane Katrina, see GAO, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, GAO-09-561 (Washington, D.C.: July 8, 2009). We reported that federal agencies provided millions of dollars to support disaster case management services to assist victims of hurricanes Katrina and Rita, but a key barrier to providing case management services was a lack of reliable, continuous funding.

Workforce Supply Grant, and ACF's 2006 SSBG supplemental funding—will no longer be available to grantees after 2010.¹⁰

Louisiana has used federal funds to help support school-based health centers (SBHC), which have emerged as a key approach in the greater New Orleans area to address barriers to obtaining mental health services for children. In general, SBHCs are located in schools or on school grounds and provide a comprehensive range of primary care services to children. Louisiana's SBHCs also provide mental health services and are required to have mental health staff on-site. Furthermore, some SBHCs in the greater New Orleans area have a psychiatrist on staff on a part-time basis. Although there is no federal program whose specific purpose is to support SBHCs, state programs have used various federal funding sources to support them. For example, a Louisiana official told us funds from HHS's Maternal and Child Health Services Block Grant and Community Mental Health Services Block Grant provide some of the support for SBHCs in greater New Orleans. During the 2007-08 school year, there were nine SBHCs in greater New Orleans, and state officials told us in February 2009 that at least four more were in the planning stages for this area. SBHCs can help address the top three barriers to obtaining services identified in our structured interviews—a lack of transportation, competing family priorities, and concern regarding stigma. For example, because SBHCs are generally located in schools or on school grounds, students have less need for transportation to obtain care and parents have less need to take time from work to accompany a child to appointments. In addition, SBHC services may be provided at low or no cost to the patient, which lessens the financial burden on the family. Also, colocation of mental health and other primary care services may reduce concern regarding stigma because the type of service the child is receiving at the SBHC is generally not apparent to an observer.

**Agency Comments and
Our Evaluation**

We provided a draft of our July 2009 report to HHS and Education for their review. In its comments, HHS provided additional information on mental health services provided in schools other than through SBHCs and emphasized the effect of a lack of stable housing on children's mental health. In addition, both HHS and Education provided technical

¹⁰For additional information about the PCASG and the Professional Workforce Supply Grant, see GAO, *Hurricane Katrina: Federal Grants Have Helped Health Care Organizations Provide Primary Care, but Challenges Remain*, GAO-09-588 (Washington, D.C.: July 13, 2009).

comments. We incorporated HHS's and Education's comments in the report as appropriate.

Madam Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

**GAO Contacts and
Staff
Acknowledgments**

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**Appendix III: Mental Health Services
Provided to Children in Greater New Orleans
Supported by Selected Federal Programs**

Figure 2: Mental Health Services Provided to Children in the Greater New Orleans Area Supported by Selected Federal Programs That Were Funded during the Period 2004-2008

| Department, agency, and program | Formula or discretionary grant program | Treatment or counseling | Substance abuse prevention or treatment | Education or prevention for children, families, educators, or the community | Referrals | Case management | Transportation | Translation | Cash assistance | Training for mental health professionals | Infrastructure or systems development |
|---|--|-------------------------|---|---|-----------|-----------------|----------------|-------------|-----------------|--|---------------------------------------|
| Department of Health and Human Services | | | | | | | | | | | |
| Substance Abuse and Mental Health Services Administration (SAMHSA) | | | | | | | | | | | |
| Community Mental Health Services Block Grant | F | • | | | | • | | | | | |
| Substance Abuse Prevention and Treatment Block Grant | F | | • | | | • | • | • | | | |
| Children's Health Fund Community Support and Resiliency Program | D | | | • | | • | | | | • | |
| Community Mental Health Services for Children and Their Families Program (Child Mental Health Initiative) | D | • | | • | | • | • | • | • | • | • |
| Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (State/Tribal Youth Suicide Prevention Grants) | D | • | • | • | | • | | | | • | |
| National Child Traumatic Stress Initiative | D | • | • | • | | • | | | | • | |
| Health Resources and Services Administration | | | | | | | | | | | |
| Maternal and Child Health Services Block Grant | F | • | | • | | • | • | | | | |
| National Health Service Corps Scholarship Program and Loan Repayment Program | D | • | | | | | | | | • | |
| Health Center Program | D | • | • | • | | • | • | • | | | |
| Centers for Medicare & Medicaid Services | | | | | | | | | | | |
| Medicaid and the State Children's Health Insurance Program | F | • | | | | • | • | • | | | |
| Professional Workforce Supply Grant | D | • | | | | | | | | | |
| Provider Stabilization Grant | D | • | | | | | | | | | |
| Primary Care Access and Stabilization Grant | D | • | • | • | | • | • | • | | | |
| Administration for Children and Families | | | | | | | | | | | |
| 2006 Supplemental Social Services Block Grant | F | • | • | | | • | • | | | | |
| Child Care and Development Fund | F | | | • | | | | | | | |
| Head Start | D | • | | • | | • | • | | | | |
| Department of Education | | | | | | | | | | | |
| Safe and Drug-Free Schools and Communities: | | | | | | | | | | | |
| State Education Agency Grants and Governors' Grants | F | | • | | | | | | | | |
| Project School Emergency Response to Violence (Project SERV) | D | | | • | | | | | | | |
| Department of Justice | | | | | | | | | | | |
| Crime Victim Assistance | F | • | | | | • | • | • | | | |
| Multilevel programs | | | | | | | | | | | |
| Federal Emergency Management Agency (FEMA) and the Department of Housing and Urban Development | | | | | | | | | | | |
| Disaster Housing Assistance Program | D | | | | | • | • | | | | |
| FEMA and SAMHSA | | | | | | | | | | | |
| Crisis Counseling Assistance and Training Program (CCP) | D | • | | • | | • | | | | | |

• = Service provided in the greater New Orleans area F = Formula grant D = Discretionary grant
Source: GAO analysis of federal, state, and local agency information, including data from the Catalog of Federal Domestic Assistance.

PREPARED STATEMENT OF MARK K. SHRIVER

Chairman Landrieu, Ranking Member Graham and members of the Senate Ad-Hoc Subcommittee on Disaster Recovery.

I am Mark Shriver, Chairperson of the National Commission on Children and Disasters and Vice President and Managing Director for U.S. Programs at Save the Children.

Thank you for the opportunity to testify today.

According to the Federal Emergency Management Administration (FEMA), the number of annual Presidential declared disasters has increased from an average of 24 per year in the 1980's to 56 per year this decade. With over 40 such disasters already on the books, 2009 is shaping up to push the average even higher¹.

And with the country in the midst of hurricane season and simultaneously planning for a H1N1 flu outbreak that will most likely disproportionately affect children², today's hearing is certainly as timely, as it is important.

Children represent nearly 25% of the American population; 73 million are 18 years of age or under³.

Yet when it comes to disaster planning and disaster management, at all levels of government, the unique needs of children are typically misunderstood and unaddressed.

As an example, state and local emergency managers are required by federal law to meet the needs of pets⁴.

But children are not considered such a distinct priority.

Instead, children are lumped together with several other "at risk" "vulnerable" or "special needs" populations, such as the elderly, the disabled and people with limited English proficiency. As a consequence, there is slight consideration given to children when disaster plans are written and exercised, when equipment and medicines are purchased, when disaster response and recovery efforts are activated.

¹ http://www.fema.gov/news/disaster_totals_annual.fema

² According to the CDC daily briefing for May 7, 2009, of the 1,639 confirmed cases of the H1N1 virus in the United States at that time, more than half (58%) were under 18 years of age. <http://www.cdc.gov/media/transcripts/2009/t090507.htm>

³ US Census Bureau, Population Estimates, July 1, 2008;
<http://www.census.gov/popest/national/asrh/NC-EST2008/NC-EST2008-02.xls>

⁴ Pets Evacuation and Transportation Standards Act of 2006; Public Law 109-308, 109th Congress; <http://www.thomas.gov/cgi-bin/query/D?c109:5:./temp/~c109hZENsp::>

The consideration of children as either “little adults” or at risk, vulnerable or with special needs, has created what former FEMA Administrator R. David Paulison termed “benign neglect” of children affected by disasters.

Congress created the National Commission on Children and Disasters as an independent, bi-partisan body to examine the gaps and shortcomings in public policy that perpetuate this cycle of benign neglect and then make policy recommendations to the President and Congress.

The Commission held its first public meeting October 14, 2008. We meet publicly each quarter in Washington, D.C. We post our work on our website www.childrenanddisasters.acf.hhs.gov

For the past nine months have engaged the prior and current Administrations with a simple objective: to push children to the forefront of their thoughts and integrate them into their actions.

But our focus is not exclusively on the federal government.

We are engaging a larger community of key stakeholders to encourage a national discussion on children and disasters. Our partners have included: the American Red Cross, American Academy of Pediatrics, National Emergency Managers Association, International Association of Emergency Managers, National Association of County and City Health Officials, National Conference of State Legislatures, National Association of Counties and the National Coalition on Children and Disasters, consisting of twenty national advocacy organizations, led by Habitat for Humanity.

This past January, we conducted a field hearing in Baton Rouge to learn first hand the frustrations and hardships of children still struggling to recover from Hurricanes Katrina and Rita. We continue to work closely with dedicated organizations like Catholic Charities and the Louisiana Family Recovery Corps.

Our interim report is due to President Obama and Congress in October 2009, followed by the final report in October 2010.

Congress requires the Commission to examine a broad set of policy areas, including health, mental health, child care, child welfare, education, transportation, evacuation, housing, juvenile justice and emergency management.

For the purposes of today’s hearing, I will focus my testimony on the Commission’s findings and preliminary recommendations on child care.

Why is child care important in disaster recovery?

1. Child care programs must be prepared for disasters, not only to ensure children’s safety and mental well-being, but also to facilitate recovery by providing support to parents, employees and employers;

2. Child care expedites recovery by ensuring children are safe while parents visit damaged property, access public benefits, search for employment and housing, and make other efforts to rebuild their lives;
3. Loss or interruption of child care services following a disaster has an adverse economic impact on parents, providers, employers and communities;
4. Parents who generally do not need child care may need it in the aftermath of a disaster.

Last month, Save the Children released a report “the Disaster Decade” which contained a report card on child care disaster planning requirements across fifty states and the District of Columbia. Among the key findings:

- Only seven states have laws or regulations requiring licensed child care providers to have basic written emergency plans in place addressing evacuation, reunification, and accommodating children with special needs;
- Only twenty-one states require licensed child-care facilities to have a designated site and evacuation route in the event of a disaster; and
- Only fifteen states require licensed child care facilities to have a reunification plan for children and families in the event they become separated during an emergency.

Here are a few steps Congress can take to address these findings and prioritize child care in disaster preparedness, response and recovery:

1. Include the provision of child care as a human service activity within the National Response Framework and in the development of a National Disaster Recovery Strategy;
2. Incorporate child care as an “essential service” under the Stafford Act. Such action will provide a clear avenue to ensure funding and support for the establishment of temporary emergency child care and recovery of child care infrastructure;
3. Incorporate child care services as an emergency protective measure under Category B of the Public Assistance Program, which allows States and other eligible governments to be reimbursed for child care services;
4. Encourage states to require child care providers to have comprehensive all-hazards plans that, at a minimum, incorporate specific capabilities such as shelter-in-place, evacuation, relocation, family reunification, staff training, continuity of services, and accommodation of children with special needs;
5. Include a requirement in the reauthorization of the Child Care and Development Block Grant that state child care plans include guidelines for recovery and temporary emergency child care operating standards after a disaster;

6. Create an emergency contingency fund to help state and local governments meet additional needs resulting from an influx of evacuated families from other states; and
7. Require child care provider disaster plans to be coordinated with state and local disaster operations plans.

The Commission is working cooperatively with FEMA, the Department of Health and Human Services, and relevant non-governmental stakeholders to develop and implement these policies, the extent practicable under current law, to provide immediate disaster assistance to states, child care providers and families in need of child care.

In conclusion, we must elevate children within the consciousness of policy-makers here in Washington, D.C. and across the country.

The Commission strongly believes that the best way to instill public confidence in the way our nation prepares for, responds to, and recovers from disasters, is to make sure the needs of children are a priority.

Children sit at the center of family and community. The H1N1 flu outbreak quickly proved this point as school and day care closings caused immediate health concerns, logistical obstacles for working parents and economic consequences for families, small businesses and communities.

To paraphrase FEMA Administrator Craig Fugate, there is no stronger indicator of hope and optimism to a disaster-affected community than to see a yellow school bus making its way down a neighborhood lane.

In the aftermath of a disaster, effectively providing for the safety and welfare of children will create greater stability and help families and communities recover faster.

Again, I greatly appreciate the opportunity to testify today on behalf of the National Commission on Children and Disasters. We look forward to providing updates on the important work of the Commission to you in the future.

I would be pleased to answer your questions.



**Safeguarding Children in the Aftermath of and Recovery from
Catastrophic Disasters:
What We Need To Do Now**

**Testimony before the
Ad Hoc Subcommittee on Disaster Recovery
Committee on Homeland Security and Governmental Affairs
United States Senate
August 4, 2009
Honorable Mary Landrieu, Chair
Honorable Lindsey Graham, Ranking Member**

**Irwin Redlener, MD
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 Subcommittee in Recovery
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Thank you, Chairwoman Landrieu, Ranking Member Graham and other Senators of the Subcommittee for convening this important hearing. I greatly appreciate the opportunity to speak with you about the many unmet challenges of managing effective disaster recovery and the very negative consequences of a prolonged, ineffective recovery on the health and mental health of children and the resiliency of our nation.

I come here wearing three hats: I direct the National Center for Disaster Preparedness (NCDP) at Columbia University's Mailman School of Public Health; I am president of Children's Health Fund (CHF); and have the privilege of serving on the National Commission on Children and Disasters (National Commission) where I serve as chair of the Subcommittee on Human Services Recovery. And before I got into some of the disconcerting details of what we have been seeing in the Gulf around children's wellbeing, and what I believe needs to be done about disaster recovery planning in general for the nation, I would like to share my overall sense of the recovery as it has played out in Louisiana and Mississippi from the initial impact of Hurricane Katrina up until this very moment.

Clinical Services

Shortly after Hurricane Katrina, under the banner of an initiative called "Operation Assist", I dispatched seven of CHF's fully-contained, mobile medical clinics and professional teams to the Gulf to provide assistance on the level of acute medical and mental health response for survivors and evacuees. Although we expected to leave within a matter of weeks, CHF mobile units have transitioned to permanent projects in New Orleans, Baton Rouge, and Biloxi-Gulfport. These projects have become integral components of the still recovering health care systems in the region.

Each Gulf project is partnered with a major local institution including, respectively, Tulane University's Department of Pediatrics, Louisiana State University's Department of Pediatrics and the Coastal Family Health Center. At each program site we have deployed two mobile clinics, one unit providing pediatric medical care and the other children's mental health services. **As of today, our clinical programs in the Gulf have provided more than 60,000 medical, mental health and special services encounters to children and adolescents.**

Long-term Cohort Study

In addition to CHF's clinical services, NCDP has been conducting one of the largest face-to-face cohort studies of how families in the Gulf have been coping –and what their children are experiencing –in the continuing aftermath of the Katrina-Rita disasters. While our clinicians on the mobile clinics and our staff working with local schools continue to report persistently displaced children in severe distress with mental and behavioral problems, data from the NCDP studies have documented realities for children that give a more precise sense of what we are dealing with.

Study Findings

In analyzing multiple interviews with about 1,000 displaced families, as well as a review of pediatric records from CHF's program in Baton Rouge, here are some of the more salient observations:

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- More than one in five parents felt that their general situation was worse than prior to Katrina and more than 40% reported that the situation was too uncertain and changing to make a determination as to whether conditions were or were not worse than prior to Katrina.
- Six years of chronic stress consequent to unstable housing, unpredictable academic and health care access and severe economic challenges can take a significant toll on the well-being of children, both short and long-term. For instance, one-third of the displaced children are at least one year older than appropriate for grade level, reflecting a falling behind in academics related, in our opinion, significant problems identifying a stable school environment.
- For instance, one-third of the displaced children are at least one year older than appropriate for grade level, reflecting a falling behind in academics related, in our opinion, to significant problems identifying a stable school environment.
- By parental report, more than two-thirds of children displaced by the hurricanes are experiencing emotional or behavioral problems.
- In terms of actual diagnoses made, in Mississippi nearly 36% of displaced children have depression or anxiety and about 46% –nearly half –have behavioral problems.
- In Louisiana, 28% have been diagnosed with depression or anxiety and some 33% have behavioral or conduct problems.
- In a study last fall of 261 pediatric records of children cared for in CHF's Baton Rouge program –a mix of indigent inner city and displaced children –41% were found to have iron deficiency, one-third had impaired hearing or vision and 55% had behavior or learning difficulties. While some of these children may have been referred to the mobile clinics because of behavioral issues, the rate of anemia was several orders of magnitude higher than is typically found in disadvantaged populations.
- Approximately half of the families originally displaced are in permanent housing, some four years after the disaster. Given the rate of housing placement, we are looking at an approximately 6 year period to assure stable housing for all families. This process may, however, slow significantly if new affordable housing stock is depleted and not replaced.

Unfortunately access to health care for children and others in the region is still highly problematic. Four years after the storms which destroyed much of New Orleans's health system, including the famed Charity Hospital, there is still –as we sit here –no final plan to rebuild the hospital or restructure the health care system. **Unresolved conflicts among state, federal and health sector players have paralyzed the decision-making process while families wait for vital medical services to get up to speed.**

How many displaced children remain at risk?

One of the most difficult challenges we have faced in our assessments of the scope of the problems facing children in the Gulf has been simply determining the number of children affected by the disaster. We know that more than 160,000 children were among the displaced families from the Gulf. Some have returned to the Gulf some have remained in communities outside of Mississippi and Louisiana including in Houston, Atlanta, Baltimore, and New York. It should be noted that it is almost impossible to determine how many children at risk remain even now in the Gulf, let alone in the communities far removed from where home originally was. The extrapolated number, based on households being supported by various state and federal

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entities—including the Louisiana Recovery Authority, equivalent Mississippi agencies, and HUD—suggest that some 17,000 children in Mississippi and Louisiana remain in unstable conditions.

However, two caveats: first, several programs do not have or will not release the actual number of children enrolled in specific programs. Second, my experience from working with large homeless populations in New York and elsewhere is that many more children and families may exist outside the formal programs and systems, than inside. My professional judgment on this matter is that **some 30,000 persistently displaced children in the two principle states is not out of the question.**

Assisting families in need during transition and recovery

Tracking and enumerating displaced children and families has simply not happened sufficiently in Louisiana. This has greatly hampered the ability of local and State agencies to provide case management and vital social services. But differences between how Mississippi and Louisiana have responded are apparent, with the former seemingly far more effective in these efforts. Among other concerns, competing case management programs have emerged with the largest of those, the FEMA Disaster Case Management Pilot Program, having been mired in bureaucratic obstacles at both the federal and state levels. Although the program is hanging on, not one dollar of the original \$33 million is yet to be used to help families who desperately needed—and still need—case management services. As a result, the original \$33 million has been greatly reduced and the number of children and families that could qualify has dwindled not from a lack of need, but a falling out of the system. **At this point, several "competing" case management programs are assisting some families, but no single standard of care or predictable expectations of availability of services following a disaster exist.**

As suggested by the data noted above, the consequences of the extraordinarily disorganized and leaderless post-Katrina recovery are devastating for children and deeply demoralizing for their families. Our children who are now developing chronic emotional problems or who are failing in school will not easily recover. We are undermining not just their current well-being, but their future potential, as well.

Challenges of Effective Recovery Following Catastrophic Disasters: Lessons from the Gulf

In my opinion, **the overall management of the recovery process from these hurricanes has been more mishandled than the initial response.** As a result of many weeks of non-stop coverage in the print and broadcast media, the inept and uncoordinated immediate response to the hurricanes and the flooding of New Orleans, with images of people waiting on rooftops for rescue, was witnessed by people in every corner of the globe. Yet the extraordinary failures of recovery and the persistence of trauma and profound disruption, while in my view more important to the long-term well-being of children and families, has been far more insidious—and invisible. The failures of recovery have lost the attention of the media, the public and, I am sorry to say, perhaps of many in government as well.

For the purposes of this testimony, I would also suggest that our clinical and public health experiences in the Gulf not only prompt immediate concern for the families who remain in limbo, but the data also reflect a profound level of dysfunction and confusion with respect to

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how we generally approach long-term recovery from major disasters in the United States. In essence, we are currently **without a dependable roadmap to guide the recovery process following the inevitable next catastrophic event, whatever the cause –be it geological, climatic, biological or terror-related.**

Here is what I see are some of the major problems in terms of effective long-term, major disaster recovery capacity in the United States:

1. **There is no master plan or framework.** Although a National Disaster Recovery Strategy, commonly called the "National Recovery Framework," was mandated under the Post Katrina Emergency Management Reform Act of 2006 (S.3721), that Strategy has yet to appear. Equally concerning, the statute requires the National Disaster Recovery Strategy to be developed among FEMA, EPA, HUD, Treasury, USDA, Commerce, and SBA –but HHS is not included. That said, I believe **under new and highly motivated and capable leadership at HHS and FEMA, that we may soon see the emergence of this critical document.** In the meantime the lack of coordination, lack of clear lines of responsibility and absence of focused accountability among relevant federal agencies and the White House is a persistent reality.
2. FEMA has responsibility for the disaster recovery functions under ESF 14, but historically that agency has neither the skills nor experience to be responsible for long-term recovery.
3. There is an important lack of clarification of what we actually mean by the term "recovery". For some it is about the rebuilding of structures, including housing, health systems, schools and so forth. For others it is about helping families sustain themselves through periods of severe trauma and loss, to recover conditions of normalcy as rapidly as possible and to rebuild communities to levels that may actually substantially improve conditions over and above what had existed prior to the disaster. In reality, effective recovery subsumes both perspectives. **We need to rebuild the physical environment and pay close attention to the human needs –especially for children –during periods of transition.**
4. Until very recently, there has been no apparent recognition that **the needs of children must be understood and absorbed in all aspects of disaster response planning, mitigation and recovery.** This, too, may hopefully change rapidly under new leadership.
5. There is a growing sense –a misunderstanding in reality –that recovery from large-scale disasters is a "local problem" to be solved and managed by states and local jurisdiction. But **the destruction at the level we saw in the Gulf post-Katrina and Rita and the flooding of New Orleans was –and is –a national problem.** The well-being of the affected states is highly material to the well-being, the economy and security of the United States. No state, no community, and no combination of voluntary organizations can rebuild or stabilize 250,000 destroyed homes, countless wrecked local economies, tens of thousand of highly vulnerable families and children without the active participation of the federal government and resources of the American people. And the safeguarding of the Port of New Orleans and the protection of the energy-related industries in that region must not be characterized as a local matter, but a vital security interest of the nation.

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Recommendations:

I want to briefly mention several overriding recommendations for enhancing the basic national capacity for effective long-term recovery from major catastrophic disasters and several recommendations under consideration by the National Commission on Children and Disasters:

General:

1. The National Disaster Recovery Strategy must be completed as rapidly as possible, preferably within the calendar year 2009, and must include a principal role for HHS.
2. A high level directorate, reporting to the president should be established to oversee and coordinate all relevant federal assets and agencies with respect to long-term recovery.
3. Recovery must be seen as responding, at every level, to human services needs during recovery transition, as well as rebuilding of the physical environment and infrastructure.
4. Federal financial resources and other assets to assist recovery in states must strongly incentivize rapid progress and disincentivize delays in decision-making and implementation of restoration and recovery.

Under NCCD Consideration (selected):

1. The National Recovery Strategy should have an explicit emphasis on safeguarding the health, mental health and academic success of displaced children until they and their families return to normal community environments.
2. The Federal government must assure a robust, uniform case management program for every child displaced by a major disaster. This program must coordinate all essential needs and provide funds for direct services, as needed. It must be under the auspices, with full accountability, of a single federal agency charged with developing the template of services and working with relevant state, local and voluntary agencies.
3. Families with school age children should be prioritized for permanent housing placement.
4. The Department of Education, Department of Health and Human Services and relevant agencies within the Department of Homeland Security must coordinate efforts to make sure that every school-age child during a recovery be eligible for rapid enrollment in a local school, accessible to the temporary placement.
5. Child care and after-school programs should be classified as essential services under the Stafford Act to ensure availability of needed funding for these programs.
6. Health, dental and mental health services for every displaced child should be assured and funded under a "medical home", comprehensive care model.

I want to express my profound gratitude to Senator Landrieu and the Committee for calling this hearing and for helping to keep our focus on some of the most critical challenges facing our nation.

Testimony of Teri Fontenot, President and CEO of Woman's Hospital
Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery
Testimony Before the Ad Hoc Subcommittee on Disaster Recovery
Homeland Security and Governmental Affairs
August 4, 2009

Madame Chair, Ranking Member Graham, and Members of the Subcommittee;

I am Teri Fontenot, President and CEO of Woman's Hospital in Baton Rouge, LA. It is a privilege to come before you today to describe my hospital's response to the evacuation and care of critically ill patients in the horrific aftermath of Hurricane Katrina, our preparations for Rita, Gustav, and Ike, the important lessons learned from those events, and our recommendations for emergency management and medical treatment of neonates.

Woman's Hospital is 70 miles northwest of New Orleans and a two hour drive from the gulf coast. Hospitals are usually a place of refuge rather than a complex evacuation site, so the need to evacuate one or a whole city of hospitals had not been considered. But in the catastrophe of Katrina, Woman's Hospital did just that by taking over the management of the evacuation of 122 infants and high-risk obstetrical patients from flooded hospitals in New Orleans in four days. Working with our heroic colleagues in New Orleans hospitals under unfathomable conditions, not one transferred baby or mother died. Unquestionably, this remarkable achievement was the result of dedication and hard work by thousands of people, not because of carefully crafted and effective planning.

In fact, the chaos was overwhelming. Blackhawk helicopters brought men, women, and children day and night to our hospital. We received, stabilized, and transferred many patients to other facilities. But the most critically ill infants and women remained at Woman's. For a month after Katrina, we cared for twice the usual number of critically ill infants, and delivered 150 babies from the affected areas. For several days there were 125 infants in our 82 bassinet NICU. We also received and provided care for over 1,100 other patients, and worked with area churches to provide shelters for 110 newly-delivered mothers and families.

This feat was successful because of our incredibly dedicated staff and an expansion to our neonatal intensive care unit that was completed just weeks before Katrina. An evacuation drill had also been held earlier in 2005 that yielded valuable information about needed equipment and processes. Fortunately, we responded adequately, but coordinated planning by all agencies involved could have vastly improved the response.

You may recall that Hurricane Rita hit three weeks after Katrina. For Rita and each storm since that time, neonates and high risk obstetrical patients were evacuated to Woman's from hospitals *before* the storm – a key lesson learned.

In early 2006, we organized a series of important activities to ensure that we could apply all that we learned. Providers of obstetrical and neonatal services throughout Louisiana convened and produced a plan for emergency management of neonates. We also contacted neighboring states to discuss evacuation, especially if Baton Rouge became the disaster site, since no other hospital in our state has the capacity to take our large number of NICU patients. We took part in research with Tulane University to study the effects of the stress of the storms on maternal and infant outcomes, and we are the officially designated provider for infants in Louisiana's Medical Institution Evacuation Plan. In short, we are committed to anything and everything that will prevent the chaos of Katrina. Today, most hospitals in Louisiana have strengthened their infrastructure and plan to 'shelter in place', with the notable exception of especially fragile patients, such as ill newborns. Those hospitals still depend on us to transport and care for their infants.

Woman's Hospital's performance after Katrina, and the three hurricanes since that have threatened the Louisiana coast, demonstrate that an expert organization with adequate capacity is critical for the emergency management of certain populations of fragile patients. The expert hospital would be the coordinator of care and have capacity to care for displaced patients. Named Operation SmartMove, it is an initiative that will ensure that infants and mothers throughout the gulf south have a safe place, as well as a network of care and services designed to mitigate the devastating stress and overwhelming anxiety of recovery.

A remarkable opportunity exists to further implement these concepts as we build a replacement hospital. Surge capability was included in the original design, but has been removed due to the high interest rates on tax exempt debt and deep Medicaid cuts to hospitals. Building standby and surge capacity is now unaffordable for us, although hospitals throughout Louisiana have counted on us three times in less than four years to fulfill this need. External financial support for the capital and standby costs for hospitals to be ready at all times is critical for proper disaster preparedness.

Another extremely important change is the amendment of the Stafford Act so that private organizations that respond will qualify for reimbursement of costs associated with evacuation. Many private organizations assist or replace governmental agencies before, during, and after disasters, yet are prohibited from directly receiving FEMA funds.

The relocation of our hospital to the new campus will provide a unique learning opportunity for other responders. Representatives from hospitals like Woman's from across the nation will participate in a real-time evacuation drill as our NICU is moved from one campus to another.

Your concern about the impact of disasters on children is appropriate and important. On behalf of the staff of Woman's Hospital, we are excited to share our experience and knowledge to improve the response and management of our most vulnerable citizens. I will close with a huge thank you to Senator Landrieu for her ongoing support of Woman's Hospital and Operation SmartMove. Thank you for the opportunity to speak today and I look forward to answering questions.

**Addendum to the testimony of Teri Fontenot, President and CEO of
Woman's Hospital, to the Ad Hoc Subcommittee on Disaster Recovery
Homeland Security and Governmental Affairs
August 4, 2009**

The testimony provided on August 4, 2009 focused on Woman's Hospital's experience in the emergency management of neonates during weather catastrophes such as Hurricane Katrina. It has now become clear that the issues raised in relation to weather catastrophes applies also to the potential for pandemic or novel influenza, notably in emergence of the H1N1 virus as a specific threat to pregnant women and their infants.

The CDC reports that 13% of the U.S. deaths from the H1N1 virus between mid April and June, 2009 were pregnant women, and this patient population is four times more likely to be hospitalized than the general population. While guidelines continue to be developed, it is clear that both the surge capacity and expert hospital status described in the original testimony will be required for the care and treatment of pregnant women with the H1N1 virus.

It is estimated that 10,000 women are pregnant at any given time in Woman's Hospital's primary and secondary service areas. While it is impossible to estimate the likely number of these women who may contract the H1N1 virus, it can be surmised that a substantial number of these women will require hospitalization.

Operation SmartMove will provide surge capacity, equipment and supplies that will be critical in the management of subsequent pandemics, a further reason to consider this reasonable investment in the health, survival and recovery of women and infants.



**Focusing on Children
in Disasters:
Evacuation Planning
and Mental Health
Recovery**

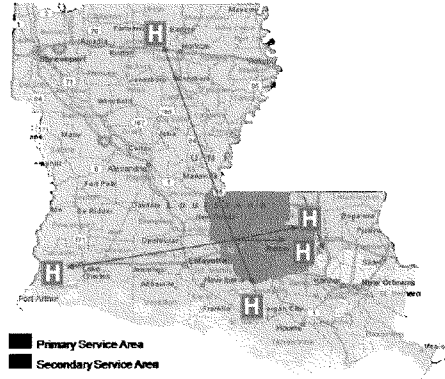
Ad Hoc Subcommittee on Disaster Recovery
August 4, 2009



About Us



- 501(c)3 charitable organization
- Level III regional referral center for obstetric and neonatal care
- Magnet® hospital
- 300 staffed beds
 - 82 bed neonatal intensive care unit (NICU)
- Safety net and lifeline in a disaster
- 490 physicians, 1,800 employees
- Obstetrics residency program
- 2007 Louisiana State Nurses Association Hospital of the Year
- 2008 Top 100 Best Places to Work in Healthcare by *Modern Healthcare* magazine



**Essential Statewide Leader in Obstetrics,
Gynecology, Breast, and Neonatal Care**



Annually

- 8,400 births
 - 70% market share in service area
 - 19th largest delivery service in U.S.
- 1,400 NICU discharges
- 85,000 pap smears
- 44,000 mammograms
- 7,300 surgeries



Specialties inhouse 24/7/365

- Anesthesia
- Ob/Gyn
- Neonatology

***Our mission is to improve the health of
women and infants***

Hurricane Katrina, August 2005



In the aftermath of Katrina, Woman's assumed responsibility for managing the evacuation of infants and mothers from flooded New Orleans hospitals

- Received/coordinated the care of 122 babies
- Cared for more than 1,100 patients and delivered more than 150 babies from the affected areas
- Cared for twice as many critically ill babies with higher acuity for four weeks
- Hired 100 nurses
- Set up shelters for pregnant women and families with newborns that were turned away from public and Red Cross facilities
- Provided clothing, formula, and diapers to 70 families
- Reunited displaced families and neonates
- Arranged 6 funeral services



Hurricanes Rita, Gustav and Ike



- ***Hurricane Rita***
 - NICU patients and hospitalized mothers evacuated to Woman's Hospital in advance of the storm
- ***Hurricane Gustav***
 - NICU patients and hospitalized mothers evacuated to Woman's Hospital in advance of the storm
 - Woman's capabilities as a surge hospital threatened by lack of complete emergency generator power
- ***Hurricane Ike***
 - Participated in Medical Institution Evacuation Plan conference calls and on standby for evacuations; none ordered

Building on Experience and Performance

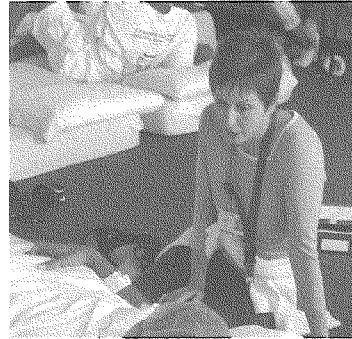


- Convened statewide meetings to rewrite the plan for emergency management of neonates
- Issues addressed included evacuation planning, patient tracking, medical information access, and moving staff to the receiving hospital

Lessons Learned



- Evacuations of vulnerable populations must occur in advance of the event
- Air and ground transportation must be dedicated for infants
- Health information must be accessible via the Internet
- Tracking of patient movement must occur in real time
- Evacuation management by a single entity able to coordinate resources and act in conjunction with government response is critical
- Adequately staffed inpatient capacity at a single expert facility provides the opportunity to position supplies and equipment in advance



Federal Policy Recommendations



- Designate a surge hospital in disaster prone regions to coordinate neonatal evacuation and care for patients
- Revise the Stafford Act so that designated (nongovernmental) surge hospitals may qualify for reimbursement of costs
- Provide support for the capital and standby costs for surge hospitals

Operation SmartMove: A National Demonstration Project



- Capacity and facility enhancements to provide for surge capability
- Equipment and prepositioned supplies
- Training and testing



Result

*Woman's
Hospital*

- A tested and proven system for the evacuation, management and recovery of hospitalized infants and mothers during disasters



Federal Programs that Support Children's Mental Health Services in the New Orleans Area*

SAMHSA

Community Mental Health Services Block Grant
 Substance Abuse Prevention & Treatment Block Grant
 Children's Health Fund Community Support & Resiliency Program
 Community Mental Health Services for Children & Their Families Program
 Cooperative Agreements for State-Sponsored Youth Suicide Prevention & Early Intervention
 National Child Traumatic Stress Initiative

Health Resources and Services Administration

Maternal & Child Health Services Block Grant
 National Health Service Corps Scholarship Program & Loan Repayment Program
 Health Center Program

Centers for Medicare & Medicaid Services

Medicaid & the State Children's Health Insurance Program
 Professional Workforce Supply Grant
 Provider Stabilization Grant
 Primary Care Access & Stabilization Grant

Administration for Children and Families

2006 Supplemental Social Services Block Grant
 Child Care & Development Fund
 Head Start

Department of Education

Project School Emergency Response to Violence (Project SERV)
 Safe & Drug-Free Schools & Communities: State Education Agency Grants & Governors' Grants

Department of Justice

Crime Victim Assistance

FEMA and HUD

Disaster Housing Assistance Program

FEMA and SAMHSA

Crisis Counseling Assistance & Training Program (CCP)

*2004-2008

ARE THE STATES PREPARED TO PROTECT CHILDREN DURING DISASTERS?

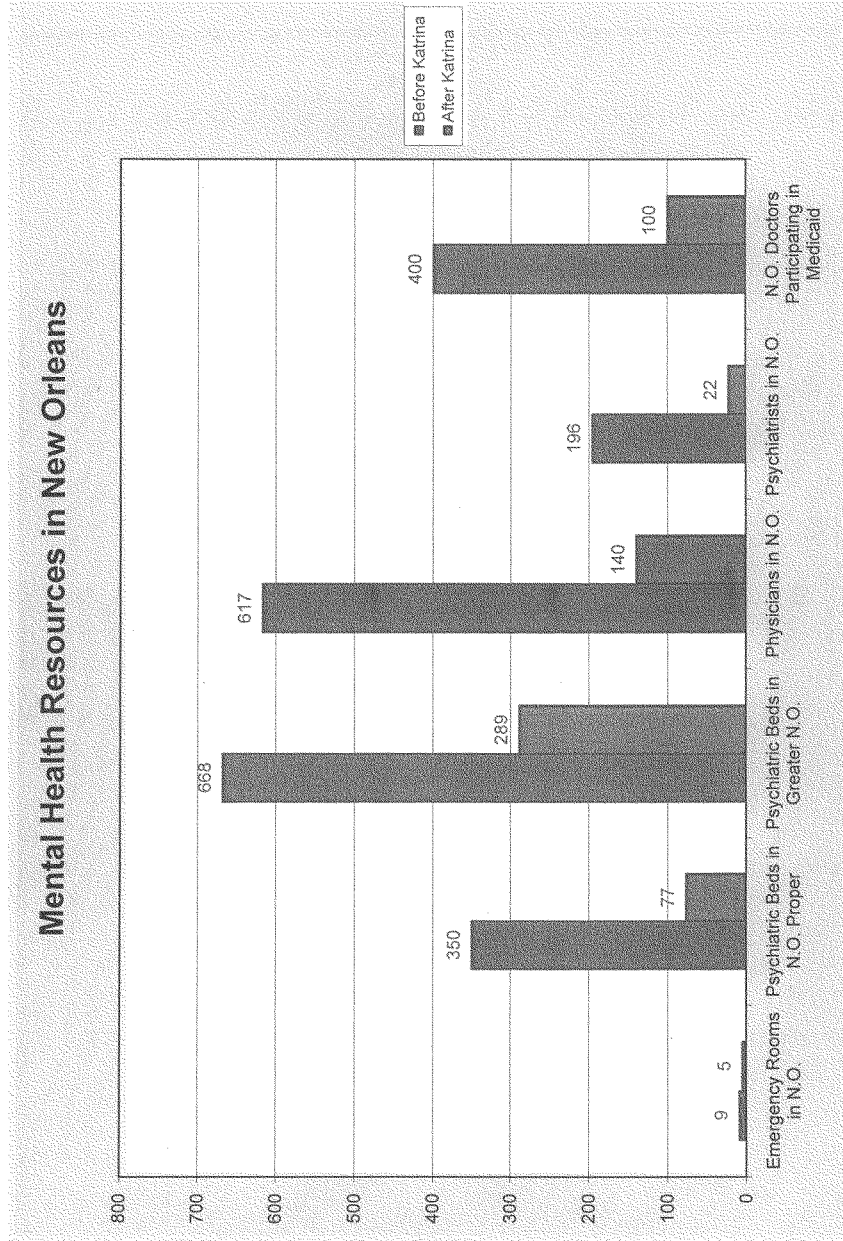
A REPORT CARD

*= Regulations under revision

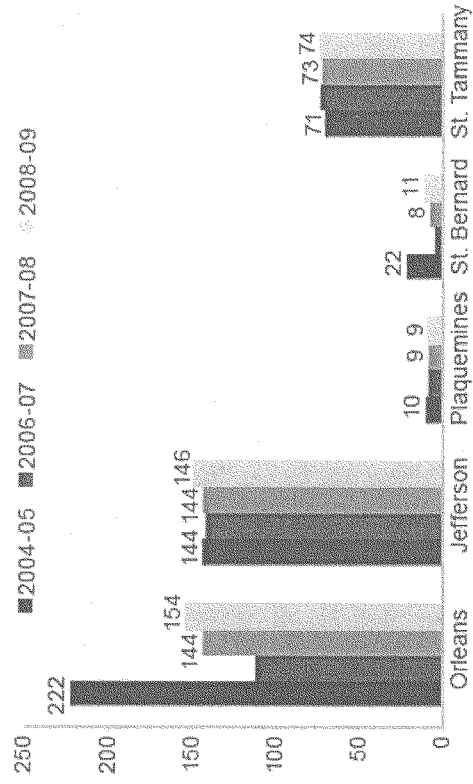
| | Evacuation Plan | Reunification Efforts | Special Needs of Children in Child Care | K-12 Written Procedure for Disaster Planning |
|-----------------|-----------------|-----------------------|---|--|
| ALABAMA | * | * | * | * |
| ARKANSAS | * | * | * | * |
| HAWAII | * | * | * | * |
| NEW HAMPSHIRE | * | * | * | * |
| MARYLAND | * | * | * | * |
| MASSACHUSETTS | * | * | * | * |
| VERMONT | * | * | * | * |
| DELAWARE | * | * | * | * |
| NEW YORK | * | * | * | * |
| NORTH CAROLINA | * | * | * | * |
| OHIO | * | * | * | * |
| OKLAHOMA* | * | * | * | * |
| CALIFORNIA* | * | * | * | * |
| MISSISSIPPI* | * | * | * | * |
| PENNSYLVANIA | * | * | * | * |
| SOUTH CAROLINA* | * | * | * | * |
| ALASKA | | | * | * |
| COLORADO | | * | * | * |
| TENNESSEE | | | * | * |
| TEXAS | * | | | * |
| UTAH | * | | | * |
| ARIZONA | | | | * |
| CONNECTICUT | | | | * |
| D.C. | * | | | * |
| FLORIDA* | | | | * |
| GEORGIA | | | | * |
| KENTUCKY* | | | | * |
| MINNESOTA | | | | * |
| NEBRASKA | * | | | * |
| NEW JERSEY | | | | * |
| NEW MEXICO* | | | | * |
| NORTH DAKOTA | * | | | * |
| OREGON | | | | * |
| RHODE ISLAND | | | | * |
| SOUTH DAKOTA | | | | * |
| VIRGINIA* | | | | * |
| INDIANA | | | | * |
| ILLINOIS | | | | * |
| MAINE | | | | * |
| WASHINGTON* | | | | * |
| IDAHO | | | | |
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| VIRGINIA | | | | |
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| WISCONSIN | | | | |
| WYOMING | | | | |



Save the Children.

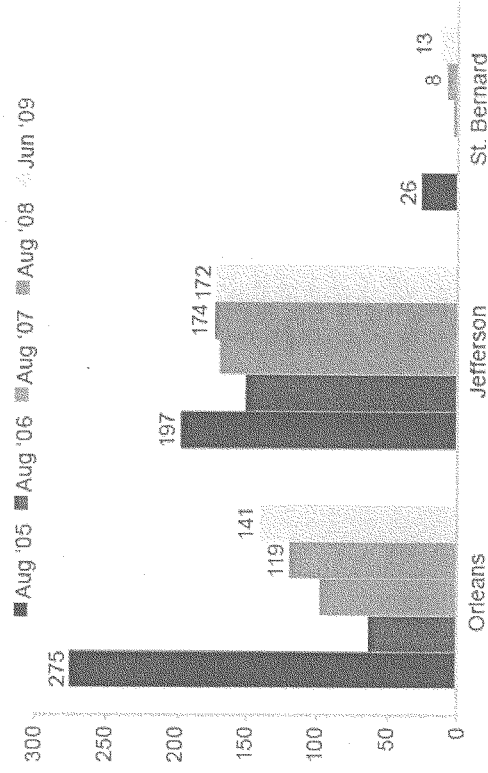


NUMBER OF OPEN PUBLIC AND PRIVATE SCHOOLS IN THE GREATER NEW ORLEANS AREA



Source: Louisiana Department of Education

NUMBER OF OPEN CHILD CARE CENTERS IN THE GREATER NEW ORLEANS AREA



Source: Agenda for Children and Louisiana Department of Social Services Bureau of Licensing

ARE THE STATES PREPARED TO PROTECT CHILDREN DURING DISASTERS?

| States | Day-Care Center Standards | | | School Standards |
|----------------|---|---|--|---|
| | Designated Relocation Site and Evacuation Route | Reunification Plan for Children if Separated from Parents | Plan Addresses Special Needs of Children in Child Care | Written Procedure for General Disaster Planning |
| Nevada | | | | |
| Utah | | | | |
| Virginia | | | | |
| Washington | | | | |
| California | | | | |
| Colorado | | | | |
| Maryland | | | | |
| Ohio | | | | |
| Oregon | | | | |
| Alaska | | | | |
| Connecticut | | | | |
| Iowa | | | | |
| Massachusetts | | | | |
| Mississippi | | | | |
| New Jersey | | | | |
| New York | | | | |
| Pennsylvania | | | | |
| Tennessee | | | | |
| Vermont | | | | |
| Arizona | | | | |
| Delaware | | | | |
| D.C. | | | | |
| Florida | | | | |
| Georgia | | | | |
| Idaho | | | | |
| Illinois | | | | |
| Indiana | | | | |
| Iowa | | | | |
| Minnesota | | | | |
| Missouri | | | | |
| New Mexico | | | | |
| North Carolina | | | | |
| Oklahoma | | | | |
| Rhode Island | | | | |
| South Carolina | | | | |
| South Dakota | | | | |
| Texas | | | | |
| Wyoming | | | | |
| Alabama | | | | |
| Arkansas | | | | |
| Hawaii | | | | |
| Kansas | | | | |
| Kentucky | | | | |
| Louisiana | | | | |
| Michigan | | | | |
| Montana | | | | |
| Nebraska | | | | |
| New Hampshire | | | | |
| North Dakota | | | | |
| West Virginia | | | | |
| Wisconsin | | | | |

Color key:

- States that meet all four requirements.
- States that meet one requirement.
- States that meet three requirements.
- States that have no requirements.
- States that meet two requirements.

If Disaster Strikes, Will You Know Where Your Young Children Are?

The Washington Post

If Disaster Strikes . . .

. . . will you know where your children are?

Saturday, June 20, 2009

IMAGINE THIS horrifying scenario: A radioactive bomb goes off in the District. Federal authorities order an evacuation within a 20-mile radius. You have young children in day care. Does the facility have an evacuation plan? Does it have a reunification plan? Child-care centers in Maryland are required to have both. The District mandates only an evacuation plan. Virginia -- like 29 other states -- doesn't require anything.

These gaps in emergency preparedness were highlighted in a report card issued Wednesday by Save the Children. According to the international advocacy organization, only 14 percent of states meet what it calls the four basic emergency preparedness standards for licensed child-care facilities and K-12 schools. It urges written and detailed evacuation plans at child-care centers for all types of potential disasters. While most states mandate that K-12 schools have procedures for some disasters, the group proposes that those plans encompass all types of potential disasters. Within those plans, attention should be paid to the care of special-needs children. And both schools and day-care centers should have an emergency parental notification plan that includes cellphone numbers and an out-of-state contact.

The National Commission on Children and Disasters plans to incorporate these recommendations into its interim report due to Congress in October. Its mission is to ensure that the well-being of children is not ignored when disaster strikes. The Federal Emergency Management Agency is taking a look at the proposals as well. "Children are not small adults," FEMA Administrator Craig Fugate told us. "You have to plan for their needs at the front end, not as an afterthought." With hurricane season just around the corner and the specter of terrorism ever-present, these sensible ideas should be adopted without delay.

FEMA to focus on children's needs during disasters

By EILEEN SULLIVAN

The Associated Press

Monday, August 3, 2009 2:01 PM

WASHINGTON -- The Federal Emergency Management Agency is going to plan more broadly for children and their needs as the government prepares for disasters.

"Children are not small adults," FEMA Administrator Craig Fugate said Monday.

Most disaster plans are crafted around adult populations, and people with specific needs - such as children - are often an afterthought, Fugate said in an interview with The Associated Press.

A new FEMA working group will work with the congressionally mandated National Commission on Children and Disasters, created in 2007. The FEMA group will focus on specific guidance for evacuating, sheltering and relocating children; helping childcare centers, schools and child welfare programs prepare for disasters; and making disaster preparation part of the Homeland Security Department's grant programs.

The working group's findings could mean changes to the country's blueprint for disaster response, known as the National Response Framework, Fugate said.

The Bush administration rewrote this national disaster plan after Hurricane Katrina. The new 82-page plan, issued in January 2008, does not include the word "children," but it does mention pets. That plan, however, is supplemented by more than 200 pages of annexes, which do address children's needs, though not in depth.

"Let's look at children not as something we're going to deal with after we write the plan," Fugate said.

He said he intends to draw more heavily on existing federal, state and local programs that already deal with children "in every community every day."

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Washington Times - Mental illness tidal wave

The Washington Times

Tuesday, August 4, 2009

Mental illness tidal wave

Audrey Hudson (Contact)

Second of three parts.

NEW ORLEANS

A mental health crisis that has swamped this city's care facilities as surely as Hurricane Katrina's floodwaters washed over the Lower 9th Ward is about to become even worse, care providers say.

New Orleans already is struggling with fewer than half of the inpatient beds for the mentally ill that it had before the 2005 hurricane - even as suicide rates and the number of people with mental health problems have doubled.

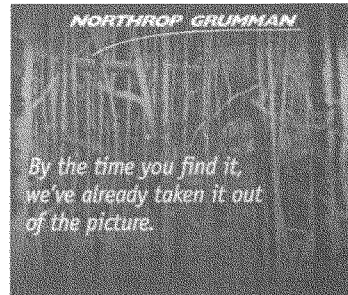
That shortage is about to become even more acute with the scheduled closing Sept. 1 of the New Orleans Adolescent Hospital (NOAH), the city's only public hospital still providing inpatient services for the mentally ill.

The closure, designed to trim \$14 million from the state's 2010 budget, will leave New Orleans with 133 beds for mental health inpatient care and will make the city jail - with 60 of those beds - the city's largest psychiatric ward.

- Click [here](#) to visit interactive Web site accompanying this series of articles about New Orleans' struggles with mental illness post-Katrina.

Before Katrina, "We had a functional system, not a Rolls-Royce, but we managed to treat patients," said Dr. Kevin U. Stephens, director of health for the city of New Orleans.

TWT RELATED STORY:



Washington Times - Mental illness tidal wave

- Mentally ill struggle in post-Katrina New Orleans

State funding for mental health services has risen steadily since the storm, from \$37.4 million in 2006 to \$74.4 million this year. Even so, Dr. Stephens said, "We have no real significant inpatient capability, and outpatient treatment is limited."

That shortage of facilities is felt most strongly by residents like Byron Turner, who four years after Katrina still is haunted by visions that eventually drove him to seek professional help.

"Life was real good for me before Katrina," he said. "I had no mental health issues ever in my life. I was never homeless. I had jobs. I had two automobiles before the storm."

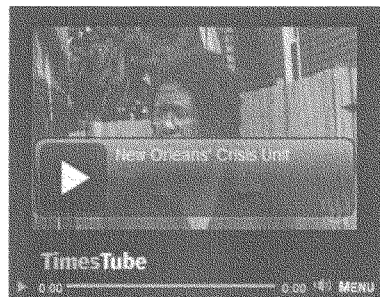
Today, he is homeless and taking medication to reduce his bouts of anger. Sometimes he's angry about his situation, sometimes he just gets frustrated with himself. Sometimes, he's still angry over the hurricane.

"I still see the bodies. I still see the dead children. I still see the elderly people floatin' in the water. I still see the water," Mr. Turner said.

Overwhelmed public health agencies in New Orleans can only guess how many of the city's residents are, like Mr. Turner, still struggling to cope with the mental and emotional consequences of a maelstrom that swept away whole neighborhoods and stole away friends, relatives, homes and social networks - the glue that holds people's psyches together.

"We all kind of crazy after Katrina," drawled Judge Arthur L. Hunter, who presides over the city's mental health court, a special facility that has convened weekly since December 2003 and handles between 100 and 200 cases a year.

"Everyone suffers from post-traumatic stress disorder, whether their house flooded or not," the judge said.



Washington Times - Mental illness tidal wave

Mental health is not easily measured, and attempts to quantify the explosion in mental health care needs after Katrina vary from agency to agency, but efforts have been made. One of the most comprehensive was by the World Health Organization, which surveyed about 1,000 Katrina-affected residents of Louisiana, Alabama and Mississippi some six months after the storm.

Comparing the results to a pre-Katrina study in the same area, the WHO found that the number of residents with serious mental health problems had shot up from 6.1 percent to 11.3 percent, and the number with mild to moderate problems had risen from 9.7 percent to 19.9 percent.

The Health Sciences Center at Louisiana State University produced similar findings in a 2007 report, which found that nearly 20 percent of the New Orleans population was suffering from serious mental illness. When the Federal Emergency Management Agency surveyed displaced families living in trailers and hotel rooms in Louisiana in February 2006, it found that 44 percent of the dwellers suffered from significant psychological distress.

'The walking wounded'

Equally telling are the suicide figures, which almost tripled in the year after Hurricane Katrina, according to the Metropolitan Human Services District (MHSD) and other mental health authorities. Dr. Jeffrey Rouse, the deputy New Orleans coroner dealing with psychiatric cases, was widely quoted in 2006 as saying the annual suicide rate had jumped from about nine people per 100,000 before the storm - slightly below the national average of 10 - to something over 26 per 100,000.

Altogether since 2006, reports show 101 suicides and 726 suicide attempts in a population that has ranged between 200,000 and 300,000. In the first five months of 2009 alone, 24 suicides and 82 attempts were reported - roughly double the national average.

They are "the walking wounded - untreated, they jump off bridges, they hang themselves, and they shoot themselves in the head," said Dr. Stephens, who has noted a spike in mental illness in his own office since the storm - including two suicides and other psychotic breakdowns.

"What we have is PTSD on steroids," the doctor said.

Recovery will require many years of sustained effort and commitment by public health officials and by the victims - people like Mr. Turner, who said he recognizes he is still in the first phase of dealing with his trauma.

Washington Times - Mental illness tidal wave

"I'm still thinking at certain streets I might walk down, you know, I might think that I'm still, I'm swimming. I might think that I'm trying to get in a boat still," he said as he described his quest to get to a place where the word "normal" has some meaning again.

In the meantime, he must still walk those streets where the flooding was deepest - some where the water was 16 feet deep - and where memories come back with the greatest force.

"I actually saw my friend's grandmother's body floatin' in front of me. I'm like, lord, that's Miss Mary floatin' right there, and she's actually dead, stiff as a piece of plywood, you know.

"So, these things are real," Mr. Turner said.

City, state and federal agencies have pointed fingers at one another for four years, seeking to lay blame for the failure of the levees that allowed the floodwaters to wash over the city. But as far as Dr. Stephens is concerned, that is no excuse for ignoring people like Mr. Turner.

"We as a society have to reach out and take care of them," he said. "Society needs to come in and be the safety net."

But the necessary health infrastructure no longer is there. Before Katrina, the city had 10 public and private hospitals with a total of more than 400 beds available for inpatient treatment of the mentally ill. Today, there are just seven hospitals, operating with fewer than 170 beds - a number that will be reduced further when NOAH closes.

Fight over NOAH

Mayor C. Ray Nagin protested the planned closing in an April 24 letter to Gov. Bobby Jindal, saying, "The City of New Orleans has faced a significant health care crisis since Hurricane Katrina. These changes would have the greatest negative impact on our poorest citizens who are frequently underinsured or uninsured."

Mr. Nagin added that those poor residents "have few options for obtaining primary, emergency, or mental health services from other providers. Due to lack of insurance, they receive exorbitant bills they cannot afford if they do seek services in community hospitals."

State Rep. Neal Abramson, whose district includes New Orleans, mounted a last-ditch effort to keep the hospital open.

"For people who need the facility, they are looking at over an hour of travel, and most people don't have the means to get there," said Mr. Abramson.

Washington Times - Mental illness tidal wave

For those who don't have cars, he said, the hospital might as well be moving to Arkansas.

Mr. Abramson succeeded in getting \$14 million for NOAH funding added to the state's budget on June 25 - the same day Mr. Jindal vetoed a separate bill that had funding for the hospital.

"The only way that hospital will close is if the governor vetoes the money again," Mr. Abramson said at the time. And the governor did.

Mr. Jindal said in his veto statement that Mr. Abramson's plan would have required the money to be pulled from other health resources in the state, forcing "unacceptable cuts" in those resources. "NOAH operates at twice the daily cost as other state inpatient facilities," the statement added.

Mr. Jindal also argued that the Department of Health and Hospitals plan he backed required no reduction in outpatient or inpatient services for the region as a whole, and provided for community-based outpatient mental health services in New Orleans.

But the veto also means mentally ill patients who have relied on NOAH will have to find somewhere else to go for inpatient services.

"I've told people for so long, just don't come back [to New Orleans] right now," said Cecile Tebo, administrator of the New Orleans Police Department Crisis Unit that responds to 911 calls involving the mentally ill.

"Don't come back if you have any kind of special needs; this is not the place to be if you have elderly that are really sick, if you have children with special needs or people in the family with mental illness or mental retardation; this is just not a good place to be right now," said Mrs. Tebo, whose own staff of volunteers is just a little more than half the size it was before Katrina.

"Hopefully, I won't have to say that in like five years. I'll say, 'Come on in, we got it figured out.' "

In that respect, Mrs. Tebo has a great deal in common with mental health patients such as Mr. Turner, who also would like to say they have it figured out.

"No I'm not normal. I would love to be normal again," said the man who still sees bodies floating through the streets.

"I would love to get back to my life that I had before Katrina ... you know?"



Recommended Changes to Federal Law to Improve Patient Care in Disasters

Hospitals are committed to serving their patients, their workers and their communities. This includes emergency situations and mass casualty events. There have been improvements in hospital preparedness since the terrorist attacks in 2001, the Gulf Coast hurricanes and with pandemic influenza preparedness, but much remains to be done.

One difficulty is that hospitals must balance many priorities, such as improving every day quality of care, moving towards an electronic health record, addressing existing workforce shortages and the already overburdened trauma care system. Even before the current economic crisis hit last year, roughly one in three hospitals were operating at a financial loss, struggling to keep their facilities financially viable on a day to day basis. With all these competing priorities, it is difficult for hospitals to dedicate significant additional resources towards mass casualty preparedness. However, as a result of the current economic crisis, the financial situation of hospitals is far more severe. As a result, hospitals have even less ability to utilize their own financial resources to underwrite preparedness activities, and are managing inventories more carefully so that, in terms of materials and staffing, overall medical surge capacity has likely declined.

Federal hospital preparedness program funds have helped but do not provide adequate amounts to comprehensively address existing gaps. These funds also come with burdensome administrative requirements – such as requirements that hospital staff take certain training and awareness courses of questionable value. In addition, while the threats to communities and health care facilities have grown and requirements that must be met in order to receive these preparedness funds have increased over time, the appropriations provided to hospitals for disaster preparedness have declined by nearly 30 percent since the program first began. Increasing health care facility preparedness does require a sustained and increasing level of federal preparedness commitment and funding. **We recommend that Congress continue to increase funding for hospitals disaster preparedness commensurate with the increasing threats and vulnerabilities in our nation.**

We also have a number of suggestions for changes to the law and regulations to assist hospital in preparing for and responding to disasters.

DHS: Stafford Act Changes

Establish a new federal approach to better recognize economic losses faced by hospitals and healthcare systems in disasters. The Stafford Act is more attuned to providing funds for property damage than for the added costs, or lost revenues, accompanying health services. A new federal approach is needed which expresses the Congressional commitment to assist hospitals in disaster recovery in a catastrophic disaster. The federal government needs to provide necessary catastrophic financial

relief to assist hospitals in caring for disaster victims and in disaster recovery, including in a pandemic in which large sections of the nation will be simultaneously impacted. This funding should recognize economic losses and should be set up to allow hospitals to remain a viable source of healthcare to deal with an influx of patients.

In an AHA focus group discussion on the topic of funding for catastrophic disaster in which the community is devastated, but the hospitals remain, we discussed the possibility of establishing a system of three phases of Federal disaster assistance. The trigger for putting such a system into place could involve such measures as physical damage to the community, population impact, labor market disruption, and/or expected duration of recovery efforts. Once the system is triggered, it would start with the Federal government as the first dollar payer for a period of time after the disaster, then move to the situation in which the Federal government would pick up the difference between what private and public insurance do not cover and then finally having the state and private sector support kick in for long-term recovery.

- In the short term (0-3 months post disaster) first dollar payment in the form of cash for first 90 days and materials/supplies to assist in response and recovery should be made available to keep the hospitals viable.
- In the intermediate term (3-24 months post disaster) reimbursement (net of insurer paid amounts) in the form of grants would be made available to assist in recovery. Expand the definition of allowable costs to include those costs that wouldn't ordinarily be considered payable such as insurance, utilities, labor (including gas, staff housing, etc.).
- In the long term (2-5 years post disaster), low interest loans with long payback terms and fixed interest rates. These should be loans that can be "forgiven."

Amend the Stafford Act to allow investor-owned hospitals and healthcare systems to be eligible for Federal Emergency Management Agency (FEMA) disaster assistance. Currently, disaster assistance grants are only available to government or non-profit hospitals and for-profit facilities are only eligible only for Small Business Administration disaster loans. The AHA supports recommendations that Stafford be amended to allow all hospitals, regardless of their ownership status, to apply for and receive federal disaster assistance. About 20-percent of hospitals are investor-owned "for-profit" facilities, many of which are located in rural communities. The Act should be revised to allow all hospitals that respond to the disaster to apply for disaster mitigation and recovery assistance.

The disasters that have taken place in recent years have focused attention on the need to prepare and respond to all types of emergencies. When disasters occur, all hospitals in the area respond, regardless of their ownership status and they should all be eligible to receive FEMA public assistance funding intended to help them recover from the impact of disasters. In many parts of the country, for-profit hospitals are the only places for the public to receive their care, so it makes sense that these facilities be afforded the same access to federal disaster assistance as are private nonprofit facilities, so that

they, too, can adequately care for patients following a disaster. The most important consideration shouldn't be a hospital's ownership status, but rather its ability to care for the ill and injured.

HHS: Changes to Medicare and Medicaid policy

The AHA is pleased that CMS puts into place a process, consistent with its current statutory authority, which allows the Secretary to waive certain regulations, such as EMTALA, in public health emergencies. However, the lessons learned from recent disasters make it clear that changes to the law are needed in order to provide additional flexibility in regulatory enforcement and payment policy so that hospitals can maximize their ability to quickly and safely respond to the needs of their communities and patients in disasters. The AHA, together with its members and state, regional and metropolitan hospital association partners, has compiled examples of areas in which changes and additional flexibility are needed and would be happy to work with Congress, the Secretary of HHS and CMS on legislative proposals to affect these changes.

Delink the 1135 waiver authority from the need for a Presidential or Stafford Act declaration. Currently, the Secretary of Health and Human Services has the authority under Section 1135 of the Social Security Act, to waive the enforcement of certain Medicare and Medicaid regulations related to EMTALA, HIPAA privacy and security policies, Medicare conditions of participation, pre-approval requirements, state licensing requirements, physician self referral regulations, Medicare+Choice regulations, and certain deadlines and timetables. The waiver of these regulations allow hospitals and other providers to provide timely and appropriate care to individuals impacted by a disaster without having to focus on strict compliance with current regulations. However, according to current law, in order for an 1135 waiver to be issued, the following two things must occur: (1) an emergency or disaster is declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and (2) a public health emergency is declared by the Secretary pursuant to section 319 of the Public Health Service Act.

The need for a dual disaster declaration in order for Medicare and Medicaid regulations to be waived has posed a significant problem, particularly in the context of an outbreak of a pandemic infectious disease. It is not clear that an infectious disease would ever qualify for a Presidential declaration. When the Stafford Act and the National Emergencies Acts were written, the authority of the President to declare an emergency or disaster primarily related to natural disasters (such as hurricanes or earthquakes) and terrorist attacks, but not infectious diseases. For instance, in the current H1N1 influenza pandemic, HHS declared a public health emergency on April 26th but, in the absence of a Presidential declaration, the Secretary of HHS was unable waive any of the Medicare or Medicaid regulations that would have taken pressure off the hospitals in the states that were most impacted by the pandemic.

The AHA recommends that Section 1135 of the Social Security Act be allow a HHS Secretarial declaration of a public health emergency to be sufficient in order to waive Medicare and Medicaid regulations.

Give CMS the authority to waive regulations for healthcare facilities in “host” states. Hospitals in states that accept patients evacuated from hospitals in the affected area are not currently eligible for 1135 waivers unless there is a federal declaration made. This means that restrictive Medicare policy cannot be waived, such as the critical access hospital bed limits, EMTALA, HIPAA rules, etc.

Give CMS authority to waive payment regulations. Currently, section 1135 does not permit CMS to waive payment regulations. This means that hospitals in the midst of a disaster must follow complex and resource-intensive policies or, on a case-by-case basis, dedicate time and resources to seeking flexibility in order to receive Medicare and Medicaid reimbursement. This includes such regulations as transfer policy, advance payment policy, etc. CMS should be permitted to revise payment regulations in a public health emergency.

More specifically, CMS should be able to waive the following Medicare payment regulations: the “25 percent” rule; the medical necessity requirements for Long Term Care Hospitals (LTCHs); 3-day hospital stay requirement prior to Skilled Nursing Facility (SNF) admission; waiver of anti-kickback regulations (to permit hospitals to provide office space within their facilities to physicians with offices damaged or destroyed or to otherwise assist physicians in caring for victims of the disaster)

Revise section 1135 waiver authority related to the timeframe permitted for HIPAA and EMTALA waivers to reflect Joint Commission timeframes. The Joint Commission requires hospitals plan to be self-sufficient for 96 hours after a disaster, but currently EMTALA and HIPAA regulation enforcement can only be waived for 72 hours.

Other recommendations for Medicare/Medicaid flexibilities. We encourage CMS and other relevant federal agencies and departments to take some additional steps in advance of the next mass casualty event to ensure a smoother response. Some of these changes will require revision of the underlying law. These include changes such as:

- In declared disasters, accept claims submitted from non-traditional locations, such as alternate care centers, field hospitals, etc.
- Accept claims for services that are provided by healthcare professionals who, in normal circumstances, would not be permitted by Medicare to provide services to beneficiaries; such as nurses providing care typically provided by physicians or residents/medical students providing services without the required level of physician supervision.
- Allow medical record documentation requirements to be modified after declaration of a disaster or emergency and create a template for documenting clinical care and/or an expedited claims form involving only minimal required elements that could be used in disasters to smooth payment.

- Loosen the rules around expedited/advance payments in disasters. These rules are currently very restrictive. If CMS does not have the authority to loosen these rules, they should seek it. This would provide additional flexibility to provide for expedited/advance payment in specific disaster circumstances, such as for hospitals experiencing a temporary decline in patient population due to disaster so as to allow the facility to get back up and running.
- Provide extensions for claim filing deadlines so that the clock starts ticking after the disaster or emergency is declared over.
- Consider periodic interim payments to providers as a means of ensuring continued cash flow to facilities affected by the disaster.
- Provide flexibility regarding coding after a disaster or emergency has been declared. Concerns raised by hospitals include: (1) denials related to coding edits and bundling; (2) coding staff requirements and emergency department documentation by physicians; (3) coding associated with the transfer of patients, for both the sending and receiving hospitals.
- Suspend utilization management functions for Medicare managed care and require contractors to do the same. Procedures include: (1) notice of admission; (2) eligibility verification; (3) concurrent review; (4) issuance of the Important Message, ABNs and HINNs; and, (5) discharge appeal process and QIO review.
- Allow CMS to issue waivers that allow state Medicaid programs to expand enrollment eligibility in disasters.

Other Statutory Changes Needed

- Provide health care workers and hospitals furnishing care and services to disaster victims with liability coverage as if the hospital was a federal facility, healthcare professionals were federal employees, and supplies and equipment belonged to the federal government.
- Provide matching grants for all hospitals in disaster areas to cover the costs of providing housing and social services for hospital and healthcare workers displaced by Hurricane Katrina.
- In catastrophic disasters, open currently unused employment-based visas under schedule 3 (EB-3) visas and earmark them for nurses, physical therapists, and other health care professionals (Schedule A professionals).
- Allow early withdrawals from retirement plans. To assist workers in need, waive the 10 percent penalty tax for premature distributions from IRAs and qualified retirement plans (including defined benefit plans, 401(k) plans and 403(b) plans) for individuals whose principal residence is in a federally declared natural

disaster area. Allow individuals to pay income tax on such distributions ratably over a three-year period.

- Appropriate sufficient funds to the National Disaster Medical System (NDMS) to ensure that all hospitals treating evacuated patients are paid according to the terms of the NDMS Memorandum of Understanding (MOU). Take steps to improve the coordination between NDMS, State Medicaid Programs, CMS and private insurers to ensure that reimbursement for care under the NDMS system is appropriately paid in a timely manner.

Please contact Roslyne Schulman, Senior Associate Director of Policy Development, by phone at (202) 626-2273 or by email at rschulman@aha.org for additional information.

Questions for the Record

Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery

August 4, 2009

From Senator Mary Landrieu to Administrator Fugate

1. Implementing GAO Recommendations on Crisis Counseling

I would like to ask FEMA about their progress in implementing one of GAO's recommendations from its February 2008 report, "Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements?"

- GAO recommended that FEMA and SAMHSA determine what types of expanded services should be incorporated into the Crisis Counseling Program. I understand that FEMA asked SAMHSA in the spring of 2008 to convene its Disaster Technical Assistance Group to conduct research on possible expanded service models.
 - Upon completion of DTAG's research, how long will it take FEMA to incorporate the recommended expanded service models into the Crisis Counseling Program?

Response: The Federal Emergency Management Agency (FEMA), in partnership with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), convened a working group to begin the process of incorporating enhanced services and other best practices in the field of disaster behavioral health in order to improve services under the Crisis Counseling Assistance and Training Program (CCP). As a result, the CCP Model Analysis: Informing the Program through Evidence and Expert Consensus Project was implemented. The purpose of this project is to validate the current principles, approaches and interventions of the CCP model that work, and to increase the effectiveness of the CCP through adoption of new principles and approaches that are consistent with best practices and expert consensus. The project consists of three phases:

1. Data collection phase (completed): Included a compilation of feedback from a variety of key informants, current and related research and literature, other similar models, as well as data collected from experts in the field.
2. Data analysis phase (completed): Resulted in identifying critical findings and recommendations. In May 2009, a focus group of CCP and disaster behavioral health experts was convened via a web-based teleconference.
3. Product development phase (ongoing): Resulted in the development of the CCP Model Analysis white paper. The white paper outlines current CCP practice and interventions, documents evidence for change (stakeholder feedback, literature review results, overview of other behavioral health models currently in practice) and lists recommendations for policy changes to the CCP model, recommendations for implementing and managing CCPs, and recommendations for working with survivors. The white paper is complete in draft form and currently under review with SAMHSA. Once final, the working group will reconvene to obtain consensus on prioritization of the recommendations and to finalize an implementation plan. Tentatively, implementation is scheduled to begin in April 2010 and continue through September 2010 (end of FY10). FEMA will continue to re-evaluate the effectiveness of enhancements and work with partners to propose further improvements as appropriate.

2. School Vouchers & Reconstruction

In November 2005, Congress passed a one-time, temporary impact aid package for local school districts and private schools impacted by Hurricane Katrina. The Katrina relief portion of the measure cost \$1.66 billion, and each eligible district received quarterly installment payments for each student enrolled in a given quarter in either a public or a private school in that district. Maximum total payment was \$6,000 per student (\$7,500 for students with disabilities), not to exceed the cost of tuition at private schools.

- What has FEMA done since Hurricane Katrina to ensure that children displaced by a disaster are able to enroll at a school in a different school district?
- Has FEMA considered policy changes that would expedite the rebuilding of schools to allow displaced students to return to their district sooner?

Response: FEMA does not have a specific policy ensuring that displaced children can enroll in a different school district. Families may be directed toward appropriate local education resources through the assistance of local case managers under FEMA's Disaster Case Management Program or through contact with local voluntary agencies.

The U.S. Department of Education offers a State-implemented Assistance for Homeless Youth program, which includes a section on counseling evacuees on the problems experienced by evacuee students, and provides Homeless Liaisons to support the program. FEMA's newly established Children's Working Group will be working with the U.S. Department of Education and other partners to identify and address children's needs such as those encountered by children displaced from their school district.

3. Neonates & Child Care

- What is the current status of evacuation planning for neonatal and obstetric patients?
- Do you believe that federal grants to day care centers should be linked to evacuation planning requirements?
- Do you believe that child care services should be classified as an "essential service" and eligible for assistance under Section 403 of the Stafford Act, which authorizes funding for emergency protective measures?

Response: Emergency mass evacuation is the movement of the general population from a dangerous area due to the threat or occurrence of a natural or man-made incident. Evacuation of the general population includes household pets and essential personal property (e.g., toiletries, change of clothes, identification documents, medications, etc.). Medical evacuation includes patients in healthcare facilities and those with special medical needs residing in the community.

Evacuation for neonatal and obstetric patients is included in the overall planning effort of mass evacuations. Evacuation of critical care, neonatal intensive care unit (NICU), pediatric intensive care unit (PICU) and mental/behavioral health patients is resource and personnel intensive.

While FEMA is the coordinating agency for mass evacuations, the Department of Health and Human Services (HHS) is the Primary Agency for Public Health and Medical Services and the Emergency Support Function (ESF) #8 Coordinator under the National Response Framework.

ESF #8 provides supplemental assistance to State, tribal, and local governments in the area of patient evacuation. ESF #8 is responsible for transporting seriously ill or injured patients, and medical needs populations from the impacted area to designated reception facilities. ESF #8 coordinates the Federal response in support of emergency triage and prehospital treatment, patient tracking, and distribution. This effort is coordinated with Federal, State, tribal, territorial, and local emergency medical services officials.

FEMA coordinates closely with HHS in the development of evacuation plans, and is a member of the HHS Senior Leader Council for patient movement. Additionally, FEMA provides funding to HHS to conduct a public health analysis throughout the nation, through an Interagency Agreement. The results of this analysis highlight potential shortfalls where Federal capabilities such as medical evacuation may be required.

Funds are provided to states and localities to address national preparedness priorities that include evacuation planning requirements, including plans for those with special needs, particularly children. States and localities are strongly encouraged to address these needs through a variety of support programs, including the State Homeland Security and Regional Catastrophic Preparedness Grant Programs. FEMA also provides planning guidance that addresses this issue.

Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, FEMA is authorized to provide assistance for actions taken before, during and after a disaster to save lives, protect public health and safety, and prevent damage to improved public and private property. This includes search and rescue; provision of shelters and emergency mass care, provision of food, water, ice and other essential commodities; among others.

The provision of child care services to individuals and families affected by disasters has historically not been an activity authorized or deemed eligible for reimbursement under the Public Assistance Program. However, FEMA's newly established Children's Working Group will be further evaluating whether some level of reimbursement may be appropriate as an emergency protective measure.

Child care facilities that are owned and operated by eligible applicants may be eligible for assistance for their disaster related damages.

Questions for the Record

Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery

August 4, 2009

From Senator Mary Landrieu to Rear Admiral Lurie

1. Implementing GAO Recommendations on Crisis Counseling

I would like to ask HHS about their progress in implementing one of GAO's recommendations from its February 2008 report, "Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements?" GAO recommended that FEMA and SAMHSA determine what types of expanded services should be incorporated into the Crisis Counseling Program. I understand that FEMA asked SAMHSA in the spring of 2008 to convene its Disaster Technical Assistance Group to conduct research on possible expanded service models.

- What is the status of the Disaster Technical Assistance Group's research into expanded service models that could be incorporated into the CCP, and what types of models are being considered?

In September, 2008, SAMHSA/FEMA convened a workgroup to ensure that crisis counseling services and interventions provided across our nation following a Presidentially declared disaster are consistent with current evidence-informed thinking, research and literature as well as to respond to GAO's recommendation "to conduct research on possible expanded service models." The findings of this workgroup concluded that the current CCP model includes effective principles, services, and interventions that can be improved by adding cognitive behavioral skill-building interventions, resembling those provided in Louisiana, called Specialized Crisis Counseling Services (SCCS). These SCCS were provided following Hurricane Katrina and continue to be provided now through the Hurricane Gustav CCP. In July 2009, SAMHSA completed a draft White Paper entitled "Crisis Counseling Assistance and Training Program (CCP) Model Analysis: Informing the Program through Evidence and Expert Consensus." Next steps include approval of the paper by SAMHSA, submission to FEMA HQ for their approval, release to GAO and other stakeholders, and FEMA/SAMHSA consensus on prioritization and a plan to address recommendations

2. Daunting Number of Programs

I mentioned in my opening statement that HHS programs have provided a significant amount of support to the Gulf Coast region for mental health services since the 2005 hurricanes. But the vast number of federal programs that must be patched together to fund this recovery mission seems to pose the risk of fragmenting and diminishing federal support, shifting burdensome application requirements onto the affected communities, fostering stove piping, spending taxpayer dollars without strategic coordination or program evaluation, and failing to emphasize patient outcomes.

- How does HHS help applicants in distress to leverage federal support in a simplified manner so they can focus on providing care to patients who need it instead of spending their time reading eligibility rules and filling out applications for 21 different federal programs?

Given the wide variety of emergency scenarios that can occur, it is difficult to provide a generic response. SAMHSA and all the HHS agencies are part of an intra- and inter-agency disaster response group that can address the leveraging of total federal support for applicant states.

For a widespread emergency, such as Katrina, there is a need for a systems approach to bring together representatives from all types of programs to assess needs and facilitate provision of needed services. For example, in Katrina, the Health Resources and Services Administration (HRSA) found it of great benefit to work with the Director of the Mississippi Maternal and Child Health program, who was able to coordinate, through the state system, an intake process which provided access to a variety of federal and state programs as they are administered by the state. These programs included the HRSA Maternal and Child Health and Children with Special Health Care Needs programs, WIC, Community Health Centers, Community Mental Health Centers, Department of Motor Vehicles, and Vital Statistics. It is important for federal staff to work collaboratively with the state staff in identifying and arranging for the appropriate state-level staff to assist in making benefits available from their respective programs. The federal plan should recognize the need to coordinate the intake process and identify the correct components within the state system to assure access and availability of all needed benefits.

The Administration for Children and Families (ACF) within HHS, created a comprehensive Disaster Case Management (DCM) pilot demonstration program, not previously utilized in disasters. This program provides a single point of contact for disaster assistance applicants who need a wide variety of services that may be provided by many different organizations. It involves the process of organizing and providing a timely, coordinated approach to assess disaster-related needs as well as existing healthcare, mental health and human services needs that may adversely impact an individual's recovery if not addressed. The HHS/ACF DCM program facilitates the delivery of appropriate resources and services, works with a client to implement a recovery plan, and advocates for the client's needs to assist him or her in returning to a pre-disaster status while respecting human dignity. If necessary, disaster case management helps transition the client with pre-existing needs to existing case management providers after disaster-related needs are addressed.

3. Data Collection

GAO stated in its report on mental health services in the New Orleans area that "it was not possible for us to calculate a total amount of federal funding allocated or spent to support mental health services for children in the greater New Orleans area or the total number of children served through federal programs because of a lack of comparable data among federal and state agencies and individual programs."

- How does HHS measure program success without tracking patient outcomes?
- Does HHS have any plans to collect data after future catastrophic disasters on federal funding for mental health services and the number of patients that funding supports?

It is essential that federal data needed be clearly defined in advance and collected in a consistent and systematic manner. With regard to the FEMA-funded Crisis Counseling Program (CCP), data and evaluation mechanisms are in place to measure the quality and reach of psychoeducational services provided.

4. Expiring Funds

The more recent GAO report on mental health mentions several HHS programs which have funded the retention and recruitment of 89 health care professionals in the New Orleans area but will no longer provide funding at the end of next month. These include SAMHSA's Children's Health Fund Community Support and Resiliency Program, CMS's Professional Workforce Supply Grant, CMS's Provider Stabilization Grants, and funds from HRSA's Bureau of Clinician Recruitment and Service.

- Does HHS have plans to extend the availability of these allocations or provide additional resources for recruitment and retention of health care professionals in the New Orleans area?

SAMHSA understands this critical need and will continue to support as directed by appropriation. HRSA currently supports 8 clinicians in the New Orleans Area -- of these, 7 will continue to serve through fiscal year 2010. As of August 17, 2009, there were 85 mental and behavioral health vacancies in National Health Service Corps (NHSC)-qualified sites in the State of Louisiana. If these sites recruit qualified clinicians as loan repayment applicants, it is very likely that they can be supported through both the annual appropriation for the NHSC Recruitment Line and ARRA funding. In addition, CMS's Primary Care Access and Stabilization Grant (PCASG) funds were made available to Louisiana for a 3-year period which extends from July 23, 2007 through September 30, 2010.

5. Housing's Impact on Mental Health

HHS provided written comments on the report that GAO released last month. I would like to read an excerpt from those comments. "One of the greatest barriers to children's mental health recovery in the New Orleans area is the lack of stable housing...in the absence of affordable, stable housing options, CMHS anticipates that a significant number of children will experience or re-experience symptoms associated with distress, trauma, and severe anxiety and depression. This is a major challenge that requires the steadfast cooperation and attention of federal and state partners to address."

- I completely agree with that statement and would like to ask if you have specific suggestions for addressing this problem.

As mentioned above, the issues identified are a major challenge. At the President's request, the Secretaries of Homeland Security and Housing and Urban Development are co-chairing a Long Term Recovery Working Group composed of the Secretaries and Administrators of more than 20 departments, agencies and offices. This high-level, strategic initiative, will provide operational guidance for recovery organizations as well as make suggestions for future improvement. This will include how federal partners could better collaborate, educate, and inform one another, and state and local leaders, about the needs of survivors and work together to address these issues as appropriate.

**Response to Post-Hearing Questions for the Record
Focusing on Children in Disasters: Evacuation Planning and Mental Health
Recovery**

**Ad Hoc Subcommittee on Disaster Recovery
Committee on Homeland Security and Governmental Affairs
United States Senate
August 4, 2009**

**Questions for Cynthia A. Bascetta
Director, Health Care
U.S. Government Accountability Office**

Questions for the Record Submitted by Chairman Mary L. Landrieu

- 1. Case Management:** GAO recently released another report on disaster case management programs that have operated since Katrina. Case managers are meant to help their clients find job training, permanent housing, relief supplies, and access to critical services like health care.
- **How effective were the case management programs you studied at connecting people in need with mental health services, and what could be done to improve their effectiveness at this task?**

Limited information is available with which to determine the outcomes of disaster case management services. As GAO reported, program data from Katrina Aid Today and the Disaster Housing Assistance Program—two of the disaster case management programs GAO studied that assisted clients in securing and coordinating disaster relief and long-term recovery services—indicated that health and well being, which included mental health services, were among the top three frequently occurring needs of clients.¹ However, the database used to capture data on the Katrina Aid Today program was of limited use in understanding outcomes of the program as a whole, including the extent to which clients' needs were met. In addition, data analyses for the Disaster Housing Assistance Program did not allow the Department of Housing and Urban Development (HUD) to derive substantial conclusions about client outcomes. Current evaluations conducted by the Federal Emergency Management Agency (FEMA), the Department of Health and Human Services, and HUD will provide valuable information on the implementation of disaster case management programs. For example, the FEMA evaluation will assess whether funds were administered within guidelines and compare the planned versus actual program costs. However, none of the evaluations will provide information with which to assess the outcomes of case management services. GAO recommended that FEMA conduct an outcome evaluation to determine the results of disaster case management pilot programs to obtain information on program results, including client outcomes and whether those most in need received services. Such an evaluation will provide

¹GAO, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, [GAO-09-561](#) (Washington, D.C.: July 8, 2009).

the information needed to identify and quantify needs and develop more effective disaster case management programs for future disasters.

Further, case management agencies experienced a range of challenges in assisting victims of Hurricanes Katrina and Rita. GAO found that staff turnover, large caseloads, and limited community resources were among the challenges case management agencies faced in meeting clients' needs. In addition, disaster victims most in need of case management may not have received services due to breaks in federal funding, inconsistent outreach, and a lack of timely and accurate information sharing among federal agencies and case management providers. To help overcome these challenges in future disasters, GAO recommended that FEMA ensure the federal disaster case management program it develops includes practices to enhance and sustain coordination among federal and non-federal stakeholders. Improving coordination could support efforts to ensure that those most in need of services are reached, that federal and state entities and case management agencies have accurate client information, and that victims receive the specific services and assistance required for recovery.

2. Catholic Charities Decision to Quit Program: Your recent report on access to primary care in Greater New Orleans indicated that Catholic Charities Archdiocese of New Orleans terminated its contract with the Louisiana Office of Mental Health in May 2007 because the Crisis Counseling Program would not reimburse indirect costs. GAO recommended a revision of this policy 18 months ago in its report on the program.

- **Can you provide examples of indirect program costs that are not eligible for reimbursement, the reason why GAO recommended revision of this policy last year, and the reason this policy caused Catholic Charities to terminate its participation in the program?**

As reported in our 2008 report on catastrophic disasters,² indirect costs are incurred by an organization and are not readily identified with a particular project but are necessary to the operation of the organization and the performance of the project. Some examples of indirect costs cited by Crisis Counseling Assistance and Training Program (CCP) providers in Louisiana include outsourced payroll processing, legal fees related to administering the program, interest on lines of credit used by providers for payroll, maintenance of email and communication software, and maintenance costs for vehicles and facilities.

In this same report, GAO recommended revision of the CCP program's policy regarding indirect costs. We found that FEMA's policy of precluding states and their CCP service providers from obtaining reimbursement for indirect costs associated with managing and monitoring their CCPs has made it difficult for states to

²See GAO, *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, D.C.: Feb. 29, 2008).

effectively administer their CCPs. State officials reported that the lack of reimbursement for indirect costs made it more difficult to recruit and retain service providers. Further, we reported in our 2008 report that other FEMA disaster response grant programs allow reimbursement for such costs, and a FEMA official responsible for CCP told us that it was unclear why CCP policy does not allow for the reimbursement of indirect costs.

According to Louisiana officials, Catholic Charities terminated its participation as a contractor in the state's Hurricane Katrina CCP because indirect costs were not reimbursable under the terms of the program, and the organization could not afford to continue as a contracted provider. As a result of Catholic Charities' withdrawal from CCP, the state program office had to manage the program for the greater New Orleans area.

Questions for the Record

*Focusing on Children in Disasters: Evacuation Planning and Mental Health
Recovery*

August 4, 2009

From Senator Mary Landrieu to Mr. Shriver

1. The National Commission on Children and Disasters will release its interim report in October of this year and its final report is due in October of next year. The Commission has stressed developing practical recommendations that can be readily implemented, and you mentioned several specific policies in your testimony that deal with evacuation planning requirements and reimbursement eligibility for child care services.

- Do you feel that your collaboration with agency officials is precipitating change from within?

The Commission has assumed a role to facilitate awareness of issues affecting children, knowledge sharing and communication across agencies and within them, in order to bring about change and coordination necessary to make children an immediate priority in disasters.

We recognize there is much work to be done to establish a shift in disaster planning and management culture that currently favors able-bodied adults with better means to survive and fully recover from disasters. We also recognize that rivalries develop when a single agency or single entity within an agency is attempting to be “the team” and fails to recognize the expertise, roles and responsibilities of its sister agencies and partners.

- How would you characterize the level of engagement you have experienced so far from FEMA and HHS?

FEMA Administrator Craig Fugate met with me within weeks of his confirmation and expressed his understanding and urgency to address the unique needs of children. Administrator Fugate and his senior staff meet with the Commission on a monthly basis. The formation of the FEMA Children’s Working Group came as a result of these meetings.

HHS' is engaged with the Commission at several levels. The Administration on Children and Families provides logistical support and houses several important programmatic areas of direct relation to the Commission's work. We have engaged the Office of Human Services Emergency Preparedness and Response, Head Start, Child Care Bureau, and Children's Bureau, which oversees child welfare issues. Similarly, the office of the Assistant Secretary for Preparedness and Response has engaged the Commission on several issues related to children and public health, including development, stockpiling and distribution of medical countermeasures, augmenting pediatric clinical care through the National Disaster Medical System, and developing strategies to address pediatric surge capabilities in hospitals. Finally, the Commission has engaged the Office of Public Health and Science on emphasizing the needs of children within recovery planning for communities.

- Administrator Fugate and Secretary Lurie both mentioned working groups that have been established within their agencies to consider the needs of children during the planning process. Have you or other members of the Commission had an opportunity to work with those teams?

FEMA recently named the internal core members of the Children's Working Group and is also building a list of subject matter experts – both internally and externally -- for additional support. The first organizational meeting took place on September 1, 2009. We anticipate working with the Children's Working Group to not only consider ways to implement the recommendations contained within the Commission's Interim Report, but also to identify additional gaps and develop solutions to address them.

The National Biodefense Science Board invited me to speak at its quarterly meeting on April 22, 2009. I presented the NBSB with several areas for potential collaboration with the Commission, including development of medical countermeasures for children and recommendations from their Disaster Mental Health Subcommittee, which have yet to be implemented.

Primarily, the Commission is represented on various ASPR working groups by our resident pediatricians: Commission Vice-Chairperson, Dr. Michael Anderson, Dr. Irwin Redlener, and Dr. David Schonfeld. All three were invited to participate in the June 17, 2009 planning session noted in RADM Lurie's testimony. In addition, they will attend the CDC-led H1N1 conference in Atlanta on September 8-9.

Dr. Anderson is leading a working group dedicated to developing a National Pediatric Team for Disaster response under NDMS. Additionally, he recently delivered a presentation before the Federal Education and Training Interagency Group. Dr. Redlener is participating in the development of manuscripts that will provide guidance in the allocation of scarce resources following an attack using an improvised nuclear device. Dr. Schonfeld was an "invited expert" in the development of the Disaster Mental Health Subcommittee Recommendations Report.

Questions for the Record

Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery

August 4, 2009

From Senator Mary Landrieu to Irwin Redlener, MD
(Dr. Redlener's replies in italics)

1. Case Management. You cited several concerns with case management service delivery in your testimony, including unclear standards of care and sporadic provision of aid.

- What suggestions do you have for FEMA, HUD, and HHS, which have each administered case management programs for survivors of Katrina and Rita?

Each of these agencies has been working on their own versions of case management with some notion of "testing" one against another for effectiveness. This is a study that does not need to be done. A standard, comprehensive case management model should be utilized that is available through any of the agencies charged with providing these services.

- What suggestions do you have for Congress about the need to expand or clarify case management authority that was added to the Stafford Act by PKEMRA in 2006?

One of the major problems has been that some families eligible for post-Katrina services were not eligible for Ike related consequences, and vice versa. This makes it very difficult for families to navigate and many have fallen through the cracks. In my opinion, I would like to see the Administration for Children and families (ACF) of HHS be the responsible agency for case management in long-term disaster recovery. They have the greatest experience and are most established in terms of providing such services. This should not be a FEMA function.

In addition, flexibility should be given within the case management programs to provide materials and other resources to families in need depending on circumstances.

2. The National Commission on Children and Disasters will release its interim report in October of this year and its final report is due in October of next year. The Commission has stressed developing practical recommendations that can be readily implemented, and you mentioned several specific policies in your

testimony that deal with evacuation planning requirements and reimbursement eligibility for child care services.

- Do you feel that your collaboration with agency officials is precipitating change from within?

Sometimes that is in fact the case; FEMA is a good example of an agency that seems to be very responsive. Other recommendations will certainly need legislative remedies and actions by the relevant Secretaries.

- How would you characterize the level of engagement you have experienced so far from FEMA and HHS?

Generally, very responsive.

- Administrator Fugate and Secretary Lurie both mentioned working groups that have been established within their agencies to consider the needs of children during the planning process. Have you or other members of the Commission had an opportunity to work with those teams?

Yes, on the FEMA side. I expect we will have –though haven't as yet – a similar level of involvement with ASPR.

Questions for the Record

Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery

August 4, 2009

From Senator Mary Landrieu to Ms. Fontenot

1. Operation SmartMove

Many gaps in disaster preparedness were exposed when Hurricane Katrina struck the Gulf Coast. Since that time, pediatric-specific and neonatal intensive care specific preparations have continued to lag behind other special needs populations resulting in deficient disaster readiness for this vulnerable population. Operation SmartMove is of vital importance to the citizens of Louisiana and potentially the nation.

- Please explain why you believe that Operation SmartMove can serve as a model for the nation as we work to ensure the safety of our most vulnerable populations.

Answer:

Operation SmartMove provides a unique opportunity to build disaster readiness for neonatal intensive care specific populations across the United States due to four distinctive factors:

1. Woman's Hospital's experience as the receiving hospital for almost all the NICU patients evacuated from New Orleans in the aftermath of Hurricane Katrina and in two major storms since 2005. There is no substitute for actual experience in this special role **not** as an evacuating hospital but as the receiving facility.
2. The replicable nature of lessons learned, including:
 - a. Equipment required for the safe evacuation and management of NICU patients
 - b. Staffing requirements for disaster readiness
 - c. Logistics of patient triage and management
 - d. Health information requirements
 - e. Family and support issues including sheltering of parents and other social service functions
3. The applicability of these learning, experiences and processes to disasters other than weather, notably influenza pandemics
4. The development of a new campus that will require a physical relocation of up to 75 NICU patients, the logistics of the move and the opportunity to build a national symposium around that move.

In summary, Woman's Hospital possesses the knowledge, experience and patient volumes to develop, test and replicate an effective model for disaster readiness for this uniquely fragile population.