Testimony
Committee on Homeland Security and Governmental Affairs
Ad Hoc Subcommittee on Disaster Recovery
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"Children and Disasters: A Progress Report on Addressing Needs"

Statement of

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Good afternoon Madam Chairwoman Landrieu, Ranking Member Graham, and other distinguished Members of the Ad Hoc Subcommittee on Disaster Recovery. I am pleased to be here today on behalf of the U.S Department of Health and Human Services (HHS) to provide you with an update on our disaster preparedness, response, and recovery activities related to children and families. Today I will talk to you about some of my Department's recent efforts, particularly those that relate to the recommendations of the interim report of the National Commission on Children and Disasters (NCCD, or "the Commission") in the areas of health, mental health, and overall coordination.

I want to begin by commending this Subcommittee for its attention to the needs of children. As Assistant Secretary for Preparedness and Response, I am mandated to address the needs of children. As a mother and a community physician, I know firsthand how critical that mandate is and I firmly support efforts to address the needs of children.

The Commission report makes several recommendations that focus on child physical health and trauma. Let me begin by talking about a few relevant activities aimed at enhancing the provision of healthcare services to children during a public health emergency or mass casualty event.

ASPR is undertaking several efforts to better assess healthcare system needs. Through our HavBed system, we have a tool to identify healthcare system stress and demand in the event of a public health emergency or mass casualty event. Currently we collect data

weekly in response to the H1N1 flu outbreak. Data elements specific to pediatrics include:

- Available Pediatric Med/Surge beds and Pediatric ICU beds.
- Total number of full feature ventilators available to the facility that can support both adult and pediatric patients.
- Number of patients who are currently being managed on rescue therapies including the number of children birth to 12 years of age.

In addition to HavBed, ASPR has a web-based capability called MedMap that incorporates information from various sources into a single environment for enhanced awareness. MedMap can provide information about the locations of public schools, daycare facilities, pediatric intensive care units, and hospitals that provide pediatric services.

Another assessment effort currently underway is examining ventilators for pediatric patients, an issue of extreme importance during the H1N1 epidemic. ASPR recently initiated an inventory of mechanical ventilators owned by US acute care hospitals. Respondents represented 85 percent of US pediatric and neonatal ICU beds. The inventory identified thousands of full-feature ventilators, mechanical ventilators designed for select pediatric and neonatal populations, and more than 16,000 transport ventilators at US responding hospitals. While the number of ventilators was about 36 per 100,000 children under 18, staff expertise for ventilating pediatric patients may be limited. Therefore, ASPR has contracted with the Society of Critical Care Medicine (SCCM) to

develop a critical care cross-training course. This web-based course will include pediatric modules and be available at no cost to US healthcare workers.

Beyond these activities, HHS utilizes epidemiological data and other data on system capacity to inform our work and anticipate future needs. This information feeds back to our Hospital Preparedness Program (HPP) grants and all our other activities. The HPP has already awarded grants focusing on pediatric issues and has elaborated on the need to integrate all "at-risk" groups into grant activities.

To enhance the National Disaster Medical System (NDMS) focus on pediatric issues, we recently hired a pediatrician as a Deputy Chief Medical Officer. This physician will be leading several initiatives aimed at improving our NDMS response capabilities with respect to our pediatric population and engaging in ongoing liaison with the American Academy of Pediatrics and pediatric hospital partners. He will also be assisting us with analyzing the findings of our recent workshop "Pediatric Preparedness and Response in Public Health Emergencies and Disasters." This workshop covered topics related to medical response and medical countermeasures for the pediatric population. Approximately 69 percent of NDMS clinicians have training in pediatric care, including nine percent who are pediatricians or pediatric specialists. The NDMS is currently evaluating its equipment caches to determine how they can be modified to meet the needs of children during responses.

ASPR is also working closely with the American Academy of Pediatrics and its Disaster Preparedness Committee. ASPR representatives attend the AAP Committee's quarterly meetings and AAP representatives have participated in ASPR pediatric conferences.

The Commission report also addresses the critical area of medical countermeasures. Our BioMedical Advanced Research and Development Authority (BARDA) actively considers the needs of the pediatric and other special populations in the community in the Chemical, Biological, Radiological, and Nuclear (CBRN) and Influenza Programs. The work of our Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Integrated Program Teams and other interagency and internal program task forces and teams review and set requirements in contract solicitations that include the special considerations and instructions within the scope of work addressing children and other special populations such as immunocompromised persons. Contract awards for countermeasure product development, acquisition, and clinical studies provide special instructions for pediatric and other special populations.

While we move forward in planning for the needs of children, we cannot forget the critical lessons learned during past events. In the aftermath of Hurricanes Katrina and Rita, HHS' Centers for Medicare & Medicaid Services (CMS) worked to ensure the portability of Medicaid and the Children's Health Insurance Program (CHIP) benefits for children and adults displaced by the disasters. Both Medicaid statute[1] and regulation[2] require State Medicaid agencies to have in place a mechanism for ensuring that Medicaid

[1] 1902(a)(16) of the Social Security Act.
[2] 42 CFR 431.52.

beneficiaries have access to care when they are out-of-state. Such State coordination typically happens in one of two ways:

1) A provider who furnishes services to a resident of another State temporarily enrolls in the Medicaid program of the individual's home State in order to receive reimbursement directly from the individual's home State, or
2) The host State provider can (pursuant to an interstate agreement) bill the host State as they would for any other Medicaid beneficiary, and then payments are later reconciled between the home State and the host State Medicaid programs.

Despite existing statutory and regulatory policies that accommodate the needs of Medicaid beneficiaries when away from home, the magnitude of devastation of Hurricanes Katrina and Rita posed unique problems for beneficiaries receiving out-of-state care. The Secretary signed a waiver, effective the day before Hurricane Katrina made landfall along the Gulf Coast that gave CMS the authority to waive normal rules and regulations to accommodate these special circumstances. CMS responded after Hurricane Katrina through a section 1115 demonstration project to ensure that displaced evacuees could receive services under Medicaid and CHIP in whatever State they were currently located.[3] Through this process, evacuees enrolled for up to five months in host-State Medicaid or CHIP programs and allowed the host-State to bill CMS directly for the cost of services provided to evacuees. CMS provided templates for the States to use in requesting a section 1115 demonstration project, and it deemed such demonstrations to be budget-neutral, to streamline approval. CMS also assigned designated casework staff to

[3] CMS State Medicaid and CHIP Directors Letter, September 16, 2005, SHO # 05-001, http://www.cms.hhs.gov/smdl/downloads/SHO091605.pdf.

work with all States hosting evacuees to ensure speedy access to Medicaid and CHIP benefits by those in need.

The work of CMS and of other HHS components on these portability concerns continues. In the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), Congress required the Secretary, through CMS, to develop a model process for the coordination of the enrollment, retention, and coverage under Medicaid and CHIP of children who frequently change their State of residency or otherwise are temporarily outside of their State of residency due to family migration, emergency evacuations, natural or other disasters, public health emergencies, or educational needs.[4] CMS is currently consulting with State Medicaid and CHIP directors and other stakeholders to fulfill this requirement and will produce a Report to Congress describing additional steps or authority that may be needed to make further improvements to coordinate the enrollment, retention, and coverage under Medicaid and CHIP. We anticipate these consultation efforts will enhance CMS's knowledge about ways to help improve the coordination of care for displaced children.

In the area of mental health, HHS has some significant initiatives that benefit children in the response and recovery phases of disasters. Effective disaster preparedness and response are an essential part of HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) public health responsibility.

[4] Children's Health Insurance Program Reauthorization Act of 2009, Section 213.

As you are aware SAMHSA has an interagency agreement with the Federal Emergency Management Administration (FEMA). Under the agreement, FEMA provides funds for Crisis Counseling Training and Assistance Program (CCP) and SAMHSA manages those funds and monitors their use. For over thirty years, the CCP has supported short-term, solutions-focused interventions with individuals and groups experiencing psychological and behavioral problems associated with large scale disasters. These interventions help disaster survivors understand their situation and reactions, mitigate against additional stress, help survivors review their options, promote mental health using specific evidence-based coping strategies, provide emotional support, and encourage links with other individuals and agencies able to help survivors recover to their pre-disaster level of functioning. As with many of SAMHSA's disaster related programs, these funds are geared to help States address the immediate needs of the affected communities until the State is capable of addressing the needs of its citizens.

In addition to the CCP, with which you are familiar, there are several other programs which help address ongoing mental health needs in local communities.

The *Children's Mental Health Initiative* provides funding to local communities to establish systems of care for children with serious emotional distress. The *Children and Violence Initiative*, carried out in conjunction with the Department of Education, provides funding to local education agencies to promote mental health and reduce violence in schools. The *Garrett Lee Smith State and Tribal Grants* provide funding to States to prevent youth suicides. The accompanying *Garrett Lee Smith Campus Grants* are

available to colleges and universities to address suicide. For several years we have funded efforts across the United States, including Louisiana, to address the effects of trauma on children through the *National Children's Trauma Service Initiative*. *LAUNCH* is a new program that promotes mental health among children under 8 years old. SAMHSA also funds *Homeless Programs* that support mental health services for adults and children who are or expect to be homeless, including supportive housing. Such grants are available from both the Center for Mental Health Services and the Center for Substance Abuse Treatment. The *Community Mental Health Service Block Grant* provides financial support to States to address the needs of adults for a serious mental illness and children with a serious emotional disturbance. And finally, the *Projects of Assistance in Transitioning from Homelessness* funds are available to States to provide mental health services to homeless individuals. More information on SAMHSA programs relative to disasters is included as an appendix to this testimony.

In a final note on mental health, my staff recently met with the staff of the NCCD to plan a coordinated response to the Commission's Interim Recommendations and the Disaster Mental Health Recommendations of the National Biodefense Science Board (NBSB). There is a great deal of synergy between the recommendations of the Commission and those of the NBSB on mental health issues. Close collaboration will be extremely beneficial to the implementation of strategies that better address the needs of children throughout each phase of disaster.

None of these efforts will have any impact without coordination between various involved agencies. ASPR has continued its commitment to take into account the needs of children in its plans for preparedness, response, and recovery through a number of coordination meetings and listening sessions with various federal and non-federal partners, including the American Academy of Pediatrics.

HHS' Administration for Children and Families (ACF) is fully committed to making children a priority at the highest level of response before, during, and after catastrophic disasters and emergency events. The agency is focused on promoting the recovery of children and their families affected by disasters and emergency events. As a whole, HHS disaster response and recovery efforts emphasize meeting the needs of children, one of our most vulnerable populations in times of crisis and emergency.

During disasters, ACF gathers information about the Head Start and child care programs, which serve children across the age range. 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 NCCD and has initiated programs and policies on a number of issues to ensure that children are given the attention they deserve before, during and after a disaster.

Throughout its Interim Report, the NCCD states that children are given less attention than necessary when disaster plans are written and exercised and that children must be considered and planned for as children. HHS recognizes that the needs of children are different when planning for disasters, and that they require different resources to assist them in recovering from disasters because they are far more than just "small adults." As part of HHS' commitment to the Commission's Interim recommendations, the agency has taken steps to help ensure that child care is addressed in both emergency preparedness planning, as well as disaster recovery and response efforts. However, much more needs to be done.

HHS supports the Commission's recommendations to require disaster planning capabilities for child care providers, and improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster. Child care provides critical support in helping families in the event of a disaster. For children, early childhood programs support healthy growth and development, which is especially important in an emergency. Parents need to know that their children are safe and supervised as they take steps to rebuild their lives.

For the Subcommittee's information, my statement today is appended with additional material specific to the Commission's recommendations that relate to ACF programs.

In closing, 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

affected by disasters and public health emergencies. We have made significant strides and we anticipate continuing this momentum in the future.

The Commission's report brings attention to the importance of children and offers many laudable recommendations. We recognize the continual need to improve our efforts and we look forward to working with the Subcommittee, the Commission, and other partners to do so. I would be happy to answer any questions.

Appendix 1

Substance Abuse and Mental Health Services Administration
Disaster Related Programs

Effective disaster preparedness and response are an essential part of SAMHSA's public health responsibility. SAMHSA was on the ground in Louisiana and elsewhere in the Gulf region within days of Hurricane Katrina. SAMHSA's practice and expectation is that it will be first to respond to a natural disaster with all available assistance it can provide. SAMHSA is concerned about adults and children who, at the time of a disaster, has a pre-existing mental health problem with no access to care or medications; those who may have developed a serious mental health problem as a result of the disaster; and those dealing with the depression of having lost family, friends, neighbors, neighborhoods, work and other familiarities of everyday life.

SAMHSA's disaster related programs are geared to help States address the immediate needs of the affected communities until the State is capable of addressing the needs of its citizens. Three programs specifically available to help individuals affected by natural disasters are described below.

- ***Crisis Counseling Training and Assistance Program (CCP):*** When it comes to disaster mental health services, SAMHSA's support comes primarily through an Interagency Agreement with Federal Emergency Management Agency (FEMA) which funds the SAMHSA-implemented and monitored Crisis Counseling Training and Assistance Program (CCP), a program authorized under Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974.

  For over thirty years, the CCP has supported *short-term*, solutions-focused interventions with individuals and groups experiencing psychological and behavioral problems associated with large scale disasters. These interventions help disaster survivors understand their situation and reactions, mitigate against additional stress, help survivors review their options, promote mental health using specific evidence-based coping strategies, provide emotional support, and encourage links with other individuals and agencies able to help survivors recover to their pre-disaster level of functioning. The Crisis Counseling Program uses an outreach model that includes, individual crisis counseling, group crisis counseling, public education, community networking and assessment and referral to reach those affected in a federally declared disaster area. The program includes both short-term (60 day) and long-term (9 month) grant funding. At the end of that period, the State becomes responsible for ongoing services. In some major cases that period is extended, but it is still the expectation that the State will right itself and serve those who are in need.

- ***SAMHSA Emergency Response Center (SERC):*** The SAMHSA Emergency Response Center, or SERC, was established to coordinate the overall Federal response for mental health and substance abuse issues around Katrina. In the days, weeks, and months immediately following Katrina, the SERC operated 12 hours a day, seven days a week at the height of the disaster.

- ***National Suicide Prevention Lifeline:*** When faced with the effects of a natural disaster, many become depressed and unfortunately too often think about or even try to commit suicide to avoid the pain. SAMHSA runs a Suicide Prevention national hotline that is connected to over 140 crisis centers to address the needs of individuals and to connect them with services.

Appendix 2

National Commission on Children and Disasters Recommendations Relative to the HHS Administration for Children and Families.

The Commission's recommendations specifically relate to the following ACF program areas:

1) Child Care;
2) Disaster Case Management; and
3) Child Welfare.

Child Care

The Commission's interim recommendations related to child care require States to develop comprehensive disaster plans for child care to ensure coordination with key stakeholders, including public health and child care resource and referral agencies. The ACF Child Care Bureau (CCB) has already taken some initial steps by providing technical assistance on emergency planning and asking States to report on disaster preparedness efforts in their State Plans for the Child Care and Development Fund (CCDF) program. In addition, ACF supports the Commission's recommendations to require disaster planning capabilities for child care providers, and improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster. The CCB also developed the Child Care Resources for Disasters and Emergencies Web site. The site is available at http://nccic.acf.hhs.gov/emergency. The site includes a wide range of information and resources about emergency preparedness, disaster and emergency response efforts, recovery resources, and lessons learned.

Disaster Case Management

ACF's approach to disaster case management seeks to assist States in rapidly connecting children, families, the elderly, and persons with disabilities with critical services that can restore them to a pre-disaster level of self-sufficiency that maintains clients' human dignity. The ACF model is based on five principles: self-determination, self-sufficiency, Federalism, flexibility and speed, and support to the States. The Commission recommended establishment of a holistic federal disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a Presidentially-declared disaster area. ACF agrees, and on December 1, 2009 ACF and FEMA signed an Interagency Agreement to allow for implementation of the ACF Disaster Case Management Program after a future major disaster has been declared by the President. We believe this program is fully consistent with the Commission's recommendation.

Child Welfare

Although State welfare agencies are required to have disaster plans, the Commission recommends that guidance, technical assistance, and model plans be provided to assist State and local child welfare agencies in meeting currently applicable disaster planning requirements and further require collaboration with State and local emergency management, courts and other key stakeholders.

Toward the goals of this recommendation, ACF's Children's Bureau (CB) Training and Technical Assistance Network proactively addresses disaster preparedness, response and recovery by providing onsite technical assistance and by developing a variety of materials, disseminated through the National Resource Centers' newsletters, websites, web casts, list serves and technical assistance. A link to the Children's Bureau Training and Technical Assistance Network can be found at http://www.acf.hhs.gov/programs/cb/tta/index.htm.

The client population served by the CB programs includes children who are particularly vulnerable and at risk due to abuse and neglect. Many of these children are already separated from birth parents or family members and may be in the custody of the State child welfare agency and placed in temporary foster homes. The Children's Bureau has worked with ACF Regional Offices and the State child welfare agencies and courts to build disaster preparedness, response and recovery plans. After the 2005 hurricanes, the CB National Resource Centers received additional funding to help States address their training and technical assistance needs and to promote disaster preparedness by State child welfare agencies.

Other initiatives and activities developed and implemented by ACF related to children and disasters include:

Office of Head Start

The Office of Head Start (OHS) has printed and will disseminate the Head Start Emergency Preparedness Manual this month. The manual will also be available for download on the Early Childhood Learning and Knowledge Center website. The manual focuses on planning for emergencies and offers grantees a wide variety of tools for assessing risks, identifying resources, and developing action plans. The manual was reviewed by the ACF Office of Emergency Preparedness.

On December 3, 2009, OHS conducted a webcast on Emergency Preparedness. The webcast featured information about the phases of emergency preparedness, including: 1) Impact: How Head Start and Early Head Start programs across the country cope with disaster while it is occurring; 2) Relief and Recovery: How Head Start and Early Head Start programs resume services and help children and families get back on their feet; and 3) Planning and Practice: How you can plan and practice your strategy to respond to a variety of potential crises that may impact Head Start programs. The website was viewed by approximately 1,400 sites across the country.

Family and Youth Services Bureau

The Family and Youth Services Bureau (FYSB) developed a disaster planning guidance document for the Runaway and Homeless Youth program. FYSB has taken the "P's and

R's" approach to planning (Prevention and Preparedness, Response and Recovery). The document is called *Ready for Anything: A Disaster Planning Manual for Runaway and Homeless Youth Programs*