NACCD NATIONAL ADVISORY COMMITTEE ON CHILDREN AND DISASTERS

PUBLIC MEETING TRANSCRIPT

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Capt. Charlotte Spires: Good morning. I would like to call this meeting to order. Welcome everyone to our National Advisory Committee on Children and Disasters public meeting. I'd like to welcome our NACCD, that's the acronym for National Advisory Committee on Children and Disasters, members, our ex-officios, our federal officials, and members of the public, welcome to this meeting.

I am Captain Charlotte Spires, the Executive Director of the NACCD. I also serve as the designated federal official for this federal advisory committee. The purpose of this public meeting is to ceremonially inaugurate the members of this new federal advisory committee, the NACCD. Before we move into introductions, I'd like to read the Federal Advisory Committee Act overview and conflict of interest rules.

The National Advisory Committee on Children and Disasters is an advisory board that is governed by the Federal Advisory Committee Act, or FACA. The FACA is a statute that controls the circumstances by which agencies or offices of the federal government can establish or control committees or groups to obtain advice or recommendation where one or more members of the group are not federal employees.

The majority of the work of the NACCD, including information gathering, the drafting of reports, and the development of recommendations is being performed not only by the full board, but by the working groups for the subcommittees who in turn report directly to the Board. Regarding the conflict of interest rules, the standards of ethical conduct for employees of the executive branch document has been received by all board members, who as special government employees and federal employees are subject to conflict of interest rules and regulations therein.

Board members provide information about their professional, personal, and financial interests. This information is used to assess real, potential, or apparent conflicts of interest that would compromise members' ability to be objective in giving advice during board meetings. Board members must be attentive during meetings to the possibility that an issue may arise that could affect or appear to affect their interests in a specific way.

Should this happen, it will be asked that the affected member recuse himself or herself from the discussion by refraining from making comments and leaving the meeting. Please note that this meeting is conducted via teleconference and webinar. Please visit our Web site at www.phe.gov/naccd for instructions on how to call in and log in to access this meeting.

The public has been notified to send in any comments using NACCD's form available on our Web site at www.phe.gov/naccdcomments. Public comment will only be received via form. Please refer to the agenda and website for the details of today's meeting. Written comments must be sent in before the meeting by using these forms. As a reminder, meeting summary and transcript will be made available on our website subsequent to this meeting.

Now before we begin today's meeting, I would like to ask Lieutenant Commander Jyl Woolfolk to take roll call. Sir, if you will call the names of the NACCD voting members, followed by the ex officio members, when she calls your name, please respond. If you are a designated alternate, please provide your name, and while Commander Woolfolk is preparing the roll call, I would like to announce a change in our agenda.

Before I introduce Dr. Kaplowitz, which I will after the roll call, I'd like to announce that Dr. Lurie will be delayed this morning due to a meeting that she was called to related to the Ebola situation. Therefore Dr. Kaplowitz will do her presentation. Then she will introduce Senator Mikulski's video. Dr. Lurie is slated to begin her presentation at 10 o'clock am, and public comments will be read at 10:45.

We anticipate adjournment of this meeting at 11 o'clock versus 11:45 as originally scheduled, and you all know that in this environment, these sorts of things happen, and so we look forward to seeing Dr. Lurie at 10 o'clock. Commander Woolfolk, are you ready to do the roll call.

Jyl Woolfolk: Yes, ma'am. Good morning, all. When I call your name, please confirm your attendance by saying present. Alex Amparo.

Alex Amparo: Here

Jyl Woolfolk: Michael Anderson.

Michael Anderson: Here.

Jyl Woolfolk: Allison Blake.

Allison Blake: Present.

Jyl Woolfolk: Thank you. David Esquith.

David Esquith: Present.

Jyl Woolfolk: Robin Gurwitch.

Robin Gurwitch: Present.

Jyl Woolfolk: Lisa Kaplowitz.

Lisa Kaplowitz: Present.

Jyl Woolfolk: Linda MacIntyre.

Linda MacIntyre: Present.

Jyl Woolfolk: Dianne Murphy.

Dianne Murphy: Present.

Jyl Woolfolk: Scott Needle.

Scott Needle: Present.

Jyl Woolfolk: Sarah Park.

Sarah Park: Present.

Jyl Woolfolk: Georgina Peacock.

Georgina Peacock: Present.

Jyl Woolfolk: Sally Philips.

Sally Philips: Present.

Jyl Woolfolk: Mary Riley.

Mary Riley: Present.

Jyl Woolfolk: Jeffrey Upperman.

Jeffrey Upperman: Present.

Jyl Woolfolk: Anne Zajicek.

Anne Zajicek: Present.

Jyl Woolfolk: I understand Gary Disbrow is still excused. Thank you.

Capt. Charlotte Spires: All right. That concludes our roll call, and we do have a quorum of member's present, thank you all. Now at this time I would like to introduce Dr. Lisa Kaplowitz. Lisa Kaplowitz is the Deputy Assistant Secretary for policy in the Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Health and Human Services, a position she has held since March of 2010.

In this position, Dr. Kaplowitz is responsible for directing and coordinating policy and strategic planning for all components of the office of the ASPR. Prior to joining the U.S. Department of Health and Human Services, Dr. Kaplowitz was director of the health department for the city of Alexandria in northern Virginia from July 2008 until February 2010. As health director in Alexandria, she was responsible for all public health activities and was also very involved in emergency preparedness in the national capital region, serving as chair of the health and medical regional planning working group of the metropolitan Washington capital of government.

From 2002 until July 2008, Dr. Kaplowitz was Deputy Commissioner for Emergency Preparedness and Response in the Virginia department of health. She was responsible for the development and implementation of Virginia public health response to all natural and manmade emergencies in coordination with hospitals, health care system and emergency response organizations in Virginia and the national capital region.

Prior to joining the Virginia department of health, Dr. Kaplowitz was a faculty member in the department of medicine at Virginia Commonwealth University and director of the VCU HIV/AIDS center. She also was Medical Director of Telemedicine and Ambulatory Care for the VCU health system. She obtained her MD degree from the University Of Chicago Pritzker School Of Medicine and completed her residency in internal medicine and fellowship in infectious diseases at the University of North Carolina in Chapel Hill.

She was a health policy fellow with the Institute of Medicine in Washington, DC in 2000, in 1996 to '97, working in Senator Jay Rockefeller's office on health financing end of life care. Dr. Kaplowitz completed a Master's of Science in Health Administration at VCU in 2002. In addition to public health and emergency preparedness, she has a strong interest in public policy, health care financing, and improving access to health care. Thank you, and now I would like to turn this mic over to Dr. Lisa Kaplowitz.

Lisa Kaplowitz: You want me to stand up there, or can I sit here?

Capt. Charlotte Spires: I think you could sit there.

((Crosstalk))

Lisa Kaplowitz: Okay, so thank you very much, Captain Spires. Makes me sound like I couldn't quite make up my mind where I wanted to be, but there is a rational succession to this, really. So I've done a little modification knowing that Dr. Lurie can't be here until 10 o'clock, so what I decided to do was to give an overview of ASPR very quick, and an overview of what we do in my office in policy, but also because of unfortunately Dr. Disbrow couldn't be here, I wanted to give an overview of the Public Health Emergency Medical Countermeasure Enterprise.

And I'm pleased to see Dr. George Korch here, so he can correct me if I don't get it quite right, but Doctor...

George Korch: You'll do perfect, no question.

Lisa Kaplowitz: Dr. Korch and I co-chair the Enterprise Executive Committee of *unintelligible*, so let's see if I can push this right. Okay, I think many people know this, but the Office of the Assistant Secretary for Preparedness and Response really was created with the Pandemic and All Hazards Preparedness Act of 2006, and she serves as the chief advisor to the Secretary of HHS for all emergencies or disasters impacting health and public health.

And we know that all disasters have a health component, including behavioral health issues. So we are responding to virtually any emergency or disaster. We have a key coordinating role within HHS for medical and public health response, plus major policy issues, and we collaborate very, very broadly across the departments, across the federal government, with the White House, Congress, and with state and local groups, both public health, health care, and emergency management as well as the private sector and non-governmental organizations, so we work with everybody.

We also have an international component that I'll talk about in my office working on biosafety, biosecurity and medical countermeasure issues internationally. So this is just a chart of the Office of the Assistant Secretary for Preparedness and Response. While we have six offices, two are clearly operational. The Office of Emergency Management is responsible for response and recovery directly, often directly sending teams to areas impacted.

And they're responsible for the hospital preparedness program, and you'll be hearing a great deal about that as time goes on, I'm sure. Then there's the Biomedical Advanced Research and Development Authority (BARDA), works very, very closely with other parts of government but also with the private sector pharmaceutical companies and biomedical companies in advanced research and development of medical countermeasures.

A gap that has been filled by BARDA and has been very important in the development of key medical countermeasures. My office was developed when I came on board March of 2010 to address policy issues across the whole spectrum of emergency preparedness and response. And just to cover briefly what we have in policy component of ASPR, we certainly deal with strategic policy, strategic planning and policy overall including the national health security strategy that I'll talk about in a minute.

We have our Medical Countermeasures, Strategy, and Requirements, called MCSR, and MCSR is key in developing all the requirements for our medical countermeasures. You've heard a great deal about the At-risk Behavioral Health and Community resilience group (ABC) run by Dan Dodgen. Biosafety, biosecurity, that group addresses safety and security at laboratories, both domestically and internationally.

We have a division of international health security, and this is the group that has put in so much work in sharing both medical countermeasures internationally as well as addressing sharing of personnel, which has become key since Haiti, and sharing of medical countermeasures, this was mainly triggered by H1N1, where the President made a commitment to share vaccines, but we realized that there wasn't a system in place to do that.

It took nine months to put that in place, and I'm proud to say that we can now share medical countermeasures and get them to other parts of the world within 24 hours of a request. There's a whole process for that, but we work very quickly. The Division of Health System Policy is relatively new as well, headed by Dr. Gregg Margolis, looking at the whole scope of emergency care, and we know that's not just EMS and emergency rooms.

It's the entire health system, and how can that work most effectively, and this includes the emergency care coordination center looking at the spectrum of emergency care, and also we have the national advisory committee, so this is a very interesting position for me to be in, to be on the committee but also have responsibility for the running of the committee, but I will leave that to Captain Spires.

She is superb and I don't have to worry about that. So we had about 65 FTEs and a number of contractors. We do a lot with relatively few resources. The National Health Security Strategy (NHSS) is a key document for all of ASPR and all of health and public health emergency preparedness and response. This was also mandated by PAHPA, 2006. The first NHSS was released in 2009.

The next iteration will be released by the end of calendar year '14 this year, along with an evaluation of the first NHSS and then the patient plan, and after that it will be every four year cycle. This has never been done before. We actually define national health security, and this will change. We had two key goals for the first NHSS and ten objectives. We're going to have five objectives in the next NHSS and really streamline the process.

Part of the challenge is realizing we can't do everything, and we try very hard in the implementation plan to not say we can do everything, but we said we could do a lot, and we have to be realistic because we know resources aren't going to be increased. So you can anticipate the next NHSS very soon. We actually have drafts that are circulating, and set the roadmap for national health security.

So Dr. Lurie may cover this as she talks about this a lot. Where are we heading in ASPR? We know we have to invest in building resilient communities, modernizing the medical countermeasure enterprise, the entire countermeasure enterprise that I'll talk about in a few minutes, and strengthening health care coalitions and the emergency response system. These are our key goals, and we're committed to innovation, sustainability, strengthening day to day systems.

If we have strong day to day systems, they will work in emergencies. We don't want systems that we only look toward when we have emergency events. Evidence-based decision making is key and continuous improvement, so these are what we're committed to in ASPR. I'll be glad to answer questions afterwards, but what I wanted to do was give an overview, you can find out about us through many, many different channels.

Our website, www.phe.gov, is really quite comprehensive, and we do twitter feeds whenever there's an event. We have ongoing Twitter dialogue through our communication group, but we've really tried to adopt social media to get our message out. At www.phe.gov , you can get all this information, and you can find the NHSS and a large number of documents there. I did want to give an introduction to the public health emergency medical countermeasures enterprise because you'll be hearing about this a great deal over the next four years.

And as you'll see, we have a major, major commitment to meeting the needs of the entire population, including vulnerable populations and absolutely including children. So this is a federal coordinating body led by HHS that protects the U.S. civilian population from national health security threats through the use of medical countermeasures. And medical countermeasures are broad. They're medicines, devices, other medical interventions that can lessen the harmful effects of threats.

We are not only addressing CBRN, chemical, biologic, radiologic and nuclear agents, but we are continuing to stand in addressing emerging infectious diseases, and this certainly includes influenza and there's no doubt it includes Ebola, and as I'll talk about in a minute, antibiotic resistant bacteria are absolutely included in what we're starting to address. I'll get in a minute to member agencies. They're not only within HHS, but also the department of defense, DHS, the veteran's administration, and USDA, all of which are very involved in medical countermeasure development, use, and monitoring.

I give this as just a bit of a timeline. It's not up to date, because we have PAHPA that passed, we have the authorization of PAHPA passed in 2013, but a great deal has happened since the anthrax attacks of 2001, and this triggered a lot of subsequent events, including the bioterrorism act and biosecurity act, the establishment of Project Bioshield, the establishment of ASPR, the establishment of BARDA, that always was part of PAHPA, but pre-existed PAHPA in many forms before that.

We work with many executive orders and directives and we weave this all into the medical countermeasure enterprise. And we talk about the entire spectrum of medical countermeasure development and use, starting with very basic research, then advanced research, then development of medical countermeasures, positioning, administering, and now with a new group, looking at monitoring of both the impact and the possible side effects of medical countermeasures.

So this is our newest diagram to try to illustrate the engagement within the PHEMCE, and we will get these slides to you, but what we want to demonstrate here is the involvement of different components in HHS, you know, the CDC, FDA, NIH, ASPR, BARDA, specifically, as well as the engagement of the department of defense which we know has been very engaged in medical countermeasures development for many years, and we really focus on not duplicating efforts.

We have limited resources. We don't want to be duplicating what we're doing for the civilian population with what the Department of Defense is focused for at the military. The veterans'

administration is engaged, DHS, and Sally's on a number of these groups, as well as USDA and it's been an incredibly positive process and has been evolving. You came onboard, George, about a year before I did.

George Korch: 2009, four weeks before H1N1 started up, so...

Lisa Kaplowitz: And...

George Korch: Timing is everything.

Lisa Kaplowitz: George has been instrumental in getting us through the whole you know, really development of defense itself. So what are the missions? We have to set requirements. What is it we actually need? And that is done in close partnership with DHS that does the material threat assessments and really threat determinations. Then early stage research, much of this is funded by the NIH but not all.

Some is occurring through private companies. Advanced development and manufacturing is a key part of what BARDA does. They work very closely with pharmaceutical companies and small biomedical companies to help the development of medical countermeasures, many of which have no commercial use, and this is a big challenge, assuring that we have MCMs even though they're not going to be sold in the marketplace.

Regulatory science is key, and the FDA is an integral part of this, and I didn't mention the FDA, you should have told me. But this is absolutely key. We work with the FDA from the very beginning. Companies work with the FDA and it's been a great partnership, sorry about that.

Dianne Murphy: That's okay.

((Crosstalk))

Lisa Kaplowitz: I know. They quietly do a great job. Procurement, inventory management, and stockpiling, I think many of you have heard of the Strategic National Stockpile, which is a stockpile of medical countermeasures available during times of emergency, focused on CBRN, but broadening out and the stockpile is the responsibility of the Centers for Disease Control, but everything that they do is in partnership with the entire PHEMCE.

The response planning, policy guidance and communication, much of this is the CDC in partnership with states and localities. We depend on states and localities for the actual distribution and dispensing of medical countermeasures, and so it's key that we maintain that

partnership as well. And we just developed a new group to look at monitoring evaluation and assessment, the last step, but very important.

Are our medical countermeasures actually working and what are the toxicities that we're seeing? This is a governance structure. Again, George Korch and I co-chair the Enterprise Executive Committee, but it's really high level leadership that makes the decisions with the enterprise senior counsel, chaired by Dr. Lurie with key leadership from all the PHEMCE departments.

And then below that we have all the people who do the actual work and put together the requirements and they do a phenomenal job, and each of these groups has representation from across the PHEMCE. These are the integrated program teams, but we have had the new one for monitoring and evaluation, and will probably look for how we integrate antimicrobial resistance into this as well.

So what started as a focus on specific threats is now much more cross-cutting, with the diagnostics, ITT, and Dan mentioned the pediatric and obstetric ITT. This has been absolutely key, looking very broadly at the needs of children, and they work closely with every one of these teams as well, and then we'll be adding monitoring and evaluation.

So I'm going to talk a little bit about the strategy and implementation plan. This was released at the end of 2012. There's now a mandate through PAHPA reauthorization that this be updated every year. We're now working on the 2014 iteration, and it really is an incredible document, and available to all of you. We're required also to do an annual review of the Strategic National Stockpile, and this involves not only the CDC but the entire PHEMCE, and an assessment of what's in there and what is it we actually need and what can we do with an ever-decreasing budget, which is quite a challenge.

Every 18 months, I'll talk about this, we do reviews of entire portfolios for different threats. We now have a mandate to deliver to Congress a multi-year budget plan. This doesn't change how the different components of the PHEMCE are actually funded. What it does is it looks at the funding across the entire spectrum and gives us a much better idea of how to plan, starting from you know, basic research all the way through monitoring and evaluation.

And George has the thrill of being in charge of that as well. Our tracking tool, we track everything monthly, right? Monthly and everybody is held accountable for something, and believe me, they have to be on the ball and have to report what they're doing, and it's made a big difference in showing that we actually are serious about our plans and implementation of them.

So I talked about the strategy and implementation. The strategy defines mission scope, goals, and objectives, and the implementation plan in December 2012 prioritized programs to accomplish these goals and objectives, and again, these will be re-evaluated annually. Here are the four goals. There are four PHEMCE strategic goals, and I want to point out goal four, which is absolutely key, addressing medical countermeasure gaps for all sectors of the American civilian population.

And children have been a major, major component of this. PHEMCE has really focused a great deal on addressing needs of vulnerable populations, and again, not only children but pregnant women as well are populations that happen frequently haven't been factored in, and this includes everything from the actual development of medical countermeasures for children, to how are we going to use them, down to how do we crush pills and what do we mix through them, and you know, who do we need liquid formulations for, not only for children, but we know that there are many adults who can't swallow pills as well, and this has been a big challenge.

I've listed high priority threats here. I want to point out that more and more we're looking at emerging infectious diseases. The focus initially, pandemic influenza, but antibiotic resistant bacteria are getting a lot of attention. It's an initiative coming out of the White House as well, and of course we have viral hemorrhagic fever as it seems to be moving up in terms of priority.

Many have recognized for years that this is an issue, including George, who has worked on that on many other things along the way. The annual review is a requirement of PAHPA. It has to be delivered to the Director of the Office of Management and Budget, and the assistant to the president of homeland security and counter-terrorism, and with reauthorization, it also will be shared with Congress, not that we want to keep anything from Congress, but they felt they needed to put it in the legislation.

So this is an annual review that goes through an entire process, starting with what's in the stockpile now and then going to all the program teams to assess if anything needs to be changed over time, and this is matched with upcoming budgets, so this year's annual review will be looking at FY16 or 17, I would think, 17. So last year's review was matched with what we anticipated to be the FY16 budget.

This is a major, major, major challenge because we have to predict where we're heading. Where we know we're heading, where we're not heading is increased funding.

George Korch: The Secretary just signed out fiscal year 16 review yesterday, so very propitious for us today, but that was a year's worth of work, and yesterday was signed out finally.

Lisa Kaplowitz: And that will be matched with the President's budget for FY16 that we're very engaged in now. So there really is a strong effort and timeliness to the budget, which is incredibly painful, because our needs far outstrip what we are able to fund, and each year we have to guess where we're heading, and we're not heading up. I think the optimists think we're over funded, so portfolio reviews are key.

We bring everybody together to address what's happening for any specific threat. We've now been through portfolio reviews for all the threats and we're heading into a second cycle, every 18 months, and this is absolutely key. Out of the portfolio reviews grow the priority action items. So what is it we really need to look at over the next 18 months, and then that is tracked until the next portfolio review.

Multi-year budgeting, I talked about this a little bit. It's a challenge because unlike I guess the Department of Defense, we can't really look at this as a composite budget. We know that the components of the PHEMCE are still going to be funded separately, but the effort here is to look at the big picture and where we're heading, so the first multi-year budget will be delivered sometime soon, sometime soon, in process.

So again I wanted to give you the Web site. You can get the strategy and implementation plans here. The 2014 will be released before the end of the year and delivered to Congress and will be annually after that. I think I ended the slides here, and I'm really glad George is here, so if there are any questions on the PHEMCE I can't answer, I'd be glad to refer them to Dr. Korch. I don't know if people know, but you were in the Army for 32 years?

George Korch: Twenty-two.

Lisa Kaplowitz: Oh, 22.

George Korch: I think I served with a few members of the Board, at least helped some of the members of the board.

Lisa Kaplowitz: And at various points he has been hands on scientist, and done some incredible work. We're very fortunate to have George on board as a key resource, and I'm glad he's here. Yes.

((Crosstalk))

David Esquith: Lisa, you mentioned budget a number of times.

Capt. Charlotte Spires: Oh, oh, introduce yourself.

David Esquith: Oh, I'm sorry, David Esquith with the Department of Education. You mentioned budget a number of times. What is ASPR's budget and where does the money go?

Lisa Kaplowitz: ASPR's budget is part of HHS's budget, so it comes from the appropriations part of the labor committee. Where it goes, it includes funding of BARDA, and that's quite significant because BARDA has contracts with many pharmaceutical and biotech companies for their advanced research and development. They also have a couple of facilities that they have actually funded to build and to run to serve as search facilities in times of emergency.

So the BARDA budget is quite significant and it's incorporated in ASPR's budget. It includes the grant program for the hospital preparedness program, and those funds go to state health departments and then to coalitions, health care coalitions throughout the country. So we have that grant program. It also funds the National Disaster Medical System (NDMS) that you'll hear about over time, which is the system that actually responds when requested by states in terms of providing medical assistance, but not only medical, behavioral health, but also mortuary assistance.

And let me see, a whole list, obviously we're funding the operations. We're funding my policy group, which isn't that much in terms of budget, but we do a lot with very little, and it funds the Secretary's operations center. And I'm sure we could arrange at some point for tours of the secretary's operations center. I mean, this is the operations center for HHS, and it is in the Secretary's suite.

It was built after 9/11 to be right there and accessible to the Secretary. It is staffed 24/7/365, works very closely with DHS and FEMA's operations center. Also CDC has an emergency operations center and, again very close partnership. So running at the Secretary's operations center is a major process as well. I'm trying to think, we now have a recovery office, so it's not only preparedness and response, but we've had significant investment in recovery as well for health and medical. Okay, what am I forgetting?

George Korch: I think you mentioned the National Disaster Medical System.

Lisa Kaplowitz: Yes, National Disaster Medical System is key. Those are teams of health care providers who can be called in and are special government employees when they're called

up. They can be sent to any part of the country. They were also engaged in the Haiti response, which was the first time those teams went abroad. So and those are individuals who've been you know, highly trained to respond to emergencies.

And we have two people here who were on NDMS team. Okay, Dr. Anderson, and the members of NDMS, the team, so I know that you'll be hearing more about them. Do you want to say anything, either of you, about...?

Mike Anderson: Andy Garrett is the, it's Mike Anderson, Andy Garrett is the Director of NDMS. I believe he's briefing us at some point. I think...

Lisa Kaplowitz: At some point. And he's a pediatrician.

Mike Anderson: So we're slowly but surely taking over the world, which is a great, I think it's wonderful if you look at whether it's medical countermeasures or NDMS or Dr. Dodgen's group, the amount of pediatric issues being addressed, you know. Dr. Garrett came after a group of sub-specialists to form a low core team. Dr. Upperman is a pediatric trauma surgeon. I am an intensive care doc. So I think that NDMS is an example of how the federal government has reached out to NGOs saying, help us figure this out.

Lisa Kaplowitz: And now you know, focusing on this Haiti was a real lesson in the need for pediatric specialists. Were either of you deployed to Haiti?

Jeffrey Upperman: I, this is Jeffrey Upperman. I deployed teams from our facility. My boss actually was one of the first. He's a native Haitian who speaks petwa. He was there, but I want to amplify a little bit on Dr. Anderson's comments. The pilot program that we were part of in the NDMS was we weren't regular NDMS response team members.

We were on a special pilot group of specialists who were identified as being key to not only figuring out our strategic problems, but any tactical planning with regard to Haiti and others that we assumed that what we had all that we needed.

And I don't know the full complement of NDMS, but I know peds was not as robust as it needed to be for the Haiti response, and therefore they felt that they needed to sort of have a list of folks to be ready. We were never deployed or engaged in anything post-Haiti, but that pilot still exists and we think it'll be important going forward.

Lisa Kaplowitz: And NDMS has come a long way to be more flexible, more you know, quicker to respond. I will tell you that during hurricane Sandy, the director of NDMS, Don Boyce, was in New York and was able to have teams in the city within four hours of a request,

and this has really changed dramatically. In the past it's been, you can count on federal assets arriving after 72 hours, and that wasn't acceptable for Mr. Boyce, so he had teams that were pre-deployed in New Jersey who were able to be in the city within four hours.

So increased flexibility, more rapid movement, increased - much better management of warehouses and supplies, which is something that's changed, you know, even since I've been on board, so it's come a very long way, and again behavioral health teams have been very valuable. Mortuary teams are also unfortunately you know, the ones in greatest demand. So it's really a very important system that's come a long way.

David Esquith: This is David Esquith. If I could just follow up, and I apologize if we already have this, but I'm interested in the actual numbers of what the budget is, what the programs are, and what their funding levels are. Could we get a spreadsheet with that at some point?

Lisa Kaplowitz: We can provide you with that information.

David Esquith: That'd be great. I think it'd be helpful.

Mike Anderson: It's Mike Anderson again, so Lisa, a wonderful presentation on the overview of ASPR and all the great work that has moved pediatric issues forward. I think as our committee is ramping up and trying to pick up the great swath of things that we'd like to look at, and the sea is very big of potential issues.

It may not be a question for today, but having you on the committee I think is key on Dr. Murphy as well to figure out what can we do better. What's the gaps that remain, because we've done great work, but as your colleague and mine always taught me, you know, continue to figure out where we can get better, how we can continue to improve capacity.

So it's not really a finite question for this morning, but obviously one of the tasks of our committee is to figure out, what are the things we can improve on, so four years from now when we continue to advise the Secretary that we feel even better about the progress that's been made, so more of a longer term question.

Lisa Kaplowitz: Absolutely, and part of that, I know has been addressed in the child report, but it's an ongoing process, and this is where we need input as well, and where are their needs that we may not have recognized? We feel as though we really have come a long, long way in addressing the needs of children.

When I was wearing my state hat I can tell you I was enormously frustrated about how little was happening, and it was on the states and localities to try to figure stuff out, and having much, much better support and guidance from the Federal government I think has helped. I'm not out in the states anymore, but they tell me it's better.

Certainly H1N1 was also key you know, event in terms of demonstrating the importance of reaching children as well as pregnant women, and the absolutely importance of schools. I was very proud of the fact that we went into every school in the city of Alexandria, you know. We had the public schools and then the private schools. I was telling somebody, initially said oh, we don't need the health department until the parents started saying wait, wait, wait, wait.

Why aren't we getting the same kind of support that the public schools are getting, that we were in all the private schools? So it's a key step. It's unfortunate that from a budget cutbacks perspective, much of that couldn't continue in terms of what we were able to do in schools. Do you have a question?

Capt. Charlotte Spires: Are there any other questions for Dr. Kaplowitz?

Lisa Kaplowitz: I will definitely need you. I have access to all my colleagues in ASPR. It's been an incredible 4 ½ years for me, and it's absolutely essential that, I was going to bring this up, before I knew I was changing gears a little, but when I took this position, I challenged myself to really figure out what is the federal role in all this, and I'll put that to the committee, because there are things that the federal government can do.

It can help states and localities, and then there's things that may not quite be in the federal role, but we need a lot of feedback on that, because all of us at the federal level recognize it's not our job to get out and do everything, but it is our job to be supportive, to put guidelines out. There's a great deal that we can do, so that's a challenge I'll put out there.

Making clear that this has to always be a collaborative effort. All emergencies are local, at least they start off local, so how do we build from what the locality does to what the state does to what the federal government does, and really work in a coordinated way? I think we've come a long way since Hurricane Katrina, which is kind of maybe a bit above low point over the past 15 years, but I'm sure that there's more that we can do.

Alex Amparo: This is Alex Amparo with FEMA. I just wanted to comment a little bit on that last comment that you made, which I think is very thoughtful and insightful in terms of what exactly is the federal role. It certainly does play a role, at least for the agency that I represent

when it comes to disasters. For instance is, you know day to day millions of people are fed by the private sector.

Yet when disaster happens there is a, in many believe in expectation that maybe that's a government role to see. And so we really work to switch that view and bring in the partners that do things, the business cases that if they do it on a day to day basis, then they can do it during the disaster as well. I think this is very applicable to what we're talking about now, NDMS being an example, of you know, care that's provided day to day. And then what do we do in disasters and how do we bring those resources and those folks that have that experience to bear?

Lisa Kaplowitz: Absolutely. I mean, there are so many initiatives in ASPR, but one for response is reaching out to pharmacies, you know? Because people need prescriptions and it's just not going to work, right? Somehow there are some people who think that everything's in this Strategic National Stockpile.

Well, it's not but pharmacies can be incredibly valuable in making sure people have access to prescription drugs, that they have the records so we know what people are taking, so that's just one partnership, partnership with insurance companies and funders, partnership, most health care is private sector. It's not federal, it's not public, and so anything we do with the health care system is engaging the private sector. And the partnerships have gotten better, but they have a ways to go.

Dianne Murphy: Let me follow up on that, because I think one of the things that...

Capt. Charlotte Spires: Just introduce yourself.

Dianne Murphy: Dianne Murphy, yes. One of the things the committee needs to know is that we have to buy information as a government sometimes. Just for example, you mentioned the pharmacies. As the food and drug administration, you want to know how much of a product has been used because we want to know, what's the, you know, you're having a lot of adverse events.

If you've got a lot of use, so if you have a lot of adverse events and you don't have very much use, and we buy that information, and so we do work with pharmacies, and we do, I just think that people have to realize one of the things I think will happen here is the education of how much of a role the government can and cannot play and how we have to leverage these private enterprise and systems that are out there.

Because you know, all these big, CVS, I'll just pick on them, they have huge distribution systems. So I think those are the sort of things we need to be thinking about also when we're talking about leveraging, because you don't want to just say, oh, we're going to come in, buy something and drop it off and then as you said there's no way we'll have everything in it or the needs for everybody.

And so it's sort of that you know, instead of feeding somebody, teach them how to feed themselves, so that type of mindset I think has to be part of engaging others in our recommendations. Thank you.

Mike Anderson: Can I ask a naïve question of the group, then, to that point? Mike Anderson again, because I think that's a great point. I'm sort of scribbling all the amazing sub-committees, I think I'm up to 47 sub-committees, so we could be in trouble. If I went to the board of pharmaceutical company X, I won't pick on a particular one, or food manufacturer distributor Y, is this on their radar? I mean, this is a general, I don't, is it on the radar? Dr. Upperman, do you believe it is?

Jeffrey Upperman: Hey, it's Jeffrey Upperman, simply responding that we've had numerous public hearings, commissions, and they've been at the table. I'm reminded of one IOM session and we had one such agency there talking about their global security plan, and they talked about this stockpiling at this event. So I think from protecting their bottom line, to protecting the folks that they are housing or the folks they're serving, they're worried about that as it affects their bottom line. But I think it sort of runs in parallel to what federal interests would be as well.

Lisa Kaplowitz: I think in many cases they are engaged. I mean, there's always going to be exceptions, but again, going back to state and local, I mean, they did engage in setting up pods and working with local health departments and doing things that the public sector can't do. So and it's variable around the country.

Capt. Charlotte Spires: Thank you all for the questions and then the wonderful comments. I think that was an excellent discussion. Dr. Kaplowitz, could you introduce Senator Mikulski's video for us?

Lisa Kaplowitz: Right, right. Well, we had hoped that Senator Mikulski could be here. She felt very, very, very strongly about having this committee, specifically focused on children in disasters. I am so pleased to introduce a short welcome video from a steadfast advocate for the value of this committee. I wanted the individual that was instrumental in making it a reality, Senator Barbara Mikulski.

She came to Congress with a career in social work under her belt and carries practical and compassionate perspectives throughout her work in Congress. She has had a long and distinguished career in the U.S. Senate. She is the longest of any woman in our history to be in the Senate, and currently serves on several key committees and sub-committees, including the Senate health education labor and pensions committee, and chairs the Senate appropriations committee. That makes her real important.

She is a strong advocate for issues of public health preparedness and response with a co-sponsor of PAHPA in 2006 and its reauthorization in 2013. She was disappointed not to be able to attend, but wanted to share some personal remarks via video. As you begin your tenure as NACCD members.

((VIDEO))

Senator Barbara Mikulski: Hello to the advisory committee on children and disasters. Today is such a special day, marking the inauguration of this committee. I sure wish I could be there with you, because I'm so proud of you. You've all devoted your time to helping the most vulnerable among us, children facing disasters. We're among the nation's most preeminent scientific, public health, and medical experts. You're representatives from federal health agencies as well as state and local ones.

You're pediatricians, all experienced in helping children when disaster strikes. In the wake of an unimaginable event, we must always find a way to protect our children, keeping them safe and healthy. Our children have special health needs. Kids battered going through disasters need special medication. Syringes that fit their small bodies, kids with chronic disease like diabetes will need their insulin, and they'll need it quickly.

Kids on life-sustaining devices need ventilators that fit their growing bodies. Kids separated from their parents and families need a way to be reunited with their loved ones. Children, babies need diapers and formula, and you know what? We can't forget our disabled children. The most vulnerable when communities are challenged, children are the smallest survivors, often facing incredible emotional and physical trauma.

They need special care to meet their needs. That's why as the chair of children and families sub-committee, I fought hard to improve disaster preparedness for kids, creating this very HHS advisory committee on children in disasters. We did it when we did our preparedness bill. I want to make sure that all agencies at every level were coordinating in every way, ensuring ongoing communication between the federal government, health and medical professionals, and

also those who will provide boots on the ground, like social workers, voluntary organizations, AmeriCorps.

This committee will bring together over 15 federal and non-federal experts in pediatric disaster preparedness, not only how we respond, but how we recover. We need your years of knowledge. You'll make recommendations to HHS for disaster preparedness focused solely on children. You're going to make sure that our country's prepared, whether it's a hurricane, a pandemic flu, or even God forbid another attack on us.

As a senior member of the health committee, I'll keep up the drumbeat to make sure we keep our children in mind using the committee and clout to get the job done. This committee will be doing good by helping you do good. It's needed now more than ever, and I'm so proud of working with you and fighting so that you could do the job that you're trained to do.

You know, each and every one of us will make a difference, and together, we can make change, and we need to change the way we respond to disasters to make sure that children are not treated like little adults, and that we reach out, put our arms around them, and be able to protect them and do what we're all best at. Thank you, and God bless you and God bless America.

((END VIDEO))

Capt. Charlotte Spires: Very nice, very nice. We will be posting that video from Senator Mikulski on our website subsequent to this meeting, and we're very thankful to her for providing it to us. It's 10 o'clock. Dr. Lurie has not joined us yet, and so actually I do believe I see Dr. Lurie about to join us now. That's about perfect timing. So could you introduce yourself please?

Robin Gurwitch: Sure. Robin Gurwitch, this is like late also. Is it possible to get the handouts and everything that we had yesterday? I think several of us left our materials.

Capt. Charlotte Spires: Yes, we will get that to you. Yes.

Robin Gurwitch: Okay, I just didn't want to have complete information.

Capt. Charlotte Spires: All right.

Robin Gurwitch: It's a lot of information. I just wanted to take it all.

Capt. Charlotte Spires: It is.

Capt. Charlotte Spires: Okay, what we'll do is let's take a five minute break, and at 10:05 we're going to reconvene in five minutes and if Dr. Lurie has not joined us we're going to

continue the ceremony and I will start it in her stead in five minutes. Okay, thank you all, five minute break.

((Crosstalk))

Capt. Charlotte Spires: Okay, everyone, could we find our seats, please?

Capt. Charlotte Spires: Okay, thank you, everyone. It's a little after 10:05. I think it's about 10:08. Dr. Lurie has not been able to join us yet, and so what I think we're going to do is we're going to change the schedule up again to try to give her an opportunity to get here, and I want to go into the public comments and to share with everyone the comments that we received prior to this meeting.

As you know, this is a public meeting, and we have made this meeting transparent to the public, and we have given the public the opportunity to communicate with us prior to this meeting to provide comments or ask questions, and so we did receive some stuff and took comments from the public, and I'd like to share those now.

The first comment that we received was from a stakeholder named Pat Frost. That's really the only information we got about this individual, and the subject of the comment was national pediatric disaster drill. The comment is drills help focus efforts to build capability and support coalition efforts. There is a need for a national drill on pediatrics to support bringing more parties to the table and hard-wiring local and regional planning.

The NACCD could play an important role in supporting this deliverable and making it an expectation. This same constituent also said a second comment, and the subject of that comment was improve access to bed capacity data for pediatric planning. The comment reads as follows. Right now it is not possible for local communities and coalitions to easily access simple data on bed capacity for children.

There's a need for efforts to make this information transparent to support situational awareness for planning and response. I encourage the NACCD to support creating a report on Web site access that provides the following information, including drill down data for licensed pediatric beds, NICUs, OBs, nurseries, and PICU beds. This information is available but in silos and needs to be brought forward.

We also received a comment from a Clifton Thornton, and Clifton Thornton is at the Johns Hopkins University School of Nursing, teaching assistant and a research nurse is how they self-identify. The comment subject is research agenda regarding NACCD. The comment reads as

follows: Good morning. I am a graduate student at the Johns Hopkins University School of Nursing, where I also work as a researcher with Dr. Tener Veenema.

Our team is currently evaluating the impact that the national commission on children and disasters, NACCD, has had with the mental health recommendations provided several years ago. Recommendation 2.2 suggested enhancing the research agenda for children's disaster mental and behavioral health needs in disasters by forming working groups of experts in the field. As I understand, the National Advisory Committee on Children and Disasters builds the recommendation on building a task force of experts.

We would like to inquire if NACCD has a research agenda to further investigate the unique mental behavioral needs of children in disasters, particularly with regard to the NACCD's outline of psychological first aid, cognitive behavioral intervention, social support, bereavement counseling support, and increasing resilience for children in disasters.

Has NACCD been able to recommend a national research agenda on mental health needs of children and families in disasters as well? Is there a group of experts who are also working on research within this field? Thank you for taking the time to review these questions and for your continued work in this field. Cliff Thornton. We have prepared a response for all three of these comments, and our response is as follows.

We thank Ms. Frost and Mr. Thornton for their comments. The NACCD will be reviewing reports on parent HHS activities, prior national commission reports, and other information to learn more about a wide array of topics and activities. This will include information about pediatric exercises, pediatric bed capacity, and disaster behavioral health.

While it is too early to say how these important issues will be prioritized and addressed, we thank the commenters for bringing them to our attention. This public feedback is helpful as the NACCD develops its agenda for the future, and again we thank our commenters for engaging with us and we look forward to addressing their questions and concerns.

We also received another piece of correspondence, and that correspondence is something that I'm going to share with you. Give me just a moment. That correspondence is from the American Academy of Pediatrics. I'd like to thank Miss Tamar Harrow, Assistant Director, Department of Federal Affairs at the American Academy of Pediatrics, who is with us in our audience today and has provided a letter from Dr. James Perrin, the President of the AAP.

The letter reads as follows. Dear. Dr. Lurie, on behalf of the American Academy of Pediatrics, AAP, a non-profit professional organization of more than 62,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents and young adults, I'd like to congratulate the members of the National Advisory Committee on Children and Disasters, and commend you for selecting such accomplished leaders in pediatric disaster preparedness.

Today's meeting, the first of this newly created National Advisory Committee on Children and Disasters is an historic moment for all those individuals and organizations who have worked hard to ensure that our nation is better prepared to meet the needs of children before, during, and after disasters. The national advisory committee brings together federal and non-federal partners, making it uniquely positioned to provide expert guidance and advice to federal agencies on ensuring our disaster preparedness and response programs are meeting the needs of children, including children with special medical and special healthcare needs.

The AAP was a strong advocate for the creation of this national advisory committee, and we applaud Senator Barbara Mikulski for her leadership in championing it in Congress. In particular, I want to recognize the non-federal and federal pediatrician members of the national advisory committee. Doctors Michael Anderson, Scott Needle, Sarah Park, Jeffrey Upperman, Diane Murphy, Georgina Peacock, and Anne Zajicek.

The AAP is honored to be represented by so many tremendous advocates for children. Congratulations on your appointment and best wishes on a productive meeting. The AAP looks forward to continuing to work with you in support of protecting all children when disasters strike. Sincerely, James M. Perrin, MD, FAAP President, American Academy of Pediatrics.

And we thank the Academy for this wonderful congratulatory letter and the support that the academy has given to children's issues and to the committee. And again, Tamar, thank you very much for delivering this message to us. All right.

Michael Anderson: She's five minutes out. She's five minutes out.

Capt. Charlotte Spires: Oh, okay, Dr. Lurie is five minutes out? Okay, then what I think we will do is I think we will take five minutes for Dr. Lurie. The inaugural ceremony is a very special ceremony, and we delight in having Dr. Lurie perform this ceremony for us. And just to give a little background, it is ceremonial. I mean, our non-federal members have been sworn in by personnel, through our personnel process.

But it's very special to us to have our members to stand up and to hold their right hand up and to repeat their oath of allegiance to the work that this committee will be doing, and also to receive a certificate of welcome from Dr. Lurie, and also have their picture taken, and that's going to happen also. I would prefer not to substitute for Dr. Lurie for that. So let's take five minutes and in fact, it's 10:23 by my clock up here. At 10:25, we will reconvene with the inaugural ceremony. Thank you very much, 10:25 we will reconvene.

((Crosstalk))

Capt. Charlotte Spires: Okay, everyone.

((Crosstalk))

Capt. Charlotte Spires: Okay, everyone, let's make our way back to our seats, please.

((Crosstalk))

Capt. Charlotte Spires: Okay. Those who have turned your mikes off, could you turn them back on please? All right? Dr. Kaplowitz, can you introduce Dr. Lurie for us?

Dr. Nicole Lurie: Oh, I thought you already did. No?

Lisa Kaplowitz: No, I didn't, and I realize this is a public meeting, but we are thrilled to have Dr. Nicole Lurie join us, the Assistant Secretary for Preparedness and Response. She's held this position since 2009, and prior to that worked for the Rand Corporation, but she continues to be a clinician and is a strong public health advocate, and interested and experienced in health systems research. So I think I'll leave it at that.

Dr. Nicole Lurie: Sounds great. Anything you want me to add? Thank you. Let me just say thank you all for being here and I'm sorry that I was late. I've been in a meeting with the Secretary for a while, and it's about a set of urgent issues, but I am just so thrilled to see this committee assembled and welcome other guests, and again thank you for being willing to dedicate your time and expertise and passions toward these critical issues.

As I shared with you yesterday, but since this is a public meeting I will share with you again, that you know, I come at this wearing a variety of hats in addition to being the Assistant Secretary. I'm also a primary care provider and stay clinically active, and most importantly I'm a mom, and so these issues around children are near and dear to my heart and to my career and to my tenure in this role. So thank you.

I think throughout these two dates, you are learning a lot, not only about the bureaucracy of HHS, which you learned about yesterday, but also about how these issues so related to children and youth in disasters have been addressed throughout HHS over the last several year. You heard Dan Dodgen, I think, discuss the child report last night, which has been one of our central policy milestones in addressing the needs of children in disasters.

And today you're going to hear a whole lot more from ASPR about how the development of medical countermeasures and in our response activities, we have elevated and prioritized the needs of children, and frankly how in doing so we've not only improved the situation, but improved the situation I think for everybody in the entire population and all of our work.

You'll also hear from the Administration on Children and Families, from NIH, from CDC, and later from other government partners about the milestones that we as government have hit. So I thought I would take a few minutes and share with you some of the highlights as well as to pose to you a couple questions about what people are going to hope you'll help us answer.

I'll tell you the outset of my vision for ASPR is that all of our work together, whether in science, whether in policy, whether in emergency management and response, ultimately strengthens the day to day systems that we count on when the chips are down, and leverages our preparedness investments to improve the resilience of the American public, even if we never had another disaster, probably unlikely to happen.

I think all of you know at this point, ASPR is a relatively new organization in government life, been here around since 2007. We are guided by a foundational document called the National Health Security Strategy, first released by this office at the end of 2009, and that has two really over-arching goals. One is about building community resilience, because we believe that that is one of the best ways to prepare a nation.

And the other is about strengthening emergency and response systems across the board. And so those two over-arching goals and everything that comes under it has really guided the work that we've done, both within ASPR and the work that we do for the nation. So in my tenure here it has really been a priority to build that resilience both for and frankly with children. And I'd like to as I said share some of the milestones with you.

The child working group has been really terrific as one of them. It coordinates policy issues related to children in disasters across the department. It's a coordinated effort with ACF, and I think you know that coordination and sharing responsibilities with ACF has been present since

the beginning of our activities with children, as it has been a coordination and partnership with FEMA, which has been really terrific.

But as I had mentioned to you yesterday in the post session, it's been really successful at pulling together the entire department to monitor and document progress from which has come new partnerships, new collaboration. It is no longer a cat-herding exercise. It has built a rich and deep social network of parts of HHS and others that work on and care deeply about issues related to children and have helped people prioritize a number of those.

We've also worked closely with our colleagues in the science agencies and coordinated with other leaders in this space, like the AAP, and they've helped inform our work on medical countermeasures through BARDA, and I know you're going to hear a lot about that, but another sort of development and milestone was the formation of the pediatric and obstetric integrated program team, or known as the peds OB IPT, which is like a mouthful in and of itself.

But there are a lot of examples in this space of tremendous successes, and I thought I would share with you just two particularly cogent ones. The first one is about *unintelligible*, which I think most of you are really familiar with, but this is a countermeasure that really mitigates the health effects of a chemical attack, but also has tremendous day to day applications in the treatment of seizure disorders and others in kids.

In collaboration with the NIH on the rampart study, and the success of moving that product all the way through the pipeline has been something that has not only helped kids day to day in peace time, helps us be better prepared for children's issues in an emergency, but frankly has really benefited the entire population when it comes to making the product and its delivery mechanisms available.

The other has been the work on the pediatric formulation of Prussian blue, which is a countermeasure that removes cesium from the system. As I think people remember, there was not a formulation that was suitable for kids, and so there's a lot of work that's been done on brushing their teeth and doing all of these things so that it was a drug that kids could get into their system.

Well sort of in doing that, in breaking it up into its tiny little pieces in a different delivery form, it has turned out that that provides more surface area to absorb the cesium, and it's probably going to turn out to be something that really benefits everybody, not just kids, and I think from that perspective very excited about that. So prioritizing the needs of children has resulted in some real advances, scientifically and translationally that have really helped everybody.

I'd also like to highlight for you some of the progress we've made in our responsibilities when it relates to kids, and I know that some of you are very, very familiar with these. These are current or former NDMS, national disaster medical system, team members. So to start off with you know, first was the recognition that our clinical assets working in this field during a disaster had to be able to adequately stabilize and treat people of all ages.

From neonates to elders, and so we elevated this priority right to the top. We named an NDMS director, Dr. Andy Garrett, who is a pediatrician with strong background in EMS and disasters and public health. He actually started with us as a medical officer in NDMS in 2001, and has been dogged and devoted to the issues of kids. It is now the case that every single one of our NDMS teams is capable of addressing pediatric care needs. That didn't used to be the case.

And this has been accomplished through a lot of targeted efforts, and some of you participated in a strategic review and workgroups and stakeholder calls and training. It required bringing a lot of people together for us to get to this point, but I'm really quite pleased with where we are and very proud of NDMS in this regard.

Another area that has been really challenging for this and has been a priority for me, it's how it is that we do new and critical science, particularly in the context of an emergency. I think some of you may know that our initiative in science preparedness and response has been one of the priorities for me and is one of the priorities for me going into this next year.

Well, but issues for children in this regard are particularly complex and particularly difficult to navigate. Again, I think when we've tried to address them it has resulted in a structure of better science for all, but I think we have you know, some particularly challenging issues to continue to struggle with as we move forward. So some of the issues in the medical countermeasures space that have been specific to children had to do with how is it, that we can best be prepared to administer some of these countermeasures in an emergency if they've never been in a child?

And the ethical issues and the practical issues and the developmental issues of testing different things in pediatric populations are very, very complex. I think you are aware that the former NBSB, and then the president's bioethics commission took on some of these issues, and I think provided for us very good guidance with the bioethics commission report and a framework for us being able to move forward to be scientifically prepared in that area.

But I think there's more work for us to do to address some of the complexities of doing science and research in real time when it comes to the issues and needs of children. The questions don't end there, but this I hope over time will be an area that you might want to weigh in on and can

provide us science, that is how we can be prepared to do the best science even in the worst of times for children.

So if you took one thing away from me, I hope that it is that at ASPR, we recognize and support this concept of whole community as it relates to preparedness response and recovery, and that children are such an important and significant part of every community, that in some sense a community is only going to do as well as its children do, and I think we recognize that and take that to heart.

And so attending to their needs has to be integral to how we conduct business. So as I think you've heard, I think we've made some really good progress and are very excited about your input about how to take our successes to the next level. Looking forward I hope that you can identify areas where we can continue to improve and show us a way forward.

I also hope that you will help us think more broadly about children in disasters in an additional way, and I know we talked about this a little bit during our closed session yesterday, but for the general public I really want to make this clear. We tend to think of children only as this frail individual in need of care and in need of yes hugs, always, but close attention, and sometimes and often that is very true.

But often kids are incredible assets. Often they are the only English speakers in their families, often they are the only link to what is going on in mainstream society and their parents and grandparents and great-grandparents, we saw in Deepwater for example, example after example of where English speaking children got to their Vietnamese speaking fathers and grandfathers and grandmothers who were involved in fishing.

We saw in Joplin how kids and their teachers on Facebook really knit that community together and helped it be resilient. There is an awful lot there, and I am really looking forward to your recommendations about how we move forward to help kids build resilience, be more resilient, contribute in all different kinds of ways during response, but are real assets. I think there are some very exciting models around the country.

I heard about some of them from you yesterday, and I anticipate that you will have tremendous advice for us going forward in this area as well as some of the others. So thank you again for your service on this committee, and I very much looking forward to the difference we can all make together. I now get according to my notes to welcome you each and every one of you personally and then we will do a brief taking an oath together, and presentation of certificates.

So first up, welcome our new chairman, Dr. Michael Anderson, who is vice president and chief medical officer at University Hospital at Case Western in Cleveland. Alex Amparo, these are all going to be alphabetical, the Deputy Assistant Administrator at FEMA's Recovery Directorate. Allison Blake, the Commissioner of the New Jersey Department of Children and Families in New Jersey, David Esquith, the Director of the Department of Education's Office of Safe and Healthy Students.

Robin Gurwitch, Psychologist and Instructor at Duke's Medical Center, Department of Psychiatry and Behavioral Sciences in North Carolina. Lisa Kaplowitz, the Deputy Assistant Secretary for Policy in my office, Linda MacIntyre, Chief Nurse for the American Red Cross, Dianne Murphy, a Pediatrician and Director of the U.S. FDA's Office of Pediatric Therapeutics, Scott Needle, our Primary Care Pediatrician for the Health Care Network of Southwest Florida, Naples, Florida, and the Disaster Coordinator for the Florida chapter of the American Academy of Pediatrics.

Sarah Park, Hawaii state epidemiologist, and Chief Hawaii Disease Outbreak Control Division in Honolulu, currently watching the weather. Georgina Peacock, the Medical Officer in Developmental and Behavioral Health Pediatrician at the U.S. CDC. Sally Philips, the acting principal deputy assistant secretary in DHS's Office of Health Affairs. Mary Riley, Director of the Office of Human Services for the Agency for Children and Families, Office of Human Services Emergency Preparedness and Response.

Jeffrey Upperman, Associate Professor of Surgery at the University of Southern California and an attending Pediatric Surgeon and Associate Chief of Pediatric Surgery at the Children's Hospital in Los Angeles, and Anne Zajicek, Pediatrician and Chief of Obstetrics and Pediatric Pharmacology and Therapeutic Branch of the National Institute of Child Health and Human Development.

And last but not least, I'd like to introduce our ex-officio, Gary Disbrow, Acting Director of BARDA's Chemical, Biological, and Radiologic and Nuclear MCM division, and Dan Dodgen, the Director of ASPR's Office of At-risk Individuals' Behavioral Health and Community Resilience. You're going to get familiar with lots and lots of acronyms as we go forward.

So it is now time for us to take the oath, so what I'd like to do is ask the members to come forward. Get up, just to stand up, not come forward. Okay, and asks for you to raise your right hand and repeat the oath after me. I, and then state your name.

((Crosstalk))

Dr. Nicole Lurie: Do solemnly swear.

((Crosstalk))

Dr. Nicole Lurie: That I will support and defend the Constitution of the United States.

((Crosstalk))

Dr. Nicole Lurie: Against all enemies, foreign and domestic.

((Crosstalk))

Dr. Nicole Lurie: That I will bear truth-based and allegiance to the same.

((Crosstalk))

Dr. Nicole Lurie: That I take this obligation freely.

((Crosstalk))

Dr. Nicole Lurie: Without any mental reservation or purpose of evasion.

((Crosstalk))

Dr. Nicole Lurie: And that I will well and faithfully discharge the duties of the office on which I am about to enter.

((Crosstalk))

Dr. Nicole Lurie: So help me God.

((Crosstalk))

Dr. Nicole Lurie: Thank you. I don't know about you, but every time I do this I get chills, so it's I think a very emotional thing for all of us as we take this oath and take it very seriously. And now I'm going to call each of you up one by one and officially present your welcome letter and certificate, so Michael Anderson.

((Crosstalk))

Dr. Nicole Lurie: Allison Blake. Okay, David Esquith.

((Crosstalk))

Dr. Nicole Lurie: Scott Needle.

((Crosstalk))

Capt. Charlotte Spires: Okay, Dr. Lurie? Could you take one more photo? Do you have time for one more?

Dr. Nicole Lurie: I have time for one more.

((Crosstalk))

Capt. Charlotte Spires: This is the last one, I promise.

((Crosstalk))

Dr. Nicole Lurie: ...for me to introduce the senator to you. So I just wondered if that would be really remiss, if I didn't just take a moment to acknowledge the incredible Senator who made me this advisory committee, she's been advocate and champion for this issue. I don't get to introduce the video, because I was late, but I just wanted to acknowledge that.

I also want to take a moment to acknowledge one other person sitting in the back of the room who's probably an unsung hero and who developed much of the infrastructure and did much of the work over the last five years to get us to where we are in our work for kids, and that's Olivia Sparer, who is now out in NIH, but one day we will get her back.

Capt. Charlotte Spires: Dr. Lurie, thank you.

((Crosstalk))

Capt. Charlotte Spires: With that, we have completed the agenda for our meeting today. Are there any comments or remarks from any of our board members or anyone? Yes, actually we do have time. I'm so sorry, forgive me. Forgive me, Dr. Anderson. Dr. Michael Anderson is our Chair-elect for the next forty NACCDs, and he will be formally appointed pending Secretary Burwell's approval.

And so that's an administrative process that we have to go through, but until then he is our Chair-elect. We are very excited with the board going forward with Dr. Anderson as our Chair-elect, and Dr. Anderson, would you like to make some remarks to the board? We would appreciate that.

Michael Anderson: Very briefly, thank you, Captain Spires. It's just a couple of thank you's and trying to set the vision for this wonderful committee. First and foremost, I thank you. I thank you, there, Dr. Lurie, not only for her wonderful remarks, but most importantly for her leadership. Like many folks around this table I've been involved with pediatric disaster response and disaster issues for quite some time.

And I can say that the tone and the tenor and the advancement that we've seen during Dr. Lurie's time has just been remarkable, so first and foremost, a thank you to her. Secondly, to Captain Spires and her wonderful group for number one, getting us on the committee which was a journey in itself, but two most importantly for your hospitality in welcoming us and setting the right tone. I can already feel the collaboration and the discreet core of this committee in just its second day.

And my thanks also to the non-governmental guests, that have joined us and for those on the phone. It's the start of an important journey. I think a lot of great stuff is going on and you've seen a summary of the great work that both our federal colleagues, say, ASPR, CDC, ACF, and homeland security, all the great agencies that we have heard from and will hear from. I really believe that we've advanced an agenda for children.

However, this committee is not here simply to celebrate success. We're here to help set an agenda and to help continue to push forward, and I know I speak on behalf of my fellow committee members that we will not rest until every child, be they in a day care center or an impoverished neighborhood, or in a hospital bed or a child with chronic health care needs, this committee won't rest until they all receive wonderful care during disasters.

So once again, I'm very proud to be here. We have an incredible group that's assembled. We've got a lot of work to do, just gathering, looking through my notes I have some ideas of what I would like to see us do, but now the important work lies ahead. And once again, thank you and welcome.

Capt. Charlotte Spires: Thank you, Dr. Anderson for those remarks. All right, are there any other comments or remarks for the good of the order? Hearing none, this meeting is adjourned. Thank you all.

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