Asian Pacific American Officers Committee Newsletter

Newsletter April 2015 United States Public Health Service

Chair, LCDR Karen Chaves
Vice-Chair, CDR Shu Yi "Cathy" Cai
Executive Secretary, LT Xinzhi Zhang
Corresponding Secretary, LT Thomas Gammarano
Treasurer, CDR Sophia Hsu

Inside

APAOC Chair's Corner	1
MMU Deployment Spotlight	2-3
MMU Deployment Interview	3-6
APAOC Members at NIH	6
Tobacco Cessation at the APhA Annual Pharmacy	7
Join a Subcommittee	8

Interested in submitting an article or volunteering?

Please submit to LCDR Theresa Liu at theresa.liu@fda.hhs.gov or LT Jeannie Hong at jeannie.hong@ihs.gov.

Want to receive weekly APAOC news and announcements to stay up-to-date?

Sign up for APAOC listserv on webpage (http://cdp.psc.gov/osg/apaoc/communications.aspx)

APAOC Chair's Corner

Welcome to the Spring Issue of APAOC's newsletter of 2015!

I can't remember a time when I was more proud to be a United States Public Health Service Commissioned Corps officer than now. The past few months have truly been historic ones for us--from the Ebola missions, to the 50th anniversary of the Surgeon General's Report on Tobacco, to the confirmation of Vice Admiral Vivek H. Murthy, our first South Asian Surgeon General.

Our voting members have hit the ground running this year. Within the first few months, APAOC members have participated in several community events to promote the USPHS Commissioned Corps, volunteered at the Officers Basic Course, and completed trainings on VA benefits and retirement. Not only that, we are also working to continue to build a strong organizational foundation for APAOC by updating our Charter & Bylaws and Standard Operating Procedures. Our voting members are rising to the challenge by their flexing strategic thinking and collaboration skills.

We bring together our strengths in order to support each other and provide opportunities to work on our leadership skills. Stay up to date on public health news and events with our weekly APAOC announcements and Facebook®page. Look out for our trainings on proper uniform wear, deployments, writing awards, and more. Join us, and you will find opportunities to make your mark in the Corps. Here's to making history with the United States Public Health Service Commissioned Corps!

All the best,

LCDR Karen Ho Chaves

MMU Deployment Spotlight

By LCDR Qiao Bobo

The U.S. Public Health Service (USPHS) Commissioned Corps has been serving at the forefront of the U.S. Government Ebola Response in West Africa. I was honored to be selected for deployment as part of the USPHS Ebola Response in Liberia. USPHS officers are currently staffing the Monrovia Medical Unit (MMU), which is a 25-bed field hospital that has been reconfigured to function as an Ebola Treatment Unit (ETU), located in Margibi County, Liberia. The focus of the MMU is to provide care to Liberian and international healthcare workers and responders who may have become infected with Ebola Virus Disease (EVD) and to continue to build capacity for responding and treating EVD. The team of specialized officers consists of trained clinicians (doctors, nurse practitioners, physician assistants, and nurses), infection control officers, pharmacists, laboratorians, behavioral health specialists, and administrative management staff.

The West Africa Ebola outbreak began in December 2013 in Guinea, West Africa, and grew to be the largest Ebola outbreak in history, eventually affecting multiple countries in West Africa and beyond. On September 16, 2014, President Barack Obama identified the Ebola epidemic and humanitarian crisis as a top national security priority for the United States. President Obama announced the mobilization of U.S. forces to help bring the epidemic under control, including a team of USPHS Commissioned Corps officers to manage and staff a hospital in Liberia to care for healthcare workers and responders who were suspected or confirmed with EVD.

On October 26, 2014, the USPHS Commissioned Corps deployed its first team of officers to Liberia to staff the MMU. The physical facility of the MMU was constructed by the Department of Defense. Team 1 admitted its first patient in less than one week after opening. On December 11, Team 2, which I deployed with, arrived to replace Team 1. We spent the first week at the MMU being trained by Team 1 prior to their return to the U.S. Team 2 continued the mission while enhancing the facility and expanding the supportive care capability. On February 3, 2015 Team 3 arrived to continue the mission until March 21, 2015. Team 4 is currently in country continuing the mission of providing care and hope to healthcare workers and responders who may have been infected with EVD. The number of new Ebola cases had dropped from a high of over 300 cases/week in November 2014 to almost Ebola free. As of April 17, 2015 (the date of submitting this article), no new confirmed Ebola case was reported since March 20, 2015 in Liberia.

Since the establishment of the MMU, deployed officers have provided high quality care for more than 40 international and Liberian healthcare workers (including the 17 that tested positive for Ebola and 9 of whom survived). The impact of the MMU goes well beyond the number of patients cared for and cured at the MMU. The existence of the MMU has encouraged international and local healthcare workers to continue participating in the Ebola outbreak response, because there is a treatment facility with a high standard of care established specifically for them. The MMU, through its unique mission, has played, and continues to play, an essential role in supporting efforts to decrease the number of new Ebola cases.

My own deployment began on December 4, 2014 when I arrived for one week training in Anniston, Alabama. I later served as an admin/finance officer with Team 2 (73 officers), led by CAPT James Dickens, Officer in Charge, and CAPT de la Cruz, Deputy Officer in Charge/Executive Officer. The Admin/Finance

section consisted of 4 members: CDR Stacy Evans (Section Chief, day shift), LCDR Mivoyel Jeanpaul (day shift), LT Thomas Maruna (night shift), and myself (night shift). We worked 12-hour shifts, capturing and transferring clinical data from the high-risk area to the MMU database and WebEOC (Web-based Emergency Operations Center), compiling daily MMU metrics (including triage, patient intake, discharge, mortality and transfer information, patient demographic and contact information) and reporting to the Liberian Ministry of Health. The MMU metrics is essential for the Liberian Ministry of Health to coordinate patient dispatch. We were also responsible for handling mail and care packages, ensuring accountability and reporting of personnel offsite movement to the MMU command staff and DART (the Disaster Assistance Response Team under the United States Agency for International Development, USAID) to ensure personnel safety.

Outside my regular duties, I served as a safety analyst tracking and analyzing the time and vital signs for all personnel entering the MMU's hot zone (high-risk area). I also assisted the Safety/Preventative Medicine team with fit testing officers with respirators . In addition, I was selected by the Officer in Charge of the MMU to serve as control officer and translator during the visit of a Chinese delegation to the facility. The delegation consisted of nearly 20 senior Chinese officials which also included Chinese medical personnel from the Chinese ETU in Liberia. I also researched and presented a peer teaching lecture on nontraditional FDA regulatory pathways used for Ebola treatment and testing during the 2014 Ebola outbreak.

The most uplifting moments of the deployment for me (and likely for many of my fellow officers) occurred when Ebola survivors were discharged from the MMU and added their handprints to the "Survivor Wall". The sign on the wall states "Today I am Healed, Tomorrow I Return to Heal Another. The Love of Liberty -- Liberty from Ebola -- Brought Us Here." I will never forget the smiles on the faces of the survivors and their family members when they were reunited. The U.S. Public Health Service, while serving the health of our nation, also contributed to the health of many nations and I was proud to be part of that effort.

An Interview with an MMU Team 1 Pharmacist: CAPT Dan Diggins

CAPT Dan Diggins (R) with CAPT Cathy Witte (L) from Team 1

1. What was/were the PHS mission and/or goal for this remarkable deployment?

The Monrovia Medical Unit (MMU), located in Margibi County, Liberia, is a 25-bed field hospital constructed by the U.S. Department of Defense (DoD) to provide care to healthcare workers, both international and Liberians, who may be infected with the Ebola virus.

The Monrovia Medical Unit is multifunctional and was reconfigured to meet the mission requirements specific to infectious disease treatment in Liberia. The primary purpose of the field hospital is to care for health care workers who become ill from the Ebola virus in Liberia. Although this is a clinical care unit, not usually intended for an infectious pathogen, the DoD and U.S. Public Health Service (USPHS) Commissioned Corps worked in partnership to reconfigure the unit to function as an Ebola Treatment Unit. In addition, experts from Médecins Sans Frontières (Doctors without Borders) were consulted on the reconfiguration illuminating the multi-sector approach in support of the U.S. Embassy Monrovia and the USAID Ebola Disaster Assistance Response Team, which is overseeing the overall U.S. Ebola response in West Africa.

2. What was your deployment role and what skill sets did it require?

I was deployed as one of the four pharmacists on the team as well as the Deputy Chief of the Pharmacy Branch, which was a night shift assignment. My inpatient and critical care experience were very valuable. In addition to preparing and dispensing medications, the pharmacists collaborated with the physicians and nurses in patient management - drug selection, dosing, information about adverse effects and interactions, in what order and how fast to infuse intravenous drugs, etc. We truly worked as a team, which planned and coordinated all activities inside the High-Risk Area. Time constraints on staff in full Personal Protective Equipment (PPE) were vital to the safety of the mission. I was also assigned as the Officer-in-Charge for the night shift on a rotating basis with two other senior officers, the assignments of which included taking phone calls, addressing potential obstacles, and relaying information to command staff when necessary. I also spent time in PPE, assisting with doffing, which is the process of removing PPE. The doffing coaches sprayed down the staff members coming out of the High-Risk Area with chlorine solution and giving verbal instructions for each required step.

3. Who were the other USPHS officers that consisted your deployment team?

There were a total of 69 Officers deployed on the MMU Team 1, which included physicians, PA's, Safety officers, nurses, pharmacists, lab technicians, logisticians, administrative personnel, and command personnel. We had an extremely talented group, comprised of many varying ethnicities, employed by many different agencies, and representing ranks from LTJG to CAPT. We also had at least one Flag Officer in country throughout the stages of the deployment. Our leadership was outstanding, and in addition to placing a high priority on our safety, made every effort to mitigate the problems and improve our comfort. The other pharmacists were CAPT Corrinne Kulick (FDA, Pharmacy Team lead), CDR Selena Ready (also FDA), and LT Sandra Mathoslah (BOP) who worked with me on the night shift.

4. Briefly describe your typical day during deployment.

For the night shift, our day began at about 4pm when we woke up, had a snack or coffee, and prepared for our bus ride. For the first 6 weeks, we were quartered in a fenced in compound of 2 bedroom "bungalows", with 12 people per unit, sleeping on cots under mosquito nets. We had a small kitchen with a fridge and a microwave, which were comforts we were not expecting. There were about 20 of us working the nightshift. A bus picked us up at 5:30PM and we rode on a 2 lane highway about 30 miles southeast to the MMU, which is near Roberts International Airport. Upon arrival, the Clinical Staff (docs, nurses, pharmacists, behavioral health, and chaplain) went to the Donning/Operations Tent, where we did our sign-out. The doctors gave an oral summary report of each patient's progress and the suggested plan for the next shift. The Chaplain performed a brief service of observation with scripture reading at this time if there were reported patient deaths, which also included singing hymns. After 31 days of eating mostly MRE's, we started getting traditional military warm meals delivered by the U.S. Army. The pharmacists would then go back to the

Donning/Ops tent, sit down with the docs and nurses, and work out the specific plan for who will go into the High-Risk Area. Planning the High-Risk Area entry included times as well as what procedures/medications/care would be performed for that shift. Pharmacist then returned to the pharmacy tent and prepared the medications. After preparing the medications, we would deliver them with special instructions if necessary. We had radios in each tent so we could contact (or be contacted by) the docs or nurses for unexpected, needed medications. We always kept one pharmacist in the pharmacy. If I was doffing, I would change into scrubs and mud boots, go through the process of donning PPE, assist the Preventive Medicine/Safety people to ensure the chlorine solution containers were filled, and then spray down the staff as they exited. This was at times a 2 to 4 hour process. We also had to allow time for cleaning up the eating area, taking out the trash, and trying to always make a pot of coffee for the day shift folks before they arrived. We then rode the bus back to the bungalows and started the process over again.

5. What were some of the challenges and how were they overcome?

There were many challenges, some of which were huge, and others were small inconveniences like climate in Liberia, which is hot and muggy year round, and either dusty or muddy depending on whether it had rained recently. Staying clean and fresh was a daily challenge. Malaria carrying mosquitos were a constant danger which implored us to use insect repellent, wear long pants, long sleeved shirts when off duty, use our mosquito nets, and most of all, take our anti-malarial prophylaxis. The biggest challenges were that we were all accustomed to providing a standard of care in our hospitals back home with very advanced technology and equipment, most of which we didn't have. But we were a resourceful team and some of the small triumphs were overcoming these obstacles and figuring out how to do something with what we had on hand. The talent of our team shone through in this regard, with our logisticians obtaining supplies, building many needed items like side tables for patients in the tents and boot racks for drying our mud boot (using lumber supplied by USAID or the DoD), our administrative folks procuring much needed drugs and blood products as well as our food. We went through an astounding amount of bottled water. Starting IVs on Ebola patients is extremely risky as well as difficult due to their state of dehydration, and we had some nurses with excellent skills. For the pharmacy, we were challenged to learn about therapies that we were not accustomed to (Malaria and other tropical diseases as well as Ebola Virus disease), and making do with alternatives to the drug of choice, which we often didn't have, particularly at the beginning. One example – for the first week or two we had no oral rehydration powder, so we prepared a home-made solution using sugar and salt packets from MRE's, injectable potassium chloride, and for patients with acidosis, we added some injectable bicarbonate.

6. How did the mission of this deployment align with that of the PHS and what could PHS officers do to continue their efforts on the visibility and sustainability of the PHS?

This mission was truly the epitome of Public Health. The words of the Public Health Service march "in the silent war against disease, no truce is ever seen" are very apt, and it is a certainty that the PHS response to the Ebola crisis (which is ongoing) will be a chapter in the next book that chronicles the history of the PHS Commissioned Corps. There was a tremendous amount of media coverage and the spotlight was definitely on the Commissioned Corps during the height of the outbreak. The officers who did not deploy but supported this mission through back-filling and shouldering extra burdens of work at their home agency should feel no less pride than those who did go to Africa. All officers should celebrate this mission and the positive impact it had on global health. We made a difference without question, but we also realize we had a tremendous amount of assistance, from other government and non-government agencies, and in particular the Department of Defense, with whom we interacted frequently. The mission has gone a long

way toward forging increased understanding and recognition of the unique skills that PHS can provide, and officers can continue to improve the standing respect of PHS by adding to their knowledge of other uniformed services and their unique talents, their ranks and military courtesies, always wearing their uniform according to regulations and with pride, and not being afraid to engage others, whether military or civilian, to respectfully tell the story of the U.S. Public Health Service Commissioned Corps.

7. What are some advices you have for future officers (especially junior officers) who are interested in deployments such as these and how they might best prepare themselves?

Being prepared for deployment should be something that should be undertaken in advance by all officers. The CCMIS website has a section devoted to the **Deployment Operations Group** (RedDOG) and this is the best resource for officers to seek information (http://ccmis.usphs.gov/ccmis/MENU_readiness_m.aspx).

My advice for those seeking deployment opportunities would be to engage others who are members of a Rapid Deployment Force (RDF) team, to find out what is involved, and then to seek approval from your supervisor to join one of these teams. Approximately 50% of our team were members of RDF teams, and their prior experience helped them as well as other team members in managing the stress and inconveniences. Deployments are like semi-structured camping trips. Things go wrong and at times you are miserable, so you have to stay calm and roll with it or you won't do well. But the gratification of working as a team, overcoming obstacles, and representing your agency and the US PHS CC makes it all worthwhile.

APAOC Members at the NIH Celebrating the Holidays

By LCDR Eric Zhou, CAPT(selected) Sally Hu, and CAPT Soju Chang

Three APAOC members along with other 12 PHS officers and staff from the National Institutes of Health (NIH) attended the holiday luncheon at the Cheesecake Factory in Bethesda on December 12, 2014.

With over 18,000 employees, NIH has yet only about 300 PHS officers in all 11 categories scattered around different locations. The interaction among officers at NIH is not optimal. To promote networking and collaboration, and to foster career development, the NIH PHS liaison Office and Social Subcommittee currently chaired by LCDR Eric Zhou co-organized the holiday luncheon. After RAMD Helen Mishoe made the welcome remark, the group enjoyed a fun ice breaker activity and wonderful food. NIH PHS Liaison officer, CDR Tiffany Edmond, also joined the luncheon.

APAOC Members attending the 2014 NIH Holiday lunch: LCDR Eric Zhou (L1), CAPT Soju Chang (L6), CAPT Sally Hu (Selected, R1).

Breaking Down the Barriers for Tobacco Cessation at the APhA Annual Pharmacy Meeting

By LT Rebecca Wong

Since 2013, the Indian Health Service has joined the national CDC tobacco education campaign to help deter the use of commercial tobacco on reservations across the country. Research shows that American Indians and Alaska Natives (AI/AN) have the highest prevalence of smoking and other tobacco use of any population group in the United States. Most smokers, over 70%, say they want to quit but there is a lack of available resources.

In October 2013, pharmacy officers LT Gayle Tuckett and myself, broke down barriers and started a tobacco cessation clinic at Tséhootsoí Medical Center (TMC), located on the Navajo reservation in Fort Defiance, AZ. The clinic empowers interested patients to quit smoking cigarettes or chewing tobacco. Previously TMC lacked such a resource and interested patients needed to travel over 40 miles to the closest retail pharmacy to obtain Over-the-Counter nicotine replacements.

At the 163rd American Pharmacist's Association (APhA) annual pharmacy conference in San Diego, CA from March 27th to March 30th, we had the privilege to increase tobacco cessation awareness and present a poster on TMC's pharmacy-managed tobacco cessation clinic. The clinic has been a success so far and has allowed multiple patients to help quit commercial tobacco.

January 11, 2014 marked the 50th anniversary of the first Surgeon General's Report on Smoking and Health, which linked smoking to ill health and laid the foundation for tobacco control efforts in the United States. RADM Lushniak, Immediate Past Acting Surgeon General, noted that evidence-based interventions that encourage quitting and prevent youth smoking continue to be underutilized. He recommended CDC-funded statewide tobacco cessation programs, smoke-free air policies, tobacco excise taxes, and increasing access to treatment. Current Surgeon General, VADM Vivek Murthy, continues to lead our nation on the forefront of tobacco cessation efforts. I would like to encourage my fellow APAOC and other USPHS officers to join VADM Murthy in this important initiative. Let's build a tobacco free environment together!

Additionally, 12 PHS officers including myself were able to participate in a 5k fun run benefiting women in pharmacy. Shown in the picture is RADM Schweitzer showing her support to the PHS team before the race! At APhA, officers were represented from multiple agencies across the country, including BOP, IHS, CDC, ICE, DOD, and Coast Guard.

Join a Subcommittee

Subcommittees & Workgroups	Chair/Co-Chair	
Awards & Recognition	CDR Fei Xu fei.xu@fda.hhs.gov	LT Jung Lee junge.lee@fda.hhs.gov
Career Development & Advancement	LCDR Khang Ngo khang.ngo.usphs@hotmail.com	LT Oliver Ou oliver.ou@fsis.usda.gov
Charter & Bylaws	LCDR Vilma Lindsteadt vilma_home@cox.net	
Communications	LCDR Diane Nhu duong.nhu@fda.hhs.gov	LCDR Ruiqing Pamboukian ruiqing.pamboukian@fda.hhs.gov
Education & Training	CDR Aileen Renolayan aileen.renolayan@cms.hhs.gov	CDR Tina Nhu tina.nhu@fda.hhs.gov
Leadership & Strategic Planning	CDR Junio Colobong junio.colobong@fda.hhs.gov	
Nominations & Membership	CDR Diem-Kieu Ngo diem.ngo@fda.hhs.gov	LT Geoffrey Wu geoffrey.wu@fda.hhs.gov
Public Relations	CDR Kun Shen kun.shen@fda.hhs.gov	LCDR Jade Pham jade.pham@fda.hhs.gov
Recruitment & Retention	CDR Hawyee Yan hawyee.yan@fda.hhs.gov	LCDR Johannes Hutauruk johannes.hutauruk@cms.hhs.gov
Social Media Workgroup	CDR Bach Beasley nhi.beasley@fda.hhs.gov	CDR Stella Wisner stella.wisner@tananachiefs.org
	CDR Stephen Chang stephen.chang@cms.hhs.gov	LCDR John Cruz john.cruz@ihs.gov
Publications Workgroup	LCDR Theresa Liu theresa.liu@fda.hhs.gov	LT Jeannie Hong jeannie.hong@ihs.gov