

DOG House News

Providing Updates from the USPHS Readiness and Deployment Operations Group (RedDOG)

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USPHS Preparedness Coordinator, LCDR Elizabeth DeGrange
Editor, LT Yvonne M. Santiago



Preparedness Coordinator's Corner

Welcome to another issue of the DOG House News! As always, we hope this finds you and your families well.

First, I'd like to congratulate all of the recently promoted officers! I'm so proud to serve with you! I'd also like to say Happy Birthday to the US Public Health Service! As of 16 July, we've been protecting, promoting, and advancing the health and safety of this nation for 217 years now! That's pretty impressive!

I would also like to remind you all that even though this summer has been quiet so far, we are still in Hurricane Season, so please be sure to update your information in Direct Access, and in the RedDOG portion of CCMIS. Once you log in to CCMIS, check on the left-hand side of the page in the "Select Activity" box, and scroll down to the "Officer" section; you'll see RedDOG as an option at or near the bottom of the menu. Once you click on "RedDOG," then you'll notice a few tabs; to update your personal information and language skills, click the "RedDOG Forms" tab. A few things have moved, so if you have questions about how to update, please let us know. It is really critical that we have your updated contact and travel information; if we're going to deploy you, and you've noted on either a survey response or through your team commanders that your information in the database is updated and correct, then we send that to Travel; so often we end up sending outdated information, which costs us crucial time and money. Please do your part to update your information!

V/r,

Getting to Know (Deployment Teams)

RIST: Regional Incident Support Teams

The Regional Incident Support Teams (RIST) provides rapid assessments and initial incident coordination resources within defined regions of the United States. There are currently eleven RIST teams, each aligned with one of the Health and Human Services (HHS) regions including the National Capital Region (NCR) and is comprised of 12-30 trained USPHS Commissioned Corps officer responders.

The primary areas of RIST activities and reporting include: rapid event needs assessment; support and direction for incoming response assets; liaison with State, Tribal and local officials; on-site incident management; and response asset for health and safety. RIST is a Tier 1 team that deploys within 12 hours of activation.

RIST team members work and live in the specific region covered by the RIST. Each team is a short-term response asset available to Regional Emergency Coordinators and Regional Health Administrators within the region. RIST deployments are very short (1-3 days) but the members are routinely deployable year-round during any month and the total deployment for any RIST member may not exceed 30 days per year. Each RIST is capable of responding to the many immediate public health emergencies and urgent health needs arising from a major disaster or other event.

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Upcoming Deployments



Getting to Know Continued (Deployment Teams)

DOG House Motto:
*It's not the size of
the dog in the fight,
but the size of the
fight in the dog*

Eleven RIST teams along with their Team Commanders are listed below:

Team	Team Commander	Email Address	Home State
RIST-NCR	CAPT Sally Hu	hus@mail.nih.gov	MD
RIST-1	LCDR Kent Conforti	kent.conforti@fda.hhs.gov	MA
RIST-2	CDR William Waldron	william.r.waldron@ice.dhs.gov	NY
RIST-3	CAPT Gilbert Rose	gilbert.rose@samhsa.hhs.gov	MD
RIST-4	CDR Bobby Rasulnia	bba9@cdc.gov	GA
RIST-5	CDR Michelle Colledge	Colledge.Michelle@epa.gov	
RIST-6	CAPT Daniel Hesselgesser	Daniel.Hesselgesser@cms.hhs.gov	TX
RIST-7	CDR Nancy Miller	nancy.miller@hhs.gov	MO
RIST-8	CDR William Boden	william.boden@fda.hhs.gov	CO
RIST-9	CAPT Jane Kreis	jane.kreis@fda.hhs.gov	CA
RIST-10	CAPT Keysha Ross	kdr6@cdc.gov	WA

Deployment News

Commissioned Officers in CDC's Epidemic Intelligence Service (EIS) Respond to the 2014-2015 Ebola Epidemic

By: LCDR Matt Karwowski, MD, MPH

CDC's response to the 2014-2015 Ebola virus disease (Ebola) epidemic is the largest in agency history. More than 1,000 employees have deployed to West Africa and hundreds more have worked in CDC's Emergency Operations Center (EOC) in Atlanta. CDC Epidemic Intelligence Service (EIS) officers were among the first agency staff to deploy to West Africa, with boots on the ground as early as April 2014.

EIS is a two-year service-based postdoctoral fellowship in applied epidemiology. EIS officers are on call 24-7 and routinely deploy on short notice for public health emergencies and investigations - from infectious disease outbreaks to disaster response - serving as the "tip of the spear" for CDC's response to public health crises in the United States and around the world.

Of the 159 current EIS officers, 81 proudly serve as commissioned officers in the USPHS Ready Reserve and represent the medical, nursing, scientist, and veterinary professional categories. All 81 officers have participated in CDC's Ebola response, with nearly half (49%) having deployed on multiple occasions (See Table). In the initial months of the Ebola epidemic, USPHS EIS officers who deployed to West Africa encountered a swiftly growing outbreak that overwhelmed the health care infrastructure in the region. Rapidly shifting needs and priorities meant that officers often learned the specifics of their assignments only after arriving in their destination country. Officers were deployed to densely populated urban centers, remote villages reachable only by foot, and everywhere in between. Their success hinged on the ability to quickly adapt to dynamic situations, find creative solutions to unanticipated obstacles, and develop and foster collaborative relationships. By March 2015, commissioned officers in the EIS program had worked more than 2,000 days in the three heavily affected countries of Guinea, Liberia, and Sierra Leone (See Table). Their mission was to support each country's Ministry of Health by establishing surveillance systems, interrupting chains of transmission through case investigation and contact tracing, providing infection prevention and control recommendations, guiding community education, and building public health capacity.

Preventing Ebola from gaining a stronghold in nearby African countries was equally important. When Mali, Nigeria, and Senegal reported cases of Ebola, officers were quickly dispatched to assist with the response. In addition, by strengthening surveillance, improving communications, and establishing response plans in unaffected countries considered to be at high risk for importation of Ebola, officers helped ensure that the virus did not spread further.

In addition to the international Ebola response, commissioned officers in the EIS program contributed substantially to domestic Ebola activities. Officers have worked more than 1,000 days in CDC's EOC, supporting colleagues in the field, state/local public health departments, health care facilities, and sister agencies (See Table). They have also conducted field investigations of domestic Ebola cases, staffed airport quarantine stations, and worked with state and local health departments to develop Ebola surveillance and response plans.

EIS officers in the Commissioned Corps were especially honored to support USPHS colleagues who had staffed an Ebola Treatment Unit in Liberia - the Monrovia Medical Unit - by assisting with public health monitoring of all four teams upon their return to the United States.

Through the collective efforts of affected countries and partner agencies, public health has altered the course of the Ebola epidemic and saved many lives. However, CDC's work in West Africa will not conclude even after all chains of transmission are severed. Rather, we will support efforts to rebuild the public health infrastructure in each country, thereby reviving vital public health programs while also increasing capacity to detect and respond to future public health emergencies.

EIS officers in the Commissioned Corps have demonstrated universal dedication to the mission shared by CDC and the USPHS: to end the Ebola epidemic. By standing ready to respond to all manners of domestic and international public health threats - infectious and noncommunicable, acute and chronic - we will continue to protect, promote, and advance the health and safety of our nation.

Table: Ebola response deployments by commissioned officers in CDC's Epidemic Intelligence Service, April 2014-March 2015.

Location	Number of Officers	Number of Deployments	Number of Days
Africa			
Guinea, Liberia, and Sierra Leone	49	66	2178
Less-affected countries and those at high risk for Ebola importation*	20	28	656
United States			
CDC Emergency Operations Center	28	29	1205
Airport Quarantine Stations	6	6	157
Texas, Ohio, and New York	5	7	72
Total	81[†]	136	4268

* Benin, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Ghana, Guinea-Bissau, Mali, Nigeria, People's Republic of the Congo, Senegal, The Gambia.

[†] Column total sums to more than 81 because 49% of officers deployed multiple times.

Acknowledgements: The author thanks LCDR Michael Gronostaj for his assistance in providing data on EIS officer deployments; LT Colleen Scott, LT Kerton Victory, LT Megan Casey, LCDR Jefferson Jones, and LT Iman Martin for contributing photographs; and LCDR Jose Hagan, LCDR Prathit Kulkarni, and LT Tasha Stehling-Ariza for their thoughtful edits and feedback on the article.



Photo 1: LT Colleen Scott (right) carefully navigates a makeshift bridge on her way to a remote Liberian village during the rainy season to trace contacts of Ebola patients. The West African Monsoon slowed travel in the region but did little to stem the spread of Ebola. Heavy rains create challenging conditions that further complicate efforts to locate, assess, and monitor contacts of Ebola cases.

Featured Articles

Step Up or Step Down: Leading through action

By CDR Charlene Majersky, PhD

There are many facets of leadership but one area that is very important is a leader's ability to lead effectively through their actions. The old saying that actions speak louder than words is so true. If a leader only talks the talk and doesn't walk the talk, then their words might be perceived by others as misleading, the result being mistrust. And without trust, there is no foundation that exists which binds an organization together to be able to operate in an efficacious manner.

From my humble perspective, other important attributes of an effective leader are consistency, integrity, commitment to personal growth through self-introspection work, and humbleness. I will briefly discuss these four areas below.

Consistency is imperative because absent it, an atmosphere of chaos and confusion prevails. If a leader is not consistent, then its followers will not be able to depend on you. Here, it's critical that your words and your actions are in synchronicity. This yields an opportunity to create and communicate your vision to your team, develop fundamental principles to build a solid foundation, and implement smooth and seamless business practices.

Integrity is an intrinsic characteristic that parallels with an individual's internal locus of control, your real self, the core of your being. A leader's moral compass and his or her ability to do the right thing no matter what is at stake is at the heart of this very profound leadership attribute.

Commitment to personal growth through self-introspection work enables a leader to reflect openly and honestly, both on macro and micro levels. This is a lifelong journey that gets to the root cause of what is and isn't working, in terms of your leadership style, communications, and interpersonal skills. The ability to look at yourself in this deep and earnest way, can result in priceless rewards at the heart and soul levels of your being.

Lastly, humbleness is equated with inner strength and balance, coupled with dedication to serving others. The beauty of the servant leadership model is that service to others is first and foremost, so being humble occurs quite naturally for a leader who exhibits a solid internal locus of control and the self-awareness to recognize his or her strengths and areas of improvement.

Serving in a leadership position is an immense responsibility. As leaders, we're expected to step up, to lead in ways that are effective to help our organization meet its mission. Leading effectively and successfully through action is key and a tall order to fulfill. If we are unable to lead in impactful ways then we might have to take the alternate route, which is to step down. Step up or step down. It's all up to you; the choice is yours!

Some Like it Hot: Providing Operational Stress Control within a CBRNE Enhanced Response Force Package (CERFP).

By LT Brian Lees

Imagine a scenario in which a storm surge collapses a warehouse containing toxic chemicals, with people inside. This mass casualty scenario was practiced in Hawai'i in June 2015 during Vigilant Guard/Makani Pahili, a yearly, combined state and DoD hurricane preparedness exercise. The first responders to this scenario were from CBRNE Enhanced Response Force Packages (CERFPs). CERFPs are National Guard units that locate and extract victims from a contaminated environment, perform mass patient/casualty decontamination, and provide treatment as necessary to stabilize patients for evacuation. To rescue and recover the victims in such a real life scenario, the CERFP responders not only have to endure the physical stress of wearing chemical suits, but also the psychological stress of being in a contaminated site and seeing people injured and killed. This is where my role as a psychologist came in.

Our mission

I had the opportunity to work with an Army National Guard psychologist and two behavioral health technicians to develop and implement the behavioral health/force protection component. There was no SOP, so we utilized our shared knowledge of military Combat and Operational Stress Control (COSC) and disaster mental health principles. The goal for our team was to 1) help responders manage their stress levels so that they could sustain maximum performance and 2) provide Psychological First Aid (PFA) to prevent the development of stress injuries, such as post-traumatic stress disorder.



CERFP responders search for and extract victims from the “hot zone”

Getting situated

The “hot zone” (the contaminated site) for this exercise was a makeshift pile of dirt and concrete blocks where manikins and actors portrayed the dead and wounded. The responders, wearing full chemical suits, had to triage the victims and extract them to the “warm zone,” where the decontamination occurred. Because of the heat generated inside the suit, teams only stayed in the suits for about 45 minutes. Thus there were different teams of responders donning and doffing their suits and moving between the zones in intricate rhythms. Our team’s first challenge on site was to find where to make ourselves most useful, while also not becoming contaminated.

The Commander of the medical operation suggested we setup just outside the warm zone, in the medical tent where the responders had their vital signs checked right after being decontaminated. Thus the medical team was addressing physical stress while our adjacent team was addressing psychological stress. While all responders were required to have their vital signs checked, given the newness of our operation, there was no requirement for them to interact with us. Still, approximately 22% of the responders took the time to sign in to our area and receive our services. This number likely would have been higher if our area was air conditioned like some of their own tents in the staging area.

Our COSC tactics

Our model was based on Psychological First Aid (PFA), which is the standard of care in disaster response situations. To establish contact we were readily accessible, but tactful and non-intrusive. We addressed safety and comfort by providing cold Gatorade and water, snacks, and a place to sit. For those cool and calm enough to receive information, we provided psycho-education about common stress reactions and how to utilize positive coping strategies (e.g. talking to supportive people, getting good sleep, not abusing substances). We encouraged the use of diaphragmatic breathing to help stabilize the stress. We also had stacks of flyers, which were developed by SAMHSA, specifically addressing stress reactions in first responders.

In regards to location, being close to the hot zone had several distinct advantages.

1) *It allowed us to be highly visible* and provided us the earliest possible opportunity to assess and intervene if needed. For example if we were situated further back in the cold zone, those in acute stress could have difficulty finding us.

CONTINUED ON NEXT PAGE

2) It also likely *helped our team establish more credibility* amongst all ranks. Seeing that we were not afraid to be close to the action likely lead others to have more respect and trust in our personnel. This in turn could lead to a higher willingness to self or buddy-refer.

3) We could theoretically *get better assessment data* on which particular responders were exposed to the most traumatic events via direct verbal reports from team leaders. We could focus our interventions on those individuals who endured the most traumatic experiences, as they would be at heightened risk for stress reactions, and possibly PTSD.

The one distinct disadvantage of being so close to the warm zone was that it was not an ideal location for finding sustained calmness, an important part of treating acute stress injuries, as there was at times considerable foot traffic in that area. Thus for those needing an extended break or more in-depth individual attention, a separate respite center in the cold zone would have been better.

Lessons learned:

Had we had more time to fully prepare for this mission, we could have given a stress-inoculation brief during mobilization and then a reintegration brief during demobilization. However, the CERFP teams were National Guardsmen from different states, so this would have required extensive coordination requiring a higher level of Command support. In the future, integrating a brief acute stress questionnaire into the required pre-post vital sign assessments would assist in measuring changes in responders' stress levels after being in the hot zone. We also did not gather any outcome data, so it is unclear if our efforts actually accomplished our goal. The next step would be to compare who did and did not utilize our services and measure each group's levels of psychological stress/problems over time. Another lesson learned is to request to have actors portray severe acute stress symptoms, so that we could test the capacity of our services.

Conclusion and relevance for the PHS Commissioned Corps

A real life CBRNE incident of such magnitude to warrant a National Guard CERFP activation could also warrant activation of the PHSCC. Given the high physical and psychological stress involved in being a CERFP responder, it is hoped that operational stress control will be a standardized component of CERFP missions. In the future we may see more collaboration between the National Guard and the PHS. We PHS behavioral health officers "like it hot" and could be augmented into these units during a disaster to provide this service, for the health and safety of our nation.

Upcoming Events

Register Now for the 2015 AMSUS Meeting in San Antonio, TX

REMINDER UPCOMING DEPLOYMENTS

- Deployments in Support of Missions in Guinea & Sierra Leone

Training Activities/Resources

American Heart Association - Training for Healthcare Providers

http://www.heart.org/HEARTORG/CPRAndECC/FindaCourse/Find-a-Course_UCM_303220_SubHomePage.jsp

NIOSH Training for Nurses on Shift Work and Long Work Hours:

<http://www.cdc.gov/niosh/docs/2015-115/>

REMINDER FOR ALL COMMISSIONED OFFICERS

1. Check your Tier: Review the RedDOG website and verify your deployment Tier. Do you have one listed? Is it correct? If the answers these questions are no, send us an email so we can address it email RedDOG-Response@hhs.gov
2. Check your contact numbers: Are your contact numbers correct? Due to the fluid nature of mobilizations, we sometimes will need to reach out to you on the fly with changes to your orders and /or itinerary. Having an off duty number and mobile number on file is critical so we provide you with up to date information and directives while you are in transit.
3. Check your email addresses: Provide us with a primary and secondary email address. It is imperative that you can access your primary email remotely (on deployment using a personal laptop tethered to hotel Wi-Fi or a personal hotspot as an example) and that the email service provider accepts attachments from outside networks.

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Interested in submitting an article to feature in any of the sections?

* Articles are due by the 15th of each month

* Please include a title and state your name in the "by" line.

* Pictures are welcome!

To join the Deployment Working Group send an email to RedDOG-Training@hhs.gov

