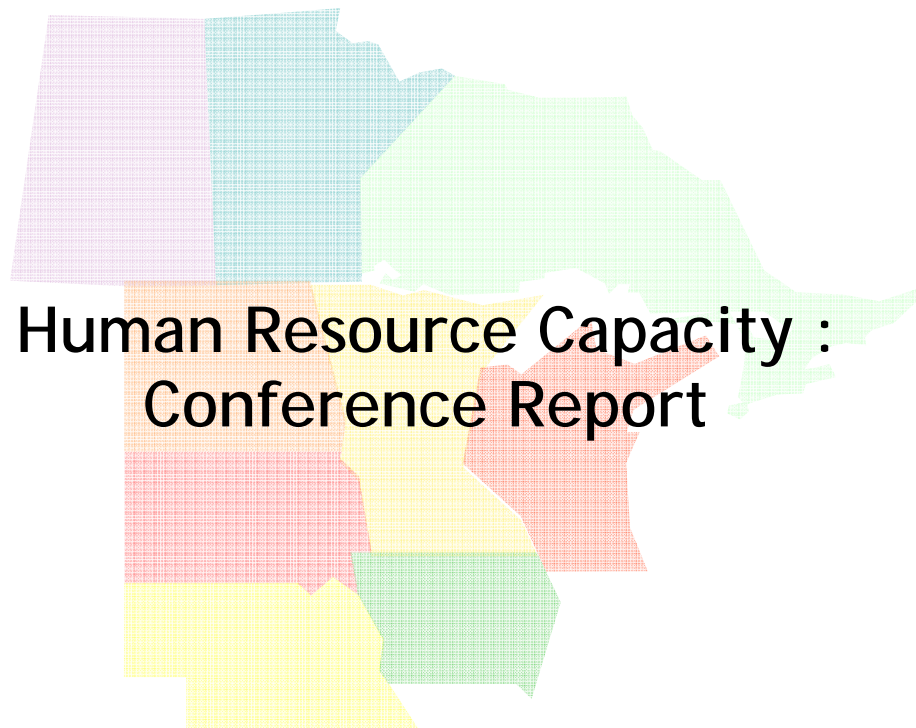


# **Public Health and Terrorism Preparedness: Cross-Border Issues Roundtable**



Human Resource Capacity :  
Conference Report

October 22, 2004  
Renaissance Savery Hotel  
Des Moines, Iowa

**Public Health and Terrorism Preparedness  
Cross-Border Issues Roundtable:  
Human Resource Capacity**

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**Conference Proceedings**

At this second meeting of the Cross-Border Issues Roundtable, individuals at the state, provincial, and local levels with bioterrorism and emergency preparedness responsibilities in the Upper Midwest and Southern Canada discussed cross-border issues for the Upper Midwest. At the first Roundtable held in December 2003, participants identified unmet needs: human resource capacity was identified as a top priority.

At the second Roundtable, representatives from Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin, and the bordering Canadian provinces of Manitoba, Ontario, and Saskatchewan reconvened to develop strategies and a plan of action to serve the needs of this region.

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The University of Minnesota Center for Public Health Preparedness  
The University of Iowa's Upper Midwest Center for Public Health Preparedness



Center for  
Public Health Preparedness



## Table of Contents

<b>Workforce Development: Addressing Issues and Challenges</b> Ed Thompson, MD, MPH	<b>4</b>
<b>Expert Panel:</b> <b>Databases, Volunteers, and Credentialing</b> Lisa Pogoff, MPH, MSW Brenda Goolsby, SPHR Paul R. Hales, JD	<b>15</b>
<b>Notes from Workgroups</b>	<b>29</b>
<b>Keynote Speakers</b> Mary Mincer Hansen, PhD Richard Raymond, MD	<b>31</b>
<b>Expert Panel:</b> <b>Training Standards/Competencies, Qualification and Knowledge, and Authority</b> Mary Jones Jerry Ostendorf Captain Bob Cox Steve Mercer Stephen S. Morse, PhD	<b>33</b>
<b>Notes from Workgroups</b>	<b>51</b>
<b>Cross-Borders Reports Back from Workgroups</b>	<b>53</b>
<b>Speaker Biographies</b>	<b>63</b>

## Morning Session

### Workforce Development: Addressing Issues and Challenges

Ed Thompson, MD, MPH

Chief of Public Health Practice

Centers for Disease Control and Prevention

Thanks for the opportunity to be here today. It is a privilege to talk about two very important, interrelated topics: public health preparedness and the workforce that will provide that preparedness.

What I want to talk about first is what has been going on in public health in the last several years, which differs from what many of us have been used to in previous years. Now, I am speaking to you from several perspectives. I am very proud to be a part of the Department of Health and Human Services at the Centers for Disease Control, but I wasn't born in the federal government, and so I view this from the perspective of someone at the state level. Someone in a situation in a place very much like most of you view it. And I don't view the world like many of my colleagues in Washington do.

(SLIDE) That is the map I use when I am in Washington. As I explain to the folks there, the star with the circle area is Washington, DC. Washington has been described as 10 square miles surrounded by reality. The other star further down is Atlanta, Georgia. That is where the CDC is located, as most of you know. But this is the part I have a hard time with: I tell them, you see the rest of the stuff over here, to the west? Those shapes are called states. And that is what you have to do when you are amidst the federal government. You have to remind folks that there is a lot of activity outside of Washington.

Because you know, as I know, that peoples' health is not protected in Washington, DC, nor is it protected in Atlanta, Georgia. It is protected in Des Moines and in Omaha and in Tupelo and in Sacramento and in places all around the country. Public health gets protected in the towns and cities of the Canadian provinces. If it does not happen there, it will not happen. One of the things showing us this is the problems with our supply of the flu vaccine. Those states with a strong and effective public health system are dealing effectively with a very difficult situation. And if that structure is not there, then some states are not able to deal with it quite as well and are having to turn to the national level for help.

Now, let's talk about what's been going on in public health. All of you are very well conscious of this, but about three years ago it began with the 2001 anthrax attacks in the U.S. There were five states that actually recorded anthrax cases, but no states were unaffected. All of the states had to deal with the threat of anthrax. We had to deal with the letters perceived as threatening, the odd packages, and the perceived threats that people encountered. I don't know about you, but I had no idea before 2001 just how much white powder there was in the world if you started looking for it. There were some real concerns in all of our states. People received packages with markings and characteristics that made them very plausible threats. And there was a need to determine whether anthrax was present or not. People encountered some powders that actually had some cause for concern. But then there were some that just never should have made it to the lab.

Bioterrorism as a whole then emerged in the public consciousness, although it had been an important issue for public health before 2001. Bioterrorism is something that is going to hang over us and that we must be prepared to respond to if it ever occurs. If you just stop and think about how much of our efforts are being devoted to this issue, in particular, as compared to all the other things in public health, you realize what an enormous shadow that does cast.

(SLIDE) West Nile Virus was the next thing that came along and captured our public health resources and attention. It has spread across the U.S. to the point that last year it had engulfed the entire country, with 990 cases and 222 deaths. This year, as of October 12, 2004, we stood at 1,951 cases and only 62 deaths. But the important point here is that West Nile has now become entrenched in the U.S., it is not going to go away. It is here now, it is a part of our public health lives, and it will continue to be so. Much public health activity has been devoted to “fight the bite” campaigns, testing dead birds, and doing public information campaigns about how to eliminate mosquito habitat and so forth.

Smallpox was the next big issue that came upon us. And most important was the need to revive a vaccine against a disease that hadn't even been seen in this country for about 50 years. And the vaccine itself hadn't been used for about 30 years. (SLIDE) In 1971 we weren't vaccinating at all except in the military and only sporadically there. In 2003 and 2004, we vaccinated approximately 39,000 people in the U.S. and about a half million of our military. An important, and very controversial, campaign, but one that one way or the other was a major public health activity. As we continue to vaccinate against smallpox, we have advanced our preparedness considerably with regard to that continuing threat.

Severe Acute Respiratory Syndrome (SARS) was the next big threat that came along. It was a serious public health threat, perhaps nowhere more so than in our Canadian neighbors' jurisdiction. It taught us something very important about the fact that infectious disease does not only affect peoples' physical well being, but the economies of entire nations. As SARS progressed there were just over 8,000 cases and 774 deaths worldwide. It appears now that the disease has been contained. The only recent cases have been those resulting from laboratory accidents where the virus is being studied. So, we have successfully fended off this emerging public health threat.

In the U.S., there were only 29 SARS cases that met the WHO's definition for a probable case and there were no deaths. Nonetheless, every time one of the 137

other suspect cases occurred, we had to respond to it as if it were a real case. We had to isolate, we had to quarantine, we had to go through all the public health activities that surrounded the control of SARS and that ultimately was the way in which we stopped its spread.

Right on the heels of SARS came the next public health threat: monkey pox. It turned out that six states were actually directly affected by real cases of monkey pox. There were 72 cases in the U.S. Essentially all of them were true cases, 37 lab-confirmed and 35 that were because of epidemiological links to the others, almost certainly true monkey pox. Nonetheless there was a tremendous amount of activity in mounting a public health response to the cases. It was a major public health event in those six states and the rest of the country had to at least expend some energy on the process.

Then after monkey pox came the flu season of 2003. Last year we had to gear up for a flu season that had some odd characteristics. First, it came very early. (SLIDE) These are graphs showing the onset of the flu and it came well before Christmas. During the time we are normally just seeing the beginning of a flu season, this one was in full swing. (SLIDE) You see there the excess deaths from pneumonia and influenza plotted out on a graph. What you take home from that, if you studied it at great detail, is that this was probably the second worst flu season we have had in the last 10 years. Not the worst flu season ever. Not even the worst in the last 10 years. Just a relatively bad flu season as flu seasons go. (SLIDE) Red states represent widespread flu activity. Blue represents regional flu activity, which is the next lower category. Virtually every state in the third week of December last year was reporting widespread flu activity. And the few that weren't in the continental U.S. were reporting at least regional flu activity.

It was, indeed, a very widespread and epidemiologically active flu season. But there were some other characteristics that it had. One of them was the fact that we tried to explain to people, this year's strain is an H3N2 influenza A virus. Now H3N2 viruses, as a group, tend to cause somewhat more severe epidemics of flu than H1N1 influenza

A viruses or influenza B viruses. Simple enough. There was a sense that this was a particularly virulent strain, a vicious flu strain that was hitting us early.

When the dust settled, I think we can all see that this was simply H3N2, a little bit worse than H1N1. But the public perception was that it was a particularly dangerous strain. Also, public attention was focused on the fact that children were sometimes dying from the flu last year. This is not new. Most of you know about 100 children a year die from flu. Every one of those deaths is tragic, but it is not uncommon. And we are still working out whether last year's pediatric deaths are unusually in excess of what we would ordinarily see.

The fact that it was affecting children, and the media was picking up on that, created considerable public interest. And then there was the fact that people actually did what we asked them to do: get their flu shots. We ended up using almost all of the 80-odd-million doses of the shot that we had available. And so we had a relative shortage. All of this wound up making it the most difficult flu year that we had had in a long time...at least that was what we thought.

Then came flu 2004, which we are dealing with now. And we are seeing now a *real* shortage of vaccines. We only have about half of what we had expected to have. We hoped to have the largest amount of flu vaccine given this year we had ever given...we are not going to see that. And people are standing in long lines. These are not lines outside of health departments; we know how to give vaccines. These are lines you are seeing in places where folks are not experienced with giving mass volumes of vaccinations. Nonetheless, the flu situation this year is a difficult one.

Let's put it into perspective for just a minute. Most years in the U.S., we give flu vaccine to about 50-60 million people who are in high-risk groups that we say are in danger of serious consequences with the flu--the elderly, very young children, persons with chronic underlying disease. That is how much vaccine we have this year...about 58 million doses total. If we successfully target virtually all of our vaccine to those

people who should be receiving it, the high-risk groups, we will have a vaccinated population of high-risk individuals. That's about the same that it has been every year for the past two or three years, and this should not be any different than other years. Now whether we can successfully do that remains to be seen. But, if we do, the situation depends entirely on how severe the flu season is. It just reminds us that there are a lot of things in public health that none of us, anywhere in government, can control. We have to do the best with what we have because nature is always in command.

The lesson from all I have just said is that some things don't change. I remember people in public health saying, "Modern medicine, antibiotics, and vaccines have conquered infectious disease and we have defeated it. Now we can turn away from infectious disease and move on to other important public health problems like chronic disease and injury." Well, the problem with that is, we were only half right. We did and do need to address problems like chronic disease and injury control that are important parts of public health. The part we were wrong about was that we had conquered infectious disease. Boy, was that a stupid thing to think. It is not nice to underestimate Mother Nature...that is what we did. We decided that we had beaten infectious disease and we put it out of the way and didn't have to fool with it. And the last three years have reminded us that infectious disease is always going to be a part of the protection of the public's health. Infectious disease needs to be job number one. It is not the only job, but it's the one we have got to tend to.

(SLIDES) On this 1990 U.S. map, light blue represents states in which 10 percent or more of the population is obese, meaning a body mass index over 30. As we move to 1991 you see a new color, dark blue, which represents 15-19 percent obese. By 1995, the dark blue has spread pretty much everywhere in the country. By 1997 there is a new color appearing, yellow, which represents 20-24 percent, or one person in every five that is obese. This problem is not unique to any one state, it is a national problem. By 2001, there is a new color, red, which represents more than 25 percent of the population in the state is obese. By 2003, almost every state in the U.S. has at

least 20 percent obese residents and five states have more than 25 percent. That is an epidemic. That is major problem in this country. It is a public health issue that we must all address.

This slide is the leading causes of death in 2001. For men it is cardiovascular disease, cancer, and unintentional injury. For women it is cardiovascular disease, cancer, and respiratory diseases. This is what is killing us, not bioterrorism, not outbreaks of infectious disease. We have to address infectious disease, but you cannot ignore the things that are really killing us as well. Heart disease, stroke, and injury are important public health problems.

This next slide shows the drop in blood lead levels that has happened from 1976 to 1999. It is a success story that we have got to complete and continue. Environmental threats continue to be a major part of our public health responsibility. Now, here you see another success story (SLIDE), which is polio and invasive Hib disease. In the case of polio, we have virtually eliminated it. Hib has been taken down to the point where it is no longer a public health problem. We have successfully implemented a vaccine that can prevent it.

So what you see from all of this is that public health in the 21<sup>st</sup> century is going to be old-fashioned infectious disease. It is going to vector control with things like West Nile Virus, but it is also going to be addressing cardiovascular disease, environmental threats, and other things.

Here are the three points that I want to make this morning. First of all, the “new normal” in public health is this: we must be prepared to respond to emergencies, but we also must protect the public’s health from predictable threats. Threats like chronic diseases, endemic infections, environmental threats, and injury. How many of you have heard someone say, “I wish we could just get through this SARS stuff, so we could get back to the really important public health problems that we need to address.” We say things like this over and over again, but the reality is that we are not going to get through the crisis and get back to what we need to be doing.

The new normal in public health is to be able to do both at once. It is responding effectively to crisis. This is new because we didn't have a lot of public health emergencies to respond to for the last couple of decades...and then all of a sudden in the last three years we have been reminded that they are a part of public health. We have also got to carry on our normal activity and address those other public health problems. And we have got to do both at once. We cannot go from one to the other and back and forth. And that is the new normal in public health.

Next, the "old normal" ain't gonna change. The U.S. public health system, and I suspect the Canadian public health system is similarly arranged, is a three-part system. Certainly it is a responsibility at the federal level, but the state and local public health systems are important to the functioning of the overall system. If you take away any one of these parts, it doesn't make a difference which one, the thing falls down. We at CDC cannot protect the public's health without you in state or local health departments and academia. And you cannot protect the public's health without us. We each have our own unique roles and interlocking roles. And when we forget that, our system does not function well. When we remember it, it does work effectively.

Really quickly, smallpox is a deadly disease, capable of inducing public panic. So is meningococcal disease. Something that we in public health deal with all the time. And sometimes we have had to vaccinate against meningococcal disease because sometimes giving chemoprophylactics to the immediate contact is not enough. Now, in an outbreak you have to vaccinate a whole lot of people in a hurry. My two favorites are displayed here (SLIDE): Carrol County, Georgia, vaccinated 22,000 people in 1993 in about three days. But the world's best was in Mankato, Minnesota, in 1995 when 30,000 people were vaccinated against the meningococcal disease. What is important here is that we have been there and done that in public health. We know how to give mass vaccinations and we can do it when it is called for again. Such as it would be in the case of smallpox. We have done it and we know how to do it.

Now when we dealt with SARS a couple of years ago, this is the way it was ultimately controlled:

- Rapid identification of cases
- Intensive case interviews
- Locate and evaluate contacts—often with limited locating information
- Prevent contacts from transmitting.

And this worked, it was successful. Brand new public health technique, right? No. That is how we dealt with syphilis and TB. That is what people in public health have been doing virtually everyday. Same techniques, different interventions. Instead of isolation we have penicillin. But the basic premise is the same.

SARS and TB are fatal lung diseases where isolation and quarantine, ancient public health tools, are the most effective responses. Some things simply do not change...and here (SLIDE)...this is the original gram stain from the first case of anthrax in Florida. And the way this case was identified was when the index case presented itself to an emergency room with meningitis. Not classic symptoms of inhalational anthrax, but with the meningitis that half of all persons with inhalational anthrax will manifest. The ER doc did what any other ER doc would do. He performed a lumbar puncture and gram stained it and he saw that (SLIDE). He decided that didn't look right and he called the public health department. The local health department immediately contacted the state health department laboratory and arranged for special transport. It went to the state lab in Florida and they diagnosed bacillus anthracis. That is how we found out that we had been attacked in the first place. The system worked.

There are lots of new surveillance techniques that are being implemented in this country. There all kinds of important things that we are learning to do that we are going to need in the future. But none of them are ever going to replace the astute clinician that has a relationship with a prepared health department that can receive and respond to those reports. That is always going to be our most important line of

protection. That is the “old normal” that ain’t going to change. Not all public health tools are new.

And, finally, the workforce for both “normals.” We are talking really about how to rebuild the public health infrastructure when we are talking about workforce, because that infrastructure is people. In our work at the CDC we have identified three things that we think all of us need to do to build that infrastructure back up and to provide that workforce. The first of these is to leverage our preparedness opportunities. Secretary Tommy Thompson a couple of years ago very specifically said, “This is our chance, with these preparedness dollars that we are getting now...this is how we rebuild our infrastructure.”

Now this is why this is important...you can spend just as much for preparedness measures that only work in catastrophic situations (SLIDE = “limited use” preparedness dollars) or, for the same price, you can get something that can be used for more than one thing that you know you are going to need (SLIDE = “full use”). We have got to work on finding ways that we can spend our preparedness dollars so that we can get full use of them. The ability to respond to the catastrophic emergency, manmade or natural, but also the ability to scale those same things down and respond to the inevitable medium and small outbreaks of disease that are going to occur.

Secondly, we have to catalyze agency accreditation. There is a demand today, on the part of the public—partly because they have understood for the first time that we in public health provide a protective service that they genuinely need and depend on—and on the part of policy makers for some kind of accountability for public health. For us to be able to demonstrate that we can protect them, and by whatever name you call it—accreditation, credentialing, certification--is saying that we have a means of measuring whether a particular health department in a jurisdiction can fulfill all the necessary functions or cannot and needs to make improvements.

The next point is that we need to build the public health workforce directly. A prepared and competent workforce in this country for public health results from the famous pipeline. This is the pipeline (SLIDE). And of course that is fed into by schools of public health, by professional schools, medical schools, dental schools, nursing schools, and by colleges and universities. They are all sources of people who then go into that prepared and competent workforce. CDC contributes through much smaller pipes—public health prevention fellows, the Epidemic Intelligence Service, and some of our field staff—we feed a little bit into that, but the pipeline—the big thing—is coming from our educational system.

Now, there is one thing wrong with our educational system. Today, about 23 percent of graduates of the American schools of public health go to work in governmental public health. The rest go elsewhere to do important things, but that does not contribute enough to the public health workforce of our country. And that is why we have to do something. We have to take some kind of steps to take *this* situation, where we are losing most of those graduates to other things, and adjust it so that more of those graduates enter the prepared public health workforce. And that is the task that lies before us.

I don't have the solution to this. But I have a few suggestions that might work. And that is if our schools of public health can achieve academic and practice integration. And the two most promising things that I see to achieve this are our Academic Health Departments and our Centers for Public Health Preparedness. If we can do that perhaps we can change the numbers just a bit and maybe 30 or 33 percent, instead of 20 or 23 percent, of those graduates will go into our governmental public health workforce. That's the sort of changes we are talking about here.

So, these three things in particular are important, I believe, to build our public health workforce. And the reason that we have to build the public health workforce is to respond to the "new normal" while maintaining our ability to continue the "old normal." This is public health in the 21<sup>st</sup> century, and it is the task that you face in

this region, and it is what you are going to be talking about for the next day or so as you work through this process. Thank you for the opportunity to be a part of all this.

### **Expert Panel: Databases, Volunteers, and Credentialing**

**Lisa Pogoff, MPH, MSW**

**Bioterrorism Hospital Preparedness Program**

**Minnesota Department of Public Health**

Thank you for allowing me to be here today. Having ten minutes to go over what Minnesota does and how we are connected with a national program is a little bit of a challenge. The name of our program is Minnesota Responds—Health Professional Volunteer Registry.

First, I am going to describe the project that Minnesota has and then talk a little bit about the national program that we are connected with. Then I will show you online how our electronic database works. So, we have two overall project goals: (1) assuring that we have surge capacity when we need it, and (2) coming up with the mechanism for organizing volunteers and making them available to the local public health departments and hospitals when they are needed.

I started out working with an advisory group that was a part of my commissioner's task force on terrorism in health. And I was involved in the workforce subgroup of this task force. And our work group's charge was to (1) identify what was needed in terms of developing workforce surge capacity, and (2) develop the mechanism for doing it. Now whose responsibility does it come down to? MDH is serving in the role of coordination and we are working with a wide variety of stakeholders to see that this actually comes about. So, it's our responsibility to develop, coordinate, and work with all the partners that we have.

(SLIDE) I will get to the actual website at the end of this, but first here is an overview of the registry site. The site talks about how the actual registration works, data practices and data privacy for the volunteers, who to contact with questions, and we have a list of FAQs and answers. Then we go to a basic registry form that everyone fills out. We have advanced forms for physicians, dentists, pharmacists, and nurses. And then at the end I will show you a way that our volunteers can go back in and update the information that they've put into our registry.

Minnesota Responds was developed in collaboration with many people. One of our IT staff worked on developing an Oracle database. And now we are working on developing the policies and procedural operations that we need to make it work throughout the state. Some of our policies and procedures are still being developed and we are still in the process of working on them.

We have determined that the onus for keeping information updated needs to be on the volunteer. That is the person who will have to go in and provide correct, current information. But we will work with our local public health departments and send out reminders that they can forward to individuals to work cooperatively on this.

Now I am going to talk about a federal program that we are working with called ESAR VHP. This stands for Emergency System for the Advance Registration of Volunteer Healthcare Personnel. The system is intended to be national but based on state-level systems that are coordinated so that they are interoperable. And to come up with an overall program, HRSA has developed 10 working groups. Minnesota is involved in the credentialing work group. The work groups are very inclusive and have people and organizations from a wide variety of stakeholder groups. These are some of the organizations that are working with HRSA (SLIDE).

So, here is an overview of how the program will work. We are going to be working collaboratively to develop national standards and definitions. And then all of the states will be encouraged to enter into agreements to work together so that we can

cross borders and boundaries. There are three phases of development and Minnesota is fortunate enough to be in the first phase. So, we are working with HRSA and all of those partners on coming up with guidelines, standards, and definitions.

Now I am going to show you the Minnesota Responds website and how it works.

(SLIDE) The pages above this give the background and information, the FAQs, and the resources links. Just to give you an idea, these are some of the issues that we are addressing and these are the questions that we are asking (SLIDE). First, personal contact information, how to get a hold of people, other commitments that they might have during an emergency. Then, we are asking some questions about employment status, where people are working, what they are doing, what county they work in, the setting, what types of activities they are involved in. Then, questions specifically pertaining to skills and services during an emergency--travel limitations, foreign languages, experience that they have had, such as HAZMAT training, First Aid, CPR. And some of the credentials, licenses, and other background information about education and training and profession.

Currently, Minnesota has 18 health boards that license health care professionals. So, this is a variety of the licensed professions (SLIDE). Then, we have a wide variety of the health care occupations that don't have licensure or registration or certification. And we want to get everybody who thinks they're in a health care occupation. We chose about 40 occupations and then "other." So anyone who feels that they are related...a medical transcriptionist...dietary aid....anybody can sign up and be in the registry.

That is the basic form for everybody. Continuing forms and more in-depth information for the professions I mentioned include questions about (SLIDE) specialty, professional activity, experience in various kinds of settings, how their private practice is set up so that we get an idea of the flexibility, some of the work that people would be capable of doing, and experience. That gives you an idea of how our system works.

Again, feel free to contact me and I can give you more detailed information about both Minnesota Responds and ESAR VHP.

**Brenda Goolsby, SPHR**  
**Senior Associate, Disaster Service and Human Resources**  
**The American Red Cross**

I want to talk to you a little about the Red Cross. I don't know how many of you have had experience with us and our disaster work. We are a humanitarian organization, led and staffed primarily by volunteers across this country. The American Red Cross provides disaster relief throughout the United States, its commonwealths, territories, and possessions.

When I came to Washington 12 years ago, a week before Hurricane Andrew hit, our database of trained disaster response workers was 6,000. As of today it is more than 27,000. And those are people from all walks of life and with all kinds of experiences who have had standardized training across the country. So when they come from Omaha or from Maine and go to Montgomery to do flood relief or hurricane relief, they are coming with a common platform of knowledge and experience.

We are congressionally chartered to provide our disaster assistance. We work in partnership with the federal government in many ways. We provide relief for victims of disasters and we help people prevent, prepare for, and respond to emergencies. Annually, on a local basis and nationally, we respond to more than 70,000 disasters. And that is all the way from a one-family fire up to the events of 9/11 in New York.

We focus primarily on the immediate emergency needs—safe shelter, food, clothing, medical needs, health and mental health services. We also work in partnership with the National Voluntary Organizations Active in Disaster to make referrals so that victims of disaster can get as much help as they possibly can to get back to where they were before the event happened. We work cooperatively also with FEMA and other government agencies, the Department of Homeland Security for instance.

We are also named, not only in the national response plan, but are also under the Aviation Act, as the agency by the National Transportation Safety Board (NTSB) to respond to air incidents such as the commuter airline crash that just happened this week in Kirksville, Missouri. We had staff on the ground there immediately responding from the local chapter. We sent some specially trained leadership staff in to help lead and work with the NTSB, the airline, and most especially the families of the victims and also with the survivors—there were two survivors from that incident. I can speak from personal experience...I think it is one of the most emotionally charged, but empowering, aspects of our mission when you are dealing with people in that kind of situation.

The Clara Barton Institute—named after the American Red Cross’s founder—is based in Pine Bluff, Arkansas. In that office we teach not only our air team—the people who respond to air incidents in leadership roles—but now our crisis response team. And they are trained in bioterrorism response; 9/11 certainly taught us those things. We have a human resource system that is web-based, and it can be accessed by our national headquarters, our eight service areas in the country, chapters around the country, and even individuals will be given access this year to go in and change some of their basic personal information in that system.

We are migrating to a new computer system, so I did not bring a sample. We are moving to a PeopleSoft based system, and we will be using the LMS system to track our training. We, in the past, have based our membership on standardized training and then leveling of experiences. We are now moving toward a competency-based system, one that will give more credit for life skills and knowledge, skills and abilities that people can bring from any walk of life. And that is a culture shift for our organization, and it has kind of been painful. This summer we started shifting some of it and we have had some strong pushback in some areas. So, we are doing some education and modifications.

We also have very strong requirements. And we have strengthened them since 9/11 for the health status of our own paid and volunteer staff that responds. We require an annual statement of health, and then biannually we are doing a more detailed statement because we have found that when we send our workers into a disaster area, such as Florida this year, there are many environmental factors that may affect one's health. Factors may include temperature, humidity, mosquitoes, water quality, and lack of electricity and air conditioning. In addition, you are away from your normal support systems—your doctor, your family. And it is emotionally impacting, dealing with people who have lost everything that they ever had in life. And you are taking that on yourself everyday, so there is a strong need for good mental health as well.

We found that a lot of the housing in the resort areas, where a lot of the damage happened in Florida, was damaged so badly that we had to find housing for our own staff. Which meant that you had to be able to sleep on the floor—with 100 other people that you had never met before—share the bathroom, eat less than delightful food, and maintain your sanity and work 12, 14 hours a day. So that is a big issue. And like anyone else, your health issues and distress manifest themselves, so we are working in this area very strongly.

How do we mobilize these 27,000 people? Well, you are never going to get 27,000 of them at one time. If we can get one-third of our force out, we consider that as doing very well. We recruit them nationally through our structures—the service areas and chapters. We arrange their travel, which is directly billed to our organization, resulting in efficiency and saving of donated dollars. We also have a contract with an outside agency that secures our housing. They negotiate based on the government contract rate for rooms, and get as low of a rate as they can for us. When we first started this I was not really in favor of it because I thought everybody gives Red Cross the best rate. This agency has proven me wrong; for the last five years we have saved \$16 million on housing alone using them.

Instead of giving people what we used to call cash advances—where the local chapter would give them a check and they would cash that and use the money—this year we are switching to a debit card that will be given to someone for a one-time assignment. We load what we have estimated to be the money needed for a three-week assignment onto that card. They can either take that out as a debit card or they can use it as a credit card. It is working wonderfully. And then if they need to stay longer or if they need more money, we can load more onto the card. This leads to less paperwork. It has really proven successful. So, we are trying to think outside the box and people are really getting into it.

To give some idea of the kind of response work that we do, the response to 9/11 in New York, Pennsylvania, D.C., the originating areas for all of the flights, and the end destinations of all of those flights--all of those operations were staffed by Red Cross paid and volunteer workers. We had more than 48,000 individual assignments. But to give you an idea, only 8,000 of those came from our system as registered, trained people. Over 40,000 were spontaneous volunteers who had to be processed, whose credentials had to be authenticated, their abilities immediately determined and assignments made.

In response to the hurricanes this summer, we have already assigned and are still working two major relief operations. We have assigned over 10,000 of our DSHR members and hundreds of thousands of other volunteers have responded across the country in those locations. And we are now starting to transition to a long-term recovery project, much as we did after 9/11 and Oklahoma City. In fact, we are still working with the Oklahoma City bombing victims. In Florida and Alabama we have so far registered 53,000 families for assistance, and we will be spending in excess of \$70 million.

As we move into these programs we need more and more health service professionals to work with us. In this summer's event, we also did what we call a "non-traditional volunteer recruitment." We recruited quite a number of people through the

professional medical groups, including Medical Reserve Corps, the APA, all of these different groups that license and serve as national spokespersons for your professions. We have had a very good response from that, and we hope to maintain it and get these people to be full-time volunteers locally and nationally.

Regarding the actual credentialing of our volunteers, you need to provide your license when you register with us or show up as a spontaneous volunteer. We verify those online or by phone. More information about how we authorize people, what levels they can work at within health service and mental health fields, is in your book. I really appreciate the time to talk to you today.

Paul R. Hales, JD

General Counsel for the St. Louis Area Regional Response System

I want to talk to you a little bit about our experience in creating and working on workforce issues. And I want to talk about three elements of that. One is the overall concept. The second is the mechanics of it. And the third is some of the legal issues.

I noticed that Dr. Thompson used the words “leveraged preparedness opportunities.” That is something we are working on too. We don’t call it leveraged preparedness opportunities...that sounds kind of like Washington speak. What we call it is “something that works all day, everyday.” I have looked through the survey responses that are in this book about credentialing, and I don’t think that Missouri is any farther along than any of the other states that have responded. We may be a little farther along in thinking about the issues, and I think that is where we can help.

We started this in the late 1990s, looking at metropolitan medical response. Let me describe the area. We are a metropolitan area of about 2.5 million people, we have two states, we have multiple counties, and we have a major city at the core. We developed a mutual aid pact among hospitals to deal with surge capacity. There are now 42 hospitals that are part of this mutual aid pact. We have a medical communications center, located in the city of St. Louis, for dispatching purposes to deal with surge capacity. We have a hospital emergency radio network that connects all the ambulances, the emergency rooms, the helicopters, and so forth. And the whole idea was to create a way for dealing with mass casualty incidents.

Then, of course, along came 9/11 and that became the foundation for dealing with both the homeland security threat and the opportunities provided by homeland security funding to allow us to continue to build this system. What we saw immediately was the need for information. We needed to know who our patients were, where they were, what their situation was. We needed to be able to dispatch

them to the appropriate receiving hospitals. We needed to be able to balance the load among hospitals. We also needed to be able to identify our health care workers with the idea that we would develop a mobile force that could respond either to a site in the field or to a hospital where the health care worker is not normally assigned.

We also wanted to be able to create a first responder identification system. In 9/11 one of the biggest issues was not being able to know where anybody was and who they were. We started working on this at a metropolitan level, and it quickly moved to a state level. We are here today on a regional, state-to-state level. I feel that it really needs to have national standards established, and I will talk about that in a minute.

With respects to the mechanics, there are two elements. One is what I think we have been calling credentialing, which is establishing what the professional credentials are and the qualifications of the health care worker. The second is badging—some system to identify those people.

In St. Louis, what we started to do was to create a badging system for all of our health care workers. We immediately ran into to issues involving legal liability. I have passed out a handout, which has to do with the legal liability. I am not going to go into that in any detail right now. But, in looking at the badging system we decided that we needed both a high-tech and a low-tech solution.

We already have a fairly high-tech emergency patient tracking system which is in operation all day, every day in the city of St. Louis, and it is being expanded to the outlying counties right now. It involves bar-coded bracelets with tear-off tags that are used when the patient is first seen. A tag is torn off at every step of the way as the patient moves on to the hospital, so we know who the person is, what their injury is, and assemble as much information as we can. This is an Internet-based database.

We wanted to have the same thing for health care workers and first responders. We also decided that the Internet might not work during an emergency, so we needed a low-tech solution as well. So the badges are being designed with color coding so that we can determine at a glance if the person is, for example, a nurse who is a burn nurse or whatever level of qualification.

In terms of the mechanics of that, we have had some design concepts and we are working with different people. Some say it is very easy and others say it is going to be very complicated because you have to coordinate multiple databases. We have vendors that, of course, say that they can do it. We are just trying to work that through right now.

In terms of verifying who the person is, we have decided to work with the state professional registration. The first group of health care workers who are going to be signed up, if you will, are the nurses, and they are re-licensed right at the beginning of next year. We are using their re-licensure as a way of establishing their credentials. Their little card that says that they are a nurse will be this badge.

In terms of legal issues, the principal issue is the liability that any health care worker faces for professional responsibility from a civil suit. There are a couple of options. One is insurance. It probably isn't a very good option. Private insurance is expensive. Private insurance for malpractice is normally limited to the place where the health care worker normally works. There could be a government insurance scheme, which might take a lot of work.

The second option is statutory immunity, which would create immunity for the health care worker under very specific circumstances with the exception of gross negligence. And the third option would be actually making them, at a time of a critical incident, a governmental employee—in much the same way that a Disaster Medical Assistance Team (DMAT) works.

One other thing I will mention is that we are concerned about health care workers who are paid as well as volunteers. As the health care personnel have pointed out, if we want to take a burn nurse for a day, that's one day to be a volunteer, but if we need that nurse to work for two weeks or three weeks or four weeks, then it becomes a completely different matter. It becomes a hardship. Asking the person to volunteer also becomes unreliable, in terms of creating a credentialed and badged workforce.

Essential to all of these things, whether there is governmental immunity or statutory immunity, is this whole issue of badging and credentialing. So, that is something that we are focusing on very much. I will just conclude there and I would be happy to speak with any of you later on. Thank you.

#### QUESTIONS FROM MODERATOR:

**Q. Lisa, in putting together your Minnesota program, what did you see as your number one challenge?**

**A.** I think our biggest challenge is that we have a statewide system that is coordinated at the state health department, but it is going to be used and accessed by local public health agencies. We are starting with a small pilot of seven counties in the Twin City metro area who are already on board with us, and now we have to figure out the best way to work with other counties, which are particularly rural counties, and getting each one linked to our system so that we can coordinate and work together.

**Q. Brenda, in managing large numbers of people, what do you see in the macro sense as the number one challenge in making sure that that is efficient and effective?**

A. I think it's a challenge to bring people from so many different cultural and economic backgrounds together in one location, under high stress, and you are trying to move them there very quickly. What we do is basically set up a huge corporation overnight. Getting that up and going—what supports it—and then getting the service delivery immediately to the clients. And getting that all done simultaneously.

Q. Paul, what is your number one challenge in getting what sounds like an extraordinary system in the patient tracking program you have put together in Missouri?

A. As far as the emergency patient tracking system goes, the challenges are really mechanical, and a lot of them have been soft. So, we have the bar codes, we have the readers that are attached to Nextel phones that most of the first responders have, and we have the software and all of that. The technical challenges have been mostly worked out. I will say that, as a lawyer, I feel that the legal challenges are extremely significant. And as a practical matter I must say that we must resolve the issues of protecting our health care workers from civil suits in order to create this workforce that we need to respond.

## Notes From Workgroups: Highest Priorities

### Databases

- Need for confidentiality in maintaining databases.
- Interoperability of systems—consistency of templates.
- Communication between systems.
- Local participation, size of files manageable and can communicate between various systems at local, state, and national levels.
- Identify what information needs to be shared before looking at interfaces.
- Knowing who to contact in other states.
- National repository that provides accessibility to all laboratorians and that can work with all of state Health Alert Networks (HANs), expand on Laboratory Response Network (LRN).
- Start with smart card Real Time Credentials database; provide information regarding individual that is drawn from multiple databases.
- Standardization and consolidation of databases.
- Point person needs to be trained to integrate database systems.
- Human Resource Management system—central access system that is accessible across regions and states.
- Standardized terminology.

### Volunteers

- Insurance and liability in scope of practice—accepted definition of what different disciplines can do.
- Look at existing processes for identifying and reporting availability of volunteers.
- Look creatively at how volunteers can be used and then what backgrounds and skill sets are needed.
- Plan that addresses surge capacity—minimal training needed, exercised routinely and done at two levels. Current professionals and local available staff.
- Need to work closely with other organizations that may control licenses.
- Need to develop relatively clear and simple just-in-time training model across states for volunteers who are called to provide services.
- Create system to develop and track volunteers expanding on existing systems—identification and training
- Adjusting liability issues including workers' compensation.
- Use Red Cross volunteer system as a guide. Market to employers.
- Plans for recruitment of volunteers along with standards and credentials/training.

## Credentialing

- Need to share information across states in what each is doing regarding volunteer databases.
- HRSA has 10 different working groups. Since guidelines developed in early January will have minimum standards regarding what volunteer databases need to include. This may answer some of questions in regard what need to do to standardize in state and across states.
- Define difference between credentials and badging. How identify difference?
- Reciprocity and education of professionals across state lines. At local level if look at physicians and different hospitals can work in how would this work. Look at EMAC at national level to see what written in policy. See what needs to be added from policy perspective.
- Standard skill set across borders. Create regional response teams.
- Every state needs lab licensure and ensure reciprocal with other states.
- Need common meaning to term “credentialing,” and there is question across professions re: what this means. Those checking databases need training in what looking for and what mean.
- Promote 10 state mutual aid compact.
- Need to universal common definition. Consider HRSA definition. Disaster definition and common definition.
- Medical Reserve Corps—have addressed these issues.
- Liability purposes—background information checks etc. Need to deal with these.

## What can we do to move forward?

- CDC and HRSA need to talk.
- Need to stop, look, and listen. Look at what is out there. Look at lessons learned from deployment of professionals to Florida and see what can be learned.
- Have up-to-date contact information for individuals from other states. So know who your counterpart is in another state.
- Expand on what currently have as 12-state database and have central database.
- Need to start to develop just-in-time training model. Address liability. Exercise/drills across state borders
- Meeting and training with key legislators on 10-state compact.
- Planning events—should invite federal-level project officers and get them involved in best practices.
- Identify needs, resources. Getting all needed entities involved. Start at local level first.
- Look at legislation to get identified standards—credentialing, liability.

## Keynote Speakers

**Mary Mincer Hansen, PhD**  
**Director, Iowa Department of Public Health**

One of the things that people in academia are frequently accused of is publishing things in national journals but not using that knowledge to help people. One of the things that I've found with the University of Iowa College of Public Health is that the work they do will make a difference in the lives of the people of Iowa.

It has become clear that bioterrorism preparedness is a role of public health. Since September 11, two things have happened: there is more money to do our job, but more importantly, we have built great partnerships.

Early in my career as the Iowa Director of Public Health, I was heading an exercise that simulated a plague outbreak. A while into the exercise, I realized we were running out of hospital beds, so I asked the Iowa National Guard to set up, or simulate setting up, some hospital beds at a local baseball stadium. I was surprised they could not fulfill this request because their beds were deployed in Iraq.

The lessons I learned from that exercise is that nothing is ever going to go as you plan, and the most important thing to have is a good relationship with one another to make sure we have the widest net of friends available to help us.

**Richard Raymond, MD**  
**Chief Medical Officer, Nebraska Health and Human Services System**

Public health issues that overwhelm our states arise daily. These issues do not always reach the level of a governor-declared emergency. Unfortunately though, we are often busy handling the problems as they arise, and put off the less urgent problems like chronic disease.

The 10 states that are part of the Emergency Management Assistance Compact (EMAC)-- Montana, Wyoming, Utah, North Dakota, South Dakota, Colorado, Kansas, Minnesota, Iowa, and Missouri--are all sparsely populated with the exception of a handful of urban centers. This limits our ability to respond to a crisis and maintain essential services at the same time. Further, many states cannot handle more than one crisis at a time.

The idea for the EMAC started from the network of collaborative public health services that we used in Nebraska. Because we do not have many people, everyone has to work together to keep the public health system working. This same model was applied to Region 7 and 8 of the U.S. Department of Health and Human Services to

respond to a crisis. This has been put together at the top levels to make sure this is a priority to the states.

There have been several examples over the past couple of years where the EMAC would have been helpful for crises that did not merit a governor-declared emergency. For instance, Nebraska's laboratories were flooded with West Nile Virus samples, there was an anhydrous ammonia spill in Minnesota, and a rubella outbreak among Hispanic males on the Iowa-Nebraska border. Therefore the need exists to develop regional cooperative programs for mutual aid and support between state and local health agencies during emergencies that fall below the level of governor-declared emergencies.

Some of the challenges we face are:

- ◆ communication of the concept to the appropriate parties in each state;
- ◆ garnering support from all states;
- ◆ large scope of implications versus daily reality of doing more with less;
- ◆ and funding.

The way to overcome these challenges is to start this program at the top levels and work down. Further, establishing medical credentials that work between states is a very important part of sharing resources, perhaps even at a national level. Having a dedicated full-time staff and director is essential to the success of this program.

Our immediate goals are to create and establish a model that can be viewed by others to identify resources essential for establishing mutual assistance programs, and to lay the foundation for regional mutual aid that starts working on the short-term goals for all public health emergency responses. A new full-time EMAC director would address some of these goals.

EMAC agreements between states have traditionally been about sharing physical materials such as snowplows to handle emergencies. What we are trying to do now is create a model so we can share people. The three areas that we need to focus on to share human resources are databases so everyone knows who is available, epidemiological support for outbreaks, and laboratory agreements to augment surge capacity during a crisis.

## Afternoon Session

### Expert Panel: Training Standards/Competencies; Qualification and Knowledge; and Authority

Mary Jones

Director, Division of Acute Disease Prevention and Emergency Response  
Iowa Department of Public Health

I want to start by introducing several people in the audience today. We have with us Jerry Ostendorf from the Iowa Homeland Security and Emergency Management Division. He is the bureau chief for the Readiness Response Bureau. Captain Bob Cox is with the Des Moines Fire Department and he is in charge of the hazardous material team in Des Moines. Also sitting in the audience is Bonnie Rubin, the bioterrorism response coordinator for the University Hygienic Laboratory. These three people, as I get into my presentation, are very instrumental in this particular project that I'm going to talk about: the Biological/Chemical Threat Agent Protocol Model.

That's a long name, but I think it serves the process very well. What we want to focus on is "authority." Going through the whole process, that was the question that was raised many, many times as we worked on this model: Who is in charge? And who's the boss? And all those questions were raised by law enforcement. Are they in charge? Are they in control? Is it fire or is it HAZMAT? Should it be public health? Should it be emergency medical services? Is it homeland security and emergency management? Or is it our government officials?

Why was this protocol model developed? It was developed to answer that authority question. And we had real life experiences to help us answer that question. Specifically, I am talking about white powder incidents. We had several white powder incidents in the Des Moines area and other areas across the state, some of which were

credible or had a credible threat associated with them, a criminal element, and some that were hoaxes. And some that were not hoaxes, but didn't have a credible threat.

So, through those experiences we learned early on that we needed some type of protocol model. And the reason we needed a protocol model is because these multiple disciplines, multiple agencies, from multiple different jurisdictions were responding to these incidents and we had problems. What kind of problems do you suppose we had? WHO'S IN CHARGE! Sometimes the fire department thinks it's in charge, sometimes public health or the state laboratory thinks that they should be in charge, and believe it or not sometimes the state emergency operations center thinks they are in charge. Or maybe the homeland security advisor thinks they are in charge, or the governor thinks that he is in charge.

So, a group of us set sail to attempt to develop a protocol model that we all, from multiple disciplines, could use during an incident. Here are the agencies (SLIDE) that came together to attempt to do this. Jerry and I went out and we grabbed a hold of the Des Moines Fire Department, law enforcement, the Department of Public Safety, the Department of Criminal Investigation, public health, the University Hygienic Laboratory (UHL), the Des Moines Police Department, and the Iowa HAZMAT task force.

But this protocol model is not owned by any state agency or any local agency. This is Iowa's protocol model and this is for every discipline that responds to these types of incidents. The team that put this together all agreed that this is not just about law enforcement...it's not just about fire and HAZMAT...it's not just about the laboratories...it's not just about public health or emergency management. It's about our ability to respond in a unified format to have successful incident outcomes, to reduce illness, to reduce injury, and so forth. It is not a product of any single agency or discipline.

We began working on this in April of this year and in August we presented this protocol model. That was after it was reviewed by a panel of medical and science experts—the state epidemiologist, the state health director, Dr. Gilchrist from UHL, the assistant state epidemiologist, the state toxicologist, and the medical director for the state poison center. So we had medical and science oversight to this process.

Then we shared the protocol model with all the associations and organizations that represent the first responder groups that respond to these types of incidents and asked for their endorsement. And so far, to date, these are all the agencies (SLIDE) that are supporting this protocol model, taking copies of it, and attempting to integrate it into their associations and organizations, and encouraging their members to adopt this response model. We are very pleased with that, and we have more that we are working on to join the ranks with us.

So, what is the purpose of the model? The purpose of the model focuses on biological and chemical threat agents. It is not a catch-all protocol model for radiological types of emergencies, for bomb threats, or for other types of weapons of mass destruction. It is for biological and chemical threats. And we learned early on that if we were to try to develop a unified model for all of these types of responses, we would have been behind closed doors for years. We had to narrow it down so that we could be successful in producing a product that was useful for all of us. However, we do believe that now that we have a product, this will serve as the framework to drop in radiological responses, bomb responses, and other threats and emergencies as they emerge.

The purpose is also to provide a uniform, statewide set of guidelines. And I would rather you called them operational procedures that we all agree upon. Law enforcement agrees to respond this way, fire agrees to respond, public health agrees to respond, and emergency management, and so on. So a common framework for “operations.” And most importantly, this is all built on the incident and unified command system for any type of responses of this nature.

We are also in the beginning stages of applying this framework to the National Incident Management System (NIMS). I am going to let Jerry talk about that in just a minute. It also clearly defines the roles and responsibilities of all these disciplines. It also outlines who has authority during these responses. And it establishes a common framework for response.

Who needs to know about this protocol model? Emergency management, fire and HAZMAT, law enforcement and dispatchers, emergency medical services, hospitals and laboratories, and public and environmental health. Those are our key focus groups that we want to present this model to. So we are doing just that. A multidisciplinary team is traveling to six regions in the state to introduce this response model. To date we have trained 450 responders on this model in multiple disciplines. We will be done by December of this year with that first round throughout the state. What I would like to do now is turn it over to Jerry Ostendorf from Homeland Security and he is going to talk about the incident command structure.

**Jerry Ostendorf**

**Bureau Chief, Readiness and Response**

**Iowa Homeland Security and Emergency Management Division**

I want to continue on with a lot of background and the format that Mary laid out. And I want to talk a little about the operational authorities as you look at these three bullet points on this slide. Incident command structure in that system is going to be very important when you respond to a major event. And it was referenced already, the terminology that is out there labels it as a national initiative called National Incident Management System (NIMS).

How many here have attended incident command system (ICS) training? How many here have actually adopted that within your discipline? Good. What I want to do is talk a little about some of the requirements coming down from the federal

government from Homeland Security. The thing that they are going to make you do eventually at the local and the state level is to formally adopt the incident command structure for your discipline, for your county, for your jurisdiction, and for the state. So when you go from one state to another state you will know how to operate within that emergency environment.

The way that we are looking at doing that right now is through your county multi-hazard emergency operation plans. In your base plan we are going to be working with the county emergency management coordinators to adopt the incident command structure and system. And that is how your local resources will be deployed during that disaster.

On the state level, we have what we call the state emergency operations plan as well. We will be adopting those standards as well within the National Incident Management System. Right now we do have a state law on the books that we can use to reassure local officials that when the state responds, it is going to be done by state law, Code of Iowa 29C, that all state resources, equipment, and personnel will be managed through the National Incident Command System, so that we have a unified, organized structure when we deploy all of these resources to the locals.

I believe all of your emergency authorities—all of the resources you have to bring to bear to this incident—are best managed through the incident command structure. I think it is very important to get that training and get the next level of NICS training because a lot of you have had just the basic; the intermediate level is next, and there are also higher levels after that. And I believe that you are going to see the federal government pursue that as well with training dollars to get a lot of the first responders to a higher level than what we see today.

Operationally, I also reference Code of Iowa 29C, which explains the governor's emergency authorities and ability to declare a state of emergency in any county that has an incident that goes beyond their capabilities. That is the mechanism that the

state uses in order to deploy any and all state resources to that scene based on the incident commander's requests and needs. In addition to that, we activate the state emergency operations plan. We activate our state emergency operations center. That facility is a coordination facility, if you will, where all the appropriate state agencies gather and coordinate our resources based on the needs of the incident commander. We do not want things being self-deployed to that location and then mucking up the operation.

Another resource management tool we have in Code of Iowa 29C is IMAC, which stands for Intra Mutual Aid Compacts. That is what the local jurisdictions can sign on to; it's a voluntary program. You can sign on right now as a local jurisdiction here in Iowa and share resources from one jurisdiction to the other. It is not as broad as the county. A county is one of the IMAC signatories, but you can get down into the jurisdiction such as a community or a town or even a school board. If they have school buses, for instance, they can use those.

That is a fairly new law and what we are doing is going out and marketing it right now. I think that we are up to 38 or 39 counties that have signed up...and probably some 160 communities in the state of Iowa. What we need to do is go out and do some intensive training on how to operationalize that law. But at least we are getting the folks signed up and on board.

Emergency Managements Assistant Compact (EMAC) was talked about earlier. And that again is in the Code of Iowa 29C. I know we have a lot of partners here from Minnesota and Wisconsin—if you don't know it, you are EMAC members. Right now we have 48 states and the only states we do not have are California and Hawaii. I have been doing EMAC for about seven years now. It works and there are a couple of things in here that I think are going to be very helpful and useful to you.

When you have a governor's state of emergency proclamation, there are articles of incorporation in that law. Two of them I think stand out. One is the reciprocity of

professional licenses. There is an article in there that addresses taking a professional license from state A to state B to respond to that disaster. I know that Steve Mercer is going to talk further about that issue later. The other piece is supplementary agreements. I think there are circumstances that may require supplemental agreements, but I would highly recommend that as you look at your compacts for any region or any type of discipline that you first look at the EMAC articles and then do a supplemental agreement and tie it to the current compact that is out there, because it is used a lot. We even deploy National Guard assets with EMAC from one state to the other.

We outlined how we are going to deploy resources through the ICS, and how we manage them from the state emergency operations center, but how do we get connected? When an incident exceeds the local capabilities, how do we relay the incident commander's needs back to the state so we can utilize our resources or involve other states through EMAC? That component is fairly new, but we are calling that a role a state liaison officer. That position is normally going to be held by the emergency management coordinator.

As you can imagine, in a protracted event the same coordinator cannot run 24-7. So, what we are doing is looking at other emergency management coordinators that can come in and be that connection from the incident commander to the state emergency operations center. If for some reason the county cannot fill that role, we will send a state person who could be from Homeland Security and Emergency Management, public health, or from a local jurisdiction. But that state liaison is going to be very important to really clarify the needs so that we don't send inappropriate resources or self-deploy resources at the scene and really cause more chaos. What we want to do is try and help people and support you anyway we can at the local level. Thank you.

**Captain Bob Cox**  
**Hazardous Materials Team**

## Des Moines Fire Department

Before the protocol model was introduced, there was an incident at a bulk mail processing plant in Boone, Iowa. An employee found a suspicious letter containing a white powder. As it turned out, it was baking soda, but it was definitely a threatening letter. Someone had written on it "die, die, die"...all kinds of stuff. But we ran into a lot of problems during the response. Jerry and Mary later contacted me about the Biological/Chemical Threat Agent (BCTA) Protocol Model they were creating, and they asked us if we would help.

The lessons that we learned at Boone were about communications and getting information back to the state. The state needs a lot of information. The biggest problem that we had were phone calls. At one point I was on the phone for 45 minutes and they asked me everything under the sun, and this was while we are trying to run an incident. I had five or ten technicians getting ready to go into a hot zone and I am still on the telephone. It kind of makes things run amuck. We worked on that and I think we have that pretty squared away now.

Security at the scene is another issue. At the Boone incident we decontaminated five police officers. We needed to tighten up our security. The police officers shouldn't have been into this product or even in the room. One of the big problems was, what is a credible threat? Does anyone know? We use FBI protocols. FBI protocols are law enforcement sensitive. Do I know those? No. So, I didn't have an idea of what they wanted. We have taken care of that problem in the BCTA, we have laid it out, we have set the standards.

Another powder incident occurred at the Capitol Complex in Des Moines. It turned out to be nothing again, fortunately. But we ran into a few more problems—public information. Public information was being put out by the Des Moines Fire Department, a regional public information officer, the governor's office, and Homeland Security. Each one was putting out different information. We all needed to

get together and put out the same message. People lose interest in it real quick if information is contradictory.

Ventilation systems... The first thing I want to do if there is a white powder incident is to shut the air handlers off. That way it keeps the spread of the product isolated. That was a real big issue, in a state building. Shutting down a ventilation system is very complicated.

Specimen collecting... We did collect the specimen of the product and we did have law enforcement on scene to take it to Iowa City to the laboratory. There was no credible threat in this. It was just white powder on the floor, in the hallway, and there was no threat.

About two weeks ago, we investigated a suspicious letter received by the Des Moines Register and things went a lot better. We used BCTA protocol—we had a copy of it laying on the desk and we actually went down the line and we actually used this product. State communication was fantastic. Our county emergency management coordinator was on scene. He would come up and ask the incident commander a few questions and he relayed that information to the state. It went real smooth.

Deployment of additional resources... We had Polk County public health on scene and they did their job. In the incident command structure we used unified command structure. The suspicious letter actually mentioned a gentleman by the name of President Bush. President Bush was going to be visiting Des Moines in two days, so can you imagine how many secret service agents were floating around in that interim? We had four secret service agents on scene. We had the FBI on scene, the Polk County sheriff, the Des Moines Police Department. And they were all in the command structure. We went right into unified command. We put them all in a truck and they made decisions as a team. And the incident ran as smooth as I have ever seen an incident run. County emergency management acting as that liaison really took the

pressure off us people out there trying to make a decision on how to take care of this situation. Law enforcement was great. They made a joint decision that made sense.

Public information... In the incident command structure, all information coming from that incident goes through the incident commander. We had several public information officers on scene. They all got together and wrote out their statement. It went to the incident commander, he looked at it and approved it, and that was the information that was put out.

Specimen collecting... The HAZMAT team made entry into the area in a fully encapsulated suit because we weren't sure what the substance was. They collected the sample and the CST was deployed by the state of Iowa. They took the sample out and ran it through their lab, all while some of the sample was going to the Hygienic Lab as the primary gold standard lab. They narrowed it down that it was snail poisoning.

So, the protocol...We did try it, and the protocol really does work. I suggest that everybody look it over because it is the way to go.

**Mary Jones**

**Director, Division of Acute Disease Prevention and Emergency Response  
Iowa Department of Public Health**

The protocol itself comes in a three-ring binder and we will complete our regional training by December of 2004. What you have on your CD is the protocol model. Tab two is the model itself. All of the other information in this protocol is supporting documentation. It is actually a four-hour training. We certainly cannot do justice in 30 minutes to present to you the impact that this will have for the state of Iowa.

The other thing to really realize is that the trainings include all disciplines. And the instructors for this training are from all disciplines. So, what does that mean for

authority? The one key message from us about authority is that every single one of these disciplines has a level of authority. You have authority for public health at the local level. You have authority from law enforcement and county emergency management at the local level. You also have it then at the state level and at the federal level. And you have to bring all of those disciplines together into one unified command and take hold of all that authority.

You need every component of authority to make these kinds of responses successful. There is not one single person or discipline that is solely in charge of these responses. And I think we learned that the hard way. There are certain things that we look to HAZMAT for when they are on these incidents and in charge. And there are certain things from the Homeland Security and Emergency Management perspective that they are in charge of. The key to understanding authority is that incident command has to play a role in all of this. Incident command is locally established and locally run. Incident command at one of these responses is not run by state agencies.

State resource coordination and management is the responsibility of state agencies. Jerry talked about EMAC and 29C and the authority in that code, and we need to understand that. Those are for declared disasters. None of these white powder incidents are at the level of declaring a disaster. So we have to learn what these authorities are with these multiple disciplines, not just for the catastrophic disasters, but for more routine types of responses--the white powder incidents.

We have heard a lot about connecting silos of knowledge and breaking those silos down. I think the one lesson that we can take away from the authorities is that you need all of those silos combined together to understand the level of authority that goes along with these responses. Thank you.

Steve Mercer

Operations Officer, Division of Acute Disease Prevention and Emergency Response  
Iowa Department of Public Health

I want to talk about EMAC, but from a public health perspective. Remember Florida? Florida had the privilege of getting hit by four hurricanes in a six-week time period. Some of the cities were hit multiple times by different hurricanes. Do you think that is a public health emergency? We don't normally think about that though, do we?

Think about being without central services for six weeks or longer at a time. Being without what we take for granted everyday. Not having running water, which means no hot showers, no morning coffee, no way to get rid of human waste... Does that become an issue? It becomes a major issue! And it is a public health issue.

When this occurred, public health had not previously responded to an EMAC request at this level. So, we were requested to help assist Florida with their post-hurricane public health response. We deployed two 16-member teams to Florida. And these two teams were on a 16-day deployment, including two days of travel. They worked 14 days for 12-hour shifts each day. And not under ideal situations. One of our groups actually slept in trailers that they swing out to the oil rigs. In each trailer house 14 individuals...group showers...porta-potties. Some were sleeping in special needs shelters. This was a crisis here.

It was quite an undertaking. I have to tell you, we received an education very rapidly about responding from a public health perspective through EMAC. We could have not bought the education that we experienced in that time period! I had black hair when this started and two weeks later I had gray hair. But it was very interesting and I want to share with you what we learned.

What is EMAC? (SLIDE) Jerry talked a little about this, but we actually have 51 total members in EMAC right now. The only two states that are not involved are Hawaii and California. Both the Virgin Islands and Puerto Rico are signed on as members. Remember, we have 56 states and territories that can fall under the EMAC. Each member state must formulate procedural plans for interstate cooperation. Most of

those are entrenched as statutes. How many of you have actually looked at your state's statutes and understand how you fall in underneath the EMAC portion? We probably need to go take a look at that sometime. EMAC is an interstate loan and delivery of resources, both human and material.

Scope of assistance (SLIDE). And again these are just highlights from the EMAC compact. If you look at your states, most of them will probably have very similar language as it goes along here. A party state may request assistance under EMAC through the authorized representative of that state. This is generally for a governor-declared state of emergency. And that state representative 99 percent of the time is the emergency management division within your state.

Ours is Homeland Security and Emergency Management. The Iowa Department of Public Health has a very good relationship with the Homeland Security and Emergency Management group. If you don't have that relationship, you need to build that relationship. It will make your life so much easier, and being able to respond that much easier.

There is a wealth of resources and knowledge out there and we need to embrace those. (SLIDE) What occurs in this when they request assistance is they provide assistance in the emergency service function (ESF)...health is ESF8. You should have a copy of it in your handouts. It should identify what assistance is needed and the length of time the assistance is needed. In our instance, they requested two 16-member teams made up of nursing staff. Well, we combined ours. We had 14 nurses, a combination of public health nurses and also clinical nurses. We chose this combination because we knew that they would be working in special needs shelters.

Special needs shelters...again...it is a whole different mindset. It is different from your day to day health care business. And it is tough to get into that. So, we did what we thought was a very good job of combining the clinical aspects and the public health aspects. And our people found that very helpful because not only did they work in

special needs shelters but they also set up public health first aid stations and they also did community health assessments.

Some of our public health nurses and clinical nurses actually worked with some of the environmental services from Florida, going in and doing community assessments. They actually went door-to-door checking on the health care needs of individuals. A lesson again that you could not have paid for.

Limitations on assistance (SLIDE). Member states that receive a request to render aid under EMAC must take necessary action to provide the requested resources. Once you sign, it is a binding contract. So if you say, "I am going to send you 143 public health people," you are going to send 143 public health people! Now, what is good about it is that there is also a provision that says that the assisting state may withhold resources to the extent necessary to provide reasonable protection for their own state. So, it is not like they are going to ask you to deplete all your resources.

Or, you need to make sure that you don't deplete all your resources. Because maybe in the middle of this Florida deployment something like a limitation of influenza vaccination occurs. You know it is going to happen. So, you need to make sure that you protect your own state too. Take care of your own, but what can you do to help your neighbor?

Licenses and permits (SLIDE). Here is the bottom line. If a person holds a license, certification, or permit issued by an assisting state, they are deemed to be licensed, certified, or permitted in that receiving state. And they operate within their home state's scope of practice, unless there are limitations placed by the governor in the requesting state. So you do not have to go through temporary licensing. When you do volunteering with some of the other agencies that are non-state assets, you sometimes have to go through a temporary licensing procedure within that state. That is not necessary through EMAC.

Liability (SLIDE). The state that is requesting assistance is responsible in tort for the actions of individuals who are deployed there. So you want to make sure that the state that is sending assistance is sending qualified individuals. The attorney general for the receiving state is the one that will provide legal aid if there is tort.

Workers' compensation (SLIDE). The assisting state is responsible for workers' compensation and death benefits. Can you see a theme here? It is a state asset. They need to be state assets, so you need to ask yourself, what do you do with individuals who are not state employees? We went through a process and made all of them emergency state employees.

Reimbursement (SLIDE). You can get reimbursed for expenses unless you agree not to request reimbursement. And reimbursement is paid to the state, not to individuals. So, it is trying to understand that whole process in between there.

Considerations under EMAC (SLIDE). EMAC response is different from other traditional volunteering processes that go into play there. It is a little bit different. Licensed by the assisting state and within their scope of practice. The assisting state should verify skills by request. If they are looking for public health skills, if they are looking for specific burn skills or a respiratory therapist, the assisting state should be the one verifying those individuals that they are sending. You are sending them as a part of your state's assets. You should assume that responsibility. The requesting state may still need to verify their existence. You need to help them with that verification process. They have already got 90,000 other things that are going on within their area.

Establish an incident command structure (SLIDE), both within your state agency and within the team. They fall underneath an individual team incident command structure, but when they go to the assisting state or to the receiving state they fall underneath the receiving state's incident command structure. I know that is hard to

separate. They work in the form of one group, but are kind of controlled by someone else.

So, please keep those issues in mind. Again, we learned a wealth of information from this and we will share more with you at a later date. Thank you.

**Stephen S. Morse, PhD**  
**Director, Center for Public Health Preparedness**  
**Columbia University**

The question of training standards and competencies remains an evolving process. The reality is that we are still learning how to do this and developing models for doing this on a national scale. We have seen a number of good national models for assistance, and I was happy to hear that the Red Cross is moving to competency-based training.

So, let me say a few words about competency and what they mean and why it just isn't an academic exercise. Basically, competencies are what you want people to be able to do when you train them. When you send these people out into the field, what is that you want them to be able to do? Communications comes up very often, among many other things. And there are various lists of competencies that have been developed in order to provide a framework for this.

One that was developed at Columbia by Christine Gebbie and colleagues in collaboration with many partners is the Bioterrorism and Emergency Readiness Competencies for Public Health Workers. And this just deals with the basic things that people need to know in order to be able to deal with emergencies. And many questions came up about how you apply these competencies. That is your framework, the baseline in which you put more specificity and additional information. In response to that need is the Competency to Curriculum Toolkit, which provides some examples of how those competencies really apply in practice.

The bottom line is that competencies really are a framework and are based on your definition of what it is you really need your workforce to be able to do, and then you train accordingly. This is a process that cannot just be an academic process. It has to be informed by the people in the field who actually know what the needs are.

How many of you are involved in project Public Health Ready? That is a model for how to get health departments prepared for emergencies. And it remains the standard, but an evolving process, so we are all still learning from this process. Clearly, there are several elements to this. One of them is to have a plan, but it is not enough to have a plan. And that is where the competencies come in; you have to be able to train to that plan with a framework of competencies. What is it you want people to be able to do...and then flesh that out with your own specific needs.

Some people almost have religious discussions about competencies. We have lumpers and splitters, people who like detailed competencies and others who like to keep them lean and simple, as are the competencies from Columbia University and Christine Gebbie's group. But they are a framework to be fleshed out more than anything else.

Then, of course, always you need to practice, to drill. Communications are often a problem. Often there is a need to drill not only within the agency, but also with the many partners who are out there. So, this is a constant process of dialog, of listening to people in the field. For us in academe, it's listening to your needs and then trying to fit those into the appropriate competencies. This will continue to be an evolving framework because we are all continuing to learn. In terms of developing national standards, we are seeing this happening through the Department of Homeland Security, through CDC's working with partners at the federal level.

For those of you who would like a concrete example of a competency training, it is not as complex as it sounds. We have several excellent examples out there around the

country. We offer an online basic emergency preparedness course for anyone who would like to take it. How many of you are familiar with the course Basic Emergency Preparedness Online? It is just one example of how to use competencies in a training program so you can apply it. The website is <http://cds.osr.columbia.edu/bepcourse/test.asp> and that will give you an example of how you go from documents like this and this to something that can actually be used.

We are always looking for feedback because this continues to be an evolving process. And one in which it's really important for all of us to have a dialog. We in academe are here to help. We obviously want to provide the expertise that we have, but you really have the expertise in the field, so it needs to be a dialog. As we work together I think we will see more national standards and more regional development as people train together and work together. Thank you for your time and the kind invitation to be here.

## Notes From Workgroups: Highest Priorities

### Training Standards/Competencies

- Public health workforce standards to be determined for emergency response: NIMS, Unified Command should be sent for all.
- An agreed-upon criteria for different types of skills needed to perform epi/surv piece. At each jurisdiction level needs to be basic skill set—applied.
- Training—need to understand what nominal base knowledge needed.
- Labs—training; need to have all agencies talk together and agree to work together.
- Labs—lack of standard system for emergency response impacts ability to provide training.
- Required training should be competency based.
- Develop national competency set and endorse cross-borders curriculum.
- Hospitals need to require competency-based training and developing roadmap for saying someone is competent.
- An evaluation process and applied practice process on what needs to be learned and the training part.
- Education of local officials important.

### Verification of Qualifications

- Knowing specific roles in emergency.
- Need to collaborate in drills and exercises.
- National databases for verification—licensure and credentialing.
- Roles and checklists for each qualification.
- Training and communication for roles standardized.
- National certification standards are not there but would be good to have. Verifying qualifications of epi team versus verifying qualifications of individual. Team critical.
- Lab—need national system to document qualifications followed by checks and build a system to document qualifications. System would include periodic updates and verification.
- Build on existing systems. (lab)
- Determine what qualifications were for various disciplines first before can move on to verification.
- Minimum qualification standards.
- Analyzing and verifying qualifications and if are current.

### Authority

- Educating locals. Build relationships within jurisdiction. Could be with appointed or elected officials or responders.
- Unified Command Structure needs to be in place for emergency events. Everyone needs to know.

- Training for governors or state agency directors (local, state, national) declarations of disaster in timely manner and understanding emergency management system.
- Help outline who has primary control. Familiarize with other states and exercise with other states.
- Many policies but main issue to educate and ensure there is an awareness of what policies are and who is command in different situations and how do we implement command role.
- Lab—lab responsible for maintaining support service and to ask for help if need it and provide support services if they are requested.
- Need to keep NIMS in mind. There should be a review of laws and regulations in states to identify similarities and differences so there can be movement toward more common approaches.
- Development of relationships prior to an event and compare various state protocols.
- Training—what does authority mean and what does it address.

#### What can we do to move forward?

- Building relationships, checking out your plan.
- Governor, legislature, and others need to have competencies for those individuals.
- Establish Focus Area G monthly conference calls. Sharon Medcalf from NE is contact.
- Actively communicate with others.
- Develop sentinel and state level lab competencies.
- Support IC.
- Collaborate with College of Public Health.
- Share roles identified by Minnesota Department of Public Health.
- Compare curricula for training and assemble lists of available trainings at different levels in different states.
- Go ahead and start looking at laws and regulations and move forward on mapping of competencies and training/mapping.

# Cross-Borders Reports Back from Workgroups

## Focus Area A: Preparedness, Planning, and Readiness Assessment

### Databases

#### Policies

Protect individual confidentiality - Human Resources

Security of database and obligation to volunteer

Accuracy of information

i.e. update of volunteer and staff information

Interoperability of systems

Local, state, and federal

Including fields within program

Consistency of templates

Need access to equipment data

Including vehicles, mobile toilets, etc.

### EMAC

#### Training/Communication

Ethics concerning use of IT system

Built in security on IT system

Linkage between databases that does not compromise security

Determine model for equipment/program needs

Training on how to access hard resources (vehicles, etc) with incident command drills involving top to bottom individuals; NIMS

Need all disciplines to have training on EMAC procedures

Develop resource with open access

Post on Web

### Volunteers

#### Policies

Spontaneous volunteer

Credentials - how to validate

One coordination agency?

Consistency on verification process between states

Insurance Liability

Immunity, i.e. make volunteers government agents

Scope of practice

Need agreed definition for use during emergencies

Multi-task volunteers (300 vs. 100 actual)

One volunteer can do 3 different positions; how to get an accurate count of volunteers

Skill sets needed for specific event

### Training/Communication

Need to know where and how to locate credential information with consistency between states

Educate legislation on importance and proposed language

Training for volunteers on any legislative and legal issues

Need to train for a range of levels for events large to small and where to put volunteer needed for a specific event

### Credentialing

#### Policies

Determination of current licenses and certifications

State recognition

Credentialing vs. badging

### What you can do to move this forward:

1. Assign to multi-discipline workgroups
  - a. Focus groups with experts from the field to establish needs
  - b. IT to evaluate systems that need modified and developed
2. Identify funding
3. Identify best practices
  - a. Uniform practices for credentialing (HRSA - VHP)
  - b. Volunteer database
  - c. Existing IT programs
4. Coordination between CDC and HRSA

## **Focus Area B: Surveillance**

### Databases

#### Policies

Use of same base language across borders

States have repository of specific workforce competencies

Standardized reporting strategies

Standardized case definitions

Single web-based reporting across borders

Planning for clearer communication

Ease of use for web-based communication strategies

Determining how important it really is for states to have access to other states' workforce data

Databases of physical resources and services offered across states

Identify what needs to be shared with other states

### Training/Communication

Training in use and field description to eliminate user error  
Training on skill set definitions; ongoing clarification  
Training on primary contacts/where to find databases, etc across borders

### **Volunteers**

#### Policies

Not a lot of volunteers in this issue—most would be advisors/consultants  
Need for locals, specialized expertise  
Need to explore role of volunteers for quarantine, patient tracking, data entry, and contacts for intervention  
    Creative thinking  
Address privacy and liability issues with volunteers working with patients  
Identify competencies/skills/backgrounds needed in order to recruit volunteers  
Identification system to legitimize with the public  
    In person and via telephone

### Training/Communication

Training for people in other areas of public health (i.e. infectious disease)  
Training volunteers on each of these roles:  
    Quarantine  
    Patient tracking  
    Data entry  
    Contacts for intervention  
Training on protocols, expectations, and checklist of responsibilities  
    Including staff training  
Public relations message about volunteers that will be contacting public

### **Credentialing**

#### Policies

Need for government level workforce  
Standard sets of skills possible to compare across states  
    Different job descriptions, etc  
    Need to understand international degrees, etc  
Currently little sharing of personnel in surveillance epidemiology  
Need to develop more specific competencies to communicate personnel needs

#### Training

Ability to capture skill sets, needs, and to clearly communicate with other entities  
Exchange standards on an ongoing basis (definitions, etc)  
Make available a regional response team with predefined credentials

### **What you can do to move this forward:**

1. Identify areas of responsibility, roles, and authority across state lines
2. Up-to-date contact list with organizational chart across state lines
3. Decide format and fields for a multi-state database. Define what information needs to be shared.
4. Formation of regional work group to define role of volunteers in surveillance. Group gets information about Minnesota volunteer management database. This database is not necessarily only for health care professionals.
5. Standardizing skill sets for surveillance epidemiology across state and country borders
6. Develop regional (multi-state) surveillance epidemiology response teams

## Focus Area B: Surveillance and Epidemiology

### Databases

#### Policies

Agree on data elements and management of files

Files must be manageable size

Design process; ease of use

Establish a strong local public health representation in establishing databases

How to share data/info across counties (chain of command)

Need for uniform databases (system) at local, state, and national level

Resources

Electronic and backup

Confidentially

Partnering and relationship establishment

Constantly update

Needs to assimilate (or at least read) existing databases

Do not recreate databases

Training

#### Training/Communication

Update training

Keep IT updated on public health issues

Keep public health updated on IT issues

Training across jurisdictions and state lines

### Volunteers

#### Policies

Pay or form of reimbursement for all volunteers

Liability

In own jurisdiction

Field interviews

Volunteers getting ill

Cross borders  
Vaccinations for volunteers  
Need purpose, role  
Job descriptions  
Skilled and non-skilled  
Recruitment and recording of available volunteers

#### Training/Communication

Interviewing Skills (Level II)  
Data entry  
If proficient in data entry in other areas (Level I)  
Paper and electronic  
Training materials  
Prepared and identification of skills necessary  
Training to match jobs with the personnel and their skills  
Review materials at least annually

#### **Credentialing**

##### Policies

Simple coding system  
Without placing personal information on shared databases (maintain confidentiality)  
Have query ability on databases  
Reciprocity for emergency situations across borders (hospital to hospital privileges)  
Establish Memorandum of Understand (MOU's) for sharing staff through credentialing process

##### Education/Communication

Education regarding system  
Educate various professions in other necessary aspects

##### What you can do to move this forward:

1. EMAC - Check on what is already covered (i.e. IMAC within Iowa)
2. Have lessons learned regarding deployment of teams from Midwest to Florida in all areas of public health and preparedness
3. Stop - Look - Listen
4. Explore LMS for competency-based training

## **HRSA/Hospital**

### **Databases**

##### Policies

Workforce registry, not just hospital database

Need person who can triage based on the event

What defines non-eligible for professional assignments?

Integration of statewide systems with hospital specific systems

Disaster credentialing vs. peace time credentialing

Need for both

Credentialing as separate than licensing

If you are privileged in one hospital, you are in others

Length of volunteer availability needs to be tracked

HRSA guidelines will determine how states will move forward

Security

Essential part of credentialing and HRSA guidelines

Need to integrate government and nongovernmental systems at every level

Misconception that HRSA funding is only focused on hospitals/health care

Needs to consider other professionals and disciplines

This continues the separation

Break at sessions today as an example

### Training/Communication

Core training and real-time training

North Dakota

Technology collection with licensure status

Alert system connected with database systems

Iowa

Integration with University of Iowa statewide education program

Work with University of Iowa on tracking credentialing

### **Volunteers**

#### Policies

Red Cross spontaneous volunteer system as guide

Employer supported policies/procedures need to be developed and expanded

Legislation is critical

Liability issues—workers' compensation, etc.

Legislative action needed

In-state vs. out-of-state

Universal identification or registry

Red Cross has good system

Volunteers as "willing to work" outside of professional settings

Marketing of volunteer programs for recruitment

Employer specific marketing

Address the competition mentality with volunteers

### Training/Communication

Core competency development

Predeployment vs. just-in-time

Incident command structure for emergency response  
Universal toll-free number (“800”) for daily updates  
    Volunteer health and care  
Site orientation for volunteers  
    Standard format needed for curriculum  
    Implications for training  
Emergency preparedness 101 for employers (health care, non-health care, policy makers)  
    Understand surge capacity  
    Rural focused

## Credentialing

### Policies

HRSA definition of credentialing should be considered when developing a common definition

    Emergency credentialing: disaster credentialing defined differently as overall credentialing definition

    Universal definition/standard needed across professions

Credentialing and standards, along with liability, are the two issues that must be addressed first

### Training/Communication

Training of hospitals about disaster credentialing needed, as well as consistency among hospitals

Educational opportunities for all agencies to bring everyone to the table

    Intrastate, interstate, and federal

Federal government should support efforts like ESAR-VHP on the front end

### What you can do to move this forward:

1. Take these ideas back to the stakeholders
2. Invite federal-level project officers to state and local efforts, planning (CDC, HRSA)
3. Learn more about already established “model” programs
4. Disseminate information and marketing tools to volunteer-related partners: intrastate, interstate, and federal

## Regional Bioterrorism

### Databases

#### Policies

Immunization Registry

    i.e. SNS

- Emergency assistance volunteer registry
  - EOC base
- Learning Management System (LMS)
- Shared local database
- Centralized data hub to connect LMS to health care volunteers and workers
  - Existing regional data
- Human resource management system
  - Volunteer and professional
  - Central access system

### Training/Communication

- Identify different systems
- Resource standards
- Standardized terminology
  - NIMS
  - IMAC/EMAC
- Maintaining centralized data hub
- Quantify for funding
  - Accountability/Identification
  - Notification/HAN, etc
  - JIRS

## **Volunteers**

### Policies

- Memorandum of Understanding (MOU)
  - Salvation Army
  - State EMA (Nebraska, Fed asking is governing)
  - DMAT
  - Red Cross
- Local workforce
  - Standards formulization and protection

### Training/Communication

- Public relations/education
- Recruitment
  - Invite credentialed individuals
  - Recognition/specialty provided
- Identification/accountability
- Regional level training (cross borders)
  - Standards
- Deployment and responsibility

## **Credentialing**

### Policies

Who decides  
Shots  
Clinics  
Hospitals' standards of operations  
Standards of care  
Medical Reserve Corps systems in place

Training/Communication  
Capabilities and restrictions  
Qualifications  
Understanding what is needed  
Volunteer management  
Other background information  
Collaboration

**What you can do to move this forward:**

1. Legislation/federal
  - a. Liabilities identified
  - b. Standards/credentials
2. Local and regional planning
  - a. Identify needs and resources on hand
  - b. Local response management
    - i. Issues, planning, and education
3. Identify funding constraints
  - a. Development
  - b. Sustainability

## Focus G: Education and Training

Databases

Policies  
Cross-reference capabilities  
Standardization/consolidation of databases, computer hardware, and software  
Confidentiality  
Data privacy  
Secure storage  
How to access data across borders  
Set policies across borders  
Credentials  
Accuracy/current databases  
Who can update databases?  
Protocol for updating databases

Training/Communication  
Who and how updates are made to databases

## Volunteers

### Policies

Standardize competence of volunteers

Create system to develop and track volunteers

Expanding on existing systems

Utilize volunteer centers to assist and process of identification and management of volunteers

### Training/Communication

How to utilize volunteers

Recruiting

Managing

Training

Processing for JIT (just in time)

Courses

Emergency Preparedness 101

Disaster 101

CPR/First Aid

## Credentialing

### Policies

Acceptance of credentials across jurisdiction

Change laws surrounding licensing across borders

Identify loopholes in EMAC

Promote 10 State Mutual Aid Compact

### Training/Communication

Inform/educate government officials

Need for 10 State Mutual Aid Compact

Tools

Memo of Agreement

### What you can do to move this forward:

1. Training on 10 State Mutual Aid Compact
2. Discussion with key people concerning the compact
3. Bring volunteers to the table
4. Educate key state legislators concerning the 10 State Mutual Aid Compact
5. Integrate the state and volunteer databases

## *Speakers*

**Christopher G. Atchison, MPA**, is Associate Dean for Public Health Practice and Director of the Institute for Public Health Practice at the University of Iowa College of Public Health. Mr. Atchison served for eight years as Director of the Iowa Department of Public Health (IDPH) where he developed a number of collaborative projects including Healthy Iowans; the Barnraising Conference, a biennial public health conference with a focus on community public health development; and the state-local public health Liaison Committee, which provided a forum for local health directors, administrators, and board of health members to help shape the state health department's agenda. Upon his departure from IDPH in 1999, he received the John F. Sanford Award from the Iowa Medical Society for his leadership on health care and public health issues in Iowa. He served as the president of the Association of State and Territorial Health Officials (ASTHO) 1994-95, chair of the Joint Council of Official Health Agencies, and chair of the Public Health Leadership Society. Since 2002, he has been a member of the Governing Council of the National Academy of State Health Policy. He was a member of the New York Academy's Committee on Public Health that authored the monograph, "Medicine and Public Health: The Power of Collaboration" and currently serves as the National Program Director for the Robert Wood Johnson Foundation's State Public Health Leadership Project. He has received both the Theodore R. Ervin Award from the Public Health Foundation and ASTHO's most respected award, the Arthur T. McCormick Award for excellence in public health. In addition, Mr. Atchison is Professor (Clinical) of Health Management and Policy at the UI College of Public Health, teaching the introduction to public health practice as well as directing the capstone experience required of all candidates for the Master of Public Health degree.

**Captain Bob Cox** is a member of the Des Moines Fire Department and leads the Hazardous Materials crew.

**Brenda Goolsby, SPHR**, is an innovative manager with more than 20 years experience in project planning and implementation, team building, human resources, volunteer administration and training. Since 1992, Ms. Goolsby has served as Senior Associate for Disaster Services - Human Resources at the national headquarters of the American Red Cross in Washington, D.C. In this role, she has provided management oversight for employee relations for human resources of the Disaster Services Human Resources System (DSHR), a workforce of more than 23,000 volunteer and paid staff, who respond annually to more than 300 disasters throughout the United States and its territories. She manages all aspects of the Disaster Reserve program, which consists of an authorized staff level of more than 350 highly trained part-time employees who respond to disasters on an as-needed basis. She also manages staff health for Disaster Services Human Resources System, ensuring that all members of DSHR meet health standards for serving on disaster relief operations and that health care is available for workers assigned to relief operations. As a member of the Crisis Response Team in the role of National Consultant, she served as liaison between the American Red Cross, National Transportation Safety Board, and airline representatives. She instituted and

manages a consistent HR administrative system for selection, hiring, and development of disaster reserves, and managed the rewrite of policy document for human resources function on disaster relief operations. A certified Senior Professional in Human Resources, Ms. Goolsby is a member of the Northern Virginia Chapter of the Society for Human Resource Management (SHRM).

**Ellen M. Gordon, MA, BS**, is an Associate Director and Faculty for the Naval Postgraduate School Center for Homeland Defense and Security. In addition, Ms. Gordon serves as a subject matter expert in homeland security and emergency management. She last served as the Governor's Homeland Security Advisor as well as the Homeland Security and Emergency Management Administrator for the state of Iowa, with 20 years of distinguished service. In this position she was responsible for the development and management of homeland security and emergency management systems, including all aspects of programs, personnel, and budgeting. Ms. Gordon is involved in national policy development committees and commissions. She currently serves as a member of the U.S. Department of Homeland Security's Homeland Security Advisory Council's Emergency Response Senior Advisory Committee, and as the Chairperson of the National Emergency Management Association's Homeland Security Committee. From 1998 through 2003, she served as a member of the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, U.S. Dept. of Defense to Congress and President, (Gilmore Commission). She is the recipient of many awards, including the Curtis K. "Butch" Straub Award for Exemplary Academic Achievement and Leadership from the Naval Postgraduate School, a U.S. Army Commanders Award for Public Service, and a U.S. Army Civilian Award for Humanitarian Service for her meritorious performance during the floods of 1993. In addition, Ms. Gordon has received the Iowa National Guard Distinguished Service Medal for her contribution and dedication to the State of Iowa, a National Weather Service Modernization Award, a National Emergency Management Association Presidential Citation, and a National Emergency Management Association Award for recognition of her dedication to and support of homeland security.

**Paul R. Hales, JD**, is an attorney in private practice. He serves as General Counsel of the St. Louis Area Regional Response System ([STARRS](#)), Secretary of the Board of Trustees of [St. Andrew's Management Services](#), a member of the Board of Trustees of [Grand Center](#), the [Saint Louis Black Leadership Roundtable Education Committee](#), and The Father's Support Center of St. Louis. He served in an advisory capacity to U.S. District Judge George F. Gunn, Jr. in the St. Louis desegregation case, *Liddell v. Board of Education* and coordinated development of [The St. Louis Career Academy](#), an [award-winning public high school](#). He is immediate past Chair of the Board of Trustees of the [St. Louis Community College Foundation](#). Mr. Hales holds a Juris Doctor degree from [Columbia Law School](#) and a Bachelor of Arts degree from [Wesleyan University](#).

**Mary Mincer Hansen, RN, PhD**, joined the Iowa Department of Public Health (IDPH) in 2000 as a research fellow on the CDC-supported patient safety research program. A registered nurse and educator, she is the first nurse selected as Director of the IDPH.

Dr. Hansen earned her Bachelor of Science in Nursing from Creighton University, and completed her MS degree in Nursing at Texas Women's University. She earned a PhD in Higher Education from Iowa State University. She has also earned a certificate from the Harvard University Executive Program in Health Policy and Management, and a certificate from the George Mason University Health Policy Institute Health Policy Workshop. Dr. Hansen has extensive experience as a health care professional as well as an educator, researcher, and policy advisor at the state and national levels in the fields of nursing and public health administration, improving patient outcomes, promoting patient safety, and creating effective health care coalitions. She has contributed to a textbook and written articles in national journals. Dr. Hansen has served on Senator Tom Harkin's Health Advisory Committee, is a charter member of the National Health Policy Council, and has served as the past Director of the Drake Center for Health Issues and Co-chair of Iowans United for a Healthy Future. She also has recently served as President of the Iowa Public Health Foundation and has participated in the Healthy Iowans 2010 review team and the Iowa Healthy Kids task force. Dr. Hansen's honors include Sigma Theta Tau Nursing Honor Society, Phi Delta Kappa International, Phi Kappa Phi Honor Society, Iowa State University Excellence in Research Award, Presidential Appointment to the John F. Kennedy Advisory Committee for the Arts, Who's Who in Medicine and Health Care, and the Iowa Nurses Association Theresa Christy Award.

**Mary J. Jones** serves as the Director for the Division of Acute Disease Prevention and Emergency Response at the Iowa Department of Public Health (IDPH). She formerly served as the State Trauma System Coordinator for IDPH, and was the Program Director for the School of Emergency Medical Services, Mercy College of Health Sciences in Des Moines. She has over 20 years experience in EMS management and education. Her clinical experience as a paramedic specialist includes county-based, hospital-based, volunteer, and aero-medical services. Ms. Jones has served as adjunct faculty for the Des Moines University and the Iowa Law Enforcement Academy. She is a past president for the Iowa Emergency Medical Services Association and has represented Iowa EMS on the National Association of EMT's Board of Governors.

**Steve Marshall, MS**, is the director of the Public Health Preparedness Program at the Wisconsin Division of Public Health (DPH). He is a four-year veteran of DPH and an epidemiologist in the Bureau of Communicable Diseases and Preparedness. Prior to DPH, Mr. Marshall served eight years as a clinical microbiology researcher at The University of Iowa in Iowa City, Iowa, coordinating studies on novel antibiotic efficacies against global pathogens; and three years as a biological aide at the USDA National Veterinary Lab Services in Ames, Iowa, assisting in a national bovine tuberculosis surveillance program. He obtained his master's degree in epidemiology from The University of Iowa and his undergraduate degree in biology from Iowa State University.

**Steve Mercer** is Operations Officer and Strategic National Stockpile Officer for the Iowa Department of Public Health's Division of Acute Disease Prevention and Emergency Response, Center for Disaster Operations and Response. Since 2002, he has

served as a member of the National Registry of Emergency Medical Technicians (NREMT) Research and Development work group, and as a member of the Board of Directors, NREMT, representing the National Council of State EMS Training Coordinators (NCSEMSTC). During that time, he also has served as a member of the Technical Advisory Group (TAG), representing the NCSEMSTC for the development of the National EMS Scope of Practice Module, and as a task force member for the development of the National Guidelines for Educating EMS Instructors. From 2001 to 2002 he was a task force member representing the National Association of Emergency Medical Technicians (NAEMT) for the development of the National EMS Core Content: The Domain of EMS Practice. In addition, Mr. Mercer was a member of the Space Medicine Workgroup (Space Medicine and Health Care Systems, NASA Johnson Space Center and National Space Biomedical Research Institute) for the development of *Resuscitation and Critical Care in Space* curriculum from 2000 to 2002. His appointments also include representing the State of Iowa as a voting member for the National Council of State EMS Training Coordinators from 1993 to 2004. Mr. Mercer is the author and editor of numerous publications, including most recently, "Instructor Manual for Pre-Hospital Trauma Life Support" (5<sup>th</sup> Edition), edited by him and published by Mosby of St. Louis, MO in 2002. He holds multiple certifications including: State of Iowa Paramedic Specialist #14, Iowa Department of Public Health EMS Instructor #T08-001-11, National Certified Investigator/Inspector - Level I, County Medical Examiner Investigator, and National Pre-Hospital Trauma Life Support (PHTLS) Instructor. Mr. Mercer is a member of the National Association of Emergency Medical Technicians, the National Society of EMT-Paramedics, National Society of Emergency Medical Technician Instructors/Coordinators, and the National Association of EMS Educators.

**James A. Merchant, MD, DrPH**, was appointed as the first dean of the University of Iowa College of Public Health on July 1, 1999. Dr. Merchant is a nationally known expert on occupational and environmental health, rural health, and public health policy. He served as head of the UI College of Medicine's Department of Preventive Medicine and Environmental Health from July 1, 1997, to June 30, 1999, directed the department's Division of Occupational and Environmental Health and Institute for Rural and Environmental Health from 1983-1997, and taught in the department since 1981. A native of Ames, Iowa, Dr. Merchant received a bachelor's degree in bacteriology from Iowa State University in 1962 and an MD degree from The University of Iowa in 1966. He completed an internship and an internal medicine residency at Cleveland Metropolitan General Hospital, followed by a fellowship in pulmonary and environmental medicine at Duke University. In 1973, he received a doctorate in public health in epidemiology from the University of North Carolina at Chapel Hill and was awarded a Trudeau Fellowship from the American Thoracic Society for post-doctoral study at the University of London's Brompton Hospital and Cardiothoracic Institute. Dr. Merchant directed the Appalachian Laboratory for Occupational Safety and Health and the Division for Respiratory Disease Studies for the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC) before returning to Iowa in 1981, and taught and practiced pulmonary medicine at the University of North Carolina and West Virginia University

(adjunct appointment). Dr. Merchant previously directed The University of Iowa's NIOSH-supported Great Plains Center for Agricultural Health, Iowa's Center for Agricultural Safety and Health, the Injury Prevention Research Center, the Center for International Rural and Environmental Health, and the Environmental Health Sciences Research Center. At the national level, Dr. Merchant currently serves as secretary-treasurer and chairs the Legislative Committee for the Association of Schools of Public Health, and is a member of the Institute of Medicine's Roundtable on Environmental Health Sciences, Research, and Medicine. Among his awards and honors are a commendation medal from the US Public Health Service, a Health Policy Fellowship with the US Senate, and the William Steiger Memorial Award from the ACGIH. He was elected to the Institute of Medicine in 1999. Dr. Merchant's research interests include the epidemiology of occupational/environmental lung disease, environmental and occupational health, rural health, agricultural disease and injuries, international health, and public and rural health policy. He has received numerous grants from the CDC, the National Institutes of Health, private foundations, and corporations.

**Stephen S. Morse, PhD**, is Director of the Center for Public Health Preparedness at the Mailman School of Public Health of Columbia University, and Associate Professor of Clinical Epidemiology. Dr. Morse recently returned to Columbia from four years in government service as Program Manager for Biodefense at the Defense Advanced Research Projects Agency (DARPA), Department of Defense, where he co-directed the Pathogen Countermeasures Program and subsequently directed the Advanced Diagnostics Program. Before coming to Columbia, he was Assistant Professor (Virology) at The Rockefeller University in New York, where he remains an adjunct faculty member. He is the editor of two books, *Emerging Viruses* (Oxford University Press, 1993; paperback, 1996), which was selected by "American Scientist" for its list of "100 Top Science Books of the 20<sup>th</sup> Century," and *The Evolutionary Biology of Viruses* (Raven Press, 1994). He was a founding Section Editor of the CDC journal "Emerging Infectious Diseases, was formerly an Editor-in-Chief of the Pasteur Institute's journal "Research in Virology," and serves on the editorial boards of several journals, including "Emerging Infectious Diseases," "Viral Immunology," and "Biosecurity & Bioterrorism." He was chair and principal organizer of the 1989 NIAID/NIH Conference on Emerging Viruses (for which he originated the term and concept of emerging viruses/infections); served as a member of the Institute of Medicine-National Academy of Sciences' Committee on Emerging Microbial Threats to Health (and chaired its task force on viruses), and was a contributor to its report, *Emerging Infections* (1992). He currently serves on the steering committee of the Institute of Medicine's Forum on Microbial Threats, and the National Academy of Sciences' Committee on Future Biowarfare Threats; has served as an adviser to the World Health Organization, Pan-American Health Organization, FDA, CDC, Department of Defense, and other agencies, and currently serves on the Weapons of Mass Destruction Advisory Group (and its Bioterrorism Advisory subcommittee) of the New York City Department of Health and Mental Hygiene. He is a Fellow of the New York Academy of Sciences and a past Chair of its Microbiology Section. He was the founding Chair of ProMED (the nonprofit international Program to Monitor Emerging Diseases) and was one of the originators of ProMED-mail, an international network inaugurated by

ProMED in 1994 for outbreak reporting and disease monitoring using the Internet. Dr. Morse received his PhD from the University of Wisconsin at Madison.

**Debra K. Olson, MPH, RN**, is the Associate Dean for Public Health Practice Education at the University of Minnesota School of Public Health and is responsible for developing strategic partnerships for the delivery of lifelong learning opportunities for interdisciplinary health professional students and the public health practice community. These programs are developed to increase the availability of public health education and to enhance the competency of working professionals through the application of innovative teaching techniques such as technology-enhanced learning. Her 29 years of experience in the practice of public health and an extensive background in the delivery of public health academic and professional education allows for leadership both in the community and the University. Ms. Olson served as Executive and Deputy Director of the Midwest Center for Occupational Health and Safety since 1995; Center Director and PI for the Midwest Center for Life-Long-Learning in Public Health, a public health training center; and Center Director and PI for the University of Minnesota Center for Public Health Preparedness. Ms. Olson is a faculty member in the Division of Environmental Health Sciences, School of Public Health and adjunct instructor in Public Health Nursing, School of Nursing and the University of North Dakota, School of Medicine and Health Sciences. As an occupational and environmental health specialist, Ms. Olson teaches extensively in the School of Public Health's core MPH curricula, specializing in technology enhanced learning. She chairs the major in Public Health Practice in the School of Public Health, which provides dual degree options for veterinary and medical students who wish to integrate population science into their clinical careers and public health certificates for working professionals who wish to obtain a credential in public health. In addition, she has extensive experience in the application of new information technologies and competency based curriculum development. She has published numerous articles relating to occupational and environmental health and the roles and credentialing of public health professionals.

**Jerry Ostendorf** has served as the Readiness and Response Bureau Chief with the Iowa Emergency Management Division since 1987. His primary responsibilities include Homeland Security policies and procedures, Emergency Management Assistance Compact activations, and the Federal Response Plan coordination with federal partners. He has served as Chief of Operations and State Coordinating office for the state of Iowa through 15 Presidential Disaster Declarations and hundreds of governor-declared disasters.

**Lisa Pogoff, MPH, MSW**, is the Workforce Registry Planner for the Office of Emergency Preparedness at the Minnesota Department of Health in St. Paul, Minnesota. In this role, she serves as project manager for the development and implementation of "Minnesota Responds! Health Professional Volunteer Registry." She also serves as facilitator of the Workforce Subgroup of the Commissioner's Task Force on Terrorism and Health. Working at the Minnesota Department of Health since 1991, she has also served as a senior research analyst and a community relations coordinator. Ms. Pogoff holds two graduate degrees from the University of Minnesota,

a master of public health and a master of social work. She earned a BS in journalism from the University of Illinois. Ms. Pogoff is an active volunteer, serving as secretary of the governing council of the Minnesota Public Health Association; a member of the board of directors of Kulture Klub Collaborative, an arts organization for homeless teens; a member of the board of directors of TCJMS, a middle school in the Twin Cities; and as editor of a non-profit organization's monthly newsletter.

**Richard A. Raymond, MD**, is Nebraska's Chief Medical Officer, Nebraska Health and Human Services System. He was appointed to the position by [Nebraska Governor Mike Johanns](#) in January 1999. He served as Interim Director of Health and Human Services from January to March 2004. Prior to assuming his position with the Nebraska Health and Human Services (HHS) System, Dr. Raymond served as director of the Omaha Clarkson Hospital Family Practice Residency from 1990 to 1998. He was also on the active staff at Clarkson Hospital and Omaha's Children's Hospital, and served as a clinical instructor at the University of Nebraska Medical Center. Raymond was in private practice in O'Neill, Nebraska, from 1974 to 1990, and before that for a year in Lynch, Nebraska. As the state's Chief Medical Officer, Dr. Raymond is a decision maker in contested cases involving health professionals, and occupational and facility licenses; he serves as a member of the HHS System Policy Cabinet; and oversees all health issues. In addition, he served as interim director of the Nebraska Department of Health and Human Services Finance and Support from April 2000 to September 2000, interim director of the Nebraska Department of Health and Human Services from January 2004 to April 2004, and is currently leading the mental health reform effort in Nebraska at the request of Governor Johanns. Among his very significant public health accomplishments, Dr. Raymond is responsible for the development of the Public Health Preparedness Workforce Development Act of 2004, a seminal legislative proposal introduced in the U.S. Senate in summer 2004 by Senators Chuck Hagel (R-NE) and Richard Durbin (D-IL). Dr. Raymond assumed the position of President of the Association of State and Territorial Health Officials in September, 2004, after serving as President-elect for the prior business year.

**Ed Thompson, MD, MPH** As Deputy Director for Public Health Services, Dr. Thompson provides leadership to improve program services and support provided to state and local health departments and health care providers. He works to improve existing and develop new partnerships, and provides leadership to streamline program support and improve communication between CDC/ATSDR and state and local programs. He takes the lead in working with CIO directors and the ATSDR administrator on HIV policies, occupational safety and health policies, injury and violence prevention policies, and health promotion. In 1980, Dr. Thompson began his career in public health in the Mississippi State Department of Health, first as a clinician and then as Deputy Chief of Disease Control from 1982-1985. From 1983-1993, he was the State Epidemiologist, and from 1985-1993 he was also the Chief of the Department's Bureau of Preventive Health Services. From 1993 until 2002, he served as the State Health Officer for the Mississippi State Department of Health. In addition, he is a Clinical Associate Professor of Preventive Medicine at the University of Mississippi School of Medicine. From 1988-1993, he was a member of the Executive Committee for the Council of State and

Territorial Epidemiologists (CSTE); he was President of CSTE from 1992-1993. From 1998-2001, he was a member of the Executive Committee for the Association of State and Territorial Health Officials (ASTHO); he was President of ASTHO from 1998-1999. Prior to joining CDC, he served on the Advisory Committee on Immunization Practices (ACIP), the Advisory Committee to the Director of CDC, and the Secretary's Advisory Council for Public Health Preparedness. Dr. Thompson received his BA from Millsaps College in Jackson, Mississippi; his MD from the University of Mississippi School of Medicine; and his MPH from The Johns Hopkins University School of Hygiene and Public Health. He is Board Certified in Public Health and General Preventive Medicine.