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Publisher's Message

By Martin (Marty) Masiuk, Publisher

DomesticPreparedness has been honored twice in recent weeks, I am pleased to report. First, we were selected to be the exclusive media partner of the National Association of County and City Organizations (NACCHO) at the association's 2007 Public Health Summit in Washington, D.C. (19-23 February at the Washington Hilton Hotel). Second, we played similar role for the National Disaster Medical System (NDMS) during that prestigious organization's annual conference (19-20 March in Nashville, Tenn.). The latter event was held in conjunction with the NDMS-sponsored Disaster Response and Recovery Expo, also in Nashville (at the Gaylord Opryland Convention Center).

The real honor for our own DPJ staff, of course, was not just to play a supporting role for these two fine organizations, but in having the opportunity to meet and talk at length with so many outstanding – and, in many cases, heroic – men and women from cities and states throughout the county who have dedicated themselves to helping others. In many instances, that help has extended to saving the lives of innocent victims of natural disasters or, in a few cases, manmade mass-casualty incidents.

By serendipitous coincidence, four of this nation's legislative leaders – Senators Hillary Rodham Clinton (D-N.Y.) and Arlen Specter (R-Pa.), and Representatives James P. Moran (D-Va.) and Christopher Shays (R-Conn.) – reintroduced a bill, on 22 March, to create a new Public Service Academy (PSA) that would train future generations of young Americans to enter government service, following in the footsteps of the members of NACCHO, NDMS, and many other organizations and associations dedicated to the protection of U.S. citizens and the preservation of American ideals.

"The PSA Act," as it is called, was first introduced in the last Congress, but too late in the session for the extensive hearings required before it could be enacted into law. Its reintroduction, this early in the current session, provides the time needed for those hearings and, in addition, for the start-up funding that is even more urgently required. The establishment of such an academy – which basically would require five years of public service in return for a "free" college education – should in our opinion be one of the highest priorities of both the Bush administration and the current Congress, as should be the appropriation of the initial planning funds also required. The latter would be used to develop a curriculum, recruit a faculty, select a suitable location for the academy, and carry out numerous other tasks prior to the official ribbon-cutting for what, in Moran's words, would almost immediately become the "premier training ground" for U.S. public-service officials for many years to come.

"Somewhere in the greater Washington, D.C., area" already has been mentioned as the most likely location for the academy, and the site of the current Walter Reed Army Medical Center – already owned by the federal government – would seem to be among the most obvious campus candidates to be considered by a site-selection committee. But there are several other possibilities in the Maryland and Virginia suburbs that also should be looked at.

The only real problem this year, it seems, might be obtaining the start-up appropriations – a particularly daunting challenge at a time when the overall federal budget picture is so grim. But except for national-defense appropriations it is difficult to think of any program that merits a higher priority. There are few, if any, in fact, that promise so large a return on investment.

We plan to follow the hearings on the PSA Act very closely this year and next, and to commission one or two Special Reports for our DPJ readers as well. There is much, much more to tell, and we intend to tell it as objectively, as honestly, and – we hope – as persuasively as possible in the weeks and months ahead. Let me close simply by repeating: we strongly endorse the PSA.

About the Cover: *CBIRF (Chemical Biological Incident Response Force) personnel triage a "casualty" during a simulated WMD (weapons of mass destruction) attack at the Landover (Md.) Metro Training Facility near Washington, D.C. (Marine Corps photo by Sgt. Christopher D. Reed) Photo provided by www.usmc.mil*

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Personnel Staffing In Times of Disaster

By Joseph Cahill, EMS

There are really only three operational states for an Emergency Medical Services (EMS) system: (a) Normal operations, during which the resources of the EMS system are responding to emergencies as part of the normal flow of business; (b) Times during which a multi-casualty incident (MCI) – a train or plane crash, for example – occurs, causing the normal operations of the EMS system to be disrupted and requiring that additional resources be employed to bring the situation under control; and (c) Finally, when a major disaster, such as Hurricane Katrina, strikes, or an influenza pandemic breaks out that threatens to overwhelm the system.

These operational states are separated by how quickly additional resources are or might be available. During normal operations, additional resources usually would be brought into the system by requesting them from surrounding communities, probably under mutual-aid agreements; during an MCI the additional resources would come from more distant communities, but for practical purposes would still be immediately accessible.

During a disaster, however, there usually would be no outside resources immediately available, either because the route of travel to the disaster scene is blocked – e.g., during and immediately after Hurricane Katrina – or because there is no unaffected area to draw on, as during an influenza pandemic. Even during the 11 September 2001 attacks on the World Trade Center there were resources available, from as far away as Canada, that were on the scene within eight hours, and adequate EMS resources were actually on the scene even earlier – almost immediately, in some cases; in other instances within the first few hours after the attacks.

EMS staff and Visiting Nurses Association (VNA) staff are among the more convenient talent pools to call on during and/or immediately after a disaster strikes – for a number of reasons: Their people are trained in many medical procedures; they have been pre-screened by their employers to work with the public; many possess advanced skills of various types; and they can monitor sick patients to determine if a change of status is warranted.

Possible Options, Plus One Important Non-Option

One important question that must be asked before these or similar groups are included in a strategic plan as potential personnel resources during times of disaster is "Who would be carrying out the duties they would otherwise be assigned?" The answer to that question seems obvious when one considers the example represented by an influenza pandemic. One seemingly attractive option at such a difficult time would be to use VNA nurses to staff a field hospital (set up in a gym, perhaps), but taking that approach would mean that many other people – senior citizens, perhaps, or handicapped persons who could not take care of themselves under *normal* conditions – would be left to fend for themselves under much more difficult conditions. Clearly, using the VNA staff would not improve the surrounding community's overall situation.

There are, however, a number of other trained personnel who *can* be accessed during a disaster – school nurses and teachers are perhaps the best examples. The value of using school nurses as an emergency nursing staff is self-evident. While schools are closed, as they would be in many if not all disasters, they would not be carrying out their usual everyday responsibilities for their normal patient population – i.e., the school children in their home communities.

Most teachers, of course, usually do not possess medical skills per se, but most school systems are governed by strict screening rules requiring fairly extensive background checks before teachers can work with students. If nothing else, therefore, teachers can be assigned tasks in times of disaster that require contact with at-risk populations. Teachers usually if not always would be

qualified to carry out these tasks because of their clearances, experience, and demonstrated ability to work with children.

In short, contingency planners at any level – state, county, or local – cannot count on staffing to meet emergency medical needs in times of disaster by stripping other essential services of their personnel without taking into account the "normal" everyday tasks the emergency workers would otherwise be carrying out. The accounting process may take the form of stretching other resources to cover the emergency tasks that suddenly develop, or making the difficult decision that the normal everyday tasks must be lower in priority – for as short a time as possible, of course. The one option that is totally unacceptable is to ignore the problem until it is too late.

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*Joseph Cahill has served as a line paramedic for over ten years in The South Bronx and North Philadelphia. He was awarded the distinguished service medal and seven pre-hospital "saves" ribbons from NYC*EMS and FDNY as well as a unit citation from the Philadelphia Fire Department, and has received both the 100-Year Association's award for "Outstanding Service to New York City" as well as the World Trade Center Survivor's Ribbon (two bronze stars).*

Special Report

CONTOMS: The Attributes of Excellence

By Joseph Steger, Law Enforcement

In both the war on drugs and the current war on terrorism, CONTOMS (Counter Narcotics and Terrorism Medical Support) has been the leading training program for federal, state, and local Tactical Emergency Medical Support (TEMS) programs. Created in 1989, CONTOMS has evolved its training curriculum to meet ever-changing terrorist threats. Tactical emergency medical technicians (T-EMTs) of the 21st century require highly specialized skills to deliver lifesaving medical care in dangerous environments – and CONTOMS training will provide those skills.

Moreover, today's threats involve not only conventional weapons such as firearms but also mass-casualty weapons such as explosive, chemical, biological, and even radiological systems and devices. Standard emergency medical services deliver patient care in relatively safe and secure environments. TEMS training is the key to providing patient care in dangerous and unstable environments. In short, the very best of today's rare breed of protectors and first responders receive their training through the CONTOMS program.

The CONTOMS program, created in 1989-90 during the height of the war on drugs, provides exceptional training for medical support personnel attached to police tactical teams. Facing extreme violence often associated with narcotics interdiction, state, local, and some federal agencies recognized the value of TEMS training as an integral component of the tactical team package. However, embedding emergency medical skill sets within tactical team operations requires highly specialized training.

Leveraging the trauma medical skills developed under the auspices of the Department of Defense's Casualty Care Research Center (CCRC), the CONTOMS program established a much-needed but previously missing link between military units possessing combat medical expertise and domestic law-enforcement tactical teams. The

CONTOMS curriculum reflects the military's need for medical preparedness and response capabilities required to counter the array of unconventional weapons facing U.S. and allied service personnel in the Middle East.

In October 2004, the CONTOMS program was transferred from DOD to the Department of Homeland Security (DHS). Today, the Protective Medicine Branch of the Federal Protective Service is in charge of CONTOMS training programs. However, nearly 40 states have embraced the CONTOMS curriculum as their adopted standard certification for local TEMS programs, so the CONTOMS concepts and methods are replicated on the state level as well.

NTOA Endorsement and Continuing-Education Credits

Described as "SEAL training" for T-EMTs, CONTOMS has been hailed as the premier tactical medical training program for civilians. The cornerstone of the CONTOMS courses is the EMT-Tactical program, which in 1993 received the strong endorsement of the National Tactical Officers Association (NTOA). Within one very long week (56 hours) of training, the T-EMT trainee learns and and/or strengthens his or her lifesaving skills through both classroom work and practical instruction. The T-EMT must then demonstrate these learned skills during rigorous field exercises carried out under extreme conditions. He or she also gains a deeper understanding of the TEMS system and rationale.

The EMT-T program, it should be noted, is not a basic certification course. It builds, rather, on the individual student's previously acquired EMT (or higher) certifications. As a prerequisite to admission for the EMT-T program, a prospective candidate must already be certified as an EMT or higher and have the endorsement of a supervisor from his or her sponsoring department or agency. EMT-T training covers a broad range of inter-related topics, including but not limited to preventive medicine, sustained team care, patient assessment and stabilization under fire, officer rescue, medical intelligence, operations planning, special and protective equipment, airmobile medical operations, and operations in toxic hazardous environments. Successful completion earns the tactical medic 45.5 continuing-education hours through the Continuing Education Coordination Board for EMS. EMT-T certifications are valid for three years. With fewer than half a dozen class offerings each year and class sizes of about 40 students, the competition for space is fairly rigorous.

Keeping the EMT-T curriculum up to date has been a major challenge for the CONTOMS faculty and board. For one thing, the TEMS knowledge base is constantly expanding. In the late 1990s,

Over the past 18 years, CONTOMS has provided critical TEMS training to over 7,000 tactical medics from federal, state, and local agencies

CONTOMS released an EMT-T advanced course, a 36-hour program that covers, among other topics, specialized extraction-and-rescue methodologies, veterinary medical skills for K-9 partners, and forensic science.

Numerous Specialized Courses Available

Another specialized course, for medical directors, is unique to the TEMS system. The Medical Directors Course focuses primarily on issues unique to the physician's oversight of tactical medical teams. Concepts of TEMS practice are covered from a physician's perspective, and include the command responsibilities of a tactical medical team and current medico-legal issues. This robust program is covered in eight hours of lecture and practicum instruction.

CONTOMS also provides a 16-hour program, specifically designed for medical-services providers, on issues related to chemical, biological, radiological, nuclear, and explosives (CBRNE) topics. This course, also delivered in a lecture-plus-practicum format, addresses the health care implications of CBRNE hazards in enough depth to meet OSHA (Office of Safety and Health Administration) regulations if they are to be in compliance with JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards. The CBRNE course certifies students to what is called OSHA Level C.

The program's Tactical First Responder course develops and enhances the lifesaving skills of law-enforcement and/or military students in a compressed 40-hour curriculum. Students who have no prior medical training are taught basic patient assessment, preventive medicine, and medical equipment requirements and utilization; they also are certified in CPR. Through lectures and training at practical skills stations, students learn, apply, and demonstrate their ability to carry out an array of essential first-responder procedures, with emphasis on the tactics and operations specifically applicable to dangerous and difficult operational environments.

Over the past 18 years, CONTOMS has provided critical TEMS training to over 7,000 tactical medics from federal, state, and local agencies. CONTOMS programs are financially self-sustained, relying on course fees to cover all program expenses. Course fees remain quite reasonable. For example, the last EMT-Tactical course (conducted in September 2006) charged a fee of $600 per student. This relatively low cost for such a rich course of instruction represents a real value of exceptional, state-of-the-art TEMS training.

Empirical Evidence and Epidemiological Research

Preventive medical monitoring, intervention, and care are the hallmark attributes of the TEMS program. CONTOMS training stresses the role of the tactical medic in caring for the team's well-being even between operations and during sustained deployments. In one major operation involving local and federal emergency-services personnel, CONTOMS-

trained medics proved indispensable in an unexpected way. During a protracted interagency operation involving a high-risk terrorist trial, an alarming number of officers and agents were afflicted with flu-like symptoms. The number of people reporting themselves sick was disproportionately high compared to the size of their departments.

To determine the cause of whatever illness they were suffering from, CONTOMS-trained medics monitored their symptoms, provided on-site patient assessments, recommended appropriate personal and clinical care, and conducted some essential epidemiological research. Eventually, the tactical medical team briefings, combined with the continuing care that was provided, allayed the concerns of interagency team-members, particularly when the CONTOMS team was able to report that the cause of the illness was Rota virus, a highly contagious disease producing a rapid onset of symptoms, including debilitating diarrhea, vomiting, and corresponding dehydration. The interagency team members had expressed concern that there might have been some relationship between the assignment and these illnesses. CONTOMS medics provided assessment briefings to command staff and carried out frequent monitoring of each team member; that combination not only restored confidence but also sustained operational effectiveness. Preventive medical skills also honed and perfected through CONTOMS training have proven equally indispensable to team members and commanders by addressing the effects of exposure to the elements and fatigue before those effects could have an impact on team safety.

To summarize: The CONTOMS program leads the way in providing and promoting TEMS training. Living up to the program's motto, *Medicina Bona, Locus Malis* – i.e., "good medicine in bad places" – CONTOMS-trained tactical medics already have saved countless lives under the most difficult operating conditions. The program's curriculum is frequently updated through the incorporation of leading-edge procedures and techniques. Thanks to the program's widespread networking within the Department of Defense, as well as with TEMS-trained physicians and medics at the local, state, and federal levels, the CONTOMS faculty members represent a repository of tactical medical knowledge that is unsurpassed in any other program of its type.

What is particularly helpful is that CONTOMS faculty members are tactical medical operators in their own right. They not only teach their own specialized subjects but also are frequently working in the field with their former students, now tactical medics applying the techniques embodied in the CONTOMS programs.

For more information about the CONTOMS program courses, see http://www.casualtycareresearchcenter.org/education_section_homepage.htm

Joseph Steger is the pseudonym of a senior law-enforcement commander whose undergraduate background in a pre-medical program led to initial certification as an EMT in 1981. He retained that level of certification for eight years and across three states while serving as a federal law-enforcement officer. Over the years, Steger has worked closely with CONTOMS-trained tactical medics and physicians in numerous situations.

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Public Safety and Pandemic Influenza – Planning for the Inevitable

By Mary Beth Michos, Fire/HazMat

It has been almost four years since personnel in the U.S. health care industry started talking about the need to be prepared for a pandemic influenza. Initially, it seemed, everyone was getting on the bandwagon and committing the resources needed to plan and prepare for the outbreak. With the passage of time, however, these efforts seem to have taken a back seat to other issues and the commitment seems to have become a lower priority. However, the risks are still as great, and the need to plan and prepare is still vitally important to the future public health of communities throughout the nation.

Although *every* segment of the U.S. public and private-sector health care community needs to plan and prepare, it is particularly important for fire and EMS (emergency medical services) units and personnel to do so. If and when a pandemic does occur, most Americans probably will do what they now do, every day, when faced with an emergency: They will call 911 and expect a quick and effective response. Health care providers have to be prepared for that contingency.

The preparations made should focus principally on the challenges that public-safety services at all levels of government probably will face in planning and responding to a pandemic. Those challenges can be grouped into four principal categories: planning; work-force issues; response; and sustainment. Following are a few important factors that should be considered in each of these planning and operational areas.

Planning: Quality Counts

The success in handling a major disaster such as a pandemic outbreak will be proportionate not only to the amount of time and effort spent in advance, but also the *quality* of the planning – which, for an event the magnitude of a pandemic, requires coordination and cooperation at multiple levels. Fire and EMS units will have to coordinate their efforts with the health-care community, other public safety agencies, and both state and local governments – and perhaps with other states in the same region of the country.

Small departments and volunteer agencies that lack their own planning resources should at least have representatives at important meetings so that as plans are developed they take into account the actual (as opposed to planned or hoped-for) capabilities of local fire-EMS resources. Those plans also must ensure that the resource needs of local providers are recognized and that the supplies and other materials required to meet those needs also are included in the planning process.

Local health agencies in communities throughout the country already are working with state officials to determine the protocols required for the distribution of antivirals and vaccines. Those plans may involve using public-safety departments to help in the distribution process, so it is important that fire and EMS agencies also be included in the planning discussions. Another reason why those agencies should be involved is to ensure that emergency-response personnel are high on the priority list of those who should receive the medications. The difficult issues of vaccine and antiviral prioritization and distribution are currently being researched and addressed at the national level, and should be given equal attention at the state and local levels as well.

Work-Force Issues: Social Distancing and Family Factors

It has been estimated that 30 to 40 percent or so of the nation's work force may not be available for duty during a pandemic. One reason is that firefighting and EMS work forces not only mirror the nation's general work force but also – because of their exposure in caring for and transporting the ill – are high-risk groups themselves. Here it should be noted that, although many businesses can limit face-to-face contact among employees and customers (through what is called social distancing), that tactic would be almost impossible to be used by emergency-response personnel.

Like almost every other factor involved in an effective pandemic-preparation process, work-force issues should be addressed during the planning phase. Also, individual workers should be involved so they have a true understanding of the situation and what the effect will be on them both personally and as members of a response unit. Involving firefighters and emergency medical technicians in the planning stage would help immensely in developing truly *workable* plans that could be used during an actual crisis situation.

One important factor that should be considered in the planning process should be the effect on emergency responders of their own family situations. If an employee's family is well prepared and taken care of, that employee is more likely to report for duty. The plans for the families of emergency responders and health care employees should include provisions for, among other things:

- The care of sick family members (alternate care givers);
- The food, water, and other provisions family members probably will need to sustain themselves during a pandemic, and
- Training in the hygiene measures recommended to help reduce the spread of the disease.

Local fire and EMS departments also must work with the community's health departments to ensure that vaccines and antivirals are available not only for emergency workers, but for their families as well. Feedback surveys from workers indicate that, unless their families are cared for, they may not be available to come to work themselves. Firefighters and EMTs are known for their bravery and dedication, but their families are likely to be their highest priority.

Another important factor in the planning process should be the development of schedules to address and/or facilitate possible reductions in the size of the work force during a pandemic. The use of alternate shifts should be considered, for example, as well as the possibility of using "non-traditional" personnel to help first responders by providing their own special services. One example of the latter would be a plan to use school bus drivers – because schools would be closed – to drive ambulances, thereby compensating for the lesser number of EMTs and paramedics likely to be available. Plans and provisions for emergency workers to remain at work between their shifts also should be considered – both as a way of ensuring that adequate staff would be available for the

next working day and/or to see that they are not exposed to family members, friends, or neighbors who are already ill.

The planning phase also would be a good time to refresh first responders in universal precautions and good "housekeeping" (i.e., station and equipment) practices – and to enforce those practices to the maximum extent possible. Studies show that during most crises most people will fall back to what they are accustomed to doing, which is one reason that effective infection-control procedures should be followed at all times, not just during training sessions. Also, the supplies and other resources necessary for maintaining universal precautions should be obtained and stored prior to an outbreak, if only because most of those supplies are likely to be extremely scarce after an outbreak occurs.

The planning phase also is an appropriate time for fire and EMS departments to initiate discussions with their risk-management agencies about any workers' compensation issues that might arise if and (more likely) when workers become ill during a pandemic.

Another important issue that should be considered in work-force planning is the development of a comprehensive and effective communications plan. Fire and EMS workers must be kept informed about all of the planning efforts as reassurance that their leaders not only are properly concerned about the communications requirements but also proactive about the safety and well being of individual employees. The communications plan should include the simultaneous and deliberately redundant (but well-controlled) use of several methods of communication – e.g., web-based information postings; hotlines; toll-free call-in voice recordings; and an alert notification system. Information on the various communications tools available has to be provided to users at frequent intervals to avoid rumors, inaccuracies, and misperceptions.

Another often overlooked work-force issue that deserves greater attention in the pandemic-planning stage are the possibilities of workers losing family members and perhaps some deaths within the work force itself. Members of public-safety departments are usually a very close-knit group, and members of the same unit often are considered "family." How the deaths of family members will be handled should be determined before the situation arises, if only because, if not managed properly, such tragic occurrences might well have a crippling effect throughout the department and impair the ability of other responders to properly serve the community.

Response: No More Business as Usual

One of the biggest challenges facing firefighters and emergency-care personnel during a pandemic will be responding to an increased demand for services with a reduced work force. Emergency responses during a pandemic will not and should not be "business as usual" – and in any case will never be the same even after the pandemic is over.

In order to meet the demand for service, some system of patient triage may well have to be instituted, or expanded, at 9-1-1 centers. Protocols also have to be developed, therefore, that not only will triage the calls from citizens suffering from flu-like symptoms, but also permit a more thorough triaging of other calls for assistance. During the height of a pandemic some situations that EMS staff normally respond to may have to be put on hold for an indefinite period of time. In other situations, service may have to be denied, if the problem is not life-threatening, or alternate service may have to be offered. To handle these and other problems, provision may have to be made to have a more experienced medical person

assigned to the 9-1-1 center to carry out the triage plan – and to make some exceedingly difficult decisions as to how limited resources will be dispatched and used.

It is vital that plans be developed for the triaging, treatment, and transport of victims of the flu. Working with the system's medical director, health department and hospital protocols have to be developed to identify alternatives for care. Those protocols must be specific as to who will be treated and left for home care; who will be treated and transported to alternate care sites; and who will be treated and transported to hospitals. Also, community plans should identify possible care alternatives, such as the availability of home care and/or the establishment of "fever centers." The latter could be facilities where individuals who are sick could be taken for short-term rehydration and symptomatic care. (Many contingency planners say that hospitals should be used during a pandemic only by the most critically ill who require ventilator support.)

The fire-EMS community should coordinate their plans with other health care providers in addressing all the issues that will arise if decisions are made by the local health department for the isolation or quarantine of certain individuals or segments of the population.

There would be significant public fear and anxiety, understandably, during a pandemic outbreak. Public-safety agencies therefore should work, in advance, with public information groups to ensure that, although there may be many voices speaking to the public, they all not only deliver much the same message, but also that message includes such information as what citizens can expect when they call 9-1-1 (if only because the response during a pandemic may be considerably different from what it is at other times).

Sustainment: Waves of Despair – and Signs of Progress

A pandemic outbreak will differ in numerous ways from the disaster situations that the United States and other nations have experienced in the past several decades. To begin with, a flu pandemic would spread across the nation in several waves. The first wave probably would be the worst, because most people will not have the benefit of being recently vaccinated. However, the second and third waves probably would not affect as many people, and therefore would not stress health care and other systems as severely. It is important, though, that fire and EMS departments capture the lessons learned during the first-wave experience to improve their response capabilities during the later waves.

Another difference during a pandemic would be the lack of mutual aid as most Americans know it. Because the pandemic will be widespread, outside resources will probably not be available. Each community would have to rely, therefore, on its own resources – and on other resources that were determined in the planning phase would be needed, and were actually obtained during the preparation phase.

To summarize: fire and EMS agencies throughout the nation should already be involved in planning and preparing for a pandemic influenza outbreak. There are many issues specific to the planning for a pandemic outbreak – but many of the planning decisions made would be applicable, fortunately, to the management of other hazardous situations. Departments that have not yet been involved in the planning efforts must reach out to the health departments and emergency-services agencies in their community and become involved – as fully and as quickly as possible.

Fortunately, new information that could assist public safety agencies with their planning efforts is becoming available every day. To cite but one example: The Office of Emergency Medical Services of the National Highway Traffic Safety Administration is supporting stakeholder meetings for the development of "EMS Guidelines for Pandemic Influenza." This document should be available later this year. There is considerable information also available on the internet to assist in planning. Some other excellent sources of information with numerous links to the most current data are listed below.

For additional information, readers should consult the following websites:

www.pandemicflu.gov

www.OSHA.org

www.cdc.gov/flu/avian

www.IAFC.org

Mary Beth Michos, chief of the Fire and Rescue Department of Prince William County, Virginia, was recognized in 2003 by Fire Chief Magazine as "Career Fire Chief of the Year." She started her career as a critical care nurse and for 21 years worked with the Department of Fire and Rescue Services of Montgomery County, Md., where she was the department's assistant chief when she left to assume her current position.

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Analysis and Commentary

A Long Litany of Difficult Questions - But No Short and Easy Answers

By James D. Hessman, Editor in Chief

When and how soon should most if not quite all U.S. troops be withdrawn from Iraq – and what happens after that? Which party will win next year's presidential election – and will the same party win the House and/or Senate as well? Again, what happens after that?

Those are but a few of the major topics in the news in recent weeks, stated in the form of questions that should be but are not always asked. Let there be no mistake about it, though – those questions, each and every one of them, eventually *will* be answered, one way or another, and many Americans will definitely *not* like the answers.

For at least the next several weeks the war in Iraq probably will continue to be the center of attention not only in the nation's capital but throughout the country – and elsewhere in the world as well. House Speaker Nancy Pelosi (D-Calif.) and most other Democratic members of Congress – some Republican members as well – want to force a presidential decision on early withdrawal by threatening a cutoff of the appropriations needed to fund the war effort. It seems likely that the legislation proposed by Pelosi and her supporters will pass the House. It may or may not pass the Senate – but if it does, the president would probably veto the bill.

That would not end the battle, though; it would merely end the first skirmish in a much longer battle. There are not only several important constitutional issues involved, there are the lives of young Americans also at stake – the men and women now serving their country in Iraq. Which brings up a plethora of other questions that also cannot be definitively answered but nonetheless must be asked: Would a congressionally mandated withdrawal of U.S. troops earlier than now planned really make America safer, or less safe, in the long run – even if it does save the lives of some military personnel in the short run? What would be the impact on U.S. allies around the world? And what would be the short- and long-term effects on the constitutional separation-of-powers principle?

Also, what would happen next in Iraq itself? Would the current Iraqi government be able to survive for at least a short time without U.S. support? Would there be another bloodbath or two, one or more civil wars, a country divided into at least three separate spheres of influence, and eventually a return to a harsh one-man dictatorship?

What would be the impact on U.S. allies around the world? And what would be the short- and long-term effects on the constitutional separation-of-powers principle?

All of these questions, and many others that might be asked, pale into insignificance, though, when compared to two additional questions that all members of Congress, and the American people, will be forced to answer in the near future – sooner rather than later, in all likelihood, and no matter what the consequences. The first question – which should be asked now, and repeatedly, of all candidates, to and through next year's national elections – is this: Will the withdrawal of U.S. forces from Iraq – at any date certain in the always uncertain future – mean the end of the U.S. and allied "Global War on Terrorism"?

Assuming that the war on terrorism would *not* be over, a reasonably safe assumption – if only because the terrorists might not agree – the second question that must be asked is primarily operational and strategic in its wording, but the answer would have profound economic and political consequences as well: Would a future commander in chief ever again be willing to order U.S. forces into battle overseas against a nation that – no matter what its leaders say publicly – is patently guilty of harboring, sheltering, sustaining, and providing safe refuge to terrorist groups and individual terrorists?

President Bush answered the second question when he announced that during the remainder of his time in office there would be *no* safe harbor, anywhere in the world, for any terrorists who attacked America. It was perhaps the most courageous and most important decision of his presidency. But it also is a decision that is not legally binding on his successors. The American people have not only the right, therefore, but also the moral duty of asking all candidates for national office next year if they would support and follow the same policy.

It is recognized that there are no short and easy answers to these and many other questions that might be asked. But a failure to ask those questions would be a dereliction of duty by U.S. voters – and a betrayal by the national media of the responsibilities they have been given along with their unique access to candidates. A failure on the part of candidates to answer the same questions – as fully and as honestly as possible – would demonstrate their unfitness for office.

In that context, it is safe to suggest, the substance of the answers given may be less important than the *willingness* of the individual men and women who would govern America to answer the hard questions that should be asked. They would thus have passed the first and most important test of leadership – a quality always in short supply, but more needed now, perhaps, than ever before in the nation's history.

James D. Hessman is former editor in chief of both the Navy League's Sea Power Magazine and the League's annual Almanac of Seapower. Prior to that dual assignment, he was senior editor of Armed Forces Journal International.

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Washington, Indiana, Oregon, and Texas

By Adam McLaughlin, State Homeland News

Washington
Seattle Mayor Seeks Changes in Emergency Response Services

Seattle Mayor Gregory Nickels has called for numerous changes in the city's emergency-response services in the wake of a recently completed report examining Seattle's response to the 14 December 2006 wind and rainstorms – which, it is estimated, will cost taxpayers about $15.5 million in overtime charges and for repairs to public structures, such as power poles.

"I am very proud of the response of our city employees. Many people worked around the clock under extreme circumstances," Nickels said. "But events like this give us a wake-up call and an opportunity to improve our response to emergencies and disasters."

Nickels said he wants city departments to:

- Implement a 311 phone number for all non-emergency calls during such events;
- Develop an outage management system to track power failures and predict how long residents and/or businesses might expect to be without electricity;
- Install emergency generators in all of the city's fire stations; and
- Carry out annual emergency-response training exercises.

Nickels said he expects that the installation and operation of the new phone line might be "fairly expensive," but noted that the city has not yet calculated an estimate. Barb Graff, Seattle's emergency response director, said that one problem during the December 2006 interruption of services was that too many people called 911 with inappropriate and sometimes "embarrassing" questions, such as when they could expect their cable service to be restored.

"Many of the lessons about coping with power outages and the need to coordinate and more broadly disseminate information are certainly quite applicable," the report said.

"But we must also apply lessons from the transportation system-crippling snow and ice of the following weeks, as well as communication system vulnerabilities and other broader structural-damage impacts to fully appreciate how much more work must be done to strengthen our community's resilience in the face of disaster."

Since the storm, more than 200 Seattle residents and businesses have filed damage claims with the city. Many of the complainants blamed Seattle Public Utilities, the city's public water company, for flooding and other damage. A large number of the claims come from Madison Valley; a number of others were from one small area in West Seattle near the Fauntleroy ferry terminal.

Indiana
State DHS to Use Software to Better Track Emergency Response

The Indiana Homeland Security Department plans to purchase and distribute the software needed to track the training, skills, and certifications of emergency-response workers throughout the state. The department tapped Envisage Technologies' Acadis Readiness Suite for the task, and plans to use federal DHS (Department of Homeland Security) grant funding to pay for the project. The system is expected to be installed in the department's headquarters within the very near future – possibly later this month.

The software will let the department keep tabs on training throughout the state for fire, hazmat, emergency management, emergency medical, search and rescue, and other emergency responders, according to Envisage, which is based in Bloomington, Ind. The Acadis Suite is designed, said Cory Myers, vice president of Homeland Security Solutions at Envisage, to create a position of readiness so that public safety organizations can track first responders' skill-sets and locations.

Among other customers for the suite are the Oregon Department of Public Safety Standards and Training, the Indiana Law Enforcement Academy, and the Federal Air Marshal Service. The company also has conducted a requirements analysis for the Florida Department of Law Enforcement, and Myers said efforts are underway there to obtain funding to purchase the suite.

Among the various modules of the suite are systems for automated scheduling, automated testing, the in-service tracking of training records, and the tracking of qualifications and certifications. Myers said the company's software provides a consolidated record-keeping system, and that organizations lacking such a system may use a mix of spreadsheets and word-processing documents to manage training and certification.

Oregon
Firefighting/Rescue Training for Oregon ARNG

Sixty members of the Oregon Army National Guard (ORARNG) received initial training earlier this month in fundamental firefighting and rescue techniques that could prove to be extremely valuable if the Guard members are called out in the aftermath of a disaster. Under the keen watch of experienced emergency responders, the soldiers spent the first of the two training days, carried out by experts at the Tualatin Valley Fire and Rescue Training Center, developing skills that not only were educational for the trainees but also taught them how they could augment the capabilities of the civilian first responders likely to be already on the scene of a future "significant incident."

"What I really gained is an understanding of how we are going to work jointly in a mass-casualty setting," said Sergeant Thomas Pettit, "especially how our forces are going to cooperate and work together as a joint task force, where we are going to fit into the division of labor, and [will] be most valuable and work as a team."

As they learned the fundamental skills required to be useful in firefighting and rescue operations, the trainees also had the opportunity to gain some practical experience as well. "I had some theories on how to do *some* [things] … but here you are actually

getting a little practical [work] on it, so when it comes down to it you have an idea of what you're going to do," said Sergeant First Class (SFC) Ronald Courtaintharp. The training not only builds skills, the trainees said, it also develops a sense of "familiarity" to and between the firefighters and soldiers.

More importantly, perhaps, it builds trust, an essential element in mounting a cohesive as well as cooperative response to any type of disaster, whether natural or manmade. "It gives us a little more understanding of the relationship between our side and the civilian side," said Courtaintharp. "So now we have an idea of where we can cross over a little bit, get information from both sides, and … work a little closer together, a little more smoothly. That trust and experience … [are] appreciated by the emergency responders as well," he said.

The idea for training Guard members in cooperation with first responders was an aftermath of the difficulties some Guard members experienced in the wake of Hurricane Katrina. SFC Bruce Cutshall, who is also a seasoned firefighter (from Eugene, Oregon), deployed to New Orleans with the 141st Brigade Support Battalion in September 2005. While there, Cutshall said, he and some of his fellow soldiers felt a certain degree of frustration at not being able to help the civilian first responders already on the scene as much as they had hoped to. Cutshall and another Guard member, Second Lieutenant William Croker – who also is a firefighter – worked with personnel from the Tualatin Valley Fire and Rescue Center to coordinate the training. Their goal, they said, was to ensure that the members of the Oregon Army National Guard could develop their capabilities to the level needed to work effectively with emergency responders during future domestic emergencies of any type.

Texas Launches Network for Statewide Crime and Link Analysis

The North Central Texas Council of Governments (NCTCOG) has announced the launch of its new Law Enforcement Analysis Portal (LEAP) network, a potentially statewide multi-jurisdictional crime analysis system designed to concurrently analyze incident and offender information provided by the more than 2,500 law-enforcement agencies of various sizes and capabilities now operational throughout the state of Texas.

Created as a shared resource that could be used by all officers in all of the state's law-enforcement agencies, the LEAP network includes what are called COMPSTAT (COMPuter STATistics) analysis and reporting modules similar to those considered to have played an important role in the reduction in major crime in New York City over the past decade. Among the network's other principal features are: (a) a "search list" capability that continuously seeks information from the entire LEAP network in search of offenders, data about similar incidents, and/or other "attributes" of a crime; and (b) a complete suite of geospatial analysis and visualization tools that can be used to assist officers throughout the state during the investigation of crimes.

"LEAP complements other important information systems and advances our vision of creating economical shared-resource information technology and services for the benefit of local governments in the state of Texas," said NCTCOG Executive Director Michael Eastland. LEAP will be supported, he said, "by the participation of local law-enforcement officers and their respective agencies on an annual subscription basis" and will be partially subsidized "by fee-based services that are made possible by the LEAP infrastructure."

The LEAP network was developed by a group of private industry collaborators who invested their own time and money to "build out" the system, officials said, for the benefit of and at no up-front cost to NCTCOG – which, however, is responsible for administering the network and has already formed a LEAP Advisory Committee, consisting of 11 chiefs of police and sheriffs, to oversee data-sharing policies.

The LEAP network is designed to be economically self-sustaining, the officials said, through the levying of nominal fees to subscribers and the development of services for other entities that will help offset law-enforcement subscriber fees.

Adam McLaughlin is Preparedness Manager of Training and Exercises, Operations, and Emergency Management for the Port Authority of N.Y. & N.J. He develops and implements agency-wide emergency response and recovery plans, business continuity plans, and training and exercise programs.

Communicating in a Crisis Is Different

By Barbara Reynolds, Viewpoint

Crises can assault a community in an instant or creep into it gradually, wreaking random havoc until the community is firmly in its grip. Conventional explosions, category-five hurricanes, chemical releases (accidental or intentional), shooting sprees, deadly disease outbreaks, 500-year floods, dirty bombs, earthquakes, and raging tornadoes – these are just some of the disasters the American people have directly experienced or have been warned about in recent years.

In almost *any* scenario involving public-health emergencies and crises, there are only two common denominators – suffering people who are in need of health-risk information; and officials who are expected to provide an appropriate response. All too often, unfortunately, a failure on the part of the official responders to "be first," "be right," and "be credible" – and deliver an empathetic message at the same time – interferes with what otherwise would be a well planned and executed response to the crisis. However, by integrating what are called CERC (crisis and emergency-risk communications) strategies into the planning and initial disaster-response stages of an incident, operations will be improved and recovery will be hastened.

> ***Empathy is most effective in the first 30 seconds of the larger message. To wait any longer is usually a waste of time***

In these situations, the public basically wants to know: first, what has happened; and second, as much information as possible about how to protect themselves, their families, and their communities. The challenge for communicators, therefore, is to give the public what most citizens need and want to know, but without making the fog of chaos even more dense – and without creating an information overload. Essentially, the public wants to be given the information they need: (a) to protect themselves and their loved ones from the dangers they are facing; (b) to make well-informed decisions in light of the information currently available to them; (c) to play an active participatory role in the response and recovery phases of an incident; (d) to act as volunteer watchdogs over the expenditure of resources (both public and donated funds); and (e) in the end, to recover and/or preserve well-being, normalcy, and economic security.

In turn, the objectives for information released to the public by responding authorities in the early stages of a crisis are to prevent further illness, injury, or death; to

maintain or restore calm; and to engender confidence in the operational responses being taken. In a public-health crisis or emergency, effective communication to and with the public is a necessity, not a luxury, because the public needs information from its leaders and, conversely, those leaders need support and cooperation from the public.

The Principles Of Tool Management

Many predictable and possibly harmful individual and community behaviors can be mitigated through the use of effective crisis and emergency-risk communications. However, CERC is not an attempt at mass mental therapy. It is a reasoned and mature communication approach to the selection of message, messenger, and method of delivery. As such, CERC offers responders communications tools as legitimate and as helpful, when used properly, as any other resource used in the aftermath of a disaster.

CERC principles stress that simplicity, credibility, verifiability, consistency, and speed all count when communicating in an emergency. An effective message must come from a legitimate source. It also must be specific to the emergency being experienced, must offer a positive course of action, and in most cases must be repeated and/or updated as frequently as needed and as the situation dictates. Communication experts – and leaders who have faced actual disasters – are virtually unanimous in describing the numerous ways to cripple or even destroy the success of a disaster-response operation. High on that list are the following five mistakes:

1. The sending of mixed messages by multiple experts;
2. Information released late;
3. Paternalistic attitudes;
4. The failure to counter rumors and myths as soon as possible; and
5. Public power struggles and other confusing actions.

Fortunately, considerable research in the history of *successful* communications, especially crisis communications, substantiates the conclusion that these mistakes, including those made during a crisis, can be overcome. The following five steps are the key to communication success:

- Execute a solid communication plan;
- Be the first source for information;
- Express empathy early;
- Demonstrate competence and expertise; and
- Remain honest and open at all times.

Empathy is the ability to understand what another human being is feeling. Empathy does not require one to actually feel what the other person is feeling, or even to agree that what the other person is feeling is appropriate to the situation. It is, rather, the ability to be able at the very least to understand and describe what the other person is feeling. In its best form, empathy is "talking from the heart" and relating to fellow human beings as just that: fellow human beings – not as victims, or casualties, or as evacuees or refugees or, more generally, "the public," but as individual human beings who, in a crisis, are hurting not only physically but also emotionally, and probably even more so.

The challenge for communicators is to give the public what most citizens need to know, but without making the fog of chaos even more dense

Empathy First, The How-To Information Later

Other research shows that an expression of empathy is most effective when given in the first 30 seconds of the larger message. To wait any longer is usually a waste of time, because the public will be waiting to hear whether or not the speaker really "gets it" – in other words, whether he or she truly understands that they are frightened, anxious, and confused. If officials do not articulate what the public is actually feeling at the moment, the audience's minds will be consumed with the question "Do they get it?" and not hear anything else that the officials are saying. A sincere expression of empathy early in the communication will allow people to answer the question uppermost in their minds and actually hear, and understand, the more substantive information those same officials will be giving them later in the message.

To achieve honesty and openness in crisis communication, however, means facing the realities of the situation and responding accordingly. It means not being paternalistic but, rather, participatory – giving people not only choices, if possible, but also enough of the substantive information they need to make appropriate decisions. In situations of great uncertainty, the public should be told *why* additional information may not be available for release at that time. To build trust, the public also should be allowed to observe the process, insofar as possible – while at the same time being reminded that following the process is what determines the quality and effectiveness of the emergency response.

Finally, trust (built upon expressed empathy and demonstrated competence, honesty, commitment, and accountability) is the foundation of effective crisis and emergency-risk communication. Therefore, building a reputation for effective risk management – undertaken well in advance of a crisis situation – is critical if an organization hopes to successfully practice crisis and emergency-risk communication. Put simply, if an organization and its leaders are not willing to put enough advance effort into building and maintaining trust – not only with its stakeholders but also with the public in general – then executing other elements of the communication plan is a wasted effort.

None of the preceding should be considered an implied promise that a community faced with a potential public health emergency or crisis will overcome its challenges solely through application of effective communication principles. However, it should be clearly understood that an organization can quickly and easily compound its problems during an emergency if it has neglected sound crisis and emergency-risk communication planning.

With current communication capabilities and the experience of numerous recent disasters to draw on, it is possible, therefore:

(a) to predict, with reasonable certitude, both the types of disasters the nation and/or individual communities are likely to face in the foreseeable future; and (b) to anticipate, with the same certitude, the questions the public probably will ask during a disaster. In that context, the best course of action for decision makers at all levels of government to follow is to *plan now* – not only with their communication and public-information professionals, but also with their disaster-response partners – including the people they serve.

Barbara Reynolds, an internationally known writer in the fields of communications and health-care matters, has been a crisis-communication consultant on health issues for Australia, Canada, France, Hong Kong, former Soviet Union nations, NATO, and the World Health Organization. Her work at the U.S. Centers for Disease Control and Prevention (CDC) has been used in the planning for and/or response to pandemic influenza, vaccine safety, emerging disease outbreaks, and bioterrorism. She is the author of, among other publications, the 2002 book Crisis and Emergency Risk Communication, CDC's Crisis and Emergency Risk Communication course, and the 2006 Pandemic Influenza Crisis and Emergency Risk Communication course. Prior to her affiliation with CDC in 1991 she served as a senior press officer specializing in infectious diseases and vaccine safety issues.

Ensuring Preparedness: The Risk-Management Approach

By Timothy Beres, Law Enforcement

It has been 10 years since the U.S. government started the first of what are now a large number of domestic-preparedness programs. In the interim, significant investments have been made in the preparedness capabilities of all levels of government – state and local as well as federal – in a major effort to help communities throughout the country prevent, protect, respond, and recover from catastrophic events of all types, whether natural or manmade. However, determining precisely how much and how well the nation is prepared today – and for what – is still a daunting challenge.

The appropriations language in the fiscal year 2007 DHS (Department of Homeland Security) budget bill requires that each state receiving federal preparedness assistance funds develop and submit a preparedness report to the department. This report must include an assessment of current capability levels as well as a description of the state's target capability levels. The appropriations language further requires that the states initiate what amounts to a "gap analysis" – i.e., a report that not only includes measurements of current capability but also identifies the additional capabilities needed to meet national preparedness priorities.

However, such an analysis can be conducted only by first determining the nature of the risk the specific state is facing and what is needed to reduce that risk. A comprehensive and quantifiable risk assessment, therefore, should be the underpinning of any capability-gap analysis and the basis on which all preparedness investments are made. It is only after a true risk assessment has been completed, in fact, that a state can: (a) determine the capabilities needed to reduce its risks; and (b) make the investments needed to acquire and/or sustain the specific capabilities that would have the greatest impact on "buying down" the state's risk.

The types and magnitude of potential incidents that the nation confronts have changed in the past, and can change again in the future.

Catastrophes and Capabilities: Some Critical Questions

The lessons learned from major disasters, natural and manmade, in the recent past – tsunamis, terrorist attacks, and hurricanes, to take the most obvious examples – have demonstrated that risks are inherently dynamic, which means that the types and magnitude of potential incidents that the nation confronts have changed in the past, and can change again in the future. What is necessary, therefore – for states to truly quantify any existing gaps in their prevention, protection, response, and recovery capabilities – is to review both their current all-hazards risk profiles and the impact of their past and ongoing preparedness investments. That review must take into account public expectations and not only current state and local capabilities, but federal capabilities as well. In short, the assessment must be risk-based, measurable, and replicable, and should help a state answer three critical preparedness questions: What capability is needed? How much capability is needed? And where is it needed?

Establishing and following a rigorous process to answer these questions not only will enable states to continuously evaluate their risks and capabilities, but also ensure that they are making the right investments to reduce the greatest amount of risk – a very high priority in an environment of limited resources. This would be the most important first step in an overall process of identifying capability gaps, investing the resources needed to close those gaps, and then testing – through frequent exercises, preferably – to ensure that the results achieved meet the expectations that have been set. Once conducted, this process should be repeated regularly, and should include both performance-based evaluations, through exercises, and the development of "score cards" that provide the transparency needed for citizens to form their own opinions of the state's preparedness capabilities.

Accomplishing all this requires that states do the following: (a) produce a credible risk picture by using relevant data (usually available from state, region, and federal governments); (b) measure current capability gaps, and the extent to which risk might be mitigated by improving and/or expanding current capabilities; and (c) develop a standardized method to measure progress and improvements. Not until each state has gone through this process will the American people be able to determine, with any reasonable degree of confidence, how well prepared their own communities, and the nation, really are.

Timothy Beres is center director (Safety and Security) of the Institute for Public Research at the Center for Naval Analyses.

Roche

Is your state prepared for a PANDEMIC?

"The reality is, when it comes to a pandemic, we're overdue and underprepared," Leavitt told about 200 state, city and county leaders during the summit. "Anything you say before it happens seems like we're being alarmist. At the same time, anything you do after the fact seems inadequate."

– Idaho Pandemic Flu Summit, 3/06

US signs deal to stockpile anti–bird-flu drug

"Helping states develop their own medical stockpiles will facilitate quicker distribution of antiviral drugs in the event of a pandemic influenza outbreak," said U.S. HHS Secretary Mike Leavitt.

–San Francisco Chronicle, 7/1/06

"Any state, any community, or for that matter any citizen that failed to prepare, assuming the federal government will take care of them in a pandemic, they're wrong," Secretary Leavitt said.

– Minnesota History Center, St. Paul

For more information, please visit www.statepandemictoolkit.com