

THE RAPID PULSE

January 2006

Faces & Places

WELCOME

El Paso, TX:

Ms. Elizabeth Hayes
Mr. Gordon Briscoe

Krome, FL:

LT Jessica Diaz

Pearsall, TX:

LT Sheila Darder-Bonilla
CDR Lynn Bullard-Weiss

FAREWELL

Queens, NY:

LCDR Nadina
Hammonds

THE DIRECTOR'S PERSPECTIVE

By Dr. Gene Migliaccio

Happy New Year, and welcome to another installment of *The Rapid Pulse*!

The year 2005 was busy – it brought us the A-76 process, opening new facilities, and a hurricane year we hope will not be repeated any time soon. We began 2006 in Houston, gathering the leaders of the Division for our first leadership conference in two years. By all accounts the week was a successful exchange of ideas and efforts to move the Division to its next “great” step. However, now the harder task of implementing the concepts discussed and actions identified begins. To truly succeed we will need everyone’s help.

This year will be one of transition and change as we implement the outcome of the A-76 process. No final word on the outcome yet; it is still under protest review. As soon as we

hear anything, we will let you know.

Additionally, we can expect new challenges as some locations move to new facilities and others expand.

It is traditional at the beginning of each year to spend time reflecting on the past and identifying areas of weakness. Let’s begin this year by looking forward - looking for the potential each new challenge brings us. Let’s choose to start each day with a positive spirit. Let’s make DIHS achieve its ‘greatness’ in 2006!

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Houston Shelter Statistics:
15,000 in Astrodome;
12,000 in Arena and Convention Centers; 55,000 in Hotel Rooms; 21 Red Cross Shelters accommodating 100-400 each; Many more in Houston homes

Key Health-related Findings:

52% had no health insurance coverage at time of hurricane; Of those , 34% had Medicaid ; 16% had Medicare

Before the hurricane: 66% of people evacuated to Houston shelters used hospital or clinics as their main source of care; A majority (54%) used Charity Hospital of New Orleans; 2nd most common care site (University Hospital of New Orleans, at 8%); 33% reported health problems or injuries as a result of the hurricane; 41% reported chronic health conditions such as heart disease, hypertension, diabetes and asthma; 43% said they were supposed to be taking prescription medications; Of those, 29% percent reported having problems getting drugs they needed; Of the 61% who did not evacuate before the storm, 38% said they were either physically unable to leave or had to care for someone who was physically unable to leave.

ADAPTING TO THE NEED

By LCDR Jean Pierre DeBarros

in collaboration with CAPT Gene Migliaccio, CAPT Christine Williams, & LCDR Deanna Gephart

Following the aftermath of Katrina, our nation found itself in a position of adaptation as it faced a somewhat unpredicted catastrophic event not only affecting the lives of those directly impacted, but also the US populace as a whole.

In the early days following the aftermath, the images of the Louisiana and Mississippi devastation were accompanied by political dialogues relating to the lack of support to the affected region. The blame game escalated with each news report, while those affected were left to employ their own survival mechanisms. It is the author's viewpoint that the Department of Health and Human Services (DHHS) did not wish to partake in this finger pointing activity, but rather be proactive in servicing the health care needs of the Katrina victims.

The weekend of Labor Day, CAPT Migliaccio received a call from the Office of the Surgeon General regarding the need for the development of a team of PHS officers to serve in Houston in support of activities for HHS. The team, here forth referred to as Team Houston, comprised of CAPT Migliaccio as Field Commander, CAPT Williams as Deputy Field Commander, and LCDR DeBarros as Public Information Officer as the Houston HHS Liaison Team, later to be joined by LCDR Deanna Gephart.

On Labor Day, a delegation composed of Secretary of Health and Human Services Michael Leavitt, our US Surgeon General VADM Richard Carmona, Major General Joseph E. Kelley, MD, Chief medical adviser to the Chairman of the Joint Chiefs of Staff and Dr. Mark B. McClellan, MD, PhD, Administrator of the Centers for Medicare and Medicaid Services convened in Houston to assess the situation first-hand.

We joined this delegation as they performed their tours of various shelters and attended the Mayor's meeting. During the meeting, the federal entity thanked the City of Houston for its generosity in extending its helping hands to the evacuees, and offered any federal resources deemed necessary to support recovery efforts.

Upon closing his speech, Secretary Leavitt asked Team Houston to stand, and introduced us as the three public health officers he was "leaving behind" as Houston's liaison to the federal entity of Health and Human Services; in short, we were the Secretary's "eyes and ears."

As you might have already experienced, the leadership quality of adaptation is vital to any deployment role, but it was more evident in this scenario given the events that ensued, the charge put upon us and the federal level from which it was directed. We realized early on that the success or failure of our mission had proportional impact on the displaced population and the image of health care's federal sector given the significant media coverage.

During the delegation's tour of the shelters, Team Houston had made its acquaintance with local health care leadership involved in meeting the health care needs of those displaced, and as the days ensued, we were firmly established as partners in this city's role in the nation's greatest recovery effort. Our typical day started out by attending the Mayor's daily briefing, followed by a meeting of the Community Health Care Working Group. These two meetings gave us the opportunity to prioritize our focus on the health care need for the day or week.

At the close of each day, Team Houston, along with other such liaison teams in Baton Rouge, Port Charles, Dallas and San Antonio met via telecon with the Surgeon General's office to provide an update so that in turn the Secretary's office could appropriately brief the President. This was our opportunity to address the local needs and submit our requests for federal support.

Into the second week following Katrina's devastation, the volunteer health care

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work force was starting to get into the burn-out stage common with any volunteer activity. In addition, many employers had been gracious enough to allow their staff to volunteer, but the two-week mark was approaching, and the expectation was that many, if not all, of the workforce would return to their original jobs.

The magnitude of the work wasn't underestimated, but adaptation had not caught up with the need. By mid-week, Team Houston briefed the Surgeon General's staff that the local health workforce would not be able to sustain the volunteer activities past the coming weekend and a plan was immediately executed to bring in a federalized force to continue the daunting task of providing health care to the evacuees.

The back-fill support came in the form of two California corporations, Kaiser Permanente and Scripps Health Care Inc. A total of 50+ volunteers were federalized as government employees and immediately embedded into the daily grind activity of treating sheltered evacuees. Team Houston acted as overseers of this federal workforce of nurses, doctors, and administrative assistants.

As the evacuees made their transition from shelters to the greater Houston area, an already stressed health care infrastructure was feeling its strain of caring for an extremely vulnerable, displaced population. Of those evacuated to Houston, 52% report having no health insurance coverage at the time of the hurricane. Of those with coverage, 34% say it is through Medicaid and 16% through Medicare.¹

As shelter attendance diminished, focus shifted to the various community health care clinics tending to the health needs of evacuees. Teams of federalized doctors, nurses and administrative assistants were placed in areas of greater need, providing primary health care to evacuees, freeing up the local resources to their primary mission of seeing the indigenous Houston population.

By the third week, the long hours were beginning to take a toll, and relief was called upon and answered in the form of LCDR Deanna

Gephart, Health Services Administrator from the Tacoma SPC. A rotational plan was established to allow team members the opportunity to get some rest and relaxation, but before LCDR DeBarros could finalize his travel plans home, Hurricane Rita was looming.

The day before Hurricane Rita was to make its path through Harris County, evacuation plans were established for those not able to do so for themselves. The George R. Brown (GRB) Convention Center, one of the original shelters, became a transition point to assess those viable for air transport vs. being bussed to areas such as Dallas.

What should have been an exercise concluding with all safely evacuated to safer haven, became a new mission for Team Houston.

Forty-nine high level acuity nursing home patients, unable to remain in their nursing home or be transported, were assigned to the GRB Convention Center to weather the storm. With the majority of the local resources tending to the needs of their loved ones, Team Houston heeded the call of city officials for assistance.

In collaboration with Houston's EMS, a makeshift total care facility was created. The Houston SPC cavalry, comprised of CDR Peggy Mathis, LCDR Karl Bailey, LCDR John Gary, LCDR Priya Navaneethan, and LCDR Martin Newton, provided continuous support until the patients could safely be returned to their homes. This presented another example of adaptation, resourcefulness and unselfish dedication to the mission.

Hurricane Rita proved insightful in the concept of expecting the unexpected. Who could have fathomed that another hurricane would befall these mentally and physically drained evacuees a second time...miles from home, as though Mother Nature was daunting them.

This became an opportunity for Team Houston to witness leadership at its best

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Hurricane Statistics (continued)

Prevalence Stats from CDC:

New Orleans ranked #1 Nationally in cases of Gonorrhea; New Orleans ranked #2 nationally in cases of Syphilis; New Orleans ranked #3 nationally in cases of Chlamydia; New Orleans has 6 times the national average of HIV cases

From the Mavor's Website:

150,000 estimate of disaster-related newcomers in the Houston area today; 115,000 people served at FEMA's Disaster Recovery Center; 60,000 volunteers; 27,000 housed in government-owned shelters - perhaps that many more in churches and homes; 12,000 evacuee children enrolled in just four major school districts; \$255 million in housing vouchers and other aid disbursed by FEMA



Our Vision:

By 2008, we will be the benchmark for detention health care systems and will be recognized as having the most prestigious, dynamic and rewarding workplace within the United States Government.

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during a time of crisis; from Houston's Honorable Mayor, Bill White, all the way down to the employees in charge of logistics at the GRB Convention Center....a constant adaptation to change.

As the weeks rolled on, our situational reports to Washington proved more favorable each night with sight on mission's end. Some health care clinics still faced distress, but with a collaborative effort between Team Houston, city health officials and the Health Resources and Services Administration, those challenges were ironed out, affording Team Houston the ability to close out its mission after six weeks on the ground.

The most apparent lesson learned by Team Houston was that of learning to adapt to the unknown while performing as a cohesive team. Evident throughout the mission was the perfect build...two seasoned health services administrators paired with two nursing professionals, each pulling from their repertoire of skill sets, whether it came from years of experience or simply thinking outside the box.

For those few weeks in Houston the U.S. Public Health Service demonstrated its role in tending to the varied health care needs of our nation without falter with each new challenge. A resolve of skill, professionalism, integrity and adaptation proved the recipe for success on a mission of uncertainty.

http://webapps.sph.harvard.edu/content/EVENT_Unspecified_2005-09-28_12-34-PM.htm

The Importance of Mentorship

By CAPT Marylouise Ganaway

As another 'PHS year' drew to a close on January 23, 2006, many have just made last minute submissions to your Official Personnel Folder (OPF), while others may not know

what an OPF is or the significance of January 23, 2006. So, to all officers, I extend the challenge of mentorship; for some of you to find one, for others, to be one.

Mentoring is an imperative asset, for it assures continuation of our daily processes. The seasoned officer can be the keystone to a new officer, constructing or breaking another officer's PHS future. Be sure that each new officer has a mentor for work orientation as well as PHS orientation.

To new PHS officers, I 'charge' you to take the helm of your career because it is **your** career so it will be what **you** make it. If you don't know something, **ask** someone.

Some supervisors/leaders do not offer information as they expect you to seek it. As you take charge of your PHS career, just like your category career, you need to ask all the questions you can to make appropriate decisions for yourself.

If you are unsure if your PHS Category has a mentoring program, you can go to usphs.gov, click on [professions](#), then choose your category. Each category has a link to their web site or they have an officer list on the main page who represent different agencies or different career aspects within the category. This gives you a wide contact scope in which to seek career-essential information.

In the event your category does not have a strong mentor presence on the web site, check with your peers or with other categories to see what they offer. I know the HSO, nurse, and engineer categories have an impressive range for you to choose from.

I would encourage you to check with several officers/categories from the area/agency of your interest to provide a diverse perspective. The more information you gather, the better informed decision you can make.

It is your career; **take charge!**

Updated Communicable Disease Advisory

Avian Influenza (H5N1)

- The World Health Organization (WHO) has issued a pandemic alert in response to the ongoing outbreaks of highly pathogenic avian influenza among chickens and ducks in several countries in Asia in conjunction with the occurrence of human cases of avian influenza infection. The following link provides updated information from the Centers for Disease Control and Prevention (CDC) on avian influenza. <http://www.cdc.gov/flu/avian/outbreaks/asia.htm>
 - As with all infectious illnesses, the first line of defense to prevent transmission is careful hand hygiene. As a general rule, wash hands frequently with soap and water or use an alcohol-based hand rub if hands are not visibly soiled.
 - Staff should be aware of the symptoms of avian influenza. Although experience with human infection is limited, persons infected with avian influenza would likely have fever and respiratory symptoms (cough, sore throat, shortness of breath). <http://www.cdc.gov/flu/avian/facts.htm>
 - For staff who interact with detainees arriving from areas with avian influenza, CDC does not recommend protective measures beyond those already in use for interacting with the general public.
 - If a detainee traveling from an area in which avian influenza cases have been reported (see <http://www.who.int/en> or http://www.oie.int/eng/en_index.htm) is ill with a fever or respiratory illness, staff should keep the sick person separated from close contact with others as much as possible. Ask the sick person to wear a surgical mask if one is available provided the person can tolerate it. If a surgical mask is not available, provide tissues and ask him or her to cover the mouth and nose when coughing. When a sick person is unable to wear a surgical mask, personnel should wear surgical masks when working directly with that person.
- As part of DIHS' preparedness plans, the following actions shall be taken:
- Enhanced Surveillance: All DIHS-staffed facilities shall implement enhanced surveillance for persons with possible avian influenza by following guidelines issued by the CDC (available at www.cdc.gov/flu/avian/professional/han020405.htm):
 - Testing for avian influenza A (H5N1) is indicated for hospitalized patients with:
 1. radiographically confirmed pneumonia, acute respiratory distress syndrome, or other severe respiratory illness for which an alternate diagnosis has not been established, AND
 2. history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans (for a regularly updated listing of H5N1-affected countries, see <http://www.who.int/en> or http://www.oie.int/eng/en_index.htm.
 - Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with state and local health departments for hospitalized or ambulatory patients with:
 1. documented temperature of >38°C (>100.4°F), AND
 2. one or more of the following: cough, sore throat, shortness of breath, AND
 3. history of contact with poultry (e.g., visited a poultry farm, a household raising

Happy New Year!

*Happy New
Year to all
DIHS
staff!!*

Thanks to everyone who helped make the Leadership Conference a success, and to all who participated!

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- poultry, or a bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1-affected country within 10 days of symptom onset.
- DIHS-staffed facilities shall assess the availability of, and requirements for, avian influenza (H5N1) testing for their detainees.
- Isolation of detainees with possible avian influenza: A detainee who meets the above criteria for avian influenza testing shall be isolated from other persons and placed on airborne, contact, and droplet precautions, either in a Short Stay Unit or referred to a local hospital. Local DIHS leadership is responsible for identifying and assessing the capability of on-site and community resources to handle a detainee with possible avian influenza. Please note that, although N-95 masks are required for personnel caring for detainees in airborne infection isolation, these masks are of uncertain value in protecting persons against inoculation with avian influenza.
- Contact Investigation: Upon identifying a detainee with possible avian influenza, and with the assistance of the local public health authorities, local DIHS leadership shall conduct a contact investigation and consider prophylactic antiretroviral medication.
- Establish communication with local pandemic preparedness resources: Local DIHS leadership shall establish communication with local community authorities responsible for planning and preparing for an avian influenza pandemic. At this time, DIHS is under the assumption that local DIHS requirements for antiviral medications and for the expected avian influenza vaccine will be supplied by local community authorities responsible for avian influenza pandemic response. Local DIHS leadership shall ensure that local DIHS requirements are reflected in community preparedness plans.
- Other DIHS pandemic preparedness plan details:
 - DIHS staff who work with patients or who work in areas where detainees are housed should:
 - receive the seasonal trivalent influenza vaccine, as per CDC recommendations
 - complete annual N-95 mask fit testing
 - read and understand this announcement



Director's Award Recipients

Congratulations to the following recipients of the Director's Award. Thank you for a job very well done!

2004

Leadership: Dr. Chang Park

Quality: CDR Brenda Bailey

Cost: Mr. Geoff Feldesman

Junior Officer of the Year: LCDR Stephen Gonsalves

Best Facility: Krome (CDR Kirsten Warwar)

2005

Leadership: CDR Danisha Robbins

Quality: LCDR Joel Johnson

Cost: LT David Lusche

Junior Officer of the Year: LT Jason Ortiz

Best Facility: El Paso (CDR Diane Aker)