

NATIONAL INSTITUTE FOR OCCUPATIONAL
SAFETY AND HEALTH

EMERGENCY PREPAREDNESS AND RESPONSE PROGRAM

Washington, D.C.

Tuesday, March 25, 2008

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

- 1 PARTICIPANTS:
- 2 MARGARET KITT
- 3 JOHN HOWARD
- 4 RICH DUFFY
- 5 RENEE FUNK
- 6 NADINE LEVICK
- 7 E. BARRY SKOLNICK
- 8 TED SCHARF
- 9 TAMARA BLOW
- 10 JOSEPH CHIP HUGHES
- 11 DANIEL YOUHAS
- 12 LAURA McNALLY
- 13 PERRY ROPER
- 14 TIM DAVIS
- 15 MATTHEW KORBELAK
- 16 JEFFERY KRAVITZ
- 17 CHIA-CHIA CHANG

18
19
20
21
22

* * * * *

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 PROCEEDINGS

2 DR. KITT: Good morning. I think we're
3 going to go ahead and get started here. Hopefully
4 everybody is sitting around where they can see
5 over the pillar here. Sorry about the awkward set
6 up for the room.

7 Good morning. First let me say thanks
8 for taking time out of your very busy schedules to
9 be here with us today and engage in this
10 conversation with us. I know that everyone in
11 this room has a real appreciation of the critical
12 role that the responder community has within our
13 nation's health.

14 So the selfless work force that we
15 strive to take care of really needs a voice to
16 help prepare it and take good care of it. And
17 NIOSH is certainly committed to be part of that
18 voice, and I know that everyone here in this room
19 is part of that voice, as well.

20 So let's go ahead and get started. I
21 know that most of you know Doctor John Howard, the
22 Director of the National Institute for

1 Occupational Safety and Health, which, of course,
2 is part of the Department of Health and Human
3 Services. Well, prior to his appointment as the
4 NIOSH Director, Doctor Howard served as the Chief
5 of the Division of Occupational Safety and Health
6 in the California Department of Industrial
7 Relations from 1991 to 2002. Doctor Howard has a
8 Doctor of Medicine from Loyola University, an MPH
9 from the Harvard School of Public Health, a Doctor
10 of Law from the University of California, Los
11 Angeles, and a Master of Law and Administrative
12 Law from the George Washington University.

13 He's board certified in internal
14 medicine and occupational medicine, and is a
15 member of the U.S. Supreme Court Bar. He has
16 written numerous articles on occupational health
17 law and policy, and we're very fortunate to have
18 him with us here today. Doctor Howard.

19 DR. HOWARD: Thanks very much, Captain
20 Kitt. I didn't know you were going to be so
21 formal here this morning.

22 Thanks for everybody taking time to come

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 to our meeting today. This is extremely important
2 for us. Just as a general background, let me tell
3 you briefly what we do at NIOSH, for those of you
4 that are not totally familiar.

5 We have a portfolio of programs that we
6 manage for the country, and of those 32 programs,
7 one of them, Emergency Preparedness and Response,
8 is an extremely important program for us. And one
9 of the reasons that you're all here today is to
10 help us determine what is the most relevant
11 research for that area, how we can do that
12 research with the highest quality scientific
13 standards in mind, and how that research can have
14 the most impact on emergency responders. If you
15 look at our portfolio, we emphasize those three
16 attributes of relevance and quality and impact.

17 Now, for those of you that are familiar
18 with a lot of our activities, you'll realize that
19 we're part of the Centers for Disease Control and
20 Prevention. We are also a part of the Department
21 of Health and Human Services. And a lot of our
22 activities that we've done in emergency response

1 since emergency response has become an area of
2 organized emphasis, if you will, with a name, has
3 largely been in response, if you will, to the
4 various real and exercised disasters that CDC
5 engages in, that HHS engages in, that across the
6 federal government, FEMA, Department of Homeland
7 Security and others engage in.

8 And for now about four or five years,
9 we've realized that our own emergency response
10 activities of significant scientific content and
11 merit really have been following along, if you
12 will, some of those cross government activities,
13 the real and the exercised disasters. And so what
14 we wanted to do is to say to ourselves, we have an
15 emphasis in a particular area of responder safety
16 and health, and it's not related to what all these
17 other agencies are doing. We, ourselves, have to
18 get together and decide what is a research
19 portfolio of programs for emergency preparedness
20 and response for responder safety and health.

21 And one of the things that I have
22 learned from my work as the Department's World

1 Trade Center Coordinator of Programs; of the
2 health programs that we coordinate for responders
3 to the World Trade Center, and most recently to
4 the community affected by the World Trade Center
5 disaster, is that we in responder safety and
6 health have to constantly remind those whose view
7 is more general and more broadly oriented that
8 responder safety and health has to be put on the
9 same plane of importance and interest and
10 financing as victim rescue is, as site recovery
11 is, as clean-up activities are, because without
12 that, we will suffer the same things that we
13 suffer now in the aftermath of the World Trade
14 Center disaster, that is, a health disaster
15 following the original response.

16 So what we want to do here is to bring
17 all of you together, bright minds coming together
18 in the same room, to help us chart a research
19 portfolio; what should we be doing at the
20 Institute to move responder safety and health
21 forward, per se, not related to victim rescue,
22 site recovery, all these other things that other

1 government agencies do. We are the only federal
2 agency whose sole responsibility is the protection
3 of individuals who work. And responders are
4 workers, workers are responders.

5 So I want to welcome you on behalf of
6 everyone at NIOSH who does this work. Thank you
7 very much for taking time out of your busy
8 schedules to come here today. I hope that we have
9 a great day.

10 Please contact me if anybody has any
11 interest in what we're doing at NIOSH beyond
12 emergency preparedness or related to anything that
13 I do. I'll give you my email address, it's
14 jhoward1, that's an aerobic number 1,
15 jhoward1@cdc.gov. So please contact me at any
16 time if you want to know what we're doing in other
17 areas of NIOSH. So thank you, I appreciate your
18 attendance today, and I hope we have a great
19 meeting.

20 DR. KITT: Thank you, Doctor Howard.
21 We're also very fortunate to have with us today
22 our next speaker, which is Mr. Rich Duffy, who is

1 the Assistant to the General President,
2 Occupational Medicine, Health and Safety,
3 International Association of Firefighters. Rich
4 holds a Bachelor of Science in both Environmental
5 Health and Business Management, and a Master of
6 Science in Occupational and Environmental Health
7 Services -- Sciences, sorry. Rich has been
8 involved with worker occupational safety and
9 health issues for over 35 years, the past 30 of
10 which have been with the IAFF. He provides
11 technical assistance on firefighter's health and
12 safety issues and is internationally recognized as
13 a firefighter health and safety expert.

14 He's responsible for the coordination
15 and technical aspects of the IAFF's Disaster
16 Relief Program and was instrumental in their
17 deployment and assistance in New York City after
18 911 and at the Gulf Coast after Hurricanes Katrina
19 and Rita.

20 He has authored numerous books, manuals,
21 and articles on worker occupational safety and
22 health issues, and we're very pleased to have Mr.

1 Rich Duffy with us here today.

2 MR. DUFFY: Thank you, Kitt, and thank
3 you, John. When I was asked to come here today,
4 obviously I could have spoken about an awful lot
5 of things as it affects emergency responders. I
6 guess I could have given John's speech, which
7 truly are some of the areas that we need to look
8 at, and we're certainly happy that the continuing
9 forum of NIOSH and the many areas is continuing
10 and trying to address these issues. So I'm
11 debating what I should talk about in a 15 minute
12 period. I want to just look and use the examples
13 that we learned very briefly after our response in
14 2005, after Hurricanes Katrina, Rita, and to some
15 extent, Wilma, and try to give you a flavor of the
16 emergency response activities, not only that we
17 were involved in, but more importantly the role
18 that the federal government needs to play and
19 NIOSH needs to play in assisting emergency
20 response and events that occur in the future, and
21 I'll attempt to look at those.

22 To give you a flavor of what happened

1 after August of 2005, we did detail, an awful lot
2 of people, which you'll see over the next few
3 moments, to the Gulf Coast, specifically in Texas,
4 and a more larger scale in Louisiana, where we
5 based our operations out of the only dry area,
6 which was in Baton Rouge, we assisted 45 of our
7 local affiliates, meaning 45 fire departments that
8 had paid career firefighters involved.

9 We did a minimum of 160 missions during
10 the first month and a half of our work out of
11 Baton Rouge, and we worked in the states of
12 Alabama, Florida, Louisiana, Mississippi, and
13 Texas. And again, as you'll remember, these
14 hurricanes happened one after the other. The
15 first responders had significant problems here.
16 This is a fire house in St. Bernard where
17 firefighters still were being deployed out of, and
18 as you can see, the water here is probably about
19 four and a half -- five feet deep in this
20 particular fire house.

21 And they stayed in their fire houses.
22 You know, you saw the pictures; perhaps you didn't

1 notice that emergency responders didn't leave
2 their particular community.

3 Not only did they stay within their
4 community, they stayed within their fire houses.
5 And this is not a rescue mission, these are
6 firefighters remaining in place at their fire
7 house.

8 They were able eventually to get boats,
9 but they kept the boats in those particular areas,
10 and, again, there were significant problems
11 associated with that. And, again, just another --
12 this is a New Orleans fire house, and you can see
13 -- and you've seen the pictures in the press.

14 I just want you to know the next time
15 you see these pictures that typically there are
16 still emergency response people in there. And the
17 same is true in other emergency response, with
18 police trying to deal within the capacities that
19 they had and the facilities that they had. They
20 weren't able to all get on a bus and leave the
21 particular area, they remained in that area, and
22 they were there for, as John alluded to, there for

1 rescue and recovery efforts after -- and for a
2 considerable period of time.

3 Regardless of the rescue and recovery
4 activities, they still did what they had to do on
5 a daily basis, and that's fight fires. And as you
6 saw certainly in the New Orleans area, fires did
7 occur, numerous fires occurred, and firefighters
8 from outside the area were deployed into New
9 Orleans to assist them in taking care of numerous
10 fire emergencies, as well. And, of course, then
11 we continue with recovery efforts.

12 The first particular area of need after
13 a disaster is clearly money and how that money is
14 used. We started a policy a number of years ago
15 where we immediately provide \$500 of relief money.
16 It sounds like a minuscule amount of money, and,
17 in fact, in the total picture, it is a very small
18 amount of money, but you can't believe how
19 important it is to put \$500 cash in someone's hand
20 after a particular event, where their ATM card
21 doesn't work, they can't cash a check, they're not
22 getting a paycheck, and they have nothing. And so

1 what you may not think is a significant issue
2 becomes a very significant issue. And within
3 hours, we had checks; in fact, we had to Fed Ex
4 them because it was the only way that we could do
5 them, sign checks without peoples' names and sent
6 Fed Ex with, I think we did \$50,000 at a time that
7 they would cover them, and got there, signed the
8 checks, and wrote them out to people, and then
9 found a place to cash them right in our area,
10 which you'll see.

11 We provided these checks within the
12 first month to over 3,500 of our members. We
13 distributed a million, almost two million dollars
14 in money that we collected. Every penny that we
15 collected, we gave out. Not only true, I should
16 say in the Gulf Coast, after 2005, but we
17 collected, in 911, about \$170 million, and that
18 \$170 million, including every interest penny that
19 was also gathered as we collected the money, was
20 divided by 347 and given to the families.

21 We kept no administrative fee, we kept
22 no set-up fees, so the money coming in, we were

1 able to immediately get that out. And every penny
2 we collected under the Katrina, Rita, and Wilma
3 Hurricanes were given out to our members that were
4 affected, as well. We also assisted, to some
5 extent, the Red Cross.

6 Besides money, there is lots of other
7 activities that I want to really touch on. We
8 provided a command staff to assist numerous
9 members that we had both in place in the Gulf
10 Coast, in Texas, and to a larger extent,
11 Louisiana. We had every problem that was
12 imaginable. Communications were a significant
13 issue. We went and we had our satellite phones
14 and our cell phones and the Nextels and the
15 radios, and for the first week communications, at
16 best, were a minimum. Face to face was typical,
17 more so than using any electronic communications.
18 But it's an area that I think everybody has
19 learned quite well from.

20 We learned certainly after 911 in New
21 York City, when we lost all the cell capability or
22 they were jammed by the media. We certainly had

1 the same problems of capabilities in the Gulf
2 Coast. And everybody that believes that satellite
3 phones are the answer, believe me, save your money
4 and probably hope for more face to face.

5 Evacuation was a significant problem
6 with our members in the Gulf Coast areas in
7 particular. In Louisiana, firefighters have
8 residency laws. They must live within the
9 community they work in. So the firefighters,
10 especially in New Orleans and in St. Bernard
11 parish specifically, almost every one of them lost
12 their home. There were just handfuls of
13 firefighters whose homes were not lost. And when
14 I say lost, I mean, as you well know from the
15 media or if you were down there, they were gone.
16 Families were evacuated. And again, I should say
17 that all firefighters remained in place, as you
18 saw from some previous pictures. Food and
19 immediate shelter was a significant problem. We
20 attempted through our network to do our best in
21 that.

22 I should say that -- well, I'll get to

1 that in the next slide. But medical care and
2 medical vaccinations I am going to specifically
3 touch on in a moment, as well as our support
4 effort, which is really our behavioral health
5 response to this particular area.

6 Other issues that have come up, and it
7 took us away from our immediate mission of
8 providing immediate assistance, both medically,
9 behaviorally, and attempting to work with
10 communications issues. There are some other areas
11 that we got directly involved in and we're still
12 evaluating.

13 Transportation was a significant problem
14 in the Gulf Coast. The best way we -- and we were
15 able to, for lack of a better word, borrow a lot
16 of boats, everywhere from tugs down to small craft
17 that just seemed to become available, that we did
18 and had to use.

19 Housing support became a very
20 significant issue, and the media report, and not
21 just for emergency responders, but everybody were
22 looking for places to live, especially for their

1 families. We had staff up here in D.C. work over
2 that Labor Day weekend, and then for the first
3 couple of weeks, and we arranged homes around the
4 country with our members that either had vacation
5 homes that weren't used, had homes -- had room
6 within their current home, had rentals that were
7 available, and they actually put together a
8 significant network that we were able to house
9 every single member that was displaced in the Gulf
10 Coast, nobody used it.

11 They weren't prepared to leave, and
12 again, people that believe that you can displace
13 people, and people are ready and willing to go, is
14 a fallacy, at least for emergency response
15 workers.

16 The families didn't want to leave, even
17 though they found relatives eventually had to go
18 somewhere because they lost their homes, they were
19 not interested in going to Seattle, or Chicago, or
20 New York, or any other places where we put
21 together with significant staff time those issues.
22 So that's an issue that we now probably have taken

1 off the board and won't use again. But even -- we
2 attempted to do it, very successful, but it was
3 not utilized whatsoever.

4 And talked about how financial
5 assistance is important. And then building
6 materials and housing repair crews, again, there's
7 a volunteer effort beyond what you can believe.
8 But certainly our people and other emergency
9 responders that are not only willing to come in to
10 assist in emergency operations, recovery
11 operations, relief operations, but actually want
12 to grab a hammer and a saw and rebuild homes.

13 Again, the coordination of this is very
14 difficult. We did the best we could with blue
15 tarp and housing materials that were sent in.
16 Because everybody wants to give materials. It's
17 very, very difficult then to find a system to
18 utilize it.

19 And I've got to give lots of credit to
20 the church groups, because the church groups were
21 really the most significant coordinator of much of
22 these events. We were able to get a church in

1 Baton Rouge, and the church, we lived there for,
2 or had crews out of there for over a two month
3 period. We assisted them in some of the
4 construction within their church and also had --
5 and eventually bought them a brand new bus because
6 they certainly deserved it.

7 We had all our relief operations and our
8 command and our medical operations out of here.
9 And I'll touch briefly on what we've done there.
10 We had crews around the clock working there that
11 we brought in from around the country to assist,
12 including significant senior staff out of the IAFF
13 headquarters in Washington, D.C., and again,
14 running all these programs, including the medical,
15 the behavior health, and the housing, and so
16 forth, and also the distribution of money. People
17 would come in, prove that they were an IAFF member,
18 we were able to check back in D.C., and the checks
19 were given out to individuals, or we made trips
20 into -- or operations into areas where fire houses
21 were still -- were firefighters were, delivered
22 that service there, as well.

1 We had all the visitors that would come
2 in, here's the Secretary of -- Department of
3 Homeland Security, he was down and visited with us
4 a couple times in the whole process.

5 And we, of course, briefed DHS and the
6 FEMA folks as we continued there for the main two
7 months of operation.

8 And, of course, we housed our people,
9 and there was no creature comforts there
10 whatsoever. We weren't at the High Regency Hotel,
11 we were in the gym of the church, and our staff
12 housing and the folks that commenced housing were
13 right here.

14 We found mattresses and bedding, and
15 there were bathrooms and some shower capabilities,
16 some washing machines that we hooked up to fire
17 trucks outside so we could clean clothes, and did
18 the best we could. But anyone that came down
19 there expecting a mint on their pillow at night
20 certainly never -- didn't find that at all. And
21 this was after a couple days. The first few days
22 were even worse than that, without bedding, but so

1 be it, we were at least dry. Again, operations
2 activities were here.

3 Two major areas that we found out that
4 were remiss, and I'll end in a moment on these
5 issues, but I wanted to touch on, and that is
6 baseline testing and medical surveillance of
7 individuals.

8 Unlike New York City, where the
9 firefighters in New York City were in a program
10 that the IAFF developed along with the fire chief's
11 back in the late 1990's called our Wellness
12 Fitness Initiative, where we put together a
13 mandatory non-punitive medical evaluation program
14 for all firefighters.

15 And in the first year of the program, we
16 implemented in ten cities, which included New
17 York, and about 26,000 firefighters, with a
18 complete medical -- full medical evaluation which
19 would be done regardless of age on all
20 firefighters.

21 And, in fact, the firefighters that
22 responded in New York City to 911, all of them,

1 depending how many years they had on the job, but
2 if they had over four years on the job, they had
3 four physicals done for them, the original
4 baseline, and then an identical physical that was
5 done every year after that. And certainly, as
6 Doctor Howard can testify as the 911 czar right
7 now, the way that we could actually respond to the
8 health needs of those firefighters, whether it was
9 lung problems or other medical problems, is, in
10 fact, that every one of these firefighters had a
11 physical within the last 12 month period, and
12 before that, and before that, and before that.

13 It didn't happen in New Orleans. These
14 firefighters, if they were lucky, they had a
15 medical evaluation when they got on the job, or if
16 they saw their doctor for another health reason,
17 they may have had a physical. There was no
18 baseline to evaluate this, and there were
19 significant concerns. And there is today some
20 more significant concerns.

21 We attempt the best we could with our
22 medical staff, as well as with folks that assisted

1 us outside, in trying to determine what we
2 immediately had to do. First of all, very few of
3 these firefighters, unlike New York City, and even
4 though there wasn't a need for it there, but in
5 New Orleans and in the Gulf, in the entire Gulf
6 region, very few people had hepatitis vaccines.
7 Ironically, hepatitis A vaccine is only required
8 for workers if you're working in -- or your
9 anticipated work is in dirty water activities.
10 Well, guess what, every one down there was in
11 dirty water activities. No one had hep A vaccine.

12 Ironically, though, kids in this country
13 can't go to school unless they have a hep A
14 vaccine. In fact, my kids, I have two college
15 seniors, my twin daughters, they can't even go to
16 a university, and they go to universities here in
17 Virginia, without getting an annual medical.
18 They're not required for emergency workers, nor
19 many workers, and this was the case down in the
20 Gulf area.

21 We did blood draws on over 1,100
22 firefighters, we did complete blood counts,

1 basically provided them a background in case
2 disease perhaps would ensue afterwards. We did
3 some other medical -- for individuals just to
4 create a baseline, and also documented what
5 vaccinations they did have, and provided -- began
6 the process for providing hep A, hep B
7 vaccinations while we were down there, and did so,
8 I don't want to say a haphazard basis, because we
9 actually recorded everything, but a very difficult
10 basis.

11 In fact, I still have medical records in
12 my office that are preserved for firefighters. We
13 were never able to get them because their homes
14 were gone and there was no place to mail them to,
15 but we're still following up on that, and have
16 some of our medical residents working on the data
17 for that particular issue. So it was a very
18 significant area.

19 And the other area was the behavior
20 health response. We learned in New York City a
21 very valuable lesson in the first few days and
22 then in the years since that, that the first need

1 for behavior health response is not an automatic
2 debriefing of people that you may hear about, not
3 bringing folks in and going through a critical
4 stress management course, it's providing for their
5 basic needs, showing people that you really care
6 about them, actually showing up in the fire house,
7 and people say I need a car, a car would show up,
8 you know.

9 I haven't had a chance to go to my house
10 to check and see if groceries are needed, send
11 someone to the house and get groceries. I got
12 called up, and we were in midtown Manhattan two or
13 three days after 911, and I got a call, and a
14 fireman called me up on my cell phone, got a hold
15 of me and said, you know what, every time a
16 firefighter dies in New York City, we put bunting
17 over the fire houses. We lost 343 New York City
18 firefighters, and there's not bunting anywhere on
19 any fire house in the city. And it may not sound
20 like a significant issue when you look at the
21 massive -- the entire problem, but it was a
22 significant issue in this guy. And we found a

1 couple of undertakers in New York, and by the next
2 morning, by the time the sun came up, every fire
3 house in New York City had bunting on them. Not a
4 big deal, but it was a big behavior health deal
5 that involved our people.

6 So we learned in New York that this is
7 not about immediately providing health care for
8 behavior health issues, it's providing a need of
9 being there for people. And not only did we learn
10 and achieve that in New York, but we also did that
11 same process, same lessons back in Louisiana.

12 And we brought teams in from here, we
13 brought them from Austin, Boston, Dallas, Fairfax
14 County, LA City, LA County, Massachusetts,
15 Phoenix, New York, and Wisconsin. We kept people
16 there for only five day deployments, we learned
17 that lesson very well, too.

18 Anything after five days, in all due
19 respect for people who have been deployed,
20 anything after five days, individuals start
21 becoming tourists. You can get them to work their
22 butts off for five days, but after that fifth day

1 comes, they want to go down -- we'd like to take a
2 trip downtown and stuff, we send them home, come
3 back in another two -- three weeks, we'll bring
4 you back again, but after five days, we found that
5 we've lost the usefulness for the projects that
6 they were involved in.

7 And that accounted our own staff. So we
8 started rotating people in and out. But I'm not
9 trying to be disrespectful, I'm just trying to
10 show you exactly what had occurred down there.
11 And we went and worked with these individuals.

12 In New York City, we built the
13 Counseling Service Unit in New York City. In
14 Louisiana, we were able to work with our state
15 association and other responders in building
16 through Louisiana State University, a project to
17 further medical -- member support, not medical,
18 member support issues.

19 Again, in the outcome, the first couple
20 of months, it was actually providing just basic
21 support. We're here to help you out, what are
22 your basic needs. And from there on, we're able

1 to intervene medically when those have to be done.

2 And that program is continuing. Many
3 multiple millions of dollars in New York City, \$5
4 million is the amount through the Louisiana State
5 program of which we continually remain above. The
6 lessons that we learned out of Katrina, Rita, and
7 to some extent, Wilma, and I don't include Wilma a
8 lot, because Florida emergency responders, if you
9 want to learn a lesson on how to respond to
10 hurricanes, you go to Florida, not only because
11 they have the experience, they have the tools, and
12 they do have regional mechanisms to respond to
13 many of these issues down there, which the other
14 Gulf states do not have. So really, it was mostly
15 Katrina, to some extent, Rita in Texas, but the
16 Wilma issue worked out much better.

17 Pre-training, pre-planning for what
18 occurs, again, we still talk about it, I don't
19 think we're there yet. There needs to be
20 considerable planning issues and continual
21 training issues on what's expected from emergency
22 response workers, both those that live and work in

1 the disaster areas and those that may be expected
2 to come in there.

3 We need to have a better control of the
4 resources that are available, what is in place,
5 what's locally available. We have to understand
6 the culture. It's very different, believe me, to
7 work in the culture of New Orleans versus the
8 culture of New York City. And again, some people
9 work very well in New Orleans, others work very
10 well in New York City, or California, and so
11 forth. And then we have to better address for
12 emergency responders arriving resources. We've
13 been working with FEMA and the Department of
14 Homeland Security, and a number of people have
15 been working on this project, not just the IAFF,
16 actually credentialing people, after, in fact, the
17 presidential Homeland Security directive, where
18 they want to ensure that federally deployed
19 resources, i.e., individuals, are capable to
20 safely perform and officially perform if they're
21 deployed by the federal government, meaning, the
22 federal government wanted to have a better control

1 of the people that they're -- everyone wants to go
2 to an emergency, and just because they're called a
3 firefighter doesn't mean they're capable of doing
4 that, and just because they're called a police
5 officer, may not be capable of doing that, or an
6 emergency response worker, or a physician, or an
7 epidemiologist or so forth, if, in fact, they're
8 not trained to do that and credentialed, we
9 believe, to do that.

10 And credentialing means that they have
11 to have specific training, and they also have to
12 have, most importantly for us, be physically and
13 medically capable to be deployed, meaning that
14 they have had a medical within the last 12 month
15 period, they had a physical evaluation during the
16 last 12 month period, they have all their vaccines
17 up to date, because you can't catch up on site in
18 Louisiana, you can't catch up on site in New York
19 City or LA or wherever the deployment may be.
20 And, in fact, if you want to have a cadre of
21 people able to perform, the only way to do that is
22 credentialing.

1 We're working on that -- FEMA has been
2 working on that for some considerable period of
3 time. The problem is, it gets lost in the
4 logistics. Who's going to buy the camera, whose
5 logo is going to be on that credential, the stuff
6 that the federal government does its best at.

7 And then, of course, the final issue is
8 post events of war. The event doesn't end in a
9 couple weeks. We're still, to this day, working
10 on issues in New York City, certainly with Doctor
11 Howard in the medical response program at Mount
12 Sinai and in the fire department of the City of
13 New York, that's continuing.

14 We're still financially supporting the
15 Counseling Service Unit in New York City Fire
16 Department. The IAFF is still financially paying
17 for that activity. And, obviously, we're doing so
18 in the Gulf. Everybody believes that you pack
19 your bags and you go home after a couple of
20 months, those activities continue for a long, long
21 period of time. And as I said, we're still
22 working on the New York and the entire Gulf area.

1 The coordinated training is still a concern of
2 ours. The communications issue which I addressed,
3 not only the multiple agency, not only the
4 interoperability buzz word that you hear all the
5 time, but the capability to speak it just to your
6 partner becomes a particular issue as you work on
7 there.

8 The needs assessment post event I talked
9 of, regional corporation systems have to look at
10 the examples that we found, at least for emergency
11 response, out of the Florida hurricane capability,
12 which is regionalized throughout the state and
13 does work very, very well. And ironically, it is
14 a labor management project. They work very well
15 with our local affiliates throughout the state.

16 And then the question is, are we really
17 ready for the next one? We certainly don't think
18 so, even though there are lots of activities that
19 have taken place in 911, there are certainly major
20 areas that need to be addressed, and hence, that's
21 why NIOSH has been working on this project in
22 multiple facets, and I think have been doing --

1 efforts in trying political and certainly economic
2 times to address these issues, and that's why
3 we're here today.

4 So to sum up for a discussion, I want to
5 bring my three areas that NIOSH needs to do
6 significant more -- continue with research
7 activities. First of all, I think that the --
8 which is one of the issues you've seen on the web
9 article is, the personal protective clothing and
10 equipment issue for emergency responders. Again,
11 we've done a very good job over the last couple of
12 decades in designing clothing for firefighters,
13 for the fire environment.

14 I think we've done a fairly good job on
15 defining clothing for firefighters, for the
16 chemical response environment. And we're starting
17 to do a little bit better job in firefighters for
18 a WMD type of environment, both in the clothing
19 that they wear and the equipment they'll use,
20 i.e., respirators.

21 NIOSH has come to the plate for their
22 certification of respirators for CBRN faster than

1 any certification process they've done in the
2 history of NIOSH, going back since the beginning,
3 in 1969 -- 1970. They were able to
4 administratively get through that process quite
5 well post 911, and we now have self-contained
6 breathing apparatus, PAPRs, and APR's that are
7 certified to weapons of mass destruction,
8 especially sarin and mustard gas, which are --
9 they're tested to not only provide a respirator
10 for CBRN, but provide a better overall -- That
11 similar job, they've done a lousy job in doing
12 respirators for health care, or biological --
13 response. And again, I'm not going to blame NIOSH
14 on this, I'm going to blame their parent agency in
15 the attempts to address that. We've done a lousy
16 job at providing respirators for those that would
17 have to respond to a biological event, especially
18 pandemic flu.

19 We, I guess the government, has resigned
20 itself to the fact that economics and availability
21 is the issue instead of worker protection. And I
22 think the silence of many is deafening on the

1 issue of proper respirators for pandemic flu
2 situations, relying on a respirator that is 95
3 percent effective based on technology for
4 certification for World War II perhaps, and not
5 looking at new technology is certainly going to
6 put significant numbers of people at risk if, in
7 fact, a pandemic flu situation does actually
8 occur.

9 NIOSH does have the capability to
10 further do that in their NPPTL, their National
11 Personal Protection Technology Laboratory in
12 Pittsburgh. Those that are not aware, and I'm
13 sure everybody in this room is, NIOSH inherited
14 the PPE facilities up there -- NIOSH work is
15 continuing at that lab.

16 That is a national laboratory solely for
17 the purpose of protecting clothing technology.
18 That needs to be funded way more than it is right
19 now, and its capabilities need to be expanded to
20 address all workers. Selfishly, we get a lot done
21 for emergency response, the firefighters, because
22 we've been personally involved in that process

1 since its inception. And again, we believe
2 there's the capability to do much more work.

3 And finally, the federal deployment, and
4 I think Doctor Howard touched on this, I need to
5 expand on it. If we're going to send the federal
6 government out to a response, I don't care if it's
7 New York City, I don't care if it's the Gulf Coast
8 after a hurricane, or Southern California, or
9 California, or the West Coast after a wild land
10 fire, we need to immediately be able to provide
11 medical and perhaps even behavioral health
12 response immediately.

13 It's only talked about when it occurs.
14 And it's been our position, and we have actually
15 gone with Congress every year for the last number
16 of years with this requirement, that if the
17 federal government declares a natural -- declares
18 a federal national emergency, that NIOSH would be
19 deployed immediately to assess and provide either
20 short term, and if needs to be, long term
21 surveillance of those emergency response workers
22 that are responding to this event.

1 What happens politically in this
2 process, people add baggage to it. And all due
3 respect for the communities that are involved,
4 every time we attempted to do this, the baggage
5 would be, well, if NIOSH is going out for the
6 workers, then the federal government has to go out
7 for everybody, because people that live there
8 probably have health effects, too. And that may
9 be right, but NIOSH's role, as Doctor Howard said
10 this morning, is for worker protection.

11 And we believe that a system needs to be
12 put in place that, in fact, if the federal
13 government believes that the emergency is such
14 that they're going to declare a national
15 emergency, a process should be in place to look at
16 short term -- first, assessment, and then long
17 term and short term surveillance and health --
18 health surveillance, behavioral and medical health
19 surveillance, those responders.

20 So I think those are probably a couple
21 of the key areas that are on your list, some of
22 the areas that certainly would merit some

1 discussion further today. And I want to thank you
2 all for giving me the opportunity to speak for
3 five minutes longer than I was supposed to. So
4 thank you all very much.

5 DR. HOWARD: Mr. Duffy, could you answer a
6 question?

7 MR. DUFFY: I can if you'd like.

8 DR. HOWARD: I think that in your allusion
9 to the last slide there, being your -- under a
10 bushel, the Safe Port Act that passed a few
11 years ago has a very important section in it, I
12 was wondering if you could comment on that section
13 so we could all -- anyone here who may not know
14 about that -- about it.

15 MR. DUFFY: Which?

16 DR. HOWARD: In the Safe Port Act --

17 MR. DUFFY: Allows for NIOSH to get
18 involved, yeah. The problem is money. I think
19 it's clearly an issue.

20 And, first of all, Doctor Howard and I
21 have known each other for a long, long time, and
22 he's the longest -- I guess you are the longest

1 NIOSH Director in the history of NIOSH, so -- and
2 I think his passion, even though he's restrained
3 somewhat, is equal to our passion. I mean I think
4 we're there for one reason, and that one reason is
5 health and safety of workers.

6 When we do have this -- there's a lot
7 difference in language that's in a congressional
8 piece of legislation than the bottom line, which
9 is the funding part of it, which is significant.
10 It costs a lot of money to do surveillance.

11 And in the current -- the current way
12 that -- and again, I'm not picking on people at
13 DSHEFS, I'm not picking on the HETAB folks or any
14 of the people out in Cincinnati that do this
15 response activity for worker surveillance issues,
16 whether it's a technical assistance or a health
17 hazard evaluation, which is specific to one cause
18 and one particular worker.

19 This is very global, nation-wide, and
20 the capability to do this, the capability to have
21 these people on standby, the capability of
22 building this infrastructure becomes quite

1 expensive. So, again, Congress has been -- has
2 included in language the need for NIOSH to be the
3 -- have the capability of doing this response,
4 they have not done so for -- appropriating the
5 correct -- the amount of money that's needed for
6 that.

7 And again, it's something that needs
8 considerable debate. It's something that needs
9 input from a lot of people. But most importantly,
10 I think the understanding needs to be there. Once
11 we get over that hurdle, once we try to let people
12 know that these first responders do have a
13 problem, use the vast information and lots of
14 successes out of New York City, how a surveillance
15 program truly should be working. And again, it
16 was very easy to do -- nothing was easy. It was
17 easier to do in New York City for political
18 reasons, for where it was, for the nation's
19 passion because of that response, but you know
20 what, the people in the Gulf Coast medically are
21 hurting just as much as the firefighters in New
22 York City. The people in the West Coast, after

1 significant exposures to a wild land fire, in the
2 case where -- most case, no PPE is -- firefighters
3 that fight fires in forests and wild land
4 vegetation typically don't have respirators, and
5 there are health effects after that, deserve that
6 same response after that.

7 And is there an employer responsibility?
8 Of course, there is. This should be in place
9 prior to this ever happening. But if it's a
10 national disaster response, there needs to be a
11 capability to begin that system.

12 I can give another better example. CDC
13 has just come out with, a couple weeks back, I'll
14 give you two, a couple weeks back on the trailer
15 issue. Everybody wants to hide from the trailer
16 issue, who was to blame, point fingers at the FEMA
17 trailers, whether they're sitting in Arkansas or
18 there are people living in them right now.

19 Every single fire house in St. Bernard
20 parish, every single one is a trailer to this day.
21 They have not rebuilt one fire house in St.
22 Bernard parish, and I think there's a dozen or so

1 of them out there. So the firefighters of St.
2 Bernard go home to their FEMA trailer, leave their
3 FEMA trailer, and come back and live in a fire
4 house. FEMA and CDC -- CDC, not FEMA, CDC came
5 out with a couple weeks ago say people should be
6 moved out of FEMA trailers. And John and I have
7 been talking, and his folks, what do you do about
8 firefighters that not only live in it, but that
9 respond to it?

10 And then if you want to care to go to
11 the web site, go to the New York Times, and I
12 think it was Sunday's New York Times, they did an
13 article about pandemic or avian flu or one of the
14 flu responses, and they address it as a public
15 health issue, and I think that's very important.
16 I think you need to address it and look at the
17 health -- local health services, whether it's
18 state or local level, and how they respond to it.

19 But they're responding to it after
20 somebody has packaged and delivered to them. And
21 the one thing that was missing in that article,
22 which is missing more, is this major emergency

1 response area. How are we going to take care of
2 the people that actually respond to the people in
3 the field and perhaps package them and deliver
4 them to a health care system where that all would
5 kick in, and then you could talk about the short
6 comings there. But there's a big void and space
7 out there that we need to do a better job in
8 addressing that issue. And, hence, I think those
9 are the issues that we're here to talk about today
10 and hopefully continue this effort to allow the
11 more programs that are being worked on where
12 emergency response is addressed and these town
13 meetings. Yes, sir.

14 MR. SKOLNICK: Barry Skolnick from -- I
15 think I met you at one of the national conferences
16 -- responders were interested in courses for
17 getting involved with -- terrorism -- and I'm
18 wondering -- at the present time -- if there's
19 been any progress and any federal support, any
20 involvement with the local responders and
21 environmental -- whether a particular building --
22 or not, and what are the characteristics of --

1 talk about --

2 MR. DUFFY: Well, in Washington, D.C., I
3 can -- we can get in my car and I can show you all
4 the sampling sites around this town where
5 measurements are done all the time, whether it's
6 being in the mall, you can go up the street and
7 you can see the sampling sites at the Pentagon and
8 so forth.

9 I think those activities in major
10 metropolitan areas may be working quite well.

11 The issue that we're concerned about is
12 the short term industrial hygiene involvement in
13 areas such as Katrina.

14 The Gulf Coast is a good example. I
15 mean the mold issue, everybody wants to hide their
16 head about, no one wants to do sampling of that.
17 So the individual response sampling is to define
18 or to assess exposures I think on the short term.
19 Individual worker process still needs a lot of
20 work that needs to be addressed.

21 I think we have capability of doing, you
22 know, badge monitoring, immediate -- acute effects

1 to have you back offer, make your determinations
2 and operations, I don't think we've done that good
3 a job in determining -- using that information for
4 initiating health care.

5 So I think we -- and I'm probably
6 rambling too much for what you're asking for. But
7 I think for that particular case, for actually
8 initiating health involvement, we're not doing a
9 good job. For initiating stand back or how your
10 operations will change, whether it's -- I think
11 we're perhaps doing -- there is a better job
12 monitoring.

13 We monitor to how -- what PPE we may
14 wear, we monitor how far we should go in, and I
15 think that process is -- we're doing a much better
16 job on. But to use -- to back off that -- to
17 bring it back into the health arena, I don't think
18 we're doing as good a job.

19 DR. KITT: We have another question back
20 here. And I would ask that anybody that asks
21 questions, if we could go ahead and turn back the
22 microphone around and identify yourself, because

1 we are transcribing the meeting.

2 MR. SCHARF: Thank you, Margaret. Ted
3 Scharf from Cincinnati. I do work in the
4 behavioral health area. I appreciate what you're
5 saying about it. I want to throw a question back
6 to you. The dedication of firefighters is very,
7 very well known, and we can cite thousands of
8 examples.

9 You show the example of the firefighters
10 staying in their flooded station. I appreciate
11 they don't want to abandon their post, but it
12 seems their post abandoned them. What would it
13 take to get them to say, okay, it's time to be
14 more effective somewhere else?

15 Or in a more general sense, what I worry
16 about, and the people I work with worry about is,
17 firefighters exhausting themselves, or, in a
18 sense, going beyond their capacity, putting
19 themselves at risk, and their crews at risk.

20 How do we find a way to provide, you
21 know, quicker turnover in staff, but also to get
22 those firefighters to say, hey, I've done as much

1 as I can right now and I've got to take a break?
2 That's a key question that we need to find a way
3 to address. Thank you.

4 MR. DUFFY: And there's one I don't have
5 the answer to, because, you know, I've been with
6 the IAFF now for 30 years, and they are not --
7 you've got to realize, someone -- someone didn't
8 have a camera in his pocket to take these
9 pictures. These pictures happened days later.
10 It's like, you know, when the fellow jumped off
11 the bridge here when we had the air crash, I knew
12 the news media wasn't there taking pictures. The
13 pictures you saw on the news last night happened
14 hours and many cases later when that TV man got
15 there, or in this case, days later when they were
16 still there. They're not going to leave.

17 You know, everyone says we're going to
18 bring outside resources in to replace people, let
19 them go home for a breather, this is their 911
20 even, this is their Katrina event. They do not
21 want those resources to replace them to go home.
22 And I wish there was a better way to do it. I

1 don't know the answer to that one.

2 They actually left those fire houses
3 when they were so dehydrated, they were sick, and
4 finally we got tugs in there to take those folks
5 out. They didn't leave -- they were not leaving
6 there, they were going to stay there in their life
7 preservers sitting on top of fire trucks until the
8 water receded. In fact, we finally got them in
9 and said, we're taking people out of here, you've
10 got to get out of here, someone else is going to
11 be here, it's okay, we're going to just get you a
12 shower and get you back here, and that was like
13 pulling teeth. They did not want to leave there.
14 They didn't want the papers -- when the papers
15 finally started coming out, they never saw papers,
16 but the USA Today saying, you know, firefighters
17 abandon their posts and they weren't going to let
18 that happen, they stayed there.

19 SPEAKER: Rich, can I ask a question?

20 MR. DUFFY: Sure.

21 SPEAKER: Just picking up on that, about
22 health and safety into the command system, where

1 would the authority come like in that particular
2 situation, like -- to make a call, like you were
3 saying the five day rule, for example, how would
4 that come in to an incident command structure, the
5 safety of --

6 MR. DUFFY: Well, we did it very easy,
7 we were paying for it, and so we made the
8 decision, here's your plane ticket, here's how you
9 get here, here's how you get home, and it worked
10 that way. I don't know, because the local
11 system -- in the Gulf Coast, there was no system,
12 the system was -- no offense the command people
13 and any of those fire departments. It was very,
14 very difficult. They had no resources, they had
15 no infrastructure, they had nothing, everything
16 was under water. And they weren't going to leave.

17 And so we have to understand that to be
18 able to address that, be able to address that
19 certainly medically in the short term, which we
20 did not do a very good job of, and the behavioral
21 health issues, which are -- which, in the long
22 term, become significant -- become significant to

1 everybody, some people just handle it better than
2 others, and some need actual medical -- behavioral
3 medical intervention. Anyway, thank you all for
4 having me.

5 DR. KITT: Thanks, Rich, for your very
6 insightful comments. I know from our own personal
7 experience at NIOSH, we found very similar
8 situations after Katrina with the New Orleans
9 Police Department, which we did some work with,
10 and also your comments about the issues of medical
11 surveillance, behavioral health issues, your
12 lessons learned are really straight to the heart
13 of what our portfolio is about and what we want to
14 be able to move forward. I met a lot of you prior
15 to starting this morning, but there's been a
16 number of people that have come in since we
17 started, and I just wanted to go ahead and
18 introduce myself. I'm Margaret Kitt, I'm the
19 Associate Director for Emergency Preparedness and
20 Response Office for NIOSH, and I'm also the
21 Program -- Research Program Portfolio Manager.
22 But as such, I'm not the person who does the real

1 work out of that research portfolio; the people
2 who do the real work are the Coordinator, which is
3 Renee Funk, and the Assistant Coordinator,
4 Chia-Chia Chang.

5 And what they're going to do before I
6 start to give you a little bit of background on
7 our portfolio is kind of give you an overview of
8 the procedures for the day and the logistics. And
9 so, Renee Funk.

10 MS. FUNK: Thanks, Margaret. I'm Renee
11 Funk, this is Chia-Chia Chang.

12 MS. CHANG: I am Chia-Chia, I'm just
13 going to start with some very basic logistics for
14 the day. The bathrooms are over there to the
15 right by the elevator. There's a coat check in
16 the front by the registration table.

17 We have evaluation forms; please do fill
18 them out. If you can fill them out by the end of
19 the day and give it to the registration table.
20 There's also a box for anonymous comments. And
21 you can also submit comments through April 13th to
22 our public docket. You are offered that, you

1 should have already had in the federal register --
2 it's in your binder. And, please, again, if
3 you're going to be speaking, please use the
4 microphone, because our transcriber is writing
5 everything down, and identify yourself. That is
6 it for logistics.

7 MS. FUNK: I just wanted to take a
8 minute to go through the binders that you should
9 have all gotten. We first had the schedule for
10 today. We do have Margaret's presentation under
11 the second tab, or first tab.

12 And I also include -- I thought you
13 might be interested on some of the projects that
14 are going on in this area at NIOSH. This one
15 flips out. These are the intramural projects that
16 are going on with NIOSH scientists in the area of
17 emergency preparedness and response.

18 And we did it in a matrix format to kind
19 of show the cross linkages between the other
20 sectors and cross sectors that we have at NIOSH.
21 And on the back side is the acronyms for -- all
22 the acronyms on the front side.

1 On the next page is the extramural
2 project. Most of you are probably aware that
3 NIOSH has an Office of Extramural Programs. We do
4 have RO1- RFI??? grants, some other types of grants that
5 we give out. And these are a couple of projects
6 that are going on in the emergency preparedness
7 and response area. And on the back side of the
8 page is the Office of Extramural Programs web site
9 and where you can find our -- we have a continuous
10 on general announcement that is reviewed three
11 times a year, the proposals are submitted there,
12 and so several of these projects are funded
13 through there.

14 Also, we periodically have like
15 specialty requests for our proposals, and so check
16 the web site periodically because those change.
17 And so some of these were funded under -- there
18 was one for infectious respiratory diseases that I
19 don't think is open any longer, but that's what
20 one of these projects is funded under, just to
21 give you an idea of what that's like.

22 The next one is the strategic goals, and

1 this is what we'll spend quite a bit of time
2 talking about today. And hopefully you've had a
3 chance to look at that a little bit before today.

4 The next one is the discussion topics,
5 and this is what was posted on our web site in the
6 federal register of the questions that we hope to
7 cover today, to hear from you.

8 And as Chia-Chia mentioned, if you did
9 want to submit comments and didn't have any
10 prepared, if you did want to use this to write
11 them out and hand them in to the registration desk
12 before you go, that's perfectly fine. You can
13 also type them up and send them in to the docket,
14 as Chia-Chia mentioned. The next is the federal
15 register notice for this meeting today. And the
16 last is the attendee list. And I know that
17 there's a couple of people who were added after we
18 types this up, so I apologize for that, there
19 might be a few --

20 And then the last, we have two CD's; the
21 first is a NIOSH -- guide for chemical hazards,
22 hopefully many of you are familiar with that. And

1 the last is emergency response resources, this is
2 mostly from our topic page on the NIOSH web site,
3 also some other useful documents and things, and I
4 think it'll be a good research for you all.

5 And I did want to take a moment to
6 introduce some of the other NIOSH staff who are
7 here. If you want to stand up and wave your hand
8 or something when I say. But I did want to
9 mention the Steering Committee sat -- it was the
10 main authors of the Strategic Goals, a document
11 that we'll be talking about today, and they are
12 the heavy lifters, so to speak. So -- Myer, Ted
13 Scharf is in the back, Kathleen
14 Kowalski-Trakofler, Joe Burkhart, Steve Ahrenholz,
15 Ken Martinez, Lisa Delaney, John Szalajda, and
16 Jennifer Hornsby- Myers. Did I forget anyone?
17 And also, in our -- just to -- we have emergency
18 preparedness and response office, and I asked
19 Margaret Kitt if that -- myself, Jennifer Hornsby
20 Myers, Lisa Delaney, Ken Martinez, and also Joe
21 Little are all in our office, we're a small group,
22 but we're mighty. And so I think that --

1 DR. KITT: Mighty, huh, okay. Well,
2 once again, thank you for being here and joining
3 in this conversation with us today. I wanted to
4 give you a little bit of an overview about our
5 office, but more importantly, our portfolio.

6 And so the Emergency Preparedness and
7 Response Office for NIOSH has really two focus
8 areas; the first sort of pillar is the
9 preparedness and deployment area of our office,
10 which includes making sure that our own NIOSH
11 personnel are as prepared as possible to deploy to
12 a multitude of different disasters, whether they
13 be natural or man made disasters.

14 The second focus area really
15 incorporates our research and technical assistance
16 capabilities. And what our office does is try to
17 sort of coordinate institute-wide technical
18 assistance and provide that technical assistance
19 to other areas of CDC, to HHS, to DHS, to OSHA,
20 and too many other agencies, as well. We have a
21 great deal of technical experience, as you know,
22 all across the Institute, in many of our field

1 offices, as well as our own office, as well. The
2 other part of that research and technical
3 assistance pillar really is what drives the heart
4 of our research program portfolio. And we have
5 been tasked to identify the Emergency Preparedness
6 and Response needs and to help prioritize and to
7 work to fund and help coordinate the Emergency
8 Preparedness Response on research projects.

9 Emergency Preparedness and Response is
10 one of 24 cross-sectors. And our research
11 portfolio, as Renee mentioned, is really through
12 the collaboration of an entire Steering Committee,
13 many of whom are here today. And it was really
14 based off RAND Volume 3, which I'm sure many of
15 you are familiar with, as sort of the starting
16 base of which to develop our research portfolio
17 and expand from that area.

18 We developed eight strategic goal topic
19 areas, which we're going to go through in a little
20 bit more detail here shortly. And we've been able
21 to solicit a long list of internal NIOSH comment
22 already on our research portfolio ideas. But

1 really this is our opportunity to reach out to you
2 as the external stakeholders, to get comment and
3 provide feedback on the relevance of this
4 portfolio, to try and identify gaps which we may
5 have missed, and really to help focus priorities.
6 As many of you know, trying to prioritize your
7 efforts is really one of the biggest challenges,
8 and we really hope that you can help us do that
9 today. So for those of you that are familiar with
10 the NORA Sector Programs and cross-sector
11 programs, I'm sure that you can see that there's
12 going to be a lot of intersection with other
13 programs that exist throughout NIOSH. And we're
14 currently working with some of these other
15 programs to identify areas for integration and
16 collaboration.

17 So I've listed some of the areas, some
18 of the program areas that we've identified, either
19 that they are very close integration with our
20 performance measures or objectives or that we know
21 that we focus on the same group of responders, or
22 partially on the same group of responder and

1 recovery workers.

2 Some of the sectors where we hope to
3 continue to develop further collaboration is
4 certainly the public services sector, and
5 particularly the public safety sub- sector, which
6 focuses on law enforcement and fire services. The
7 health care and social assistance sector, which
8 incorporates all our health care workers, and as
9 Rich mentioned, there's quite a bit of issue
10 related to respirator use and protecting our
11 health care workers. The transportation,
12 warehousing, and utility sector, obviously, is
13 very important, as we will rely heavily on these
14 individuals during a time of disaster as we rely
15 on them every day. The cross-sectors that we have
16 close integration with, certainly a personal
17 protective technology cross- sector, work
18 organization, and stress related diseases, and
19 traumatic injury. During disaster is probably one
20 of the most important times to have good work
21 organization, and we feel like this is an
22 extremely important part of our portfolio.

1 And as you've already been introduced to
2 our research program portfolio staff, myself,
3 Renee, and Chia-Chia, but really the whole
4 Steering Committee and the -- and my entire office
5 really contributes significantly to the portfolio.

6 And this is the entire portfolio
7 Steering Committee, recognizing those people that
8 couldn't come and be with us here today. But you
9 can see, it's a very multi disciplinary group that
10 stretches all across the Institute.

11 So here I've listed the eight emergency
12 preparedness and response topic areas for our
13 strategic goals. And as Renee mentioned in the
14 briefing book, we have a full description of those
15 strategic goals and the performance measures
16 associated with them. We are going to be in the
17 process of revising those based on what we hear
18 today, some of the other comments we get through
19 the docket, or our anonymous comments, as well as
20 sort of a revamping of the way we're dealing with
21 our performance measures, and so we hope to, over
22 the next six months, come up with a revised plan

1 based on all the different input.

2 But the topic areas that we came up with
3 were safety climate, personal protective
4 equipment, engineering and technological
5 interventions and controls, characterization of
6 potential hazards, subgroup specific strategies,
7 surveillance, environmental microbiology,
8 environmental and biological monitoring of
9 terrorism agents.

10 Now, like I said, the briefing book has
11 a lot more detail on this, so we're just going to
12 talk about them briefly. But the first topic area
13 is safety climate. With the strategic goal to be
14 to improve the organization of emergency response
15 work, to reduce exposure to risks, and enhance the
16 health and safety of emergency responders.

17 And in developing this strategic goal,
18 we felt that it was important to have a discussion
19 on how to improve preparation and organization
20 during emergency operations, to minimize
21 exposures, to prevent injuries and illnesses, as
22 well as to promote work force resilience. The

1 safety climate is obviously influenced by many
2 factors, which include the nature of the hazards,
3 management practices, crew base collaboration,
4 communication, and training, and spans all phases
5 of a response from pre-event to after action
6 review.

7 So I've listed out here, it's not a
8 comprehensive list, but I listed out some of the
9 issues that we think are very important to focus
10 on, including work hours, and shift work, work
11 force resilience, and recommendations that we hope
12 to be able to make on appropriate screening
13 programs.

14 The second strategic goal is to improve
15 PPE assortment, proper selection, and wear, and
16 decontamination.

17 And obviously, our NPPTL office has a
18 lot of work in this area that they're currently
19 conducting.

20 During the earliest phases of the
21 response, responders and safety managers need
22 guidelines, checklists, and decision-making tools

1 to develop those initial strategies, and need to
2 be able to ongoing -- to develop ongoing
3 reevaluation of those protection strategies.

4 Current issues that are in discussion
5 are things like preventing cross-contamination
6 from victims to responders, how to estimate the
7 quantities of PPE that is going to be required for
8 a given incident, how to manage donated PPE
9 supplies, which can be an enormous problem and
10 challenge to overcome, and PPE decontamination,
11 and certainly reducing the physiological burden
12 that certain PPE brings along with it in order to
13 maximize our protection and minimize the burden on
14 the responders.

15 The third strategic goal is to improve
16 engineering controls, technology, and tools, to
17 minimize responders' exposures to or hazards
18 associated with CBRN, which is chemical,
19 biological, radiologic, and nuclear, which I think
20 most people in this room are familiar with that
21 acronym, toxic industrial compounds and other
22 hazardous materials.

1 Prior -- I mean, sorry, poor integration
2 of engineering controls during structural design
3 and procedural developments result in almost total
4 dependence on PPE to minimize exposures during
5 emergency response operations. So focusing on
6 engineering controls must be addressed even if
7 complete control of hazard can't be achieved
8 through engineering controls alone.

9 The fourth strategic goal is to develop
10 methods to evaluate the spatial and temporal
11 distribution of gases, vapors, and aerosols, as
12 well as liquids or particulates associated with
13 surface contamination. Knowledge of this
14 distribution, resuspension, and persistence of
15 aerosol is extremely important in determining the
16 risks associated with aerosol agents. Developing
17 methods to evaluate the spatial and temporal
18 distribution of biological and chemical aerosols
19 is critical in identifying sampling strategies to
20 predicting exposure based risk and designing PPE
21 and engineering controls, as well as identifying
22 strategies for building reoccupancy.

1 Strategic goal number five is to improve
2 sub-group awareness, develop targeted messages,
3 and expand sub-group preferred channels of
4 communication. Protective messages may not
5 equally reach all of its intended audience due to
6 cultural, social, and language barriers.

7 Furthermore, sub-groups may not fully
8 understand or appreciate the importance of
9 implementing protective guidance. And one of the
10 issues we've currently been involved with is
11 trying to focus messages specific to strategies
12 and communication efforts to migrant workers
13 during a pandemic event, as we realize that this
14 may be one challenging issue during an influenza
15 pandemic, but that's just one example.

16 The next strategic goal is to develop
17 surveillance reporting systems to improve
18 emergency responder safety and health through a
19 systematic collection analysis and interpretation
20 and exposure, hazard, injury, and illness data,
21 obviously, a huge task. But surveillance data can
22 certainly identify sub-groups at risk of exposure

1 to specific hazards so that problems can be
2 identified early, interventions can be
3 implemented, and plans can be made for longer term
4 surveillance of effective workers.

5 Currently, and I'm going to speak about
6 this in just a few minutes, developing an
7 inventory of what response surveillance resources
8 are out there today is an important starting
9 point. And then trying to apply those
10 surveillance information data sources can mitigate
11 consequences.

12 Strategic goal seven is to improve the
13 understanding of environmental biology of threat
14 agents. And I think we know that there are
15 critical gaps that currently exist in the
16 knowledge based of environmental microbiology and
17 the relationship to public health emergency caused
18 by microbial agents. And these pathogens can
19 include bioterrorism agents, as well as emerging
20 infectious pathogens.

21 It would be certainly desirable to have
22 the capability to estimate risk of human infection

1 using data on the number and viability of
2 organisms in an environment, the persistence of
3 the agent, dose infection relationships, and
4 anti-microbial resistance patterns. And last, but
5 not least, the final strategic goal is to improve
6 the identification and characterization of terror
7 agents to reduce exposures to response and
8 recovery workers.

9 In some instances, we may be able to
10 measure how much of an agent is absorbed into the
11 body using biological monitoring techniques.
12 Rapid and field deployable methods that can be
13 used to assess exposures are certainly essential
14 and need to be timely in order to quickly identify
15 positive agents. And how effective is the PPE
16 that we have for reducing exposure to these
17 terrorist agents?

18 Now, one thing I wanted to mention, it's
19 somewhat tied in with what Doctor Howard brought
20 up about the Safe Port Act, which was passed I
21 believe in 2006, and gives through the president
22 the direction to the HHS secretary to initiate the

1 Safe Port Act, and there's certain criteria that
2 need to be met in order to do that.

3 But in the Safe Port Act, there is a
4 section about what needs to be done for the
5 responder community, and that involves
6 surveillance issues, exposure monitoring, it
7 involves looking at what the -- how you can tie
8 all that information to determine the longer term
9 surveillance efforts that may or may not be needed
10 for the community. As a result of getting some
11 interest and awareness that the Safe Port Act was
12 out there, as well as many other issues that were
13 going on at the same time, Doctor Howard asked my
14 office to come up with a project plan to look at
15 responder safety and health before, during, and
16 after a disaster.

17 I should add that along with the Safe
18 Port Act, there were not resources allocated to do
19 any of these activities. But we've taken on in
20 our office sort of the baby steps of starting to
21 implement such a program, where we would try and
22 develop and provide guidance that could be

1 tailored to the federal community, to the state
2 and local community, as well as private employers,
3 and non-governmental organizations, and volunteer
4 agencies, that could sort of walk them through the
5 process of what needs to be done for
6 pre-deployment screening, training, and
7 credentialing, worker exposure assessment during
8 events, how to roster workers during disasters,
9 who's going in to the event, what type of activity
10 are they doing, what type of geographical location
11 are they in, what their exposures are, in trying
12 to work on this very big issue of disaster
13 surveillance systems and monitoring for workers
14 during an event if it's necessary. And then how
15 do we link all that exposure data and health
16 information together to determine what the needs
17 for long term monitoring are, so that we don't get
18 into the same situation that we did with the World
19 Trade Center in many instances. So that's
20 currently a really exciting project for our
21 office, because I think it goes back to the heart
22 of what we need to be doing. And it really sort

1 of touches on a lot of the different aspects of
2 our research portfolio.

3 And I would also like to say that Dori
4 Reissman and Jennifer Hornsby, my -- from NIOSH,
5 have been working with HHS on developing a plan
6 for what HHS responder program would look like.
7 And the other part of that is, Renee and I will be
8 working with some of our state partners. NIEHS
9 has agreed to work with us on a CDC workshop at
10 the end of May, where we're going to bring in
11 about ten states to attend the workshop.

12 The first day is going to be the
13 disaster surveillance working group doing a
14 presentation on overall surveillance tools and
15 getting input from the states on what they have
16 available.

17 And then we're going to actually have a
18 second day that's going to be a breakout session
19 just for occupational safety and health with about
20 ten states. And with the health -- NIEHS, we're
21 going to hopefully make that a very successful
22 workshop to get us started with the state and

1 local health departments. So that really is sort
2 of a quick overview of what people have been
3 working on for the research portfolio for a very
4 long time and sort of a short summary. So I don't
5 know if there's any questions at this point.

6 MR. SKOLNICK: Yes, I'm Barry Skolnick,
7 an independent analyst. And I'm curious, up until
8 now and into the future if you'd comment on the
9 extent to which you reach out to extramural
10 involvement of academic and industrial scientists,
11 not in the government, for purposes of peer review
12 and for purposes of actual project involvement in
13 research and development in any of these areas.

14 I'll talk later about the -- service
15 testing, where this has been quite deficient in my
16 experience. But I wanted to know in general, in
17 your philosophy, whether you are engaging the
18 larger scientific community or limiting yourself
19 to in-house resources.

20 DR. KITT: Well, I think the fact that
21 we are organizing this town hall meeting is the
22 first step in recognizing that we do want external

1 input, it's very valuable to us, obviously. So
2 this -- the comments that we can get from you,
3 both in writing, verbally, anonymous, through the
4 docket, or if you have colleagues out there that
5 couldn't come today or were unaware of our town
6 hall meeting, you know, I would encourage you,
7 they can still go into the docket and submit
8 comments, and we really would appreciate those
9 comments, and we will use them to try and help us
10 move further forward.

11 And then as Renee mentioned, there's
12 opportunities for extramural program funding
13 through the OEP Program and through that web site
14 that you have in your book. So we'll have to take
15 that issue of extramural funding as things come
16 along. Thanks to Jennifer for walking the
17 microphone around for us.

18 MR. KRAVITZ: Jeff Kravitz - Mine Safety and Health
19 Administration. I've got a question about your
20 pre-disaster screening. Does that go beyond the
21 fitness for duty exams that we normally have? And
22 how far along are you in determining what that

1 should do?

2 DR. KITT: Well, I think that, you know,
3 it's not a new concept by any stretch, it's a
4 matter of getting that concept out to a much wider
5 group. I was in the Air Force for many years
6 before I transferred over to the Public Health
7 Service, and it's a concept that's very well
8 embedded in the military organization. It's based
9 on the same concepts as fitness for duty, but I
10 think it's a little bit -- it's a little bit maybe
11 more proactive, trying to get it done all -- as up
12 front as possible. But it incorporates a lot of
13 the same issues.

14 And where we are right now, like I said,
15 it's not a new concept, there's plenty of programs
16 out there that have pre-deployment screening in
17 place, it's just a matter of getting it tailored
18 to each different sort of activity or each sector
19 to make it appropriate for what they need and what
20 they can do.

21 MR. SKOLNICK: Barry Skolnick again;
22 there are two buzz words that I think are valuable

1 and I wonder if you can comment on their utility
2 up until now and the future. One are lessons
3 learned, and secondly are best practices.

4 And I'm particularly interested to know
5 in terms of the inner agency, the effort to avoid
6 stovepiping and to try to learn from what DOD and
7 EPA and others have done, whether you found that
8 it's important to focus considerable effort on
9 gathering information both historically and in the
10 future about lessons learned and best practices,
11 because others in NIOSH have been involved in some
12 of these incidents in the past, and it's always
13 tough to gather people together, or if you do it
14 in this day and age, you may be able to do it by
15 teleconferencing, not have to move people in the
16 same room. But I'm wondering if you could speak
17 to those two points of lessons learned and best
18 practices.

19 DR. KITT: It's interesting, I forget
20 where I was just not too long ago and we were
21 talking about this phrase, lessons learned, and
22 it's great to have lessons learned, but then

1 you've got to do something about it, and so I
2 think it's a matter of incorporating all the
3 different stakeholders, what their experiences
4 have been, and try and determine what the lessons
5 learned are all across the board and where you can
6 make some end roads.

7 Best practices, well, that's kind of
8 maybe an over used term in certain circumstances.
9 Everybody is going to have their own different
10 view maybe of what best practices are. But, once
11 again, I think it's the melting of all the
12 different stakeholders and have their best
13 practices in place and see how they can be
14 tailored to different uses. So I think there's --

15 MS. LEVICK: Nadine Levick, EMS Safety
16 Foundation. I just wanted to follow up on that,
17 with the use of buzz words and probably knowledge
18 transfer of what's underlying this in many ways.
19 And I think the interdisciplinary aspects of
20 knowledge transfer are very critical when it comes
21 to emergency response safety, both for the
22 responders and the public. And the issues of

1. understanding, as you mentioned, characterizing
2. the hazards and risks, and the issues that --
3. system that has transportation as a component, and
4. integrating personal protective gear with
5. transportation safety issues such as head
6. protection device that's going to protect someone
7. from a head injury, as well as protect them from
8. biohazards, and transferring knowledge, what we
9. have in related transportation, systems
10. engineering, with our understanding of health
11. care, safety, and biohazards I think is a big
12. challenge for emergency responders at the moment,
13. and isn't really well addressed, it's sort of
14. outside of the transportation industry, where
15. there isn't much overlap between our health and
16. safety and transportation safety and protection.

17. DR. KITT: Thank you. I guess the other
18. thing I would encourage everybody to do, if you
19. haven't signed up to speak today, that's fine, but
20. if you have had a change of heart or would like to
21. sign up to speak and have a five minute time slot
22. dedicated to you, there's still opportunities for

1 this afternoon if anybody would like to do that.
2 But at the end of the day also, if you hadn't
3 signed up and you still would like to make some of
4 those comments, if we have the latitude, and
5 time-wise, you'll be welcome to do that. Okay. I
6 think, Renee, is it time for a break? Okay. We
7 have until 10:30, thanks. I think we're going to
8 go ahead and get started.

9 MS. CHANG: Hi, we're going to get
10 started now. I forgot to mention that we have a
11 list of restaurants outside on the registration
12 table. There are little sheets of paper like
13 this, there's a map of the local area, and on the
14 back are a list of restaurants for lunch.

15 We're going to start with the public
16 speakers. We're going to ask the people who have
17 signed up to please come up and use the
18 microphone. And questions, please save them for
19 the afternoon session. We'll start with the first
20 one, Tamara Blow, Director of the American
21 Association of Occupational Health Nurses.

22 MS. BLOW: Thank you. Good morning,

1 everyone. My name is Tamara Blow and I represent
2 the American Association of Occupational Health
3 Nurses. For those of you that don't know about
4 AAOHN, we are a national professional organization
5 that's dedicated to the health and safety of
6 workers and worker populations. And we just
7 appreciate this opportunity to be able to speak,
8 because employee health and safety is not only
9 important to us because we take care of worker
10 populations, but also, we are first responders in
11 many instances to emergencies. And one of the
12 things that is near and dear to our hearts is the
13 concept of the possibility of having health and
14 wellness and ongoing activities for emergency
15 responders, particularly having mandated annual
16 testing for our worker populations.

17 A survey that was conducted with our
18 constituency indicated with the 911 event that one
19 of the major barriers to being able to administer
20 appropriate health care was not having data on the
21 employees, medical surveillance data, as well as
22 no environmental data, and communication was one

1 of the major barriers.

2 The second barrier that was hindering us
3 from being able to utilize our services or
4 administer our services was actually legal and
5 regulatory red tape, and those were two things.
6 Now, the survey and the study was limited just to
7 our occupational health professionals, but it was
8 all based on not being able to have everyone
9 communicate and collaborate, having a side load
10 approach to emergency preparedness, and everyone
11 having their own regulations. And we feel that
12 because the emergency responders are so dear that
13 they do need to have a gate keeper, they need to
14 have someone to oversee their health and wellness
15 activities, and so some of the things that we
16 suggest would be having that mandated annually,
17 having medical surveillance for emergency workers,
18 and having it being regulated.

19 The second things that we came up with
20 was the training, what's expected of them, because
21 every emergency responder has different
22 regulations and state plans and what not, and so

1 they need to be trained on the appropriate hazard
2 response and that type of situation.

3 We've seen that not only in the work
4 place, but in community response. And primarily
5 health and wellness activities, not only just
6 surveilling for hazards, but health and wellness,
7 looking at biomarkers, and determining whether
8 those people would need further intervention.

9 Now, I know it's always about the money,
10 they're always saying it cost too much to do
11 medical surveillance, but research has shown that
12 for every dollar spent on health and wellness
13 activities, there's a \$3 ROI, return on
14 investment. So -- and we could just look at what
15 happened in the past with the 911 event. We spent
16 -- 70 percent of our workers were exposed,
17 firefighters, law enforcement officers, and
18 construction workers, volunteers and other
19 workers, they all have lung problems. This
20 accounts to hundreds of millions of dollars spent,
21 it calls for workers compensation, as well as
22 lawsuits. Now, if you consider that amount and

1 the amount it would have saved if we would have
2 had that data, I want you just to ponder that,
3 it's mammoth.

4 So it's not about the money, it's about
5 caring for those special populations that respond
6 and care. And uniquely, occupational health nurse
7 professionals, we do show that caring, because,
8 again, not only do we function as gate keepers to
9 perform medical surveillance, but also, we convey
10 the ongoing, dealing with work force resilience,
11 and monitoring the environment, and making sure
12 that those who do respond, communicating that
13 caring.

14 They need that, not just -- but I care
15 about you, I care, have you gotten your proper
16 rest, have you gotten your sleep, and have you
17 eaten, those things as a firefighter who spoke
18 this morning and said that's very, very hallmark,
19 it's important to know someone cares about you.
20 So thank you for this opportunity for us to speak,
21 and take care.

22 MS. CHANG: Thank you very much. Now we

1 have Mr. Joseph "Chip" Hughes, Branch Chief of the
2 NIEHS Worker Education and Training Program.

3 MR. HUGHES: Good morning. I'm really
4 excited to be here. And like the previous
5 speaker, I'm fired up about this issue and that's
6 why I came. I wanted to thank Margaret and her
7 staff and also John Howard -- I think are trying
8 to explore, as the comment was made before, how to
9 break down stovepipes in the federal government.
10 And I see that as really a critical issue that we
11 need to figure out in trying to move this issue
12 forward definitely. We'll talk more about that in
13 a minute.

14 I work for the National Institute of
15 Environmental Health Sciences, we're in the
16 National Institute of Health, we're a sister
17 agency to NIOSH in the stovepipe department. The
18 HHS, which, you know, sort of about as stovepiped
19 as that other DHS department, which really has a
20 lot to do with why this problem hasn't gotten
21 dealt with.

22 So we were -- and actually, to be

1 honest, that was one of my final comments, which
2 is, you know, really a lot of this issue is owned
3 by DHS and FEMA, and you know, I think one of our
4 challenges as public health people is, you know, I
5 don't know if there's any staff here from either
6 of those agencies, but if there's not, that's
7 really sad, but, you know, because I think part of
8 our mission is to try to figure out how to get
9 them to the table on this issue particularly, and
10 it goes beyond just incident command, I mean it's
11 to try to figure out how does health and safety
12 fit in with an overall response, and that's kind
13 of been a passion for us, our program, since we
14 started in 1986 under SARA (Superfund Amendments and
Reauthorization Act) , under the Super Fund

15 Act, and our program is specifically focused on
16 hazardous waste workers and emergency responders
17 and trying to figure out what training
18 requirements there need to be for that population.

19 And we're the HAZWOPER people -- 120.
20 If this is -- nobody knows what I'm talking about,
21 I'm sorry. I'm a bureaucrat, I talk in acronyms.
22 But, you know, HAZWOPER really is the basis of

1 response in our country and it's the most
2 comprehensive standard. It encompasses all the
3 aspects of the issues that Margaret had talked
4 about earlier.

5 So, again, our passion is to try to
6 figure out how do we take that message out to a
7 better population. And we are really excited that
8 NIOSH is trying to I'd say elevate this issue
9 within your own agency and hopefully within the
10 federal government.

11 Because what we've done is, through the
12 extramural community, through cooperative
13 agreements, we fund training programs all around
14 the country that are university based, union
15 based, community college based, and I think, what
16 I was going to say to John was that, you know, I
17 think we have a broad group of stakeholders that
18 are out there in the emergency response community.

19 We also -- our program has been, to my
20 mind, a prevention laboratory. Over the years,
21 we've really tried to figure out, how do we take
22 an issue or a training topic or a situation and

1 turn it into a learning opportunity.

2 And I feel like we've probably not done
3 a great job in publishing in the peer review
4 literature as much as we need to. We've done
5 probably a better job in capturing our own lessons
6 learned that we've done, out of every incident
7 from the Exxon Valdesse in '89, Love Canal, to the
8 more recent ones that have been talked about here
9 this morning, and take that from a worker safety
10 and health point of view.

11 So, again, in terms of the development
12 of the NIOSH agenda, I just encourage you to look
13 at the things that we've already created in terms
14 of our own training materials, our own
15 interventions that we've done, our own lessons
16 learned reports that we've created, and hopefully
17 some of that can be raw material for developing a
18 research agenda. And that's kind of what I wanted
19 to, in my five minutes, say something about. Our
20 staff had a really good meeting with Margaret and
21 with Jen, I don't know, about a month ago, and I
22 think we would like to try to figure out how we

1 could have an MOU with NIOSH that would really lay
2 out specific areas that we could cooperate on that
3 I think both relate to thinking about, well,
4 breaking down the stovepipes, number one, but
5 also, how could we leverage, you know, training
6 that's done by IAFF, and then have that somehow
7 relate to, you know, the NORA Agenda for thinking
8 about how preparedness can be better for emergency
9 responders, and how could we sort of leverage
10 things that we have going on in the training world
11 and help them, you know, feed this needed agenda
12 for EPR.

13 So that's something that I think we
14 really would like to help figure out how to do
15 that as bureaucrats, and hopefully we can sort of
16 maybe match our resources and match money and, you
17 know, do something more with less, which is --
18 that's our goal as bureaucrats always.

19 The other thing, I think that much has
20 been talked about safety climate. You know, I was
21 actually just talking with Margaret about the
22 mining community, and you know, thinking about

1 Rich and IAFF, and you know, thinking about the
2 last 30 years of don't just rush in kind of
3 culture. I probably know more about it from the
4 construction macho culture. But, you know, I
5 think there's been some success in sort of turning
6 around the just don't rush in rescue culture that
7 we've seen over this past decade that's really I
8 think an important development, and that has to do
9 both with individuals as responders, and it also
10 has to do with responder organizations.

11 You know, as we think about what it is
12 that is the basis of making a decision, go, no go,
13 what's my mental checklist for why I need to take
14 a step back right now versus go in.

15 So I think from the mental health point
16 of view, in terms of responders, we've seen a lot
17 of good developments of resilient capacity, to use
18 Dori's term, that we have within the responder
19 community, and I think a lot of what NIOSH could
20 also bring to the table is to kind of think about
21 what the progress is that we've made in that
22 community and maybe how we can do a lot more, how

1 we can, you know, kind of package it for people,
2 turn it into, you know, potential training
3 opportunities, and hopefully kind of create some
4 diffusion around what our program believes is
5 everyone's emergency response collateral duty.
6 You know, in the HAZWOPER world, really every
7 person has an emergency response collateral duty,
8 which is the fact that you might find yourself in
9 a particular situation, in a particular time where
10 you may actually be part of a response. And for
11 us, in terms of first on the scene, training and
12 HAZWOPER, which is basically get out of the way,
13 stand back, call 911, et cetera, you know, those I
14 think are concepts that we need to diffuse across
15 our whole culture.

16 And then also, you know, as we think
17 about emergency response, we need to think about
18 who has the capacity to actually respond and
19 understand how to get those people onto the scene
20 in a timely way.

21 So those are kind of some issues that I
22 thought would be good to explore more. And, you

1 know, really I think the other part is that the
2 response culture does not think about worker
3 safety and health issues, and that has to do with,
4 of course, with FEMA and with DHS, with the
5 Incident Command System, with our ongoing effort
6 to like infuse worker safety and health into the
7 Incident Command System.

8 You know, those are maybe more --
9 they're political issues, they're structural
10 issues, but I think they're clearly issues that
11 NIOSH should really wrestle with as we think about
12 how to diffuse the safety culture into the
13 emergency response process. I guess just to
14 close, bringing VHS and FEMA to the table, you
15 know, what I've seen as a big issue is that health
16 and safety decisions are not being made by health
17 and safety people, and so we need to figure out
18 how to turn that around or at least get to be at
19 the table when those decisions are made, maybe
20 activate our own department, HHS, to take a stab
21 at doing that.

22 I think the other thing is, we've

1 actually been engaging in some of these national
2 exercises, like -- two, three, and four, thinking
3 about how to infuse worker safety and health
4 issues into those exercises, and I guess I'm
5 bringing this up as kind of research thought that
6 there might be a way for NIOSH to kind of be part
7 of those exercises, try to do evaluation, try to
8 infuse worker safety and health into those
9 processes.

10 Again, with VHS, and with our program,
11 and every local community in this entire country,
12 people are doing exercises and they're doing
13 training, you know, how can we sort of be part of
14 that process, infuse health and safety into that
15 process.

16 And I think the challenge there is with
17 how big this problem is to how small we are is,
18 you know, how can we have small pilots, small
19 studies, small interventions that could, you know,
20 lead to those bigger words, best practices, SOP's,
21 lessons learned, so that we can kind of make some
22 dent in this ongoing issue that we joined with you

1 in trying to figure out how to make better. So
2 anyway, that's my rant. Thank you all, I
3 appreciate it.

4 MS. CHANG: Thank you. And we really do
5 appreciate everybody having kept within the five
6 minute time limit, that really helps us out a lot
7 with our scheduling. Next we have Mr. Daniel
8 Youhas with MTB, Incorporated.

9 MR. YOUHAS: Good morning. Actually,
10 I'm with NIHS, National Clearinghouse for Worker
11 Safety and Health Training. The National
12 Clearinghouse supports the work of NIHS Worker
13 Education and Training Program's staff and its
14 awardees. It is the national source for the
15 worker education and training community to access
16 technical documents and workshop reports, safety
17 and health information, and curricula produced by
18 any NIHS WETP awardee.

19 The Clearinghouse also provides numerous
20 services for NIHS WETP staff, awardees, and the
21 public. We facilitate the dissemination of
22 technical information related to the development

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 of safety and health training. We arrange,
2 manage, and document NIHS WETP technical meetings
3 and workshops related to scientific,
4 administrative, and regulatory issues associated
5 with training for hazardous waste worker and
6 emergency responders. We also develop, analyze,
7 and compile NIHS WETP research products to enhance
8 ongoing initiatives, support new training
9 initiatives, and the continuation of program
10 efficiency.

11 NIHS and the Clearinghouse have a long
12 history of involvement in emergency response and
13 preparedness activities. NIHS and its awardees
14 have participated in the response activities for
15 the Oklahoma City bombing, World Trade Center
16 attacks, anthrax attacks, Hurricanes Katrina and
17 Rita, and the October, 2007 California wild fires.

18 We've also been working to prepare
19 training tools for workers who will be involved in
20 responding to avian influenza outbreaks, dirty
21 bombs, and earthquakes. The Clearinghouse, in
22 conjunction with NIHS and its awardees, with input

1 from multiple stakeholders, have developed
2 training tools for hurricanes, avian influenza,
3 and dirty bombs. We are currently working on one
4 for earthquakes.

5 These training tools are by no means
6 full blown curricula, but basic information that
7 identifies the hazards workers and volunteers and
8 likely to face. Generally speaking, we are trying
9 to reach skilled support personnel who may not
10 have had any training on the hazards they may face
11 on the work site. Trainers can use these training
12 tools to develop curriculum. The next training
13 tool we plan to develop will address the hazards
14 of chemical attacks.

15 I've actually brought with me today some
16 of the training booklets. I'll put these out here
17 for anyone to take. We have the AI booklet, which
18 has been translated into Spanish, and the
19 hurricane booklet has been translated into Spanish
20 and Vietnamese.

21 And for anyone who's interested in
22 ordering some of these booklets, you can go to the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 web site, I can give you the url later, but
2 there's an order form on the National
3 Clearinghouse web site, if you'd like to order any
4 of these booklets free of charge.

5 The NIOSH program portfolio talks about
6 the importance of using lessons learned. NIHS
7 held two particularly important workshops that
8 sought to identify the lessons learned following
9 both the World Trade Center attacks and Hurricanes
10 Katrina and Rita. We will submit each of these to
11 the record when we file our written comments.
12 With regard to NIOSH's strategic goals, we will
13 provide more information specific to what we think
14 are the three top goals when we submit our written
15 comments later this month. Generally speaking,
16 safety climate, specific sub-group categories, and
17 surveillance are likely to be our top picks.

18 Finally, we know more effort is needed
19 to ensure workers who are likely to participate in
20 a disaster recovery and response receive through
21 pre-incident safety and health training and that
22 more attention must be paid to the psychological

1 hazards that workers face in a disaster response.

2 Thank you.

3 MS. CHANG: Thank you. Next we have Mr.
4 Barry Skolnick, Technical Analyst with Johns
5 Hopkins.

6 MR. SKOLNICK: Thank you. Actually I'm
7 not with Johns Hopkins, I'm unaffiliated, so I
8 wouldn't want to blame them for anything I have to
9 say. I am an independent analyst and have evolved
10 into rather a harsh critic of the environmental
11 surface testing practices used in the anthrax
12 incident which remains today, so you should take
13 everything I say with a grain of salt and give it
14 the kind of critical scrutiny which I wish were
15 more applied to these issues.

16 To start off, I want to give you a set
17 of four brief quotations that I think apply to a
18 lot of these areas of emergency response -- and
19 particularly to the anthrax incident type of
20 response. The first is three parts of a Chinese
21 or a Persian proverb, depending on who you
22 attribute it to. He, and I appreciate the ladies

1 for the gender bias, but it goes like this; he who
2 knows and knows not that he knows is asleep, wake
3 him; he who knows not and knows that he knows not
4 is a child, teach him; but he who knows not and
5 knows not that he knows not is a fool, spurn him.

6 And I know, like John Rumsfeld, there
7 are things I don't know that I don't know, and
8 that may apply to everything I have to say, so
9 take it -- take a grain of salt.

10 A couple more, and this one is a little
11 provocative attributed to Doctor Ellen Rayber at
12 the Lawrence Livermore Laboratories back in 2002;
13 it is possible to do a poor job of decontamination
14 and to make it look good by doing a poor job of
15 sampling an analysis. And this does not
16 necessarily mean, I must say, intentional, it
17 could be unwitting problems, which is what I think
18 was the case.

19 And parenthetically, I'd like to say
20 that EPA has the Triad Program which is based on a
21 recognition that sampling uncertainties may be
22 more important than analytical uncertainties in

1 the overall test method uncertainties. And it is
2 the sampling that is kind of a weak link in
3 environmental response for a bioterrorism
4 incident, in my judgment. A third one was a
5 comment made at a hearing in 2003, one of four
6 oversight hearings that had been held dealing
7 with, to some measure, with anthrax incident
8 response, by a Doctor Jack Melling, who was a lead
9 scientist with the British Center for Microbiology
10 -- which is their combination of CDC and
11 biodefense establishment.

12 He said a concluding remark in terms of
13 quantitation, it was a British scientist, Lord
14 Kelvin who said, if you can't put numbers on it,
15 it's not science. And this relates to the broadly
16 qualitative character of the anthrax testing that
17 was done in 2001.

18 And finally, and in a self to facing
19 mode, there's a proverbial sign that hung in
20 Albert Einstein's office that was said to have
21 said; not everything that counts can be counted,
22 and not everything that can be counted counts.

1 And having said that, I just -- another
2 -- finish my preamble by saying that over a period
3 of six years or more, I've tried to study some of
4 the science behind environmental testing of
5 surfaces for microbial contamination, and I have
6 Powerpoints, I have a lot of -- allocated files
7 and things, I'd be glad to share with anyone
8 interested. The basis of what has been a
9 conclusion, that there's over 20 variables that
10 have not been evaluated by the government
11 agencies, including NIOSH, to my knowledge, that
12 may be important in the efficacy of surface
13 testing methods.

14 And I would hope that eventually,
15 hopefully before some of the modern friends
16 package again, that a lot of these will be looked
17 at scientifically. I will offer three ideas; the
18 first one relating to all these others. You can
19 either think as I do that the surface testing
20 message are untrustworthy and have not been
21 scientifically substantiated.

22 And, in fact, the government

1 accountability office said in 2005 that none of
2 these methods are validated. And there is a
3 project aimed at validating message. That's kind
4 of the gold standard of providing insurance.

5 But before validation, you just have to
6 substantiate that they work in some -- some
7 context. And I would argue that that hasn't been
8 done either to the extent that -- and the way they
9 called for, which is kind of an end to end
10 process. But let's assume they do work as
11 designed, that isn't enough, you have to make sure
12 that they will work and practice. And so the
13 first issue that I wanted to raise with -- is the
14 idea of positive control. And I would make the
15 argument that there's an experience in NASA called
16 the Planetary Quarantine or Planetary Protection
17 Program which goes back to 1960 in which a
18 credible positive control approach was used for
19 the testing of environmental services for public
20 contamination, and that this might be a model for
21 -- that is usable in the field under a
22 bioterrorism condition.

1 And without going into detail, I'll just
2 make an assertion, but I will give you a notional
3 idea of what I think would be an effective
4 positive control. It would be something like you
5 would dispatch a team with a bell jar type of
6 shroud and with a little inhaler type of meter
7 dose dispenser, and you put the shroud on the
8 surface, and -- you would put a meter dose of a
9 power that would be allowed to float down to the
10 surface and sit there, and that powder would have
11 in it probably a combination of simulants of
12 spores that you can grow as simulants of anthrax
13 or some other agent, and also something else that
14 you can see visually, and that's actually my
15 second point, I'll get to that.

16 But the point is that by creating a
17 contaminated surface on site, on varying kinds of
18 surfaces, with a predictable amount of some
19 measurable agent, you raise the possibility of
20 having a predicted outcome, the end to end process
21 of collecting the sample, transporting the sample,
22 analyzing the sample in a laboratory. Without

1 that, at least at the stage of method development,
2 you don't have a control system.

3 And I would just point out that in the
4 anthrax incident, there are plenty of examples
5 that work very well of negative control, they were
6 called sample blanks, and in these you would
7 handle everything in a similar way to actually
8 collecting a specimen, but you wouldn't touch the
9 specimen, so it should be negative.

10 And if it's not negative, it suggests
11 either you get a cross-contamination in the field
12 or a cross- contamination in the lab. And people
13 understood that very well and this was done, maybe
14 one in ten specimens collected of -- were that
15 kind.

16 But they did have positive control.
17 Until you have a positive control system, you not
18 only don't have control of what you do, I would
19 argue you don't have a basis for proficiency
20 training, for quality assurance, for
21 certification, for anything associated with the
22 kind of regulated scientific science based

1 behavior that applies in almost every other area
2 of clinical practice that I know of, critical
3 laboratory practice or environmental monitoring
4 science. So there's really a deficiency here, and
5 I hope that the agencies, not just NIOSH, but all
6 of them, will start working more on it,
7 particularly since there's been congressional
8 hearings and GAO's saying that this was needed.

9 So that's the first idea is of positive
10 control and one that would not only be used in a
11 lab condition, but could be deployable. And there
12 may be other techniques. You can even say as a
13 secondary approach that if you had pre-
14 contaminated surfaces like little thin layer
15 chromatography sheets or something that you could
16 put that on a surface and have somebody rub it and
17 collect a sample.

18 Well, after these poor folks in their
19 personal protective equipment ensemble have been
20 working for an hour and they're totally fatigued
21 and fogged up in their face masks, they may have
22 lost the ability to collect a sample adequately,

1 and you might catch that by bringing with you a
2 contaminated surface to be sampled on site.

3 That would be a different kind of
4 positive control, but it doesn't deal with the
5 essential problem on site. Not only do surfaces
6 vary under the best of conditions, but they might
7 have toxins on them. And part of my message to
8 people that I've communicated with is, there is a
9 legacy science going back about 90 years in food
10 sanitation and other fields, this is not a blank
11 slate that you can write the book as you go along,
12 there's a history. Part of that history is the
13 recognition that toxins exist on surfaces. If you
14 want to measure microbes, you have to take in
15 account the fact that when you pick up a sample,
16 you may kill it after picking it up, and you have
17 to protect it.

18 That applies to clinical specimens, too,
19 by the way. The biological transport system to
20 avoid killing clinical samples are quite
21 sophisticated. But that's just one area where,
22 again, without a positive control, you may not

1 know it, and there's some incidents during the
2 anthrax response like that.

3 So that's one idea of positive controls,
4 it needs a lot of focus, because without it,
5 nothing else can be truly convincing to an
6 observer or the public, particularly negative test
7 results, which, of course, predominated in the
8 anthrax incident, all the buildings were
9 fumigated, et cetera. Okay. The next one is a
10 simpler idea to think about, it's kind of common
11 sensical; what if you had a powder that had
12 intensely florescent particles in it, so that
13 you'd spread it on a surface rather thinly, and
14 then if you darken the room and shine a black
15 light, you might see individual particles because
16 of the intensity of florescent. You could also
17 see them on the swab or the wipe when you pick
18 them up.

19 I believe that adding such a particle,
20 along with maybe viable spores to a simulant
21 powder, would provide part of a positive control
22 system and a training system.

1 People need some sensory feedback as to
2 what they're doing. One of the characteristics of
3 the anthrax incident response, as I understand it,
4 is that the target was invisible except for the
5 letter or -- letters, you actually saw the powder.
6 Everybody was sent in wearing all this protective
7 gear to look at an invisible enemy, invisible
8 target, with no way of knowing maybe when they
9 were doing their sampling how effective their
10 sampling was.

11 And I believe that focusing on a visual
12 detection of these micron scale particles, it
13 can't be too big, and they have to have some of
14 the physical attributes of the -- first powder,
15 this should not be difficult. And there are other
16 aspects of the same thing. You can have chemical
17 reactions on bio -- that have enzymes the same --
18 and get response. But the idea of giving the
19 responder something to look at will tell him and
20 his trainer and his supervisor on site that he's
21 doing it right, whatever that is, I think it's a
22 valuable area to explore. That's number two.

1 Number three is much more provocative and
2 controversial and may not work, it may get a lot
3 of people killed.

4 But I would point out, it's time to get
5 real about the scale ability problem with an
6 anthrax incident response.

7 The number of buildings effected, the
8 number of people killed and contaminated and sick
9 last time, was relatively small.

10 What would happen if one of those
11 proverbial plumes went out over a city and you had
12 hundreds of buildings actually or suspected of
13 being contaminated? The models we have now,
14 particularly of sending in responders with level A
15 particular equipment, I would argue, is not
16 realistic scale up in the event of a large attack.

17 We must come out with more appropriate
18 technology, cost effective ways, including
19 protecting our people. But here is what I would
20 propose as far as that's concerned, an approach
21 that would attempt to move from level A, protect
22 very complex and extensive equipment to level B

1 and C, okay, that puts people at risk, what do you
2 do about that? There are two conditions that I
3 believe are feasible to reach to allow you to do
4 that with acceptable safety, keeping in mind that
5 our purpose is to protect the public, and exposing
6 the responders to some elevated risk is a price we
7 may have to pay to serve the public that we're
8 there for. But one approach is to -- one
9 requirement is medical surveillance and
10 therapeutic, that is, in the case of bioagents
11 between the vaccines, which have to be given in
12 advance, you have to know what you're giving it
13 for, you may be able to protect individuals so
14 that some minimal exposure is less likely to cause
15 illness.

16 There's also therapeutics, the Cipro,
17 the antibiotic type treatment, and others. And
18 nature bioagents is that they don't generally
19 incapacitate immediately, so that even if you
20 really are exposed, you have time to be treated
21 substantively and to be monitored, and that should
22 allow a certain degree of acceptance of higher

1 risk.

2 But it's the second one that may be
3 controversial and a little out of the box
4 thinking. What if it were true, as I believe it
5 is, that anthrax more specifically lost their
6 infectivity without being killed because of some
7 phenomenon that either occurs naturally or that
8 you could induce rather rapidly. It turns out
9 that there is such a mechanism possible, and I've
10 been trying to speak to this with various people
11 in government for years now without much success,
12 an engineer named Willis Whitfield at --
13 Laboratories who is famous for developing laminar
14 flow principal use for biosafety cabinets. And
15 they just erected a statute with his apogee, in
16 commemoration of that.

17 He did experiment in early 1970 for
18 NASA, demonstrating what he calls humidity
19 immediate adhesion of fine particles of surfaces.
20 And what he showed was that particles below ten
21 microns exhibited a hygroscopic type of effect
22 whereby they would either resolve something or

1 zoot something either that they picked up or that
2 they had in -- dust and building, making them
3 stick to a foil surface and resist being thrown
4 off by a puff of gas.

5 And he shows this is progressive and
6 would approach 100 percent of all the particles in
7 a mixed dust sample at elevated humidities above
8 90 percent, 93 percent, 100 percent. And even in
9 low humidities, as low as 30 percent, you saw
10 productivity.

11 And the implication of this kind of has
12 to be related in the case of anthrax specifically
13 to what happens in nature. Why is it you have
14 animal outbreaks -- or zoonotic outbreaks, you
15 have animals die, very few people are reported as
16 victims of inhalational anthrax disease. It may
17 well be that the simple reason is, you rarely get
18 particles smaller than the five to ten micron
19 level, which is believed by experimental work to
20 be necessary for anthrax. Anthrax is very
21 sensitive to particle size to cause inhalational
22 disease, cause cutaneous disease, gastrointestinal

1 disease, yes, but inhalational, it has to be very
2 small apparently, and that's based on animal model
3 studies and his convention to wisdom.

4 If you could make the particles bigger,
5 then you may no longer have infectivity that is
6 high enough to be worried about.

7 I believe that's possible for anthrax
8 specifically. There's recent work saying that the
9 -- the organism for -- which is not a spore, that
10 causes plague also shows a size dependent
11 infectivity in animal models. Most of the select
12 agents won't. And maybe some day a bioengineer
13 practice won't. But as far as anthrax is
14 concerned, it may be possible to apply a
15 treatment.

16 Again, a notional idea is, you mist the
17 room with humidity and which has some carrier
18 particles in it, big enough, the anthrax will
19 stick to it efficiency, you let it fall, you let
20 it dry out, and you vacuum it all up, and you may
21 be able to do this as a precautionary treatment
22 and go in with minimal respiratory and protective

1 gear. And you could also argue that -- and maybe
2 this is more fanciful perhaps, but when
3 decontaminating, instead of trying to
4 decontaminate a fully clothed personal protected
5 gear enclosed person with bleach or other agents
6 intended to kill the agent, what if you tried to
7 treat it with something that will render it non-
8 infectious -- disinfection, it doesn't kill it,
9 but it aggregates it -- it, and you know, maybe
10 sticky stuff will do that, spray maple syrup on
11 them or something.

12 And it just may turn out that if you
13 focus on this non-lethal approach -- and by the
14 way, part of my notion which is in the -- what I
15 put on the docket, I have an 11 page document I
16 put on the docket that describes all this and
17 gives some citations to the work, is that you
18 focus on efficient removal.

19 This is probably already done, but if
20 you have surfactants in your water, detergents,
21 alcohols, like windshield washer fluid, you may do
22 a very good job of removing most of the spores or

1 other agents that are on the body as opposed to
2 just plain water, and there's also the possibility
3 of -- with spores of inducing germination by using
4 some small -- additives. Once they germinate,
5 they're vulnerable and they won't survive and they
6 probably won't infect you either. So there are
7 different ideas. But this third idea, which is a
8 little radical, but it's based upon the firm
9 belief that we will not be able to respond to
10 large scale incidents using the models of very
11 cumbersome and -- limited responders on the one
12 hand and the very expensive fumigation type
13 decontamination approaches on the other.

14 That's what we did in 2001, it's not
15 scalable, it leaves us vulnerable in the future,
16 and we need to do some creative thinking to be
17 able to -- so those are my three ideas. Thank you
18 for your time.

19 MS. CHANG: Thank you. If anything
20 you've heard this morning inspires you to come out
21 of your shy shell and come up and speak, please do
22 sign up for speaking this afternoon. We are done

1 for the morning. We're breaking for lunch until
2 1:00, as scheduled. Please let us know if you
3 have any questions. Thanks.

4 (Whereupon, a lunch recess was
5 taken.)
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

1 A F T E R N O O N S E S S I O N

2 MS. CHANG: Good afternoon. I'd like to
3 welcome everybody back. We are going to start off
4 with a recap of the morning session by Doctor
5 Kitt. I hope you had a good lunch. All right,
6 thank you.

7 DR. KITT: And don't worry, I don't want
8 to hear myself speak anymore than -- over again
9 than you do. So I just wanted to, for the benefit
10 of -- there's at least a couple people that were
11 not here first thing this morning, so I just
12 wanted to briefly go over some of the highlights
13 from this morning's discussion. And I'm Margaret
14 Kitt, I'm the Associate Director for Emergency
15 Preparedness and Response for NIOSH.

16 And as I mentioned this morning, we have
17 two primary focus areas within our office. We
18 have the preparedness and deployment aspect of our
19 office, which helps to prepare our own NIOSH
20 personnel for deploying and have them be as
21 prepared as they possibly can for disasters,
22 whether they be natural or man made, and make sure

1 that we are integrating with other CDC, HHS
2 policies related to preparedness and deployment.

3 And then the other side of our office
4 focuses on research and technical assistance. We
5 provide sort of the coordination for NIOSH, for
6 the Institute to provide technical assistance to a
7 multitude of different agencies, including other
8 parts of CDC, as well as HHS, DHS, OSHA, et
9 cetera.

10 But the real piece that we're talking
11 about today is the research aspect. And our
12 office was tasked with developing a research
13 portfolio related to emergency preparedness and
14 response. This portfolio is one of 24
15 cross-sectors within the NIOSH program. We worked
16 through a NIOSH Steering Committee to construct
17 this portfolio, and it was a very collaborative
18 effort from a multi disciplinary group across
19 NIOSH.

20 We developed eight strategic goal topic
21 areas. We've had some internal feedback from
22 NIOSH itself, our -- parts within NIOSH. But now

1 is the time when we really want to hear what our
2 stakeholders feel and have the external community
3 review and comment in order to provide us feedback
4 on how relevant our portfolio is, identify gaps
5 that we may not have seen, and to really help us
6 focus our priorities.

7 There's a much more detailed listing in
8 your briefing book about what goes into each of
9 these topic areas for strategic goals in much,
10 much more detail, so I'd refer you to that. But
11 essentially we focused on safety climate, personal
12 protective equipment, engineering interventions
13 and controls, characterization of hazards,
14 sub-group specific strategies, surveillance,
15 environmental microbiology, and environmental and
16 biological monitoring of terrorism agents.

17 I mentioned also briefly a project plan
18 that our office is working on right now through a
19 request that Doctor Howard has made of our office
20 to try and reach out to the federal community, the
21 state and local health, the non- governmental.
22 agencies, private sector, as well as volunteer

1 agencies in order for us to help guide them and
2 provide them guidance on all the aspects of
3 responder safety and health before, during, and
4 after a disaster, and that includes pre-
5 deployment screening, training, and credentialing,
6 exposure assessment during an event, developing
7 rosters during disasters so that we can identify
8 who's going into an area, what their geographical
9 location, what their activities are, and how long
10 they're spending within those areas doing those
11 tasks, improving the disaster surveillance system
12 and medical monitoring for workers if it's needed,
13 and then how do we link all this information
14 together in order to determine the longer term
15 monitoring needs of the worker population.

16 So that's something we've just embarked
17 upon, and we're in the process of our initial
18 stage of gathering information from all those
19 different stakeholders and working with them.

20 So this morning, just to sort of recap
21 some of the things that we heard, and this is not
22 an all encompassing list, we will have the

1 transcript available at a later point in time that
2 will be posted on our web site. But we talked
3 about the issues and the importance of medical
4 surveillance, the issue of annual health
5 evaluations for emergency response workers, the
6 need for a gate keeper for the emergency response
7 community, health and safety to be on the radar
8 screen along side of victim rescue, converting
9 what we have learned into training opportunities,
10 continuing to move resiliency issues forward,
11 making sure that those with occupational health
12 and safety expertise are more engaged in the
13 actual decision-making processes, increasing the
14 use of training tools, and then there was also an
15 increased emphasis on improving our environmental
16 sampling strategies, and just a couple points on
17 that suggestion for positive controls, as well as
18 issues related to a large scale event and more
19 realistic approaches to the PPE.

20 So those are some of the things we heard
21 today. We'll be addressing those, as well as some
22 of the other comments as we move forward. Doctor

1 Howard did have to leave, he had another
2 engagement he had to follow up on, so he wanted
3 to, once again, thank you for your participation
4 in this meeting. And I think we're ready for -- I
5 think we'll be able to wrap up early today and
6 hopefully get everybody out a little bit early,
7 and turn it over to Chia-Chia.

8 MS. CHANG: The first speaker we have is
9 Nadine Levick with the EMS Safety Foundation, the
10 Director of Research.

11 MS. LEVICK: (Off mike)

12 MS. CHANG: I'm sorry?

13 MS. LEVICK: (Off mike)

14 MS. CHANG: Okay, sure. The next
15 speaker is Perry Roper, Industrial Specialist,
16 Public Research Management Association.

17 MR. ROPER: Good afternoon, everyone.
18 My name is Perry Roper and I represent the Public
19 Risk Management Association. We are literally two
20 metro stops away. And when I walked in this
21 morning -- first of all, let me just state that
22 this is the first meeting I've ever had with

1 NIOSH, and I really didn't know what to expect.
2 It's sort of like walking into a party and not
3 knowing anyone, but also realizing that, oh, gee,
4 I am in the right place, because all through the
5 presentations, I was nodding, going yes, yes, this
6 is really making sense to me.

7 Let me give you an idea of what the
8 Public Risk Management Association is about.
9 Since 1978, we've represented public risk managers
10 throughout the United States and Canada, as well
11 as we do have some international members.

12 Risk managers, we serve over 1,700
13 entities within the organization, and risk
14 managers do quite a variety of jobs in this
15 capacity. We're also huge users of NIOSH
16 material, so we're very familiar with NIOSH. What
17 we would like is for you all to become familiar
18 with us, and we'd like to offer our services to
19 NIOSH.

20 As I stated before, we serve over 1,700
21 entities within the organization. And there's a
22 garden variety of issues that pop up for us as

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 risk managers, many of those that were cited
2 earlier today. For instance, we administer many
3 of the HAZCOM programs, for instance, within
4 cities, towns, counties, states, and other public
5 entities, joint powers, authorities in California,
6 for instance.

7 We also administer the workers
8 compensation claims process in many instances. So
9 essentially, we're the ones who see the claims, we
10 administer the claims, we see the actuarial data
11 that we have access to, and also, we sometimes
12 provide some of the training for emergency
13 responders or we help them develop it or we find
14 it for them through a third party.

15 So we're heavily involved in -- with
16 fire departments, police departments, in
17 particular, EMS in particular, as far as training
18 and as far as safety and loss control issues are
19 concerned. We also are the purchasers of
20 insurance, as well. So we're the ones who take a
21 look at the policies and determine what's right
22 for that particular entity. In addition, we also

1 have access, as I said, to the claims and
2 actuarial data. But earlier there was talk about
3 benchmarking, medical -- baseline medical
4 information, and we do sometimes have access to
5 that information, as well, through our members.

6 We also write many of the RFP's for the
7 organization. And so we get involved in not only
8 the RFP's, but often times the purchasing
9 function. A prime example of this would be in
10 relation to the bridge collapse that occurred in
11 Minneapolis last year, where the risk manager for
12 the city of Minneapolis was the person designated
13 to purchase the PPE for those first responders.
14 And she was also a part of the incident management
15 team. It's not unusual to see a risk manager as a
16 part of the incident management team whenever some
17 sort of crisis occurs.

18 Basically, we're called upon to help
19 public entities determine a lot of different
20 things, and that includes lessons learned and the
21 best practices. We often sit in on those sessions
22 with the fire departments, with police

1 departments, with others involved in the process.
2 Basically, what I'm here for is to offer you our
3 services. Be aware that you can get access at the
4 ground level. We work with the folks on the
5 ground level. We work for those entities, as
6 well.

7 We have a global view of the
8 organization, so we get to see the risks in a
9 totally different light than others, where we're
10 not in a silo, we do get to work with everyone
11 within the organization, including the responders
12 and the people that they work with. So we do have
13 a different view of the process.

14 Also, we also have some venues of our
15 own through Prima. We have our own conference
16 once a year that allows folks to come in and talk
17 about their various topics, one being emergency
18 management and preparedness. We also have a Prima
19 Institute that allows you to come in and actually
20 teach.

21 So those are some other resources that
22 are available, as well as our Internal/External

1 Affairs Committee, say that five times real fast,
2 which is -- by the way, how I found out about this
3 particular meeting was through a member of our
4 External Affairs Committee who happens to live in
5 Arizona and said, hey, you're right up the street
6 from here, why don't you go over there and see
7 what this is all about, and I'm really very happy
8 that I received that phone call. This has been a
9 very valuable meeting for myself. And, in fact,
10 we have a meeting of the External Affairs
11 Committee coming up on Thursday, and I will be
12 very, very happy to pass on the information that
13 I've received and speak of the people that I have
14 met today. I've been very pleased to meet some of
15 you and speak with you. And it sounds like we
16 could have some really good collaborations going
17 on.

18 So I want to make my comments just very
19 brief and say, please take advantage of this
20 offer. My information is on the very last page of
21 the handout. And I look forward to working with
22 you at some time in the near future. Thank you

1 very much.

2 MS. CHANG: Thank you. And Dr. Levick,
3 again.

4 Dr. LEVICK: I'm not to use the
5 computer, so -- bad luck. You missed out on the
6 pictures, but I can show them to you later. I
7 think they illustrate a lot of the issues. But
8 let me run through what I think this perspective
9 can bring to this group and what I see as some of
10 the gaps in knowledge that are unfolding in front
11 of us in the delivery of particularly emergency
12 medical services. Let me just go through a little
13 bit about where my background and where I'm coming
14 from and why I'm here. I'm an emergency medicine
15 physician with a public health degree from Johns
16 Hopkins, and I've been actively involved in the
17 safety of emergency medical service delivery and
18 transport for some time, and was actually -- am
19 responsible for conducting the first ambulance
20 vehicle crash test for my claim to academic fame.
21 It sure beats doing a chart review.

22 But anyway, what I'm here to talk about

1 is, from the platform of the research director of
2 the EMS Safety Foundation, which is a new not for
3 profit that has really been established to fill
4 gaps in safety interdiscipline safety innovation
5 in the delivery of emergency medical care,
6 technical knowledge transfer, practical
7 interdisciplinary R and D, evaluation and
8 implementation of system safety enhancements for
9 emergency medical and medical transport services.
10 And this has been established as a not for profit
11 institute.

12 Some of the key issues that were
13 mentioned earlier this morning, characterization
14 assessment of potential hazards, safety climate,
15 engineering, technological interventions and
16 controls, personal protective equipment, our very
17 key to the central core and theme of the
18 activities of this not for profit institute. But
19 really what we're talking about is system safety.
20 We should be looking at global hazard analysis and
21 integration of safety solutions that address each
22 of the elements of a global hazard analysis. Key

1 issues, if you do look at what data we can scrap
2 together, and particularly in contrast to what we
3 have with the fire service, and in many ways other
4 emergency responders. Emergency medical service
5 providers don't have a lot of health and safety
6 data.

7 But looking at what we do have, the
8 occupational environment clearly is in two fairly
9 distinct environments, whether it's day-to-day
10 practice or a mass disaster, transportation and at
11 the scene, whether the scene is a biohazard scene
12 or a violent scene or some scene where there's
13 some hazard to the provider.

14 The nature of the hazards that the
15 providers are exposed to are automotive, in the
16 vehicle, transportation, during transport, at the
17 scene, at risk of other automotive events, at risk
18 of being pedestrian, they have huge -- hazards.

19 Whoever designed an ambulance has
20 obviously never sat in one and tried to provide
21 patient care, they had to have arms like a
22 gorilla. Psychological and criminal consequences,

1 two-thirds of the people killed by ambulances are
2 the public. If you are driving that vehicle, you
3 have two big problems, you have a psychological
4 problem, your OC health and safety problem, and
5 you go to jail for vehicular manslaughter. These
6 are issues that pertain to the big, broader scope
7 of delivering emergency medical care. And, of
8 course, there's bio hazards.

9 So really one of the focuses of this
10 particular foundation is R and D, rip off and
11 duplicate. Avoid reinventing the wheel at all
12 costs. Where are the best practices that we need
13 to transfer knowledge from? We don't have the
14 luxury to go reinventing the wheel, conducting
15 studies that have already been done in a related
16 area or by the transportational ergonomics.

17 There are three ergonomic papers on
18 planet earth pertaining to emergency medical
19 service care. One is pertaining to stretchers
20 written in Germany last year; the other one was
21 pertaining to the ambulance environment written
22 two years ago in the UK and not really relevant to

1 our environment; the most recent one was December,
2 last year, done in Israel, that's it.

3 You've got 10,000 papers on the
4 ergonomics of a work station. When were you last
5 called to an emergency response because someone
6 sat wrong at their desk? We have three papers on
7 the ergonomics for the emergency medical service
8 provider. So, as I mentioned, we've got to
9 transfer knowledge from day-to-day safety
10 practice, getting it right day-to-day, so that
11 when we're dealing with a mass disaster, when
12 we're dealing with a casualty environment, when
13 we're dealing with a hazardous environment, we
14 sort of just at least have got basic day-to-day
15 safety practice to develop from, to expand upon,
16 so people have got some basic fundamental
17 knowledge.

18 And the other issue is, as I touched on
19 just at the start, yes, we're worried about
20 provider safety, but the safety of our patients,
21 the people we're transporting, and the public. As
22 I said, two-thirds of the people involved in

1 emergency vehicle adverse events were not the
2 patient. And that falls back to what's our
3 transportation policies, how do we address
4 intersections, how do we interact with the society
5 as the society is dealing with a mass disaster or
6 even day- to-day events.

7 Ambulance is actually responsible for a
8 fatality every week with the vehicle alone.
9 Seventy-four percent of EMS providers that get
10 killed at work get killed in a transportation
11 event. Biohazards are less than three percent of
12 the fatalities. So are health and safety in this
13 arena is almost fundamentally a transportation or
14 automotive safety issue. It's a system safety
15 issue, not just what we've learned from health
16 care, understanding biohazards. As a matter of
17 fact, biohazards have a whole bunch of safety
18 standards for our providers. They've got no
19 traumatic injury safety standards, no ergonomic
20 safety standards, what they can lift, how they can
21 lift. It's s shame you're missing out on the
22 pictures.

1 But anyway, they have a unique work
2 place, it's in vehicles, and it's at the road side
3 and other emergency scenes. We need to focus our
4 attentions on what do we need to know and
5 understand about those two environments so that
6 our providers can provide their care safely for
7 themselves, their patients, and the public.

8 A bit more data that we've just pulled
9 recently, and, in fact, the most lethal vehicle on
10 the road per mile traveled happens to be an
11 ambulance. It's three times more lethal than any
12 other vehicle on the road per vehicle, as well as
13 per mile traveled.

14 There's no transportation systems
15 oversight over the system engineering of that
16 transportation system. And it so happens that the
17 vehicles themselves in this country are not
18 designed by automotive engineers, nor are they
19 based on any known automotive safety technology or
20 ergonomic practice.

21 So importantly, ergonomics and
22 automotive transportation safety issues are

1 interrelated in the safe delivery of emergency
2 care and response.

3 A good example of that, and there was a
4 picture, is an event that took place in Anchorage.
5 The medic was in an emergency vehicle responding
6 with a patient on board to the hospital, and he
7 undid his seat belt to stand up to put the needle
8 in the -- container on the other wall of the
9 ambulance. Unfortunately, he did that at a time
10 when the ambulance driver was driving the
11 ambulance through an intersection against a red
12 light.

13 Unfortunately, the ambulance was painted
14 red, the most invisible color that we know from
15 our automotive science and optic science. You
16 can't see red at night; it was at night. So some
17 passenger vehicle maybe didn't see them, maybe
18 couldn't stop in time, ran into the side of the
19 ambulance.

20 Well, the ambulance wasn't particularly
21 badly damaged because they're not designed to
22 absorb energy and crumple like an automotive

1 vehicle because they're not designed by the
2 automotive industry, because they're not designed
3 to meet a single standard for occupant protection.
4 Once you're 60 centimeters, seated two feet behind
5 the driver of that vehicle, once you're in the
6 back, the only thing that's going to protect you
7 is luck, and luck wasn't working that day. So as
8 the guy stood up to put his needle in the
9 biohazard container on the other side of the
10 vehicle, they got hit.

11 Well, he's not a paramedic anymore, he
12 has a life threatening head injury. He was
13 intubated at the scene by the medical director.
14 The problem is, what could we have done in system
15 safety design for this man? Multiple things from
16 the color of the vehicle, to the vehicle
17 operations, to where we put the -- container, do
18 we need the -- container, should the equipment be
19 able to self -- sort of absorb its needle to how
20 we design that vehicle.

21 A lot of issues. When I mentioned
22 global hazardous analysis, this is a very

1 characteristic example. We need to make sure
2 we've got all those things in mind. And then just
3 so we -- well, we can't change a fleet of 50,000
4 vehicles over night, but we recognize the hazards.
5 Maybe there should be head protection, okay. So
6 you've got head protection. What then when you
7 want to put on your biological PPE, is it going to
8 work with your traumatic head protection? That's
9 where we need to be thinking globally. We need to
10 be making sure that no one goes off on a tangent
11 and design something to meet one hazard that fails
12 in another hazard, a clear example that we saw
13 here. The biohazard was perfect, it nearly killed
14 the medic. His risk is traumatic head injury in
15 that environment.

16 So I think when you start to look at
17 fatality rates of 100,000 workers, they're very
18 high for EMS providers, and they're high and
19 skewed towards transportation issues. And if it's
20 a bad day today, as I said at the start, it's
21 going to be just as bad, if not worse, during a
22 disaster.

1 So one of the issues that I think is
2 very important to focus on is, capturing the data
3 of how we're getting hurt, what are the
4 mechanisms, as you've said, surveillance, very
5 important, so we can make sure when we target our
6 solutions, they're well targeted to embrace the
7 global hazard, not targeted down one stream or
8 another without a win.

9 The problem that we have is an
10 automotive safety person who's not an ergonomist,
11 and a biohazard person who doesn't even speak the
12 same language as an automotive safety person. And
13 we also have this bizarre situation, more in EMS
14 than in fire or any other emergency responder.
15 There are really no safety standards for biohazards,
16 so the people who are designing products don't
17 know what to design to. Yet there are unique
18 safety and hazard protection needs that I've just
19 touched on very briefly. We also have the
20 situation now where there are a number of lists
21 and appropriate products out there that may
22 actually make the overall situation more

1 hazardous. But we're not capturing surveillance
2 data, so we won't know until it's quite late.

3 So, you know, I'll quote the head of
4 safety for General Motors NASCAR, who I spoke to
5 about this topic about this time last year. And
6 he had had the opportunity to look in an emergency
7 vehicle, and his comment was, on the patient
8 compartment, where you provide your occupational
9 environment, this is a death vault.

10 So there's a lot that we need to do and
11 we need to do it bridging the disciplines that are
12 out there that have this. We do need to rip off
13 and duplicate, we do need to transfer knowledge,
14 we don't have the luxury to reinvent the wheel and
15 to go and do all the automotive research, it's
16 already out there. And I think that my appeal to
17 this group is to make sure that
18 interdisciplinary approach is there. I follow up
19 on one of my colleague's comments, reach out to
20 the academic and technical worlds where this
21 knowledge is sitting, where people are very keen
22 to collaborate, and to participate with projects

1 that are underway. I'm feeling -- interested to
2 look at the pictures. I'll show them to you
3 later. But I think that's my five minutes, right,
4 so thank you. There's a web site. If you want,
5 I'll give you a card with a web site. There's a
6 web site where we've got all the activities that
7 have been undergoing with the foundation, so if
8 you want that, just let me know and I've got --

9 MS. CHANG: Thank you. Our next two
10 speakers are both with the Department of Health
11 and Human Services, the Office of the Assistant
12 Secretary for Preparedness and Response. The
13 first would be Tim Davis with the National
14 Disaster Medical Service.

15 MR. DAVIS: I'm Tim Davis, Commander --
16 Deputy Chief Medical Officer, I was acting, but
17 Deputy Chief Medical Officer in EMS. So I'm
18 actually not going to talk about -- response, but
19 something I did in a previous life. I come out of
20 CDC, I'm a -- the injury epidemiologist figure me
21 as a disaster epidemiologist, my disaster friends
22 consider me an injury epidemiologist, but it kind

1 of plays out in both ways here. And just sort of
2 to point out that just one letter is missing after
3 CBRN (chemical, biological, radiological, nuclear) and that's
the E for explosives, and

4 if you look at just what the threat to first
5 responders is as far as terrorism goes, it's
6 bombs, it's bombs 74 percent of the time based on
7 some State Department study, what terrorists use.
8 And then incendiary bombs are actually used
9 additionally to that.

10 But if you look at all violence towards
11 things against what terrorists use, it's like 99.9
12 percent are conventional types of weapons, be it
13 stones, sticks, guns, bombs, and things like that.

14 If you look world wide who victims of
15 terrorists' bombs are, it's very unusual, 65
16 percent are between the ages of 15 and 29, that's
17 the population at risk, that's world wide. It's
18 different, though, when you look in the United
19 States, who the victims of terrorists' bombs are,
20 because it's actually everybody in this room, it's
21 government workers, our people that have business
22 in government buildings, New York, the World Trade

1 Center, the New Jersey New York Ports Authority
2 building, the government building, the Pentagon,
3 Murrow Federal Building in Oklahoma City, judges, post
4 offices; and then as far as workers goes, it's
5 soldiers, it's EMS, it's fire, it's, again, judges
6 and soldiers, things like that. So the population
7 at risk is actually the people in this room, but
8 it's actually the people we've come here to talk
9 about, and it's the first responders. And I don't
10 just surrender that risk when we look at the
11 hazards to disasters and response to just the
12 security folks that we need to protect us and
13 sweep the area for bombs, because we are the
14 population at risk, it's our job, we are going to
15 go into that area, that's our job, but we need to
16 make sure we're not a naive population going in
17 there.

18 In epidemiology, we generally don't send
19 the population at risk into ground zero, but
20 that's our job, the people we're here to serve,
21 and just sort of keep that in mind. I know the
22 focus is not on explosives, but that is what, at

1 least in the immediate future, that's going to be
2 our biggest risk for the people we're here to
3 serve. Thank you.

4 MS. CHANG: Thank you. And the next is
5 Captain Laura McNally with the state and local
6 initiatives in HHS.

7 CAPT McNALLY: Good afternoon. My
8 presentation will be five minutes or less. But at
9 any rate, what I wanted to do is just sort of give
10 you a very quick overview of some of the things
11 that ASPR is looking at. I've only been with ASPR
12 since January, but I have been involved in the
13 emergency preparedness arena through an OPDIV
14 since right after 911. And so I have watched what
15 ASPR is doing and how it's emerging and how it is
16 collaborating and how it's, you know, it's its own
17 silo, I won't lie. However, it is. But one of my
18 responsibilities on the state and local
19 initiatives team as the team leader is to take
20 many of these parts and try to pull them together,
21 because ultimately, as we know, all disasters are
22 local, state and local response, you know, I am

1 responsible for what's going on out in those
2 states and at the local level, and trying to
3 ensure, particularly through the PAHPA (Pandemic and All
Hazards Preparedness Act) legislation,

4 that coordination that may or may not be
5 happening, that may have gotten broken down, and
6 so when it comes to the health and worker safety
7 project, I do have someone on my staff who has
8 been working with a number of the NIOSH
9 individuals, slowly, baby steps, and she is
10 leaving, and so I am really working to try to
11 identify someone who will be able to step into
12 that role and run with it at a higher level.

13 There are a number of activities going
14 on in ASPR, they're just not very well connected.
15 We are going to be working with NDMS. We have a
16 meeting set up for the beginning of April to begin
17 looking at that collaboration with all the NDMS
18 folks. We've got the ESAR-VHP (Emergency System for Advance
Registration of Voluntary Healthcare Professionals) program, which is
19 your, you know, registry in the states of all your
20 volunteers, and they work with the MRC (Medical Reserve Corps)
program,
21 which, again, is the volunteers. So there are a
22 number of activities that are going on, and I

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 become within my team the pivotal point of trying
2 to link these up.

3 I also am involved with DHS. We have a
4 committee that meets on a monthly basis, and
5 they've had a lot of changeover there. And so one
6 of the things that we're going to be doing is
7 meeting with the Office of Health Affairs folks to
8 try to, again, bridge some of those gaps that are
9 going on and to begin doing more discussion and
10 collaboration on how we can work together, not
11 just around the grants that we give out, but
12 around some of these other kinds of projects.

13 So while we all know that DHS and FEMA
14 are, you know, an entity into themselves and a big
15 black hole, we are trying to make some inroads.
16 So I just wanted to let you know that representing
17 ASPR, I am somewhat new, but not new to the field,
18 and am fully aware of the projects going on.

19 One of the others, of course, as an
20 officer that I've always been concerned about is
21 the 6,000 commissioned officers in the Public
22 Health Service that get deployed, and what are the

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 kinds of information and the instructions that
2 are being given before we deploy. And I have to
3 say, sometimes it's just -- So, you know, whether
4 it be the civilian out in the state and local
5 community, whether it be the NDMS volunteer who
6 has been federalized, whether it be me, as a
7 commissioned officer, or whether it be my staff
8 person who's a civilian, all of those are
9 interwoven and are a part of what ASPR is trying
10 to give more attention to, so thank you.

11 MS. CHANG: Thank you. Next we have
12 Matthew KorbelaK, an industrial hygienist with the
13 Federal Bureau of Prisons.

14 MR. KORBELAK: Well, they were begging
15 for folks to fill some time, I guess, so I felt
16 inspired. I wanted to get up here and say hello
17 and echo some of the sentiments we've already
18 heard. I had not planned on saying anything,
19 though I felt prompted to do so.

20 Especially I had written down the words
21 "reinventing the wheel" prior to just being
22 spoken, and then the mention of explosive devices

1 I had down in my notes, as well. As that has been
2 part of the course I teach on weapons of mass
3 destruction, the problems seen here with secondary
4 devices being a problem for responders and
5 rescuers. So this is a new aspect of responding
6 that we have to look at and be aware of and
7 sensitive to. I've also been involved with the
8 Incident Command System. How many of you have
9 taken some of those FEMA courses, incident
10 command, so you're familiar with the incident
11 command structure maybe a little bit. There's
12 command staff, general staff, and other
13 nomenclature that goes with that.

14 I would say that the role of safety
15 officer as it's coming on as being developed is
16 one that we need to keep developing and one that
17 is to be involved in the organization running
18 management of a crisis situation under the NIMS,
19 National Institute Management System, Incident
20 Command System there.

21 This is one of the command staff roles,
22 a very integral part. This is one where we have a

1 huge say so. This is one where we, the safety
2 officer, can address issues of PPE, adequate rest
3 for our transportation, we can talk towards that,
4 and proper protocols there, and certifications,
5 licensures, just not rushing in. And so those
6 aspects I wanted to echo.

7 I also wanted to say why reinvent the
8 wheel if someone else has already looked at
9 something. Has USAMRIID gotten data on anthrax? Do
10 they have information that could be helpful to us
11 on respirable anthrax for quantities and such that
12 we don't have to reinvent the wheel and study
13 again? Can we get into that? Is there something
14 that may be declassified, or if we know somebody
15 that -- can we get something declassified that
16 would be helpful and beneficial to our workers
17 that might be posed with such a threat? So I
18 would encourage developing a relationship there
19 possibly or other folks that have dealt with such
20 weapons of mass destruction in their study.

21 Lastly, I wanted to say some notes. As
22 a photographer, I studied some photos from

1 Hurricane Katrina. I was developing a catalog of
2 photographs, and I noticed that several of the
3 earlier ones coming out, when the workers were
4 photographed inside the homes, these flooded
5 homes, and you see knee high water and water marks
6 up on the walls, and mold everywhere; do you
7 remember those photos?

8 Those really struck a note with me,
9 especially when I noticed that the workers weren't
10 wearing any PPE, they were in there without masks.
11 And then it wasn't too long after that that I
12 started noticing similar photos a week or so
13 later, where those workers did have masks and
14 protective equipment in similar conditions.

15 So the word got out, but it wasn't right
16 away. A good safety officer on the site would
17 have taken the classic industrial hygiene
18 anticipated recognition of hazards and applied
19 those prior to going in there and saying --
20 anticipating that, or at least first being in
21 touch with the people that were out there, saying
22 we might have something, is that something that

1 our workers are at risk on, and can we do anything
2 about it. Anyway, that's all I have. Those are
3 some of my notes that I was reflecting on, I just
4 wanted to share them, and thank you.

5 MS. CHANG: Thank you. I wanted to
6 remind everybody to please fill out your
7 evaluation forms. We've moved the anonymous box
8 to just the table inside the room, so that's not
9 next to the registration table, so it really is
10 anonymous. Do we have any other speakers that
11 suddenly feel inspired? If not, we will have
12 Doctor Kitt come back again, and we'll start the
13 discussion for the afternoon.

14 DR. KITT: I actually think it's going
15 to be a little bit more of a wrap up session.
16 But, once again, I wanted to -- I think I've asked
17 everybody from our Steering Committee if there's
18 anything particularly that they wish to bring up.
19 I haven't had any takers thus far, last
20 opportunity. So I appreciate all the speakers,
21 especially the last minute people who volunteered
22 to contribute their words. And this has been very

1 useful for us. It certainly is a first step. And
2 Renee is going to talk a little bit more about how
3 we can continue on with this dialogue. I just
4 thought I would open it up for one last
5 opportunity, if people wanted to discuss anything
6 or had any specific questions for us. Yes, sir.

7 MR. SKOLNICK: Barry Skolnick again,
8 analyst. Yeah, first of all, I'd have to say
9 about Ms. Levick's -- Doctor Levick's comment,
10 I've caught up with the new terminology, R and D,
11 rip off and duplicate, I -- and in conjunction
12 with that, I wanted to put in a plug and maybe
13 refer specifically to Laura McNally's area in
14 ASPR under HHS.

15 The Department of Homeland Security
16 funded, starting several years ago, a series of
17 centers of excellence, which are academic
18 consortia that put in certain grants, proposals,
19 involving faculty from multiple universities, and
20 they funded them, and they have been cooking along
21 for several years now, and it represents an
22 immense talent pool of academic people in a

1 variety of disciplines that are relevant to some
2 of the things here that you're talking about,
3 which is funded by DHS, in one case EPA -- funds,
4 the CAMRA, Center for Advancing Microbial Risk
5 Assessment, that's just one of them. And I was
6 reminded, listening to Mr. Davis and Laura
7 McNally, that -- just as an example, there's a
8 professor, Assistant Professor Hodges of - -
9 Hodges at Hopkins, it's called hygiene, who made a
10 presentation last year and this year, they had
11 university networking summits every year, and
12 they've had two of them now, and I attended both.

13 And last year they were talking about
14 this new assistant secretary for, was it ASPR for
15 disaster preparedness response or something, I
16 don't remember the terminology, but it was an
17 academic study of the new law, the legislation
18 that was implementing that and some of the issues
19 that might arise with the interaction with local
20 authorities.

21 And I thought it was very interesting
22 just because it was a proactive sort of thing from

1 an academic perspective. And what I don't know is
2 whether HHS has, even though there's an -- there
3 needs to be an arms length relationship between
4 the government and academia, but it may represent
5 a source of academic expertise and motivated
6 students and so forth that would be helpful.

7 And this year actually I heard that one
8 of the things that this same young faculty member
9 is doing is working on model memos of
10 understanding that would get local responder
11 organizations to make proactive arrangements with
12 government authorities on what to do in case of
13 emergencies.

14 Now, HHS may be doing that themselves,
15 but this is, again, coming from the academic. So
16 the message I wanted to suggest for anyone
17 involved in this whole field is, look for those in
18 academia that have like interests, and if somebody
19 else is funding them, maybe you can escape the
20 stovepipe and get the advantage of their
21 curiosity, interest, and motivation, and kind of
22 rip off the, you know, the work that's being done,

1 and seek, you know, a relationship.

2 And who knows, this is very naive, but
3 if DHS has the deepest pockets, and maybe NIOSH
4 has something that might be worth some
5 collaborative study, it's through the academics,
6 maybe new funding can be gotten to accomplish what
7 you're trying to do with limited budgets if you
8 could take advantage of the academic community.

9 So this is a model, the centers of
10 excellence, of which there are five or seven or
11 so, and they just announced three new ones this
12 year, are doing a lot of things in the disaster
13 response area that are relevant, and I would just
14 encourage anyone in this field to learn about
15 them, mostly through the DHS web site, and I can
16 certainly provide some links to anyone interested
17 in pursuing that further to see which of these are
18 doing things that are relevant.

19 DR. KITT: I think one of the clear
20 messages we hear from a number of people today is
21 there are some real opportunities for us to form
22 some more collaborative partnerships, including

1 academia outside the federal government, so we
2 hear that. Anyone else? Okay, Ted.

3 MR. SCHARF: Ted Scharf, NIOSH
4 Cincinnati. I'm one of the psychologists, and
5 everybody always wonders what's a psychologist
6 doing here. I'm really grateful for all of the
7 preparation on safety climate.

8 I was reminded of something from Doctor
9 Levick's talk that sounds like a contradiction,
10 but it's really crucially important, and that is,
11 while we look for generalizations across different
12 emergency settings and situations, it's also
13 critically important to understand what might seem
14 like petty, unimportant details of each particular
15 emergency setting.

16 I had no idea that ambulances weren't
17 qualified in crash tests. I mean that's just an
18 astounding thought to me.

19 But that's the environment those workers
20 are in every day, and so they understand that.
21 What's the message to them in terms of safety
22 climate? Well, your safety doesn't matter that

1 much. And so I guess what I want to encourage all
2 of us to do is, on the one hand, while we try and
3 draw out the broader themes from today, we also
4 don't lose track of some of these important petty
5 details, because to the workers in that situation,
6 they are not petty, they accept the climate of --
7 another great example is a respirator that's
8 uncomfortable; if it's uncomfortable, you're going
9 to find a reason to take it off sooner than you
10 would otherwise.

11 Stupid little stuff like that can make a
12 huge difference. And at the risk of saying we
13 have to pay attention to everything, we really do,
14 it's just -- it's a difficult task we face.
15 Anyway, sorry for that, and thank you.

16 DR. KITT: Anyone else? Okay. Well,
17 before I turn it over to Renee to kind of wrap us
18 up for the afternoon, I certainly want to thank
19 the Steering Committee for all of the work that
20 they have done over the course of the last several
21 years. And certainly for those of you who could
22 make it to attend today, it's very important for

1 us to have you here.

2 Certainly to my office, who, no matter
3 how small an event like this is, you can imagine
4 how much work it takes, especially when you're in
5 a different city and you're trying to organize
6 something here, so I certainly thank everybody in
7 the office. And then most especially to Renee and
8 Chia-Chia for all of the hard work that they've
9 done. And for you for all being here, we really
10 do appreciate it, and I know Doctor Howard does,
11 as well. So I will turn it over to Renee.

12 MS. FUNK: I just wanted to talk for a
13 few minutes about -- just to let you all know what
14 we plan to do with this information today. This
15 has really been sort of the first opportunity that
16 these strategic goals that we've developed have
17 had an opportunity to be reviewed by external
18 partners, and so we really appreciate all the
19 information you provided us today.

20 And we will be revising them, based on
21 your comments, and also some requests from the
22 NIOSH OD, as well.

1 And we'll post that up on our web site,
2 and we'll let you all know once that has been
3 revised.

4 One of the things that we have been
5 talking about is how could we sort of engage you
6 all on a more regular basis, and so one of the
7 thoughts was to start a stakeholder list or
8 something like that, and I think by you all's
9 participation today that you sort of identified
10 yourself as someone who's interested in this topic
11 area. So I don't have that set up yet, but I will
12 email that out soon. And if you don't want to
13 participate, there will be opt out instructions,
14 so don't worry about that. But it's probably just
15 easier to put you all on, and you can individually
16 take yourselves off if you want to. So just to
17 let you know about that, and that way you can be
18 aware of what's going on in this research area and
19 what our office is doing.

20 So I think that's everything. Please do
21 fill out your evaluations before you leave. And
22 if you didn't have a chance to prepare your

1 , comments today, you have until April 13th to
2 submit them to the docket. So thank you very
3 much.

4 (Whereupon, at 1:54 p.m., the
5 PROCEEDINGS were adjourned.)

6 * * * * *

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190