COCA Conference Call – CDC Preparedness and Response Activities
Thomas Reynolds and David DeSantis, MSCIS
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Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until the question and answer session of today's conference. At that time, you may press star-1 on your touchtone phone to ask a question.

I'd also like to remind parties, this call is being recorded. If you have any objections, please disconnect at this time.

I'd now like to turn call over to Mr. Jim Schwendinger. Thank you, sir. You may begin.

Jim Schwendinger: Thank you, Jane.

I'd like to thank everyone for calling in for today's COCA conference call. It's very exciting. We have two very, very experienced emergency preparedness response subject matter experts here from the CDC who are going to talk about CDC's activities in the preparedness and response arena.

Our two speakers are very experienced as I mentioned. I've had the pleasure of working with both of them for a number of years here in activities related to the Emergency Operations Center and they're just amazingly skilled and experienced and knowledgeable as far as the process and the in the weeds so to speak implementation of our CDC mission protecting the public health.

First off, I'd like to introduce David DeSantis. He is in my center in the National Center for Health Marketing here at CDC, my center emergency coordinator.

Prior to that, he began his career with the United States Army and was in the military for 15 years in logistics and it shows because he is a very organized and go-to kind of guy. He gets things done when we need it done.

He then went from the military to the Department of Defense and worked as a Computer Specialist for 18 years.

He then came over to the Centers for Disease Control and Prevention as a Systems Engineer and was later promoted to the Lead Technology Officer in the Division of Emergency Operations within the CDC Emergency Operations Center.

And most recently, as I just mentioned to you, he moved over to my center where he is very valued as our Emergency Coordinator for the center.

So without further ado, I will turn the call over to Mr. DeSantis.

David DeSantis: Good afternoon, everybody.

It's an honor and privilege to have this have this time to speak to everyone. What we're wanted to do is just take a minute of your time and kind of give you an overview of the CDC preparedness and response activities.

A lot of questions have come in the past in reference to how does the CDC respond to different types of public health emergencies?

One of the important things to note in that is that where does this authority come from to do - to declare a public health emergency, and that comes either from the President of the United States or the Secretary of the US Department of Health and Human Services.

And what that means or described is as like this.

The Secretary of Department of Homeland Security Services has the authority to declare a public health emergency under Section 319 of the Public Health Service Act; a declaration is limited to a 90-day time frame after which the declaration expires. The declarations may be extended by the Secretary.

A public health emergency may be declared as the Secretary determines after consultation with such public health officials as may be necessary that 1), a disaster or disorder presents the public health emergency or 2), a public health emergency including significant outbreaks and infectious diseases and bioterrorist attacks otherwise exist.

The declaration of a public health emergency facilitates funding and mobilization of resources to respond to the emergency.

Following the declaration of a public health emergency, the Secretary may do one of a few things.

He may make grants entering the contract and support investigations into cause, treatment or prevention of the disease or disorder. Also, make temporary up to one year or the duration of the emergency one-year appointment of personnel to physicians that directly respond to the public health emergency. Also, authorize the emergency use of investigational products under Section 564 of the Federal Food Drug and Cosmetic Act. And finally, access no year funds appropriated to public health emergency funds.

I wanted to give that overview just so that you have understanding how when a public health emergency has been declared and the CDC starts to get involved.

Now, I was going to do the presentation - the remaining of this presentation but now that I moved to the National Center for Health Marketing, I felt it's imperative that we have what I consider as one of the top subject matter experts on how CDC respond and that is Thomas Reynolds.

Thomas is the team lead for the CDC Plans, Training, Exercise and Information Operations for the CDC Emergency Operation Center.

He is a subject matter expert on Emergency Management, Incident Command System, the National Response Plan, the National Incident Management System and Emergency Operations having served on numerous national level committees for the rewrite and revision of these documents.

Mr. Reynolds' resume includes 21 years as an army civilian in the special weapons arena and radiological, nuclear, emergency response team, and seven years with FEMA as a response specialist dealing with nuclear power plant, community preparedness, and inspection.

He was also the operations section chief for FEMA Region IV during activation for a national disaster.

Mr. Reynolds currently has three years at CDC and is the lead ERS for emergency response for the Director's Emergency Operations Center here at the CDC, planning, training, and exercising CDC responder capability using an all-hazards approach in the incident command system. He was also a 20-year volunteer firefighter and line officer in Upstate New York.

As you can see, Mr. Reynolds is very well versed in all of this information and I'm honored to have him and I appreciate his attendance in this and I will turn that over to Tom.

Thomas Reynolds: Thank you David and welcome to the presentation this afternoon. I'm honored to do this presentation.

If you bring your slides up to the front slide, as you can see on the slide, there are six things listed on there at COTPER and CDC, COTPER is the Coordinating Office of Terrorism Preparedness and Emergency Response. The CDC deems necessary as a goal for our preparedness for the agency.

If you go on to our Web site at cdc.gov, you can look at these goals and understand what we mean about each of these goals.

I don’t want to go at length into these goals on your slides. So if you go to the next slide.

During my presentation, we’re going to talk about our CDC preparedness and response activities. We’ll give you a brief description of the basis of authorities for CDC response, what CDC’s current management structure is like, and our field management structure also because I think that’s important to you as clinicians.

We’ll also give you an overview of our deployment processes and supporting incident management structure.

Next slide.

This is the picture of our state-of-the-art, two-year old Emergency Operations Center.

As you can see, there are 66 seats on the main floor of the DEOC, we affectionately call it the DEOC, it's the Director's Emergency Operations Center and we use our operations center for our subject matter experts across the agency, across CDC anywhere from the scientific aspect, ethics, DOD, liaison, our SMOs or our State Management Officials that we have out in the field that most of you or some of you are aware of.

We man these desks when needed. They don't all necessarily have to be filled during an event but on a day-to-day basis, it pretty much looks like this.

What you don't see on the right hand side of the screen is our watch desk. When you call into the CDC number at the top, the 7100 number, you get our watch desk, 24/7, 365, they're always there, they answer calls and answer questions from clinicians.

Next slide.

This sort of gives you an idea of how CDC is laid out. As you know, Dr. Gerberding is the Director for CDC and where we are in the Coordinating Office of Terrorism Preparedness and Emergency Response is to direct reports to the CDC Director.

She is intimately involved in every event that CDC has during the year anywhere from the *E. coli* event to whatever circumstances are out there. We recently sent a couple of people to Ghana to deal with some issues over there and she is well-aware. She likes to know where her people are and where they're going.

Next slide.

Within my Division, Division of Emergency Operations, you can see how we're set up. We have a division director and chief health and science officer that input scientific aspects into emergency operation. That's a little bit different than the normal everyday variety emergency operations center.

We need a scientist that can take these data that's coming in from the field and analyze it for us as emergency managers in how it relates to the scientific field.

Down below you can see the four sections that we have. DBS is our business services. We have an operations section, a log section, and myself is plans, training, information, and exercise.

Next slide.

Here are our preparedness goals and I showed you some of them at the front. I'm not going to go through each of these but there are nine for us. Where we mostly get involved in is in the control, decrease the time needed to provide counter measures and health guidance to those affected by a threat to the public's health. That is our entire goal here in emergency operations section.

Some of the guiding - next slide.

Some of the guiding references and some of you may or may not be aware of the national level law guidance that is out there is HSPD-5, Home and Security Presidential Directive 5 and 8 that establish a mechanism for the

United States to prevent and respond to not only terrorism attacks but major disasters and all hazards which is what we're all about also.

The basic premise in the base plan for that response is the national response plan. It's an all disciplined, all hazards plans that really gets the federal agencies together in a common framework for the good or the response to the state.

And then, we all are using of course the National Incident Management System and that's a common language. It's a common communication aspect of how to do incident command and incident management.

Next slide.

Here are some more and you may or may not have seen these target capabilities. These are essential capabilities that all states and locals and Fed should have and you can read through those if you go to nimsonline.gov and you can look at all of these.

The universal task list is a menu of task that the federal government thinks that you should be able to perform during mitigation preparedness and response.

The 15 national planning scenarios is really what the nation is planning around currently.

And the planning scenarios are also listed at nimsonline.gov and you can see what those are. Some of the examples are smallpox, earthquake, hurricane, nuc death -- nuclear death nation, 10-K. Nuc death is one of the 15 planning scenarios.

And the last - the next one down, the national preparedness goal is what the nation's goal is for preparedness and you can read that.

Underneath the all of that, we have our CDC emergency operations plans with approximately eight annexes and about 20 appendices that deal with each of the specific agents or hazards that the nation has to deal with.

Next slide.

The national response plan of course is the guiding principle for domestic incident. It doesn't come into play for international incidents but it's an all discipline, all hazards plan. It gives us a common framework to work through for management of domestic incidents with the states and local, territorial and tribal.

It also provides a structure for the federal response and the federal support and it consists of the same thing as a CDC plan, a base plan, support annexes, and then incident-specific annexes against the national planning scenario.

Next slide.

NIMS is not a new term for you all out in the field. It's a consistent nationwide approach for incident management. Fire service has used that since the mid to late '70s.

It's a way that everybody can talk the same lingo in the field for incident management and it requires that the fed, the state and local territorial, tribal and local governments work together before, during and after.

It’s just not during the event you have to plan, then you have to respond and then you have to recover.

It involves the training for in preventing all of those domestic incidents and of course law enforcement gets involved in that. And it doesn’t matter - NIMS can be used no matter what the size of the event. Whether it’s a small forest fire like - well, it’s not small anymore but the one that we have here in South Georgia but, you know, it could be a local incident of a chem spill or whatever. It can be used for any incident no matter what the size or complexity.

But the important thing is that an incident commander is an incident commander whether it’s at the local level or the fire chief that’s on the ground or here at CDC where the incident commander is commanding the resources that CDC has.

We don’t command really and I’ll talk about that in a little bit. We look at it as a management of resources.

Next slide.

The national response plan shows 15 emergency support functions. We are part of both six and eight. Our main lead is the Department of Health and Human Services under public health and medical services and then we get involved in mass care, housing and human services. That’s one of our missions that we have recently picked up under the ongoing rewrite at the new national response plan that isn't out yet.

Next slide.

We as a primary agency, Department of Health and Human Services are to coordinate federal assistance to the states and locals for public health and medical needs following a disaster emergency.

As you can see below, we use a lot of other federal agencies to help us provide that support. If we needed nurses and docs, we reach in to DOD, we reach to the VA to get those assets to put in the field for an effective public health response.

Next slide.

Here are some of our overall ESF 8 responsibilities and I use that term as CDC in conjunction with HHS and the other offices that work under CDC and HHS.

But you can see, a large number of these are critical CDC missions. Take for example, public health surveillance. We are the nationally known and internationally known premiere organization for public health surveillance. And we can do a laundry list of things under that premise.

We deal with food safety to a small degree. We work with the USDA and the FDA for events such as *E. coli* and those other things.

We have a NIOSH unit that works with the Office of Health and Safety for CDC that deals with mask issues, PPE, those type of things.

Vector control were known for a mosquito spraying control and those types of things.

You can look down through there and pretty much pick out what CDC is mainly responsible for but all of these missions are ESF 8 missions.

Next slide.

We like to use director's critical information requirements. These are the things that we would get Dr. Gerberding up at 3 o'clock in the morning and say, "Hey, we got this going on. You need to know about this. What do you want us to do? Do you want us to activate the operations center and call in all of our resources or whatever?"

But these are the things that we look at on a regular basis that is very important to this agency and to HHS as a whole and to the federal government.

So if one of these things happens, we're calling her. It doesn't matter what the time of day or night it is or if she's in overseas. She has a set phone on her all the time. We can get her 24/7, 365.

Next slide.

This is really the most important slide here for clinicians. One of the things that we do and you can see on the left hand side there about three down from the left is where the clinician comes into play.

The most important thing that I want to tell you today is that when you call 7100, the number that for the CDC DEOC, more than likely, they're going to refer you back to the state because that's where you have to deal with if from a clinician's aspect on a regular daily basis. They will refer you back to your Department of Health.

If it is other than on duty hours, then we can refer you to our SMEs or our subject matter experts.

Some of the things and majority of our calls to our hotline from clinicians and I just got this off of our watch desk today was that the three big ticket items that they always get called for are botulism cases, malaria suspected cases, and rabies.

Those are the things that keep coming up over and over and over again everyday and every shift it seems like.

Most of those will refer back to the state. Like I said, we do have subject matter experts on call 24/7 that if a doctor with a patient needs to have advice in the off hours, we will connect them to a SME, we will connect them to each other so that they can talk about the particulars of that particular case and try to come to a resolution.

But the DEOC is just a conduit. We have protocols in place when we receive a call for consults on malaria that we would call our subject matter expert and put them in contact with that clinician.

However, I do want to emphasize that 90% of the time, we're going to refer you back to the state health department because that is your main resource.

Next slide.

This is CDC's response in conjunction with the HHS response and then way over on the left side; you can see the Department of Homeland Security advisory system. We use all three in our response.

Our everyday mode that we use is our watch mode where we have at least two watch desks and a duty officer on duty 18 hours a day and then two watch desks overnight and that's our normal monitoring mode, we look across the country and across the world for anything that pops up.

We've got 18 TV screens here that they're monitoring 24/7 for anything. They could possibly pop and that's our normal everyday duty watch mode.

When we get into some things that are starting to happen, i.e., we get those case, you know, of a possible *E. coli* event or something dealing with lettuce or spinach or something, then we start moving into a phase that we call alert and that's where we start getting involvement from our subject matter experts out in the coordinating offices and centers here at CDC.

We do a mission analysis review of what they know about the disease and what we should be doing. And then if it's a bigger case, then we start talking to our federal and state counterparts for future planning and future deployment for Epi-aids or whatever the case may be.

If we need to they need additional resources from the centers, we can call in those resources and start the deployment. That's when the center goes to a full alert mode and you'll see it in the next slide here of how we face those responses.

Usually, the last one there is full of response mode is for a catastrophic incident or some type such as Katrina.

We do do incident planning in accordance with ICS components. We use a lot of resources together or intelligence to report information and you out in the field are paramount in our information gathering.

We have to rely on the data that you are giving to CDC in order to effectively respond to state and local requests.

We'll talk about the SMO there on the bottom. Shortly, we'll go through what he does for the states that have an SMO out in the state.

Next slide.

Here, you can see our alert to response mode. Our everyday normal watch is tier zero. When we start moving in and the center can't control it, this deals with that issue, say it's botulism and they can't control it within the center with the few people that they have or they start working across the agency with other subject matter experts in other centers, then we would ask them to bring it in to the DEOC so that we can give them the resources that they need to respond.

Something like E. coli was a Tier 1 response where we had 25 to 30 people in the DEOC 24/7 working the issues, others on in the weekend and mainly that was because the laboratories didn't always work 24/7 out in the state and local.

But, you know, if it were a bigger event of course, we would ask them to open up and work the issue.

As we move into a bigger response, a good example was the start of SARS. That moved in to 100 people really quickly and we started looking at SARS

and then it finally grew to over 200 and some people at CDC for involvement across multiple centers and that would be a full Tier 3 response or catastrophic response.

Next slide.

This chart is very busy but I just wanted to show it to you because as we're starting into the hurricane season, how we deal with HHS and DHS and how they look at landfall in pre-phases and stages and tiers. It's too complicated but it sort of gives you a look at that we're tying in to the rest of the federal agencies of how they're responding so we meld into the federal government response as the CDC response.

Next slide.

Most of you already know ICS and this is a basic structure and the incident commander at the top with his command staff or safety PIO and liaison and then flop down on the bottom, operations, planning, logistics, finance and admin.

Next slide.

Some of the challenges that we have here at CDC in particular are stabilizing our management structure because we have so many centers here that deal with different types of issues.

We have, you know, the center for environmental health, we've got - and center for infectious disease and they all deal with different things. So the management structure has to change from event to event to event. So we

sometimes struggle with stabilizing that management structure but we're working through those issues.

The core elements for the response always are the same. You always have the flop, you always have the command staff, you always have the general staff underneath.

One of the things that we use and I'll show you in the slide here in a second, is the CDC system for response and one of the most important things in the planning cell is what we call the technical specialty unit.That is where all of our scientists fit in to what CDC does to respond to an event.

Reporting hierarchy as with any federal agency, we have to report to everybody and what we call the big green monster out there for wanting information is constant for us to try to get and try to feed.

For personnel accountability, for Katrina, we deployed over 600 people out in the field so that was a difficulty for us trying to keep control of where they were at, who they were with, when they are coming home, how they were getting home, so you can imagine when you deploy that many people in the field, the problems that you would encounter.

And then refining and exercising the plan. That's a continuing cycle. You have to write the plans, then you have to train to those plans, and then you have to exercise those plans to see if the plan is valid and if it's not, then you have to go through in that direction process to revise the plan and start the cycle all over again.

Next slide.

I told you a little bit about that I want to talk a little about command and management and what the difference is.

What we look at here at CDC is the incident commander is the person that's on the ground dealing with the incident.

CDC isn't ever there. We're not going to be there. We're not going to be the incident commander. It's always going to be the states and locals that are dealing with the situation on the ground.

So we look at our piece as incident management. We are managing CDC resources that we would send to respond to that incident.

We use most of ours just to provide technical assistance to our subject matter experts either to the - the incident commander on the scene or to the incident management team here at CDC.

We don't have any direct authority over your field resources but we do provide resources as requested through the normal mechanisms that we'll talk about here shortly to the field and through the federal system.

Next slide.

This just shows - the everyday normal duty business is done within the coordinating centers. When - it's a small event - they handle that event within their offices.

When it gets overwhelming and they start using multiple centers or need additional resources, that's when they mold into the technical specialty unit and we activate the full incident command system.

Next slide.

This sort of gives you a little idea about, you know, how we're doing pandemic influenza in the WHO phases -- WHO phases. In zero to two, you know, most of it is being done in the coordinating centers and coordinating by our chief health officer and providing guidance to the country, to the nation, to the international teams that are out there and providing those resources.

When we get in to WHO Phase III, some of that responsibility shifts in to a response mode and we go into an incident management as soon as we get notification of a suspected case of PI in the United States and we'll be in incident management mode and then we'll bring everybody and start working the issue.

But as you look the bottom there, accountability still remains within the centers because that's where the expertise is.

Next slide.

Very busy slide and just for your edification so that you can look and see how we're structured.We're structured a little bit different than, you know, most federal agencies or most state and local agencies because we have subject matter experts.

So if you look in the center of your screen where it says tech specialty unit in red, that is our scientific component and that is what we need to have in order to effectively respond.

We bring in those people at these, you know, the environmental health folks, the red nuc specialists, whomever we need that we have here at CDC to effectively respond.

Next slide.

This just gives you an idea of how we're set up, the operations sections in the three branches.

Next slide.

Planning section like I said, the tech specialty unit is our bread and butter. We do a documentation unit just like everybody else, incident action planning, after-action reviews, and demobilization planning. And then we also have a situational awareness unit.

Next slide.

Log and finance. We kind of combine these two because we don't have a good breakout of how they respond. They respond effectively together because they have to deal with so many of the same issues.

So we - they are separate but they're in the same room talking to each other at the same time.

Next slide.

I wanted to put the slide in here for you to look at how we respond during a national event and if you look on the far left side where you see the PFO or the Principle Federal Official and the Joint Field Office, JFO, where do we fit

in to the scheme of things and if you go up to where DHS is under ESF 8, the component for ESF 8 is - are the health and human services there and then it goes down to the CDC and the other office that are underneath HHS and then down to the DEOC back up to the stock and then you can see our structure on the side.

One of the things that we have that HHS has put out into the field is this IRCT concept. That is the Incident Response Coordination Team that fits with DHS ESF 8 component and directing control the medical resources that are needed in the field and they talk back and forth through the JFO, to the states and to the local, what are the health and medical needs out in the field.

We'll talk about to senior management official and what they do here shortly. I've got a complete slide set up for those.

Next slide.

So what are our potential CDC missions; conduct public health needs assessments, and environmental assessment, provides vaccinations and medical supplies, we have the strategic national stock pile housed here at CDC, conduct disease surveillance -- our primary mission, and then provide mental health assessment and response and deploy the pharmaceutical and medical supplies that we have.

Next slide.

I just wanted to touch very briefly on the mission assignment process and you can look through this slide but really, the request starts from the state. That's where the mission originally originates and that's where it has to go.

It has to go from the state to FEMA through the joint field office before it gets assigned to one other federal agency.

When it gets to DHS, then they look at it and see if it's a valid mission, and then assign it to their appropriate what we call OPDIV, operating division for activation of that response and that's how we get the mission assignment down through the process in the federal bureaucracy for that effect.

But it takes a while. Some it takes a day or two to go through this process and I hate to say that but we're getting better to increase scripted mission assignments so we can get requests for assistance out to the states a lot faster.

Next slide.

This sort of gives you an idea of what our structure was, our federal structure was for the Texas response during Katrina and Rita. And you can look and see where ESF 8 is and then CDC ultimately on the bottom.

Next slide.

So what is the CDC emergency, or a senior management official, and what is their role in emergency response.

In the picture on the next slide you can see one of our guys in the right hand. You see Bodenheimer in the state of Arkansas. They are really the oversight of CDC resources in the state during the emergency and they provide that technical public health CDC's assistance to the state during that emergency.

Next slide.

They also give us at CDC a situational awareness of what's happening on the ground and in the state so that we can more effectively respond to any request.

And they are our point of contact for state and federal response to interact with all of the other federal agencies that are in that state or sitting in that state EOC.

Next slide.

Oversight of the CDC resources that we put into the field, we tried to let the SMO manage those resources effectively and they are responsible for those people in addition to the incident response coordination team that is sent by HHS and we want to assure that we're maximizing the coordination of - and effective use of our team.

Next slide.

You can see how the senior management official relates across spectrum back and forth to the state health department, the joint field office, the incident response coordination team, and then ultimately, to the CDC field team.

One of the things that, you know, sometimes, we never know when to come home so we struggle sometimes when the CDC mission is over.

To the average person that's out in the field, I want to get out of there within two to three weeks so that's one of - one of our role is rotation of our staff.

And then containment and mitigation of the event, state - when the state actually resumes their roles and responsibilities or has the ability to do that, when the Secretary of the operations center and says go back to your normal

operations or when the RRCC which is the Regional Response Coordination Center for the FEMA region that’s out there returns back to normal operations. That’s when we think that our mission is over.

Next slide.

Let's skip this one and then go to additional resources.

I put this in here because most of you should - if you get a chance to take these four courses, I would advice anybody that is responding to any events out in the field to take these four IS courses through the FEMA Web site.

This basic incident command and 200 is a little bit more in depth. The IS 700 course is how incident management system works, and the introduction to that, and then the IS 800 which should be shortly revised as initial response plan.

Next slide.

In addition, there's a lot of other things that you can look at and the states offer a lot of these courses. So if you’re interested in further ICS training, go to your state health trainer and maybe they can find those online for you.

Next slide.

I just want to remind everybody that the DEOC or the Directors Emergency Operations Center is operational 24/7, 365. We do use incident command. We do conduct this incident management and information management so that we are - we do have situational awareness and a common operating picture of what’s going on as best we can.

We have a complete logistics section that supports our CDC deployers no matter what the time of day and we do have redundant communications, a lot of you already have communications with us to HF - UHF radio.

And each of our seats has a functional area action officer that can reach back into the organization to get the help that you need.

The number at the bottom is very important. If you're a clinician and you've been referred to your state health director and they refer you back to CDC for further consultation, call that number. Our three - our desk officers will triage the call and hook you up with the appropriate subject matter expert for that particular case.

And next slide.

If there's any questions right now, I did put a list of acronyms in there after the question slide because a lot of us in emergency management sometimes like to use weird acronyms that not everybody in the world knows.

But I thank you for this opportunity and we'll take some questions at your leisure, Jim.

Jim Schwendinger: Well, thank you very much Tom and David. That was excellent.

What we have tried to do, you know, we have some feedback from our COCA audience that, you know, it really is kind of a mystery to the folks that aren't involved in any kind of emergency response.

I mean, as Tom mentioned, you know, the history of ICS goes back to the fire service but there are folks that just have never, you know, interacted with an emergency kind of situation in that way and it is really kind of a mystery.

So you've done a great job. Thank you for doing that for, you know, shedding some light hopefully.

Jane, I'd like to actually open it up if there's any callers with questions, we have Tom and David, you know, at your reserve to answer any questions you might have about the presentation.

Coordinator: Thank you. We will now begin the question and answer session.

Question: My question is regarding a legal advice. I've given a lot of presentations and talks to other groups and, you know, the question about quarantine, isolation, and, you know, the state lawful, you know, well, I've heard people say well, it's the CDC's call, you know, it's the state's call, it's the local, you know, local group's call.

Is there any legal consultation with the CDC that is able to advise and assist someone calling from the state that would be able to add that kind of information for them?

Jim Schwendinger: I'll actually answer that just because it's kind of out of the scope of this presentation but, you know, briefly, legal consultation I think is a term we should not maybe use but I mean, the short answer is that, you know, if the state or, you know, the existing system in the local or in the state health department system is unable to answer, certainly, CDC has, you know, we have an entire legal affairs office, a public health legal office actually as well.

We actually had a COCA presentation by the quarantine staff a couple of months ago that answers some of this. I mean, briefly, you know, there is a line of authority as far as declaring a quarantine.

CDC is involved in that, however, we, you know, it typically comes from the federal government -- from the Secretary of health and human services and the President.

So what I would actually like to do is that question please and any others that are involving really the legal aspects, if you could send them in an email, we can make sure that we answer them, you know, accurately because I am not a subject matter expert on the legal authority quarantine, I'll say that. But we can, you know, certainly get request and direct it to those individuals.

So if you could email us at COCA, that's coca@cdc.gov, I will be sure to get that question, you know, to the legal quarantine subject matter experts for an answer but that's an excellent question. Thanks for asking it.

Question cont'd.: Well, the thing that come up before is, you know, when you look at your prevent, detect, investigate, control, recover, and improve, when you go to the investigate stage and then you start determining what new actions need to be taken, it goes beyond the simple, you know, the medical side of it, you know, where clinicians involve and then, you know, this person needs to be detained or this incident, you know, this area needs to be quarantined because of the risk, you know, for the group.

That's where I'm - that - when you look at NIMS and ICS, the legal side of it - it's an adjunct, you know, it's a subject matter expert that called in and I do training for incident command and unified command and that's one of the things that's sort of missing is how to answer some of the legal questions that

people are going to ask, you know, what authority do I have to do certain things and it might be nice that there was a little cookbook type form when an, you know, EOC stood up just exactly what can we answer.

And like you said, you know, it's nice to ask those questions now but is there something out there that could be helpful at, you know, when it hits the fan so to speak.

Thomas Reynolds: Absolutely. This is Tom again.

During our response and when we're in response mode and alert phase, we bring in our legal specialist into the DEOC…

Question cont'd.: Good. Okay.

Thomas Reynolds: …those types of questions from the states and local that you can get clarification of those answers.

Question cont'd: Thank you. I just didn't - I guess the print was so fine. I couldn't make it out in the slides so maybe they're in there somewhere. I just didn't see it.

Thomas Reynolds: We had to put an eye Chart in there somewhere, you know.

Question cont'd.: Thanks.

Thomas Reynolds: You're welcome, sir.

Question: My question is a little bit off task in regards to pandemics but could possibly be related.

There was a smallpox vaccination that was given to service member of the United States. I don't know if he was army, navy, marines or what he was but he came home and he was playing with his 28 months old baby boy on a four-day leave and the boy became infected and had a severe case.

Can you speak to that, please?

Jim Schwendinger: I'm sorry. That's really beyond the scope of this call. I mean, we certainly are aware and we were involved in that case, you know, work of the management.

Please email me that question and I can give you particulars. I mean, I'm not trying to, you know, leave the question. It's just we got, you know, we really kind of put the word out about this call. I was talking about the, you know, more high level kind of response and that's really kind of a specific case.

But if you email us at coca@cdc.gov, I'll be happy to give you, you know, the background information that we have.

Question: Do you have the written procedure or some description you can provide us that tells us how you transfer from the center to the alert to the response phase so we can make sure our plans match up?

Thomas Reynolds: Absolutely.

We're going through the clearance process in our emergency operations plan and that should take about another month and then we can send it out to the state as soon it's been vetted through the CDC and HHS.

I don't have it right in hand right now. It will take about a month's time but I'll make sure that Jim gets it and put on the COCA Web site.

Question cont'd.: Okay. Along the same lines, we saw the duty statement and I think it was for the SMOs but will you have a little bit more definitive similar description so we can also make sure that our plans and procedures match up.

Thomas Reynolds: Absolutely. I do have that and I do have the statement of work for our SMOs out there in the field and I'll also have that posted to the COCA Web site.

Question: Texas Department of State Health Services. My question pertains to the technical specialty unit. The individuals that staff that unit, are they physically in the DEOC or they in their offices or just patch in when issues arise?

Thomas Reynolds: Excellent question. As you can well imagine, what we're trying to use is action officers here in the DEOC because we don't have space.

Some of our teams - what we call teams during a response are 20, 30 people that work together as a cohesive unit to try to mitigate the event.

We - for each of those boxes there, we have a space here in the DEOC that that person is responsible for any action for that particular action officer, whether it'd be epi or surveillance or, you know, clinician care or whatever the case may be, they're responsible to take that and give that to the team that's working behind them. They reach in to the organization and the team that's behind them that may be working in their offices or in a conference room somewhere else in CDC campuses is support to the DEOC.

Question: My question involves the primary response functions of the SMOs. I was wondering just like the previous questioner, that is - would that include personnel resources to assisting the field meeting team deployment if necessary?

Thomas Reynolds: Great question. Yes. They can coordinate some of that through the CDC DEOC and through the mission assignment process to the federal government and that would work through the joint field office that FEMA would set up during the disaster.

Their everyday function though for the senior management officials in the ground - on the ground is to work with their Department of Health on a multitude of issues.

Only during the response, do they roll into controlling CDC assets on the ground.

Question: On the technical specialty unit, did you call it?

Thomas Reynolds: Yes, that's what we call our scientific planning component.

Question cont'd: And I believe you just said that because of the size they made, they might actually be located slightly differently than in your DEOC.

Are you including your laboratory experts in that group?

Thomas Reynolds: Absolutely. In the first block under the infectious disease team, it includes all of our laboratory network that is out there to (LRN), our response and they tie into our CDC laboratories here is all inclusive in the TSU.

Question cont'd.: And in the material that you might be posting -- the procedures - plans and procedures you might be posting soon, will you also include a description of how that unit operate?

Thomas Reynolds: We can. We can give you what their roles and responsibilities are during our response in generics.

Coordinator: We have no further questions from the phone lines at this time.

Jim Schwendinger: Well, great.

I would just like to remind the listeners, thank you for - thank you first for participating and, you know, if you didn't have chance or you think of a question later, I know that I always think of five as soon as I hang up. You know, you can always email us at coca@cdc.gov and we've already worked out with Mr. DeSantis and Mr. Reynolds that they will kindly answer the ones that are specific to the presentation today.

Also remind you that the audio track of this conference will on the Web pretty shortly. We already have the slides there and, you know, in a timely manner, we'll have a transcript posted.

And, you know, again, email us at coca@cdc.gov and we can get those answers for you and I will turn it back over to Jane who will talk about the replay number. But thank you again for participating and please stay tuned for details of our next COCA conference call.

Coordinator: Thank you. And again, as a reminder, if you would like to listen to the replay of this call, the dial in number is 866-483-9031. Again, that replay number 866-483-9031.

That concludes today’s conference. Thank you for participating. You may disconnect at this time.

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