

Bulletin

INTERNATIONAL ASSOCIATION OF EMERGENCY MANAGERS

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“Public Health & Disaster Response, Part 1” appeared in the May 2006 IAEM Bulletin.

Call for Articles
Special Focus Issue:
“Technology & Research in Emergency Management”
Copy deadline:
June 10, 2006
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Special Focus Issue:

Public Health & Disaster Response, Part 2

Think Theme Park Lines and Time Motion Studies: A New Approach to Exercising SNS Plans

By Kathleen Henning, MA, CEM,
IAEM Region 3 President, KGHenning & Associates

It is critically important to exercise all aspects of the disaster plan, and that includes testing the effectiveness of clinic procedures anticipated for a catastrophic response to a bioterrorist event. The public health scenarios for responding to smallpox, plague, anthrax, various potential bioterrorist agents and even pandemic influenza are being played out across the country as public safety officials test their plans for distribution of the Strategic National Stockpile.

Montgomery County, Maryland is located in the National Capital Region,

an area of high risk for potential terrorist events. On June 21, 2004, the county conducted *Dagwood*, a smallpox exercise to test the mass dispensing/vaccination components of their emergency plan.

In an actual event, public health and public safety officials would be required to effectively move millions of medical supplies toward people in a race against the clock. In the *Dagwood* exercise, staff from 23 local government departments and agencies, federal and state

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IAEM: Working for You

■ **House Appropriations Committee Votes for Increase in EMPG Funding.** On May 17, the full U.S. House Appropriations Committee completed its deliberations on the U.S. Dept. of Homeland Security appropriations bill. In a “managers” amendment passed by the full committee, an additional \$6 million in Emergency Management Performance Grant (EMPG) funding was added to the Homeland Security Subcommittee’s markup of \$180 million. This brings the total appropriation for EMPG in the House to \$186 million, a \$16 million increase over the Administration’s request.

■ **IAEM and Partners Request Increase in EMPG Funding.** IAEM and a number of its partners have sent joint

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Ontario Association of Emergency Managers Joins IAEM. On Apr. 28, members of OAEM voted to become a chapter of IAEM Canada. Pictured from left: OAEM Secretary-Treasurer Paula-Marie Jannetta; IAEM President Marg Verbeek, CEM; OAEM President Alain Normand; and IAEM Executive Director Beth Armstrong, CAE. See Pages 2-3.



From the President

Ontario Association of Emergency Managers Joins IAEM

*By Marg Verbeek, CEM, MCIP, IAEM President,
Manager of Emergency Measures, Regional Municipality of Waterloo,
Kitchener, Ontario, Canada*

So many of you have contacted me in recent weeks, not only to congratulate the Ontario Association of Emergency Managers (OAEM) for joining IAEM Canada, but also to find out just how we made it happen. So I wanted to write about it and share our success with you! I also want to say "thank you" to my colleagues in Canada, primarily in Ontario, who have contributed to champion this effort, as well to those who have sent such kind congratulatory messages. Thanks for the support and acknowledgment.

Well, it was nothing short of "history in the making" for our profession and organization at the Annual General Meeting of the Ontario Association of Emergency Managers (OAEM) on Apr. 27 in Toronto, Ontario. OAEM became the Ontario chapter of IAEM Canada.

While we do appreciate that it will take a bit of time to work out all the fine management details of our affiliation between the associations, this is great news for IAEM and emergency management professionals in Canada. Not only did we add more than 400 members to our organization, but we have now made major strides toward establishing one strong premier emergency management organization for Canadian practitioners.

At the Feb. 3 OAEM Board meeting, IAEM Canada President John Ash and I presented a proposal that OAEM would become a regional chapter of IAEM, that the President of OAEM would hold a seat on the

IAEM Canada Board, and that OAEM would continue to exercise autonomy in addressing provincial issues. The Board unanimously supported these motions and tabled them for their upcoming AGM.

While Paula-Marie Jannetta (IAEM Canada's Secretary-Treasurer filling in for vacationing President John Ash) presented the proposal to OAEM members, both Beth Armstrong and I answered numerous questions and provided the historical context of how this initiative on Apr. 27 came to be.

I am very proud of the accomplishments of OAEM to date, and may I suggest that you check out their Web site at www.iaem.ca. OAEM just might become our most active chapter! May you be challenged to undertake as many initiatives in your region as OAEM has. OAEM President Alain Normand is to be commended for his leadership, vision and courage in merging his successful association into IAEM Canada.

You know that it is so hard for me to hold back my enthusiasm! To say that I am thrilled is an understatement. I am deeply proud! This effort was many years in the making. Back in September 1996, I approached IAEM President Jerry VeHaun and IAEM Executive Director Beth Armstrong, and asked for consideration to create and establish NCEM Canada. I also became aware that one of my Canadian colleagues (Mark Bennett, formerly from Manitoba) had essentially proposed the same idea some time earlier. Both of us had come to the same realization that the time was right to establish one

emergency managers association in Canada. I am most grateful this request was then headed for deliberations by the Board of Directors. It was a defining moment for our organization, I thought, as we evolved into becoming international. This, among other initiatives, soon led to the name change from NCEM to

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OAEM Joins IAEM for Single Largest Membership Jump in IAEM History

Joint IAEM-OAEM News Release

On Apr. 28, the members of the Ontario Association of Emergency Managers (OAEM) voted to become a chapter of IAEM Canada. "This is the single largest membership jump in IAEM's history, adding more than 400 new members," said IAEM Executive Director Beth Armstrong, CAE, on hand for the deliberations. "IAEM is committed to the new partnership with OAEM to deliver membership benefits for emergency management professionals throughout North America and the world." Armstrong indicated that

this includes additional representation for Canadians on the IAEM Board of Directors, as membership numbers warrant.

IAEM President Marg Verbeek, CEM, also a past president of OAEM, noted that this merger has been in the works for several years, since IAEM began development of its internationalization plan. "We envision the next step is adding a new level to the IAEM governance structure which would ensure that the organization is serving all constituencies globally," she noted. This would take the form of a body such as a "World Council" with seats for each member country or continent comprising IAEM. OAEM President Alain Normand facilitated the

action, which included a mandate that the OAEM Board of Directors work in partnership with IAEM Canada to formulate administrative details to support the decision. "OAEM goals are to encourage the growth and expansion of the association, to continue improving the level of service to our members, and to foster greater recognition of the field of emergency management as a profession," said Normand. "The action taken yesterday is in perfect sync with these goals." For more information about the Ontario Association of Emergency Managers, visit their Web site at www.oaem.ca, or contact Alain Normand at president2006@oaem.ca.

From the President

(continued from page 2)

IAEM. While I attended my first IAEM Annual Conference in October 1996 in Anchorage, Alaska, the Board decided to create an International Region and not NCEM Canada. So my work and the challenges of becoming the first International Regional President, while hoping to create NCEM Canada, had begun.

How fortunate I am to have had so many colleagues share the vision of creating IAEM Canada (just back in October 2005) and working together to make this happen. There is essentially more leverage and momentum now to entice other provinces, territories or regions in Canada who have existing emergency managers associations to join IAEM (Canada).

IAEM Canada President John Ash and his executive team are off to a great start, have a proposed

draft governance model in mind, and continue to collaborate with their colleagues

across this country to gauge the interest in becoming part of IAEM Canada. I believe that more IAEM Canada success will prevail, and I look forward to the upcoming IAEM Canada Annual Membership Meeting, set for June 18 during the World Conference on Disaster Management.

May this effort inspire you and perhaps serve as a model in your

region or country to create an IAEM legacy.



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Public Health Innovations in North Carolina

By Sharon Pigott, CPDM, Local Technical Assistance & Training, NC Division of Public Health

North Carolina Public Health has gone from an unrecognized emergency management resource in 1999 to a welcomed partner today. Among other accomplishments, this evolving partnership has enabled North Carolina to develop one of the first state comprehensive pandemic flu plans (www.epi.state.nc.us/epi/gcdc/pandemic.html). Here are some highlights of how it happened.

It Began With Floyd

Hurricane Floyd came ashore in North Carolina in September 1999, flooding 31 of the state's 100 counties. The N.C. Division of Public Health (NCDPH) activated 24 hours before landfall and staffed the state EOC 24 hours a day for more than three weeks, despite the fact that there was not even a public health desk in the facility! While the state already had a Bioterrorism Task Force, NCDPH and North Carolina Emergency Management (NCEM) lacked the structures and procedures to work together on other issues. Functioning in an ad hoc arrangement, 60+ NCDPH staff and approximately 300 volunteer nurses were deployed to the affected area over a period of three weeks. Transportation was frequently by helicopter, because of the impassability of virtually all roads.

The First Anthrax Case

In September 2001, a Florida man visiting North Carolina began to feel ill and returned to his home. A week later, he was confirmed as the first known case of a now-recognized series of deliberate anthrax attacks. NCDPH began an intensive investigation, assisted by state and federal law enforcement, public and private health providers, the CDC and Florida public health

authorities. NCDPH officials (now Public Health Preparedness and Response) were instrumental in the investigation of this case. This experience proved valuable two years later, as the state investigated nine suspected SARS cases (one confirmed).

One of the most important outcomes of the anthrax attacks was a recognition at local, state and federal levels that public health and emergency management truly needed to be partners. North Carolina has since established a Public Health Command Center that is activated for outbreaks, hurricanes and other emergencies with a public health component. This command center coordinates with the state EOC through the public health desk that now exists there. At this point, any activation of the state EOC includes a public health presence.

N.C. Public Health Innovations In Emergency Response

■ Seven public health regional surveillance teams have been established and strategically located across the state. Whenever there is an emergency or outbreak, these teams become a vital resource "on the ground" in the response or investigation. In addition, many of the state's local health departments have a public health preparedness coordinator on staff.

■ North Carolina has three new public health laboratories supplementing the "main" lab in Raleigh, the state capital. Suspicious samples can be tested much more quickly with less law enforcement time needed for transport (an issue identified when hundreds of "anthrax-suspicious" samples had to be transported to Raleigh). BSL-3 capability at the main lab and two of the regional labs will allow quicker response than sending samples to the CDC.

■ North Carolina's innovations are providing benefits to other states as well. Within 24-48 hours of hurricane landfall, community health and needs assessment teams are activated and deployed. These teams deployed to Florida in 2004 and 2005 and to the Gulf region in 2006. The teams are equipped with hand-held computers containing GIS and special software, which enable them to conduct reliable assessments and quickly produce useful data for decision makers.

Where Do We Go From Here?

Since 2003, Trust for America's Health has assessed state health preparedness, measuring different indicators each year. North Carolina has achieved 5-9 of 10 indicators, earning rankings from mid-pack to the top slot. At this point, though, most of NCDPH's response capability and awareness is concentrated in two programs. NCEM is reaching out to include other areas in discussions and decisions. For instance, task forces that include representatives from NCEM, NCDPH, Social Services, Mental Health, the Division of Aging and others are currently working on mass sheltering and special needs sheltering plans.

NCDPH has raised awareness of EM issues throughout its organization. Staff at all levels are training in ICS, and there is a growing recognition that emergencies could impact any or all aspects of public health. Response capabilities are better than ever, whether dealing with traditional hazards such as hurricanes or planning for emerging threats such as pandemic flu. With emergency management as a partner, North Carolina Public Health will be able to provide quick, effective and compassionate response to residents impacted by emergencies or disasters of all types.

Water Quality and Public Health

By Gregory W. Solecki, CEM, Disaster Services Officer,
City of Calgary Disaster Services, Calgary, Alberta, Canada

With all the risks inherent at water treatment facilities, it is imperative that an emergency response plan is in place to include water quality incidents that affect public health. We only have to look at the past decade of water crises in North America to find examples of catastrophic health-related events. A well-coordinated and practiced emergency response plan that incorporates the local public health authority not only enhances emergency response, but also facilitates prevention.

Walkerton, Ontario Crisis

In May 2000, Walkerton, Ontario experienced the worst contaminated water crisis in Canadian history, as half of the town's population became ill and seven people died. The water system was supplied by three ground water wells. Daily routine checks by employees of the water utility included gathering test samples that could indicate problems with water quality, including the deadly E.coli bacteria.

On May 17, the utility was advised of positive test results from the regional private laboratory that indicated high levels of E.coli. The first indication of sickness was on May 18, when school children and residents of a retirement home became ill. On

May 19, the local Public Health Region contacted facility employees, but were not given any indication that there were any problems with the water. The illness spread quickly throughout the town, and the first death was on May 22.

The local Public Health Region shocked the country by alluding to the fact that the utility knew about the contamination days prior. The local health unit was able to issue a boil water advisory, but notification was very limited and marginal at best. The municipality's mayor was notified, and although an emergency response plan was in place, it was not activated and there were not any further actions.

Milwaukee Crisis

Similarly in the United States in the early 1990s, a waterborne disease outbreak in Milwaukee resulted in 400,000 people infected and 100 dead. The crisis began when the microbe *Cryptosporidium* (the bug also known as "Beaver Fever") made it through the city's water filtration system into the water supply. *Cryptosporidium* is an intestinal parasite found in surface water. Conventional water treatment methods, such as chlorine, will not kill it. Instead it must be filtered out. It is estimated that the outbreak cost \$131 million in treatment of the illness and lost productivity.

Calgary, Alberta Crisis

Aside from water quality issues, the public health authority may have to deal with another type of water crisis. In Calgary, Alberta, during the month of February 2004, a major feedermain burst, depriving the northeast portion of the city of a potable water supply. This area of the city also contains a public health care facility that at

any given time houses 500 patients and 2,000 employees. The critical nature of a water supply became evident, as the hospital not only uses water for consumption, cleaning, cooking, waste removal and oxygen delivery, but also for its hydronic heating system. This left the facility with a major dilemma, because if a water supply is not available within a certain amount of time, countless problems and crises will have to be addressed. The public health care facility operators had a small window of opportunity in order to decide whether to evacuate patients and staff to alternate facilities. In the end, water pressure in the immediate area was restored within hours, which was just enough time for the hospital to rescind activation of their emergency evacuation plan.

Strategies To Keep in Mind

Water impacts public health in critical ways, and there are various strategies to keep in mind when developing relationships between the local health authority and water facilities. These include:

- Identify trigger events that would prompt an emergency. These could be mechanical failures at the water facility or contaminants in the water supply or distribution system.
- Ensure the availability of 24-hour current contact information for facility and health care professionals.
- Make sure both parties are aware of federal and state/provincial regulations and guidelines.
- Involve each other in operational meetings.
- Develop tabletop exercises with scenarios such as the ones described above.

Water facilities are responsible

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IAEM 2006 Mid-Year Meeting

June 2-4, 2006
National Emergency
Training Center
Emmitsburg, Maryland

News and photos from the IAEM
Mid-Year Meeting will appear in the
July 2006 IAEM Bulletin.

New Approach to Exercising SNS Plans

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agencies, public schools, statewide public health officials and the University of Maryland partnered to plan, implement and evaluate the event. Dagwood involved four assembly/staging sites, use of public school buses, a mass vaccination clinic at Kennedy High School, an on-site Unified Command Post, the Public Health Center Command Post, a Joint Information Center and activation of the County's Emergency Operations Center. Five area hospitals tested their disaster plans simultaneously. Time motion was evaluated as part of the overall evaluation strategy.

Time Motion Study

Theme parks have a reputation for managing the movement of adults and children, keeping folks directed toward the main event despite long lines. The better managed parks have studied the most effective movement of people, and often provide distractions or "educational" displays along the way as people are skillfully moved from station to station. Public health officials and emergency managers can take a lesson from theme parks.

The Montgomery County exercise moved more than 700 participants through triage, registration, education, medical screening and simulated vaccinations or alternative intervention. To better evaluate the design of the clinic, a time motion study was conducted by Daniel Cook and Dr. Jeffrey Herrmann of the Institute for Systems Research by the University of Maryland. The team used a number of university students to assist in testing patient flow efficiency. Students under the direction of the institute were stationed at various areas to monitor patient flow through the

use of timestamp forms distributed to each patient. Forms were given to the patients on arrival and stamped at six key locations. Video cameras recorded specific processes for evaluation and training purposes.

The patient distribution between arrival and leaving times varied. The exercise design team built in a patient surge as part of the exercise. During the surge, the average time in the clinic increased from 45 minutes to a maximum of 90 minutes and then decreased back to 45 minutes. Results from the Cook-Herrmann study identified the average time spent not only in the clinic, but also time spent at the various stations in the clinic and time spent walking and waiting. Based on the field data collected, a clinic capacity analysis was done. The analysis looked at average processing time and the number of personnel assigned to various tasks. Specific attention was given to patient lines. Results from the Cook-Herrmann study identified areas of excess capacity, as well as problem areas and stations with adequate capacity that would need careful management.

Simulation Models Enhance Field Studies

The study was conducted over a period of just under two hours. Workers commented on problems with the highly uncomfortable cafeteria tables and suggested changes for proposed 12-hour shifts. This suggested that fatigue and reduced efficiency would have occurred if the study had proceeded for longer than its allotted time. The institute has since used simulation modeling "to predict changes to clinic performance under different scenarios, as well as to identify better clinic configurations."

Partner with Universities

Public health officials and emergency managers are encouraged to establish similar partner-

ships with universities to do time motion studies for their exercises. Based on the Cook-Herrmann study, changes have been made to the Montgomery County, Md., SNS plan for layout, staffing, signage and time allocations for key stations in community distribution clinics. The exercise received a NACo Achievement Award and was recently honored in Montgomery's Best Awards. The county continues to partner with the University of Maryland, and time motion studies are being considered for future exercises. This project, in close collaboration with the Montgomery County Public Health Services, has yielded the Clinic Planning Model Generator. It can be downloaded from the University of Maryland Web site at www.isr.umd.edu/Labs/CIM/projects/clinic/.

Water Quality

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for delivering safe, potable drinking water, while health authorities are responsible for the well-being of the communities that the facilities serve. As with so many other types of crises, it is much easier to make the contacts, develop the relationships and practice the response prior to a potential water quality disaster.

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Protecting the Public in the Event of a Microbial Assault: A Hard Pill to Swallow!

By James C. Hagen, PhD, MBA, MPH, CERC, Certified Emergency Response Coordinator, Director, Public and Non-Profit Management Programs, Professor of Public Health, Saint Xavier University, and Beverly Parota, MEd, MBA, CERC, CPHA

There is great controversy, and an increasing level of confusion, concerning the best mechanism to prepare for mass infection through natural (i.e. pandemic) or manmade (i.e. bioterrorist) means. This potentiality has caused the worlds of emergency response and public health to intersect in ways not experienced previously. New diseases and re-emergence of old killers have resulted in heightened awareness and the demand for shortened response time in the health sector. The reality and threat of terrorism and natural disasters in our nation have increased recognition of the lack of adequate communications (both vertically and horizontally) and the need for improved emergency management.

Bioterrorism and the potential for pandemics have caused the sectors of health and emergency response to collide, and have forced interactions that will result in protection of both our first responders and the community. In these events, there will be a need for mass use of antibacterial and/or antiviral agents.

The Original Idea: Movement of Masses to Dispensing Sites

The primary goal of any government is to protect residents. In a public health emergency, all branches of government must take steps to ensure that medications are rapidly dispensed. Large scale dispensing sites were proposed throughout the population, which in some cases would result in 150,000 to 200,000 people obtaining antibiotics from one site. Logistics, staffing of such a site and law enforcement issues eventually made this option untenable.

To segment the population, plans to operate municipality-based "mega sites" were developed. Utilizing geopolitical units was seen to be the most logical means to assure control over the various departments and sectors that would be required to interact. Tens of thousands of people would be expected to pass through these locations. Extensive cooperative planning would be required by emergency management, local governments, law enforcement, fire, public works, site personnel, public health and the health care community. Utilization of hundreds of trained non-emergency workers and volunteers is required to ensure the success of such an operation. The Cities Readiness Initiative (CRI) calls for all residents to receive antimicrobials within 48 hours of the identification of the causative agent.

Major issues identified include: stressing local law enforcement; assuring the safety and security of residents, the site and hospitals; communities sharing control and resources; volunteering as a responsibility of all citizens; identified staff requiring training and timely retraining; the need for accurate and consistent media messages; liability and insurance for workers; and legal concerns related to non-medical personnel dispensing medications.

Movement of Antimicrobials To the Public

It would seem logical that to avoid all of the issues associated with mass gatherings, antimicrobials might be directly moved to the public. "Just-in-time," or prophylactic placement of, drugs in each household might be possible. The postal service was examined as the

only entity already capable of reaching the majority of the population within one day. Drugs might be provided to each household to initially protect residents until longer-term antibiotics could be dispensed if needed. Safety of postal workers, misuse of antimicrobials, potential side effects and communication issues are of most serious concern. Another option might be to place a sealed package of antimicrobials in each household, not to be opened until instructed. The same concerns of "just-in-time" delivery apply. Homeless and other vulnerable populations would be handled through alternate means.

The Challenge

In the event of mass infection, traditional public health methods utilizing surveillance and disease tracking would be replaced by demand for mass use of antimicrobial agents for protection. Public outcry, panic and media messages would hasten the need for providing medications to everyone, not just those exposed.

The general public, first responders and health sector professionals question the ability to obtain or dispense medications within the required time frames. New diseases have surfaced which may or may not have related medications in the federal drug caches. Success of plans is based on heads-of-household obtaining medications. Emergency workers and volunteers may be unavailable. Police may be unable to protect residents and the sites. Community resources will be quickly depleted.

There must be serious innovative thought and a unified plan to

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Building an Effective Response

Tips for Integrating Public Health Into Emergency Response

By Thomas E. Poulin, ABD, Adjunct Faculty, University of Richmond and Old Dominion University, Battalion Chief, Virginia Beach Fire Department, Virginia

With the threat of avian flu, public health systems are exploring means of providing effective response should a crisis arise. Public health agencies are often called upon to provide services and guidance to other agencies and the public after a disaster. Public health has not been commonly associated with on-scene first response, which may affect their ability to integrate into emergency operations. They may do so more effectively by applying virtual organization theory.

Response to an emergency, especially a large-scale incident, requires the concerted efforts of organizations that typically have little contact. In effect, they create a new organization, developed to serve together a limited time for a specific mission – a virtual organization. A basic knowledge of virtual organizations may be critical to successfully integrating public health into emergency response.

Basic Components to Virtual Organization Development

There are five basic components to virtual organization development: communications, knowledge management, technology, quick trust and a common mission.

■ **Communications.** Communications interoperability is a major issue impacting response. While the issue often focuses on first responder agencies, clearly each part of a virtual organization must be capable of communicating. There are various means of achieving this, including common radio systems and cellular phones or something as archaic as the use of runners. Any effective plan for integrating public health into a

virtual organization must include a means of transmitting information.

■ **Knowledge Management.** Communications deals with the technological ability to communicate, while knowledge management deals with the interpersonal capacity to share information. Effective virtual organizations maintain open communications channels, permitting the free flow of information. It isn't just about speaking to one another; it is about sharing the right information at the right time. To integrate public health into emergency response effectively, processes and relationships to share information must be developed. One means of facilitating this is developing informal, collaborative relationships between people from differing agencies prior to a disaster and limiting the use of professional jargon.

■ **Technology.** When agencies from different backgrounds come together, it is likely they will have different technologies. This is not solely when the agencies provide different services, such as law enforcement and health care, but also when agencies have differing operational needs or purchasing systems. Illustrative of this, all fire departments use breathing apparatus but, depending on the manufacturers, they may not be able to share air cylinders. One means of addressing such technological differences is to organize tasks in the virtual organization along the lines of component agencies. Whatever means is to be used, it will be more effective if it is planned, communicated and exercised beforehand.

■ **Quick Trust.** Typically, trust is built over time, relating to shared experiences. Quick trust is different, emerging rapidly among strangers. It is founded on professional respect for the qualifications

of those in other fields or on the reputations of the agencies involved. Quick trust differs from trust in two fundamental ways. Not only does it appear rapidly, it is far more fragile. While professionals coming together into a virtual organization may initially trust one another, a simple error may shatter the quick trust irreparably. Quick trust may be facilitated through the development of appropriate position requirements for all personnel, by the clear definition of roles, and through pre-incident, multi-organizational training.

■ **Common Mission.** In normal times, each organization has its own mission – its own measure of success. Virtual organizations created to meet the demands of a large-scale disaster require each individual agency to modify or change its sense of normalcy to meet new demands. When other factors impacting the development of virtual organizations fail, the organization may yet be sustained by focusing on a shared goal. If the organization is running well, a clearly identified common vision aids in focusing all efforts. If the organization is beginning to collapse, a clearly identified common mission may at least keep all disparate parts working in the same direction until the mission is accomplished.

Summary

Public health systems play a vital role in disaster response, not just during events involving pandemics or epidemics. The staff, resources and technical expertise they bring into play makes them invaluable parts of any emergency response. As disparate components, individual agencies must

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Collaboration Enhances Response in Arlington, Virginia

By Donna Caruso, Chief, School Health Bureau,
Arlington Dept. of Human Services, Public Health Division, Arlington, VA

Before Sept. 11, 2001, and the ensuing anthrax incidents and fears of smallpox, few people were aware that their local health departments existed. They knew even less about their work and how they respond to disasters. Almost no one thought of health departments as first responders. Since then, public health has become a recognized member of the emergency management team in Arlington, Va. Response to the anthrax events in the metropolitan area provided some realization of the health department's role in disaster response. However, it has been more difficult for the traditional first responder community to understand the roles, responsibilities and culture of public health. Understanding the first responder role of public health takes time and education.

How Our Partnerships Began

We began the educational process about our role as "first responder" serendipitously in 2003, when a teacher in a local middle school died suddenly of meningococcal disease. Two days before his death, he attended an overnight school "lock-in" event with 120-some students, parents, school staff and county recreation staff. The county manager determined this was a good opportunity to use incident command to handle the situation. Thus, the county emergency management team, school staff, public health staff, police, fire and public relations were called into action. This strategy, bumpy as it was, proved to be effective and educational for all.

Public health staff had previously had little training in incident management and were astounded at the additional resources available to them to manage this tragic and potentially dangerous situation.

A large contact investigation was organized, a medication dispensing clinic was set up, and risk communication teams proactively provided information to students, parents, schools, parks and recreation staff, and the community. The public remained calm, investigations were completed efficiently, and those needing it were given medication.

This was a great learning experience for public health, police and fire departments in partnering to respond to an emergency. We all realized that there were many differences in our agencies' procedures, languages and cultures. For instance, our law enforcement partners didn't quite understand our decision points and reasons for waiting for definite lab results. Why did we need to wait for confirmation of meningococcal bacteria to give medications to those who were potentially exposed? Why not just medicate everybody? We, on the other hand, did not wish to unnecessarily expose children and adults to medications with potential harmful side effects. Knowing the incubation period of the disease, we knew that we could afford to wait. At the same time, public health staff did not clearly understand how police and fire operated. It was the first of many opportunities to learn to work together.

Planning for the Future

Although public health had always played a role in the county emergency response system, it became clearer that with emerging biological threats, public health will need to play a greater role than before – even taking the lead in a public health emergency response. With this in mind, a nursing manager from public health was assigned to be public health liaison to the county Office for Emergency Management (OEM).

During this two-year assignment, she worked to help educate OEM team members about public health, how it operates, its language and the sharing of information about specific diseases or concerns. She also informed OEM members about current public health issues. In turn, the nurse was learning about emergency management and about the culture and language of public health's primary partners – law enforcement and firefighters/emergency medical services. This mutual understanding has proven to be helpful in improving communication among partners and has created a more productive team effort during responses.

We have continued working together toward mutual understanding and collaboration. For instance, representatives from police, fire and public health drafted a procedure for joint response to suspicious powders, and partnered in a number of tabletops, training and exercises, including dispensing site exercises and real events. In 2005, the health department obtained a one-year grant to fund a full-time public health staff person to spend a year in the OEM facilitating cross-cultural training between public health and its partners. This public health nurse worked with fire and police department representatives to identify gaps in knowledge about public health and provide training on basic disease prevention and control. She also worked within the OEM office to help coordinate the local response to Katrina.

We believe that the continuous effort to learn more about each other and to increase our work together as a team has made Arlington unique, in that public health has really good communication channels and works well with its other emergency response partners.

CEM® Policy Changes

Several CEM® policy changes have been implemented by the CEM® Commission with approval by the IAEM Board of Directors. If you have not already submitted your CEM® credentials or recertification credentials for review by the CEM® Commission (next review meeting occurs June 2-4), you must use the updated application booklets which indicate “Version 05-11-06” on the bottom righthand corner of each page. If you need an updated version of each application package, please e-mail Sharon Kelly at info@iaem.com. Also the “Appendix A – Sample Training Allocations Chart” has been updated significantly and is available at www.iaem.com/certification/generalinfo/documents/trainingallocation2006.xls.

Recent policy changes include:

- Application packages that are

not typed, inserted in a three-ring binder and properly tabbed will be returned to candidates, and not considered.

- The reference requirement was amended allowing any current CEM® to serve as a reference in lieu of the candidate’s supervisor for those candidates who do not have a direct supervisor, such as an independent consultant or president/CEO of an organization. (The “Reference” forms should also include “after-hours” contact information for references.)

- Use of a master’s degree to satisfy general management training for initial certification can have been earned more than 10 years ago.

- The category of “Membership” under the Professional Contributions requirement was amended to delete the statement that organizations without the term

“emergency management” do not qualify. The basis of qualification for this contribution is the organization’s mission, which should be concerned about one or more phases of emergency management and consistent with the protection of life and property from disaster. If the mission of the organization is not apparent by its title, it should be provided in verifiable format (such as from the organization’s web site). The scope of the organization should be state/provincial, national or international.

- A copy of each course syllabus or curriculum outline is required as part of the training documentation for courses that are not on the “CEM® Training Allocations Chart.”

- One full day of training receives 6 hours credit per day, unless otherwise documented.

About the Certified Emergency Manager® Program

IAEM created the Certified Emergency Manager® Program to raise and maintain professional standards. It is an internationally recognized program that certifies achievements within the emergency management profession. CEM® certification is a peer review process administered through the International Association of Emergency Managers. You do not have to be an IAEM member to be certified, although IAEM membership does offer you a number of benefits that can assist you through the certification process. Certification is maintained in five-year cycles.

The CEM® Program is served by a CEM® Commission that is composed of emergency management professionals, including representatives from allied fields, education, the military and private industry.

Development of the CEM®

Program was supported by the Federal Emergency Management Agency (FEMA), the National Emergency Management Association (NEMA), and a host of allied organizations.

Here are just a few of the reasons why many employers now list the CEM® as a job requirement when posting open positions for emergency managers:

- A Certified Emergency Manager® (CEM®) has the knowledge, skills and ability to effectively manage a comprehensive emergency management program.

- A CEM® has a working knowledge of all the basic tenets of emergency management, including mitigation, preparedness, response and recovery.

- A CEM® has experience and knowledge of interagency and community-wide participation in planning, coordination and management functions designed to improve

emergency management capabilities.

- A CEM® can effectively accomplish the goals and objectives of any emergency management program in all environments with little or no additional training orientation.

There are many reasons why emergency managers decide to pursue certification as a Certified Emergency Manager®. Here are some of the benefits:

- To receive recognition of professional competence.

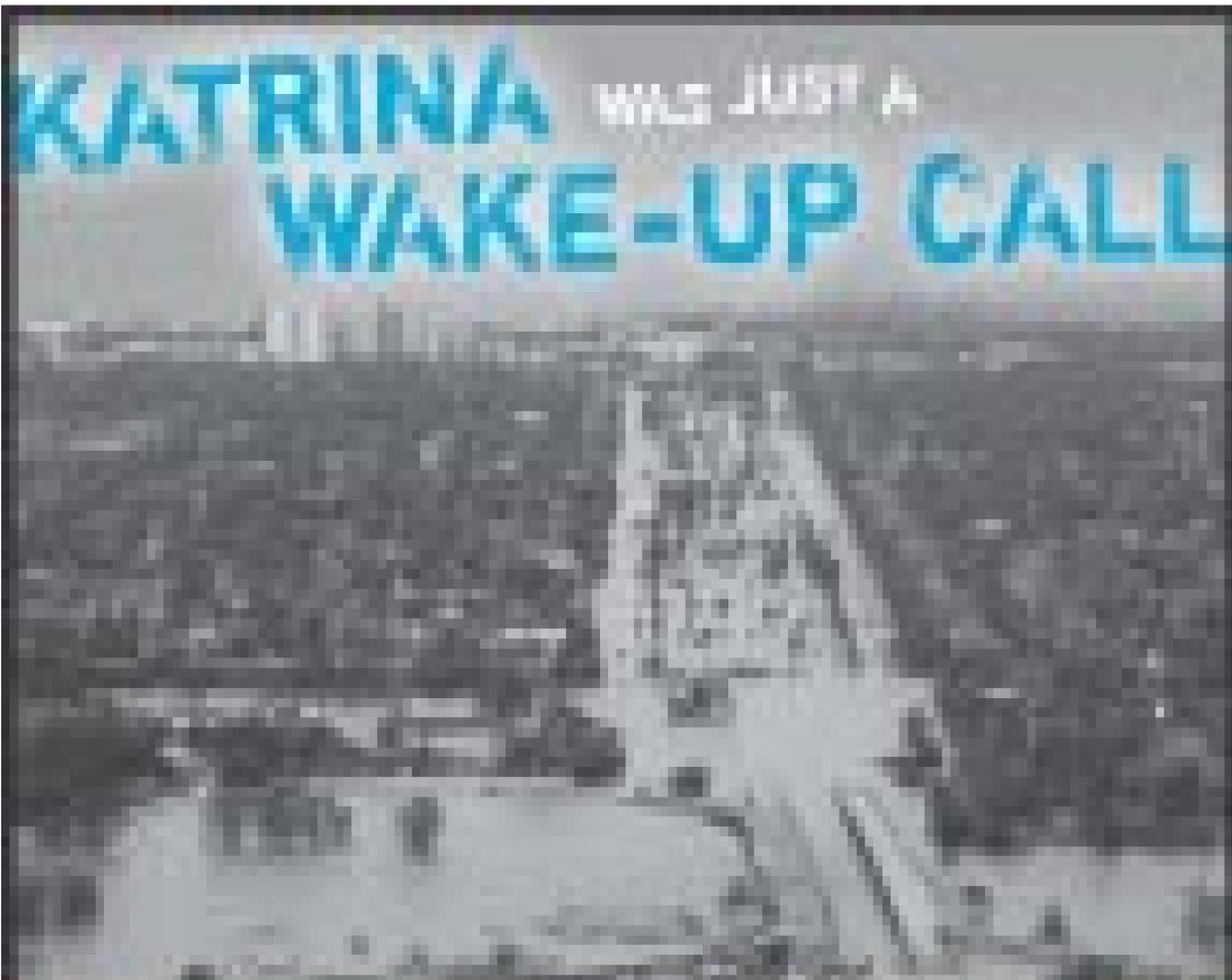
- To join an established network of credentialed professionals.

- To take advantage of enhanced career opportunities.

- To gain access to career development counseling.

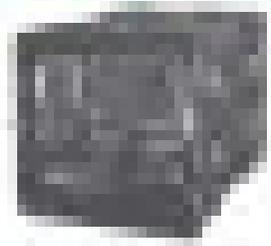
- To obtain formal recognition of educational activities.

Learn more about the CEM® Program at www.iaem.com.



Are your communications systems ready for a decade of disaster?

Examining the various communication technologies used in 2005, we analyze the specific problems that communications during a crisis experienced. We investigate the various communication technologies used in 2005, and we analyze the specific problems that communications during a crisis experienced. We investigate the various communication technologies used in 2005, and we analyze the specific problems that communications during a crisis experienced.



What do you expect to happen in the next decade?

What do you expect to happen in the next decade? What do you expect to happen in the next decade? What do you expect to happen in the next decade?

REGOR LLP

Bulletin Extended Online Edition

There's more to this month's *IAEM Bulletin* than what arrives in your mailbox. Download your copy of the **extended electronic edition** of this issue on the *IAEM Bulletin* page in the Members Only area at www.iaem.com.

Extra material in the online version includes:

- ["Upcoming Grant Deadlines,"](#) compiled by Suzanne Boccia, Booz Allen Hamilton.
- ["The Role of Public Health in Disaster Response,"](#) by Lawrence R. "Mac" McKeough, CEM, Joplin Health Dept.
- ["The Need for Universal First Responder Credentials,"](#) by Robert Barnes, Robert B. Barnes Associates, Inc.
- ["Public Health Departments: Often a Neglected Entity in Disaster Response Planning,"](#) by Bob Sampe, Landstuhl Regional Medical Center, Germany.
- ["Non Traditional Roles for Dentists in Catastrophic Events,"](#) by David A. Williams, DDS, MSSM, MPH Candidate.
- ["Public Health Emergency Preparedness: Important, Yet Needing to Grow,"](#) by Patrick J. Lindner, MS, Saint Louis Co. Dept. of Health.
- ["Integration of Public Health](#)

[and Emergency Response: Getting Public Health to the Table,"](#) by Brendan McCluskey, New Jersey CBRNE Center for Training and Research.

- ["The Medical Reserve Corps: An Update,"](#) by Marna Hoard, Medical Reserve Corps Program, Office of the U.S. Surgeon General.
- ["National Interoperability Baseline Survey,"](#) by Kevin McGinnis, National Association of State EMS Officials.
- ["Pandemic Shut-Down,"](#) by Dr. Charles M. Solnik, EdgeTrack Solutions.
- ["The Importance of Evidence-Based Disaster Training,"](#) by Erik Auf der Heide, MD, MPH, FACEP, Agency for Toxic Substances and Disease Registry (ATSDR), U.S. Dept. for Health & Human Services.
- ["Quarantine: The Ethical Dilemma of Duty to Care,"](#) by Rebecca L. Sicheloff, NREMT-P, CRA, Inc.
- [IAEM New Member Listing, Apr. 16-May 15, 2006.](#)
- [New Certified Emergency Manager® Listing.](#)
- [IAEM Awards and Media Contest.](#)
- [E.M. News](#) and [Resources.](#)

Building An Effective Response

(continued from page 8)

unite into a virtual organization to achieve an effective response. To accomplish this, all agencies must realize that the integration process is not automatic. It requires a great deal of planning and patience. But if approached properly, these efforts may contribute to the development of the highly effective and efficient response organization the public expects.

Protecting the Public: Microbial Assault

(continued from page 7)

provide antimicrobial agents to all residents in the shortest time possible. We must decide on one mechanism and work toward that end. Different geographic areas and subpopulations cannot use drastically different methods. Public health and emergency management must work together to facilitate the cooperation necessary to make this happen.

Member News

■ **In Memory of John Laye.** IAEM members were saddened to hear of the loss of John Laye, 72, who passed away unexpectedly May 5. The managing partner at Contingency Management Consultants, Orinda, Calif., Laye was a long-time IAEM member and former chairman of the Public-Private Partnership Committee. Laye was one of the original team who developed the premier Integrated Emergency Management Course at the U.S. Dept. of Homeland Security's National Emergency Training Center (NETC), where he began lecturing on managing large-scale disruptive events in 1982. Much of what was introduced then is now standard practice. He was director emeritus of the business continuity certificate program at University of California at Berkeley, and was assistant professor of organizational and business continuity and survival at California State University. He was a past president of the California Emergency Services Association. Laye wrote the book *Avoiding Disaster – How to Keep Your Business Going When Catastrophe Strikes*, a university text and executive reference published by Wiley & Sons. Read career highlights and tributes at www.disaster-resource.com/newsletter/subpages/v135/meet_the_experts.htm.

■ **Retirement of Bob Johnson.** Long-time IAEM member J. Robert Johnson retired from his position as emergency manager for Sterling Heights, Mich., on May 31. For many years, Johnson was IAEM's "go to" person for family preparedness issues. He contributed to member knowledge by writing a column for the *IAEM Bulletin* for several years called "72 Hours." Johnson plans to stay on as Michigan Emergency Management Association President throughout 2006.

Share member news by e-mailing Editor Karen Thompson at thompson@iaem.com.

Association News

■ **Call for IAEM Officer Nominations.** IAEM members will elect a new First Vice President, Second Vice President and Secretary at the 2006 Annual Conference. Candidates must submit credentials by **Sept. 1, 2006** to IAEM Headquarters.

To be placed on the ballot, candidates must submit: a letter stating candidacy; a letter of permission from the immediate supervisor supporting the time and travel necessary to fulfill the duties of the office; a brief resume; and confirmation of membership of at least three consecutive years immediately prior to seeking office. Individual members are eligible to hold national office provided they have been a member for at least three consecutive years and have served as a regional or national officer, national committee chair or active national committee member for two consecutive years.

■ **Help Wanted: CEM Commission.** The CEM® Commission is looking for candidates for two to four openings for the Class of 2009, who will serve on the panel from November 2006 through November 2009. The CEM® Commission sets policies and procedures governing the certification program, and reviews packets of applicants for the CEM® (Certified Emergency Manager) and AEM (Associate Emergency Manager) credentials. Commissioners who are local practitioners must have earned the CEM®. If you're interested in serving, submit a letter of interest and a summary of your credentials to IAEM Headquarters by **July 3, 2006**. E-mail IAEM Membership Director Sharon Kelly at info@iaem.com for details.

IAEM Bulletin Call for Articles

Technology and Research in Emergency Management

The IAEM Editorial Committee has issued a Call for Articles for our next Special Focus Issue of the *IAEM Bulletin* on the topic of **Technology and Research in Emergency Management**. The deadline for article submissions is **June 10, 2006**. Please keep your articles under 750 words, and submit them to *IAEM Bulletin* Editor Karen Thompson at thompson@iaem.com. See detailed author's guidelines and advertising guidelines at www.iaem.com.

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IAEM: Working for You

(continued from page 1)

letters to the U.S. Senate and House Appropriations Subcommittees on Homeland Security, requesting an increase in Emergency Management Performance Grant (EMPG) funding. The Senate and House letters can be downloaded at www.iaem.com.

■ **IAEM Supports Paulison To Lead FEMA.** On May 17, IAEM submitted a letter to the U.S. Senate Committee on Homeland Security and Government Affairs in support of the nomination of R. David Paulison as the Under Secretary for Federal Emergency Management at the U.S. Dept. of Homeland Security. The letter can be downloaded at www.iaem.com.

■ **IAEM President Delivers Keynote at Disaster Resistant California Banquet.** The California Governor's Office of Emergency Services invited IAEM President Marg Verbeek, CEM, to be their keynote speaker at the Disaster Resistant California Banquet in San Francisco. The banquet was held during the 100th Anniversary Earthquake Conference in April. "Managing Risks in Earthquake Country" was the



IAEM President Marg Verbeek, CEM, and Thomas Lambert, Vice President and Chief of Police, Houston Metro, at the ITS America Annual Meeting. Lambert was installed as ITS America's Chairman of the Board during the conference.

conference's theme, commemorating the 1906 San Francisco Earthquake.

The conference was one-of-a-kind, as 3,500 earth scientists, earthquake engineers, emergency managers and policy makers joined together to explore how to better manage risk in earthquake country and to share what they know within their own disciplines. This highly successful conference was convened jointly by the Earthquake Engineering Research Institute, the Seismological Society of America and Disaster Resistant California.

■ **IAEM Represented at NCCC Focus Group.** IAEM Region 3 President Kathleen Henning, CEM, represented IAEM at the National Citizen Corps Council (NCCC) focus group on "Managing and Leveraging Volunteers in Times of Disaster," held Apr. 6-7 in New Orleans. She stated that her "major contribution, as the only emergency manager at the meeting, was to ensure that all the attending volunteer groups understood the importance of working within the existing EM system and establishing relationships prior to events." Henning noted that the group did pick up these points in their recommendations.

■ **IAEM President Speaks at ITS America 2006 Annual Meeting & Exposition.** The Intelligent Transportation Society of America held its Annual Meeting May 7-9 in Philadelphia, Pa. ITS' mission is to improve transportation by promoting research, deployment and operation of intelligent transportation systems through leadership and partnerships with public, private educational and consumer stakeholders.

IAEM President Marg Verbeek, CEM, participated on panels in the Homeland Security and Public Safety Forum, which focused on emergency management and evacuation. At the panel on



From left: Paul Jacks, Deputy Director, Governor's Office of Emergency Services; Marg Verbeek, CEM, IAEM President; and John Rowden, Hazard Mitigation Branch, Governor's Office of Emergency Services at the Disaster Resistant California Banquet.

"Emergency Management & Evacuation: A Multi-Perspective View," she shared information on IAEM, the role of emergency managers, the challenges we face, managing complex operations and evacuation considerations. At the panel on "The Emergency Operations Center View of Evacuation," she talked about the role of an EOC, its challenges and functions, and demonstrated emergency management software that she uses in her community.

In addition, she discussed partnership opportunities between IAEM and ITS with the incoming ITS Chairman of the Board Thomas Lambert.

■ **IAEM Represented at Asian Securitex 2006.** Victor Bai, the China national representative for the IAEM International Region, represented IAEM as a guest speaker at Asian Securitex 2006 in Hong Kong.

■ **IAEM Submits Comments on DHS Preparedness Directorate's Strategic Plan.** The U.S. Dept. of Homeland Security sought comments from IAEM members on its Preparedness Directorate Strategic Plan "Commitments in Principle." Member comments were compiled by Steve Detwiler.

E.M. Calendar

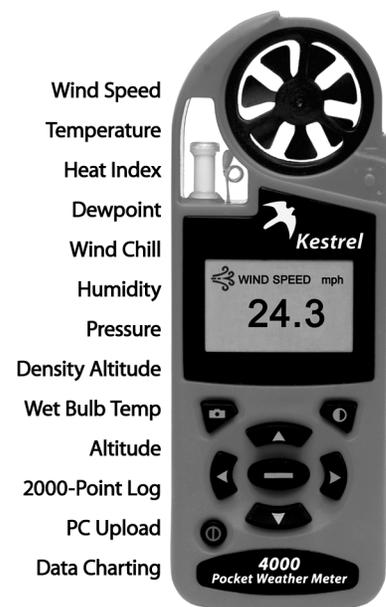
- May 31- June 3 National Conference on Animals in Disaster 2006, Arlington, VA, www.hsus.org/ncad06. Presented by Humane Society of the U.S.; **endorsed by IAEM.**
- June 2-4 **IAEM 2006 Mid-Year Meeting**, National Emergency Training Center, Emmitsburg, MD, www.iaem.com.
- June 18-21 16th World Conference on Disaster Management, "The Changing Face of Disaster Management: A Global Perspective," Toronto, Canada, www.wcdm.org. Presented by the Canadian Centre for Emergency Preparedness, IAEM, DRI International and DRI Canada. **Preferential rate for IAEM members** is \$895 CDN (about \$790 USD); use priority code "IAEM1295."
- June 18-20 National Conference on Volunteering & Service, Seattle, WA, www.volunteeringandservice.org.
- July 9-12 Hazards Research and Applications Workshop, Natural Hazards Center, www.colorado.edu/hazards/.
- June 19 Disaster Studies Workshop, Civil Emergency Management Centre, University of Hertfordshire, UK, www.britisoc.co.uk/specialisms/45.htm.
- June 19-21 New Zealand Security & Civil Defense Conference, Wellington, New Zealand, endorsed by IAEM, www.iir.com.au/conferences.
- July 11-13 Transportation Disaster Response: Family Assistance, National Transportation Safety Board Academy, Ashburn, VA, www.ntsb.gov.
- July 20-26 2006 International IMSA Conference, Overland Park, KS, www.imsasafety.org.
- Aug. 16-19 Chicago Fire Dept. 2006 Life Safety Conference, "Large Scale Incident Evacuations," Navy Pier, Chicago, IL, www.cfdconference.com.
- Sept. 6-8 8th Annual Technologies for Critical Incident Preparedness Conference & Expo, Atlanta, GA, <http://www.regonline.com/eventinfo.asp?EventId=88623>. Presented by DHS, DOJ, and DoD; IAEM is a conference co-sponsor.
- Sept. 10-16 International Conference on Infrastructure Development and the Environment, Abuja, Nigeria, www.iseg.giecs.uncc.edu/abuja2006/.
- Sept. 25-26 EMS EXPO 2006, co-located with National Association of EMTs Annual Meeting, Las Vegas, NV, www.publicsafetyevents.com/pub/ems/index.po. IAEM is a supporting organization of the expo.
- Oct. 11-13 IDER 2006, International Disaster & Emergency Resilience Conference & Exhibition, Italian Fire Service College, Rome, Italy, www.iderweb.org. IAEM supports the conference, and IAEM President Marg Verbeek, CEM, will be a speaker. For details on IAEM **group package** with discounted registration fees, contact Clay Tyeryar, IAEM Staff Executive, at ctyeryar@iaem.com.
- Oct. 18-19 IMF 2006: International Conference on IT-Incident Management & IT-Forensics, Stuttgart, Germany, www.gi-ev.de/fachbereiche/sicherheit/fg/sidar/imf/imf2006/index.html.
- Nov. 12-15 **IAEM 2006 Annual Conference & EMEX Exhibit**, "Going All the Way...Putting Plans Into Action," Orange County Convention Center, Orlando, FL, www.iaem.com.

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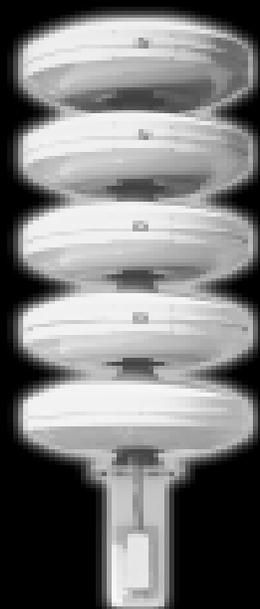
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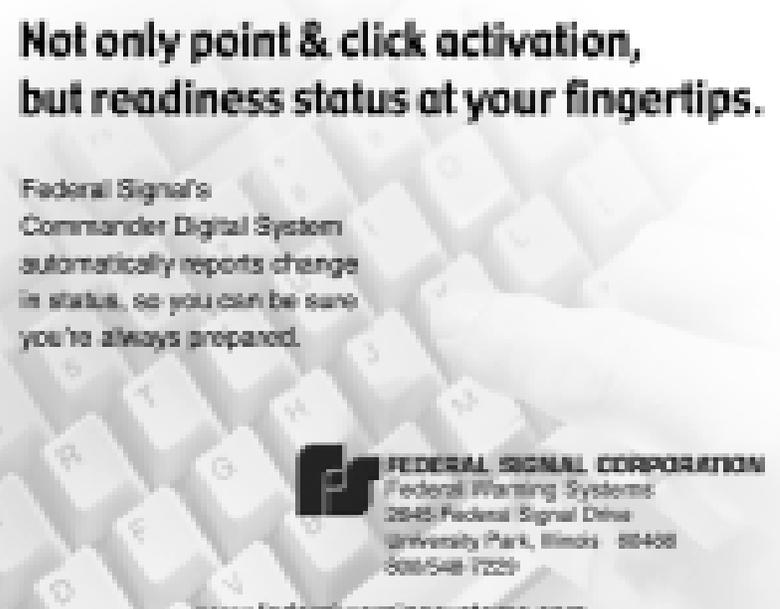
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- Representation on federal level working groups addressing vital issues such as terrorism preparedness, emergency management, program standards, communications, disaster assistance delivery, and others.

- A unified voice at the federal, state and local levels to educate decision makers about the impact of policies and legislation on emergency management services.

- The *IAEM Bulletin*, a monthly newsletter that is the definitive source for emergency management news and information.

- Conferences and workshops to enhance networking and inform members about legislative issues. Our Annual Conference and EMEX Exhibit offers

networking and information on current emergency management issues. Our Mid-Year Workshop, held in the Washington, D.C., area, focuses on committee work and federal legislative issues. Regional conferences give members the chance to exchange information with colleagues closer to home.

- WWW.IAEM.COM is the portal to the world of emergency management. The IAEM Web site offers discussion groups and a wealth of other professional tools, including the popular career center.

- Alliances with a network of related associations and organizations to further the profession and its members.

- Professional recognition of individuals through an annual awards program.

- Scholarship opportunities and funds for students enrolled in emergency management courses of study.

- Professional development through in-person meetings, networking and training opportunities.

- Discounts on certification program fees, selected publications, conference registration and more.

Upcoming Grant Deadlines

Compiled by Suzanne Boccia, Associate, Booz Allen Hamilton, Reston, Virginia

Repetitive Flood Claims (RFC) & Severe Repetitive Loss (SRL) Program

www.fema.gov/government/grant/rfc_srl/index.shtm

Application deadline:
June 30, 2006

- **Funding:** Authorized up to \$10 million annually
- **Purpose:** Reduce flood damages to properties that have had at least one or more claim payments under the National Flood Insurance Program (NFIP).
- **Eligible Mitigation Activities:** Acquisition of properties, and either demolition or relocation of flood-prone structures, where the property is deed restricted for open space uses in perpetuity.
- **FY 2006 Priority:** Acquisition of severe repetitive loss properties (including non-residential properties that meet the same claims thresholds) currently insured under the National Flood Insurance Program.
- **Federal/Non-Federal Cost Share:** Up to 100 percent federal funding; no non-federal cost share required

HRSA-06-067 Bioterrorism-Hospital Preparedness Program (NBHPP)

www.hrsa.gov/grants/preview/healthcaresystems.htm#hrsa06067

Application deadline:
July 1, 2006

- **Purpose:** The purpose of the National Bioterrorism Hospital Preparedness Program (NBHPP) is to improve the capacity of the nation's health care system to respond to biological, chemical and radiological terrorist attacks, infectious disease epidemics and acute mass casualty events. The primary focus of NBHPP is to develop, implement and intensify regional terrorism preparedness plans and protocols for hospitals, outpatient facilities, Emergency

Medical Service (EMS) systems and poison control centers in collaborative statewide or regional models.

- **Eligibility:** Health departments of all 50 States, the District of Columbia, the nation's three largest municipalities (New York City, Los Angeles and Chicago), the Commonwealths of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the U.S. Virgin Islands, the Federated States of Micronesia, and the Republics of Palau and the Marshall Islands.
- **Review Criteria:** Final review criteria are included in the application kit.
- **Funding Priority:** Priority will be given to applicants who demonstrate significant experience working with populations targeted by this initiative.

Tools to Mitigate and Understand the Mental Health Effects of Natural Disasters

www.grants.nih.gov/grants/guide/pa-files/PA-06-336.html

Application deadline: Multiple dates – earliest is July 1, 2006

- **Purpose:** This funding opportunity announcement (FOA) solicits Small Business Technology Transfer (STTR) grant applications from small business concerns (SBCs) that propose to support research and development of novel, or the enhancement of existing, commercializable products to mitigate (e.g., tools to be used in assessment, preventive or treatment interventions, and information dissemination) or understand (e.g., research tools) the mental health effects brought on or exacerbated by the aftermath of national disasters, such as Hurricanes Katrina and Rita, including victims and those who responded to their needs. These tools might be used by researchers, mental health professionals, other

health care providers, as well as by those in the broader community, including educators, day care providers, family members of victims, etc. These tools must take into account the cultural context of the target population to assure their effectiveness and validity.

- **Scope:** Budgets up to \$250,000 total costs per year and time periods up to two years for Phase I may be requested. Budgets up to \$450,000 total costs per year and up to three years may be requested for Phase II.
- **Funding:** No funds have been specifically set aside for this program; the number of awards and the amount of funds provided for awards will be determined by the quality and number of applications as well as availability of funds.

2006 Homeland Security Award

The Christopher Columbus Fellowship Foundation, a U.S. federal agency, is accepting nominations for the 2006 \$25,000 Homeland Security Award, to be presented by AgustaWestland, a Finmeccanica company, one of the largest helicopter companies in the world.

The award will be presented to a U.S. individual or company making a measurable and constructive contribution related to basic or advanced research in homeland security that will result in a significant benefit to society. The entry must demonstrate innovative thinking that has or will lead to creative work, process, product or other achievement in the homeland security area and that has or will make a significant and beneficial impact on society.

The deadline for nominations is **June 16, 2006**. Details are located at www.columbusfoundationawards.org.

The Role of Public Health in Disaster Response

By Lawrence R. "Mac" McKeough, CEM, Bioterrorism Disaster Response Planner,
City of Joplin Health Department, Joplin, Missouri

The word "emergency" has taken on a whole new meaning since the terrorist attacks of Sept. 11, 2001. Bioterrorism preparedness has not traditionally been an everyday concern of local public health departments. However, the likely first responders to a biological bioterrorism event will be local public health personnel. Prior to Sept. 11, little federal funding found its way to local public health departments, and for the most part, they had not been included in planning or training for bioterrorism preparedness – with maybe the exception of some of the very large cities. Bioterrorism is no longer a hypothetical event. A bioterrorism attack has occurred and could occur again at any time, under any circumstances, and at a level or magnitude possibly far greater than we have ever seen before.

Bioterrorism Scenario

In a bioterrorism scenario, hundreds, thousands and maybe even tens of thousands of people would likely need immediate care, and many could require intensive therapy, including ventilators and other specialized breathing assistance. Hospitals, already overburdened with their day-to-day operations, are just really starting to get onboard with bioterrorism planning, preparedness and response activities.

Few cities have sufficient numbers of beds, specialized equipment and qualified staff. A sudden influx of seriously ill patients, especially after any type of biological attack, will easily and quickly overwhelm even the largest, best-staffed and best-equipped facilities. The biggest problem facing medical and public health personnel will be the number of individuals seeking care

because they are fearful of being sick (the worried well).

Public health agencies at the county or city level will be the focal point in recognizing and responding to a bioterrorism attack. Public health response activities will be especially vital and essential in shaping the response and outcome of a bioterrorism attack. Containment of a transmittable disease outbreak will be a massive undertaking – the mobility of urban populations and their ability to leave one area and be on the other side of the world, in a matter of hours, is amazing. The limitations on public health's legal authority, and the challenges of containment (such as isolation and quarantine) are all factors that may impact the management of a biological epidemic by any health department.

Analyzing and Monitoring the Epidemiological Situation

The ability of local and state health departments to analyze and monitor the epidemiological situation is the key component of the response effort by public health. Epidemiological analysis of the initial victims will be critical in determining where and when the attack occurred, who might be at risk and who requires prophylactic treatment. Mass prophylaxis involves the distribution and medical application of appropriate antibiotics, vaccines or other medications, in order to prevent disease and death in exposed victims. The speed with which medical prophylaxis can be implemented efficiently is critical to its success. A key component in any biological-related event, is trying to limit the number of people who become ill, which includes: the identification of contacts, the vaccination of responders, the provision of antibiotics and, in

some cases, the institution of quarantine for those exposed. The biggest tool that the health department has in its arsenal is its ability to conduct and receive timely health data via surveillance.

Types of Surveillance

Prior to the Sept. 11 terrorism and follow-on anthrax attacks, the average small town and rural health departments traditionally relied on *passive surveillance* for gathering health-related data – they relied on physicians, schools, hospitals, laboratories and other reporting agencies to provide information to their respective health departments at their convenience.

Shortly after Sept. 11, Missouri implemented *syndromic surveillance*, which actively seeks information from physicians, laboratories, hospitals and other reporting agencies. It has proven valuable both for tracking international terrorist attacks using biological agents and for monitoring naturally occurring diseases.

Some health departments use *passive-syndromic surveillance*. They actively seek out disease information weekly, through the state, from reporting agencies that input this information constantly, specifically looking for and taking notice of "spikes" in specific areas: influenza-like illness, hemorrhagic diseases, chemical exposure and death. A proactive surveillance system implemented and used by local public agencies is all part of a new level of defense against bioterrorism and other health threats.

Coverage by the media during any bioterrorism event will have a profound influence on the outcome of response efforts. Public information and rumor control are vital

(continued on page 23)

The Need for Universal First Responder Credentials

Who is this person, and is he/she qualified to do this job?

By Robert Barnes, Robert B. Barnes Associates, Inc., Scottsdale, Arizona

From the tsunami in South East Asia to the hurricanes in America and the earthquake in south Asia, 2005 could very easily have been called the “year of major disasters.” It could also have been called the “year of major human failures” because these worldwide disasters severely challenged many nations, even the United States, to effectively coordinate timely and effective emergency response.

At the forefront of such responses are the first responders. They are typically thought of as local firefighters, law enforcement and medical personnel. But they actually include a much wider variety of specialists – usually from outside the disaster area – who are required to stabilize a disaster scene, support the rescue/recovery effort and save lives.

The Identification Challenges

Who are these people? What are their qualifications? Where are they positioned? What additional resources do they have available? How can they most effectively be deployed? These are questions that must be answered in the first few hours by on-scene commanders, or lives will surely be lost.

The answers to these questions are relatively simple in a localized disaster scene, but grow increasingly more complex as the geographical extent of the devastation expands to include multiple towns, cities, counties, states and even nations. The scope of the disaster not only increases the need for qualified responders but also complicates their identification, authorization and deployment.

One highly qualified first

responder summarized the feelings of many when he recently said, “A nationwide system would be nice and could likely be built upon existing technology and systems. I think that trying to coordinate several thousand jurisdictions in 50 states and other territories will take some time. I see a better approach as defining a standard specification that all can adopt in their local IDs. Portions of the ID data will likely only be accessible to the local hardware and software, but some of it would be readable through a standardized system.”

NIMS Requires Broad, Nationwide Credentialing

Local fire, law enforcement and emergency medical personnel, although vital, are only one part of the first responder network. If food, water, transportation and other logistical requirements are not handled correctly, many more people can lose their lives unnecessarily in the days and weeks that follow an event.

In response to this broader need, the U.S. Department of Homeland Security developed and issued a March 2004 guidance for a National Incident Management System (NIMS) to ensure interoperable disaster communications processes, procedures and systems. Based upon a process introduced in 1982 to facilitate the management of wildland fire fighting, NIMS is designed to help emergency managers and responders from different jurisdictions and disciplines work together more effectively to manage domestic incidents no matter what the cause, size or complexity. Full compliance will be required in

Fiscal Year 2007 for states, territories, tribes and local governments in order for them to receive U.S. federal preparedness funds.

The development of a nationwide credentialing system tied to training and certification is a fundamental component of NIMS and responds specifically to the “secure and reliable forms of identification” requirement of Presidential Directive HSPD-12. (See Figure 1.) This universal credential is intended to provide incident commanders and supporting multi-agency coordination systems with the means to verify, quickly and accurately, the identity and qualifications of emergency personnel responding to an event. While such a system is primarily meant to verify the identity and qualifications of emergency responders, it should also help prevent unauthorized (e.g. self-dispatched or unqualified personnel) access to a disaster or incident site.

Thus, the United States has now defined, at the highest level, its vision for a universal first responder credential, and the necessary standards are currently “under development.”¹ But in the words of one experienced disaster recovery manager, “How do we

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Figure 1. “... for purposes of this directive [‘secure and reliable forms of identification’] means identification that (a) is issued based on sound criteria for verifying an individual employee’s identity; (b) is strongly resistant to identity fraud, tampering, counterfeiting and terrorist exploitation; (c) can be rapidly authenticated electronically; and (d) is issued only to providers whose reliability has been established by an official accreditation process.” – U.S. Homeland Security Presidential Directive/HSPD-12, 27 August 2004

¹ NIMS welcomes the participation of all credentialing stakeholders in its working group. For further information, contact the NIMS Integration Center at (202) 646-3850 or send an e-mail to nims-integration-center@dhs.gov.

Public Health Departments: Often a Neglected Entity in Disaster Response Planning

By Bob Sampe, Emergency Manager, Landstuhl Regional Medical Center, Germany

As an emergency manager at Landstuhl Regional Medical Center, Germany, I am versed in and understand the emergency planning process. Emergency managers, like other professionals, often get caught up in their own world. We feel that our responsibility for plan or program development entitles us to total ownership of the project because of our personal investments, title and status.

Often we miss an important link, namely our public health leaders. I have nearly 18-and-a-half years of military emergency management planning experience, and I have coordinated plans through medical organizations – and I had no idea who actually coordinated on those response plans. If I knew then what I know now, I would have made it a priority for the public health department to be a primary agent in the development of the plan from the beginning. Public health must hold a leadership role in the set up and execution of your sheltering plan, the sanitation of the facility and the myriad other public health issues.

I have been tasked to write a pandemic influenza medical preparation and response plan. We brainstormed a scenario for pandemic influenza to follow to assist in developing our plan, and came up with a workable outline for the plan. We got all the typical base support players together – police, legal, laboratory staff, chief nurse, ER doctor, etc. – and filled in the plan outline. To make the process more interesting, this plan is developed for a diverse population of Army and Air Force in a German community. The planning process is lengthy and based on what the German government, local community and U.S. military have to offer through mutual aid and response agreements. We

thought we had a workable plan until we got to our higher headquarters-sponsored pandemic influenza table-top exercise, where I heard a presentation from the chief public health nurse from our medical center.

The presentation identified significant shortfalls for a workable plan, and there is always the challenge of the unknown. Our present planning and decision-making may not cover all aspects of the situation. Plans and SOPs are lengthy and overly cumbersome. Decisions are made by non-medical entities (emergency managers, city mayors, state governors, etc). We must deal with the philosophical shift from saving the most serious first to survival of the masses, a concept not easily executed by cops, EMTs and firefighters who daily respond using traditional triage concepts of treating the worst first. Our planning failed to identify capabilities.

The Million Dollar Question

The million dollar question is: What are your capabilities should the disaster involve 30, 300, 3,000 or 300,000 casualties or displaced persons? We must look at immediate sheltering, mass patient care, alternate care facilities, the possibility of activating alternate emergency operations center(s) and protecting emergency responders/caregivers. A painstaking but critical way to assist in determining capability is to assess staff size during expansion and facility availability to use for sheltering, treatment and feeding.

Are maps available to identify structures using building numbers and grid coordinates? To be effective, use community maps. Develop facility assessments based on building capabilities (number of

showers, toilets, kitchens, maximum number that can safely be sheltered, H/VAC and electrical capabilities, ambulance access) and include specific information obtained from the tenants (i.e. unique capabilities for broadcasting, high grade electrical wiring to support ICU ventilators, etc.). Who should be on your team to perform a facilities assessment? Team members instrumental in conducting a facilities assessment include community health nursing, industrial hygiene, environmental science, American Red Cross and facilities management. The public health department is the Department of Preventive Medicine at the Landstuhl medical treatment facility. Community or public health nursing serves as the team leader. Community and public health nursing are the local experts for population-based health, community resources and cost-effective options using critical decision-making involving mass sheltering and displaced persons' health and sanitation.

Public health is of great importance in any community and becomes paramount during disaster management. Public health officers must hold leadership roles in planning for, responding to and recovering from all types of disaster situations and medical emergencies. The purpose of emergency planning is to reduce the number of casualties and the severity of injuries, and to protect property. With the help of your public health nurses and other preventive medicine officers, your emergency response plans will certainly meet your organization's purpose and improve the outcome. Recommendation: If you haven't, it is of utmost importance to employ your public health professionals in all of your emergency planning endeavors.

Non-Traditional Roles for Dentists in Catastrophic Events

By David A. Williams, DDS, MSSM, MPH Candidate

Catastrophic events have unfortunately become a way of life for us in the United States. Whether they are natural occurrences or technologic, preparation for these events is critical for mitigation, response and recovery. Medical assets will be pushed beyond their limitations, and every medical professional will be needed to implement any sort of successful response.

Dentistry has historically been a critical aspect of identification of human remains in the case of multiple fatality incidents, and will continue to be so in the future. However, dentistry can provide an important response to other catastrophic events in a variety of ways that are typically not appreciated by the emergency management community, the public health community or the medical community.

Dental facilities comprise one-third of the non-hospital medical assets within a community. In the event of hospital closures as we saw in the SARS epidemic, dental facilities are more diffuse within a community and would be less likely to suffer from contamination. Dental offices have the basic elements of any medical facility, including patient treatment areas, excellent illumination, suction, oxygen, and staff trained in patient treatment and infection control.

Except for physical therapists, dentists spend more contact time with their patients than any other health care worker – so they know how to treat patients in a competent and caring manner. They have an extensive medical background that includes taking histories, diagnosing and treating, and they are accustomed to working with patients in a medical setting. They have clinical skills that easily can be transferred to emergency situations; they are high-level thinkers; and they are used to managing resources, including

ancillary personnel, materials and facilities.

Dentists also are second only to physicians, and as good as surgeons at triaging in mass casualty situations. In addition, they are among the top three professions in the public trust, and provide a valuable source of medical information to their patients.

With these attributes in mind, it is critical to incorporate dentistry within plans for catastrophic events.

Levels of Response

■ **Surveillance and Reporting.** All dental professionals can be responsible for surveillance and reporting. This would require minimal training, most of which would closely parallel the oral pathology taught in dental school, with emphasis on the likely (CDC Category A and B) agents and information on radiological and chemical contamination and their clinical presentation.

Many of the CDC agents first present in the oral cavity, and early detection could greatly shorten the time from infection to identification.

■ **Advanced First Aid.** With limited or no additional training, the dentist could provide pharmaceuticals, including vaccinations, treat wounds with suturing and debridement, stabilize long bone fractures, maintain airways, treat facial trauma, treat for shock, provide non-invasive stabilization of chest wounds, and perform a variety of other procedures.

■ **Medical Augmentation.** The Army has “Dental Ready Response Teams” (DRRT) that are deployed when needed for such an event. This could provide an excellent model for the highest level of utilization. They are trained in Incident Command, Advanced Trauma and Life Support (ATLS), HAZMAT, and other areas.

Limitations

■ The procedures outlined here, while within the attainable knowledge of the dentist, extend beyond the scope of the Dental Practice Act in every state. This would present liability and possibly criminal issues for dental professionals and would need to be addressed by state or federal laws.

■ Education and training would need to be funded to ensure that personnel are ready for these events.

■ There would need to be credentialing of dental professionals to the level of training. This could be statewide – or better still, national – so that the professionals are not hindered by artificial boundaries. The individuals would need to be identified for deployment, requisition of materials and travel purposes.

■ There would need to be supplies available, as well as requisition authority for additional supplies.

Conclusion

Dentistry can be an extremely valuable asset to the community in a time of crisis. Dentists have a history of aiding in the identification of victims of multiple fatality incidents, have needed clinical skills, and are highly trainable in other skills that would provide substantial assistance to the health of the citizens. They make up an abundant amount of the non-hospital medical assets in the community, they are trusted medical professionals, and they have a high degree of credibility.

To not use dental professionals in the event of a bioterrorism or catastrophic event would be an unfortunate waste of valuable resources.

Public Health Emergency Preparedness: Important, Yet Needing To Grow

By Patrick J. Lindner, MS, Regional Disaster Response Planner, Saint Louis Co. Dept. of Health

Public health can trace its roots all the way back to the time of the Romans. For centuries, people have understood the necessity of ensuring the health of a given population. In fact, many jurisdictions have operated public health agencies for longer periods of time than those of traditional first responders (police, fire). However, in the areas of comprehensive disaster planning and emergency response, public health can only look back five or six years for relevant experience. The anthrax attacks of 2001 introduced this nation to the threat of bioterrorism on a massive scale, simultaneously launching public health into a seemingly unknown arena.

From Floods to...

Prior to 2001, public health served a somewhat minimal role inside disaster response, typically in flooding events. Within this function, public health representatives served on disaster survey teams, ensuring that the health of the community was maintained during recovery operations. A more common example involved determining if a flooded-out restaurant could reopen by performing the necessary inspections. Other responsibilities included public education on health hazards, vector control, environmental inspections and providing necessary immunizations (tetanus, hepatitis). In general, public health mainly took a small "reactive" role in disaster response. Today, however, public health must be more proactive in its emergency preparedness efforts and institute a wide range of planning activities.

Fitting in...

It is important for public health

to first understand that because of its lack of experience in emergency preparedness activities, acquiring health-focused funding and materials from traditional first responder sources will be difficult. Fire, police and EMS agencies perform "emergency" activities on a daily basis and can therefore justify their need for resources without much debate. Placing public health in the same category as first responders has been difficult, but does need to happen.

Fortunately, there are additional avenues for public health to seek out the funding and resources it needs for emergency preparedness. The Centers for Disease Control and Prevention (CDC) as well as the Department of Health and Human Services (DHHS) greatly recognize the need for public health preparedness and have put forth specialized funding opportunities. Pandemic influenza and issues pertaining to the Strategic National Stockpile (SNS) allow public health agencies to receive necessary resources. If either of these events were to occur, then the responsibility for coordinating the emergency response would fall directly upon local public health agencies.

However, it can also be said that planning for these events opens the door for public health and traditional first responders to work together toward a common goal. Such cooperation can only increase the opportunities for public health to finally, and justly, fit into the first responder category.

Planning Is the Key

Comprehensive, all-hazard based plans must be developed, exercised and maintained by each public health agency. To do so, public health must now think like emergency managers or planners

in regard to their own operations. Functions such as epidemiological surveillance and investigation, quarantine and isolation, mass prophylaxis dispensing, risk communication, mass fatality incident management, as well as volunteer recruitment and maintenance, must be considered and included inside this all-hazard approach. Furthermore, public health should not reinvent the wheel in the process, but be willing to seek out guidance from other partners and first responder agencies. Plans should be comprehensive, but most importantly, adaptive to allow for a response to an unforeseen event. Finally, these public health emergency response plans should be incorporated into a given jurisdiction's basic Emergency Operations Plan (EOC).

Reaching the Next Level In Emergency Planning

The recent emphasis on pandemic influenza allows for public health to further refine their EOPs and overall planning abilities. Key issues such as quarantine and isolation need to be, and can only be, addressed by public health agencies and experts. Plans must not only reflect what each first responder agency will be responsible for in a pandemic event, but also put forth guidance to corporations, social service agencies, health care and the general public.

The time is now for public health to reach the next level in its emergency planning evolution. Partnerships must be formed and a first responder status must be reached in order to implement these plans and other emergency preparedness activities effectively. The pandemic is inevitable and will require a competent, proactive and, most importantly, prepared public health system.

National Interoperability Baseline Survey

By Kevin McGinnis, Program Advisor, National Association of State EMS Officials

This spring, the Department of Homeland Security's (DHS) SAFECOM program is fielding a groundbreaking National Interoperability Baseline Survey. The survey is designed to assess communications interoperability capacity among law enforcement, fire and emergency medical services agencies across the United States.

SAFECOM is asking approximately 22,400 randomly-selected agencies from 50 states and the District of Columbia to respond to the survey. Randomly selected respondents will receive information and instructions for completing the on-line survey by mail.

As part of the assessment, SAFECOM is also asking state

homeland security directors for the 50 states and the District of Columbia to complete a shorter version of the survey. This component of the survey is expected to generate insights about governance issues at the state level.

SAFECOM is encouraging selected agencies to respond so that the survey can successfully provide the vital statistical snapshot for which it was intended.

Five Critical Areas

The elements of SAFECOM's Interoperability Continuum provide the framework for the National Interoperability Baseline Survey. More comprehensive than its preceding assessments, the survey is designed to measure and generate insights into five critical areas that determine an organization's capacity for interoperability:

- Governance.
- Standard operating procedures.
- Technology.
- Training and exercises.
- Usage of interoperable communications.

To measure these areas, the survey asks participants to select a description of an interoperability level that best represents the situation in their organization. In addition to collecting survey data, SAFECOM officials will reinforce the online survey findings by

conducting approximately 30 site visits in nine regional areas to gather supplementary qualitative and anecdotal information from the public safety community. Preliminary findings will be released in August 2006, with a final report anticipated by October 2006.

Results To Guide Decisions About Next Steps

SAFECOM hopes that these findings will provide a deeper understanding of where the United States stands in achieving interoperability and will help guide decisions about next steps for strengthening public safety communication interoperability.

SAFECOM, a communications program of the Office for Interoperability and Compatibility (OIC), with its federal partners, provides research, development, testing and evaluation, guidance, and tools and templates on communications-related issues to local, tribal, state and federal public safety agencies.

Learn More

The Department of Homeland Security's OIC is managed by the Science and Technology Directorate. For more information about the SAFECOM program, visit www.safecomprogram.gov or call 866-969-SAFE.

Universal First Responder Credentials

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get from here to there as fast as possible, because we may very well be faced with another disaster tomorrow?" As usual, the answer involves both focus and funding. This same official reflects that "the technology is here today, but we need to learn how to bring it together in a smart way."

What Is Required?

The best technical design for a universal first responder credential will be one that provides sufficient flexibility to meet the local needs of different responding organizations encountering different levels of risk, but is still capable of working across multiple jurisdictions. Therefore, it should be capable of local implementation but be universally acceptable. And it will quickly answer the question: "Who is this person, and is he or she qualified to do this job?"

Role of Public Health in Disaster Response

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for informing and instructing the population in ways that enhance the emergency response and avoid panic. Opportunities for misinformation, rumors and contradictory statements will confuse, anger and fuel public mistrust. Providing the public with accurate, timely

information that people will not only believe, but act on, will save lives and make the handling of such an event smoother-running and less stressful for all involved. Having a proactive style of surveillance in place (one like we currently use) will help spot ongoing and/or new problems and allow us to plan for and distribute prophylactic medications on time or ahead of a major outbreak.

The Medical Reserve Corps: An Update

By Marna Hoard, MPA, MPH, LT, USPHS, Program Officer (Outreach),
Medical Reserve Corps Program, Office of the U.S. Surgeon General

The October 2004 *IAEM Bulletin* included an article about a relatively new program, the Medical Reserve Corps (MRC). This article will provide an update on this growing program, which started in July 2002, grew to more than 200 MRC units and almost 30,000 volunteers at the time of the October 2004 article, and has now reached a status of 420 MRC units in 49 states, the District of Columbia, U.S. Virgin Islands and Guam, with more than 75,000 volunteers.

The MRC is a nationwide network of community-based citizen volunteer units, which have been initiated and established by local organizations for their communities. MRC units are local assets to meet locally determined needs. Medical and public health volunteers in the MRC can utilize their professional expertise to contribute to local public health initiatives on an ongoing basis and to supplement the existing response capabilities of the community in emergencies.

Local MRC units promote and support activities that have an all-hazards and broadbased public health focus. Particularly encouraged are those activities that align with the public health priorities of the U.S. Surgeon General – increasing prevention efforts, eliminating health disparities and enhancing emergency preparedness.

Hurricane Response

The role that the MRC played during the 2005 hurricane response and recovery efforts serves as an example of how the program continues to meet local community needs, while growing and adapting to the ever-changing public health response needs of their states and the nation. An estimated 6,000 MRC volunteers supported the

response and recovery efforts in their local communities. In the hardest hit areas, as the storm forced hundreds of thousands of Americans to flee the affected areas, MRC volunteers were ready and able to help when needed. They assisted as evacuees were welcomed into their communities. These volunteers spent countless hours helping people whose lives had been upended by these disastrous events through:

- Establishing medical needs shelters to serve medically fragile and other displaced people.

- Staffing and providing medical support in evacuee shelters and clinics.

- Filling in for others who were deployed to the disaster-affected regions at local hospitals, clinics and health departments.

- Immunizing responders prior to their deployment.

- Staffing various response hotlines.

- Teaching preparedness to community members.

In addition to this local MRC activity, more than 1,500 MRC members were willing to deploy outside their local jurisdictions on missions to the disaster-affected areas with their state agencies, the American Red Cross and the U.S. Department of Health and Human Services.

MRC units across the nation are training, drilling and activating with their local response partners, and many are included in their local and state response plans. Acceptance and support of the MRC program goes well beyond that of their local response partners.

Collaborative activities with the Centers for Disease Control and Prevention's Strategic National Stockpile (SNS) program and with the Department of Veteran's Affairs have developed and expanded. The MRC program is also written into the National

Response Plan as a resource to be tapped under the guidance of Emergency Support Function (ESF) #8. The Joint Commission on Accreditation of Health Care Organizations recognized the MRC as a mechanism for hospitals to pre-identify and credential volunteers to "facilitate the assigning of disaster responsibilities to volunteer practitioners at the time of a disaster" (Standard HR.1.25, effective July 1, 2006). Most recently, the MRC was highlighted in the White House report, *The Federal Response to Hurricane Katrina: Lessons Learned*, as part of what went well during the response efforts. The report also charged HHS to "organize, train, equip and roster medical and public health professionals in pre-configured and deployable teams," and to include the MRC on these teams.

Local MRCs determine their needs, manage their volunteers and respond in the cities and counties where they live and work. Through these actions, each community is better prepared. As we strengthen the public health infrastructure and medical surge capabilities at the local level, we strengthen every state and the nation as a whole. The MRC is where hometown health and safety meets homeland security.

Learn More

Those interested in establishing an MRC unit are encouraged to talk to all community partners (e.g., public health, emergency management, hospitals, city government, police and fire) to fully integrate the MRC and obtain buy-in. For more information on starting an MRC, visit our Web site at www.medicalreservecorps.gov or contact the MRC Program Office at MRCcontact@osophs.dhhs.gov or (301) 443-4951).

Pandemic Shut-Down

By Dr. Charles M. Solnik, CEO, EdgeTrack Solutions

The Likely Scenario

A patient stumbles into a crowded emergency room located in a major urban center. He collapses. The triage nurse surges forward to find a body covered with hundreds of vesicles. She calls the MRP, and he understands what has just been discovered – smallpox! What is the operative plan of action? Where and how did this occur?

Assume that any global terrorist organization that wishes to inflict maximum damage on a “western nation” will target the most fundamental components of that society. For us, this is the economy. The most effective way to damage that economy will be to create a situation that causes the maximum casualties in the shortest time frame.

An extremely effective way is through the use of any biological agent that will be very contagious with disabling effects but not necessarily fatal. The agent that comes to mind would be a genetically altered smallpox-like virus.

A terror organization could infect one (or more) of its homicide members and send them immediately to a major urban center.

In the case of Toronto, Canada, he would be sent to Square One, Yorkdale, Promenade, Eaton Centre, Queens Park or Centre Island – just to name a few – and use public transportation. He would be exposed to thousands of people and even senior government officials. After the first signs of illness, the infected terrorist would return to his/her apartment; close the washroom to minimize smell (and therefore prevent notification of death and the source of the illness); and take a cyanide tablet.

Approximately 10 days later, the first case would present itself at an ER or walk-in clinic with or without a history of travel. It might not be picked up in the first visit. When

the innocent victim affected is toxic, he will go to a hospital ER that is likely not to have an infectious disease plan in triage.

The best case scenario is that the ER doctor would understand what has transpired. The hospital would shut down and be quarantined until confirmation of smallpox, but by that time there would be many cases sprouting up throughout Toronto.

The Unknowns

All you will know is that there are smallpox cases. You will not know what to do unless you have worked backward from the worst case scenario. The worst case scenario must be assumed and prepared for.

In the case of SARS, the Canadian authorities were fortunate that: (1) the patient and family gave a history which included recent travel to Hong Kong, China, and (2) while the first patient was a “super infector,” SARS itself was not very infectious and eventually burned itself out. The next time a pandemic starts, whether manmade or naturally occurring, we may not be so fortunate.

Key Questions

Key questions that must be asked in advance and prepared for are:

- Who is in charge of the operational plan?
- Is there a body that coordinates between army, Royal Canadian Mounted Police (RCMP), Canadian Security Intelligence Service (CSIS), police agencies, health care officials and politicians? Who will make the key executive decisions in a real time and effective manner? Who will speak to the public? (During SARS, there were three to four people speaking at each press conference, taking over half an

hour at each briefing, which gave me “SARSitis.”)

■ How will the public respond? How will health care, government and security personnel respond?

■ How many will follow the plan? How many workers will show up to man critical positions?

■ Where will suspected cases go? There is no elasticity in the hospital bed situation. If cases go to health care providers or hospitals, they could cause a quarantine (and effectively shut down) the general health care system.

■ Who will ensure that the quarantine population stays quarantined? How will basic services, such as food, be supplied to the general public?

Potential Solutions

The most important first step is the creation of an operational body that’s singular in purpose to prepare for and execute such a plan. Its job is to represent and coordinate all levels of government (i.e. health care, transportation, environment, police, army and intelligence branches). Further, it is to communicate and control the flow of information and instructions to the public.

The next step for the organization is to ensure that its plans are truly operational. Almost all municipalities, provinces, states and federal governments have plans. Have these plans been seriously tested? Are first line responders, community leaders, major businesses and other stakeholders aware of and familiar with the relevant components of those plans? The answer is no!

The evidence is plain for all of us to see. SARS Commission 2004 and Katrina 2005 represent all the evidence we need. Therefore, it is essential that part of any emergency/disaster plan incorporate an auditing/testing program as a critical component.

Integration of Public Health and Emergency Response: Getting Public Health “to the Table”

By Brendan McCluskey, Interim Executive Director, New Jersey CBRNE Center for Training and Research, University of Medicine and Dentistry of New Jersey, Newark, New Jersey

A terrorism incident preparedness training program was recently conducted for public sector executives. Leaders from law enforcement, fire service and emergency management agencies were present. But only two representatives of the public health community made up the audience of close to 50. The frustration of one of those public health leaders can be summed up in her statement: “Once again, public health is late to the table.”

In virtually every disaster situation, from hurricanes to building collapses to bioterrorism, there is a public health component. It is incumbent upon both the “traditional” emergency responder and the public health communities to ensure that public health is consistently “at the table” during all phases of emergency management.

Public Health Involvement at Local Level Is Critical

Historical and more recent events, including the Sept. 11 terrorist attacks, the dissemination of anthrax through the mail system and Hurricane Katrina, bring to mind massive responses from local, state, federal and private organizations. With the looming threat of pandemic influenza, as well as an ever-present risk of natural disasters and terrorism, it is critical that public health professionals are included in prevention, protection, response and recovery activities. It is most important for this to occur at the local level, where almost all disasters are first encountered.

The University of Medicine and Dentistry of New Jersey (UMDNJ), the nation’s largest independent academic health sciences organization, has – over

the past five years – put together a number of model innovative programs aimed at helping to integrate public health into the emergency response community.

Three Initiatives

Highlighted among the repertoire of programs are three initiatives that have helped bring public health practitioners and emergency response professionals closer together for the goal of comprehensive emergency management.

■ Within days of the announcement of the anthrax attacks, an official from a local urban health department made a call to the Department of Preventive Medicine at UMDNJ’s New Jersey Medical School looking for help. “How do we deal with all of the issues if something like anthrax was to affect this city?” was the substance of the conversation. Members of the university community responded by forming what became known as the “Thursday Night Group.” A diverse collection of academicians, public health workers, emergency managers and other interested parties began to meet every Thursday evening to look at domestic security issues facing the city, state and region. The group brought together local and county police and fire officials with public health, hospital and airport personnel, among others. Many of the participants, all leaders in their respective fields, met for the first time at one of these sessions.

After nearly five years, the result is a core group of dedicated professionals who continue to meet on a regular basis, although no longer weekly, to work on emergency preparedness from the grass roots level. The development and strengthening of critical thinking

skills and professional relationships have made these sessions successful.

■ The UMDNJ Center for BioDefense, under a grant from the state department of health, conceived and produced the novel training course, “Public Health-Emergency Services Integration.” This modular class promotes the incorporation and interoperability of public health professionals and emergency service responders during critical emergencies. Using a multimedia approach, the course introduces the roles, responsibilities and resources of the public health system to emergency service providers, as well as those of emergency services to public health officials.

A facilitated discussion, using a scenario developed with clips from the movie *Outbreak*, allows attendees to practice participation in the decision-making process as well as hone their critical thinking skills. An expert panel offers insight via a videotaped presentation as part of the scenario. The program also offers an excellent opportunity for networking with professionals across disciplinary lines and promotes close working relationships through knowledge of key duties and tasks of the different responder types.

■ The New Jersey Center for Public Health Preparedness, one of 52 CDC-sponsored centers around the country, has created the “PHLIER” program: Public Health Leadership Initiative for Emergency Response. PHLIER is an advanced eight-month, preparedness-focused seminar program for New Jersey’s existing and emerging public health leaders. The program is not just leadership training; it is designed to allow

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The Importance of Evidence-Based Disaster Planning

Issues in Emergency Medical Response

By Erik Auf der Heide, MD, MPH, FACEP, Medical Officer, Agency for Toxic Substances and Disease Registry (ATSDR), U.S. Dept. for Health & Human Services, Atlanta, Georgia

Full transcript of EIIP Virtual Forum Presentation, Apr. 12, 2006: www.emforum.org/vforum/lc060510.htm

Some have suggested that disasters are just like daily emergencies, only larger, and the best way to deal with them is by expanding your normal emergency response. However, disasters are different than daily, routine emergencies. They present a number of problems that have no counterpart in routine, daily emergency responses. This is may help to explain why routine emergency procedures often fail and why planning specifically for disasters is necessary.

By looking at the evidence from field disaster research studies, we can learn how they are different. This knowledge may be helpful to planners and practitioners who want to avoid repeating the errors that have occurred in the past.

Seven Common Assumptions

To illustrate the importance of evidence-based (or research-based) planning, we will look at several common assumptions, contrasting them with field research findings and discussing the implications for planning. The seven assumptions are:

■ **Assumption 1.** Dispatchers will hear of the disaster and control which emergency response units are sent to the scene.

Research Finding: Emergency response units, both local and distant, often self-dispatch. Planners therefore need to:

- (1) plan for both the community and intercommunity levels;
- (2) expect unsolicited responders; and
- (3) plan for coordinating them.

■ **Assumption 2.** Trained emergency personnel will carry out field search and rescue.

Research Finding: Most initial search and rescue is ad hoc, uncoordinated, and carried out by the survivors themselves, rather than by trained first responders. Survivors often know the location of missing persons. Law enforcement agencies may not anticipate that search and rescue are their official duties, but often become involved anyway.

Planners therefore need to:

- (1) train first responders, including law enforcement officers, to work with survivors to coordinate search and rescue; and
- (2) designate personnel to obtain information from survivors about missing persons.

■ **Assumption 3.** Trained EMS personnel will triage victims, provide care and decontaminate exposed casualties before transport.

Research Finding: Casualties will likely bypass field triage and decontamination sites and go straight to the hospital. Thus, hospital staff need to assume arrival of untriaged, undecontaminated and unstabilized casualties.

Planners therefore need to:

- (1) develop instructions for survivors on how they can protect themselves, provide first aid and manage contamination;
- (2) provide citizenry with first-aid, search and rescue, and disaster-care training; and
- (3) send first responders to hospitals to help out (e.g., extrication of casualties from cars).

■ **Assumption 4.** Casualties will be transported to hospitals by ambulance.

Research Finding: This doesn't happen most of the time. Most casualties reach the hospital by private cars, police vehicles, buses,

taxis and on foot. Thus, EMS authorities should not assume that they have control over their EMS systems either in terms of patient destinations or timing of transport. Survivors will be difficult to track.

Planners therefore need to:

- (1) educate the public about proper transport techniques; and
- (2) establish procedures for obtaining information from hospitals about casualties they have received.

■ **Assumption 5.** Casualties will be distributed proportionately to hospitals.

Research Finding: Most casualties go to the nearest or most familiar hospitals, thereby overloading some hospitals with a disproportionate number of patients and with patients for which the hospital may lack needed specialty services, such as burn care expertise. All hospitals need to expect contaminated casualties and prepare to decontaminate them.

Planners therefore need to:

- (1) consider bypassing ambulances around closest hospitals;
- (2) strengthen EMS system mutual aid and communications systems to facilitate efficient casualty distribution; and
- (3) have a protocol for distributing ambulance patients pending information on hospital capacities and patient loads.

■ **Assumption 6.** Authorities in the field will notify hospital staff promptly about the disaster and the patients they are likely to receive.

Research Finding: Hospital staff will likely hear first about the disaster from first-arriving casualties or the media, and the quality and timeliness of updated informa-

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Evidence-Based Disaster Planning

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tion about incoming casualties will be poor.

This means that hospital response capability will rest on resources already in house, and protecting the hospital and staff against contamination (e.g., donning chemical-resistant suits, taping plastic on walls and floors, and erecting stand alone decontamination facilities for chemical casualties) may be impractical.

Planners therefore need to:

- (1) base initial hospital response plans on in-house rather than on-call resources;
- (2) provide in-house staff with authority to activate and modify the plan; and
- (3) develop plans for the expedient decontamination of unannounced casualties, such as the use of fire hoses supplied with warm water pending availability of more sophisticated decontamination equipment.

■ **Assumption 7.** The most serious casualties will first be transported to hospitals.

Research Finding: Often it is the least serious casualties that arrive first. Frequently, this is because the more serious cases are trapped in the rubble, cannot be extricated by themselves or other survivors, or may be unconscious and unable to call to rescuers for help. Because of inadequate communications with the

field, hospitals may not be aware that more serious casualties are yet to come. As a result, when they do arrive, they may find all patient beds already occupied.

Planners therefore need to:

- (1) assign field responders to communicate casualty information to the hospitals; and
- (2) reserve beds at hospitals for possible later-arriving more serious casualties.

In Summary

It is important for communities to plan and train for disasters. However, planning and training are not enough: one must plan for the right things. Valuable lessons can be learned from formal disaster research studies. Often disaster plans fail to anticipate common response problems that have been identified during systematic field research studies.

For More Information

The material for this discussion is summarized from a recent paper, entitled, "The Importance of Evidence-Based Disaster Planning," which was published in the January issue of the *Annals of Emergency Medicine*. A full-text copy of that paper is available at the ATSDR Web site at no charge for non-commercial use: www.atsdr.cdc.gov/2p-emergency-response.html. The paper provides additional sources for learning about the results of field disaster research studies and how they can be applied to help you develop successful, reality-based plans.

Getting Public Health To the Table

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participants to learn to apply the knowledge and skills each one already possesses in new and innovative ways.

Scenarios are the heart of the PHLIER program. Participants work through real-world public health dilemmas, similar to tabletop exercises, facilitated by experts from various disciplines, including public health, law enforcement and emergency management. In addition, site visits, interaction with community, public health and emergency response leaders and group exercises help the participants to identify solutions to today's and tomorrow's public health emergency response challenges.

Successes

The "Thursday Night Group" has been the most successful of the programs thus far. Enhanced response protocols for the nearby international airport, thorough consideration of quarantine and isolation issues and improved communication among the various constituent groups, have and are taking place. There was almost no cost to implement that project, and it has provided a simple yet effective solution to the problem of integrating public health and emergency services.

The other two programs are new and just now getting off the ground. They are expected to help get public health "to the table." With the potential for a public health component in every disaster and emergency, both natural and manmade, now is the time for innovative thinking about developing ways to bring public health and emergency services practitioners together for a common cause.

8th Annual Technologies for Critical Incident Preparedness Conference & Expo 2006

IAEM is a co-sponsor of the 8th Annual Technologies for Critical Incident Preparedness Conference and Exposition 2006, scheduled for Sept. 6-8, Atlanta, Ga. The conference is presented by the U.S. Dept. of Justice National Institute of Justice, in association with CTC, Inc.-Public Safety Technology Center. The conference will highlight technology and training tools currently available and being developed. Learn more and register at www.ctc.org.

Quarantine: The Ethical Dilemma of Duty To Care

By Rebecca L. Siceloff, NREMT-P, U.S. Dept. of Homeland Security Contractor, CRA, Inc.

Quarantine has long been recognized as an effective means of containing outbreaks of infectious diseases. Until recently, familiarity with its practice had vanished, since no large-scale human quarantine has been implemented in the United States during the past 80 years. Pandemics and bioterrorism concerns have increased the awareness of this effective public health tool, and its implementation is emerging as a likely action identified in disaster and terrorism preparedness drills and exercises across the country. A large-scale bioterrorist event or pandemic would not only overwhelm the public health system, the call for quarantine would provide unique challenges for emergency management agencies. It is an uncharted course yet to be traveled and filled with uncertainty, and has raised concerns over potential issues and challenges that front-line providers are not fully prepared to face. One such issue is the duty to provide care.

During outbreaks within the public health arena, front-line providers have a duty to provide care. Yet many will say there is a limit to the extent of their commitment and the exposure they are willing to accept professionally. The obligation to care competes with personal demands and conflicting values that pressure providers to protect not only their own health but also that of their families.

Some ethicists reference the medical or professional code of ethics as a foundation to analyze the issues and conflicts surrounding the dilemma. While public health officials often encounter ethical situations, medical codes of ethics have no standard framework with which to approach this sensitive issue. Such suggested themes as going above-and-beyond

the call of duty and doing the ordinary under extraordinary circumstances does not change the dilemma facing front-line professionals today. The question of how to best balance public safety with professional responsibility – while containing an epidemic or bioterrorist agent – remains unanswered.

Quarantine Authority Defined as Priority

In 2002, the President of the United States, in his National Strategy for Homeland Security, listed quarantine authority as a priority. Last year, it was listed as a Respond Mission Area-Target Capability for Homeland Security's Office of State and Local Government Coordination and Preparedness. The recognition of the need for modern day quarantine guidelines may rest with the federal government, but the responsibility to preserve public health still rests with the local and state governments. In order for communities to cope with quarantine environments, the current infrastructure needs rebuilding. Yet due to advances in medicine and the decline in infectious diseases, many governing bodies have failed to address outdated laws and guidelines. In light of emerging threats and security concerns, some jurisdictions are beginning to reconsider their stance on response to such emergencies and how they will handle the sensitive issue of duty to care.

Those entrusted with decision-making – be it government agencies, hospitals, emergency management or service organizations – should make decisions openly, with their rationale explained in advance. In essence, mechanisms should be in place to communicate major decisions, expectations and obligations regarding the worker's

duty to provide care. Such discussions should take place prior to an outbreak or disaster, and even at time of employment. As volunteer agencies brief new members of their responsibilities and potential job risks, the topic of duty to care during emerging threats to our nation should be included in the discussion.

Employers and volunteer organizations must ensure that front-line care providers have sufficient support to handle their conflicting duty to provide and care for their family, including benefits for death or disability. The recognition of fear, isolation and abandonment exemplifies an employer's or agency's understanding of the dangers facing front-line care providers.

Changing Environment Forces Changes in Approach

There is no question that we face a changing environment with emerging threats of bioterrorism and communicable diseases. Simple administration of vaccines and implementation of standard operating procedures are no longer enough to control a pandemic or bioterrorist event. Focusing on the possibility of quarantine may encourage public health decision makers to look beyond epidemiological facts and consider the rights of front-line care providers. Likewise, front-line professionals must begin to weigh their values about liberty, protection from harm and protection from stigmatism with their duty to provide care. How far does one's professional obligation extend when care poses a direct threat to the health of providers or their loved ones? The answers are catching many people completely off guard and posing significant challenges to the public health and emergency management communities.

New Members: Apr. 16-May 15, 2006

A monthly listing of new IAEM members appears in each issue of the *IAEM Bulletin*.

REGION 1

Michael Bernacchio
Middleboro, MA

John M. King
Medford, MA

REGION 2

Jo Jordon
New York, NY

Jason Molino
Batavia, NY

John Morrison
Florham Park, NJ

REGION 3

Scott Bliss
Mechanicsburg, PA

Ray Chevalier
Waynesboro, PA

Charles A. DeFrangesco
Eagleville, PA

Megan Jones
Alexandria, VA

Dennis W. Lejeck
Bethel Park, PA

Michelle Lilly
Leonardtown, MD
Sponsor: Timothy Bennett

James T. Mendelson
Manassas, VA

Alexander Romeyn
Washington, DC

James F. Smith
Floyd, VA

REGION 4

Edward Allen
Sanford, FL

Steve Creech
Plymouth, NC

Mark H. McCain
St. Helena Island, SC

Arthur Seypura
Melrose, FL

Troy Stalvey
Panama City, FL
Sponsor: Steve Prier

Michael Williams
Raleigh, NC
Sponsor: Martin Chriscoe

REGION 5

Thomas Ciciora
Sandwich, IL

Mark Owen
Milwaukee, WI

Christopher A. Walker
Oak Creek, WI
Sponsor: Rick Comerford

REGION 6

Syd Amanullah
San Antonio, TX

Robert Chadborn
Metairie, LA

Kathleen Hicks
San Angelo, TX

George D. Mosho
Joliet, IL

Laleh Soltan
Plano, TX
Sponsor: CJ Howard

REGION 7

Robert Michael Buser
Cedar Rapids, IA
Sponsor: Walter Wright

Major Tom Lynch
Overland Park, KS
Sponsor: Mike Selves, CEM

REGION 8

Jeffrey M. Goldberg
Colorado Springs, CO

Byron P. McDaniel, Jr.
Golden, CO

Chuck Vale
Steamboat Springs, CO

REGION 9

Matthew Ankley
Long Beach, CA

Phill Dupree
Hesperia, CA

Edwin Lorenzo Jones
Scottsdale, AZ

Tim Karney
Folsom, CA

Mark Mintz
Los Olivos, CA

David Stuhan
Las Vegas, NV

REGION 10

Daniel G. Good
Brier, WA

REGION 11

Michael Shane Bayley
New Plymouth, Taranaki
New Zealand

Kenneth S. Brown
APO, AP

R. Martin Closa
Buenos Aires, Argentina

McCleary Frederick
Grand Cayman
Cayman Islands

Trevor Glass
Cape Town, South Africa

Sarone A. Kennedy, Sr.
Marsh Harbour, Bahamas

Joseph Mulupi Musuya
Geneva, Switzerland

Andrea L. Stevens
Cayman Brac
Cayman Islands

Peter Williams
Newbury, United Kingdom
Sponsor: Kevin Stirzaker

REGION 12 (STUDENT REGION)

Dawn M. Angel
Chicago, IL

Susan Arevalo
San Dimas, CA

Patrick Brejcha
Alexandria, MN

Leo Chiang
New York, NY

Robert Davidson
Fargo, ND

James L. Dieringer
N. Canton, OH

Danielle Dracy
Fargo, ND

Doug Duerr
Russellville, AR

Jill Eitel
Chicago Heights, IL
Sponsor: Mike Fagel, CEM

Roland Farkas
Scarborough, ON

Lt. Col. Joe Haggerty
La Plata, MD
Sponsor: Tom Greenlee

Gordon Hamel
Fairfax Station, VA

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Please join us in welcoming these new IAEM members!

E.M. Resources

■ National Pandemic Influenza Plan Released.

The U.S. "National Strategy for Pandemic Influenza: Implementation Plan" has been released. The plan describes more than 300 critical actions, many of which have already been initiated, to address the threat of pandemic influenza. You can download the plan at www.whitehouse.gov/homeland/pandemic-influenza-implementation.html.

■ **GAO Publishes Report on Military Response to Katrina.** The U.S. Government Accountability Office (GAO) has issued a report on "Better Plans and Exercises Needed to Guide the Military's Response to Catastrophic Natural Disasters." The report includes recommendations for executive action, especially in light of the 2006 hurricane season. You can download the report at www.gao.gov/new.items/d06643.pdf.

■ **UK Civil Contingencies Act Guide Released.** The United Kingdom Civil Contingencies Secretariat has issued a revised and updated version

of the short guidance to the Civil Contingencies Act. The Act, and accompanying regulations and non-legislative measures, will deliver a single framework for civil protection in the United Kingdom capable of meeting the challenges of the 21st century. You can download the guide at www.ukresilience.info/ccact/15mayshortguide.pdf.

■ **FEMA Multi-Year Flood Hazard Identification Plan Looks to the Future.** The Multi-Year Flood Hazard Identification Plan is a five-year initiative by FEMA to remap U.S. floodplains and provide digital maps accessible to the public via the Internet. A significant component of the plan is public awareness and education. To learn how map modernization is going to effect local communities and how to get the public involved with this initiative, visit www.fema.gov/plan/prevent/fhm/mh_what.shtm.

■ **Research Available Through NPS.** The Naval Postgraduate School's Center for Homeland Defense & Security (CHDS) has provided homeland security graduate and executive level education since 2002. NPS and the U.S. Department of Homeland Security are partnering to pioneer the development and delivery of homeland security education programs for governors, mayors and senior homeland security leaders from across a wide spectrum of disciplines in local, state and federal government, and the military. Research results and master's theses are posted on the school's Web site at www.chds.us/?research/overview. Subject areas include emergency management, homeland security, terrorism, border security, public health and more.

■ **New Edition of Emergency Response and Salvage Wheel Released.** Heritage Preservation has released a new edition of its *Emergency Response and Salvage Wheel*, a tool for protecting collections from disasters. This resource has been used by archives, libraries, museums and historic sites since 1997 in more than 40 countries. It has been translated into Chinese, Dutch, French, Italian, Japanese and Spanish. About 1,400 special versions of the *Wheel* were donated to institutions in the Southeast after Hurricanes Katrina and Rita. Learn more at <https://www.heritagepreservation.org/catalog/Wheel1.htm>.

■ **Disaster Preparedness Booklet for Children With Special Needs Available Online.** The Florida Institute for Family Involvement (FIFI) has developed *Disaster Preparedness for Families of Children With Special Needs*. The 10-page booklet is organized to assist families to prepare and be ready. It is divided into three sections: thinking ahead, disaster planning and preparation, and response and recovery. You can download the booklet at www.fifionline.org.

New Members

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Gabriel Hayes
Fargo, ND

Philip J. Jass
Chicago Heights, IL
Sponsor: Mike Fagel, CEM

William Kennedy
Fargo, ND

Jeremy Kirchner
Corona, CA

Ashley Kristjanson
Fargo, ND

John Lester
Fargo, ND

Lt. Christopher Miller
Arlington, TN

Mary Ellen Ramsey
Huntsville, AL

Pascal Schuback
Portland, OR

Sherry Shows
Pell City, AL

Kent Theurer
Fargo, ND

Thomas Tzimirotas
Hauppauge, NY

Linda Vig
Bismarck, ND

Todd M. Wardwell
San Pedro, CA

Zach Wilson
Columbus, OH

Veronica Windley
Bronx, NY

IAEM CANADA (REGION 13)

Sean Bertleff
Niagara on the Lake,
Ontario, Canada

Gundula Brigl
Cranbrook, BC,
Canada

Paula-Marie Jannetta
Niagara on the Lake,
Ontario, Canada

Josiane Simon
Montreal, Quebec,
Canada
Sponsor: John Ash

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E.M. Resources

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■ **Exploring Accreditation Project Examines Feasibility of National Public Health Accreditation System.** The National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO) are coordinating the “Exploring Accreditation” project to examine the implications and feasibility of a voluntary national public health accreditation system. This initiative began in 2005 with funding from the Robert Wood Johnson Foundation and the Centers of Disease Control and Prevention (CDC).

Building on the expertise and experience of professionals at every level of public health, and with opportunities for public comment, the Exploring Accreditation project is examining all aspects of accreditation issues, including: governance studies; roles of federal, state and local governmental public health entities; financing; and research and evaluation components. The project’s steering committee has reached consensus on several aspects of a model system, which can be viewed at www.exploringaccreditation.org/27.html.

■ **Official Report on 2005 London Bombings Released.** The “Report of the Official Account of the Bombings in London on July 7, 2005” can be downloaded at www.homeoffice.gov.uk/documents/7-july-report.pdf?view=Binary. The report details an official account into the events on and leading up to the terrorist attacks on July 7, 2005. It summarizes the discoveries the police, intelligence and security agencies have made so far, including what is known about those responsible, and how and why they carried out the attack.

■ **FEMA Web Site Reorganized.** The reorganized FEMA.gov

Web site has been recognized by Keystone Systems, Inc., as the fastest performing and most available Web site in the federal government, based on the company’s index of 40 government sites it measures. The site is well-balanced, easily navigable and significantly improves communication to consumers, according to Keystone. FEMA conducted a year-long study of the Web site and is implementing recommendations from both disaster victims and disaster response and recovery specialists. The new, customer-friendly FEMA.gov design puts information about programs like training, preparation, mitigation, response and recovery fewer clicks away from the home page. In addition to the new design, FEMA has added an improved search engine capability and content management system to ensure that content is current and easy to find.

■ **Hearing Summaries Available.** A summary of the latest U.S. Senate Disaster Prevention and Prediction Subcommittee hearing is now available at the American Geological Institute Web site at www.agiweb.org/gap/legis109/arthobservation_hearings.html#mar30. Additionally, a summary of a hearing by the U.S. House Subcommittee on Water Resources and Environment addressing the National Levee Safety Program Act is posted at www.agiweb.org/gap/legis109/floods_hearings.html#apr6.

■ **RAND Corporation Establishes Public Health Preparedness Database.** The RAND Corporation has established a searchable public health preparedness database that contains exercises used to evaluate public health preparedness. The database was developed under a contract from the U.S. Department of Health and Human Services Office of Public Health Emergency Preparedness. Materials were designed to help state and local public health officials identify and evaluate exercises to be used

in preparedness activities in their local areas. For more information, visit www.rand.org/health/projects/php/index.html.

■ **Traffic Incident Management Community of Practice Web Site Launched.** The National Traffic Incident Management Coalition has announced the availability of the Traffic Incident Management Community of Practice (TIM CoP) Web site. The site is intended for traffic incident responders to share their experiences and knowledge, collaborate, identify and exchange best practices and advance the state-of-the-art in the field. The goal of the TIM CoP is to transfer knowledge within and throughout the traffic incident management community to promote better decision-making, spark innovation and improve the quality of service to customers and partners. The TIM CoP also serves as a “one-stop” online destination for practitioners to ask a question, find an expert or learn more on a specific traffic incident management topic. Visit www.timexchange.org to join the discussion.

■ **COMCARE Launches Patient Tracking Web Site.** As part of the Integrated Patient Tracking Initiative, COMCARE has launched the Patient Tracking Web Site (www.PatientTracking.org), a resource portal for communities procuring and implementing patient tracking programs. The Web site includes practitioner resources, briefing papers, news, funding opportunities, a calendar of upcoming events and a technology dictionary. It will provide open access to an implementation toolkit, including a model RFP, policy guidelines, best practices and lessons learned, which will be developed in Phase II of the initiative. A comprehensive directory of technology vendors offering components for an integrated patient tracking solution also is included as a key feature of the Patient Tracking Web Site.

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E.M. News

■ **GAO Issues Report on Organizational Placement of FEMA.** Because of the Federal Emergency Management Agency's (FEMA) mission performance during Hurricane Katrina, questions have been raised regarding the agency's organizational placement, including whether FEMA should be disbanded and its functions assigned to other agencies, remain within the U.S. Dept. of Homeland Security, or again become an independent agency. The U.S. Government Accountability Office (GAO) report notes that a number of factors may be ultimately more important to FEMA's success in responding to and recovering from future disaster than its organizational placement and provides key issues to Congress as it considers changes. Report highlights are found at www.gao.gov/highlights/d06746thigh.pdf. The full report is located at www.gao.gov/cgi-bin/getrpt?GAO-06-746T.

■ **Committee on Homeland Security Announces Katrina Legislation.** On May 11, six members of the U.S. House Committee on Homeland Security introduced H.R. 5351, the National Emergency Management Reform and Enhancement Act of 2006. The bill takes steps to improve communication and coordination at the federal, state and local levels; strengthen disaster preparedness and response capabilities nationwide; and eliminate waste, fraud and abuse.

"Since Hurricanes Katrina and Rita struck last year, members of our committee have met repeatedly with the local and state-level first responders and emergency coordinators, people who were on the ground and understand where our response fell short and what needs to be done to correct it," Chairman Peter T. King (R-NY) said. "And I'm proud to say that their input – and the suggestions of first responders like them all across the

country – played a major role in the substance of this legislation. I look forward to working with my colleagues on both sides of the aisle to pass this important piece of legislation as quickly as possible." Download the related press release at www.hsc.house.gov/PDFs/PR_Katrina_pre-Hearing050906b.pdf.

■ **DHS Names Lead Federal Officials for the 2006 Storm Season.** The U.S. Dept. of Homeland Security (DHS) announced the unprecedented pre-designation of five teams that will coordinate the federal government's role in support of state and local governments in preparing for and responding to major natural disasters this storm season. In total, 27 federal officials have been appointed, each with unique expertise and considerable experience. Primary responsibility for disaster response has always been at the local level. DHS appointed federal teams for the Gulf Coast Region, Florida, Northeast Region, Mid-Atlantic Region and Texas. For a list of appointed principal federal officers, deputy principal federal officers and federal coordinating officers and their regions, visit www.dhs.gov/dhspublic/display?content=5552.

■ **NIPP Base Plan Status Update.** Following two rounds of public review and comment, the draft base plan of the National Infrastructure Protection Plan (NIPP) was provided to the Homeland Security Council's Critical Infrastructure Protection Policy Coordinating Committee. This interagency group reviewed the document and provided concurrence. The plan is in the process of being reviewed by the HSC Deputies Committee. Once that committee gives its concurrence and/or recommendations, the NIPP Base Plan will be readied for the interagency signatory process in anticipation of its final release.

■ **DisasterHelp.gov Announces New Features.** The DisasterHelp.gov portal now offers an IRS community page with information about relief provisions designed to assist those in disaster areas. Also, the site is now the home for the weekly "Emergency Management Response Infograms." Apply at DisasterHelp.gov for access to collaborative tools, including discussion threads and secured document sharing.

■ **American Red Cross Expands Capacity To Handle Disasters.** At the National Hurricane Conference in Orlando, the American Red Cross detailed plans to expand its capacity in disasters, dramatically increasing pre-positioned supplies to assist communities across the country through the earliest days of a disaster. The Red Cross also said it plans to form partnerships with community-based organizations to speed assistance to disaster victims and bring help closer to where they live. Most elements of the initiative will be completed or underway by July 1, 2006.

The initiatives include:

- Dramatically increasing the stockpiling of supplies (food, cots, blankets, comfort kits, etc.) in key risk states, which will enable the Red Cross to serve one million meals and shelter 500,000 people per day in the initial days after a disaster strikes. This represents an additional investment of about \$80 million for supplies and nearly tripling of warehouse space around the country.
- Pre-stocking one million debit cards for families displaced by catastrophic events.
- Pre-positioning redundant communications equipment – satellite phones, cell phones and radios – in 21 cities in nine coastal states.
- Upgrading the Red Cross's IT infrastructure to allow it to speed

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financial assistance to one million affected families within a 10-day period and two million over a longer term. During Katrina, that system strained after it exceeded 100,000 cases, though the Red Cross ended up serving more than 1.2 million families across the Gulf Coast through a variety of means.

- Creating, with FEMA, a nationwide database that will help officials track the location of shelters – as well as the number of people in them – during a major disaster.

- Dedicating Red Cross staff to coordinate closely with state emergency management agencies in 13 high-risk areas.

■ **DHS Secretary Outlines Steps Toward Improving Interoperability.** At a May 8 speech, Homeland Security Secretary Michael Chertoff outlined the next steps the U.S. Dept. of Homeland Security will take to improve the interoperability of emergency communications systems used by first responders. Secretary Chertoff emphasized that the technology to allow for interoperability exists and called on states and localities to take the

E.M. Resources

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■ **FDA's Latest Patient Safety News Video Available Online.** The U.S. Food and Drug Administration (FDA) has posted the April edition of *Patient Safety News*, a Web-based video news program aimed primarily at health professionals. The program features information on new drugs, biologics and medical devices, as well as FDA safety notifications and product recalls. To access the program, go to www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/index.cfm.

leadership actions necessary to implement interoperable communications. A department survey is being conducted of some 23,000 state and local government users that will establish a baseline. Then DHS will form a task force led by state and local participants to work toward a set of functional requirements that state and local governments can use to guide their equipment purchases.

“We must recognize it is not up to industry to define what is needed. It is up to all of us to define these requirements and tell industry what we need,” said Secretary Chertoff. “In the long term, we are continuing with the rigorous process of arriving at technical standards for future generations of communications equipment, working with our partners in government, the private sector and international standards organizations. But, as important as that is, we cannot wait for the arduous technical standards process to play out before we achieve the improved state of interoperability that we need to respond to our citizen’s needs.”

■ **DHS Conducts Drills for 2006 Hurricane Season.** On May 3, the U.S. Department of Homeland Security kicked-off the first of five regional hurricane preparedness exercises to test improvements made since last year’s hurricane season and to identify areas that require additional coordination before the start of this hurricane season, which officially begins June 1. The table-top exercises focused on several key preparedness and disaster response functions, including evacuations, sheltering, National Response Plan implementation and National Incident Management System activation.

“Hurricane preparation is a shared responsibility among local, state and federal agencies and our non-governmental partners,” said George Foresman, Under Secretary for Preparedness. “By training together now, we better integrate planning and response capabilities

and make certain that roles and responsibilities are understood at all levels of government.”

The Preparedness Directorate’s Office of Grants and Training developed the exercises with FEMA to engage officials from states and territories in the likely hurricane impact zone. The exercises included partners at all levels of government, as well as tribal entities, non-governmental organizations and private industry.

Exercises were held in Philadelphia, involving Pennsylvania, Virginia, Maryland, Delaware and the District of Columbia; in San Juan, Puerto Rico, involving Puerto Rico and the U.S. Virgin Islands; in New Orleans, involving Louisiana and Arkansas; and in Atlanta, involving Alabama, Florida, Georgia, Kentucky, Mississippi, Tennessee, North Carolina and South Carolina. The final exercise will take place June 20-21 (location TBD), involving New York, New Jersey, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. To learn more, visit www.dhs.gov/dhspublic/interapp/editorial/editorial_0852.xml.

■ **Global Leadership Consortium Formed as Research and Learning Network.** The newly formed Global Leadership Consortium is a research and learning network designed to support federal agencies in developing leaders who can excel in the global environment. One consortium goal is to help define competencies for leading, living and managing more effectively in an increasingly seamless international environment. The consortium plans to provide leadership and education/training resources for government agencies to assist them in the development of globally literate and successful leaders. The group was founded by the National Academy of Public Administration, the Federal Executive Institute and the U.S. Dept. of Agriculture Graduate School. Learn more at http://www.napawash.org/pc_global/recent_projects.html.

IAEM Conference Sponsorship Opportunities Available

IAEM is looking for sponsors for the upcoming IAEM 2006 Annual Conference & EMEX Exhibit, Nov. 12-15 in Orlando. IAEM conference sponsorships are a great way to enhance your presence at this event. IAEM can work with any budget, and co-sponsorships can be considered. To discuss these and other sponsorship ideas, please contact IAEM Executive Director Beth Armstrong, at 703-538-1795, ext. 6 or armstrong@iaem.com.

■ **Platinum Conference Sponsorship:** \$10,000+. Sponsors receive premiere recognition on pre-event materials, prominent entrance signage, designation as a specific meal or break host (choose one), and a one-time rental of IAEM's member list.

■ **Conference Luncheons:** \$19,750 each (2 sponsors). Lunch is served Tuesday and Wednesday; on Tuesday, it is located in the exhibit area.

■ **Exhibit Opening Reception:** \$12,000 (1 sponsor). EMEX begins with a opening ceremony and reception on Tuesday, 4:00-5:30 p.m. This is a great PR opportunity for the sponsor.

■ **Cyber Café:** \$9,975 (1 sponsor). Internet-connected stations are located in the EMEX exhibit hall for visitors to access their e-mail while at the IAEM event.

■ **Registration Bags:** \$8,500 (1 sponsor). Canvas briefcase-style bags will be provided to each registrant, containing conference hand-outs and reference materials.

■ **Breakfasts:** \$8,550 each (2 sponsors). IAEM seeks support to provide continental breakfasts for all attendees on Tuesday and Wednesday.

■ **Welcome Reception:** \$5,000 (1 sponsor). This Sunday evening gathering includes a brief overview of IAEM for newcomers in an informal setting, and provides the sponsor ample exposure as party host.

■ **Scholarship Auction:** \$3,500 (1 sponsor). IAEM provides refreshments during this Tuesday fundraiser to raise scholarship funds for emergency management students. There is a cash bar and light hors d'oeuvres.

■ **EM Career Workshop:** \$2,500 (1 sponsor). Sponsorship is perfect for those recruiting EM and homeland security professionals – it is a popular session for students graduating from EM degree programs. *Note:* Speakers and topics are determined by the IAEM Conference Committee.

■ **Afternoon Coffee Breaks:** \$2,200 each (2 sponsors). Two breaks in the exhibit area offer attendees coffee, tea, sodas and an afternoon snack, and allow networking.

■ **Morning Coffee Breaks:** \$2,000 each (3 sponsors). Three breaks in the exhibit area offer attendees coffee, tea and sodas, and allow networking.

■ **President's Hospitality Suite:** \$2,000 per night (4 sponsors). Attendees can relax after-hours in a suite organized by IAEM. Assorted beverages and snacks will be served. Four nights.

■ **Champagne Toast:** \$1,500 (1 sponsor). Wednesday evening, the IAEM President's Banquet concludes with a toast to Certified Emergency Managers® and others.

■ **IAEM Board Meeting:** \$1,000 each (2 sponsors). The IAEM leadership meets twice during the conference. Refreshments and materials are provided.

Benefits of Sponsorship

■ Publicity is included in pre-conference literature and materials (commit early to take advantage of this benefit).

■ Sponsor logos are printed on a premier page of the conference program.

■ Attention-getting signs announcing sponsors are posted.

■ Sponsors receive verbal recognition from the podium.

■ Meet-and-greet the more than 900 emergency management professionals who will attend this annual event.

■ Sponsors receive additional publicity in IAEM's post-conference newsletter coverage. The *IAEM Bulletin* reaches more than 3,100 via print and an average 10,000 electronically each month.

■ Your company sponsorship is announced on www.iaem.com with a link to your Web site.

■ You may receive tax deduction to the extent permitted by law. Check with your financial advisor. IAEM is a non-profit, charitable organization.

Other Opportunities

■ **EMEX Exhibit Booth.** In conjunction with the conference, IAEM showcases all significant suppliers of homeland security and disaster technology. See www.emex.org for a map of current space available and a list of your competitors.

■ **Scholarship Auction.** Goods, services and cash donations are sought for this charitable program that supports the study of emergency management and disaster preparedness. Contact Dawn Shiley at 703-538-1795, ext. 3, or shiley@iaem.com.

■ **Doorprize Drawings.** Items are publicized in conference materials, and the drawings provide additional exposure for donors' products and services.

■ **Registration Bag Inserts:** \$300 per item. Get details about your product or service into the hands of every attendee.

■ **Student Sponsorships.** Cover the costs for students to participate at the conference (registration fee is \$200 per student, and travel expenses vary), or contribute to a central fund for this purpose. Contact Sharon Kelly at 703-538-1795, ext. 2, or info@iaem.com to discuss these and other participation ideas.

EMEX 2006 News



Virtual EMEX 2006 Is Up-and-Running!

Exhibitors who have reserved space at EMEX 2006 already have their company profiles posted at www.emex.org. The Virtual Expo offers a year-round presence for EMEX exhibitors, including a direct link to their Web sites for more information.

IAEM 2006 Annual Conference & EMEX Exhibit: "Going All the Way... Putting Plans Into Action"
 – Nov. 12-15, 2006, Orange County Convention Center, Orlando, Florida –

IAEM Annual Conference & EMEX Exhibit

**November 13-15, 2006
Orange County Convention Center
Orlando, Florida**

The information, products and services you offer are vital in today's high-threat world, so there's no better time than now to reach the customers who will see your resources through IAEM/EMEX. EMEX 2006 is the show that brings together homeland security and disaster preparedness suppliers in the same building, under the auspices of the International Association of Emergency Managers (IAEM).

Attendee Profile. More than 900 leading emergency management and homeland security decision makers will convene in Orlando at the Orange County Convention Center for IAEM's 54th Annual Conference. The majority of attendees are purchasers or specifiers for their jurisdictions or corporations, to include disaster planning and preparedness managers, first response coordinators, emergency communications managers, private industry security and contingency planners, government continuity of operations managers, and contract services providers.

Conference Theme. "Going All the Way...Putting Plans Into Action." The IAEM Conference Committee is currently putting together an exciting program based on this theme.

Book a Booth. Large display space or 10x10 exhibit booths are available and come with standard amenities. Exhibitors also are included in a virtual trade show. With the unprecedented success of the 2005 show in Phoenix, we are expecting a much greater interest from even more companies at EMEX 2006 in Orlando. Visit www.emex.org to see complete details and reserve your space today! There is booth space still available – but prime locations will go fast!

Book Vehicle Space. If you're interested in booking vehicle space in the show room, contact IAEM Headquarters for details.

What They're Saying...

What are people saying about the **Emergency Management & Homeland Security Expo**, featured at each year's IAEM Annual Conference?

"EMEX is our #1 destination each year."
 – Eric Sutliff, Twenty First Century Communications

"EMEX is the place to see the latest and greatest lifesaving equipment from the different vendors, as well a chance to network with international and local decision makers."
 – Chris Roller, American Signal Corporation

"I've found EMEX to be the best! All the newest and latest in emergency management in one location."
 – Michael D. Selves, CEM, IAEM First Vice President

I WANT TO BECOME A MEMBER OF IAEM.

Pay annual membership fee of \$170 U.S. individual (\$50 for members outside United States), \$25 student, or \$500 affiliate (corporate). Fill out this form and mail with your check to:
 IAEM, 201 Park Washington Court, Falls Church, VA 22046. Or register online today at www.iaem.com



Name _____ Title _____
 Organization _____ Recruited by _____
 Mailing Address _____
 City/state/zip _____
 Phone/fax _____ E-mail (if available) _____

I can't join now, but I would like to receive more information on the benefits of IAEM membership.

New Certified Emergency Managers®

Approved Feb. 19, 2006

Michael G. Bertrams
City of Beaumont Fire Dept.
Beaumont, TX

Catherine Blair
Toronto Transit
Commission
Oakville, Ontario, Canada

Brian V. Bovyn
Manchester Police Dept.
Manchester, NH

James L. Bowden
General Physics Corp.
Nashville, TN

LeAnn M. Coletta
City of Moreno Valley
Moreno Valley, CA

Patrick M. Collins
Prince William County
Manassas, VA

Frank W. Comer, IV
DoD-National Geospatial
Intelligence Agency
Gainesville, VA

Brian A. Crawford
Shreveport Fire Dept.
Shreveport, LA

Paul B. Crawford
Rhode Island Emergency
Management Agency
Cumberland, RI

Terry A. Gitlin
California State Automobile
Association
Castro Valley, CA

Johnny Gonzalez
U.S. Coast Guard
Guaynabo, PR

Lt. Col. Terry Hamilton
Air Force Inspection Agency
Albuquerque, NM

William T. Jackson
Iredell Co. Office of
Emergency Management
Statesville, NC

William R. Jenkins
City of Cleburne
Cleburne, TX

Phyllis A. Johnson
City of Yuma
Yuma, AZ

Dr. Jane Kaminski
FEMA Region V
Detroit, MI

Glen Karpovich
Ramsey Office of
Emergency Management
Ramsey, NJ

Ronald O. Kirk
U.S. Postal Service
Las Vegas, NV

Steven R. Marshall
Somerset County
Princess Anne, MD

Bill Mitzel
Unigard Insurance
Issaquah, WA

John T. Moore
Reedy Creek Improvement
District
Lake Buena Vista, FL

Wayne R. Morris
City of Calgary Fire Dept.
Calgary, Alberta, Canada

Stacy Peerbolte
U.S. Senate
King George, VA

Dan Robeson, Jr.
Johnson Co. EM &
Homeland Security
Olathe, KS

Anthony Russell
FEMA-DHS
Albuquerque, NM

Stan Smoke
City of Wenatchee Fire &
Rescue Dept.
Wenatchee, WA

Jennifer Smysnuik
City of Toronto Office of
Emergency Management
Toronto, Ontario, Canada

Gregory W. Solecki
City of Calgary Disaster
Services
Calgary, Alberta, Canada

Deborah Steffen
San Diego Co. Office of
Emergency Services
San Diego, CA

Hui-Shan Walker
Chesapeake Emergency
Management
Chesapeake, VA

Valli Wasp
City of Austin Office of
Emergency Management
Austin, TX

The IAEM 2006 Annual Conference & EMEX Exhibit program will feature:



**IAEM 2005 Annual Conference
& EMEX Exhibit
"Going All the Way...
Putting Plans Into Action"**

Nov. 12-15, 2005 ■ Orlando, Florida

Register online: www.iaem.com
Tour Virtual EMEX 2006: www.emex.org

- Keynote Presentations by U.S. DHS Under Secretaries George Foresman (Preparedness) and David Paulison (Federal Emergency Management)
- Disasters Through Time, by archeologist and author Brian Fagan
- The Five Concurrent Themes for Success, by highway patrol officer, attorney, risk manager and humorist Gordon Graham;
- Developing Legal Trends in Emergency Management, including Making Your Case on a FEMA Appeal, by Ernest Abbott of FEMA Law Associates
- Wal-Mart's Hurricane Response, by Jason F. Jackson
- Life Ain't Certain: Ride Your Best Horse First, by Sandy Davis
- The Political Realities of Disasters, by former FEMA Director Mike Brown
- U.S. National Incident Management System (NIMS); multiagency coordination systems; resource management; public information systems; and many additional sessions and speakers.

IAEM 2006 Award Nominations and Media Contest

The IAEM Annual Conference is the time when IAEM recognizes members who have made special contributions. Nominations for awards should be sent IAEM Headquarters. Nomination deadline is **Sept. 1, 2006**.

Include a written report detailing actions of the nominee and their significance to the organization. Remember to indicate the award for which you are nominating someone.

Award Categories

■ *Presidential Citations.* Bestowed by the current President on outstanding representatives of the principles and practices of IAEM.

■ *Executive Citations.* Selected by regional presidents with input from regional members, and given to members who exemplify the image of professionalism.

■ *Honorary Citations.* Granted to two individuals from any profession who have actively supported IAEM. Recipients are selected by the IAEM Board of Directors.

■ *Membership Award.* To the person most active and successful in recruiting new members.

■ *National Security Award.* To a person who has significantly contributed to efforts promoting national security. Selected by the IAEM Board.

■ *Partners in Preparedness Award.* Given by the Awards & Recognition Committee to an organization for its support of local emergency management.

■ *Business & Industry Preparedness.* Bestowed by the Awards Committee.

For more details, on IAEM awards, visit the IAEM Web site at www.iaem.com.

Media Awards

IAEM Media Awards recognize successful promulgation of emer-

gency management related information through the media via:

- Newsletters.
- Special publications (posters, brochures, educational campaigns, reference materials).
- Individual media items (news/promotional story or photo, editorial).
- Audiovisual products (video-tapes, audiotapes).
- Computer products (Internet sites, bulletin board, interactive software).

Entries can be submitted in one of three divisions:

- Local (entries must be submitted by IAEM members).
- State, regional or national government or nonprofit organization.
- Commercial or for-profit entities.

How To Submit Media Entries

Samples for the Media Contest should be sent to IAEM Headquarters for judging by a panel of media experts. Include a cover letter explaining how the project was created, distribution methods, how it was funded (if appropriate), a statement granting IAEM the right to reprint entries, and exact wording on how the recipient's name should be listed on the

awards certificate if selected.

Contestants may submit no more than one entry per category. Entries must have been published or developed during the period of Apr. 1, 2005 to July 31, 2006. A label must be attached to the front cover of the entry showing the name of the contestant, the category, and the appropriate division, if applicable.

Entries should be submitted to IAEM Headquarters no later than **Sept. 1, 2006**. Entries will be displayed during the Annual Conference in Orlando, where winners will be announced. Entries not picked up in Orlando will be discarded. More details can be found at www.iaem.com.

Clayton R. Christopher Award

The Clayton R. Christopher Award is presented by Region 4 to a member who is a local director, in recognition of unselfish devotion and outstanding contributions to emergency management. Any member may nominate a candidate regardless of location. For details, contact Larry Gispert, Region 4 President, 813-276-2385 or gispert@hillsboroughcounty.org. The deadline for nominations is **Sept. 1, 2006**.

IAEM and HPP To Co-Sponsor 2nd Annual Interagency Disaster Preparedness Award

The 2nd Annual Interagency Disaster Preparedness Award is co-sponsored by IAEM and *Homeland Protection Professional* magazine (www.hppmag.com). This award was established to recognize and encourage the crucial role of interagency cooperation in keeping citizens and communities safe from both natural and manmade disasters in the post-9-11 world. To be eligible for consideration, a program must be an ongoing multi-agency effort whose mission is primarily disaster and/or terrorism mitigation, prevention, response, and/or recovery. Entry is open to U.S. and Canadian emergency response, emergency management and emergency support agencies (such as public health and public works) and their municipal, county, tribal, state, military or federal jurisdictions or parent agencies. Entries are judged on the extent to which their collaborative efforts demonstrate results in disaster or terrorism preparedness. Entries must be received at IAEM Headquarters by **Sept. 1, 2006**. Please see www.iaem.com for details about IAEM Awards.

Invitation to Participate in IAEM Region 9 Roundtable on “H5N1 Bird Flu – Threat of an Influenza Pandemic?”

July 11, 2006 – 10:30 a.m.-2:30 p.m.

**Gilbert Fire Department Amphitheater, 85 E Civic Center Drive, Gilbert, Arizona 85296
(located about 25 miles southeast from Downtown Phoenix, south of the 60 Freeway)**

May 23, 2006

Dear Friends and Colleagues,

The IAEM Region 9 Roundtable on the H5N1 Bird Flu in Los Angeles on May 15 was very successful. More than 80 government agencies in the Greater Los Angeles Area were represented. Also in attendance were some of the larger industry employers and subject matter experts from public health services, as well as a variety of IAEM Region 9 members.

Our second IAEM Region 9 Roundtable on H5N1 Bird Flu will be held on **July 11** in the City of Gilbert in the Greater Phoenix Area, Arizona. I invite you to participate in this second IAEM Region 9 H5N1 Bird Flu Roundtable in cooperation with the Gilbert Fire Department (www.ci.gilbert.az.us/fire/default.cfm).

If you would like to participate, please send your registration ASAP. Space is limited to 80 participants. We will be accepting both credit cards and checks.

If you have any questions, please do not hesitate to contact me.

Best Regards,

Gunnar J. Kuepper
IAEM Region 9 President
Emergency & Disaster
Management, Inc.
5959 West Century Boulevard,
5th Floor
Los Angeles, CA 90045

Phone: (310) 649-0700
Fax: (310) 649-1126
E-Mail: gjk@edmus.info
Web Site: www.edmus.info

Region 9 Roundtable Program

The H5N1 Bird Flu Virus has already killed at least 200 million wild birds and poultry throughout Asia, Africa and Europe. Worldwide 217 people have become infected, and 123 of those have died. In February, the virus had reached Germany, Italy, Austria and other countries in Western Europe, which created significant challenges for the governmental agencies, emergency services and the communities affected.

Using astonishing images and animations with PowerPoint technology, the roundtable will describe and demonstrate:

- i. the H5N1 Bird Flu Virus, its history, mode of action, infectivity and virulence. The limited effectiveness of antiviral drugs such as Tamiflu will be explained. The complexity of the current situation throughout the globe will be shown in a comprehensible manner
- ii. the lessons learned from recent experiences in Western Europe, such as:
 - o protocols for collecting and transporting deceased birds
 - o unexpected infections of cats and other mammals
 - o miscommunication and confusion between local, state, and federal governments, particularly in Germany
 - o public health concerns and public education
- iii. the WHO (World Health Organization) protocol for rapid response and containment, followed by
- iv. Discussion and exchange of information on the threat to Arizona, effective preparations and our state of readiness.

In addition, we will introduce the National Institute of General Medical Sciences simulation of different various flu pandemic scenarios in the U.S. We will also present the study’s findings for successful intervention strategies.

Admission (including coffee, tea and an excellent lunch):

- o for IAEM Region 9 members – US \$25
 - o for members of AESA, public sector agencies, emergency services community (fire, EMS, law enforcement, emergency planning and business continuity), health care and public health, or members of civic organizations such as the Red Cross, Salvation Army, Rotary – US \$45
 - o for others not affiliated with any of the above institutions – US \$165
- Please register via e-mail (info@edmus.info), fax (1-310-649-1126), or mail and provide payment no later than **July 4, 2006**. Please make checks payable to Emergency & Disaster Management, Inc. Since space is limited, we recommend early registration. Registration is transferable to another person. Walk-in will not be possible.

Registration:

Name: _____

Title: _____

Agency/Group: _____

Address: _____

Phone: _____

Fax: _____

E-Mail: _____

- o IAEM Region 9 Member Registration – US \$25
- o Member AESA Registration – US \$45
- o Emergency Service (fire/EMS/law enforcement) or Governmental Agency Registration – US \$45
- o Civic Organization: _____ Registration - US \$45
- o Other Registration - US \$165