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DHS/FEMA/RESILIENCE/NPD/NTED

FEMA

TPP Times

Welcome!

Welcome to Winter 2019 issue of the TPP Times! As we make our way through the muddy end of winter, we're saying goodbye to FEMA Administrator, Brock Long, who resigned last month, saying, "While this has been the opportunity of the lifetime, it is time for me to go home to my family my beautiful wife and two incredible boys. As a career emergency management professional, I could not be prouder to have worked alongside the devoted, hardworking men and women of FEMA for the past two years." Deputy Administrator Peter Gaynor will serve as the acting FEMA Administrator until a permanent replacement is confirmed.

We're sad to see Mr. Long go, but we're happy to be able to highlight in this issue the return of some of our personnel who have recently been deployed, James Dansby and Lillie Sapp. Also in this issue, our cover article does a deep dive into the Ebola Epidemic of 2014 – 2015 and the lessons our community has tak-en away from that event. If you have ideas for future cover articles, please let us know!

Under "Events," you'll see information on the upcoming Homeland Security National Training Program Kick-Off Meeting and other FEMA happenings.

And as always, we have new information on accessibility in "Section 508 Quarterly," NIMS news, and course updates, including the recertification of PER-221 Tactical Operations for CBRNE Incidents Course by Louisiana State University.

We welcome your input on the TPP Times, including comments, questions, and information you want to share with other Training Partners. Email us at TPPTimes@fema.dhs.gov.

In This Issue

United States Africa Command Photo

Ebola Virus Disease: Where Are We Now?

By Chris A. Smith

In 2014, the largest ever outbreak of Ebola Virus Disease (EVD) devastated parts of West Africa and caused considerable disruption, panic, and fear, as well as two deaths in the United States. The outbreak is believed to have started in a rural area of Southeastern Guinea, but quickly spread to Liberia and Sierra Leone. Four months later, the outbreak was declared a Public Health Emergency of International Concern by the World Health Organization (WHO). When the outbreak was declared over in June of 2016, it had infected over 28,000 people and killed at least 11,308—a shocking 39% fatality rate.

International partners, including the Centers for Disease Control (CDC), the WHO, U.S. Government agencies, and ministries of health, worked intensely to control the epidemic. Factors that impeded the control of the spread of the disease included the massive numbers of people infected, the wide geographic spread, a delayed response by the international community, poor public health and healthcare infrastructure, and distrust of and among government authorities and healthcare workers.

The strategy used in West Africa to control and eventually bring this outbreak to an end focused on quarantine of infected people, improved laboratory testing, effective infection control for healthcare workers, follow-up with people who had come in contact with infected patients, and safe burials.

Meanwhile, in the United States, efforts were underway to prepare for the possibility of a domestic outbreak. The CDC was very active in issuing education and guidance to public health and medical partners at all levels. Laboratories were equipped and trained on how to test for the virus to ensure rapid diagnosis. Hospitals relied on their infection control practices and federal guidance to protect their healthcare workers. Traveler screening and monitoring were put into place at international airports that provided service to impacted regions of the world; travelers returning to the U.S. who were exposed to the virus were quarantined; and health-care workers who cared for the infected were actively monitored twice daily for signs and symptoms of the illness.

While these efforts were thought to be sufficient at the time, those assumptions proved incorrect upon the first confirmed case of EVD in Dallas, TX, in August 2014. This patient later died from the disease and widespread panic ensued when two of the nurses who had cared for this patient became infected with Ebola virus. They were both hospitalized and later recovered. In total,

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Chris A. Smith, MHA, MEP, has worked in public health and healthcare emergency management for 17 years at the local, regional, and state levels. She is currently the Sr. Manager of Emergency Preparedness for Brigham Womens Health in Boston, MA. This article was condensed for the *TPP Times* from a longer academic piece. We will regularly solicit articles from experts in emergency management to provide you with the latest insights and expertise in the field.

eleven people were treated for EVD in the U.S., two of whom died. Most of these patients were infected with the Ebola virus outside of the United States and medically evacuated to the U.S. or returned to the U.S. via commercial aircraft.

As more patients entered the U.S., hospitals simultaneously struggled to equip and train their healthcare workers to ensure they could be prepared to care for EVD patients. Adequate preparation at all levels remained a challenge.

In December 2014, the U.S. Department of Health and Human Services (HHS) released the initial Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease (EVD): A Framework for a Tiered Approach. To ensure a realistic level of preparedness across the U.S., the CDC and HHS defined three tiers of hospital readiness:

- Frontline hospitals that would identify patients with signs and symptoms, and/or at-risk persons;
- Assessment hospitals that could evaluate and care for a suspected patient for up to 96 hours; and
- Treatment hospitals that were trained, staffed, and equipped to care for and manage an EVD patient throughout the disease process.

In response to the outbreak, Congress appropriated $5.4 billion in emergency supplemental funding to several federal agencies, geared towards supporting the international response, research and development, and the U.S. response. Of this appropriation, $259.7 million was designated to support the rapid development of the tiered hospital response network. It was the hope that preparedness for EVD, through this framework, would also increase the levels of preparedness for other novel, highly pathogenic diseases.

As experience with treating EVD patients in the U.S. grew, the realization arose that EVD patients are clinically complex and require advanced technology and skilled healthcare workers. This combination is not found equally across the country, and so the regional framework was designed to ensure there were capabilities to care for EVD patients within 400 miles of any location in the majority of the country. This strategy also depended on every frontline hospital being able to have the capability to *identify, isolate, and inform* if receiving a patient suspected of EVD.

The regional framework allowed for a tiered response by capability of the hospital, and allowed hospitals to appropriately

U.S. Air Force Capt. Tanya Tsosie draws blood from a simulated Ebola patient during the week-long training course at the San Antonio Military Medical Center. Tsosie, a nurse from the 959th Medical Group, is assigned to a 30-member medical response team designed to support civilian medical professionals in the event of an Ebola outbreak in the United States. (U.S. Air Force photo/ Master Sgt. Jeffrey Allen)

President Barack Obama greets Nina Pham, a Dallas nurse diagnosed with Ebola after caring for an infected patient in Texas, in the Oval Office, Oct. 24, 2014. Pham is virus-free after being treated at the National Institutes of Health Clinical Center in Bethesda, Md. (Official White House Photo by Pete Souza)

scale their resources. The hospitals that accepted the responsibility as a Regional Ebola Center or other special pathogen treatment center received funding to be specially equipped and trained for this purpose.

The National Ebola Training and Education Center (NETEC) was created through an allotment of $24 million of the Congressionally-allocated funds to support the regional treatment network with by sharing expertise and best practices of Special Treatment Centers.

Quarantine capacity and capability were also expanded by awarding $20 million to the University of Nebraska Medical Center for training, simulation, and a 20-patient quarantine center.

What Did We Learn?

The Ebola Virus Outbreak of 2014–2016 taught the public health and healthcare communities around the world a variety of lessons. The U.S. HHS deployed more than 4,000 personnel to respond to this epidemic—a strategy that was key in controlling the epidemic and spread of disease to the United States. However, the extent to which the outbreak was allowed to progress without the declaration of a Public Health Emergency of International Concern, contributed to the rapid spread within West Africa. The progression was fueled by the cultural practices, population density and mobility, poor public health infrastructure and expertise, and lack of medical capabilities. The aid finally sent to assist with the outbreak had implications with healthcare workers and travelers returning to the United States due, in part, to exposure and medical evacuations.

Much work has been done in federal, state, and local preparedness since 9/11. The National Response Framework, Pandemic Influenza Planning, and work in Risk Communications all should have provided a framework for the U.S. Ebola virus response. However, these plans were not effectively implemented. Emergency Support Function #8—the Public Health and Medical Services Annex—was not activated to coordinate the federal response. Further, HHS did not activate a centralized response structure, which complicated the coordination efforts. The risk communication process was not fully utilized, and early public communications provided a sense of confidence that later proved to be false. Pervasive across the country were fear, mistrust, and lack of confidence in hospital readiness and in the credibility of government officials.

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Spotlight: FEMA Deployments

From the Editors

Over the last 2 years, FEMA has faced record-breaking challenges in deploying personnel to support disaster-afflicted areas, including Puerto Rico, North Carolina, Texas, Louisiana, and more. In the autumn of 2017, for example, 73% of FEMA's response workforce was deployed, as well as over 4,000 employees from the Surge Capacity Force. In this period, the National Training and Education Division (NTED) saw two of our personnel—Ms. Lillie Sapp and Mr. James Dansby—deployed to support Puerto Rico and North Carolina respectively.

Ms. Lillie Sapp is a Quality Assurance Officer of Training and Instructional Systems Design Specialist for NTED. A disabled veteran and formerly a professor at the Army Management Staff College, she has been with NTED for 7 years. Lillie deployed to Puerto Rico for 10 days in October 2018 as part of the Disaster Field Training Operations (DFTO) cadre. FEMA has 22 deployment cadres, in areas as disparate as Equal Rights, Information Technology, and Alternative Dispute Resolution. The DFTO cadre plans, develops, promotes, and delivers disaster performance improvement and training opportunities. The cadre also staffs the training unit in the joint field office, plans and coordinates training activities, oversees the development of training collateral, and provides guidance.

Puerto Rico was hit by several major hurricanes in succession, the last of which, Maria—which hit on September 17, 2017—left the U.S. territory utterly devastated. FEMA deployed over 5,200 federal staff and approved over 467,000 individual assistance applications. The current efforts on the island are part of the "recovery phase," which follows the "response phase" after immediate needs, like power and clean water, have been restored. FEMA has stated that the recovery phase will most likely take years.

> "The Puerto Rican people are so warmhearted; they just take you in."

FEMA Photo by Eduardo Martinez

FEMA Photo by Liz Roll

As part of the DFTO, Lillie trains local hires to take over disaster recovery efforts so that deployed federal personnel can return home or support other areas. "FEMA is the largest employer in Puerto Rico right now," Lillie said. "We hired 2,700 people." These local hires go through a training process that moves them from being "temporary hires" to the status of being FEMA-qualified. Lillie supported two sessions of a disaster management course that trained 20 hires each.

Lillie has previously visited Puerto Rico with her husband on an anniversary trip. "Going as a vacationer, then turning around to go back as a disaster relief person…it was amazing to see that kind of destruction," she said. "However, the people were still the same. They are so warmhearted; they just take you in." She added, "They were so grateful and gracious—but almost sorry that they needed help."

An important element to the DFTO's deployment effort was to communicate with the public about "how FEMA operates," Lillie said, "and to communicate with the residents about the limitations of the federal system's resources, with three hurricanes hitting at the same time, along with wild fires, etc." Lillie and her cadre worked to engender patience and understanding, while reminding residents, "We're here to help until it's over."

Mr. James L. Dansby is an NTED Program Manager, managing a Training Partners portfolio including the University of Hawaii's National Disaster Preparedness Training Center and the Mission Support and Test Services, Counterterrorism Operations Support's Center for Radiological/Nuclear Training. He has been with NTED for 14 years. James was deployed to Central North Carolina as part of the Disaster Survivor Assistance (DSA) cadre, to provide assistance in the wake of Hurricane Florence. The DSA cadre establishes a timely presence focused on addressing the needs of impacted populations and disaster survivors. They collect targeted information, provide accessible in-person information and referrals, and identify public information needs.

Hurricane Florence caused severe damage in the Carolinas in September 2018, and James and his cadre arrived on Septem-

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Ebola—(Continued from page 2)

The complications that hospitals faced were widespread as well. Hospital staff experienced fear and anxiety with the thought of contracting the disease, despite the use of personal protective equipment (PPE). Initial CDC guidelines on PPE were not sufficient and had to be increased to ensure protection, which undermined confidence in safety and the guidelines being provided. Hospitals began to stockpile PPE regardless of the risk. The ever-changing PPE guidelines, the lack of commercial availability of PPE, and the levels of training did not reassure healthcare workers of their safety. It became apparent that it was not realistic to equip all hospitals in the U.S. to face the challenge of caring for an EVD patient.

There was also a varied application of public health control measures, such as quarantine and surveillance. Several states implemented control measures that were more restrictive than the CDC recommendation. Logistical challenges also surfaced with those who were placed under isolation and quarantine. PPE waste disposal proved to be a challenge that took some time to resolve, with waste piling up in the meantime. Enhanced surveillance measures to track at-risk persons became a huge resource burden.

Are we better prepared in 2019 than we were in 2014 for caring for EVD patients in U.S. hospitals? Undoubtedly, we are. Hospitals across the country have readied themselves for an EVD patient. Facilities have been enhanced, equipment has been purchased, plans have been developed, and training has been provided. Memory fades, however. As the threat diminishes, more immediate risks take precedence.

The threat in 2019 is still very real. An EVD outbreak is ongoing in the Democratic Republic of the Congo, after a few years of very few cases. This outbreak involves a politically unstable area of the country and the outbreak is proving difficult to contain. As of the writing of this article, total cases were up to 689 and deaths at 422 with a catastrophic 58% case fatality rate. At this time, the outbreak is not considered a Public Health Emergency of International Concern; however, it is being monitored closely.

Hospitals that have maintained the funding for preparedness as an assessment or treatment hospital have maintained their readiness for Ebola virus as a requirement of their funding. But the majority of hospitals across the country did not receive such funding. Astute infection control and emergency management practitioners at these hospitals assess risks continually and should be ensuring that their hospitals are prepared if a suspect patient walks through their doors. This work takes an understanding of risk, an awareness of global and local diseases of concern, and perseverance to ensure that the specialized PPE supplies remain adequate, with little to no external funding, and that staff maintain a level of awareness and training to be able to *identify, isolate, and inform*.

It is not a matter of *if* we will see another EVD patient in the U.S., it is a matter of *when*, and all hospitals must be prepared for this reality.

Deployment—(Continued from page 3)

ber 14, 2018 as part of the immediate response phase, just as Florence was making landfall just south of Wrightsville Beach, NC. Florence was downgraded to a post-tropical cyclone on September 17.

"In a nutshell," said James, "our cadre has five essential functions." These are to assess, inform and report back to the Operations Section and other Joint Field Office leadership for decision-making purposes; register survivors for disaster assistance, provide guidance on the registration process, and provide an overview of the assistance available; review onsite survivor information to provide survivors with basic information about their application and available assistance; engage with survivors and local officials in affected communities to identify immediate and unmet needs for quick resolution; and conduct community outreach and create partnerships with various local and state organizations.

"Our number one objective is to get out there and help the survivors," said James. "We try to bring them back to normal as best we can." As a part of a 9-member team, James served the central North Carolina region, including Craven, Durham, Greene, and Scotland Counties. In total, the cadre processed over 34,000 individual assistance applications.

"They were long days, I'll tell you that," James said. Members of the cadre worked 12-hour days, 7 days a week initially. "But you couldn't feel sorry for yourself. I feel great about the work we did."

Both James and Lillie are experienced in deployments. Puerto Rico was Lille's sixth deployment, and North Carolina was James' seventh. "Service is what I do," said Lillie. James echoed the sentiment: "FEMA is always ready to go. When they call, we answer the call."

Their positive, optimistic attitudes about their experiences are reflective of FEMA's larger service mentality. On FEMA's *Deployment Policies and Procedures*, there is a list of "Items to Bring for Daily Living." Alongside sunglasses, batteries, and a flashlight is listed "FEMA pride."

NTED Course Updates: New, Revised, Recertified, and Retired

From the Editors

New

- None

Revised

- None

Recertified

- PER-221 Tactical Operations for CBRNE Incidents Course, Louisiana State University

Retired

- PER-273 A Coordinated Response to Food Emergencies: Practice and Execution, Louisiana State University
- PER-250 Emergency Response to Terrorism: Operations, International Association of Fire Fighters
- Per-250-1 Emergency Response to Terrorism: Operations, International Association of Fire Fighters
- Per-250-C Emergency Response to Terrorism: Operations, International Association of Fire Fighters
- Per-250-W Emergency Response to Terrorism: Operations, International Association of Fire Fighters
- AWR-342 Maturing Public-Private Partnerships: Expanding Collaboration, Engagement, and Resilience, Frederick Community College

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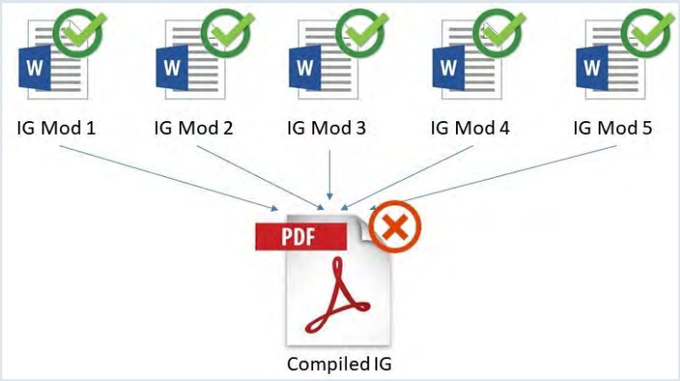
FEMA Photo by Andre R. Aragon

Ensuring All Files are Tested

From the Editors

Certifying Section 508 conformance is one of the last milestones of the course certification process. It's an important step, ensuring that the valuable information in the course is accessible to all who need it, regardless of disabilities or limitations. Unlike a SME review or a NIMS review, however, the Section 508 review focuses less on the course content, and more on the course files themselves. This makes version control a critical consideration when thinking about accessibility.

Course files come in many different types and are created in a variety of ways, and it's important to understand that 508 conformance in one version of a file does not necessarily translate to another version. For instance, a conformant Word document will not necessarily make a conformant PDF.



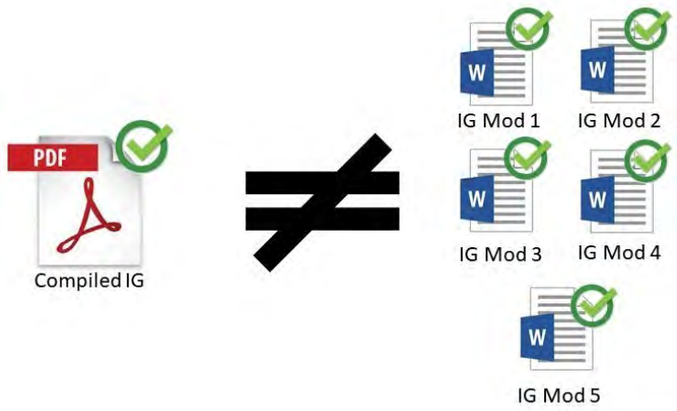
Combining compliant files does not guarantee a compliant file.

For this reason, it is critical that developers submit a course's final filesfor testing, whatever format they come in. Moreover, once they are certified as conformant, they must be carefully managed to ensure that all end users—including students, instructors, and FEMA personnel—have access to the materials.

Many courses only have a single version, with its own single set of course materials. Once these files are certified as conformant, they can be copied and distributed as needed—as long as they aren't altered or changed. Sometimes, however, course materials developed for one version of a course are leveraged to create additional versions, such as train-the-trainer courses or lower-level offerings that only use introductory modules. For these courses, it's essential to submit for testing *all* of the files that make up *all* of the versions of the course.

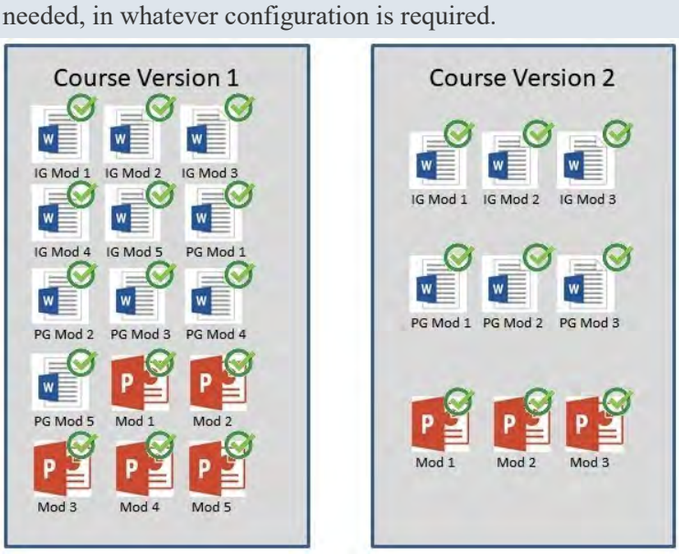
For example, let's imagine a course with five modules, each module a Word file of its own. The full version of the course covers all five modules, and so Instructor Guides and Participant Guides are created by compiling the individual Word files into a single file, which is submitted for 508 testing. Let's imagine that the course has an introductory version that only covers the first three modules. If the compiled version of the full course is Section 508 conformant, can a conformant version of the introductory course be created from that file?

The answer, unfortunately, is no. While the compiled file may be conformant, any elements extracted from it (Modules 1–3 in this case) won't necessarily also be conformant. Could the individual files for Modules 1–3 be combined into a new compiled file and not require testing? Again, the answer is no.



A file's conformance does not extend to its component parts.

For any course, the ideal solution is to submit all of the individual files for testing. Once those have been certified as conformant, they can be copied, packaged, and distributed as needed, in whatever configuration is required.



Compliant files can be packaged and distributed as needed.

Ultimately, whatever version of the course files is going to be the final—the files that will be sent to students and instructors, posted online, or used to print copies—is what should be submitted for testing. If your course files are going to be used to create multiple versions of the course, having each component tested ensures that whatever way the files are packaged, the end users are receiving course materials that have been certified as 508 conformant.

Find more resources at: https://section508.gov/create

Looking for More 508 Tips?

In response to requests for additional Section 508 guidance and support, we will be including more tips and training in each issue of the *TPP Times*. This quarter, check out:

- ☞ Section 508 Community of Practice: Screenreader Simulation is a brief video that demonstrates the impact of inaccessible on the user experience for users with visual impairment.

- ☞ Section 508 Community of Practice: How to Caption Videos is a brief video demonstrating the steps involved in captioning video.

NIMS Alerts

From the Editors

These alerts provide important information on new NIMS guidance, tools, and other resources. Since the October 2018 issue of the TPP Times FEMA's National Integration Center released the following NIMS Alerts:

- NIMS Alert 32-18: FEMA Releases PrepTalk On Healthcare Emergency Preparedness and Response (Nov. 2018)
- NIMS Alert 31-18: National Engagement Period: NIMS Resource Typing Definition and NQS Job Title/ Position Qualifications and Position Task Books (Nov. 2018)
- NIMS Alert 30-18: Core Capability Development Sheets Updated (Oct. 2018)
- NIMS Alert 29-18: FEMA Seeks Comments on Senior Leader Toolkit (Oct. 2018)
- NIMS Alert 28-18: FEMA Releases PrepTalk on the Value of Insurance (Oct. 2018)
- NIMS Alert 27-18: FEMA Announces Webinars about Updating the National Response Framework (Oct. 2018)

Use Caution When Accessing Online NIMS Resources

From the Editors

FEMA released the refreshed National Incident Management System (NIMS) doctrine on October 17, 2017. Since that time, FEMA has been diligently updating related supporting guides, tools, courses, and weblinks. The refreshed NIMS policy retained key concepts and principles from the 2004 and 2008 versions, while incorporating lessons learned from exercises and real-world incidents, best practices, and changes in national policy. The refreshed NIMS policy supersedes many previously issued NIMS policy documents. However, it is important to understand that many outdated and obsolete NIMS still can be found and accessed on the internet, and even through official FEMA channels. Active weblinks of outdated and obsolete policies or courses should not be construed as official policy.

Training Partners with questions regarding NIMS should contact their respective Training Partners Program Program Manager. Stakeholders seeking guidance on issues related to the adoption and implementation of NIMS are encouraged to contact their FEMA Regional NIMS Coordinator. The FEMA Regional NIMS Coordinators act as subject matter experts regarding NIMS for the local, state, territorial, and tribal jurisdictions within their FEMA Region, as well as for the FEMA Regional Administrator and staff.

Upcoming Events

From the Editors

2019 Hazard Mitigation Workshop

- **Dates**: April 1-5, 2019
- **Location**: Emergency Management Institute, Emmitsburg, MD

FY 2018 Homeland Security National Training Program Kick-Off Meeting

- **Dates**: April 10-11, 2019
- **Location**: FEMA HQ, 500 C St SW, Washington, DC

FEMA Sustainable Preparedness Summit

- **Dates**: April 22, 2019
- **Location**: 615 Chestnut Street, Philadelphia, PA

National Preparedness Symposium

- **Dates**: May 21-23, 2019
- **Location**: Center for Domestic Preparedness, AL

Emergency Management Higher Education Symposium

- **Dates**: June 3-6, 2019
- **Location**: Emmitsburg, MD

NDPC Quarterly Meeting

- **Dates**: July 15-18, 2019
- **Location**: Louisville, KY

Emergency Management Institute (FEMA Photo by Kristin Kendall)

The FEMA Higher Education Program

This year, the FEMA Higher Education Program, part of the National Training and Education System team at FEMA's National Training and Education Division, celebrates 22 years of creating an emergency management system of sustained, replicable capability and disaster loss reduction through formal education, experiential learning, practice, and experience. Connecting to over 600 colleges and universities nationwide, notable recent achievements led by academics and researchers in emergency management and facilitated through the Higher Education Program include:

- Building Cultures of Preparedness, Report For The Emergency Management Higher Education Community, January 2019
- A Proposed Research Agenda for FEMA
- FEMA Case Study Development Process, 2018
- The Next Generation Core Competencies for Emergency Management Professionals, August 2017
- Weekly Higher Education Newsletter

This year, the 21st Annual Emergency Management Higher Education Symposium will have a special focus on diversity, inclusion, and unity of effort in the emergency management academic community. Register early, as the Symposium has a maximum capacity of 300 attendees!

For more information on the FEMA Higher Education Program please contact Wendy Walsh, Program Manager, at wendy.walsh@fema.dhs.gov.

Did You Know?

In 1960s Pittsburgh, police vans responded to medical emergencies because there were no paramedics yet. However, minority neighborhoods were often underserved with police emergency vehicles often refusing to go to poor black areas. In 1967, Dr. Peter Safar—known as "the father of CPR"—implemented a plan, together with Pittsburgh's Freedom House, to train unemployed African American men and women in these troubled areas to serve as ambulance drivers and EMTs. This program is recognized as foundational to the paramedic services we see today. Click here for more

Questions, comments, or story ideas for the *TPP Times*?

Email TPPTimes@fema.dhs.gov

www.firstrespondertraining.gov

Disclaimer: The reader recognizes that the federal government provides links and informational data on various emergency management and first responder community resources and events and does not endorse any non-federal events, entities, organizations, services, or products. Please let us know about other events and services for individual and community preparedness that could be included in future newsletters by contacting TPPTimes@fema.dhs.gov.