



the E **CHANGE**

ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE



Welcome to Issue 1

Since launching in September 2015, [ASPR TRACIE](#) has published three issues of *The Exchange*, covering topics such as [crisis standards of care](#), [cybersecurity and cyber hygiene](#), and [preparedness and response for no-notice events](#). In this issue of the ASPR TRACIE newsletter, we highlight articles on disaster behavioral health from the federal, state, and local perspectives. We hope that the information and real-life experiences shared by subject matter experts complement your existing efforts, or “toolbox,” help raise awareness, and advance survivor, responder, and your own personal adaptive skills. We also continue to release new [Topic Collections](#) and respond to a variety of [requests for technical assistance](#). Your feedback is what makes us successful — please [contact us](#) with comments, questions, technical assistance needs, and resources to share. We look forward to our continued collaboration!

Shayne Brannman, Director,
ASPR TRACIE

John L. Hick, MD, Senior Editor

The ICF ASPR TRACIE Team:

Meghan Treber, Project Director
Audrey Mazurek, Deputy Project Director
Corina Solé Brito, Communications Manager and
Technical Resources Lead
Bridget Kanawati, Assistance Center Lead
Jennifer Nieratko, Special Projects Manager

Foreword

Disaster Behavioral Health: Unseen Effects on Survivors and Providers

Sometimes it can feel like we are racing from one emergency to the next. And at times, some of us actually are. Responding to “traditional” emergencies that involve a few people can be challenging enough — there is often carnage, confusion, and property destruction, but we are typically in and out quickly and can treat patients in a controlled, predictable environment. Large-scale incidents and public health emergencies are different. As health care practitioners first on the scene of a mass shooting or explosion, we may encounter survivors who are scared, angry, shut down, and/or in shock. On the scene of a natural disaster, we may be working in a physically damaged environment, with distraught patients who have lost their belongings, part or all of their homes or businesses, or — in the worst case — loved ones. During an infectious disease outbreak, fear of the unknown, concern for loved ones, and the stress of waiting to be seen by a professional can take its toll on patients and caregivers. And in all of these scenarios, health care practitioners and first responders may also be dealing with the same challenges and feelings involving loved ones and belongings. Planners and behind-the-scenes workers can sometimes be affected, too. How can we as responders and health care providers better prepare to help survivors cope with the negative behavioral health effects of disasters? How can we protect and help ourselves to ensure that we are able to be fully present and effective while on scene? What resources are available that can help us at the local, regional, state, and federal levels? At the [Office of the Assistant Secretary for Preparedness and Response \(ASPR\)](#), we know that awareness, planning, training, flexibility, and innovation are key to managing disaster behavioral health, and through [ASPR TRACIE](#), we are pleased to highlight resources, lessons learned, and best practices from the federal, state, and local perspectives in this issue of *The Exchange*. Please do not hesitate to reach out to the [ASPR TRACIE Assistance Center](#) with additional best practices or ways you have addressed this issue, so others may benefit from your advances. Or if you require technical assistance or have questions about this topic, please send your inquiry to askasprtracie@hhs.gov. As always, we [welcome your feedback](#).



Dr. Sally Phillips, RN, PhD,
Deputy Assistant Secretary for
Policy, Office of the Assistant
Secretary for Preparedness and
Response, U.S. Department of
Health and Human Services

At a Glance

2 Disaster Behavioral Health: What Do the Feds Do?

Rachel Kaul (ASPR ABC) and Terri Spear (SAMHSA) discuss how their respective federal agencies manage — and complement each other's — behavioral health services in a disaster. A sidebar shared by Cynthia Rubio (ASPR OEM) provides an overview of the Emergency Prescription Assistance Program and recent experiences.

7 Florida's Integrated Disaster Behavioral Health Response: The Pulse Nightclub Shooting (Commentary Provided by Dr. John L. Hick; Sidebar Written by Jack Herrmann)

In this article, stakeholders responsible for various aspects of Florida's disaster preparedness and response efforts share their thoughts on the local disaster behavioral health response to the Pulse Nightclub shooting.

14 Healing After a Traumatic Incident: A Responder's Perspective

Ross Chávez shares his personal experience with identifying the need for and receiving mental health assistance after managing a distressing crash scene.

18 Helping the Helpers: Building Responder Resilience

The authors provide an overview of responder behavioral health and emphasize the importance of top-down support for related programs.

22 Recommended Resources

23 Upcoming Events



Photo courtesy of HHS ASPR.

What's New With ASPR?

Since our last issue was published, Dr. Thomas Price was sworn in as the 23rd Secretary of Health and Human Services, and Dr. George Korch is serving as the Acting Assistant Secretary for Preparedness and Response. And just in time for this issue, ASPR team members shared blog entries on [community resilience](#), [Resilience AmeriCorps](#), and the recently updated [Disaster Behavioral Health Concept of Operations](#). This spring, ASPR's Critical

Infrastructure Branch plans to continue working with the [Critical Infrastructure Partnership Advisory Council](#) to [strengthen the links in disaster supply chain management](#). Interested in learning more about how ASPR is working to strengthen the nation's ability to prepare for, respond to, and recover from emergencies? Visit the [ASPR webpage](#) and [blog](#)!



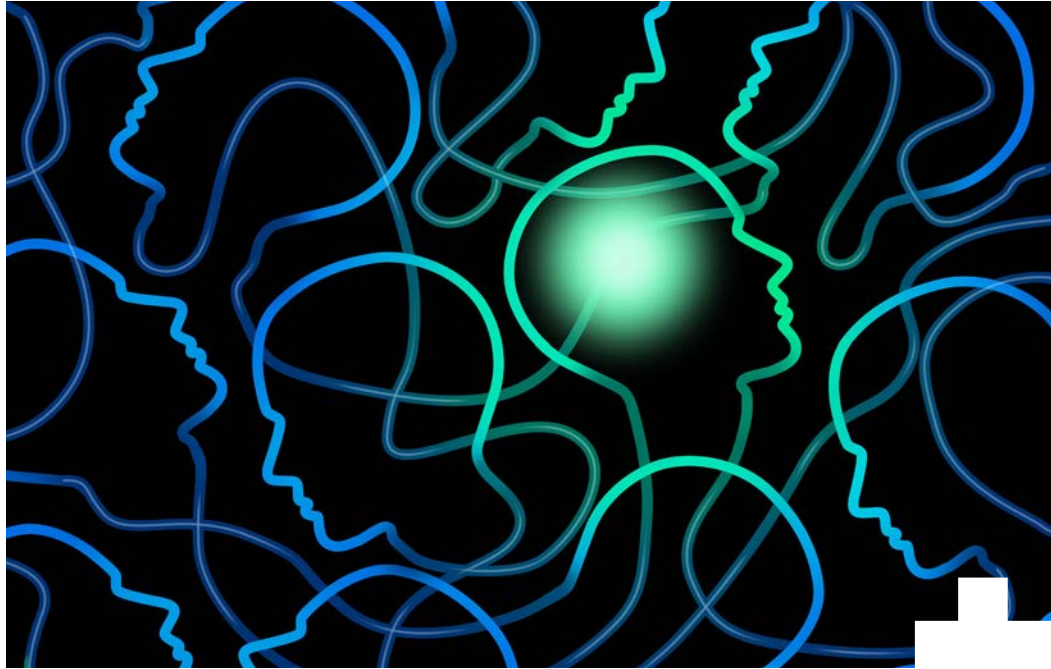
HHS Secretary Price receives his daily brief in the Secretary's Operation Center. Photo courtesy of HHS.



Disaster Behavioral Health: What Do the Feds Do?

Contributed by Rachel Kaul, LCSW, CTS, ASPR/OPP/ABC and Terri Spear, EdM, SAMHSA/OPPI/DPI

Emergency planners and responders recognize that disaster behavioral health (DBH) is an integral part of the overall public health and medical response to any emergency event. DBH addresses the psychological, emotional, cognitive, developmental, and social effects that disasters have on survivors and responders as they respond and recover. Even knowing this, not everyone understands the federal role in DBH. The majority of DBH activities are accomplished by state, local, tribal, and territorial (SLTT) entities, and [voluntary organizations active in disaster](#) (VOADs). Therefore, the federal role, largely carried out by the U.S. Department of Health and Human Services (HHS), includes providing preparedness, response, and recovery support to SLTT communities. Federal behavioral health support typically includes the provision of technical assistance, educational resources, and grant assistance; deployment of trained behavioral health responders; actions to support federal responders in managing stress and maintaining resilience; and participation in response and recovery planning and coordination efforts at the SLTT and national levels. Although behavioral health activities occur across



HHS, the primary agencies that engage in activities specifically related to disasters are the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Office of the Assistant Secretary for Preparedness and Response (ASPR)

ASPR works on behalf of the HHS Secretary to direct and coordinate all federal public health and medical assistance — including behavioral health assistance. Within ASPR, the

[Office of Emergency Management](#) (OEM) and the [Office of Policy and Planning](#) (OPP) work closely together to carry out the activities directed toward overall public health and medical coordination for ASPR.

OPP, Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC)

Within ASPR OPP, the [Division for At-Risk Individuals, Behavioral Health, and Community Resilience](#) (ABC) is responsible for ensuring effective coordination and providing subject matter expertise so that DBH needs are identified and

continued on page 3

continued from page 2

addressed as part of federal public health and medical response efforts. The primary mechanism by which this is accomplished is through convening the Federal Disaster Behavioral Health Group (FDBHG).

Coordination and Technical Assistance

The FDBHG includes participants from across HHS as well as national, state, and local stakeholders typically engaged in DBH, such as SAMHSA, the [Administration for Children and Families](#), the [Health Resources & Services Administration](#), the [Centers for Disease Control and Prevention](#), the [American Red Cross](#), state mental health authorities, and HHS regional staff. After mass violence or terrorism events, the FDBHG will also include partners such as the Department of Justice, the Federal Bureau of Investigation, and the Department of Education. The goal of the group is to implement a coordinated approach so that outreach to state and local behavioral health stakeholders is targeted, appropriate, and not unnecessarily duplicative. The FDBHG also establishes bidirectional communication through relevant agency programs and grants to identify needs, share governmental information, gather essential elements of information, and develop a common operating picture regarding

behavioral health. It allows the broad range of participants to analyze information and identify capabilities and gaps to make response recommendations. Often the group identifies informational and psychoeducational resources related to the disaster event and mobilizes access to this information through public information systems. Or it generates information and conducts analysis to inform the transition to recovery, long-term recovery, and after-action/lessons-learned activities. ABC and key partners of the FDBHG, such as SAMHSA, work closely with ASPR's OEM to ensure that information and recommendations are captured and provided to decision makers, response and regional staff, and responders.

Resource and Guidance Development

ASPR ABC engages in preparedness activities when not supporting response efforts. ABC works closely with ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE) to address specific information requests. ABC also creates tools to help with the coordination and understanding of federal behavioral health activities and to assist SLTT planners in enhancing their ability to provide behavioral health services during and after emergency events.

Examples include:

- ▶ The [HHS Disaster Behavioral Health CONOPS](#), which outlines how federal and SLTT collaboration uses the strength of the existing health and behavioral health structures to achieve success in both response and recovery.
- ▶ The [Disaster Behavioral Health Coalition Guidance](#), which provides a rationale, guidance, and suggestions for forming successful DBH coalitions.
- ▶ The [Capacity Assessment Tool](#), which helps state and local agencies as well as provider organizations assess DBH capacity and its integration into all planning, preparedness, response, and recovery efforts.

Office of Emergency Management (OEM)

ASPR OEM carries out the administrative and functional activities of public health and medical response and recovery, including behavioral health, and ensures that ASPR has the systems, logistical support, and procedures necessary to coordinate the Department's operational response to threats and emergencies. Within ASPR OEM, several components work in close collaboration with ABC to ensure that federal behavioral health preparedness, response, and recovery activities are provided and appropriate. These include

continued on page 4

continued from page 3

the Emergency Management Group, the Secretary's Operations Center, the Regional Emergency Coordinators, the Incident Response Coordination Team, and the Division of Recovery, specifically assigned behavioral health liaison officers from the Public Health Service. OEM oversees the assessment of needs, the provision of technical assistance and resources, and the deployment of behavioral health personnel when necessary.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission is to reduce the effect of substance abuse and mental illness on America's communities and to support SLTT and voluntary organizations as they prepare for, respond to, and recover from disasters. SAMHSA oversees and administers the vast majority of day-to-day mental health and substance abuse programs and also uses several mechanisms to coordinate behavioral health resources to help responders and communities.

Communication and Coordination

One of the main ways SAMHSA coordinates behavioral health resources is through the SAMHSA Emergency Coordinator, who maintains contact with SAMHSA grantees and other response partners (e.g., state departments of mental health/behavioral

health, substance abuse/addiction services). This coordination involves communicating with the State Disaster Behavioral Health Coordinator and stakeholders in any affected region to assess whether there are unmet behavioral health needs, and, if so, SAMHSA offers applicable technical assistance and resources. Examples of relevant projects and grants include the [National Child Traumatic Stress Network](#), suicide prevention, block grants, tribal programs, and mental health and substance abuse prevention and treatment programs.

SAMHSA also helps VOADs and professional guilds that provide behavioral health services, such as the [American Psychological Association](#), the [National Association of Social Workers](#),

and the [American Counseling Association](#), to coordinate and integrate their activities with federal and SLTT efforts.

Technical Assistance and Provision of Resources

SAMHSA provides technical assistance and administers the [FEMA Crisis Counseling Assistance and Training Program](#) (known as CCP; a Stafford Act program) and the SAMHSA Emergency Response Grant program, which can help SLTT entities meet survivors' DBH needs. CCP assists individuals and communities in recovering from the challenging effects of disasters through the provision of community-based outreach and psychoeducational services. Services are typically provided by



continued on page 5

continued from page 4

behavioral health organizations through contracts with a state's department of mental health. SAMHSA's role in DBH also includes dissemination of resource materials via the [SAMHSA website](#), SAMHSA's [Information Clearance Center](#), and SAMHSA's [Disaster Technical Assistance Center](#) (DTAC).

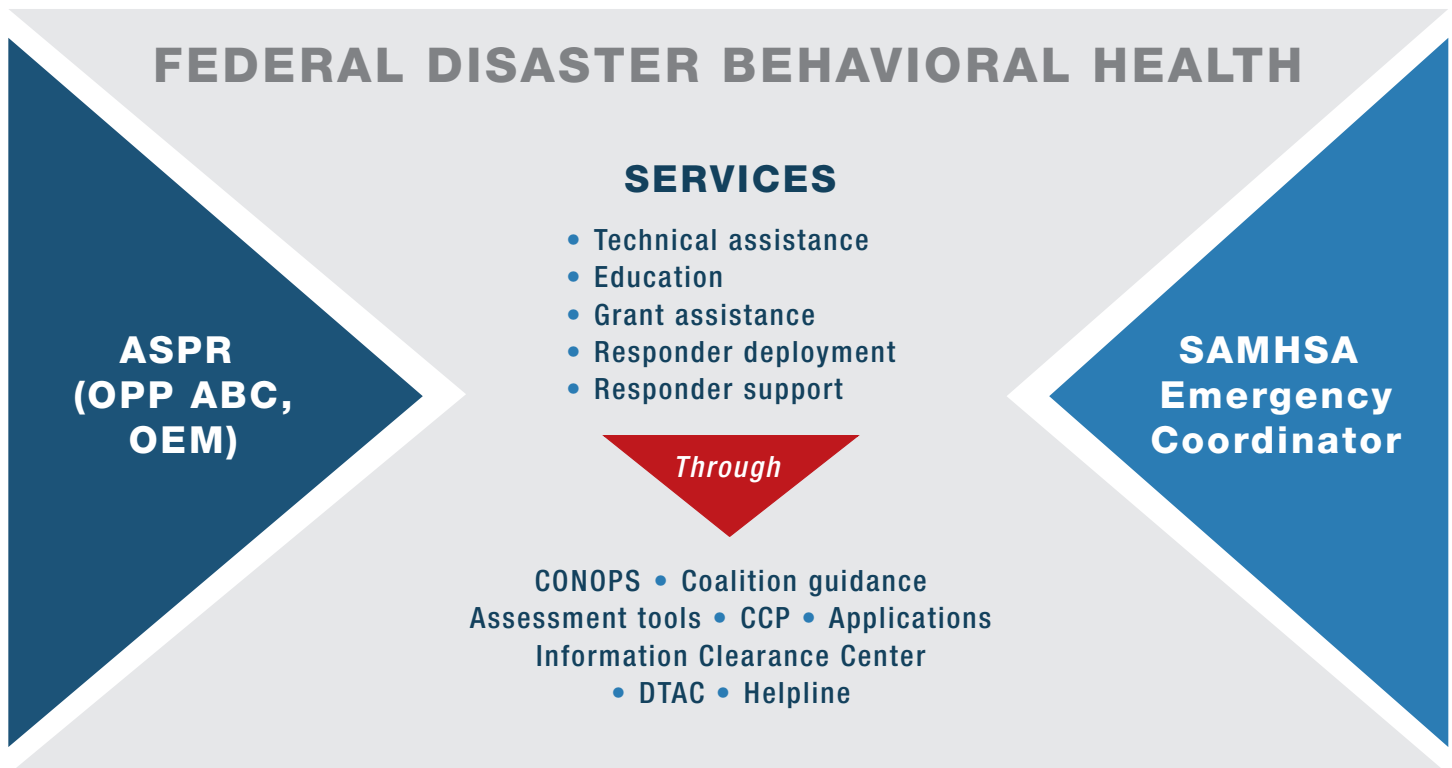
In addition, the [SAMHSA Disaster Distress Helpline](#) connects individuals experiencing emotional distress related to a disaster with crisis counselors who can provide support and referrals to local

resources. People can access the helpline 24/7 by calling 1-800-985-5990 or texting "TalkWithUs" to 66746. [SAMHSA GO2AID—The Field Resources for Aiding Disaster Survivors App](#) allows responders to access critical, disaster-related behavioral health resources from their phone.

Interdependent Efforts

It is important to understand that DBH activities require interagency efforts, as well as coordination among the federal government, SLTT governments, and nongovernment stakeholders.

During and after emergency events, the behavioral health scope of care must be based on an assessment of behavioral health needs with SLTT officials in consultation with SAMHSA, the Emergency Management Group, the Incident Response Coordination Team, ASPR-ABC, and local VOADs. It is only through building and leveraging partnerships among all of these stakeholders that the essential element of overall health — behavioral health — is recognized, assessed, supported, and strengthened.



continued on page 6

continued from page 5

The Emergency Prescription Assistance Program and DBH

Captain Cynthia Rubio, PhD, RN, National Clinical Program Lead, ASPR/OEM/Logistics

According to a recent [Mayo Clinic and Olmsted Medical Center study](#), 70 percent of Americans rely on at least one prescription drug, and more than half take two. Many of these people rely on their medications to control chronic conditions like heart disease, diabetes, depression, and pain. When a disaster strikes, medications can get lost or damaged, putting patients' health and well-being at risk. People without insurance and those with mental health conditions can be disproportionately affected.

Ensuring that patients are able to continue to access the medications, medical supplies, vaccines, and durable medical equipment (DME) that they rely on every day is an important priority for emergency management. When disasters strike, emergency rooms fill up quickly — but they aren't just full of people who have been injured by the disaster directly. When people's medication, medical supplies, or DME get lost or

damaged in a disaster, a condition that was previously manageable may become more serious, causing these people to seek care in an emergency room or go without needed care.

[The Emergency Prescription Assistance Program](#) (EPAP) provides an efficient mechanism for enrolled pharmacies to process claims for prescription medications, medical supplies, vaccines, and some forms of DME for uninsured eligible individuals in a federally identified disaster area. The program provides a 30-day supply of covered drugs and medical supplies that can be renewed every 30 days for as long as EPAP is active. EPAP allows any enrolled pharmacy in the United States and its territories to use existing electronic pharmacy systems to efficiently process prescriptions for individuals from disaster areas. This effort is performed under the authority cited in the Robert T. Stafford Disaster Relief and Emergency Assistance Act or under the authority

More than 72,000 pharmacies are currently enrolled in the Emergency Prescription Assistance Program.

of the [National Disaster Medical System](#) (NDMS) to provide emergency medical care to the victims of public health emergencies and catastrophic events that overwhelm the capacity of state and local emergency medical systems to respond to these disasters. In 2016, EPAP was used to provide mental health medications during the Louisiana Major Flooding response (Figure 1); these prescriptions constituted 13.5 percent or more of total claims. As knowledge of EPAP increases, the amount of mental health medications acquired during disasters through this program also will likely increase.

The following ASPR TRACIE fact sheets provide an overview of EPAP and how it has been used in past disasters:

[EPAP Overview Fact Sheet](#)

[EPAP: Hurricane Ike Data Fact Sheet](#)

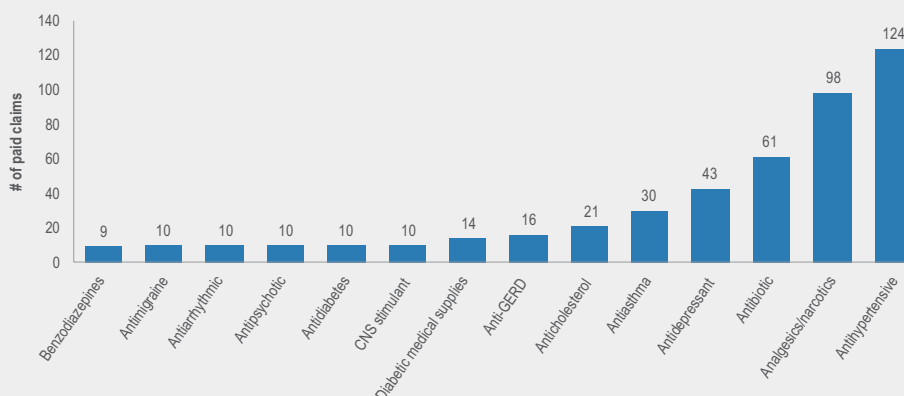
[EPAP: Hurricane Gustav Data Fact Sheet](#)

[EPAP: Superstorm Sandy Data Fact Sheet](#)

[EPAP: Baton Rouge Flooding Data Fact Sheet](#)

Ensuring that people are still able to access the medications, medical supplies, vaccines, and DME that they rely on every day helps patients cope with a disaster more effectively and prevents stress on the health care system. More information and live updates about EPAP activations are available at www.phe.gov/EPAP. ■

Figure 1. Louisiana Major Flooding, 2016



Florida's Integrated Disaster Behavioral Health Response: The Pulse Nightclub Shooting

(Commentary Provided by Dr. John L. Hick; Sidebar Written by Jack Herrmann)

Abstract: *The state of Florida frequently responds to hurricanes and flooding, and these disasters take a prolonged emotional toll on community members. Disaster behavioral health (DBH) services are provided through regional systems of care coordinated by the state through contracted systems that serve as “managing entities.” In June 2016, when a gunman killed 49 people and wounded 53 at Orlando’s Pulse nightclub, the state responded to an event unlike any it had faced before. Dr. John Hick (ASPR TRACIE’s Senior Editor) interviewed the following state DBH professionals who were part of the response to this horrific incident to learn more about Florida’s experiences with this and other catastrophic incidents:*

- ▶ Michael L. Haney, PhD, NCC, CISM, LMHC: Clinical Director, Florida Crisis Consortium
- ▶ Jimmers Micallef, FCCM: Chief, Substance Abuse and Mental Health Contracts, Florida Department of Children and Families
- ▶ Mark O’Neill, PhD, CPM: State ESF-8 Plans Chief, Bureau of Preparedness and Response, Florida Department of Health



Photo courtesy of Brett Roberts, American Red Cross

Jimmers Micallef (JM): The Department of Health (DOH) is the state lead when the Emergency Operations Center (EOC) is activated. The Florida Department of Children and Families (DCF) is the designated state mental health and substance abuse authority. DCF works through a contracting structure with seven regional systems of care or “managing entities.” Our agency contracts with managing entities, who then subcontract with local substance

abuse and mental health service providers — the community resources that the local emergency management community would turn to.

Dr. Haney describes the Florida Crisis Consortium in [this YouTube video](#).

continued on page 8

continued from page 7

JH: Is the Florida Crisis Consortium a public or private entity?

Michael L. Haney (MH): The consortium is a public/private partnership of all the organizations in Florida involved in disaster response, and it was formed after the 2004 hurricane season, when Florida was struck by four major hurricanes and a tropical storm. We realized then that there was a large lack of coordination and cooperation among disaster response groups, so we pulled everybody together. Any group involved in disaster response can come to the table. We also recruit, train, and credential our multidisciplinary volunteers through DOH — we currently have about 60 relatively active volunteers right now, and we try to maintain regular contact with them. During the planning phase, we do our best to carry out a series of activities, including all-hazards training and exercises.

JM: In 2004, all 67 counties in the state were under multiple declarations. Some providers were not able to reopen for their own clients, let alone take on additional clients or services. We created a series of ad hoc units serving different communities, funded under

several [FEMA Crisis Counseling Assistance and Training Program \(CCP\)](#) grants that ran for some time. Once the grants closed, we created the consortium, operationalizing a mechanism by which we could identify in advance who we could expect to deliver counseling services and provide these individuals with training on risk assessments and the administrative challenges of implementing a new program. Today we have, at minimum, an annual review with each managing entity and its designated DBH providers, where we work through both the administrative implementation issues and programmatic issues associated with FEMA CCP.

MH: During an event, I look at the clinical issues and triage all of the requests that come into the state EOC and then gather Jimmers' DCF perspective on things like disaster recovery centers and community grant funds that can be used to provide support services. Consortium members arrive on scene about 72 hours after an event and stay for about three weeks or until community resources stabilize. It's important to note that the mission of our consortium members is to provide psychological first aid —

I don't think the stigma that is attached to community mental health is the same for law enforcement and CISM because it's peer-driven and much more widely accepted.

— Michael Haney

not “do mental health.” While some volunteers have a clinical background, the primary role of the team is to consult with the local EOC on mental health issues, conduct a site assessment, identify gaps, and work with local partners to fill them. Sometimes that means [Critical Incident Stress Management](#) (CISM) teams for first responders; and some of our clinical volunteers are affiliated with CISM teams around the state (and may also be first responders), so they may be assigned. We also get requests to work with emergency room or triage staff who are exposed to a lot of trauma.

JH: How are community-based teams set up under DCF?

JM: The managing entities do not provide direct services, but they direct DCF funding to local subcontractors who provide community and residential substance abuse and mental health care. As part of the managing entities' contract with us, they must also identify in every county a

Access the Crisis Counseling Assistance and Training Program Toolkit [here!](#)

continued on page 9

continued from page 8

lead provider to be our emergency response designee. All providers are engaged with emergency management, but when a county experiences an event, we rely on the one preselected provider. If this provider cannot follow through because the incident has affected it, we arrange for another region to provide assistance. The managing entities also participate in drills and trainings to help establish capacity.

Consortium volunteers are the responders of last resort.

— Michael Haney

JH: Tell me more about the state's experience with the Pulse Nightclub shooting.

JM: This incident did not receive a presidential declaration. DCF looked to the Orlando region's pre-identified business partners and designated DBH providers to assist, and they were already engaged in the response at hospitals and family centers when we reached out to see how we could support them.

Mark O'Neill (MO): The Florida Crisis Consortium was put on standby by the state ESF-8 Emergency Coordinating Officer. She worked with other ESF-8 stakeholders to activate and

provide material support, including FEMORS, the Florida Emergency Mortuary Operations Response System. In the end, Orlando and Orange County were able to handle the attack with local resources and mutual aid and did not require a state-level activation. The state, beginning with Gov. Rick Scott, was ready to provide whatever the locals needed. When I checked the incident command structure for the Orange County Health Services Department, I saw that it already had a mental health group identified. The health department positioned itself locally to handle victim-related issues very quickly. I contacted others, including Jimmers, in accordance with our plan, but for the most part, I watched while locals took care of things with some state support from DCF.

JH: What specific DBH challenges — for both responders and survivors and loved ones — were you aware of?

MH: I recently attended a panel at a state conference where responders talked about the Pulse shooting. They all spoke to the resources that were made available to them and the community very quickly, and commended the strong social support system in Orange and surrounding counties. It's an ongoing process — many families were initially reluctant to accept

Relevant ASPR TRACIE Resources and Topic Collections:

[Mental/Behavioral Health Topic Collection \(Non-Responders\)](#)

[Responder Safety and Health Topic Collection](#)

[Tips for Retaining and Caring for Staff After a Disaster](#)

[DBH: Resources at Your Fingertips](#)

[EPAP Fact Sheets](#)

support and services, but as time goes on, many families are coming forward to ask for help.

JH: What kind of funding did you use to help with the DBH response?

JM: DCF reprogrammed the first \$500,000 from state funds set aside for June, July, and August. We were able to redirect these funds to groups we don't traditionally work with — including the LGBTQ community, groups that serve young adult Latinos, and Hispanic family counseling providers — to help them expand their capacity. While we were conducting our needs assessment, we identified the SAMHSA Emergency Response Grant

continued on page 10

continued from page 9

(SERG) program — considered “funds of last resort” from the federal government. SERG funding is only provided when no other funding is available. It took a while to get through the system, but three weeks ago we were awarded \$500,000 for a year’s program of targeted services that we’re using to keep the effort going and to ensure that there are DBH services for those who need it, at least until the anniversary of the event.

JH: *Tell me more about Family Assistance Centers — are they still operational?*

JM: The City of Orlando and Orange County opened Family Assistance Centers (FACs) in response to the incident. With the initial money mentioned earlier, DCF was able to pay for therapists, case managers, and critical social workers who staffed the FACs. These centers eventually evolved into the [Orlando United Assistance Center](#), where the city, the Orange County government, and United Way are working together to provide mental health support and timely information to people affected by the Pulse shooting.

The existing model gets adapted to meet the circumstances.

— Jimmers Micallef



JH: *From a DBH perspective, what was the most challenging aspect of the response?*

JM: I’m hearing that many of the first responders — and this includes law enforcement and EMS teams from other agencies who came to help — are still having a hard time coping with such an intensely painful crime scene and set of circumstances, like spending hours hearing cell phones ringing in a room full of bodies. We can always use additional DBH support for first responders. I’ve also heard that there has been a conscious effort to provide support to members of the mortuary who handled the bodies.

JH: *What keeps you up at night?*

MH: This sounds horrible, but it’s the lack of response and lack of events. It’s hard to maintain interest when you’re not doing response. It’s been a challenge in terms of keeping volunteers

engaged. Resources, funding, the ability to support the team and do the training and exercises (which are often cut when budgets are constrained). We currently don’t have any independent grants at the moment, so we’re dependent on state and federal funding.

MO: I worry about the effects of a bioterrorism or high-severity-index pandemic event — we haven’t planned adequately for an event like that.

We look at what happened during the anthrax attacks of 2001 and how the mental health effects taxed the system — even though it wasn’t a mass fatality incident — we just know we have to coordinate what we have among the people who know what’s there.

MH: One of our strengths is that we have very strong lines of communication and partnership between DOH and DCF, and that makes a big difference.

continued on page 11

continued from page 10

John Hick Commentary: Although our interview concentrated on the systems that Florida has in place, it's critical to keep in mind that mass casualty and mass fatality events can affect mental health for a long time and last far beyond the rest of the response, in many cases. Survivors, family members, and responders all need initial support, including psychological first aid (and similar techniques), a clear understanding of normal stress responses, and frequent encounters with peers to "check in" with each other.

Florida did an excellent job of leveraging its existing systems to identify the key stakeholder LGBTQ and Latino groups it could work with to ensure that there were trusted peers to assist with support and follow-up. Expecting responders or survivors to feel comfortable with Employee Assistance Programs and other personnel who have not experienced their trauma, are not in their community, and do not understand their context can be challenging, and usually that contact needs to be bridged by a peer.

Florida benefits from a very strong regional system through which existing service providers are funded. These providers help coordinate other public and private entities so that when a disaster occurs, there is a robust local response that can also be supported by inter-regional resources. The ability to redirect funds at the state level and use emergency funds from federal

sources speaks to the need for flexibility and a good understanding of the options. Notably, following a federal declaration, communities have only a few weeks to propose a budget and services for the response. This can be extremely difficult, and a system for target population impact assessment and needs analysis is critical to ensuring that appropriate resources are requested and defensible.

As emphasized, local support and the traditional sources of support are best — so broad integration of programs with training in psychological first aid and other techniques with responder, health care, faith-based, and other communities is crucial.

Issues often occur with authorities and roles at the Family Assistance Centers. Community planning with jurisdictional law enforcement, emergency management, medical examiner/coroner, American Red Cross, and other organizations can help greatly to define the mission, scope, potential locations, information sharing (including victim information for reunification), and communications support, and help reduce the potential for confusion and anxiety for responders and families. Plans should be exercised and understood by health care coalition members so that there is good understanding of who will do what and when.

As providers and planners, we must understand that the stresses of specific incidents affect different

providers in very different ways and that we must do a better job of tracking our responders for days, weeks, months, and even years after incidents to ensure that they receive the support and services they need to be healthy and resilient. Early engagement of providers in after-action reviews (not focused on emotion, but on generating a common situational understanding and examining the response itself) can help greatly to reduce stress by offering engagement in improvement processes as well as an opportunity to ask questions and receive answers about specific operational areas of concern.

Finally, we need to promote health and resilience in our community and among our responders. The public domain is filled with individuals who are intensely committed to their profession, often at the risk of damage to their private lives. Understanding that success on the job relies not only on performance but on the person and his or her ability to manage stress and maintain health is critical to a healthy daily life and is a major contributor to healing after a critical event.

Health care coalitions have the right stakeholders together to take a whole-community approach to behavioral health issues and are encouraged to leverage that ability to develop operational mental health plans that are not an afterthought when a response occurs.

continued on page 12

continued from page 11



Jack Herrmann,
Deputy Director
ASPR Office of Policy and Planning

On June 12, 2016, I watched as CNN reported on a mass shooting that happened hours earlier at Orlando's Pulse Nightclub, a bar that I had been to many times over the years. It was unfathomable to think that such a tragic event could occur in a place I knew so well — immediately I wondered, "What if I had been there?" I watched coverage of first responders arriving, the injured being carried to ambulances, and scenes of distraught family members looking for their loved ones; scenes that are becoming unfortunately too familiar. In more than 20 years as a disaster mental health volunteer with the American Red Cross on such events as the plane crash of TWA Flight 800; the terrorist attacks on the World Trade Center on September 11, 2001; and Hurricane Katrina, these scenes bring back many memories.

Later that morning, I was contacted by the Red Cross to see if I was willing and available to go down to Orlando and coordinate the organization's mental health response to the Pulse shooting. I arrived at 10:30 a.m. on Monday, was briefed by the local and regional Red Cross leadership, and then headed to

the makeshift Family Reception Center, which was located in a local community center. There were people everywhere; cars were parked on the lawn, side streets, or anywhere drivers could find a space. The media were set up outside the building, people were milling about, and it seemed as though one of the first rules in situations such as this — to secure the perimeter of the Family Reception Center — had been violated. Once inside, I found it hard to discern family members from first responders (except for those in uniform) or staff. After multiple attempts to determine who was in charge, I was able to finally connect with my colleague from the Federal Bureau of Investigation's Office for Victim Assistance. Because this was a suspected terrorist incident, the FBI was the lead for the response, which included coordinating the provision of family assistance services. Over the years, and as a result of previous incidents, the FBI and Red Cross have established good partnerships.

The Red Cross and the FBI worked together with the City of Orlando on a plan to meet the behavioral health and other needs of the victims and

their families. On Wednesday, June 15, the City of Orlando opened the official Family Assistance Center at Camping World Stadium. More than 30 federal, state, local, and community-based agencies provided a range of services for surviving victims and their families, as well as for families of the deceased (e.g., transportation, social services, medical examiner services, and funeral services). The [FBI Office for Victim Assistance](#) provided information about support that victims and their family members were entitled to under law, and the Red Cross, along with the county mental health agency and community-based organizations, provided mental health and spiritual care services.

The Family Assistance Center stayed open for approximately eight days before it transitioned to a smaller community assistance center. Support for the community at large included candlelight vigils and memorial services, mental health and spiritual care support offered by community- and faith-based agencies, and identification of funds to help those who were affected by the incident.

continued on page 13

continued from page 12

Lessons Learned

Events such as the Pulse mass shooting present a variety of challenges for first responders, the health and behavioral health care systems, governmental officials, community-based agencies, and, of course, the victims and their families. Having a good behavioral health plan and exercising and drilling that plan are key to ensuring the best response and outcomes. Tips for an effective behavioral health response include:

- ▶ Know your partners: Federal, state, and local agencies (governmental and nongovernmental) should know each other before an incident occurs and negotiate what roles they will play and responsibilities they will have in a mass casualty incident, and know the authorities that exist (which may be event-dependent – e.g., the Red Cross role after an aviation incident).
- ▶ Train first responders and other key personnel so they are prepared with the knowledge and skills needed to respond to these events, including psychological first aid training for peer support. Community-based behavioral health and spiritual care providers should be specially trained in DBH so they can provide immediate support to survivors and their family members.
- ▶ Pre-identify and define the roles of: Family Reception Centers and Family Assistance Centers (and their locations), health care facilities, and local Red Cross chapters. Anticipate the needs of survivors and their families and determine ahead of time which agencies and what services will need to be available.
- ▶ Understand that a community's recovery from an incident such as a mass shooting is not a short-term event. Those affected, directly or indirectly, must understand that recovery can take years and elected officials; county, city, and community-based agencies; and others need to be prepared for the long haul.
- ▶ Consider that the media can be key partners in helping communicate behavioral health issues to the community at large. Community media can be excellent partners in this process. National media may be much more difficult to manage. Regular briefings and access to selected supervisors for interviews is far superior to allowing them to attempt to gain unstructured access to family members or responders. Protecting family members and survivors from unwanted media attention is an important consideration for Family Reception Center and Family Assistance Center planning.

Jack Herrmann, MEd, NCC, LMHC,
Deputy Director, ASPR Office of
Policy and Planning ■



Healing After a Traumatic Incident: A Responder's Perspective

In November 2013, Ross Chávez was serving as the EMS Duty Chief for Hennepin EMS when he responded to the scene of a crash involving five children and a female driver who had lost control of her car and landed in a retention pond. All five children were in cardiac arrest when retrieved from the sunken car, although three survived. Ross shared his experience with identifying the need for and receiving mental health assistance after the incident with Dr. John Hick.

John Hick (JH): What immediate support did you receive from your agency and more formal chains?

Ross Chávez (RC): Just after the incident, the fire department hosted an immediate debriefing session with the various agencies that responded to the scene. Critical Incident Stress Management counselors directed the high-level debrief, which was beneficial for several reasons. First, while it wasn't so much an emotional debrief, it did allow everyone the opportunity to put the pieces together. We heard what firefighters saw when they arrived on scene; then we heard from the medics' and law enforcement's perspective. There were a lot of validating

"a-ha" moments for many of us, and we shared our challenges and experiences. For example, hearing the firefighters talk about having to use their feet to search for the children (because their suits made them buoyant and they couldn't go under water) made us appreciate their experience even more. Everyone reacted differently to the debrief; some were reluctant to attend, and for others, it was good for them to share.

Afterward, I stayed at EMS headquarters for most of the morning to continue managing the aftermath and support my team — the rest of the command staff were also supportive. I was personally struggling with my role at that time, because as deputy chief, I felt

responsible for ensuring they were all doing well. Later that morning, I went home and got some sleep. For some reason, when I woke up, I didn't feel like I had gotten any rest. I felt like I had been crying all morning, and I couldn't get the images of the scene out of my head.

JH: When did you realize that this was not a "usual" stress response?

RC: Probably a month in. While I never resorted to any "bad behaviors" (e.g., substance abuse, eating disorder), I experienced what I call an "emotional heaviness" and I wasn't able to get those thoughts out of my head. I was also troubled by my continued sense of responsibility to staff and

continued on page 15

continued from page 14

making sure they were getting the resources they needed — I knew other colleagues were having trouble. Finally, I realized I had to delegate my involvement with the staff to someone else because I knew I couldn't take care of them and myself at the same time.

JH: Did you meet with the psychologist?

RC: I did. I've been in EMS since 2001. I started as a volunteer firefighter in my local town — I saw some really bad things, and nothing ever really seemed to bother me. After many traumatic scenes and hot washes, I never understood why some of the more experienced team members said they wanted to go home and hug their kids. But this was a triple load — there was the incident itself, the feelings I was having, and my feelings associated with caring for my staff. For these reasons, I did seek the help of the psychologist from the facility. I knew that not dealing with my feelings could have great consequences if I didn't take care of it.

JH: What steps did you take for yourself once you delegated your management responsibilities?

RC: I needed to separate myself from the responsibility of managing employees. Validating my own feelings was so important, and the psychologist gave me tools I could

take home and use (e.g., practicing meditation, ensuring I was getting enough sleep, eating well, and eating healthy food). It was so helpful for me to understand that while this incident and my reactions will never completely "leave me," I can deal with it in a constructive way and make it a positive experience instead of a negative one that haunts me. But it's important to remember that nobody can make you do that — they can only give you the tools you need to do it yourself.

JH: How much did the incident affect your work and home life?

RC: In the ensuing months, I felt numb. At work, we had a second "insult" a few months after the drowning: a large structure fire in Minneapolis that resulted in the death of five children. I responded to this with a medic and a student who had been at the drowning incident with me — this definitely didn't help us heal. At home, I am fortunate that my wife is in health care and understands some of the situations and related feelings, but unless you've experienced something like this before, there is no way you can totally understand. There was value in talking to some colleagues who had gone through the pediatric drowning scene, and we still check in with each other via text and visits. This incident bonded us forever.



JH: How long after the incident was it before you felt like you were able to go through the day without having intrusive thoughts?

RC: Probably months — and then things got better. A few weeks after the incident, I had to listen to the radio recordings as part of a review of the cases for our internal Critical Care Conference, and that was one of the most difficult things I have ever done in my career, besides managing the incident. By spring and summer, things were back to normal. Then the first anniversary hit, and I gave a presentation for a local EMS conference — another challenging milestone. But by making the presentation with my colleagues, we were able to share our perspective with those who weren't there. We see it as our responsibility to share experiences so other responders can learn

continued on page 16

continued from page 15

from our experience and apply our lessons, should they be faced with a similar situation.

Two years after the incident, I developed and delivered a speech with some of my colleagues who had been on the scene with me. After this particular lecture, it took me two days to get my head back in the right place. It was the first time we had all presented together, and it brought me right back to that day and took my recovery back a few steps. I swore I wouldn't give the talk again. Since then, I've been able to work on that and rehash the lecture. I'm able to handle it with the tools I have and know that it's making a difference for other responders to hear the struggle I went through, and everything I went through up to this incident that caused it to be the straw that broke the camel's back.

JH: *What would you say if someone came up to you and said they were in a similar situation — what were the most helpful things you did to get through?*

RC: This incident was a big wake-up call. I'd been on really challenging scenes before but never understood the complexities that these incidents can create in the emotions of the responders. I'm now able to speak from a very personal perspective on how these incidents can affect us. Whereas before I'd had a hard time presenting and sharing the experience, I've since mapped the entire thing and can speak to it from a responder mental health perspective, and explain how it affected me and the community of responders who had experienced several tragedies

before and after the drowning. I refreshed the talk, and I've given it several times since. What gives me strength and allows me to give the talk while being emotionally well is — every time — one or two people come up to me afterward and share their experiences and either thank me for normalizing their feelings or thank me for giving them a way to talk to a friend who has been through a similar situation.

One of the most helpful things I think you can do after an incident like this is to find a coworker or peer you are comfortable sharing your deepest, darkest feelings with, and who is equally comfortable sharing at the same level with you — this has to be a two-way conversation. This is especially good if the person you can talk to has the tools, resources, or insight to help you through your own challenges. Also, if things aren't going well, remember it is so OK to get professional help. That is sometimes the most difficult step to take because there is still so much stigma around it. Many feel like they are admitting defeat when they seek help — and it's important to change that perspective. It's important to keep trying — you might have to meet with a few counselors until you find someone you match up with well and who can help you. Finding someone who has been through similar situations and experiences can also be helpful, but it is not totally



continued on page 17

continued from page 16

necessary. In fact, I currently read books on meditation and gratitude and I use the authors' tools — while the authors don't have experience in public safety, the tools they share can be applied to any situation in life.

It's also important to remember that healing is not time sensitive — it's an ongoing process. There's no box that fits every person who goes through an incident. Some may want to talk about it, some may not. Some may want to keep working so that they're around their peers; it may not be the healthiest thing to send someone home, especially if they live alone. There's no one solution to figuring these situations out. They're multifaceted.

I hope that agencies and institutions continue to refine their response guidelines to help responders and health care professionals deal with the aftermath of incidents (of any size or nature). This would include getting rid of the stigma associated with asking for help and emphasizing the importance of sleep and good nutrition, emotional stability, and healthy relationships in our personal and professional lives.

John Hick Commentary: *This incident prompted the Hennepin County Medical Center to restructure its critical incident stress support program to include an early focus on a rapid "CARES" approach (Common understanding, Acknowledge impact, Review*

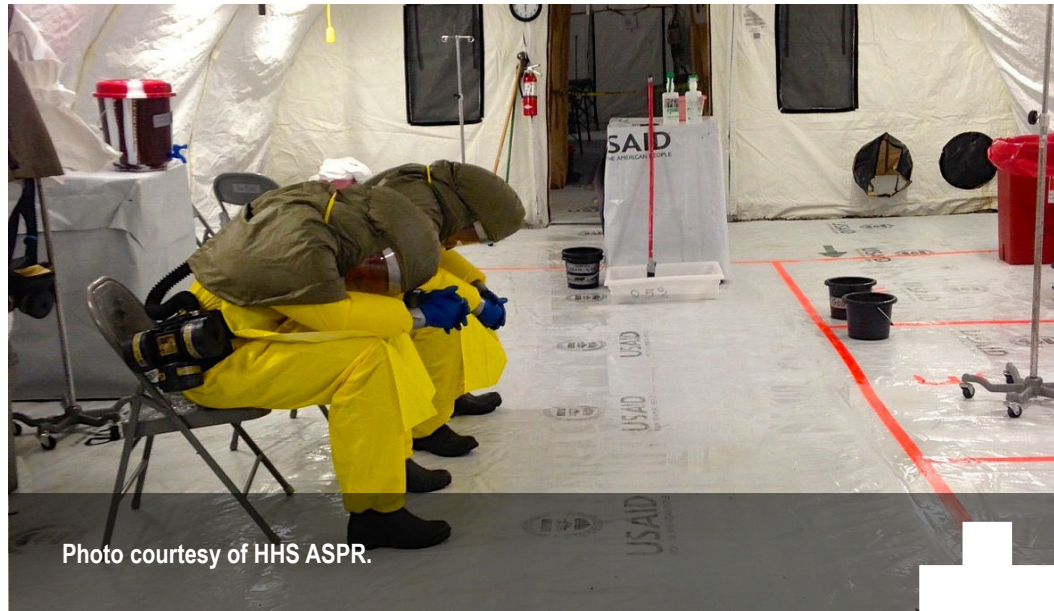


Photo courtesy of HHS ASPR.

strengths/weaknesses for future events, Educate about stress reactions, and Support [psychological first aid, or PFA, and other professional resources] or "hot wash" to ensure that questions about the event are answered and employees feel empowered to identify improvements that can be applied to future situations. This early discussion does not encourage sharing of feelings. PFA is provided by peers; professional individual and group support begins 48 hours later with identified at-risk employees, and it is followed by supervisors at intervals appropriate to the situation. The supervisor also assesses the employee's ability to safely work and encourages early return to usual duties when appropriate.

Ross brings up many key and common issues that responders encounter — you never know what

specific event is going to be the one that has negative effects on you. And the interaction between a responder's or health care provider's cumulative stress and the trigger event is critical to acknowledge. When it happens, the earlier you can identify persisting or damaging symptoms, the better. Peer support is critical and needs to be combined with professional support to obtain the tools to help process the event and guide the return to normalcy.

Ross Chávez currently serves as the Referral Source Liaison for Trauma Services at Hennepin County Medical Center. John Hick currently serves as the Lead Editor for ASPR TRACIE and practices at the Hennepin County, Minnesota, Medical Center. ■



Photo courtesy of HHS ASPR.

Helping the Helpers: Building Responder Resilience

Contributed by CAPT Dori Reissman, MD, U. S. Public Health Service (USPHS) Commissioned Corps, and Corina Solé Brito, MA, ICF ASPR TRACIE Team

Responding to disaster scenes and public health emergencies, where there may be physical destruction, chaos, and people experiencing emotional distress, can take a toll on emergency response personnel, and it is challenging to prepare them for some of the situations they might encounter. Health care practitioners may find themselves practicing quick triage and providing mass care for wounded or sick patients in nontraditional, austere settings, where rest and healthy sustenance are hard to come by. In addition to “traditional responders,” those who are deployed to quickly and safely manage a mass fatality event may be faced with managing

the emotional turmoil of grieving loved ones; thus increasing the complexity and psychological pressures of the job at hand. If these responders and providers live or work in communities affected by the incident, they may also be experiencing various losses such as changes to the built or natural environment or the loss of colleagues or loved ones, adding to the stress of the situation. Even highly trained and experienced responders can be distressed by some situations, particularly the death of children. And during disasters, some responders may be tasked with assignments that surpass their areas of expertise or their ability to cope. When you are

You may be operating or functioning outside the realm of your training. You may be used to caring for a “packaged patient” in relatively controlled situations, but disasters may find you working with frightened, emotional patients. And you may be doing this while worrying about your own loved ones, if you live in or near the disaster scene.

— CAPT Dori Reissman,
Associate Administrator,
CDC/NIOSH World Trade
Center Health Program

continued on page 19

continued from page 18

Access SAMHSA's [Behavioral Health Treatment Services Locator](#) for confidential information on treatment for substance abuse, addiction, and mental health problems.

already functioning in a stressful work environment, the threat of the unknown — whether it is due to terrorism, a natural disaster, or a highly infectious disease — can amplify fear, uncertainty, and any existing personal behavioral health risk factors.

The National Association for Emergency Medical Technicians (NAEMT) just published results from the 2016 [National Survey on EMS Mental Health Services](#). This survey was designed to assess how the field was attending to job-related mental health issues and was sent to emergency medical technicians, EMS managers, and medical directors in all 50 states. Nearly 2,200 responded and more than 500 shared their personal thoughts in response to open-ended questions. Some key findings include:

- ▶ Nearly 60 percent of respondents were not satisfied with the EMS mental health services provided by their organization.
- ▶ Close to 100 percent of respondents said that their agency had a policy regarding drug and alcohol use, but only a quarter reported that their

agency had a program that could help those suffering with abuse and addiction.

- ▶ Not everyone trusts the confidentiality of employee assistance programs (EAP), and some feel that that short-term nature of free EAP counseling (usually six sessions) may not be enough.

Occupational Health and Wellness Programs

An effective, comprehensive health and wellness program must incorporate evidence-based, confidential (when necessary) behavioral and mental health tools and strategies. NAEMT survey responses were nearly split in half when respondents were asked whether their agencies offered health and wellness services. The

One survey respondent noted, “Most of the people in my organization do not feel comfortable using any service provided by the organization for fear that the information will come back and be used against them in the future.”

top five services offered by these programs were: on-premises fitness centers (52 percent); tobacco cessation programs (41 percent); dietary/nutrition counseling (33 percent); substance abuse counseling (28 percent); and membership to a local fitness center (25 percent). Just one-fifth of these programs offered classes in stress management, and approximately one-third of respondents said they were not allowed to access mental health services while on duty. A recent [survey of health and wellness programs for hospital employees](#)

SAMHSA's Disaster Technical Assistance Center (DTAC) recently published [Tips for Disaster Responders: Identifying Substance Misuse in the Responder Community](#). The tip sheet explains that working in disaster response can increase the risk of substance misuse, as responders may turn to substances for help with forgetting their experiences or to numb emotional pain.

continued on page 20

continued from page 19

The SAMHSA DTAC publication [Preventing and Managing Stress](#) highlights information on preventing, identifying, and managing personal (responder) stress before, during, and after the response phase.

By addressing mental health issues and emotional wellness, employers are addressing the total health of an employee when combined with programs for clinical measure achievement. That makes everyone stronger, more productive, and happier.

— Judi Hennebry Wise,
[Mental Health as Part of Corporate Wellness Programs](#), *Corporate Wellness Magazine*

sponsored by the American Hospital Association found that while nearly 90 percent of the 882 hospitals that responded had health and wellness programs, participation rates varied; maintaining employee motivation was listed as one of the top challenges to program effectiveness.

The Centers for Disease Control and Prevention's National Institute for Occupational Safety and

Health (NIOSH) embraces a "[Total Worker Health](#)" philosophy. The [promising practices](#) and [planning, assessment, and evaluation](#) resource pages highlight real case studies that can help agencies of any size create or improve their own programs.

The Importance of Fostering Resilience: It Starts at the Top

NAEMT received dozens of comments that expressed disappointment with managers' and colleagues' attitudes related to mental health services. Some felt as though seeking help was seen as a weakness, while others wrote that they sensed a lack of concern from leadership. When it comes to responder and community resilience and a comprehensive disaster response (which includes disaster behavioral health), it must address both leadership and workforce concerns and become ingrained in the organizational culture and safety climate. When leaders take into consideration the physical, behavioral, and mental health of their staff during preparedness plans and exercises,



Louisiana flood survivor hugs NDMS responder. Photo courtesy of HHS ASPR.

and during a traditional work day, it increases staff resilience and the feeling among staff members that they matter. It is also important for leaders to demonstrate their investment in staff through organizational resources and policies that support self-care, adequate rest, a healthy diet, and good fitness habits. In the article [Mental Health as Part of Corporate Wellness Programs](#), the author

Access ASPR TRACIE's new tip sheet [Disaster Behavioral Health: Resources at Your Fingertips](#) for links to information that can help you build responder and community resilience.

continued on page 21

continued from page 20



Photo courtesy of HHS ASPR.

Judi Hennebry Wise emphasizes the increased productivity and lower incidence of job burnout, workplace violence, and injury associated with EAPs.

At ASPR TRACIE, we know that the work our stakeholders and partners perform can be stressful, even during nonemergency times. Many of you provide excellent medical care in challenging conditions, often while your loved ones and your property may be

experiencing the negative effects of the same emergency. In a disaster setting — as well as every day — it is important to remember that behavioral health and physical health should be addressed together — yours, your patients', and your team's. Showing your colleagues and your staff that you care and support all aspects of their health will in turn create a more caring, resilient workplace and community.

Dr. Dori Reissman currently serves as the Associate Administrator of the CDC/NIOSH World Trade Center Health Program and is a Captain in the U.S. Public Health Service Commissioned Medical Corps. Corina Solé Brito provides ICF contract support as ASPR TRACIE's Communications Manager and leads the ASPR TRACIE Technical Resources domain. ■

SAMHSA DTAC's Helping Staff Manage Stress When Returning to Work includes tips that can help supervisors prepare their staff to respond to disaster scenes, ease the transition back into the regular workplace environment when they return, and identify and address employees experiencing difficulties.

What occupational health and disaster behavioral health strategies have you incorporated to improve your, your team's, or your community's resilience? We want to hear from you. Please email us your input (including tips, plans, and templates) at askasprtracie@hhs.gov to be considered for a future ASPR TRACIE resource.

RECOMMENDED RESOURCES

TECHNICAL
RESOURCES

ASPR TRACIE has developed two Topic Collections that can be used to improve responder and community wellness and resilience, including [Mental/Behavioral Health](#) (nonresponders) and [Responder Safety and Health](#). Be sure to bookmark our page that includes [all comprehensively developed Topic Collections](#), as it is updated often.

ASSISTANCE
CENTER

When disaster strikes, the ripple effects can be significant. Health care providers and staff who maintain facility operations are not immune to these negative effects. Access [Tips for Retaining and Caring for Staff After a Disaster](#) to learn more about general promising practices — categorized by immediate and short-term needs — for facility executives to consider when trying to retain and care for staff after a disaster.

You can also access a [summary of sample technical assistance requests](#), which range from providing individuals with topic-specific resources to researching and providing individuals with more in-depth responses (e.g., evacuating patients with mental illness in disasters).

INFORMATION
EXCHANGE

[Register for the ASPR TRACIE Information Exchange](#), where you can click on the [Mental/Behavioral Health](#) or [Responder Safety and Health](#) threads and share your opinions and resources with us and your colleagues. Already have an account? Simply log in and share your feedback!

Need help registering for the Information Exchange? Access our quick tutorial [here](#).

UPCOMING 2017 EVENTS

April

April 17–20; New Orleans, LA **[National Hurricane Conference](#)**

Attend the ASPR TRACIE panel “Who Is TRACIE and What Can She Do for Me? Introducing the ASPR Technical Resources, Assistance Center, and Information Exchange” on April 17, from 1:30 to 3:00 p.m.

April 25–28; Atlanta, GA **[Preparedness Summit](#)**

On April 28, from 8:30 to 10:00 a.m., ASPR TRACIE will be participating in the panel session “Dispatch to Definitive Care: How to Safely Manage Ebola Patients.”

April 30–May 3; National Harbor, MD **[Urgent Care Association of America Convention and Expo](#)**

Learn more about staffing recruitment and retention, contracting best practices, and other factors essential to running an urgent care business.

May

May 1–3; Washington, DC **[National Hospice and Palliative Care Organization Management and Leadership Conference](#)**

This event enables end-of-life leaders to share lessons learned and promising practices in areas such as hospice and palliative care service delivery, compliance concerns, and staff and community engagement.

June

June 6–8; Buffalo, NY **[2017 National Homeland Security Conference](#)**

Be on the lookout for an ASPR TRACIE session on the Centers for Medicare & Medicaid Services Emergency Preparedness Rule at this conference that brings together emergency managers, homeland security professionals, members of the private sector, and others from the largest metropolitan areas in the 50 states and U.S. territories.

July

July 11–13; Pittsburgh, PA **[National Association of County and City Health Officials Annual Conference](#)**

This conference allows health officials and their staff the opportunity to share the most current research, ideas, and strategies in local public health.

July 25–26; Rockville, MD **[Radiation Injury Treatment Network Workshop](#)**

Attendees will participate in sessions on topics such as mitigation and treatment of radiation damage and lessons learned from collaborative preparedness efforts.

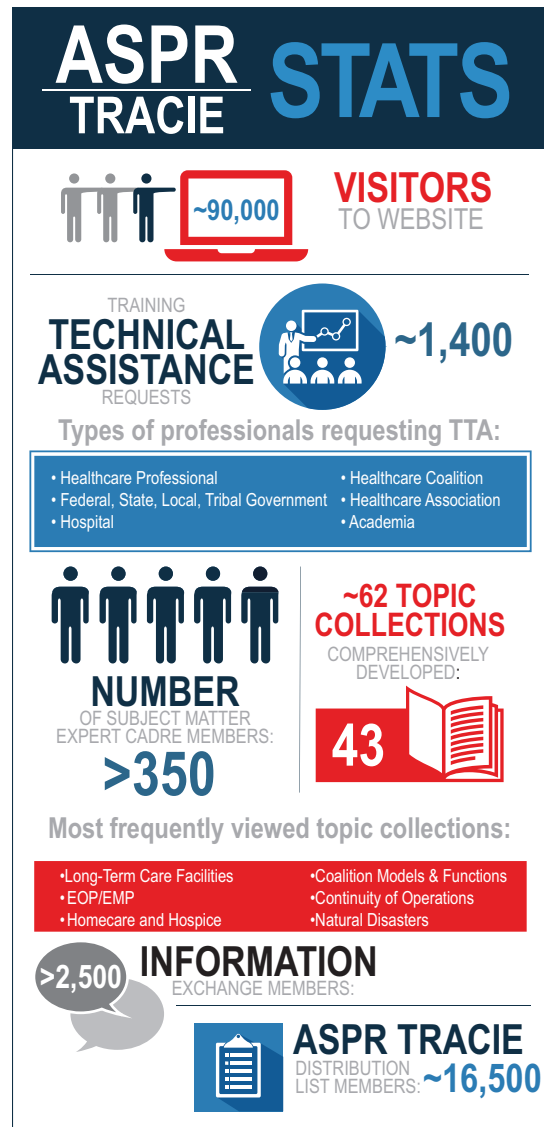


ASPR TRACIE:

Your Health Care Emergency Preparedness Information Gateway

The Exchange is produced by the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). Through the pages of *The Exchange*, emergency health professionals share firsthand experiences, information, and resources while examining the disaster medicine, health care system preparedness, and public health emergency preparedness issues that are important to the field. To receive *The Exchange*, please go to ASPR TRACIE's homepage (<https://asprtracie.hhs.gov>), and enter your email address in the "Subscribe to the ASPR TRACIE Listserv" box on the bottom right.

ASPR TRACIE was created to meet the information and technical assistance needs of ASPR staff, health care coalitions, health care entities, health care providers, emergency managers, public health practitioners, and others working in disaster medicine, health care system preparedness, and public health emergency preparedness. The infographic illustrates ASPR TRACIE's reach since launching in September 2015.



CONTACT US

ASPR TRACIE

Toll-Free: 1-844-587-2243

askASPRtracie@hhs.gov

<https://asprtracie.hhs.gov>

The Exchange is not responsible for the information provided by any webpages, materials, or organizations referenced in this publication. Although *The Exchange* includes valuable articles and collections of information, ASPR does not necessarily endorse any specific products or services provided by public or private organizations unless expressly stated. In addition, ASPR does not necessarily endorse the views expressed by such sites or organizations, nor does ASPR warrant the validity of any information or its fitness for any particular purpose.