U.S. FOOD & DRUG ADMINISTRATION

# FCON COVID-19 Deployment
# Oral History Interview
# CDR Frank Verni, MPH
# LCDR Malcom Nasirah, PharmD, MS
# and
# LT Chiemena Anyanwu, RN

**FCON History Committee**
**FDA History Office**
**Collaborative Oral History Project**
**Edited Transcript**
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## Oral History Abstract

In this group interview, CDR Frank Verni, LCDR Malcom Nasirah, and LT Chiemena Anyanwu discuss their deployments as Public Health Service officers who are in the USPHS Commissioned Corps in response to the COVID-19 public health emergency. CDR Verni was the group supervisor for the mental health, COVID swabbing, public health & non-medical screening teams during the quarantine of the Diamond Princess cruise ship passengers at Miramar Marine base in February 2020. He also served as the Site Lead for a COVID-19 Community Based Testing Site (CBTS) in Pasadena, TX, which was staffed by PHS officers, clinicians, law enforcement, volunteers, and local health personnel. The site administered more than 11,000 COVID tests. LT Anyanwu served as a Services Access Team Case Manager for citizens repatriated from Wuhan, China and quarantined due to Covid-19. She also served as a Nurse providing patient care and infection control training to long-term care facilities (LTCFs) in Pennsylvania. LCDR Nasirah provided logistical support for the COVID-19 Wuhan Federal Quarantine Response, including the repatriation of 195 American Citizens evacuated from Wuhan for the first COVID-19 Federal 14-day Quarantine in Feb 2020. He prepared medical kits for the PHS Diamond Princess Cruise evacuation mission, triaged 329 cruise ship evacuees into housing in the Quarantine Zone on Travis Air base, and conducted wellness checks on quarantined Americans while attached to Administration for Children and Families in assistance with repatriation support.

## Keywords

Commissioned Corps; Community-Based Testing Site (CBTS); COVID-19; deployment; Diamond Princess; Long-Term Care Facilities (LTCFs); nursing homes; quarantine; repatriation; Services Access Team (SAT); Wuhan, China;

## Citation Instructions

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## Glossary

| | |
|---|---|
| 510(k) | Section of the Federal Food, Drug, and Cosmetic Act establishing a premarket notification requirement for medical devices that can demonstrate substantial equivalence to approved products |
| ACA | Affordable Care Act |
| ACF | Administration for Children and Families |
| ACS | Alternative Care Site |
| AEG | Agency Executive Group |
| AMSUS | Association of Military Surgeons of the United States |
| ASPR | Assistant Secretary for Preparedness and Response |
| ASPR TRACIE | Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange |
| BARDA | Biomedical Advanced Research and Development Authority |
| BOP | Bureau of Prisons |
| BSL Lab | Biological Safety Levels Laboratory |
| CAP Team | Capital Area Team, U.S. Public Health Service |
| CAPT | Captain, U.S. Public Health Service (O-6) |
| CBER | Center for Biologics Evaluation and Research, FDA |
| CBP | Customs and Border Protection Agency |
| CBTS | Community-Based Testing Site |
| CCHQ | Commissioned Corps Headquarters |
| CDC | Centers for Disease Control and Prevention |
| CDER | Center for Drug Evaluation and Research, FDA |
| CDR | Commander, U.S. Public Health Service (O-5) |
| CDRH | Center for Devices and Radiological Health, FDA |
| CFSAN | Center for Food Safety and Applied Nutrition, FDA |
| CMO | Chief Medical Officer |
| CMS | Centers for Medicare and Medicaid Services |
| CONOPS | Concept of Operations |
| CPR | Cardiopulmonary Resuscitation |
| CRAFT | COVID-19 Response Assistance Field Team |
| CTP | Center for Tobacco Products, FDA |
| CVM | Center for Veterinary Medicine, FDA |
| DART | Disaster Assistance Response Team |
| DHS | Department of Homeland Security |
| DMAT | Disaster Medical Assistance Team |
| DOD | Department of Defense |
| ECMO device | Extracorporeal Membrane Oxygenation cardiovascular life support |
| EHO | Environmental Health Officer |
| EMS | Emergency Medical Services |
| ER | Emergency Room |
| ESF | Emergency Support Function, FEMA |
| EUA | Emergency Use Authorization |
| FDA | Food and Drug Administration |
| FEMA | Federal Emergency Management Agency |
| FMS | Federal Medical Shelter, FEMA |
| FOIA | Freedom of Information Act |
| HHS | Department of Health and Human Services |

| | |
|---|---|
| HIPAA | Health Insurance Portability and Accountability Act |
| HIS | Indian Health Services Agency |
| HRSA | Health Resources and Services Administration |
| HSIN | Homeland Security Information Network |
| HSO | Health and Safety Officer |
| HVAC | Heating, Ventilation and Air Conditioning |
| ICS | Incident Command System |
| ICU | Intensive Care Unit |
| IMG | Incident Management Group |
| IMT | Incident Management Team |
| JIC | Joint Information Center |
| LCDR | Lieutenant Commander, U.S. Public Health Service (O-4) |
| LT | Lieutenant, U.S. Public Health Service (O-3) |
| MCAS | Marine Corps Air Station |
| MD | Medical Doctor |
| MMU | Monrovia Medical Unit (Liberia Ebola Response) |
| N95 | Particulate filtering facepiece respirator, NIOSH rated “not-resistant to oil” filtering 95% of airborne particles |
| NCTR | National Center for Toxicological Research, FDA |
| NDMS | National Disaster Management System |
| NIH | National Institutes of Health |
| NIOSH | National Institute for Occupational Safety and Health |
| NIST | National Institute of Standards and Technology |
| NP | Nurse Practitioner |
| NPI | National Provider Number |
| OASH | Office of the Assistant Secretary for Health |
| OC | Office of the Commissioner, FDA |
| OFDA | Office of U.S. Foreign Disaster Assistance |
| OLS | Office of Laboratory Safety, FDA |
| OMB | Office of Management and Budget |
| OPDIV | Operating Division |
| OPM | Office of Personnel Management |
| ORA | Office of Regulatory Affairs, FDA |
| OSHA | Occupational Safety and Health Administration |
| PA | Physician Assistant |
| PAPR | Powered Air Purifying Respirator |
| PCR | Polymerase Chain Reaction (test) |
| PHS | Public Health Service |
| PPE | Personal Protective Equipment |
| PTSD | Post-Traumatic Stress Disorder |
| RDF | Rapid Deployment Force |
| RedDOG | Readiness and Deployment Operations Group |
| RIST | Rapid Incident Support Team, U.S. Public Health Service |
| RN | Registered Nurse |
| RT-PCR | Reverse Transcription Polymerase Chain Reaction |
| SAMSHA | Substance Abuse and Mental Health Services Administration |
| SAT | Service Access Team/s, U.S. Public Health Service |
| Sitrep | Situation Reports |
| SME | Subject Matter Expert |
| SNS | Strategic National Stockpile |

| | |
|---|---|
| SOC | Security Operations Center |
| SOFR | Safety Officer |
| SOP | Standard Operating Procedure |
| TAT | Technical Assistance Team |
| TDY | Temporary Duty Assignment |
| TPN | Total Parenteral Nutrition |
| USACE | Army Corps of Engineers |
| VA | Veterans Administration |

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## Interview Transcript

VB: This is a contribution to the FDA Commissioned Officers Network and FDA History Office collaborative research project to document officers COVID-19 deployment experiences. I'm Vanessa Burrows from the FDA History Office.

JS: I'm John Swann from the FDA History Office.

VB: We are speaking today with Commander Frank Verni, Lieutenant Commander Malcolm Nasirah, and Lieutenant Chiemena Anyanwu. If you could all go around and introduce yourselves and just state for the record your name, rank, FDA title and how long you've been at FDA that would be great, Thank you. Commander Verni, can we start with you?

FV: Surely. Hello everyone. My name's Commander Frank Verni and I'm a Pharmacy Officer with the United States Public Health Service. I'm currently stationed at the Food and Drug Administration within the Center for Drug Evaluation and Research. I've been with the FDA and the Public Health Service for a total of about 14 years now.

VB: Thank you, and Lieutenant Commander Nasirah, will you introduce yourself?

MN: Greetings, my name is Lieutenant Commander Malcolm Nasirah. I am a pharmacist in the United States Public Health Service currently assigned to the Food and Drug Administration in the CBER office, the Center for Biologics Evaluation and Research. I work as a regulatory officer in BIMO office, which is the Office of Bioresearch Monitoring, where

we ensure the safety and welfare of human subjects during clinical trials involving biologic agents.

VB: Thank you very much, Lieutenant Commander. Lieutenant Anyanwu, would you please introduce yourself?

CA: Yes, ma'am. Hi everyone. My name is Lieutenant Chiemena Anyanwu, and I'm a Nurse Officer in the United States Public Health Service assigned to the Food and Drug Administration in the Center for Food Safety and Nutrition. I currently work as an international policy analyst, and I have been with the FDA almost two years. I came right before the pandemic at the end of 2019.

VB: Thank you all very much. I'd like to go around in the same order and ask you to just very briefly at this point describe your COVID-19 deployments, just dates, to the extent you remember how specific they can be, where you were assigned and the general nature of your assignment.

FV: Surely. So, this is Commander Frank Verni. I was deployed twice for the COVID-19 mission. My first deployment took place in March of 2020 from the 11th to the 28th, I was deployed to San Diego, California to Miramar Marine Base. At that site, we were quarantining people from the Grand Princess cruise ships at that stage. My involvement during that mission, I'm actually an officer in a Tier 1 Public Health Service deployment team, the NIST, which is the National Incident Support Team as an Operations Officer. My role during that mission, I was a group supervisor, and I was overseeing different contingencies that had different functions during that deployment, being a mental health

team, a team that was performing COVID swabbing, a team that was performing non-medical screening and also a team that was trying to assist with logistics for the passengers.

VB: Approximately what time was your deployment or what period?

FV: March 11th to March 28th, 2020.

VB: Thank you, and did you have a subsequent deployment after that?

FV: Oh, I did. Sorry. My next deployment took place from June 29th to August 1st, 2020. During that deployment, I was sent to Pasadena, Texas, and to one of our community-based testing centers where we were overseeing testing, being performed at the local level, however, under the auspices of the Federal procedures and materials that were being provided to the local community.

During that deployment, I was a Site Lead and our responsibilities were overseeing all the healthcare practitioners that were provided by the local health department and State Health Department in order to perform COVID testing for that specific area. So, we were there a little over a month and we oversaw the administration of about 11,000 COVID tests. This was when Texas was at one of its initial peaks for numbers of COVID cases down there.

VB: Thank you very much. Lieutenant Commander Nasirah, will you please describe your deployments.

MN: Hello. Yes, I am on a Service Access Tier 2 deployment team. And I was assigned initially to go to March Air Base in California. This was around February 8th or 9th in 2020.

We were there to assist with the Federal quarantine and repatriation of those and persons or citizens who had been evacuated from Wuhan, China.  It was the first Federal quarantine in, some people were saying, over 80 years. It was also the first Federal quarantine that also involved repatriation element. My team worked with the CDC, the US Marshall Service and various elements of the Incident Command Structure who are all also parts of Health and Human Services. So, my mission there was to make sure that the citizens had access to medical care and food and that their shelter was clean and viable. We basically served as liaisons to get them the services that they would need or answered their questions if they had any. Overall, just trying to make them feel comfortable.

So that went on for – I came during the last week of their quarantine, at that time it was 14 days, and was there through their release. After the successful release of those of those US citizens, I was sent to Fairfield, California to go receive the evacuees from the Diamond Princess cruise cohort. They had been stuck on the coast of Japan for several weeks on the Diamond Princess cruise ship. Finally, accommodations and planning had been made to begin to get these persons back on US soil, so I was there to receive them literally on the landing pad of the Air Force base and saw their entire triage through finally getting safe and stable in their assigned dorm rooms on the base. Those were my two experiences.

VB: Thank you very much, Lieutenant Anyanwu will you please describe your deployments?

CA: Sure. I was on similar assignments as Commander Verni and Lieutenant Commander Nasirah. My first deployment was the beginning of February, I think it was February 2nd. I was deployed to Miramar Air Station in San Diego as part of Service Access Team 5, where we were involved in the repatriation of us citizens and nationals from Wuhan, China.  I was

responsible for helping those individuals with whatever they needed to complete their quarantine, a large part of it was grandparents traveling with their grandkids and trying to get diapers and other items that the children needed. We also helped them coordinate their onward travel after quarantine. So that was the first mission in San Diego.

The second mission that I was involved in was the end of May through I believe the first week of July. I was in the state of Pennsylvania, it was the Pennsylvania Long-term Care Facilities Mission, where we went to different long-term care facilities to assess their practices in relation to reducing COVID. We provided infection control practices, and we assessed the facilities and gave them recommendations. We also helped fit test so different nursing education services that I was involved in and once in a while helped provide patient care while the staff at the facilities had to go – just to help cover their shifts as they went to do the fit testing and other training.  So that was basically a summary of the second mission.

VB: Thank you very much. I'd like to ask you each, and at this point feel free to jump in at any point, I'd like to ask if you have any insight into how your assignments were [determined]?  If you had any input into the nature of your assignment, or if you were just called up and asked if you'd be available to deploy and given the assignment to carry out?

FV: Hi, this is Commander Verni, for my first assignment at Miramar Marine Base in March, by virtue of being on that Tier 1 deployment team, the NIST, or the National Incident Support Team, we were actually given specific training so I've been an Operations Officer on that team for quite some time.

During that initial deployment, I was chosen because of that skillset I possessed from my experience on the NIST. For the second assignment which took place during most of July of 2020 I was chosen at random. It was from another officer that knew me and certain

capabilities, but it really wasn't anything I performed before or during a deployment but somewhat related to my work as an Operations Officer. They were identifying folks for those missions based on previous skill sets and experience.

MN: Hello, this is Lieutenant Commander Nasirah, being on a Tier 2 SAT4 Service Access Team, at that time, we had on call months. Since then, we have moved away from specific on call months, and now because of the nature of the public health emergency, the entire Public Health Service is on call, each and every officer. But at that time, it was my particular on call month, and as a Tier 2 SAT Team member, you have to be ready to deploy within 48 to 72 hours. You get the notice at a minimum of 24 hours in advance, and you have some time to prepare but you just may not be aware of where you are going until the day that you receive your flight itinerary. That is why I was sent out the month that I was, it was just my time to go.

CA: This is Lieutenant Anyanwu. As Lieutenant Commander Nasirah said, when you're on a Services Access Team, I'm on Service Access Team 5, we get trained on how to procure different – I guess what the client needs, different ways to get the services or items, whatever that they need.

That was why I deployed, it was me and some of my team members on SAT5 that went out on the first deployment in February. And then for the long-term care facilities, since the mission called for medical professionals with clinical expertise or background, I assumed that's why I was put on the team. I didn’t have any say so, I was just called and told, about the deployment and then sent an itinerary.

MN: I did want to add that prior to February the Service Access Teams, all of us had received an invitation for training by ACF, and that is the Administration for Children and Families, I just wanted to get that correct. We did receive a training from ACF about the history of repatriation and how repatriations occur and how they're managed. So that is also one of the reasons why I think that SAT teams were also pulled into the various aspects of this mission.

VB: That's very interesting. Could you share a little bit about what the ACF training covered?

MN: Yes, they basically talked about the repatriations that had happened recently using examples with the hurricanes in Puerto Rico and other places that had a war disaster and as a result citizens had to be repatriated. It's been a long time since there has been a mass repatriation due to a war situation. So, most of the trainings were focused on what has happened after severe weather situations throughout parts of the world where US citizens may be serving or live, and they have to be returned to America and resettled here.

Then they also educated us on the process of applying for the loans that they are eligible for and how that works, what the repayment options are, the services available to them as repatriates. It was a very informative presentation and I thought it was very interesting that we had just received that training, and then we were put into the situation to literally go deal with the repatriation because the average officer has never had to deal with the repatriation in tandem with a quarantine.

There were even officers in ACF who hadn't necessarily dealt with a repatriation in quite a while, so it was more like a refresher. Then also trying to tie in the various deployment aspects of the United States Public Health Service, and then, educate us on the

mission for ACF, because they are the ones who are in charge of repatriation support. That's not the direct mission of the US Public Health Service, but the Service Access Teams can be pulled by ACF to assist during times of public emergency. I hope that answers the question.

VB: That seems like incredible timing and obviously useful knowledge that you were able to apply. I'm curious, since you guys all were deployed or your initial deployments were based on your membership in different teams, do your teams get deployed as a whole, or are there rotating positions on the teams? Do you always deploy with the same officers?

FV: This is Commander Verni, on the NIST teams everyone's pretty much trained in different specialties, and do they actually use us piecemeal where we're needed. So, for example, we have officers that are trained in planning positions, officers that are trained in admin and finance positions, logistical positions and operations positions. So what they'll do is, normally the Department of Health and Human Services, specifically ASPR, the Assistant Secretary for Preparedness and Response, they'll make requests to PHS for specific positions. For example, we need four group supervisors in the operation section and a Planning Section Chief, and then they'll pull from whatever team is on call that month, those specific positions.

So during the our Miramar mission, we had five officers from NIST-B, which is our team that deployed together. But we were fragmented all over the country because this quarantine mission was happening on several sites throughout the country. So, we were split apart, and that does normally happen during NIST deployments.

JS: Commander Verni, I wanted to confirm, are the members of NIST – they're not necessarily just from FDA they're from any number of the OPDIVs within the HHS, is that correct?

FV: Yeah, that's correct. For example, on my team, we have officers from NIH, CDC, Indian Health Service, FDA, I believe even SAMHSA. So, there are officers from a slew of different agencies.

JS: Thank you.

[00:19:55]

MN: This is Lieutenant Commander Malcolm Nasirah, our team consisted of only those who were on my SAT 4 Team, but at that time, there were five Tier 2 Service Access Teams or SAT Teams. So, you are deployed with members of your team and you also go to training usually with members of your team.

So the Lieutenant who's also on the call, she is on a different SAT Team and we have never met and we deployed on different dates and different missions but SAT Teams and all of the PHS deployment teams are not exclusive to HHS. You also have officers from Department of Homeland Security and Bureau of Prisons.

Some of the other – under the umbrella of the Commission Corps, but usually for those officers, it is harder to deploy because they work daily in a mission critical atmosphere. But I was with several officers from Homeland Security. They were outside of HHS, but on my SAT Team.

CA: This is Lieutenant Anyanwu, I joined SAT 5 while I was previously with the Bureau of Prisons and Bureau of Prisons has a different memorandum of understanding. I was serving as a nurse at the BOP and it is mission critical, that February deployment was

actually my first time being able to deploy because I had accepted this position at the FDA, which has a bit more leeway since it's not a clinical position.

So that was my first time deploying, although I've been on the team. And we get trained with what the team entails, but while on the team and serving with the BOP, I was still in augmentation status because the other officers on the team, if they were serving in agencies where their roles were not critical, they were going to be pulled first.

VB: What a deployment to have as the first time you were ever deployed. As a as an officer serving on a first deployment, did you receive any mentorship or any specific support in filling your role?

CA: We actually had pre-deployment meetings before being sent out on that first mission. And then also, because the communication came from my Team Leads for SAT5, it was a little easier because they gave you more information.

The funniest thing happened while I was leaving for the deployment. I think I had only the flight booked – and I was originally supposed to be at March Air Force Base and then they redirected me midair, so I ended up having to drive, but on the same flight, I met another SAT5 officer that was actually assigned to me as a mentor on the team. I don't know how we – we walked by each other because we have never met before, and I think she said she overheard me saying something to the gate agent and then she came up to me and introduced herself. So we were on the same flight into LAX, and I think she ended up being at March and then I was redirected to San Diego, so it wasn't too bad after I met her.

VB: That sounds really fortuitous that you guys ended up on the same plane. So, I guess carrying off of that, I'd like to ask you to think back to March and February of last year and

what we knew of the state of the pandemic at that time. What anxieties you might have had, or just general knowledge of what the extent of this crisis was, did you have any particular concerns unique to this deployment as you were setting out on your deployments?

FV: This is Commander Verni, during my first deployment, this was very early on in the COVID battle, there were still a lot of unanswered questions about the virus, the disease, the transmission, things like that. They had good hypotheses, but nothing was concrete yet. It did cause a lot of anxiety within officers, their family, and of course the individuals that we were taking care of that were quarantined or repatriated. I do remember during that initial deployment in March of 2020, in hindsight and retrospectively looking back saying the world changed during that deployment for me.

For example, when I got the orders to deploy, I flew out of John F. Kennedy Airport in New York in March, and I remember being on a plane and the plane was full, every seat taken, and I had a mask on, some others had masks on it wasn't really mandated at this point yet. And during the deployment it almost seemed that COVID was spreading extremely quickly all over the country.

At that point, when I first landed in San Diego and we were taking care of the individuals from the Grand Princess, that was the initial focus where the outbreak was starting. However, very quickly into March, it started spreading like wildfire through some parts of the country. It was very interesting because I'm from New York and watching the news live in the kind of situation room near Miramar Marine Base. I saw that New York was getting hit extremely hard.

I remember talking with my sister, who's an ICU nurse in Northern Queens and she was saying that she'd never seen this kind of activity in her 20 year career in the hospital. When I finally flew home from San Diego, it was March 28th, and I remember going from a

full plane and a packed airport to being on a plane with six people on it. Everyone was wearing a mask, no one talked to each other, no food being served, no drinks being distributed.

We landed in Chicago's O'Hare airport, because we were connecting out of there, and if anyone's been to Chicago's O'Hare on a Friday at 5:00 or 6:00 PM, it’s shoulder to shoulder people and it was desolate, nothing was open. Then flying into New York, I flew into LaGuardia Airport, which if anyone's been there on any Friday evening, it's also a very busy place and it was just empty and it was really it was scary to see actually.

MN: Hello, this is Lieutenant Commander Malcolm Nasirah. I was home, of course, watching the news like everyone else and at that time, the major headline was what was going on in Wuhan, China. And I had a feeling, and I told some family, I said, listen, I really think they're going to call on the Corps pretty soon, because if this is not contained, this is literally the epitome of what we're called to do as Commission Corps Officers to protect the health and safety of the Nation.

I had this emotional calm, and I was literally preparing myself to be called upon, and then it happened. And the email said, “You're going to serve in a quarantine mission for the Wuhan cohort.” So as the Commander said, life was pretty much, conducting itself normally throughout, I would limit that comment to the United States, and here we are going to serve, care for and quarantine the people who are being evacuated from Wuhan. And of course, there was some anxiety involved in that decision, but I was also excited about it because we had not really been put in that position as a collective Corps in a long time.

The closest thing in my lifetime, as an officer, would've been the way that we responded to the Ebola outbreak. But during that mission, we went over to West Africa and contained the outbreak there, and now we have an opportunity to contain an outbreak on our

own soil. So, I saw it as a privilege, and I think each and every office officer shares that sentiment.

Like the Lieutenant said, you can be on a deployment team and if there's no opportunity to deploy and you're not needed, you might not go for several years. So, to have this happen, and then this is your opportunity to step up was quite an experience, whether it was your first deployment or your 10th.

So I go to California, and again I'm observing the rest of the US carry on as business as usual, and we literally had people from Wuhan quarantined on these military bases around the country. The focus was just on China and coming and getting those persons from Wuhan out of Wuhan who may or may not have been infected. The Wuhan cohort was released with no infection. So when that happened I felt really proud of the mission and what we achieved as a Public Health Service, but also as with Health and Human Services and with the Military, the CDC, everyone working in tandem to conduct a very thorough and well organized quarantine, and then release of those persons.

So they were released with no symptoms, everyone was tested, and then I was sent to Fairfield, California or the Japanese cohort from the Diamond Princess cohort from Japan. Those people were very ill because those were the mostly elderly group who had been stuck on that ship for almost a month.

I was able to talk to these people and you're hearing about them on the news, and a lot of them were really upset because they followed quarantine guidelines. They stayed isolated in their room for almost a month. And they were put on a bus when it was time to evacuate, with people who were symptomatic, people who did have COVID, so they became exposed. Then those persons were put on the flight, but the people who were positive or symptomatic were separated and cared for in the back of the plane. And those who were negative, I really

don't know if they were all tested, but those persons who were "healthy" were in the front of the plane, but everyone was flown together.

But the fact that they spent hours on a bus together was not something that everyone was privy to, and they were really upset about it when they landed. So, then they began to come down with the virus, but luckily, they were already quarantined. So we began to get a lot of positive cases, during their quarantine days, which was 14 days, but we were consistently testing them in full PPE and we had to do a lot of monitoring on them.

I had to do a lot of chatting with families who were concerned about loved ones who were also separated during those flights because some families were sent – they were all under the impression that they were going to the same Air Base. And when they got separated on the planes, they didn't find out that grandma and grandpa's not with us until they are literally getting off the plane the next morning. So being around a lot of persons who were positive, and then at that time, not understanding a lot of the signs behind the transmissions, what an asymptomatic carrier versus symptomatic carrier, really looked like and who was at the greatest risk.

There was a lack of testing at that time. We all know that were no vaccines and no true course of care. So, I had a lot of worry upon coming home and at that time, flights were still full. So, when I flew home, I had a very eerie feeling that this might be the last flight that I was going to be on with the plane packed the way it was if the greater goal of our mission, was not successful and the mission of the collective United States to try to get this under control.

For most officers, at that time, when we returned we took a huge risk because we knew we could possibly contract the virus and there would be no treatment for us if we did. And then we had to isolate on our own upon returning and then also do our best with protecting the public when we were traveling. Wearing a mask at that time wasn't the norm,

but a lot of us traveled with masks after our mission, to try to do something to mitigate the spread.

But at that time, a lot of it just wasn't on a lot of people's minds. So, I think traveling, and then observing the behavior of the public compared to, the behavior of the people that you were just around for several weeks, whether they were infected or the people on the mission, and then just seeing that the public didn't really seem to be very concerned about what was truly at stake was very eerie.

And of course, when we finally returned having anxiety about protecting our loved ones and our family was something that I think officers had to carry on their own, and we did. The hardest part for me was how do I protect my loved ones and my family when I return, but I was healthy and well, and I just isolated in a hotel for several days. Excuse me, if I went on a little bit too long there.

VB: Not at all, thank you for sharing that. I just to clarify that the decision to isolate was completely a personal decision? The Corps or FDA didn't provide any guidance about, or any instructions as to whether you should isolate before you re returned home?

MN: It wasn't about the FDA they had nothing to do with our – they had nothing to do with the deployment. So, the guidance was coming from CDC to officers and they were recommending that we did. But the issue was there was no place for us to go. You just had to find a place to isolate on your own because there was just so much unknown. The guidance was different, if you had been exposed and you were symptomatic, then we have Safety Officers and all kinds of – there's a lot going on during the mission to make sure that everyone is healthy, well and accounted for, and if you didn't feel well, then you would be cared for during the mission and then triaged in a separate area, and then maybe released

separately too. But for healthy officers, there was no guidance or mandate that said that we had to isolate for 14 days when we returned from the mission.

JS: And just again, a point of clarification, when you did isolate in a hotel or something who, who covered that? Was that covered by FDA or CDC or the PHS, or was it the Lieutenant Commander?

MN: That was the Commander, the Lieutenant Commander at that time, that was on your own dime and okay. Yeah, but it was about the greater good at that time. So, I think that, because it was on people's own dime, that might have also been limited the fact that some officers could do seven days, verses 10 days, verses 14 days.

But I think that changed later on as the missions evolved and more was known about the virus. There's a huge difference in those early missions where a lot wasn't known about the virus as opposed to the deployments that were occurring, in April, May and then, so on even through today.

VB: We would like to touch on that exact issue a little later on in the interview. But I wanted to shift a little bit and talk – alongside all of these really tense issues about the earlier deployments. What was your day-to-day routine? For each of you what were the general duties you had to perform or was it something new every day and you had to just meet the need as it presented?

FV: This is Commander Verni, during my initial deployment we were taking care of the quarantined passengers from the Grand Princess, I was a Group Supervisor and responsible

for certain teams performing certain functions like the mental health team, swabbing team, there was a non-medical screening team that took temperatures of all the guests twice a day.

But essentially like everyone else had been saying, the US hadn't conducted a large-scale quarantine in quite some time and you were really pulled to do other duties as needed quite often. We were really not used to essentially being a hospitality staff on top of all our other medical missions and other types of missions.

[00:40:11]

If you had to pitch in to distribute lunches, that's what you had to do. If you had to pitch in to get folks medications at outside pharmacies, that's what you had to do, just to get basic needs for some of the people that they didn't have, similar to what was described earlier, a lot of these folks, especially the cruise ship passengers, they've already been quarantined for quite some time on the cruise ship. They're being brought onto US soil and now they're quarantining for at least another two weeks. A lot of people were upset, a lot understood, but a lot of their basic needs had to be met. We had to be resilient and think outside the box to meet those needs and similar to the Diamond Princess, the Grand Princess cohort was a very elderly cohort.

We were trying to use technology so they could communicate with their families, and a lot of them didn't know how to use technology. So fortunately, we actually had some officers that were very IT proficient that would go around and help some of these cruise ship passengers set up iPads that were donated to so they can FaceTime with family.

I know one very interesting anecdote, there was a mechanic on the Grand Princess that was quarantined in San Diego and he had to miss his daughter's wedding because of the quarantine. And the team there set up an iPad on an IV stand and used it so he could virtually

walk his daughter down the aisle. So, it was really – you were doing anything that you could do to help these folks besides your normal duties.

MN: Yes. I absolutely agree with the Commander, after our basic mission duties, the general mission after that was meeting their basic needs. And I found that during the Diamond Princess cohort portion of my deployment, that a lot of the repatriates they just wanted someone to listen to them because as Commander Verni said these persons were isolated in a cruise ship room, a very tight space for almost a month. And now, they just had a very arduous journey, and now they're going to be quarantined again, when they just followed the guidelines for a month somewhere else, and then compounded with the fact that they were on a bus with people, who were symptomatic.

We had a main phone line in the lobby of one of the hotels on the base in the quarantine zone, and I spent a lot of time taking calls and listening to them, but calls that began with – that were supposed to only be about the basic needs being met and what they needed for the day, and especially with continuing their pharmaceutical care, which was a huge part of our mission, because again, you had an elderly population who likely had chronic medical conditions.

So, we had to connect them with pharmacies, get their medical history, but in making those calls, sometimes I had to also give them a moment to release their tension and empathize and just be an ear to them. And I found that was very helpful.

CA: This is Lieutenant Anyanwu, for the first mission, my team was supporting the Administration for Children and Families. We basically had a little office in the Command Center where we would be briefed on whatever the mission was for the day. It could include

going to find out how many families have kids, the age group of the kids what the kids needed.

Each of the officers were assigned a group of passengers. There were 200 and something passengers, and then the passengers were broken up into groups, so I had about 35 passengers that I was responsible for. And so, for the day ACF would tell you, “We need to find out the ages of the kids and what items that they need.” And then you start working on that and it could be three hours later and would say “Sorry, we mean, we need you to do this now.” And so, it varied. When we initially got there, it was it was a bit difficult and fast paced because you were just doing assessments, meaning we kept having to go into the quarantine zone to touch bases with the passengers.

Then we got cell phones to assign, so we were able to give the passengers cell phones. After the initial five days of them being there and everything settled, we were able to make contact with them over the cell phone to assess whatever needs that they had and whatever was going on without having to keep going into the quarantine zone, so that was what it was.

Then for the second mission was also changing by the day. Especially since we were traveling across Pennsylvania, so we would get to one city in Pennsylvania and then we had, I think two or three facilities to see. So that took a few days to assess what the facilities were doing and give our recommendations and teach. And then we had to pack up and move to the next city in a few days. So, it was fast paced and a bit different each time. But mostly were providing infection control teaching, nursing, and medical services.

MN: I wanted to add, I'm sure you can hear through the tones of all the officers speaking that the dynamics of the mission and what you were going to do daily changed based on where you entered the mission. Are you arriving, and is there even a quarantine zone set up? Some officers arrived into more of an emergent situation where you have the Wuhan cohort

landing, but there's no quarantine zone even set up on the base yet. What are your duties and how do you adapt to that?

Then you have some officers who come after those officers leave and they're coming into a more stable quarantine zone where, these citizens or repatriates are also now more used to the situation, and their mental health is probably a lot more stable, and your duties and how you adapt to that are maybe not as not as stressful on an officer.

Some of the missions, like the one that I was on, you are literally receiving the cohort and you're the first Americans that they've seen in months. They've been away from the states for over a month and they have this harrowing experience and you're actually triaging them, placing them into their housing, ensuring them that they're safe and all is well, but you're there at the inception of the actual of the quarantine mission for that cohort.

So, your duties might be a lot different than the officers who are coming in behind you when things are a lot more stable. I would say about a week into each quarantine mission, it was definitely a different experience for everyone involved, those of us serving and then even for those evacuees. You could definitely tell a difference in their attitudes. I was on both, I had an experience of two different cohorts, two different missions, so I just wanted to make that comment.

VB: Thank you. It seems to me that after everything these people went through just to get back to the United States, it must have been extremely reassuring for them to be able to interact with officers that could provide guidance and help put some of their anxieties at ease.

I wonder, and I suppose this goes to mostly to Commander Verni and to you Lieutenant Commander Nasirah, to what extent did you draw on experiences from past deployments? And then also the Lieutenant Anyanwu, to what extent did you draw on your professional experiences to help with this –what you guys have described as needing to wear

many different hats and be able to shift from moment to moment in order to meet the needs that arose in these deployments?

FV: Hi, this is Commander Verni and I think no deployment is textbook. I've been in the Public Health Service for quite some time now and on a Tier 1 Team for quite some time. So, I've been on a double-digit number of deployments and even though on my deployment team, I have a very specific role I think the one general rule is be prepared for anything during deployments and they prepare you for that.

You have to be resilient and able to adapt to any situation because even during my earlier deployment days, when I just deployed as a pharmacist, I remember one of my first deployments being in in Texas during hurricanes Ike and Gustav, I went from filling prescriptions to going out and picking up water, and bags to fill sand up with the next day. You have to be resilient and adapt to any situation available to you. If you could help in another emerging kind of problem that they're seeing during the deployment situation, you just have to go for it. So I think Public Health Service really trains you in that way during your deployments to really expect the unexpected, which was very helpful for these deployments, because these deployments, you really had to adapt and overcome.

One of the more difficult things like everyone was saying is there was still a lot of unknowns out there a lot. The folks that were quarantined and repatriated had a lot of questions that we just didn't have answers to. And I think past experiences really helped us adapt to that situation and put people at ease.

MN: Yes, I absolutely agree with the Commander. One thing that we are taught about in the Corps is resiliency and the fact that again, no deployment is like the previous and you shouldn't go into any mission or deployment expecting the outcomes that it might have

happened on the last mission that you were on or comparing mission to mission. You have to go into it with a very open mind, and again, being extremely resilient and willing to adapt to whatever challenge is placed in front of you. Some officers have a lot more experience than others, but we do receive training during our Officer's Basic Academy and there we learn a lot about emergency preparedness.

There are opportunities for officers to take trainings, throughout the course of their career, and we learn a lot about the Incident Command System because when you are deployed, you're only one piece of a very large puzzle. I think the Corps does a good job in helping us to understand where we fit in that puzzle so that when you arrive on the mission you understand that you're not there to give orders, you're there to take orders depending on the mission and the deployment team that you're on. There's a lot of – very humble in your approach to your deployments, because you're on the line right now with a pharmacist and a nurse, but the fact is, like the Commander told you, he was also bagging dirt.

I spent the daytime, trying to assess these person's medical history and get a record of their medication so that I could make sure there was no gap in the course of care, but in the evenings, I was delivering their meals too. So, you just have to be very humble and very adaptable.

CA: Yes. This is Lieutenant Anyanwu, for the first mission in February last year, that was my first time going out so I overpacked, and I didn't know what to expect, and by the time summer rolled around for the second mission, I was a bit more versed on – to not have any expectations.

I've only been in the Corps for four years and one of those years was – I came in as a senior [co-step/indiscernible], which is a training program that the Public Health Service has to commission officers. So, I haven't been in that long, but I do know sometimes it can be a

bit chaotic and so I just went with the flow and then also working with the BOP in a prison setting, I was familiar with chaos that kind of helped with the missions. It's just showing up and expecting to do whatever you need to do to accomplish the mission.

MN: I wanted to add something else, I think she made a great point be because a lot of officers work in high stress environments like with Indian Health Service, Bureau of Prisons, Department of Homeland Security, you can have a small public health emergency there on site, at your clinic or in your prison or at your detention center. When I worked for Homeland Security, we had a measles outbreak in the state of Arizona, and then we had one in the detention facility, and I had to do a lot of work as a pharmacist at that time to help mitigate and control the spread of the measles outbreak within the detention facility, of course, working with the entire medical staff.

But this is the kind of work that Commission Corps officers are doing every day. So, when you are deployed, sometimes is just an extension of what you may do every day on top of some of the more humble duties, like try trying to be more compassionate serving meals and bagging dirt. There's really nothing that we won't do during a mission and nothing that we're really not capable of doing.

JS: Thank you for that. One of the things we're trying to do through these Oral Histories also is gain additional insight into what the patient experience must have been like and through the eyes of our Public Health Service officers. We have a few questions we want to ask about that. We are not asking you to divulge any kind of personal information about the patients you were involved with. But hopefully, you can share some of that experience through stories about individuals any way you'd like to take that.

One question I'd like to pose to each of you regarding your experience with the evacuates and with repatriation efforts but also, we're interested to hear about your experiences, and for a couple of you, your subsequent experience in testing patients and hands on care, or educational care in the long-term care facilities. Could you tell us a little bit about your experience with the evacuees? For example, how were patients who tested positive versus those negative processed differently? Commander Verni, could we begin with you?

FV: Surely, during the quarantine mission at Miramar, the one thing I have to note especially is that, whenever someone's ill, of course there are some fears and some concerns and that was definitely amplified during this mission with COVID-19. There were just so many unknowns with the virus and how the disease progressed and the severity of it and that was a huge aspect for some of these patients. They were very fearful.

During this mission, we had a mental health team that was extremely helpful. We were doing routine swabbing of all the guests. And we did have a number of positives, so whenever we got a positive they brought in a clinician which consisted of either a physician or a physicians assistant, coupled with a mental health provider to go there and inform the patient that they were positive for COVID and what the next steps would be, and to try to alleviate any of their concerns.

When I was there, they actually leased out a hotel nearby and anyone that was positive was actually transferred to that facility for a higher-level care. It was staffed by a number of clinicians, and they were actually removed from the Marine base in that quarantine setting and brought to this other setting for treatment. If need be, they were taken to the local hospital system, if things got exacerbated if their symptoms or their disease progressed quickly. But I clearly remember from dealing in other missions and hurricane settings and

whatnot, that the level of anxiety among the patients was extremely noticeable during this mission, but they did a great job of trying to identify patients that were positive and moving them offsite in an attempt to not spread the virus, to folks that were there.

[01:00:00]

Our guests were housed on the Marine base in three separate buildings. So, there was the potential for spread because they did have some common spaces. They were sequestered to their rooms, but they did have some areas where they could walk around freely outside just to get some exercise and whatnot. So that's how they handled patients that were positive. And of course, on top of that we had a pretty elderly population. So, we were having a lot of non-COVID related medical issues happening as well. A lot of these folks were away from home for quite a bit of time, under a lot of stress, not eating their normal diet and normal ailments were being exacerbated and we had several incidents of folks having to get rushed to local hospitals for other treatments as well.

MN: With the Diamond Princess cohort mission, at least the inception of it, there were a lot of positive cases and people who were very sick and they were in the back of the plane, and the people “not infected” were on the front of the plane. When the plane landed, it was about 5:00 AM, I don't remember the date, but somewhere before the 21st of February, because I was flown back home on the 21st. So first the medical doctors with HHS – those doctors, who were also deployed, were in full PPE and white zip up suits with eye shields. They rushed onto the airplane first, and then they removed the most critically sick persons, and they were brought into a separate area through the air hanger where everyone was being

processed. But we wanted to focus on those persons first, and they were triaged and a separate area sectioned off from everyone else.

The remaining passengers were processed off the plane. They had to clear documentation with Homeland Security and Border Patrol. I'm sure they did some sort of symptom screening and temperature monitoring probably right there on site, if not during the flight. Then then those people were assigned housing, and then we also gave them meals. The issue was, at that time we just didn't know a lot about the virus. So, a lot of the people that I processed, and then the other officers – a lot of us were exposed, but again, everyone was protected in PPE.

We found out later they were asymptomatic positive people because they had all been on a plane together and were in direct contact with people who were ill. So once they were quarantined, we conducted daily mental and physical health checks on them and then testing them as well.

The CDC was conducting testing as well because we were all aware that they had been in too close of a proximity with these people who were very ill and had the virus. And a lot of them did begin to test positive, and if they were positive, as the Commander said, they were brought – if they were ill, they would be brought to hospitals for care offsite, and then it would no longer be under the management of the deployment or HHS or ACF.

At that time, the state would take over their care and basically manage the situation from then on once they had to leave the military base, because I'm pretty sure that the bases were very strict. If you had any positive tests, those people had to be quarantined away from the base in order to protect the Military members on the base and everyone on the military base.

So we did have a lot of people beginning to test positive, and so we had to do a lot of back and forth into the quarantine zone. And as a Lieutenant said that these people were

eventually given cell phones, but that did not happen during the time I was there. So again, like I mentioned, you had to adapt depending on the day and the mission you were on.

We still had to do a lot of footwork back and forth to test these people and to also communicate with them at least for the first week or so, if not the whole entire 14 days, depending on where you were. So again, once they were positive, the state took over control and management of those cases.

JS: I want to confirm, if a patient was positive, then the care was delivered by state officials. Is that correct?

MN: Yeah, they would be taken – yes, they would. Especially if they had to be hospitalized, they would basically never come back to the base, so they would continue the quarantine off base and their care if indicated off base too.

FV: This is Commander Verni, that's what happened initially, as time progressed, of course, things changed. During my mission, like I said, they obtained a hotel, and they rented the entire hotel out, that was run by HHS, and was eventually transferred over to contractors.

And we brought our positive patients there. And I know one of the main pushes for that in the San Diego area, the cases within the local county were going up pretty quickly. And they were nervous that the folks that were positive on the base being shuffled to their hospital system would overwhelm their hospital system. So at some point they thought it would be prudent that anyone positive, who wasn't in a dire emergent situation, was shifted to another HHS run facility. So they could quarantine there if they were positives or asymptomatic or mildly symptomatic. So, they didn't inundate local hospital systems because that was definitely a concern, because some of these sites had several hundred passengers

from these cruise ships. So, if something were to happen where a large number got sick, and we had to send them all into the local healthcare infrastructure that could have been devastating to the local community as well.

JS: Lieutenant Anyanwu, what was your experience in dealing with the evacuees as patients? Also, I'd be interested to hear about your additional experiences in your other deployment as well.

CA: For the first deployment with the evacuees if I recall correctly, we were told that the evacuees were screened for symptoms prior to leaving Wuhan and that they were all negative. I guess they were assuming that they were negative for coronavirus, but as we know, the symptom screening doesn't mean you're negative. You could be positive and asymptomatic. And so as the days went on and the evacuees were on the base some of them did come up positive and I believe they were they were transferred to the local hospitals for care.

I think they had to finish their quarantine, and then onward travel planned. I can't really speak to the specifics of what their care looked like when they were positive since the CDC was the lead. In terms of providing the temperature checks and whatever medical needs that the evacuees needed.

Since I was on a SAT Team, we were mainly focused on fulfilling this mission to help the children and families. In terms of the second mission with the long-term care facilities, at this point it was summertime, and we knew a little bit more about the virus, but the long-term care facilities were hardest hit because all the residents are in close proximity with each other.

I do remember a lot of the facilities being that the residents were old, some of them had dementia and other diseases and they were cognitively impaired, so they couldn't really

keep their masks on. It was a requirement to have their mask on if they came out from their room. Sometimes they were able to move around in their wheelchair and they couldn't put their masks on because they either they forgot, or they just couldn't find it. But the facilities at that point had stopped certain activities that would have all the residents together in an enclosed area. They stopped doing activities like games that they normally do in those type of facilities. Also, for mealtimes, the meals were then brought to their rooms and the residents had to eat in their rooms.

I think it was other factors that made the virus spread in those long-term care facilities and one of them be in the shortage of PPE. We had to come up with strategies to teach to the facilities to help extend their PPE. Because I think some of the teachings that they were getting from the CDC, they were interpreting wrong and implementing it wrong. So, when we were able to go in the facility and stay the whole day and observe the staff, we could come up with strategies like, "Hey, you really should be cohorting your residents in terms of green, yellow, red." If they're positive, they need to be in the red zone and you cannot intermingle your staff coming out from the red zone to someone that maybe was exposed, but you don't know what their status is or that they're confirmed with a negative test to be negative.

You want to lower the risk of making them positive, and that really is determined by if you have staff that's going from treating a resident that's positive for coronavirus and they provide care, and then they go to the green zone. They're bringing the germs in there. So just simple things like that that people are not really thinking of because – in working in the hospital as a nurse, we haven't really had a pandemic or anything of this magnitude. You do have certain diseases that you have to wear PPE when you go in the room, but when you come out of their room, you're able to wash your hand and go to the next room. But with this

virus, we weren't sure how it was spreading, it was just best to, and especially in the long-term care facility, it was best to do something more drastic just to be extra sure.

In this type of facility, if the residents are in their rooms and you're not doing activities, the numbers are spreading so high because of the staff that's going home and coming back and then other practices like the shortage in PPE. And then just simple things like, you come out of a red zone and you don't know if you have those particles of the virus on you and you go to someone that's, negative and two days later they come up positive. So, it was just very different and eye opening.

JS: It sounds like they really needed some professional advice on dealing with this PPE shortage since there were many problem issues as you pointed out that certainly was one of them, right?

CA: It was yes. That was the biggest thing because I think with the – I have never had to reuse disposable PPE, but in a situation like this, if you're going to reuse it is best that you do it where everybody has coronavirus, so then I don't really need to change my PPE to come out from one room that's positive to the next room because they all have the same virus.

So, there's no risks of transmitting the disease if they already have it. So, it was just things like that. We have to alter in our mind because we are so used to using the PPE and throwing it away to go to the next room, even if they have the same type of disease. You're assuming one PPE per patient that was back then when we had the luxury of having all the PPE in the world.

JS: Commander Verni, I wanted to ask you, you used a jarring word to describe the patients that you experienced on your first deployment and that was fearful. What was it like

when it came to the mass testing in Texas when there were so many people, this was when the cases were starting to peak in Texas when you were there, so the folks that came through at this mass testing site in Pasadena, how would you characterize what the folks were like then? Were they – did you also see a sense of that in these patients or maybe not so much?

FV: We did, not to the degree we saw during these initial deployments, just because of the unknowns associated with these initial deployments. When I saw the folks coming through in Pasadena, a large number of them were very fearful. The case rates were going very high and no matter what people hear about in the news, until it really hits home, some people don't really grasp the gravity of the situation until they start to see family and friends become infected. They start to see folks that wind up in hospitals and on ventilators then reality really hits.

A lot of the individuals that were coming to our site were symptomatic looking to get tested, and that level of fear was definitely there, you definitely saw it. There were, of course, the contingency of people that just wanted testing either for employment reasons or just for general knowledge or they thought they may have been exposed, but a large portion – it was definitely a tense situation which of course is exacerbated by the Texas heat in July and very long lines and wait times. Some people got a little heated, but we understood, and you had to really understand where they were coming from and their concerns.

JS: It certainly had to be challenging for all involved and along those lines you mentioned earlier, and I'd be interested to hear insights from all of you, but I'll start with you Commander Verni. We heard that so many that people that were being repatriated came from families, grandparents, grandchildren. Were there circumstances where families had to be split up as part of this process? That must have been quite an ordeal if that indeed came up.

FV: Yes, during our mission, the folks from the Grand Princess cruise line couldn't fit onto one base. So they were split up, I think there was one in Northern California, ours in San Diego, and there might have been a third location that housed some. Unfortunately, they were grouping them by rooms, but as families can be in multiple rooms.

They tried their best to consolidate people. And there were examples of when people were actually shifted from site to site based on bringing families back together. If there were elderly parents that were on the ship with their adult children, they wanted to bring those adult children to those parents so they could have a support system.

There was some shifting, back and forth when resources allowed that to happen but unfortunately, there was some of that. Luggage was lot or was sent to the wrong place, and with all the craziness going on at the beginning of these missions, some people didn't have luggage for the first five or six days, which made a bad situation, even worse because they are in the same clothes. Unfortunately, it did happen, but we did pull through and bring people together when there was the need for it, and resources allowed.

MN: This Lieutenant Commander Malcolm Nasirah, we saw a lot of families unintentionally being separated with the arrival of the Diamond Princess cohort to California. In most cases it was the elderly grandfather or grandmother who was on vacation with the rest of the family, and they assumed or were told that everyone was going to land in the same place. But those decisions were actually – everything that happening was very fluid, and the decision as to where certain planes were going to land was actually being made in the air, because you can imagine, the logistical burden involved where you have you have these planes landing on military bases that are likely to disrupt military operations.

So, in the air, it was decided where certain planes were going to land, and at that point families began to be separated. We weren't able to get cell phones to everyone for almost a week. This is the Diamond Princess cohort, and we also had a situation with there being a language barrier. You had these separated elderly people, so the SAT Team had a direct line if families that were separated needed to reach people at Travis Air Force base, where I was, and they were at another because some of them went to Texas, so they would call me and they would say, “I'm looking for my relative, grandpa, grandma, can you please go get eyes on them for me?”

I spent a lot of time doing that. You can't just walk into their room. You have to don and doff the PPE correctly because these people are still being monitored. They've been exposed, and you don't know if they're positive. So, I did a lot of footwork just trying to get my eyes on these separated elderly people and then putting them on the line with their loved ones so that they could calm their anxiety.

I had one situation where the grandpa had an entire room, I mean he had a two-bedroom suite that could fit the whole family, but he was in there by himself, but the rest of the family was in a really tight room in Texas. It was no one's fault, this was all new for each and every one of us involved in this mission.  That is where I think that as a Service Access Team and as officers we did a great job just trying to be that middle person to manage that anxiety the families were dealing with by being separated. Because again, there wasn't a lot known about the virus and these people had been shuffled from, Japan back to the US, to find out that they're going to be quarantined again, and now they're separated from their loved ones for another 14 days, if not more, depending on the outcome, and if they test positive.

[01:20:43]

I had another family member call me and actually – she was separated from her parents, and she called and told me that she suspected that they were not being honest about their symptoms and the way that they were feeling with her. So, I asked a Medical Officer, if we could conduct a wellness check on this couple based off the suspicions of their own daughter. And it was either the wife or the husband that ended up testing positive because of the wellness check that we conducted. And then that person had to then be taken off base, but that intervention possibly saved their life.

Those are examples of some of the challenges with the separations of families and how we worked to intervene and be a more of a place of refuge and just an ear and someone that these people could depend on to be that middle person. It was a very important aspect of our mission too.

JS: You mentioned, I would say this has come up more than once about the variety quarantine sites literally around the country, and how were decisions made about which groups went to, which quarantine sites.

MN: From what I know that was made mostly by the State Department and those decisions were made, in flight, with the State Department working with ACF, but those decisions were well above our heads and where we fit into the puzzle as PHS officers on deployment.

To give you a clear answer on that is just something that we really don't know. I just know that's what we were told during our brief meetings in the mornings, and our daily meetings, you knew that the State Department has decided where these planes would go, who we are going to be receiving, and who are we going to be processing, whoever that is, [indiscernible] based on who we're going to receive, but HHS did not make those decisions.

JS: Thank you.

FV: And to just piggyback on that, this is Commander Verni, the amount of individuals that could be housed was something else that I think the DOD had a say in as well, because for national security you have to maintain the base in proper order and operation. We couldn't bring thousands of people onto one base. It would really disrupt operation, so we were limited, per base to the amount of folks we could actually quarantine on them.

MN: I do know that at March Air Base we were not able to get an extension to conduct another quarantine mission there because the base needed those barracks. They were being set for a group of Marines in their Enlistment Training Academy. Those missions and operations were beginning to be impacted. So once we released the March Air Base group, we began to deconstruct the quarantine zone and then move the mission to another base wherever that was, but we shut down operations at March because the military really needed that back.

JS: Many of you obviously experienced patients who were on cruise ships, and just curious if any of you can recall the any stories you might have heard about their experiences on these cruise ships or in transit from Wuhan back to the states. As we've heard already, they were in quarantine or in isolation in their rooms on these ships for quite a while, but I was curious if any of the folks you encountered shared any of their experiences while they were on the cruise ship before they made it back to the states?

FV: My experience with the folks from the Grand Princess and I'm sure others that were actually in Japan had a much longer and arduous journey, it was a lot of confusion, fear, and

frustration.  Just imagine packing for a seven-day cruise where you're supposed to be playing bingo, overindulging, and eating, and then you get put into this situation. It was very difficult for them, and you could tell that in speaking with them. Many of them did understand, they understood why they were there, but again, we didn't do this in many years, and the process didn't run like clockwork. There were hiccups that had to be overcome. Many of the folks were understanding, but you did see frustrations get the better of some people.

An interesting thing I was discussing during that March quarantine that I dealt with when we first got there, the US was pretty much business as usual during their quarantine period. The one thing they had was access to of course, was television and they were watching a lot of it. They saw what was happening in the rest of the country. And some folks even expressed to us during the end of their quarantine, that they actually felt safer here than what they're hearing is going on in the rest of the country, because they knew we were putting proper precautions in place, which was interesting to hear, and that really helped us, and it really let them understand how serious things were getting in some places, especially in the Northeast, like New York.

They were hearing stories of refrigerated trucks behind hospitals because of the level of individuals that were getting gravely ill from this virus. So, they were almost appreciative at the end for being taken care of like they were, but again, it was a roller coaster of emotions for those patients, for sure.

MN: Yes. Again, like I mentioned earlier, I spent a lot of time just listening to people after the call began trying to understand what their pharmaceutical care needs were. But one guy was extremely angry, and he told me his whole story, he said, “We adhered to what they told us to adhere to with isolating ourselves on a cruise ship. Then we sat on the bus for almost 12 hours, waiting to go. Then they put people who were sneezing and coughing on a bus with us.

And we sat there on the bus with them for several hours. Then we get on a plane and here we are quarantined all over again, and we don't know if we're positive or negative because we just spent 12 hours on the bus with these, with people who were sneezing and coughing, and we're going through this all over again, when we thought we were on the other side of it when we thought we were coming home to something different.” I had to listen to a lot of those stories and just let those people talk.

There was definitely a lot of anger and anxiety around that. They seemed to be more bothered by being quarantined again than the actual danger of the virus, because they felt like they had, in some ways, beat it because they spent such a large amount of time isolated already, but then again, they were exposed and they didn't know if they were positive or negative.

So, it seemed that a lot of them just wanted the “nightmare” to end, and they just wanted to be responsible for themselves again, because they were just being shuffled around so much and they had a lot of their basic freedom taken away for almost two months. There was a lot of frustration for these people.

VB: Commander Verni, I know you said there was formal mental health services available, it seems like a lot of them legitimately needed to vent and have someone listen to them. Did they have any need for more severe interventions or at the March or Travis Air Force Bases, were there any mental health providers available to treat people if they had the need?

FV: Like I said, that was definitely an important piece of the puzzle that was identified from very early on is to have that mental health piece. I know if things got to a level of kind of extreme severity, they would actually bring them to an outside facility. I wasn't aware of that happening, but our mental health team did a real good job with the folks there and

handling their immediate issues. I wasn't aware of something that had gotten escalated to the point that they needed to be transported off site for more involved mental health.

MN: We did not have any situations where anyone had to be transferred off site or became combative or extremely irritable to the point that they needed an intervention. We have a mental health team that is always attached to the mission and those officers are responsible for checking on the deployment professionals, as well as the evacuees.

In doing the daily physical exams, they also did daily mental health and wellness checkups too. And that was random, and then it could also be based on them calling us, but there were no mental health emergencies. Again, I think a lot of the anxiety calmed down, anywhere from three to seven days within the quarantine zone. I think once they finally had more stability and they could finally the light on the other side was there if they could just get through these last 14 days, compounded with the care that we were giving them, things became a lot more easygoing for them.

And when we get to the end of the talk, I would like to share a copy of a thank you letter that a family wrote to us when they finally ended their 14-day quarantine from the Diamond Princess.

VB: Thank you so much for offering to share that, it sounds really touching and would be a wonderful thing to capture in this interview. I will definitely save time to do it.

I wanted to also ask Lieutenant Anyanwu, in terms of mental health concerns when you were on the Pennsylvania deployment, I'm sure that some of the patients were really suffering from feelings of loneliness, isolation and depression. Did you in encounter any his or did you see anyone with a need for mental health intervention?

CA: The mission with the long-term care facilities in Pennsylvania was a bit different than the first mission where the citizens were evacuated from Wuhan and were being held on the base. A lot of the mental health worries or complaints really came from the staff from the facilities we went to visit. I'm sure a lot of the residents also, there were a few issues especially because they were older adults. At that point, the facilities couldn't accommodate visitors and they hadn't seen their families in a while, but a few of the facilities were able to, in lieu of the normal activities that they had, they were able to come up with different innovative ways for the residents to see their families.

I think it was the activity person from the facility – I know at least one of the facilities we went to had an iPad and they set out different times for the residents to call their families and do a video call with them over the iPad. And they also had a music teacher that would play – I think she was playing the violin or some instrument, and the activity coordinator would go to the different the residents.

For the staff they would just approach us and, make their complaints about the facility or how it's being handled, and if it was something valid that could be something of great concern, then I would take it back to our team lead to be able to voice those concerns to whoever was running the facility so that we can also give suggestions on how to alleviate those fears, like mitigation strategies to help fix the complaint as best as we could.

FV: Another big aspect with these missions is actually the mental health of the responders which is always a concern during deployments when you're in austere conditions. But for these COVID-19 missions, I think it was ramped up a bit more. Even Corps Care, which are our mental health folks, had really stepped up and learned a lot from the initial deployments and really did a lot more communication with officers just to ensure their mental health during these deployments.

MN: I also wanted to mention that one thing that calmed our evacuees at Travis Air Force base, is that we established a daily quarantine newsletter and it had, various updates on where they were with their release date, some updates on what was going on in the news around the world, and with the virus. We had a reminder that they could always reach out to us for personal needs.

They were informed about when the temperature checks were going to happen. There was information on how to get deliveries, once we established that. They had their mealtimes, if they needed medical services the number was in there too, and infection control guidance was in the newsletter. And then, again, information on what was going on with visitors and that they couldn't receive visitors, but they could receive gifts and support from visitors, and then we would assess getting that stuff to them. That communication helped out a lot, I think to reduce the anxiety –

JS: I'm just going to jump in, if it's possible, it would be wonderful to have a copy of one of those for documentation purposes, because it sounds like a pretty useful means of communication to the guests. We can talk about that offline if you'd like, but it's sounds like a wonderful and very useful piece of information that was shared with the folks at the base. Thank you.

VB: Yeah, it definitely sounds – communication, isn't an antidote for loneliness, but it sure helps. And I bet it was really reassuring to have constant access to that level of detail for the evacuees.

I did want to return to Commander Verni's point about taking care of responders' mental health and ask all of you if there were unique mental health needs for particular

deployment or this particular response that you noted, not even if it wasn't personally, just perhaps that you observed and how the Corps provided for officers' mental health needs. And then just as a tag on maybe informally how officers maybe could let off steam, or just decompress after what must have been an absolutely harrowing experience.

FV: During these earlier missions, the responders, Commission Corps, HHS civilians and all the other responders, had a lot of the same concerns that the quarantined passengers had. It was a very new virus, new disease and there were a lot of unanswered questions. A lot of fear is still going around of what could happen to you if you contracted the – and this really exacerbated people's anxiety coupled with what other people were mentioning about the PPE shortages. So now you're asking clinicians that were deployed to do things with PPE that they're just not accustomed to and it added to that level of anxiety.

During the earlier missions, we really relied on each other for a really good support system, which was great, as these missions started moving forward, the Commission Corps really noticed that there was a great need for mental health intervention with folks that were deployed and that's where Corps Care really came online and started to be a very integral part of our deployments. They would give you resources that you could utilize, they would call you sporadically during your deployments to check up on you, see how everything's going.

They definitely had communications and had contacts you could reach out to. Of course, early on, we didn't have that formalized of a system. But fortunately, we were deployed in settings with folks from the Corps, from HHS from ASPR, the Assistant Secretary for Preparedness and Response and other local responders and things of that nature, so we really utilized ourselves as a support system.

[01:40:00]

MN: This is Lieutenant Commander Nasirah, one thing that the mental health team established at Travis Air Force Base, was an actual quiet space. It was just a hotel room in the quarantine zone but it, was fully furnished. There were some snacks in there and we shared the key, and it was open to anyone. Each group, depending on which HHS team you were deployed with, everyone had their own room as a group. So the SAT Team had a room I think we shared with some of the logistics HHS personnel. I had to use that space several times, and that definitely made a difference. I think, depending on what your mission was, the level of exhaustion wasn't always the same for everybody.

For some of us, myself, particularly on the SAT Team that I was with, we were separated and we flew from Ontario, California to Fairfield, California, where Travis was. We landed at 12:00 or 3:00 PM and we reported, then we drove back to the hotel. We were able to rest for at max two hours, and then we went back to Travis to begin to set up to repatriate and triage and receive the Diamond Princess cohort. We were waiting for them from I think, 7:00 PM till 5:00 AM. By the time we were finished with the last repatriate, it was probably 5:00 or 6:00 AM and we had to go back to our hotel, and we had to be ready to assist these people again at 0800, because they were going to wake up with a lot of needs and as well as questions.

Having an opportunity to access that quiet space sometimes made a difference for my mental health during the mission as a responder, and I'm sure for many other officers too. So small things like that definitely helped us to be better responders during the mission.

CA: I don't recall any of that where we were at so I'm not really sure what to contribute in terms of – I think we were one of the first people out the door in February. If there was – I

just I don't recall us being given the opportunity to sit in a quiet room. We just had to do the mission and then go home to rest,

VB: Perhaps your cohort's experience contributed to demonstrating the need for some resources like Lieutenant Commander Nasirah described.

CA: I hope so.

VB: I imagine that one thing that's really crucial for mental resiliency in situations like this is having a strong team and being able to count on the people that you're working with.

Could you each share a little bit about what the team dynamics were like, who were the people that you interacted with on a routine basis, whether they were Commission Corps officers or other federal personnel or local staff or officials. Who were members of your – the network that you relied on during your deployments?

FV: For myself, when we deployed to Miramar in March, it was a real mix of different personnel. We had PHS officers that were from different deployment teams, different agencies, and different parts of the country. We had a lot of civilians that were part of NDMS, which is the National Disaster Medical Service. They are also like federal intermittents that deploy for these types of – and they have teams that range from logistical teams to medical teams, to a whole slew of other teams.

We had folks from ASPR. We had folks that were liaisons with state and local contingencies. We had folks from the VA, we had representatives from the cruise line with us. It was really a robust mix of personnel in this mission. And I think that was helpful

because it gave us a lot of different perspectives. And very quickly you learned how to work as a cohesive unit.

Like we were saying before, everyone had a defined mission, but it was really one team, and everyone was very well aware of that, and really utilized each other's skills, knowledge and other things like that to help each other throughout the mission. Really, it was the dynamics of the team that kept everyone focused on the mission, kept everyone levelheaded in order to identify any issues quickly and try to resolve them. So as far as the team's mental health, having each other was the biggest asset we had there, in my opinion.

VB: Go ahead. We can hear you.

MN: I don't have much to add, I think the Commander covered that well, because that was pretty much uniform, at least in the quarantine responses on the military basis, that diversity of the structure and NDMS people with the NDMS personnel and the medical personnel involved. I wanted to add, which I thought was really interesting, because this was something that I don't remember ever being taught about, and it's to no one's fault because this was, again, this has hadn't happened, in almost maybe 80 years or so.

When I arrived to the quarantine zones, or was there to set up the quarantine zones, seeing the US Marshals as a part of the deployment response was a different dynamic. And that is a dynamic that you would normally never see in a typical PHS, Public Health Emergency Deployment Response, but they were there because when a federal quarantine is initiated and official, now the citizens have to stay in the quarantine zone, if they go outside the quarantine zone, they're breaking federal law.

The Marshals were basically there to assess and secure the quarantine persons and make sure that they did not leave the quarantine zone and break the federal quarantine

mandate because if they did, then they were subject to arrest. They also made sure that everyone going in and out had on PPE and also sanitized our hands or cleaned our hands very well. And if you didn't do that, you would definitely hear from the Marshals, no matter who you were. They really were very strict about that.

They were this additional layer of security, both to make sure that the spread would be mitigated, and then also to enforce the law, if any of the citizens wanted to get out of the quarantine zone, but there were never any problems. They were very friendly and professional but having an opportunity to work alongside US Marshals is something that the average officer probably won't ever have an opportunity to do and that's just fine, but that different dynamic was that was definitely something that I thought was very interesting. But we all worked well together each and every one of us. So, it was great.

VB: I find that really interesting, thank you for sharing that. Especially because it sounds like these teams were assembled from people that have different authorities assigned to their position and the "all hands on deck" spirit that you guys have described coupled with these – how did that that feeling that everyone's accountable and everyone has a role to play in helping with whatever arises. How did that intersect with the systems of hierarchy that come along with the different kinds of organizations that were staffing this mission?

FV: think that's one of the great things with PHS is that we adopt that ICS sub structure, that Incident Command Structure, without it, it would be a hornets nest of activity, because like you said, there's people with different capabilities, they come from different agencies and under that structure, you can take those differing assets and create some sense out of chaos where you have a specific someone assigned as the Incident Commander and then you have

different heads of different contingencies like operations and logistics and planning. Below that it funnels out into what looks like an organizational chart.

So, you could very quickly hit the ground no matter what the incident and develop that structure extremely quickly and plug people in where they need to be. Without that it would be chaos. It would be chaos in any deployment, especially something like this, and it really goes to show you how fitting that system is during a deployment because without it, it would've been a nightmare.

MN: This is Lieutenant Commander Nasirah, I agree with the Commander, and again, like I mentioned earlier, we get exposure to the Incident Command Structure whether it's an HHS agency or non HHS agency. And to just make it easier to understand, basically when you report, you're looking for the Incident Command Leader, who's at one of the heads of the Incident Command Structure, depending on the deployment that you're on.

It's implied that, those persons are leading the mission. So, the sub lead for my smaller SAT Team is looking up the chain of the Incident Command Structure, for that head. And then they [inaudible] to me and I don't go around them. It is very well organized and it's nothing new, it’s just something that is inherent with the ICS system.

The commander talked about the National Disaster Medical Service, and these are things that just the average American citizen is not privy to, but they have a stake in because tax dollars are used to fund these trainings and this level of HHS personnel. So, we all go into it with the understanding of who leadership is. We don't get there and try to establish the leadership, and then organize. It's inherent, and it's already done, and it's a great. It's really amazing when you see it working the way that it did, especially with this situation, it was new, but because of the resiliency, I would say the ICS structure, definitely helped get us

through that first year for sure. And I think it was a real test of the resiliency of the ICS structure. So that's my comment.

CA: This is Lieutenant Anyanwu, I think all the missions are different. With the first mission in February that I was involved in, it was a mix of all the different government agencies that are typically involved with what this type of mission calls – the type of services needed for the mission. We're all assigned the different tasks we are to complete. And as I previously stated, our Service Access Team was working with ACF. So ACF had their mission and what they had to accomplish, and then they let us know what tasks we needed to complete to fulfill that mission.

And then the Operations section was led by CDC I think, and I don't know. It was a mix of different agencies, and everybody was assigned to whatever section that they had to accomplish for the whole mission. And I believe the base that we were on, I think some part of their Command Section was also a part of the mission.

Every agency had their own assigned role and task working together to support the mission. And then for the second deployment, with the long-term care facilities it was all PHS officers and one ASPR asset. And he was there to support us with travel since we had to travel to different parts of Pennsylvania. He basically helped us procure rental cars as needed. Made sure we had lodging for the next destination that we were going to. So, he was helping coordinate the moving pieces, if I remember correctly.

MN: This is Lieutenant Commander Nasirah, I wanted to add that during hurricane Katrina, there was definitely a breakdown in the way that the Federal response managed that natural disaster, but ICS took the lessons learned in Katrina to update and prevent those kinds of errors from ever from happening again, and created a more robust Incident Command

Structure. We take the ICS courses, and some of that coursework includes the lessons learned from Katrina and what you know and what ICS did as a result, and what we learned and how we basically reorganized the Incident Command Structure. The way that's been managed and the way we've responded to the COVID-19 pandemic is evidence that it definitely made a difference, and that we are much better now to respond to public health and weather disasters.

VB: I'd like to hear a little bit about what the what the formal process was or what was prescribed by the ICS, or the US Marshals in transitioning out of the mandatory quarantine period, but also any stories you have about what it felt like as you released evacuees and you prepared to transition out of your role in those deployments.

FV: This is Commander Verni, in our mission it was interesting to see we didn't have Marshals on our site, at the actual base the Military Police were handling that, but it was very interesting because we had to deal with our state counterparts a lot. We had people from numerous states and each state was defining their own requirements for their people housed within those states.

Some states were stating that they would take folks before the quarantine period ended on private flights, and they would continue their quarantines at home in their home states. Some states wanted folks to remain on site for the whole duration of the quarantine. Some states were requiring testing before they were allowed back in, and some weren't. So, there was a lot of juggling and working with our state counterparts to decipher who went where and when.

It was it was interesting to see, some folks actually got released well before the 14-day quarantine period from our site, which was interesting because it was the folks that were still there were disheartened to see some people go and they still had to be there, but it was

interesting. I remember someone was mentioning about a newsletter, we had something similar at our site as well, and we would have countdowns, and people would contribute to the newsletter to express their concerns about going home or not going home early. But it seemed to be a very – it was a somewhat cluttered process because of what we had to do with our state counterparts. But overall, it was very happy for the folks there. And of course, for the folks that were deployed to respond, it was it was a feeling of relief to get everyone home safely quarantined and to get ourselves home fit safely back to our families

MN: This is Lieutenant Commander, Malcolm Nasirah, the exit process day was a day I would describe it as a day of Jubilee. I was there for the Wuhan cohort final release day, and that began at 6:00 AM. They received the temperature monitoring and symptom screening, and if they passed, then they went through a CDC exit process. The CDC actually gave them documentation with their name showing that they were released and cleared the federal quarantine, and essentially, they had their freedoms back. And then they were placed on one or two buses that were going to LAX Airport.

Once that happened, they were just so excited. They wanted to take pictures with those of us who had been there with them and took care of them. I dealt with a lot of the staff who worked at the US Embassy in Wuhan or the consulate, and those people were very, grateful for what we had done for them. And you just saw this energy that you didn't see in these people for several weeks, literally like a light bulb, like a shot of the adrenaline just surged through their bodies and they were very excited. And I still have a lot of those photos with them.

[02:00:19]

One of the issues that we did have to deal with though was confusing the news media and trying to protect their identities because, we wanted them to be able to continue to live a normal life and not have this bias against them. So we confused – we did a dummy bus where we sent a few buses through one gate where the media was and then we had the Military base open up another gate that's normally closed, and then we sent them basically through the back door so they could go ahead and move on with their lives. The dummy buses were the ones recorded by the media, but those buses were totally empty.

Off base later on some of the staff from the US Embassy did do a local news media interview. But it was really a great day, and it was a historic day, and I was really proud to be there and be a part of that.

CA: I forgot what the question was. sorry.

VB: No problem, I was wondering what your experience was in transitioning out of the quarantine period helping evacuates prepare to leave, or preparing yourself for your return back to FDA any stories you care to share?

CA: I think for the first – we had two cohorts of people quarantining at the base when I was at Miramar. And so, I got to see the first people leave after their 14 days. Basically, it was a few days prior to the end of their quarantine, as long as they were symptom free, they were able to book travel to their final destination. And so just keeping them updated with the information and then trying to coordinate what time to get them off the base to the airport or train station for them to go home. I was really involved in the logistics of them booking their flights in accordance with what time we can get them off the base to go home.

And sometimes that kind of involved – we had a lot of older adults that could not speak much English, so trying to get an interpreter and then trying to communicate with their family members that, that they were returning back home, just those different aspects.

We didn't have much direction in terms of when we returned back to work. There was not any clarity on whether we could quarantine at home and then go back to work. I don't quite recall, but I think we were told we, as long as we felt, okay, we can go back to work. After our deployment you get one or two respite care days, and then you go back to duty. So, I believe that's what happened.

For the second deployment, it was a little bit more coordinated where we had to, at this point, everybody was working for home anyway, but they had more of established protocols on, if you return back to your duty station, you have to quarantine at home for two weeks before returning back to the office, but we were all working from home, So it didn't make much of a difference.

VB: Maybe at this point it would be a good time. Lieutenant Commander Nasirah, if you'd like to read the letter you talked about,

MN: Okay. Give me one moment, I collected letters, some artwork that some of the – there was an artist at Travis Airbase, and she did some really nice sketches of how the cohort basically spent their idle time every day. So let me see, this letter is dated February 19th, 2020, and they were a Wuhan cohort 2, and they were being released from Travis air force base.

It says: "To all the wonderful staff at Travis Air Force Base, From the bottom of our hearts, we want to thank you for all your hard work, unrelenting kindness, and thoughtfulness, constantly looking for ways to brighten our stay here and connect with us as

people. We all knew you needed to protect us and the country from the virus, but your warmth and generosity went far beyond what anyone could have asked.  Outsiders will pity us for having to endure this quarantine, but we who were here know the truth. We will never forget you all and your service to us. God bless you."  Signed, the names of the persons who wrote the letter and it was a family of four and that's the end of it.

VB: Thank you so much for sharing, that is so moving and really is a testament to the immense value above and beyond what your call was to be there for those people. And I'm just really moved to listen to it.

MN: I'm glad to finally be able to share it, because I think that the early deployments were probably the most pivotal ones and those were the most high-risk ones in my opinion. And because things were moving so fast, I think that those early missions got caught up in the wind, so to speak because it was just a never-ending situation. It's something we're still in a year later, but I'm glad that I had the opportunity to read that.

That letter is a testament to the collective service that we as PHS officers provided, during this time and that we're still providing. I was really proud that someone expressed that, and it was dedicated to everyone involved in the ICS response. It's not a letter just for the PHS officers, this letter was written to everyone who took care of these people, from beginning to end. So, I wanted to share that.

VB: I am so grateful to all of you for your service and for sharing your memories with us today. If anyone has any closing remarks, they'd like to make you're more than welcome to, no pressure though.

FV: This is Commander Verni, I wanted to thank you for this opportunity, as time goes on and memory fades, it's nice to have these anecdotes to really capture what truly happened because the last mass quarantine happened in the early 1900s. So, this really is an important part of history. So, thank you so much.

VB: It's really an honor for us to take part in documenting this history. Thank you all.

JS: I thank you as well. I also wanted to ask, whatever you might have we talked about, newsletters or things like that. Any images other things that can help document your experience on these deployments, we would love to have copies if that's at all possible, be they electronic, or physical or what have you. We can certainly give you information where to send those, but that would also help document this experience. So really appreciate your time.

MN: I can share the letter and artwork that I collected.

VB: We would really appreciate that. I'm going to close the recording now.

[END OF INTERVIEW]

**DEPARTMENT OF HEALTH & HUMAN SERVICES** Public Health Service

National Institutes of Health
National Library of Medicine
Bethesda, Maryland 20894

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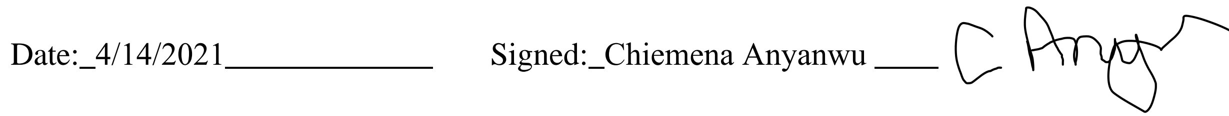

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Last position held:__Analyst____

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