DOG House News

Providing Updates from the USPHS Readiness and Deployment Operations Group (RedDOG)

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Preparedness Coordinator's Corner

Welcome to another issue of the DOG House News! As always, we hope this finds you and your families well. Some of you might have noticed that we missed the April Edition of the News… that's because I was in Liberia, working with Monrovia Medical Unit (MMU) Team 4 and the Command Staff to get the MMU closed down, decontaminated, and a decommissioning plan set. I just ran out of hours! Thanks for not being upset.

All that said, the MMU has been officially closed, and all 4 teams that staffed the MMU are home safe and Ebola free! We'll still be following up with all of the MMU and West Africa deployers, and we are so thankful for everyone who also stood up to serve and backfill those who deployed here at home; there's no way this mission could have been successful without all of you.

Again, thanks to those of you who have already responded, and for others, if you are interested in assisting with this newsletter, the Readiness and Deployment Operations Group has formed a Working Group and is seeking members as well as articles and/or any training resources you'd like to share with officers. Please send an email to RedDOG-Training@hhs.gov with the subject line reading: "DOG House Newsletter."

V/r,

LCDR (Lybarger) DeGrange

As CAPT Beck said "I want to leave you with a picture from the MMU decommissioning that for many of you I hope will be a reminder of the power of faith and hope…that such faith and hope restored can literally breathe life.."

Getting to Know (Readiness)

Readiness News and Updates

New Annual Physical Fitness Test (APFT) guidelines

As of July 1, 2015, option to participate in the President's Challenge program as an alternative to completing the Annual Physical Fitness Test (APFT) will be eliminated.

Starting July 1, 2015 all officers must complete the Annual Physical Fitness Test (APFT) every 12-months to maintain the physical fitness criteria for basic readiness.

President's Challenge Awards (PALA, Gold, Silver, Bronze, Platinum) earned prior to July 1, 2015 will be accepted towards satisfaction of the annual fitness requirement for one-year from the date of the award. For example, if an officer earns a PC award on 6/30/2015, that officer would satisfy the annual fitness requirement until 6/30/2016 and would not be required to perform APFT until June 2016.

Getting to Know Continued (Readiness)

***DOG House Motto**: It's not the size of the dog in the fight, but the size of the fight in the dog*

New APFT guidelines will be effective beginning January 1, 2016.

Current APFT guidelines (http://dcp.psc.gov/ccmis/RedDOG/Forms/CC%20Basic%20Readiness%20Standards.pdf) will remain in effect until December 31, 2015. Between July 1, 2015 and December 31, 2015, officers that need to renew their annual APFT should follow current APFT guidelines.

As before, officers who are unable to perform the APFT due to temporary medical limitation(s) should submit request for a temporary waiver to medical affairs.

Relocation of Medical Affairs, Compensation, and the Division of Systems Integration (DSI)

Effective June 1, Medical Affairs, Compensation, and the Division of Systems Integration (DSI) will move from their current location in Silver Spring, MD to Commissioned Corps Headquarters' main office in Rockville, MD.

New address for Medical Affairs, Compensation, and DSI mail and courier deliveries will be: 1101 Wootton Parkway, Rockville, MD 20852

With respect to Readiness, it is critical that officers ferret-out pertinent addresses and fax numbers for timely completion of administrative completion of Readiness requirements. Officers should regularly visit Medical Affairs, Compensation, and DSI sections of the CCMIS website (http://dcp.psc.gov/ccmis) for up to date information about changes in room numbers, telephone and fax numbers, as well as other contact information.

During the transition, there may be a delay in the processing of non-critical tasks and/or the response time of CCHQ staff.

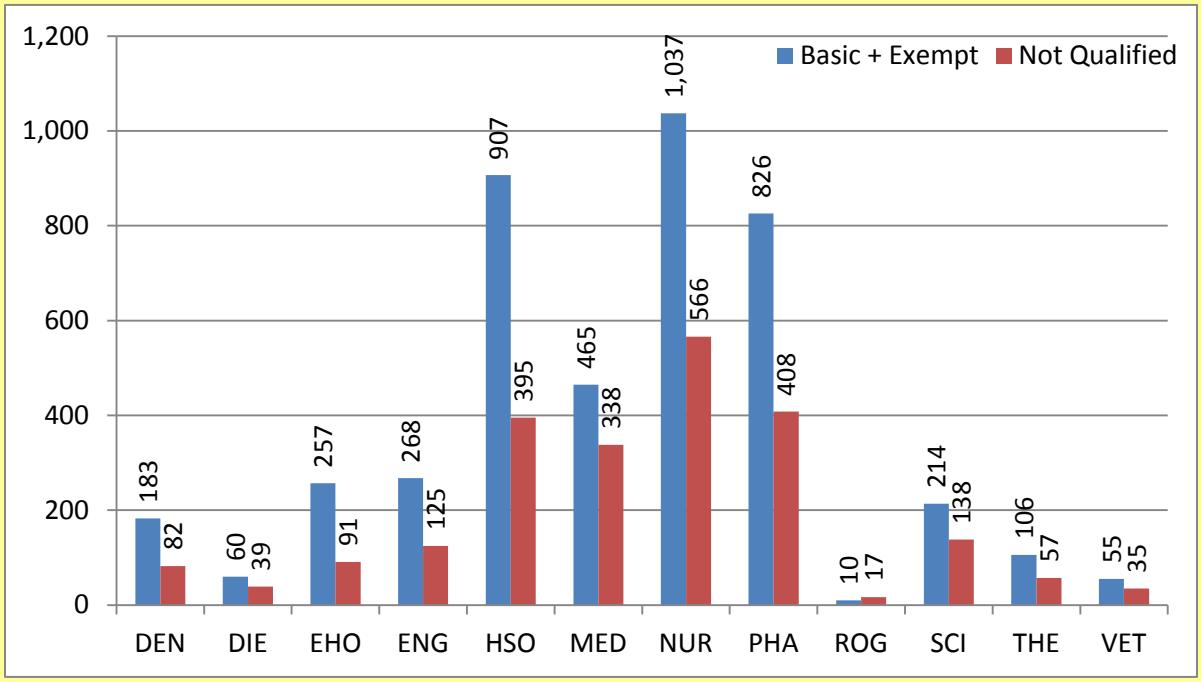
Readiness portals online

Ensuring accuracy of your official Readiness is a top priority for RedDOG. Behind every officer's Readiness status in Direct Access are regularly executed technically complex procedures by RedDOG that synchronize data from multiple data systems that have unique constraints and managing entities.

Following table is a very simplified portrayal of the current Readiness web portals and their utility for you as an officer.

	FREQUENCY	DIRECT ACCESS https://portal.direct-access.us	CCMIS http://dcp.psc.gov/ccmis	E-LEARN https://respondere-learn.hhs.gov
Airport Information	Update as needed	n/a	Self-report & view	n/a
Annual Physical Fitness Test (APFT)	Every 12-months	Self-report & view	n/a	n/a
Basic Life Support (BLS) Certification	Every 24-months	Self-report & view	view only	n/a
Deployment Role	Update as needed	Self-report & view	n/a	n/a
FMRB Status	n/a	n/a	view only	n/a
Height and Weight	Update as needed	n/a	Coming soon	n/a
Immunizations	Update as required	view only	view only	n/a
Language Skills	Update as needed	n/a	Self-report & view	n/a
Licensure	Update as required	View only	View only	n/a
Medical Exam	Every 5-years	View only	View only	n/a
Passport Expiration Date	Update as needed	n/a	Self-report & view	n/a
Personal/Work Information	Update as needed	Self-report & view	Self-report & view	n/a
Readiness Course Completion	Once, 12-modules	n/a	n/a	Yes
Readiness Course Status	Anytime	View only	n/a	View

Readiness statistics - Projected for 7/1/2015 as of 5/6/2015



Category	Basic	Exempt	NQ	Total	B+E	Proj 5/6	Proj 5/6	Proj 4/16	Proj 4/16	Ready 4/1	Rank 4/1
EHO	254	3	91	348	257	73.85%	1	71.39%	1	93.64%	5
HSO	866	41	395	1,302	907	69.66%	2	66.18%	3	94.52%	2
DEN	181	2	82	265	183	69.06%	3	61.98%	4	93.92%	4
ENG	264	4	125	393	268	68.19%	4	66.58%	2	91.26%	8
PHA	815	11	408	1,234	826	66.94%	5	61.86%	5	93.07%	6
THE	102	4	57	163	106	65.03%	6	61.25%	6	97.50%	1
NUR	1,026	11	566	1,603	1,037	64.69%	7	59.50%	7	91.22%	9
VET	55	0	35	90	55	61.11%	8	55.56%	10	91.11%	10
SCI	211	3	138	352	214	60.80%	9	57.71%	8	91.35%	7
DIE	60	0	39	99	60	60.61%	10	56.57%	9	93.94%	3
MED	460	5	338	803	465	57.91%	11	53.45%	11	87.45%	11
ROG	10	0	17	27	10	37.04%	12	37.04%	12	62.96%	12
Total	4,304	84	2,291	6,679	4,388	65.70%		61.41%		92.07%	

Deployment News

Reflections of An Officer: Thoughts on the Liberia Deployment

By CDR Andrew Chen, Deputy OIC MMU-4

I've been home now for about a week, and am finally pulling my thoughts together on my recent deployment to Liberia. This is quite long, so please bear with me…

I had the most humbling, once-in-a-career opportunity to serve as Deputy Officer-in-Charge of U.S. Public Health Service Commissioned Corps Team #4, which was deployed to Harbel, Liberia. We were gone from our homes, families, and friends from March 6, 2015, until about May 4, 2015 (some of us got home a little bit after that). Our fellow servicemembers in DoD will laugh at this (and rightly so), but the 60-day deployment for each of the four teams were the longest PHS deployments in recent memory.

Background: in the early fall of 2014, the President announced that the military would deploy and set up a military field hospital in Liberia, and we (officers of the USPHS Commissioned Corps) would configure it as an Ebola treatment unit (or ETU) specifically and solely for healthcare workers, and staff it for patient care. Known as the Monrovia Medical Unit (or MMU), it was the only U.S. Government-run ETU and the most advanced ETU in Liberia, if not in all of West Africa, bringing 1st world medical care into a 2nd or 3rd world environment.

We would be the force multipliers: saving the lives of those healthcare workers who contracted Ebola in order to get them back out in the community to treat others, as well as inspire confidence in the international community to deploy their healthcare workers to West Africa to serve their fellow human beings. Best as we can tell, the strategy worked: Liberia was able to drastically reduce the number of new cases of Ebola, and Sierra Leone and Guinea have also started to reduce their number of new cases as the British and the French instituted similar strategies in those respective countries. (There is a NY Times article out there questioning the effectiveness of the overall U.S. Ebola strategy and the speed in which the U.S. Government responded; I'll simply say that our ETU was the first American ETU to open for patient care…we were available to accept patients on November 7th, not November 18th as reported in the article, and well earlier than the December 22nd date mentioned in the article.) By doing so (and by extension), we were protecting the United States, preventing cases from entering our borders by helping to quash Ebola in West Africa. (The U.S. Surgeon General recently posted a blog about our deployment, and why it's important for the PHS Commissioned Corps to be on the forefront of international responses: http://www.hhs.gov/blog/2015/05/06/today-i-am-healed-tomorrow-i-return-health-another.html.)

We were also all volunteers. To a person, no one was involuntarily ordered to deploy. We all wanted to go and be there. (Why would I want to volunteer? I'll answer that question last.)

Team #1 was "First In". Led by CAPT Calvin Edwards, they deployed in October 2014 with very little knowledge of the environment into which they were going. All they knew was that it was going to be novel, difficult, and dangerous…and it was. They set up the configuration, developed the policies and procedures, and took care of the first patients. They ate MREs pretty much the entire time they were in-country. They were the Rangers, the scouts, the tip of the spear – you name the metaphor. They laid the groundwork for the overall success of our mission. (CAPT Edwards wrote a great blog post here: http://blogs.fda.gov/fdavoice/index.php/2015/03/turning-the-tide-on-ebola/ – and the University of Pennsylvania did a great piece on several of their alumni who are USPHS officers, including CAPT Edwards, and who deployed as part of Team #1 here: http://thepenngazette.com/penns-ebola-fighters/.)

Team #2 deployed in November 2014, "Building on Excellence". They were led by CAPT James Dickens, and they continued the outstanding patient care that was expected of the MMU. They solidified the protocols, they continued treating infected healthcare workers – and that was their full-time mission. At that time, there were enough healthcare workers contracting Ebola that treating them was all for which Team #2 had the bandwidth.

Team #3 deployed in January 2015 in order to provide "Steadfast Treatment, Enduring Hope". Led by CAPT Dean Coppola, they had the privilege of seeing the first signs of success: overall patient volume began to drop in the country, and there was serious talk of Liberia becoming declared officially Ebola-free. Team #3 began the process of planning our transition out of Liberia, and what we would need to do to see a successful conclusion to this historic mission.

And then there was us, Team #4; led by our "Bossman", CAPT Jose Belardo, our goal was to leave behind "A Legacy of Hope" by ensuring that local healthcare workers had the training they needed to sustain this fight against Ebola, as well as transitioning the patient care mission of the MMU to the Liberian Ministry of Health. We were also charged with "casing the colors" and bringing everyone home safely…all in addition to being ready to provide patient care to a healthcare worker who had (or was suspected of having) Ebola.

I wound up as the Deputy Officer-in-Charge (DOIC) purely by circumstance. I was originally supposed to be the Logistics Chief (and then the Operations Chief), but a last-minute scrub by the officer who was originally rostered as the DOIC left a void, and the decision-makers decided that I would make a good DOIC. Whether or not I was a good DOIC – you'll have to ask CAPT Belardo and the members of Team #4. *grin* However, I will say that it was a bit surreal to essentially be running a hospital again…and in an Air Force field hospital, no less (in which I had trained back in June 2004 at Fort Drum, NY…but that's a different story for a different day).

Prior to arriving in-country, we spent a week training on how to wear protective gear (called PPE – personal protective equipment), including two sets of gloves, two face masks, goggles, a Tyvek suit, a plastic apron, a Tyvek hood, and big, heavy, rubber boots; how to run an ETU, including protocols and procedures, and talking with other people that had served in ETUs all over West Africa; and learning how to clinically treat critically ill patients in austere settings. As an example, kidney failure is common amongst Ebola patients – but guess what? We can't do kidney transplants or have the patients undergo dialysis in West Africa, courses of treatment we basically take for granted in the U.S.

And we started off with a bang: we arrived in Liberia to a patient census of zero at the MMU, but 4 days after arriving in-country (the evening before Team #3 redeployed back to the U.S.) we were notified that we would be receiving a confirmed Ebola-positive patient the next day. (*sigh* So much for Liberia being officially declared Ebola-free; it eventually was by the WHO on May 9, 2015, over a week after we left.) Team #3 left in the wee hours of the night, and our patient arrived that morning – no practice, no warmup, no help; we were on our own, and this was not a drill. Our clinical and safety teams were absolutely brilliant – they took dive after dive (the term "diving" was coined for donning PPE and going into the hot zone), doing their best to save the life of our patient while also protecting themselves and each other. I also got in on the action: I was cross-trained as a doffer (the person who coaches the "diver" on how to remove their PPE, as well as spray them down with a chlorine solution to break down and kill the Ebola virus), and spent as much as a full half-hour helping each diver get out of his/her protective gear.

Sadly, our best efforts were all for naught: our patient passed away on the 6th day she was with us. For those of you who may remember my cryptic "star and halo" message on Facebook in late March, the explanation behind that message is this: two officers from Team #1 had drawn a mural of the MMU and began placing stars in the sky for each patient that was treated there. If the patient survived, the halo around the star was left uncolored; if the patient died, then the halo was colored in with a yellow marker. The subsequent teams carried on with this practice, and so we drew in a star with a colored-in halo for our first patient. By the time the mission ended, the mural was filled with stars – about 1/5th of them had colored-in halos. (Not all of our patients were Ebola patients; we had our fair share of malaria patients as well.)

Our "primary" primary mission was to ensure we all returned home healthy and safely, which I'm proud (and relieved!) to say that we did; our "secondary" primary mission was to take care of patients. Our secondary missions, however, proved to be more challenging in some ways than our primary mission: (1) train local Liberian healthcare workers on whatever topic that was needed, and (2) decontaminate our facility, and figure out what we were leaving behind and what we were bringing back home. Our Liberian partners, through no fault of their own, were simply overwhelmed and had precious little extra bandwidth to be able to consider the training component, but at the last minute, they sent about a dozen healthcare workers from one of their ETUs and we were able to provide some well-received training on the various pieces of equipment that we had and were going to leave behind. However, while leaving behind equipment for them to use is a great idea in theory, the challenge is the ongoing preventative maintenance and cost of repairs: if the Liberians were not able to maintain/repair the equipment, was it really fair to leave it behind for them? Our secondary missions became all about managing expectations and anticipating unintended consequences.

One of the neater things we were able to do was conduct exchange visits with other ETUs in the greater Monrovia area. The first one was with the ETU that was jointly run by the Liberian Ministry of Health and Medecins Sans Frontiere (better known in English-speaking countries as Doctors Without Borders). We discussed differences in our approaches to patient care protocols, procedures for donning and doffing PPE, and other topics, but the best part was that Dr. Jerry Brown, of Time magazine fame, was part of the group that visited us and we were able to have him sign our copy of that special issue of Time magazine.

We also did exchange visits with the Chinese ETU, which is run by their military, and they got a big kick out of the fact that the #2 guy responsible for the American ETU was a Chinese-American officer. They even know the term "ABC" (American-Born Chinese), and wanted pictures with all three of us! (LCDR Mark Chen and LT Crystal McBride, née Eng, were the other two.) Of course, my Mandarin is virtually non-existent, so they all laughed when I said (in Mandarin), "I'm sorry, but I don't speak Mandarin!" A few of their folks do speak the Shanghai dialect, so I was able to converse with them. They were very interested in how and why we have behavioral health specialists on our team, so we were able to give them some information on that topic, and they were very gracious hosts in feeding us authentic Chinese snacks when we were at their ETU.

We also hosted our own run/walk event, the Camp Eason 4-Miler. (Team 4…4 miles…get it?) We had about 140 or so participants, including members of the Chinese ETU, the aforementioned Ukrainians, U.S. Army soldiers who were also deployed here, folks from CDC and NIH, and the US Embassy. Even the U.S. Ambassador to Liberia participated! Not being a runner (I don't run at home, and I didn't train for the event), I managed to do the four miles in about 48 minutes, even in the African heat. My goal was simply to cover the four miles without quitting or landing myself in our medical tent!

The weather was, predictably, "Africa hot". Actually, the temperatures weren't all that hot: consistently in the high-80's to low-90's Fahrenheit, but because we were so close to the equator (only some 300 miles away), the angle of the sun made it extremely hot during the day if there was no cloud cover; along with the high humidity, heat indexes were routinely between 105F and 110F when the temperature was only in the low-90's F (not to mention that the angle of the sun made even cloudy days very bright). The evenings were generally pretty comfortable: low- to mid-70's F, and usually with a breeze. We were also there for the start of the rainy season, and my goodness…the sustained downpours we experienced were something to behold. I've been in some torrential downpours in the U.S. where it just opens up for about 10-15 minutes, but never for the hour or two at a time that we experienced there (and we left before the true rainy season began)!

I also had a couple of chances to get out and see the countryside…and I have to admit, this is one of the poorest nations I've ever been in. The main highway that connects Monrovia (the country's capitol) with the international airport (which is near where we were located) is basically a small two-lane road. There are small shops all along the road, selling fish, cold drinks, sometimes groceries, wood carvings, and other sort of knick-knacky things. I've read that Liberia was on an economic upswing prior to the Ebola outbreak, after so many years of economic depression due to the civil wars and all, but early in the deployment most of the people I saw on the streets had a sort of resigned fatalistic air about them…as if this was their lot, and they would simply deal with it. If I take absolutely nothing else away from this deployment, the one thing I will take away is how good we have it in the United States, and how grateful I am for all the opportunities that we have. The term "first world problem(s)" has taken on a completely new meaning for me.

By the time we left, though, I noticed a change in attitude had started. More people were starting to smile, schools were open again, and I even saw kids playing soccer with glee on their faces. We also had the opportunity to invite a Liberian cultural troupe to come and perform for us, and it was a great experience to see how they sing and dance. As opposed to the sense of resignation I saw in the countryside, the dancers were all smiles and energetic…it was good to see some sense of happiness returning to the people.

They also have many of the same societal issues we have here in the U.S.: as an example, about two weeks before we left Liberia, there was a riot in the town of Paynesville. The cause of the riot? A motorcyclist had been killed by a police officer for allegedly running a barricade. This occurred just as we were leaving the Chinese ETU from our visit there and not that far away from us, but fortunately we were headed in the opposite direction to return to our compound.

So in closing, a few things:

First and foremost is that I'm incredibly grateful to my wife, Jessica, for being so supportive of my deployment, and for picking up the slack at home while I was gone. She knew how important it was for me to be a part of this historic mission, and despite some initial misgivings for my safety, etc., she encouraged me to volunteer and be part of Team #4. (I'm hopeful that my fellow teammates feel the same way about their families.)

This was the longest I've ever been away from home…again, those of you who are/were DoD servicemembers, my hat's off to you. I have no idea how any of you could this for 12-15 months at a time. This was honestly the first time in my life that I became homesick (including many summers of camp, three years of boarding school, and four years of college)…I missed my wife, I missed Claude, our cat (though Jessica was great in constantly sending cute pictures, which I promptly posted on Facebook, as you all saw!), and I missed the comfortable life that we so take for granted back in the United States. Jessica was left to do the chores that I normally do, as well as eat her meals alone pretty much every night. That said, I'm still really glad that I deployed and am incredibly proud of what we (Teams #1 through #4) all were able to accomplish over there.

Team #4 was, in two words, simply awesome. Very few of us knew each other prior to deploying, and we came together not just as a team, but as a family. (I'm sure Teams #1, #2, and #3 had similar experiences.) The skillsets that were brought together meshed beautifully, and many of us eagerly sought out unfamiliar roles and learned new skills in order to accomplish our mission. The junior officers in particular were outstanding, both in the knowledge/expertise they brought as well as their overall "can do" attitude, and if any of the JO's on the other teams were of the same caliber as those on Team #4, the future for the entire USPHS Commissioned Corps is bright indeed. We truly lived up to the three rules that I had laid out at the onset of the deployment: (1) Take care of each other; (2) Meet the mission; and (3) No whining. A tip of the hat goes to LCDR Elizabeth DeGrange for selecting the members of Team #4 and making us a team, and also to her staff (LCDR Jessica Fox, LCDR Tina Smith, and LT Yvonne Santiago) for corralling us during our week of training prior to deploying to Liberia.

Last, but not least: why did I volunteer? That's kind of a hard question to answer…because the truth is that I didn't really want to go as part of an MMU team. That's a strange admission given that I wanted to be part of the mission, but I was actually hoping to deploy as an in-country liaison officer to DoD instead. That opportunity didn't materialize, so I opted to deploy as part of Team #4.

So as soon as the mission was announced in the Fall of 2014, I knew I had to participate…I felt called to deploy on this mission. After all, to quote CAPT Edwards (the Team #1 Officer-in-Charge) from his FDA blog post that I linked earlier, "How often in our lives do we get a chance to do something so big?" One never quite knows how we will live out God's plans, but in this case, it really became evident to me that I was living out His plan: deploying not in the role that *I* wanted to deploy in, but in a role in which *He* wanted me to deploy, utilizing the unique skillset that He had developed in me over the years – that of working with external partners: managing expectations and avoiding unintended consequences; while at the same time leading and managing the day-to-day operations of a talented, yet very diverse, healthcare team; all wrapped up in a challenging/austere environment that I happened to have trained in some 11 years ago. How else can I explain winding up as the DOIC over more senior-ranking officers (we had several other Captains on our team in addition to our OIC, CAPT Belardo)?

If you're still reading this, thanks for making it this far. I hope you were able to get a good idea of what all of us experienced while we were "downrange", and gain a small insight as to why we all volunteered to be a part of this mission (my reasons are but one of many for volunteering). Please do keep the country of Liberia and all of West Africa in your thoughts and prayers as they continue to recover from this devastating outbreak. When I first arrived in Liberia (and was still standing on the tarmac at the airport, having just gotten off our charter flight), I asked CAPT John Smart, a friend and colleague from our regional office in Seattle (and the final in-country liaison to DoD), how it was going: he simply stated to me, "This is the mission of a lifetime." I couldn't agree more, and am sincerely grateful for the opportunity.

Deployment News Continued

Peace Officers Memorial Day

By LCDR Matthew Brancazio

Peace Officers Memorial (POM) Day is observed annually on May 15th. On this day, America pays tribute to the local, state, and federal peace officers who have died in the line of duty. My deployment during POM Day can be exemplified by one word: Dedication. As the day progressed, I stood humbled as we remembered and celebrated the sacrifice of thousands of peace officers and their families. Their dedication will be remembered for many years to come. Additionally, I saw a similar mindset of dedication and observance from the DHHS support teams called in from all over the country to support this event. The members of these Disaster Medical Assistance Teams (DMATs) and Logistics Response Assistance Teams (LRATs) operate under ASPR and the Office of Emergency Management and come from a variety of backgrounds including firefighters, professors, physicians, and pharmacists. These DMAT and LRAT teams were instrumental at the Frederick warehouse and "on-the-ground" during the event. They served tirelessly to ensure that all personnel were available, trained, and supplied with the necessary equipment to make the observance of POM Day as safe and secure as possible. Lastly, the cadre of PHS Commissioned Corps officers that I had the privilege of working with embraced the unofficial motto of "semper gumby" as the roles, dates, and times of our deployment were often modified to meet needs of the mission. For example, I was initially deployed as a logistics officer, transitioned to my clinical role as pharmacist, and then finally combined both roles (along with whatever else was asked of me by the Deputy Incident Commander)! Overall, the experience was humbling and gratifying: we paid tribute to our fallen heroes, our DMAT and LRAT colleagues excelled in the execution of their duties, and officers fulfilled a variety of roles necessary to accomplish our mission. Oh, and "bumping" into the Surgeon General inside the Humphrey building was a nice touch!

The Importance of being more than just a Native Speaker

By LT Jay Wong, PharmD, MPH – Clinical Pharmacist

¡Hola! ¿Cómo estás? Mi nombre es Teniente Wong, farmacéutico…

Without understanding what you just read, you could probably guess that it was the Spanish language. In America today, there is a good probability that you will be providing care to one out of six Americans who are of Latino or Hispanic origin. Across our nation, there is a lack of health care staff who are proficient in medical Spanish and culturally adept. This situation also exists within the Commissioned Corps. As such, this is an important issue that warrants further discussion.

In deployments that involve care to Latino/Hispanic communities, conversational Spanish is simply not adequate in the context of administering health care. Medical terminology in a language that the patient can understand allows both patient and provider to interact with regards to important health-related questions. In the 2014 Unaccompanied Children (UC) deployments, the Hispanic Officers Advisory Committee (HOAC) highlighted the need for intra-agency partnerships to obtain the necessary resources for assessing and improving the cultural awareness and language proficiencies among our Corps officers. Based on this gap, HOAC is working with RedDOG and the Office of Minority Health to finalize an MOU where all Corps officers would be receiving the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care training.

What language resources can assist with learning Spanish that includes proficiency with medical terminology? In the past, some officers were able to take advantage of Rosetta Stone Spanish through RedDOG laptops. RedDOG is looking at the possibility of bringing back this resource and expanding its access. Another learning avenue is a free language-learning and crowdsourced text translation platform called Duolingo. Duolingo learning allows the user to progress through practice lessons and tests at his/her own pace. In 2013, Apple chose Duolingo as the iPhone app of the year, and this was the first time that this award was bestowed on an educational program.

There are a couple of other notable organizations that have tried to fill the medical Spanish learning gap. Domestically, there is Canopy, which is sponsored through an award from the National Institutes of Health. Canopy provides a three pronged approach via mobile phone applications or personal computer: 1) medical translator in 15 languages, 2) medical language training which provides a self-paced learning of medical Spanish for individuals and institutions, and 3) national certification for bilingual healthcare providers. Internationally, there is the Global Medical Brigades, which provides Central American and West African communities with health and economic assistance from volunteers. There are educational tools available on their website, which covers general conversational Spanish and medical Spanish terminology in areas such as medical triage, dentistry, and pharmacy.

Although the aforementioned is by no means exhaustive, the hope is to provide the spark to a meaningful discussion on this important topic that affects the future of the Commissioned Corps as we seek to serve the most vulnerable and underserved. Our USPHS officers wear many hats. We are often known as public health advocates, first responders, and caregivers of life; however, our officers should also be known from a global public health standpoint for his/her linguistic proficiency and cultural sensitivity.

For more information on this topic or interest in some of the additional HOAC resources in this area, please contact the HOAC Deployment Training & Education WG Co-Lead, LT Jay Wong at jay.t.wong@ice.dhs.gov

Upcoming Events

Register Now for the 2015 AMSUS Meeting in San Antonio, TX

REMINDER UPCOMING DEPLOYMENTS

- **Deployments in Support of Missions in Guinea & Sierra Leone**
- **July 4th Celebration at our Nation's Capitol, Washington, D.C.**

Training Activities/Resources

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
https://www.thinkculturalhealth.hhs.gov/content/clas.asp

American Heart Associantion – Training for Healthcare Providers
http://www.heart.org/HEARTORG/CPRAndECC/FindaCourse/Find-a-Course_UCM_303220_SubHomePage.jsp

FEMA Emergency Management Institute:

Training Opportunity Pandemic Influenza June 15
https://training.fema.gov/emigrams/2015/1159%20-%20training%20opportunity%20-%20vttx%200023%20%20-%20pandemic%20influenza%20june%2015.pdf?d=5/13/2015

RedDOG Newsletter Team

LCDR Elizabeth DeGrange
LT Yvonne M. Santiago

Interested in submitting an article to feature in any of the sections?
* Articles are due by the 15th of each month
* Please include a title and state your name in the "by" line.
* Pictures are welcome!

To join the Deployment Working Group send an email to RedDOG-Training@hhs.gov

VADM Vivek Murthy at the Memorial Day Observance in the Nations's Capitol Region