

CDC Ebola Response Oral History Project

The Reminiscences of

Patricia M. Simone

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Patricia M. Simone

Interviewed by Samuel Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson here today with Dr. Pattie Simone. Today's date is July 14th, 2017, and we're in the audio recording studio at CDC's [Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. I'm interviewing Dr. Simone today as part of our CDC Ebola Response Oral History Project, which we're doing for the David J. Sencer CDC Museum. Dr. Simone, thank you so much for being here. I'm wondering if you could start by saying "My name is" and then pronouncing your full name.

Simone: My name is Patricia Marie Simone. I'm called Pattie.

Q: Thank you so much. Could you give me your current position at CDC?

Simone: At the moment I'm acting chief of staff for the CDC director. My permanent position is the director of the Division of Scientific Education and Professional Development in CSELS [Center for Surveillance, Epidemiology and Laboratory Services].

Q: If you were to give somebody just a short description of your role in CDC's Ebola response, what would you say?

Simone: My role was mainly deploying EIS [Epidemic Intelligence Service] officers and some other fellows and managing the deployment activities for them during the Ebola response.

Q: Can you tell me when and where you were born?

Simone: I was born in Chicago in 1961.

Q: Did you grow up in Chicago?

Simone: For a few years. I moved when I was six years old to Memphis, Tennessee—an interesting time, 1967, 1968, in Memphis. I lived there for most of my growing up. My father worked at St. Jude Hospital there.

Q: When you say an interesting time, you're referring to the Civil Rights Movement?

Simone: Yeah. That's when Martin Luther King [Jr.] was killed and the garbage strikes and I distinctly remember the curfew. One of my neighbors was very scared about the garbage strike and nervous. For some reason—my father was a physician—it was decided that we should go over there to talk to our neighbor across the street. I was six years old and I remember thinking there's a curfew, we're not supposed to be out. I was a little rule follower. And my mom saying to me, "It's okay, your father has special

dispensation because he's a physician," which I think was a complete lie, but I was thinking, okay, that's good for him but what about the rest of us? Like somehow the police were going to come down our street in suburban Memphis and say something to us about being outside at curfew.

Q: That's adorable and such a kid thought. Did you live in Memphis through high school?

Simone: Through high school until my senior year. My father worked at Stanford [University] for a year and we moved out to California. Quite a difference. Then I applied to Stanford and went there, and he moved back to Memphis and the family moved back but I got to stay. So I went to college at Stanford. I went to medical school back in Memphis, so I lived back there then, and then residency at Vanderbilt [University] in Nashville and fellowship in Denver. I was there for one year after fellowship, and then my husband and I moved to Atlanta, where I started working at CDC and he joined a private practice.

Q: Why did you decide to go into medicine?

Simone: Probably because of my father's influence, although he never really pushed it at all. I hadn't really made up my mind when I went to college that that's what I wanted to do, but I thought, I'll just be a pre-med [pre-medical student] and see how I like it. And I just did it.

Q: When you say there's a fellowship in Denver, what kind of fellowship?

Simone: Infectious disease. Mostly in tuberculosis. That was how I got started here at CDC is working in the TB [tuberculosis] division.

Q: What interested you about tuberculosis specifically?

Simone: I really wanted to do infectious disease, and it turned out that Denver was a good place for my husband and I. He was doing pulmonary. I met this man, Jim [James] Cook, who was the lead for the infectious disease section at National Jewish Hospital. He said to me, this is a great time to work in tuberculosis because the old guard is retiring and there hasn't been anybody really learning about TB since it had been low for a long time, and there's this big opportunity to make a career doing TB work because the cases were going up and the drug-resistant cases were going up at that time. I thought that sounded interesting, and so it worked out well for my husband and me, so that's what I did.

Q: How did you find Atlanta when you came down here?

Simone: We liked it. We've always have liked it. We've enjoyed living here and my husband says there's more days where you can be outside than most places that we've lived and there's plenty to do and good food. We liked our neighborhood. We lived in the

same house for twenty-five years and our kids grew up here and my son was born here, my daughter was born in Nashville. But yeah, we've enjoyed it.

Q: What year was it that you moved down here?

Simone: In '92.

Q: And you were immediately doing infectious disease work?

Simone: TB. It was at the peak of the resurgent TB epidemic, and I had been working with drug-resistant TB in Denver and nobody here had really done any drug-resistant TB because there wasn't that much in Atlanta. I was hired to be sort of the drug-resistant TB expert. I worked a lot in New York City with Dr. [Thomas R.] Frieden and others, and it was a great experience for me. I didn't really have a public health background. Coming in, I wrote a lot of guidelines, I gave a lot of talks, I wrote a lot of chapters, so I really learned the public health part of things and really enjoyed working with the state and local health departments and others trying to do TB control.

Q: How long were you doing that?

Simone: I did that about eight years, and then since then I've done a little bit of everything all over the agency. Even though I'm a physician by training, I sort of have an interest and knack for management. I became a branch chief very early in my career, and

then different leadership positions, and I feel like I'm sort of a turnaround person too, sometimes. I get asked to do different positions. I was a commissioned officer for twenty-one years, which makes it really easy to move around. People would say, Pattie, are you interested in coming and doing this job? And I'd be like, okay. Go do something else for a while. So I got a lot of great experiences.

Q: What are some of those positions?

Simone: After TB, I worked in the Office of the Director in the National Center for HIV and STD Prevention [human immunodeficiency virus, sexually transmitted disease]; now it has "Hepatitis" in there, but it didn't have it at the time. Working in the Office of the Director doing the minority health, correctional health, women's health, all those interesting crosscutting things, field services. Then I worked in the HIV program there for a bit on a detail, and then in the middle of SARS [severe acute respiratory syndrome] I took a position as the associate director for science in the Division of Quarantine, and showed up on my first day in the emergency operations room and they were like, okay, Pattie, you're the team lead for quarantine. I'm thinking, I don't know anything about quarantine or anything about SARS, but here we go, I'll just do it. It was a lot of fun. I learned a lot. That was the first time I'd worked outside of that center, so I got to meet a lot of people from NCID [National Center for Infectious Diseases] at the time and learned a lot about emergency response activities, and met a lot of people from across the agency, so that was a lot of fun.

Q: Can you tell me about something that you learned or an experience you had that resonated once you were deploying EIS officers for Ebola?

Simone: Not from SARS, but just from Ebola?

Q: Well, something that you learned from SARS that you later saw in this other epidemic, coming to the—

Simone: I don't know if I did in particular. I would say the thing I learned the most, and that is interesting to me about responses, is how we can come together and do things quickly and make decisions more quickly when we need to, because we are so slow and deliberate most of the time in this agency. We are so interested in the scientific accuracy almost to the point of paralysis at times. Yet when we're in the middle of the response, we were turning out guidelines really fast and we'd have them cleared in twenty-four hours and we'd have all these partner calls and make sure we were addressing their issues. I liked that rapid response. You don't need to get it perfect, you just need to get it pretty good and then you can fix it as you go. That was a fun experience and helped me when we were in that mode again for other things. You're trying to do what you can that's the best right now and the more important thing is to make sure that you're getting people the information they need.

Q: So, SARS, 2003, around then?

Simone: Mm-hmm.

Q: How about the next seven years?

Simone: After quarantine I worked in hospital infections for a little bit. Then in 2005, Eugene McCray, who I knew in TB, asked me to come over and work in the Center for Global Health—but it wasn't called that at the time, it was just transitioning—and to be the director of the Field Epidemiology Training Program. That is an EIS-like program where we help other countries build their own, basically, EIS program. I had never worked in global health. I did a little bit in TB, but not very much. But really, how you work with countries is very similar to how you work with states. I didn't know all the players, but I knew the—you know, you're a guest in their country and you're there to provide help and consultation. They understand the local situation better than you do, but you understand the national-international situation. This partnership that worked well for me in TB when I was doing field services work there. So I did that for about five years and I liked that a lot. That was really fun for me. It was a division that needed strong management, and it hadn't had it for a while, so it was fun for me to set up good management systems and to address some of the concerns that the staff had and learn the players internationally and really help build things and see the amazing things that building a little capacity in countries can do. Of course, there's a lot of good examples during Ebola that showed that the FETP [Field Epidemiology Training Program] worked, even though they were young programs and they hadn't been there for a long, long time. They made a huge difference in some of the countries, and the countries where there

wasn't anything, you could really see how that was problematic for initiating the response activities in those countries. We didn't really have anything in West Africa, and it showed. I did that for five years, and then in 2010 I joined the Office of the Director when Kevin [M.] De Cock became the center director for the new Center for Global Health. We stood up that center, and there were some other programs that were added to the center at that time, and we developed a CDC global health strategy which I was the lead for, and did some other work. I enjoyed it a lot. It was good work and I really enjoyed working with Kevin, as I mentioned earlier.

Q: Backing up to FETP for a second, did you work much in either the Democratic Republic of Congo or Nigeria for those programs?

Simone: We had a program in Nigeria that was getting started. The DRC program was just getting started I think when I left. There was some [Bill & Melinda] Gates [Foundation]-funded work. It was focusing on surveillance. We were just getting that going, and then I did a little bit of help with that, continuing to coordinate that work with the CDC Foundation and Gates once I went in the Office of the Director in the Center for Global Health. But I never visited either of those two places, which is interesting because I visited a lot of countries. I counted with my nephew the other day and I think I've been to thirty countries, which there's still 160 or whatever that I haven't been to, but that's pretty many. A lot of them are places that aren't particularly glamorous to visit, but I did get a chance to visit a number of our FETPs and that was good.

Q: Can you tell me a little about getting to know Kevin DeCock and developing that professional relationship with him?

Simone: Well, I started out by just doing a detail right when he was coming, and my job was to get everything set up so he could pick his new staff and get things started. I spent a lot of time getting the packages ready and identifying the panels to review the applications for the senior leadership, and setting up the management systems and basic things like that. Teeing it all up for him to make the decisions that needed to be made. Then he completely surprised me by saying that he wasn't going to pick somebody else for the principal deputy, that he wanted me to stay. I was like, I'm going to make a list of the reasons I don't want to stay and the reasons—you know, the pros and cons or whatever. I had this really long list of reasons to go back, and then I thought, either way he's going to be my boss, so I just need to do whatever he needs me to do. So I said okay. But I'd been telling all my staff that I was definitely going back, and then I didn't. But it was good. I enjoyed it a lot. We had a very good working relationship. I really liked working with Kevin.

Q: That CGH [Center for Global Health] work was for how long?

Simone: I was there for about three years. He was there for a little over two years. We overlapped by two years, and then we had an organizational improvement review. Dr. Frieden did those for a lot of the new organizations that he had developed when he came,

and that came out really well. Pretty soon after that, he [De Cock] decided to go back to Kenya.

Q: So that's early 2010 maybe?

Simone: Twenty ten is when I started, and then sometime late 2012, he left, and [Anne] Schuchat became the acting director. That's how I ended up working with her. She was there for about nine months. Recently, I was the acting principal deputy director here at CDC when Anne was acting director till like last week, because it was a similar role that we had worked in in CGH, so she asked me to come up and do that with her. So that was good.

Q: I guess 2013 maybe you make a transition, or end of 2012?

Simone: Yes. January 2014, I took a detail in the Division of Scientific Education and Professional Development. Chesley [L.] Richards asked me to go over there. Michael Iademarco, who is my supervisor, was coming there right at the same time to be the center director. Denise [M.] Cardo, who I'd worked with in hospital infections, had just done this big review of OSELS [Office for Surveillance, Epidemiology, and Laboratory Services] and they were changing to CSELS, so this was all part of that.

I didn't go through EIS. In fact, I have a funny story about that. When I was applying for a job at CDC, my husband was looking at a job in Atlanta. I had known some people

from my work at National Jewish at CDC. I wrote a letter to Dixie Snider because there was no such thing as email and said that I was interested if he had any position in the Division of TB Elimination. He said, “No, but you should apply for EIS.” So I applied for EIS not really having any idea what I was doing, and came here for an interview. At that time, I interviewed with some people in TB, and they said, oh by the way, we just got a bunch of money and a bunch of FTEs [full-time equivalent employees] for the drug-resistant TB resurgence and we have some positions. I ended up interviewing with them for a job, which turned out to be good since I got waitlisted for the EIS program. I took the job and became a staff person at CDC. It’s sort of ironic because now I’m head of the EIS program and when we have the interviews, I get my letter out that shows that I was put on the waitlist. It says, “We do not have a place for you right now in the class of EIS” or something like that. It’s really funny. [laughter]

Anyway, January 2014, I took the position. The division has the EIS program and related fellowships. We have elective programs, medical and veterinary students do electives. It’s really popular and a lot of them end up applying for EIS. We have some student programs where we sponsor the Science Olympiad for the public health part of that, disease detective part. We teach teachers how to teach science in the Science Ambassador program. We started in 2015, I think, the Laboratory Leadership Service, which is a new laboratory fellowship based sort of on the EIS program. That was a lot of fun, too, so that’s a newer fellowship in the division. I also have in that division the [Public Health] Informatics Fellowships, Preventive Medicine Residency [and Fellowships], [CDC Steven M. Teutsch] Prevention Effectiveness Fellowships, we have the ASPPH

[Association of Schools and Programs of Public Health] fellowships, those kinds of things. Then we have a training and education group that does curriculum development, continuing education credits for the agency, the online learning platform CDC TRAIN [TrainingFinder Real-time Affiliate Integrated Network] and CDC Learning Connection. We have all those things in the division. I think of it as workforce development activities, and even though we don't have all the workforce development activities in the division, we work in a cross-cutting way across the agency with other fellowships and workforce development programs.

Q: As head of the EIS program, have you gotten a chance to interact a lot with the EIS officers themselves or is there some level of separation there?

Simone: There's a chief of the EIS program that I supervise and then there are staff in that branch that have the more day-to-day interactions, and then as you may know, they're assigned to states and assigned to CIOs [centers, institutes, and offices], so they have their primary supervisors in those places. There are times where I get more engaged with them. I was very engaged early on in my tenure with Commissioned Corps issues with EIS, and there's lots of stories about that. If you were ever interested I could tell you all about them. It was quite arduous, but we had very good resolution of some of the issues they were facing. That's where I actually probably worked with them more closely. But I was without a branch chief and an EIS chief for—well, when I started there was no permanent—all of my branch chiefs were acting, and so I announced it and I made a selection in August. This is when Ebola is starting to really ramp up. I decided to

select someone who was overseas and wasn't coming back until June, so I had to cover that work with my associate director for science. We split that work up. We did those jobs during that time until he came in June. We were dealing with Ebola, short-staffed, starting this new Laboratory Leadership Service fellowship that winter, and I'm not really sure how we did all that. But anyway, it was quite a challenging little time there.

Q: At what point in the Ebola epidemic does it become clear, or did conversations start happening about involving EIS officers in the epidemic either domestically or internationally?

Simone: I don't remember exactly because we always deploy EIS officers for whatever the response is. They deploy for Epi-Aids, which are a formal mechanism of requesting and sending a team of EIS officers. We have a process for that, and that's part of their training and they do that all the time. And then whenever the EOC [Emergency Operations Center] is activated, we often deploy EIS officers. I'm certain from the very beginning we started deploying them. Some of the things that we had to do that I recall is we actually had a desk for a while where one of the staff from the EIS program, supervisors would be sitting there all the time to help facilitate the deployment. We worked closely with the Commissioned Corps desk as well because some of them are commissioned officers. Figuring out who could be available when, some were being deployed domestically, some overseas. We had to do things like who has what kind of background, who has what kind of language skills, and who's available when, like somebody is getting married so they can't be deployed then. We didn't have really good

electronic systems for that. It was mostly spreadsheets and that kind of thing, so it's something that we've been working on since then to try to make that a little easier for folks to do that.

But from the very beginning, I don't remember exactly when, but I'm sure after the EOC was activated, we got involved very quickly. It became clear that the demands were going to be high pretty soon. We had a lot of people that were eager to deploy, but also there was a lot of need. We started tracking how many people were out and then how people were going to be ready to tee them up for deployments for rotations. I do remember one thing. I'm pretty sure we sent people either right after the summer course or maybe even at the end of the summer course. Every year in July, the new class comes in, and we started sending people either directly after or even near the end of it. Very quickly, people either went to their assignments for a short time, or sometimes not even at all. It was ramping up pretty good by that time.

Q: By July.

Simone: Yeah, the end of July for sure. Yeah, probably in July, the earlier class was probably already deploying.

Q: I remember from some conversations that at some point Dr. Frieden was addressing some EIS officers and said, "Many of you might be involved in the Ebola response coming up," and then all of the incoming class got involved.

Simone: He normally addressed the summer course at some point in the first week or so, and that's probably what it was. We were realizing that we were going to have to have all of them deploy in some way or another really, so we started tracking and looking at who had been able to deploy and who hadn't. Some people were deployed to quarantine stations or places that were more local, but not doing their day job and deploying for Ebola. We got down to—I think we had almost everybody, and there were just the last few. We were determined that everybody was going to have this experience, and sure enough, every single one of them had some kind of Ebola experience. It's really unprecedented. Many of them multiple times.

Q: In one of your emails that I saw that you exchanged with Kevin De Cock recently, you had talked about needing to work together with the EOC to get a more consistent—here's something that you said at the end of July. "We're trying to work with the EOC so we can get regular updates about the officers' health and safety through regular channels." When I read that, I thought what is your typical interaction, what is your typical communication like with officers and their health and safety, or is that normally even a concern?

Simone: Normally when we send them on an Epi-Aid, there's a lead person here who is checking in with them like every day. They're guiding their response activities and helping them decide what more needs to be done or who to meet with or whatever. There's this regular engagement. It's part of their training to have them have a leadership

role in the field but to have mentored supervision. Often, there's somebody who goes with them, a more senior person, and so there's this idea of a team and everybody has their role. It's something that we're used to and it's the normal way of business. I hadn't been with the program for so long, so I guess I don't really know what would be normal in a big response. I wasn't there for SARS, but we were sending people, and there's a lead in-country and there were designated roles. I assumed that these things were happening, and then it became clear that the supervision wasn't very consistent and standard or regular. There were things like officers being sent on their own to really rural places that were dangerous, that they had to sleep in the car, and that there was no communication and things that made me very nervous for a trainee. Some of them have had a lot of experience and some of them haven't, but that wasn't part of the criteria for sending them. They just sent people where they were needed, and it was happening so quickly that I think sometimes thinking about, is this the right role for a trainee versus a more seasoned global responder, wasn't always considered.

I started asking my staff to start checking in with folks regularly. This was a little bit of a problem because in a deployment, really everything is supposed to go through the incident management structure, and I'm all for that but if it's not working, I'm not going to jeopardize the safety of my staff. I was like, when you guys have it set up, we'll be happy to defer to that, but in the meantime I need my staff to check in. So I started having where they were doing check-ins more regularly. We were learning some things. Then I asked them to summarize some of the things that we were learning—

Q: Asked who, sorry?

Simone: My staff who were talking to the folks in the field on a regular basis. Because I wanted to work with the people who were working on the safety and security of the staff to implement things that needed to be implemented. Supervision was an issue with some and many of them. Some were being deployed without appropriate communications ability. There were issues with the local drivers. This was a big issue—they were being given local drivers who were not being screened for Ebola. They were needing to work, and so they were working even if they were sick, and so this was worrying people. There was this particular incident where there was—I don't even remember what country it was—you may remember, but there was an EIS officer as part of a team with WHO [World Health Organization] people, local country people, all working in this small room together on surveillance or something and one of the WHO people was sick for several days and didn't say anything and had fever. It really worried—we actually had an EIS officer and a preventive medicine resident there at the same time, and so this is the call I get on a Saturday morning from the incident manager saying, your EIS officer may have been exposed to a case of Ebola. The WHO worker was sent to a hospital, he ended up dying of Ebola. Of course they were concerned. It was decided to bring them back quickly, and so the CDC plane was sent for them and then they came here and they were put on home quarantine.

Q: Are there typically procedures for medically evacuating EIS officers?

Simone: There's good procedures set up for medical evacuations, mainly used for internationally-assigned permanent people. The embassy gets involved and there's a regional medical person who gets involved and there's a decision made if somebody needs to be evacuated or not. That really has to do with, can you get local care or can you—you know, if you're having your appendix out, you might get sent to South Africa or something to have surgery rather than—you know, it's not safe to come all the way back to the United States. Those sorts of things are in place. This was a little bit of a work-in-progress for Ebola, and there was not confidence that there was good medical care in these countries for the deployed staff. They were setting up the MMU [Monrovia Medical Unit], but I don't remember if that had been set up yet. I think that was later. Then we had this [Serious Communicable Diseases] Unit at Emory [University Hospital] that we have a contract with that's specifically for that. The decision was made that while we were still in incubation period, to get them back and then have fever checks done on them. I'm remembering things as we're talking about this. What I remember about the EIS officer, when she got back, turns out that nobody called her for the first five days to check on her fever. I had assumed that this was set up to do. We were checking in with her, but then she told me that she hadn't heard from the clinic or anybody, and I was completely appalled. It turns out that she didn't have a work number, and she actually had never moved into her apartment because she went so soon after the summer course, and she didn't have internet, so they were emailing her but she didn't have access and she didn't have a BlackBerry or a cell phone or anything. She must have had a personal cell phone, I don't remember, but somehow the connection was never made and nobody made

the extra effort to find her. When I found that out, then I notified the clinic. She was fine, so it was okay, but that was not good.

The other thing that I learned after she got back was that nobody was checking anyone's fever or symptoms in the workspaces. MSF [Médecins Sans Frontières] had set up in the clinics—I don't know what they call it, but like a perimeter. If you were going to go in or out of the perimeter, you had to have either a fever check or a symptom check or something. But that wasn't happening in the administrative workspaces, and I'm like, why not? These are all people that are out in the community. When I brought this up, people said, we don't have enough staff. I'm like, I think this would be kind of a high priority. You just need a little thermometer, and it's not that high technology. This is something I kept pestering everybody about. There was a bit of a disconnect for a while. There were staff, Jeff [Jeffrey B.] Nemhauser and others, whose job was safety and security, and they were really trying to bring these things up, and they were working on plans and things at a much slower rate than I would think you need to in an EOC activation. Their sense they conveyed to me was they were having trouble getting leadership in the incident management structure to recognize this as important enough to dedicate resources to it. Later on, they deployed a person whose job was the safety and security or whatever to be in charge in-country in each of the countries to make sure the processes were in place, but that was quite a bit later. At least it seemed like it was a lot later. Early on, I was getting—I'd go to the briefings or call people up and have meetings with people. Why is this happening? We can't be sending people—our staff are our

number one asset. To me, that could've been taken care of much more quickly. We were lucky nobody got sick.

Q: It sounds like this one incident of this EIS officer having to come back to Atlanta—was that really what revealed some of these more systematic issues with, actually there's no system in place for everybody?

Simone: For me, that's how I found out. I think others were sort of aware of it, but I didn't get the sense that there was good awareness in the leadership in the EOC or recognition of the importance of it maybe at the same level that I thought it was important. It's my staff, so of course I'm going to think it's important. But I was frustrated for a while with that, and so I kept pushing and offering to help with protocols. I'm trying to be part of the solution, not just complain. But I don't think it quite got the attention that it should have gotten early on.

Q: I have a number of things that I'd like to talk about, and another is, how does the matter of international deployers, non-US citizens being deployed internationally, come up and be an issue regarding what happens to them if they have an exposure? I know at some point many EIS officers in the country became worried that they might end up stuck there.

Simone: It's interesting. I had no idea it was an issue. We treat our international officers, our non-US citizen officers, the same as we do our US citizen officers for the most part.

There's issues with how they're paid and taxes or whatever, but for the most part during the class, we give them the same experience as everyone else. Many of them have experiences or language skills that are very helpful in an international response.

Somewhere along the line—and I in fact distinctly remember sitting in the CSELS chair in the Emergency Operations Center for one of the updates and them saying there's an issue with the Department of Homeland Security approving repatriation or whatever of anyone who gets sick overseas if they're not a US citizen. They said that the Department of Homeland Security said they should go to their home country and that we're only bringing US citizens back. By this time, I think that there had been a number of healthcare workers who had come back, so people were very keenly aware of this.

They're all in the news, you know about all of them. So I'm sitting there thinking, you're kidding me. You knew this was an issue and you didn't tell me, and I've been sending international officers all this time? I raised my hand and I said, "If you can't figure out a solution by Friday"—this was like Wednesday—"then I'm going to bring them all home." The leadership there said, yeah, I guess that's what you have to do. I told people in the chain of command that I was going to do that because I knew that—some of them had just arrived, so it's a big expense. But I had no guarantee that if they got fever that they'd be able to come back. We notified all of them and we started their travel orders and we brought them all back. I think there were probably—seems like there were six or seven of them out, and they were so disappointed. They were not angry and they completely understood, but they were so disappointed. They were really enjoying it and looking forward to it, and some didn't get to go at all. It was hard, and it actually raised awareness. It's become an issue on an ongoing basis of being able to have assurance that

we can medically evacuate non-US citizens. Whenever they're deployed internationally now, we have to check and see what the circumstances are. But it's becoming a problem long term and we're trying to figure out how we're going to be dealing with that.

Q: Sure, so not yet solved exactly.

Simone: No. I don't know if it's going to be solved. The solution may be that we can't deploy them internationally, and a lot of people don't want to hear that, but their safety is the most important thing. There's lots of domestic deployments. We'll have to see. Anyway, we're working on that still.

Q: Thanks for talking about that. I want to make sure we get also to issues with returned EIS officers and the environment to which they returned. There was a lot of fear here, there was a lot of stigma. How did those issues present themselves to you?

Simone: My first experience with that was we had an officer who we had assigned to CMS.

Q: CMS?

Simone: Centers for Medicare and Medicaid Services in the [Washington], DC area. That was a first for us to have somebody there and we were excited to have someone there. We had an agreement with them. We had some former CDC folks who were working there

who were our counterparts and good supervisors and things, so they were good about letting her go and deploy. Then when she returned, unknown to me, they asked her to work at home during her period of monitoring or whatever.

Q: Incubation period, twenty-one days.

Simone: Yeah. She was working, but she was working at home that whole time and I hadn't realized that. But then, it was the end of her twenty-one days, and they called because they said there were a lot of staff there who didn't want her to come back at all. It wasn't her immediate supervisors, and those folks—they got it and they understood—but there was a lot of fear and stigma and lack of understanding of the epidemiology. But CMS management was asking for a statement from CDC officially that she could return to work. I looked to see if there was anything that talked about return to work in the criteria on the web pages and there wasn't anything. This is August, September or something, and there wasn't anything. I knew this was a big issues in SARS, so this is when I reached out to the head of communications and the incident manager and said, "I need to talk to you about this. CMS needs something that says it's okay for this employee to return to work. Can you write something, or is there something"—they really wanted something that was specific, but I was thinking that if we had an information sheet that was appropriate, that that would be okay, too. And they just kept telling me—first, they kept telling me just read the guidelines. They can just read the guidelines. Well, there were these dense, multi-tiered guidelines that are not appropriate for the administrative staff in the office or whatever to understand any of that. I'm like, no, no, this isn't going

to work, we need something else. Then they were like, okay, we'll get you something. Then like a week goes by and I don't have anything and I'm like, are we in emergency operations mode or can I help you draft something? I get that they were busy, but it was really frustrating.

Q: Which branch of the EOC is that?

Simone: It was the JIC [Joint Information Center] and the incident manager. It wasn't that they weren't sympathetic, but I think the level of understanding of what the situation was in the agency and other places at the time hadn't quite sunk in, in my assessment. So I actually called the Office of the Director here and I said, "I need your help engaging with CMS. I don't have what I need from the EOC and this doesn't make any sense." The chief of staff office got me in touch with Karen DeSalvo—I think she was the acting ASH [assistant secretary for health] at the time. I got on the phone with her, and she's like, "Oh my God, that doesn't make any sense at all, that's ridiculous. I'll call"—I think it was Mary [K.] Wakefield or somebody who was head of CMS at that time. She called and said, "Okay, it's taken care of," and they let her go back to work. But that shouldn't have to happen, right?

Then I'm thinking, this is not going to be the only one. In fact, I had a staff person who deployed and came back and went to a neighborhood activity where there was somebody else from CDC there who was a scientist who said, "Why are you here?" and "You shouldn't be around the children." This staff member of mine was aghast that she, who

should know better—this was a person in a position that should know—was propagating fears that weren't scientifically based. I kind of get it when the non-scientists have misunderstanding, and fear is normal and it's also completely expected. We saw this in SARS, it was during graduation and all the universities had Asian students and the parents were coming. This was all completely predictable. Yet, the recognition that stigma and fear in our staff—it took a long time for that to really sink in, in my view, in the EOC. It wasn't until much later, I think November or December, when Dr. [Ileana] Arias was going around and meeting with each of the centers to talk about this, and had people who deployed and talked about their experience and how they felt when they were coming back. Right around then was when this whole issue of embracing people when they came back and making them feel welcome and understanding what they're dealing with and understanding people's concerns who are here, too. It was probably a couple months, but it seemed like ages at the time where it really needed to be addressed.

Q: When you look back, did that issue, or the others that we've talked about, do you think that they had longer-term effects on how EIS is run?

Simone: Well, I think the international officer issue is one that we're still dealing with, and there's other—the deployment is one of several issues. We're in an age where people who aren't US citizens, they're treated in many ways very differently, and this is only getting more rather than less. It's an issue that we have to deal with, and we have some thoughts about that. I would say there are things that were needed not just for EIS officers

but for everyone: pre-deployment briefings, post-deployment briefings, thinking about what is voluntary and what is required.

Q: What do you mean by that?

Simone: Well, are you required to have a post-deployment briefing or is it allowable?

Another thing I instituted was requiring that my supervisors have a post-deployment briefing with each of the returning EIS officers and get lessons learned. We put that kind of stuff together to help inform the continuing deployments that were happening at that time. We did that for a while until we felt like we had pretty much heard it all, and then we did less rigorous gathering. But we did that for quite a bit of time. So we'll do that a little bit differently. We're tracking people being out and who's available for deployment and spacing deployments and things a little differently, but those are just continuous quality improvement kind of things that we're doing.

Q: Things like monitoring EIS officers for symptoms? When they're in—

Simone: Well, I think that sort of thing we would implement depending on what the situation is. It's so rare that we deploy people in a place where there's a high community risk, and that's why Ebola was so different. Normally, it's very clear where the transmission is taking place and it's in certain groups or in certain settings—

Q: That makes sense that it wouldn't typically be a concern.

Simone: Right. Safety might be, but in the sense of infectious disease safety, not so much, usually. I think we look at it differently. We're doing a little bit more training for international deployment and things. I think we know better how to prepare people and what to expect. So I don't know that it fundamentally changed things. I would say it had a huge impact on those two classes that deployed, and it's something that shaped their experience and their learning in a way that they'll always remember. They all talk about it that way and what a big impact that had on their learning and their career thoughts and things. It was a big event, so in that sense it had a big impact on the program.

Fundamentally, we do things the same way. We are having fewer Epi-Aids than we used to, and it's not exactly clear why, there's a lot of different reasons. There's fewer opportunities for deployments for EIS officers on a regular basis, so I think that these responses will play an important role for future classes as well. Zika, a lot of people deployed for Zika.

Q: Is there anything that I haven't asked about that you'd like to talk about? Any last reflections?

Simone: Well, there's one more thing that came up that is interesting. When you have employees that are deploying overseas and something happens, then they become a patient and an employee. This line between what's private information between them and their provider, and what is an employer who is deeply concerned about this person who sent them and who the employee often shares information with, where does that line get

drawn? We've run into little issues with that now and then. I think that we have that better laid out, but that was something that came up during Zika where if an employee is ill or needs testing or whatever, then there needs to be this firewall between—so our job is to make sure they are referred to care, and then care happens without us necessarily being involved or knowing the details. On the other hand, we have this responsibility. We're sending other people out. Are there things we need to do? It's an interesting line, and I think we can balance it appropriately, but it is another aspect that is not just for EIS officers, it's for anybody who deploys. But we have this close relationship in the sense of we feel so much responsibility for them as a group because we're training them and our job is to make sure everything is okay for them. So it presents specific challenges, but important ones to address and we can address them.

Q: Yeah. I hadn't considered that but it makes absolute sense.

Simone: Mm-hmm. It's interesting, the same thing holds for the EOC. Once an employee becomes one of the cases, then they have to separate those two things and there isn't always a clear-cut way to do that and can be a little challenging at times.

Q: Another thing to continue working on that's still in development.

Simone: Yes, that's right.

Q: Dr. Simone, I want to thank you for your time. This has been brilliant. These are really important issues. Thank you again.

Simone: You're very welcome.

[break]

Q: Do you think that some of these issues that came up with the EIS program have been addressed in lessons learned?

Simone: They're in the reports, and we talked about them. The big thing I think is that if you're not ready to institutionalize something as soon as the next response starts, then you're doomed to repeat your mistakes. We talked about things like we develop new data collection instruments every single time we start a new response, and then we're like, okay, now we have another one that's not like any of the ones we already had. Is there a way to tee up certain things? I do think that the safety and security thing is something that everybody is taking seriously, and I hope that we have things that can be ready to go and that we don't have to wait. You're not going to get it perfect at first, but if you get started and you're continuously improving, then it's okay. You just need to get started with the right ideas in mind and then adapt to the situation. They're all a little different. They're a lot different sometimes.

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