



FDA U.S. FOOD & DRUG
ADMINISTRATION

**FCON COVID-19 Deployment
Oral History Interview
CDR Maria Nguyen, RN
and
CDR Quocbao Pham, PharmD, MBA**

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

In this interview, CDR Maria Nguyen and CDR Quocbao Pham discuss their deployments as Public Health Service officers who are in the USPHS Commissioned Corps in response to the COVID-19 emergency. CDR Pham is currently a Pharmacist in the Office of Surveillance and Epidemiology in the Center for Drug Evaluation and Research at FDA. During his first deployment to Kirkland, WA, he served as the Lead Pharmacist for the Incident Management Command, then as Information Section Chief. During his second deployment, he was the Officer-in-Charge of Augmentation Team 9 in Whiteriver, AZ. CDR Pham deployed a third time to Buffalo, NY, where he worked at a mass vaccination site. CDR Nguyen works in CDER in the Office of Medical Policy Initiatives as a patient labelling reviewer. During her first deployment to Kirkland, WA, Nguyen provided direct patient care in a nursing home. For her second deployment, CDR Nguyen was deployed to a mass vaccination site in Buffalo, NY, where she worked in the observation area, helped coordinate the distribution of the vaccine to residents, and reconstituted the vaccine in preparation for administration.

Keywords

Buffalo, NY; Commissioned Corps; COVID-19; deployment; FEMA; Indian Health Service (IHS); Kirkland, WA; mass vaccination site; nursing homes; patients; Personal Protective Equipment (PPE); Public Health Service (PHS); vaccines; Whiteriver, AZ

Citation Instructions

This interview should be cited as follows:

“CDR Maria Nguyen and CDR Quocbao Pham Oral History Interview”, History Office and FCON Historical Committee, U.S. Food and Drug Administration, Department of Health and Human Services, May 20, 2021.

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	Extracorporeal Membrane Oxygenation cardiovascular life support device
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

JS: This is John Swann of the FDA History Office, and this is another in our ongoing series of oral histories with members of the PHS Commissioned Corps within FDA and their experiences deploying to respond to the COVID epidemic. This is a collaborative effort between the FDA History Office and the FDA Commissioned Officers Network and the PharmPac as well. Captain Pincock?

LP: Yes. Hi, good afternoon. This is Captain Laura Pincock. I am a Pharmacist Commissioned Corps Officer with CDER, the Office of New Drugs. My affiliation here is with the PharmPac History Workgroup.

JS: Okay. Commander Agarabi?

CA: Good afternoon. My name is Commander Cyrus Agarabi. I am a Laboratory Chief and Pharmacist in the Office of Biotechnology Products in CDER, and I am a member of the FCON Historical Committee and I'll be joining in this role.

JS: Okay. Commander Pham?

QP: Hello, I am Commander Quocbao Pham, and I am a Pharmacist in the Office of Surveillance and Epidemiology, which is in CDER, and I'm a Regulatory Scientist in the immediate office. We work with the tools and developing the tools needed for our colleagues to use to identify adverse event signals and making regulatory decisions.

JS: Thank you, Commander Nguyen?

MN: This is Commander Maria Nguyen I am in CDER in the Office of Medical Policy Initiatives. I am a Patient Labeling Reviewer, and we work with all of the different review divisions to review the patient labels.

JS: Thank you very much. I want to begin with a brief statement from you both starting with Commander Pham. If you could indicate how long you've been with FDA and with the Public Health Service, and a little bit more about your deployment, and if you have had previous deployments, could you please indicate those? And for the record I want to indicate we're having this Oral History on May 20th, 2021. Please Commander Pham if you could start.

QP: I started at the FDA in 2019 with CDER in the Office of Surveillance Epidemiology as a reviewer for the Division of Pharmacovigilance, and I transitioned over to my current position in 2013, and I've been here since. In terms of previous deployments, I've deployed quite a number of times. I was a member of the RDF1 Team, Rapid Deployment Force 1, so I've been deployed a lot. I've been deployed to Super Storm Sandy. I was deployed to Monrovia as an MMU3 pharmacist, I was deployed to Florida for the epic hurricanes a couple years back. And I've been deployed three times for the COVID responses. I'm pretty sure I'm missing a couple of deployments, but those are the major ones.

JS: It sounds like there've been a number of them. So, appreciate that. Commander Nguyen?

MN: I came to the FDA in 2018. I started off at CBER in the Office of Management and then in 2019 I transitioned to CDER and my current office. I just came back from Buffalo about a month ago for COVID deployment. And prior to that, I was in Kirkland, Washington in March of last year. Prior to these last two deployments, I had not been deployed since 2015 and that was for a hurricane and I had four others, but those were prior to 2010. I don't really remember those. There was a big stretch between deployments.

JS: Okay, thank you. That's very helpful. Before we go into the details of your deployments. Could you both begin by telling us what you were deployed for during the COVID response? Where this was and the essence of what your responsibilities were in each of these deployments. So again, Commander Pham if you could begin please.

QP: I was deployed three times for COVID response. First time was to Kirkland, Washington. The second time was to Indian Health Hospital in Whiteriver, Arizona, and the third time to Buffalo, New York for mass COVID vaccinations. The first deployment I was sent to in Kirkland, Washington, I was embedded into the logistics team primarily to handle the medications that the logistics team brought with them and they required a pharmacist to look after the controlled substances and whatnot. I also helped the Logistics Team with inventory. Count the masks and PPEs and determine burn rates and order more protective equipment. Actually the mission weighed down after two weeks, and then I was reassigned and the actual mission was expanded and FEMA took over instead of ASPR and it took on in life of its own and turned into a mission where I became the Information Section Chief and I provided sitrep

reports monitored the news for new information about COVID for the Region 10. Making sure that everyone was kept abreast of the ongoing developments concerning COVID.

I also helped out quite a bit about just in terms of information. How to present it in a meaningful way to management and higher ups so that they understood where the critical needs for hospital beds ventilators, PPE, equipment and the extent of the pandemic was in each particular region or county or zip codes of Region 10. Should I go on for the next deployment?

JS: Yeah, that would be great. Again, just a very brief overview of the others so we have it, so it's easier for folks to follow.

QP: Okay. I was the Officer in Charge of a deployment to Whiteriver Indian Health Hospital. They had an outbreak of COVID where a lot of the staff, including nurses and the Command Staff there got infected with COVID. They brought our team in to help augment and manage the situation while the resident staff was being treated for COVID and resting and getting better.

The mass vaccination in Buffalo is exactly what it sounds like. I was there to help with the coordination and reconstitution and management of the vaccines in the effort to vaccinate Buffalo residents.

JS: Okay. Terrific. Thank you. Commander Nguyen?

MN: My first COVID deployment was to Kirkland, Washington. We were in the nursing home, I'm a nurse, and I worked the night shift and did direct patient care. In Buffalo at the mass vaccination site I did a little bit of everything worked in the observation area. Helped coordinate

the distribution of the vaccine to the Buffalo residents, logistics, sometimes reconstituting the vaccine.

JS: Great. Thank you. Okay, terrific. I'd like to start this by having each of you recall that moment, right before you made your first deployments that you've described here. I think it would be helpful to understand – this was in March, so very early in this pandemic. What was your impression of what you were getting into? You were about to get very deeply involved into at this time. There must have been some concern based on what you had already heard about the epidemic. Did you have concerns about this initial deployment Commander Pham, if you want to take a stab at it first?

QP: Yeah, I'm trying to, it's been a while. First deployment since March of 2020. I remember hearing about the Coronavirus in 2019, and it almost started as a joke, something that was so far away that it wouldn't affect us. And then slowly as we started to hear more and more about it, it became apparent that it was going to spread almost throughout the world, and it would be difficult to stop. Because I was part of a Rapid Deployment Force, I was keeping one eye on the news, and I had a student at the time and repurposed my student to help me search for aspects about the Coronavirus that I would need to know should I have to deploy. And they looked it up for me and things like that.

I remember being called up to go and when that happened, it happened pretty quickly, and I guess I was just used to being deployed and I was already ready. Within 24 hours I said goodbye to my wife and kid and got on a plane to go, not knowing what my role would be and not knowing who I would be working with. And I think the only thing I knew was that they were

specifically asking for a pharmacist and a clinical pharmacist, which was something that I am. So, I was okay with that.

JS: Okay. Commander Nguyen?

MN: When I was called to deploy last year, I really didn't think coronavirus was going to affect the United States the way it did. I just thought it was going to stay over there on that side of the US. Like Commander Pham was ready to deploy everything was ready. My biggest concern was I did not want to catch something and bring it home to my family. I just figured there was going to be steps taken to make sure that we were all okay. And then when I got there two days later, and they shut down the schools in Virginia and PHS was all over the news, then I realized, this is really something big that we're going into.

That night, when we got to the hotel, there was a lot of concern during our briefing meetings, and our conversations lasted I would say well into well to three o'clock in the morning, Eastern standard time. But when we finally did go into the nursing home, it was just very sad and shocking. The people in the nursing home they're like a family and these employees – it was just sad. A lot of the residents had already passed. So here we were, they were looking to us to help them.

JS: Kirkland was in the news before you left, right?

MN: Yes, I remember that first night when we got to the nursing home, the news was outside of the nursing home. There were these big, I don't know what kind of trees we were, I'm just

going to say there were these big pine trees, but people were in the trees, snapping pictures left and right. So, before we got out of the van, we were told to put our heads down and don't talk to anybody. But they were all over the place.

JS: We've heard that in other places too where early on in the in the pandemic, particularly for where patients were being repatriated, the press was obviously very interested in what was going on. What was the trip like for both of you going out to Washington at this time, what was the airport like, what were the flights like? That must have been pretty interesting.

QP: Yeah. I think I can't remember specifically the flight, how crowded it was or anything, but I don't think it was very crowded at all. Just to give you an idea, I had an inkling that would I be working around the issue of the nursing home, but I wasn't sure, I wasn't actually told. So, I remember the thing about the flight, and looking back on it, flying there, I don't think people were taking any precautions yet. There were no guidelines, and you think about back then, right? There'd be an entire plane full of people who were nervous about this thing, but they weren't all. Nobody was necessarily putting on mask going there. That all changed four weeks later when we went home, we had the plane to ourselves and everyone was wearing N95 masks and were six feet apart. I was more shocked by coming back than going. Coming back, I'd never seen Dulles Airport so empty quite honestly.

JS: Must have been just jarring to see something like that upon your return. One month later, and it looks like some kind of dystopian setting or something.

QP: When my wife came to pick me up at the airport usually, I don't know if you know Dulles Airport, but it's usually four lanes of people trying to pick each other up, and pick up their loved ones, but it was like I was the only person there. She picked me up and then we drove home. But there was literally no one in the entire airport.

JS: We want to get to more of the post-deployment concerns, too, in a moment in the interview. It sounds like when you both arrived in Kirkland and Commander Nguyen you mentioned the nursing home was crowded with press, obviously the residents had already seen number of casualties. That must have alarming to see what was ahead of you for the next month or so.

MN: Yeah, it was really heartbreaking and the patients or residents I should say, I wouldn't say they were neglected, but there was not enough staff. So, when we came in there, they were really hungry to speak to another human being. They were scared they wanted to address their concerns. I know that each of us were spending a lot of time talking to them and comforting them. So, we really got to know them, and it was a lot of hard work, and I was really sad to go because I still wonder whatever happened to them. By the time I went home a month later I think there was only about 76 residents left, and the nursing home prior to the COVID outbreak, it was a 284-bed facility.

[00:19:53]

JS: Wow. Now had most of those in that difference, were those primarily patients that had passed away or had relocated, or do you have any idea?

MN: I know a lot of them passed away. I don't know these exact statistics, but I know the day that we all started our shift in Kirkland, six people died that morning.

QP: I think a lot of people were actually transferred out. If I had to make a guess, I would say 50% of the folks became ill enough to not be in the nursing home and were transferred to other, higher levels of care. And then then there were others who passed away. And then there were 70 something remaining.

JS: Are you, so are you saying that these people that were transferred, were they transferred just routinely or were they ill? Were they transferred because of illness that, that they were suffering?

QP: Yeah, they were transferred because of illness. Because it's a nursing home. They decompensate and they require higher levels of care which is more than the nursing home can take care of.

JS: Hopefully, most of them made it. We want to get into some details and Commander Agarabi, I'm going to turn it over to you.

CA: Sounds great. This is Commander Agarabi, I'm following along on the questions. I just want to make sure it sounded like they covered day one in Kirkland. I'm going to pick up there. Can you tell us after day one, what were your typical days like during this deployment? And what were your routine duties?

QP: I can go, I actually supported the group supervisor in a lot of the tasks that she had to do. I did whatever she asked me to do I did, and whatever others were asked to do they did, because she was the supervisor. It could be anything from carrying boxes, restocking supplies, cleaning up the conference room, and then there were periods of time where I was following instructions from the Logs Chief who needed to have an accurate count of the inventory of personal protective equipment. Not just overall masks, but very specific types of masks. This one is, made by this manufacturer. It's how many smalls, how many mediums, how many large masks, how many of this type of face shields and all of the above. We spent a lot of time in a kind of a trailer full of supplies counting supplies every day and making sure that the inventory, or the counts for the inventory stays very accurate. We did a lot of driving to and from where the supplies were, grabbing 10 boxes of masks and sending it over to the nursing home and things of that nature.

CA: Commander Nguyen do you want to add your experiences to that?

MN: My role was full direct nursing care for the residents. So, the first couple of hours we had to get oriented to the facility itself to find where supplies were held. Get oriented quickly to their computer system, and their medication cart and just direct patient care. I think we all had about 16 patients each, and there were two nursing assistants for the entire nursing facility. It wasn't

just direct patient care, it was also doing all the nursing assistants work because you don't want to disturb people multiple times.

CA: Can you tell us about your team members, who did you report to and were there any other agencies that were represented outside of the staff that were there?

MN: There were usually two nursing assistants for the entire nursing home. I remember there was one contract nurse at night, the Director of Nursing that worked for the nursing home. She just tried to pop in during the night shift, but the other team members I mentioned that those were the other PHS officers. I think there was probably seven of us on the night shift and we also had two PHS physicians.

CA: And do you have a sense from which agencies they were from?

MN: FDA, and (inaudible 00:24:33). At least from the night shift, I am not sure about other shifts.

CA: No, that is absolutely understandable. Commander Pham, you mentioned your work in supply and other restocking, but also your team members and who you reported to as well, were either PHS officers or officers from other agencies represented while you were there?

QP: I worked with a group supervisor who was an FDA PHS officer also worked with a lot of the FEMA personnel who supported the original mission of taking care of the nursing home,

which later on expanded and FEMA was supporting ASPR. ASPR was using the FEMA 10 site. My location of duties was all over the place, but generally it was at the FEMA 10 site. I was there with the SOC and all the all the Command Center that was the brains and the information surrounding that whole mission.

CA: Excellent. Thank you. I will turn it back over to Mr. Swann.

JS: Thank you. You mentioned a number of federal entities that were there working with both of you. What about state and local officials, were they involved the state of Washington the county officials. Did you see much in the way of collaboration support from those entities in what you were doing?

QP: I was able to observe, I didn't interact with state officials directly in terms of the nursing home. I know that our Chief Medical Officer and our physicians interacted with the Medical Officer from the State Department of Health. And there were a lot of different discussions, because no one had experience with this new virus. So, there were a lot of discussions on, who to test, how often, what should be done for the residents at the nursing home. And what other things that can be done in terms of gaining experience and knowledge about the situation. I think there was a little bit of discussion surrounding whether we can capitalize on a bad situation and learn from it and then document what we can learn and disseminate it to other sites in nursing homes. So, that discussion was held, but I wasn't directly involved because it was a position-to-position conversation, but I was in the room.

JS: You bring up a good point though, because we've heard in other interviews, it sounds like there's some variance from situation to situation. But I know it's those who are arriving on a new deployment sometimes have the opportunity to pick up so they can hit the ground running when it's time to but can get some insights and briefings from those who've been there for a month. So, I guess having that experience and being able to share it is very helpful thing for the next group that's filling in behind you when you leave a deployment.

QP: It wasn't just transferring of duties and experience from one group to other, but more of what do we learn from this situation that can be applied across all nursing homes. Can we publish something? Can we or should we? So those questions arose. A lot of our PHS officers, their day jobs are, at least the medical officers, are doing research. So, a lot of times they were thinking, this is a really good opportunity to gain some knowledge early on. And it's an opportunity to disseminate, what we learned for others to follow.

JS: A longer term benefit if possible then.

QP: There was a lot of discussion surrounding testing, because at that time there weren't a lot of tests available, period. And I believe if I'm not mistaken, the State of Washington or University of Washington Hospital had to used their own machinery to develop their own test and they didn't have too many of them. So, there was a discussion of how do we test our residents, our colleagues and our deployed colleagues so that we get home safely and not expose our families to COVID.

JS: Were there State or County Health Officials closely involved in what was going on in the nursing home in Kirkland that you came into contact with or has some observations of?

MN: No, I didn't come into any contact with any other officials. I remember twice the owners of the nursing corporation did show up. But they mainly spoke to the two PHS physicians that were with us. I do remember there was a PHS Officer one morning – usually we had to go to a post briefing meeting right after in a conference room. And I remember all of a sudden there was a psychologist from Health Service deployed to speak to all of us. A lot of officers were having a hard time emotionally with the COVID situation. But I didn't come in direct contact with any other state officials.

JS: Okay. Thank you. We want to pursue that last point that you mentioned a little bit more. Commander Pham, you mention that logistics was what much of what you were doing there. I'm curious if the supply of PPE, the supply of ventilators and other medical equipment and so on, did that seem to be adequate for the needs there on this deployment?

QP: I think you can break my deployment into two pieces. One was specifically the nursing home aspect. When a contract was put in place and they took over the duties of a lot of our members. And then that's when I transitioned over to the Information Section Chief. In terms of immediate supplies to the nursing home, I think it was apparent we had enough. But it was also apparent if this outbreak was extensive as we were observing that it would be, we wouldn't have enough. And there were discussions along the way of should the nursing home personnel be

using our PPEs versus their own, so that kind of discussion was happening also. For us, we have enough in that trailer, but you can imagine there's hundreds if not thousands of nursing homes.

JS: That that's a good point. Did you see a microcosm there in Kirkland? What could have been truly a catastrophe if this had progressed. Was that communicated then back to whoever needed to know back in headquarters?

QP: Yes, it was clear from the amount of PPEs that our team was burning through. If this were to occur, in multiple locations we wouldn't have enough PPEs at least not within the FEMA warehouses and ASPR warehouses and state warehouses. After the nursing home was taken over by the contractor, part of my job was to try to track where the supplies are coming from and how many, and where are they going? Asking at the State level how many they have in their own State warehouse and tallying all of those up and making sure that those are in good supply. But it was clearly evident that we would be running short of PPEs. Some of the recommendations were coming out that everyone should be masked and should wear a mask if they go outside. I don't think people were prepared. I don't think the national supply was prepared for this kind of pandemic and obviously, the news caught onto that.

JS: You alluded to the nursing home being taken over by contractor, right?

QP: Correct.

JS: When did that happen, and can you just briefly narrate the circumstances there?

QP: I think commander Nguyen would be better in terms of narrating what happened during the exchange. But I know that at around two weeks in, our team had stabilized the situation. We got things in a routine. And then the question became what is the end point of our mission, and when do we know that we're successful and we can return home. That was where the idea of getting a nursing contract to come in with their own supplies to start taking over the duties that our PHS officers were doing.

JS: Commander Nguyen could you follow up on that please?

MN: I think it was when we were nearing the 17th day because we were working every day. I remember being told during one of our post briefings that the owners of this nursing home corporation had put together some contracts to bring in some contract nurses. And on our last night shift, we did see a lot of those contract nurses come in and they were going to get oriented on the shift. So, after our shift ended that morning, it was the [inaudible 00:34:55] that was my only interaction.

But as Commander Pham was talking about the PPE, I do remember that I was not worried about not having enough because we had a Safety Officer for each shift, and they basically were there to police our PPE cart. Every hallway had four PPE carts and this particular safety officer for the night shift would go around telling the one nurse that was part of the nursing home staff that was there at night and the two nursing home assistants that were there, that they could not touch our carts, that the PPE is for us.

Every time we went into a resident's room, and sometimes there were two residents in one room we had to change our PPE each time. So, we were going through a good amount of PPE every shift.

JS: Thanks for sharing that, you anticipated my question there. We want to learn through these interviews about the experience of patients in this situation. I think that's really one of the best ways to understand what's happening. I know some of you have seen more of this or have a closer experience with patients than others, while we're not looking to ask for any revelation of privacy information, it would be really helpful to understand more about the patients and the kind of patient experiences that you observed. You must have some stories that have stuck with you from this deployment, could you share some of those?

QP: I didn't have much experience directly with residents at the nursing home because I was at the SOC and doing inventory and things like that. I do feel like I have some connection with seeing the family members outside the facility and observing from afar and feeling like that's a serious situation because I have parents who are also in their nineties and trying to empathize with them and what they may be feeling, from within. One of the funny things is after the nursing home mission weighed down and I was doing the Information Section Lead Chief's duties, and I was monitoring the news almost 24 hours a day to keep abreast of the most important news to put into the, IEP and sit reps.

One of the stories that stuck out was the state had bought an Econo hotel that was defunct, and they wanted to put homeless folks in there free of charge. And there was one guy who broke out and it was a manhunt for this person who was seen on camera crossing a highway.

And I remember it was out of this world because it gives the illusion that this thing can still be contained. If we find this individual, then perhaps you cannot spread it to other people, hindsight is 20/20, this is going to spread all over.

JS: Sorry to interrupt. I wanted to mention to you that you'll be hearing an announcement that the interview -- that the meeting's being recorded. "This meeting is being recorded." There you go, that's what I was going to warn you about. Vanessa was able to trigger the recording. Fortunately, we do have a backup that's covering what all the wonderful things you've shared with us so far.

That's really helpful to have those observations. Commander Nguyen, you came into very close contact with so many patients are there experiences from that you can share? This must have been difficult on all involved, certainly it was but for the patients, for the family and for the caregivers like yourself.

[00:90:00]

MN: They missed their families and they wanted to talk, and they wanted to hug and, we could talk to them, but we couldn't hug them. We were all gowned up in our PPE and I could get as close as possible, but I couldn't hug them. I probably only had one, one resident that couldn't speak, everybody else could speak. And they were very lonely and there were times where they wanted to call their families in the middle of the night, but they didn't know how to use their cell phones. They wanted a lot of human interaction. The way the facility was set up was if you had a

window in your room and your bed was by the window, then your family members could go to your window to see you.

So they could have some type of interaction with that, so towards the end of the night shift a lot of the nurses we were going around to the patients that had their beds by the windows because they wanted us to help them get dressed because they were going to see their families. Their families were coming every day to the window to spend an hour or two to speak to them and see them. I remember there's this one resident and she was really funny, and she was probably about 86 and you can tell she was probably really spunky in her youth. She had a lot of energy, and her granddaughter was coming to see her, she had flown in from New York or something. And she was the only one that she had not seen. So, her granddaughter is coming, and so she says to me, "help me put some makeup on and fix my hair, and somebody brought me a tiara from a dollar store, help me put that on." So, I was helping her do that, then I was moving her bed and rearranging the room so that it would look presentable because every time you opened the blinds for these windows, the press was right out there taking pictures.

And this one particular morning she saw the sunlight coming in through the blinds, and she asked me to pull on the rope to open those blinds. She wanted to see the sunlight but didn't want anybody taking any pictures of her. I don't know if I was just too tired or too strong, but when I pulled on that string, the blind fell off the window, and the press was there, and this woman ended up on the cover of Time Magazine. And when I found that out, I said, I'm so sorry, I didn't know what to say to her. But she said to me that's okay because I had my tiara on. And he fixed my hair and put my makeup on.

JS: Oh, my goodness. That's amazing. That's the sort of thing that sticks with you.

MN: She's someone who I wonder what happened to her. I hope she's still here with us.

JS: That has to be so difficult when you've invested so much in the care of these patients for such an intense period and then you have to leave, and you don't know. I guess you wouldn't have had too much contact, with families of the patients?

MN: No. There was one night, or I would say it was probably like four o'clock in the morning, there was some banging on the front door, and there was a gentleman out there and he was demanding to see his son and his son was in a vegetative state, and had been in this nursing home for something like 22 years, and he really wanted to see his son but we were not allowed to let anybody in. So, the physicians just reasoned with him through the glass door. That was really the only interaction I had.

JS: And I'm assuming they had to be separated from one another. They couldn't engage each other within the home.

MN: Yeah. No one came in.

JS: Thank you for sharing that. That's a that's a wonderful story. Commander Agarabi, would you like to pick up on the on the next question?

CA: Thank you. If you had deployed prior to the COVID-19 pandemic, which both of you have expressed you have, so we're going to switch gears a little bit here. We'll start with Commander Pham, can you please describe your previous deployments and how that might helped prepare you for the deployments we're focusing on today? And you had mentioned you had done several deployments. So, I would say one or two that you feel really prepared you for the COVID response prior to COVID.

QP: I was deployed to Liberia for the Ebola response as part of Monrovia Medical Unit 3, and actually for the Kirkland mission, there were decent number of RDF1 folks on that mission. And then there were also a decent number of RDF1 folks on MMU3 to Liberia. As you can imagine if you're deploying to Ebola the PPE standards are even more intense and strict and the discipline that you would need to not touch one another and to maintain distance, to practice personal space so to speak, and hand hygiene and all the above was even more intense. So, I think I've brought that along with me to the deployment in Kirkland.

And I think also the idea that, we always say everyone's a Safety Officer. Every time I notice that people are crowding up near each other, I would say we should spread out a little bit more, especially in the SOC. The SOC was in a kind of a postwar war II bomb shelter facility that was repurposed to become the region 10 for FEMA facility. You go through these heavy doors, like nuclear bomb shelter kind of doors, and everyone was underground in that facility. I remember really suggesting we should be able to operate remotely if we don't need to be here. I think this is getting to a point where there are so many people next to each other that if it's spread among us, we'll all get it.

I think that helped with the situation, because I think everyone was thinking that, but you're afraid because you have to remember, how we act normally. It's hard to break from that until the new norm comes and we realize it's okay to work from your hotel and to call into a meeting because we're in a totally different situation.

CA: Commander Nguyen, can you also describe previous deployments that have prepared you for this COVID deployment?

MN: I had not deployed as much as Commander Pham prior to the first COVID mission, probably years before the first COVID mission. So, when I was rostered to go, I guess my first feeling was I was just a little scared. And then I had spoken to some friends that had gone for the repatriation and that fear just went away. I just figured when I got to the airport, I'd probably see someone that was PHS officer and make friends like starting a new school and ask questions and go from there.

CA: I know you said it had been years before, and I think that's actually helpful. Would you describe any conspicuous ways in which the COVID 19 deployments differed from those previous emergency response deployments that you had been on?

MN: I felt that the Kirkland mission, even though it was a lot of work, which was a good group of people. Everybody knew what they needed to do. I didn't feel like there were any egos or attitudes. People were just willing to share information and really were taking care of each other. I know on the evening shift, there was one nurse that was really having a hard time and she

wanted to go home. There was an enterprise rental car across the street from our hotel and she had been going around telling people that she wanted to leave. She lived in the next state, and she really needed a buddy and people to be with her and talk to her, and that's when a lot of the morale building started. So even though I haven't deployed as much as Commander Pham I feel like that was one of the best deployments ever because there were no egos, and everybody was so supportive of each other.

QP: I totally agree. Although I supported the mission, as in logistics, and assisting the group supervisor. When I look back looking back on it in the situation that we were in, we were at a nursing home where an outbreak occurred and nobody wanted to work there, and there were very few people but within 17 days they were able to stabilize the situation to the extent that we could send in a group of contractors to carry on the care of the remaining individuals. And I feel like the direction of the rest of the country wasn't necessarily in the same direction of that mission. So, we were doing well in that mission, but the rest of the country was slowly being affected by the overall pandemic.

I see it as true success because that was a very short time in which we had to learn. Commander [Green-48:20] had to go in, learn a new computer system they have in there, learn how to perform nursing in a nursing home in a new manner, and make adjustments because there are certain state regulations to do. For example, Q2 vitals or something that was a little bit unreasonable, and they had to make adjustments. Every day was adjustment after adjustment until it got to the point where it was stable and doable. And I'm very proud of the people I deployed with.

CA: And would you say your responsibilities in your role at the FDA informed or assisted you in carrying out your responsibilities while on deployment for?

QP: For me, absolutely. My responsibilities at the FDA, I see myself as somebody who is able to look behind a clock and see how all the pieces work together so that everyone else can look at the front of the clock and use it. That's how I think of myself at the FDA and in the same manner during deployment, I see where things need to get communicated or get done or something needs to be fixed.

I was sitting beside the CMO for a lot of hours in the day and kind of thinking about other things and suggesting things. The second part of the deployment for sure, because I work primarily developing tools in the FDA. A lot of the stuff that they developed for GIS monitoring of where the hospitals were and, how many beds there were and where the PPE supplies were, and where the warehouses were. Doing each of those overlays of information, I understood that. And I worked with the GIS team and FEMA to create something that was actually useful by the time we were done.

CA: Commander Nguyen can you also let us explain how your responsibilities in your role at the FDA assisted or informed in helping you carry out your responsibilities while you were deployed.

MN: So, my current role at the FDA is I work within patient labeling. And so, it's a lot of educating the patients. So, in that aspect, I feel that my current position helps. The residents did

not understand coronavirus at all. So just sitting with them and putting it in simplified terms so that they could grasp the concept. So that's how my current role helped with that mission.

CA: Okay. Thank you. I'm going to turn it back over to John Swann and this concludes my portion. So, I thank you for your time and your input, and I look forward to hearing it all when it's done. So, thank you very much. This is Commander Agarabi and I'm handing it back over to John Swann.

JS: Thank you, commander. I appreciate your help with this. I want to turn to something that's come up a couple times here particularly from you Commander Nguyen, and that's the stress that you're all under particularly in a deployment like this one, where the circumstances are difficult the casualties are mounting. Obviously, everyone's doing everything they can to help. Commander Nguyen, you mentioned a visit from an IHS Psychologist, and you had also mentioned an experience with another nurse that wanted to leave. Could you both share a sense of how you dealt with this stress. If Corps Care was of assistance to you, or did you rely on other officers there to converse with or download with? Obviously, you're on the job so much during the day, but did you have a chance to have coffee or dinner with your colleagues and help each other get through these circumstances? I'd really love to hear more about that. Commander Nguyen, why don't we start with you on that one?

MN: The IHS psychologist that came she really wanted us to sit down to talk about our feelings and talk about things that might have happened during the night shift, the good and the bad, what we can make better? I'll be honest, I'm not someone to sit there and talk about my

feelings. I will talk about them if I'm feeling something at that moment in time. And this is after a 12-hour shift at nine o'clock in the mornings, we were all tired. I really relied on my shift PHS officer that I was working with, we had become very close, very quickly, which I am very thankful for. We were all just helping each other at all times. It wasn't unusual for someone to just knock on your door. You're half asleep, it's 10 o'clock in the morning, and you just went to sleep. If someone's upset or they can't sleep or something or they cannot stop thinking about a situation that happened during the night shift, and they just wanted to talk.

We all made it a point to check in on each other constantly, whether that was just going to the gym together, taking a walk around the building. The two-night shift physicians that we had with us, they had known each other a long time and they were marathon runners and their idea of supporting each other was piling all of us into this big Tahoe and going for a run up some mountains, so we quickly did not want to do that every day.

As much as we could we were trying to get together, even in the lobby just anything to feel normal. I know what helped for me was having that good group of people. But also knowing that I had the support of my family at home, knowing that everything was okay. I think if I didn't have that, I would've been more stressed out during this mission, and I wouldn't have been able to concentrate as well. The whole support system helps.

JS: Okay. Thank you. Commander Pham?

QP: I would reiterate everything that Commander Nguyen said. One of the things that I take out of each deployment, and that I look forward to are the new people I meet and the new connections that I have. I try to focus on that more than my own potential stress, or what I'm

missing out on, because I was missing out on quite a bit my daughter literally took her first steps without me there. Those are moments that I know I'm going to miss. But I try to focus on the new people I meet reconnecting with old people, because a lot of a lot of the folks that you deploy with, you tend to only see during deployments otherwise you wouldn't cross paths and you get to reconnect with them and do your best to form a cohesive team and to get the mission done.

I always know that there's a stop date, at some point it will stop, not always the date that we want. We would like it to be two weeks versus four weeks versus six weeks or whatever. But I always think about the folks that have to stay behind because that's their community, and I'm a little bit of an interloper.

I get to go back to my home, my "steady state," and my goal is just to make it home. To do a good job and to make it home, and that's served me well overall. And maybe I'm unusual but try not to get too stressed out about what I have to do during deployment.

JS: Okay. Appreciate that. We're fortunate to have Dr. Burrows join us and she's going to pick up with the next question Dr. Burrows.

VB: Hello to everybody and especially to Commander Pham and Commander Nguyen, I'm so glad to be able to speak with you this afternoon and to hear your stories. I want to make sure that we capture the breadth of your deployment experiences. So, I wanted to shift gears a little bit to talk to Commander Pham about your deployment to Whiteriver, if you could start at the beginning and tell us about how you were contacted to deploy and how much time you had to prepare. And also, what it was like when you arrived in Arizona?

QP: My deployment to Whiteriver was completely different. Obviously, all deployments are very different, but the one to Whiteriver was unusual in several regards. First of all, I was told that it was high profile. Secondly, it was, from what I can tell, the very first time that PHS was deploying to an IHS facility that was primarily run by PHS officers themselves. It was like PHS deploying to itself, so it's a little bit weird. And at this point in time in the pandemic I think there were a lot of deployments and a lot of officers out in the field, and we were deploying less as big cohesive teams, and more as smaller strike teams and augmentation units.

When I deployed I tried to get as much information as I could before leaving, but I kept on getting the line “You'll see when you get there, this is a highly sensitive deployment” and things like that. I never understood what that meant, but as it turns out when I got there, I learned Whiteriver had an outbreak at the hospital itself. A lot of the staff had gotten COVID and were out including the Command Staff that was stood up to deal with the outbreak, and to manage the outbreak. Almost everybody in the Command Staff, except for one or two people had been positive for COVID and had to stay home and quarantine themselves or ended up in the hospital.

When I got there, it was quite a situation to wrap my head around because there was so much work to be done, and so many people had contracted COVID that there weren't a lot of bodies to help do it. In addition to us who were officially deployed through CCHQ, there were also at least six PHS officers who had a TDY there. So, it was interesting how we interacted with them because, being deployed and doing a TDY are two different things. Even though we're all PHS officers going to Whiteriver a TDY means that you potentially have the weekends off and things like that, whereas we didn't have weekends off.

[00:59:50]

We ended up doing a couple of things that they assigned to us, they put us where there was the most critical need. One was answering phone calls for COVID. There was a COVID call center and they would receive hundreds of calls a day. There would be a room of at least six or seven people in there, and most of them had contracted COVID also, so we went there and manned that. There was also an area where we triaged the respiratory symptom patients and asked questions to figure out whether they have been exposed to COVID or not, so we can direct them to areas of the hospital where we try to segregate the respiratory symptom patients from the non-respiratory symptom patients.

We also did outpatient filling of prescriptions, but not just outpatient, but it's outside and the patients never left their cars. We would get their prescriptions from their cars either as refill or new prescriptions, and put it into the computer, fill it. And then once it's filled, we would go out to their car and deliver it to them and counsel them in the hot Arizona sun. So, we could limit people congregating. The last thing that we were assigned to do was to help out with nasal swabbing and data entry of the individuals, like registration of individuals for COVID testing.

Those four were the main things we did, but what we were also tasked to do was to observe the facility and to help the Safety Officer with how the facility can be better at preventing the spread of COVID. There were a lot of things that we could improve on, which they did improve signage, improve flow of traffic, improve policies of handling patients and things like that.

It was actually a month and a half deployment, I believe. And so, it was quite some time and spending time out there was a change of pace. But I was glad I went, and I know we did a lot

of improvements. If you look at the infection rate before we came and then after we left, there was a drastic difference. It was nice to see the hospital staff start coming back when we were demobilizing, they were starting to come back and taking over their original positions. It was nice to help out our sister agency so to speak and hopefully, they've carried on.

VB: I was wondering if you could share a little insight given the fact that you provided guidance to the Health Officer about how to improve safety protocols. How do you think the situation got so bad in Whiteriver? How is it that so many members of the Command Staff came down with COVID?

QP: This is my opinion, because when I got in it was already [indiscernible] situation. I think when you're living out in a rural area like that, your mentality changes a little bit. This is a virus that affects big cities, people who travel from city to city and since we are secluded from that kind of travel and it wouldn't affect us as much. Also, when I got there the kinds of things that were put in place to combat COVID seemed to me to be on a smaller scale. I think they were kind of overwhelmed, it was easy to get overwhelmed at first. It's a disease that sneaks up on you. When there's somebody who is COVID positive, you can think that's just one person, but so many people were asymptomatic and so many people were carriers and spreading the virus before they became symptomatic. And then it ballooned and blossomed much faster than they expected, at least that's my suspicion. I don't see any reason why they would be able to – any reason why they would think ahead of time to prevent people from congregating near each other.

It's a strange thing. Why should we prevent all these people from sitting together at the same table, if only one person has COVID. I don't think there's one thing that you can point to and say this was the reason why it got so bad. I think it just spun out of control.

VB: Thanks for sharing those insights. And it's just a shocking case study in how this virus spreads, that it could take hold so deeply, and so quickly I was wondering if you could tell us a little bit more about your team or your immediate points of contact on this deployment. I'm particularly curious to learn about how in a facility that is a PHS facility, how the emergency response protocols played out. How the ICS worked or how the Chain of Command worked, and how did the other officers that were there on TDYs fit into the emergency response structure?

QP: That was new to me too. A lot of these deployments, you have more than one boss, so I was getting instructions from CCHQ on a daily basis and reporting to CCHQ. At the same time there was an Incident Command at Whiteriver that gave me instructions to go here or there or do this or do that or come in on a weekend and do this instead of that, and we would report to them. It just so happened that when we arrived, there were two PHS officers from Phoenix were doing TDYs at Whiteriver to augment the Incident Command, because the Incident Command had been decimated to almost no one.

And so those two PHS officers literally became Incident Command with one or two people who were COVID negative from Whiteriver, and then we took instructions and reported to them. So, we didn't report to folks who were necessarily Whiteriver Incident Command, but more like IHS Incident Command who came from the Phoenix area office.

I think our roles fell into place and then and we worked out a game plan of what needed to be done. Each day we had a hot wash with these two officers and reported what we saw and what our recommendations may be to resolve some issues. And each day they would try to resolve those issues, or they might get the resources we need to make sure the process works the way it's supposed to work. I think it's hard for me to tell because there's a lot of moving parts and I also feel at the Incident Command level they were able to bring in other folks.

I remember near the end of my time there, there were VA nurses that were coming in to help out, and there were other Safety Officers that that came. So, there were quite a bit of external folks who came to assist in the outbreak at Whiteriver.

VB: And by and large was the staff that was coming in just from across the HHS OPDIVs or a lot of FDA folks? A lot of NIH folks? Was it just a mix?

QP: My particular team was all FDA and the Safety Officers were NIH. And there was a nurse team before us, we didn't particularly interact with them, so that was another strange thing. Usually when we come, we come as a big PHS team, everyone knows each other and interacts with each other, but I didn't get to see the nurses that much. We overlapped by only a week, and then there was a lab team that came, and I didn't get to see them much either, and they were PHS Lab Officers also. The facility was quite affected by COVID. You can tell by the number of officers and PHS offices were deployed there

VB: Could tell us a little bit about what you observed about the local community to the extent that you have any stories you can share about patients you interacted with. This is a community

that was so severely impacted by COVID it would be great if you could give us a little bit of a sense of what it was like for the people of Whiteriver.

QP: I think it devastated the population there. It was a sinister pandemic that led to people turning on one another. In a middle class, upper middle-class situation, when you are COVID positive and you quarantine yourself, you go to the basement and you get food put at the door and you can literally quarantine yourself. But in the reservation, there may be a two-bedroom house with multi-generational families of 10 or 11 people. When one person is positive, they are ostracized from the family. They have to live in a tent outside. And then people start to blame each other. Being a part of the call center and hearing all of this was sad, because one thing we know is that anybody can get COVID at any time. But I think in this particular community there was like a level of assigning blame to certain folks, and it was hard to combat that.

It was really difficult, and you hear lots of stories for instance, I fielded a phone call and a guy called me and said he was quarantining wanted to go to someone else's house to take a shower. And I'm like it's supposed to be in quarantine, but he didn't have running water and hadn't taken a shower in 10 days. It's not funny, but you start thinking about ways to remedy the situation. Do they have an outside shower? Can they shower with a hose? A bucket? Is that enough for him? I don't remember exactly how I ended up resolving that situation, but things like that, we take for granted. As PHS officers, most of us, live in homes and have the means to quarantine and the means to self-isolate. But in that community, it, it really affected the entire community in a really bad way.

VB: That's just heartbreaking to hear about. And really gives a sense of some problems that are really significant for reservation populations that we absolutely take for granted and having access to running water. I was wondering if you could tell us a little bit about what – this was last summer, right? At that stage of the pandemic, we only had so much in our therapeutics arsenal to help out. What sort of therapeutics were being dispensed? And what kinds of comorbidities were common in this population that needed to be treated alongside COVID?

QP: I wasn't so much involved with, the dispensing of, treatments for COVID per se. A lot of things I did were outpatient based, triaging outside, call center, doing COVID tests and filling outpatient prescriptions. I do know that their ER facility was isolated, even though it's Whiteriver, and it's one of the larger facilities in Indian Health, it's still isolated. And I think what happens a lot of time is you see the helicopters come in and out, and whenever a patient decompensates substantially, they get flown out to different hospital to be taken care of.

I actually don't know of the treatments that were done at that particular facility at Whiteriver, so I can't speak about it. In terms of comorbidities of the population, diabetes was high on the list, and then, hypertension and high cholesterol, although you can't really see high cholesterol.

Outside we ended up treating a lot of small wounds and skin infections. I think hygiene at the reservation was – they weren't able to maintain a high level of good hygiene, not hand hygiene, but basic hygiene. A lot of folks came in with skin infections and spider bites, they call them spider bites, but they weren't really spider bites, they were skin infections. And a lot of folks who were obese, it also took a toll on the elderly population there. And one thing I've never

seen it before, were kids who shouldn't be driving, were driving their grandparents around to get treatment. So yeah, it was an eye-opening experience for sure.

VB: In light of what you said about the issues with running water, it really puts into context how the problems with hand sanitizers became so significant in Native American communities last summer. If I have the timing right, I believe it was around July last year that we started detecting the adulteration of imported hand sanitizers. Did you notice any impact of that at all during your deployment at Whiteriver?

QP: I did not. The hand sanitizers we used at Whiteriver I thought were fine, they looked right. I couldn't tell whether they were adulterated or not, but they looked like they were legit some of them left some sticky residue that was annoying. It was hard for me to say whether, even though the hand sanitizers are all about compliance and using hand sanitizers was universal among the patients that came to the hospital. I remember we had to constantly say, sanitize your hands as they're walking through the door. So that, at least they would get prompted to sanitize their hands. Then also, a good number of people didn't have masks. So, we would physically hand them a mask and say you have to put on that mask before you go into the hospital. I can't speak to the specific issue of adulterated hand sanitizers affecting the community there.

VB: When this deployment came to an end did you, by this time we had diagnostics that were widely available, did you or were you advised to take a COVID test or to quarantine or both before you returned home?

QP: We were, we did. What happened was, we traveled back to the Phoenix area to Luke Air Force Base, and with the help of CCHQ, we set up an appointment at Luke's Air Force base COVID testing center there. We got a PCR test and we were quarantined for a week until the PCR test came back. We were all negative, thank goodness, and we were cleared to go home. So that was the process. That whole process took about four or five days after we had already left the Whiteriver area.

VB: One of the things that I find is one of maybe one of the most overt characteristics of this emergency response is how many officers have served multiple deployments and been called out multiple times on different missions. You've already served a considerable amount of time, and as you mentioned, when you have a very small human being at home that is growing, and then this past April you were deployed a third time. At this point, I'll shift back to Commander Nguyen to talk more about the Buffalo deployment and tell us the story about how you were contacted about this deployment and what you were told about your role and what it was like when you arrived there.

MN: Kirkland was my first COVID mission, but beginning in July of 2020, and I literally would say almost every two weeks, until I went to Buffalo this past March, I was called and told I was rostered. So, I literally have had bags packed and sitting in my house since that point in time. Prior to going to Buffalo, I was actually supposed to go to Dover and we were supposed to drive our own cars and I was actually canceled right when I got on the interstate. And then two weeks later I went to Buffalo. So that was frustrating. Basically, I've been in limbo for months,

waiting to go on these COVID missions. I wanted my kids at least to have some type of normal normalcy eventually, and that's why I wanted to go on these missions.

JS: Can I interrupt for a second? Do you know why it was canceled at the very last minute? Was that information ever shared with the officer?

MN: The Delaware mission?

JS: Yes.

MN: No, they just called, and they said – we actually had a briefing meeting that morning at seven o'clock to eight o'clock, and right before the eight o'clock meeting ended, we were all told to get into our cars and drive to Delaware to such and such location because we have a meeting at 12:00. So, I was anxious to get ready to go, and I just got on the interstate, and they told me to stand down, turn around and go back home and don't unpack. But no, I wasn't ever told why.

JS: Okay, thank you. I didn't mean to interrupt, but it makes one wonder.

VB: If I could just piggyback on that question. So, when you're told every two weeks that you've been rostered when do you hear back that you're not actually going to be deployed? How does that work?

MN: I was never told, at one point, I think it was right before Thanksgiving, I had been on probably four calls to go to an Indian Health Reservation. And then I was on an extra call with a small group of officers telling me I was going to Montana. I was ready, at this point I'm wanting to go, I need this luggage out of my house, and I felt like I was making my family anxious, not knowing when I was going to go. And then I never went, but I was never told why. I would inquire that I would never get an answer.

VB: That must be extremely frustrating to be in a ready posture and then to be on hold. So, by the time you were deployed to Buffalo I'm sure you were had to update what you had in your suitcase for the season.

MN: The night before, when I was on a pre-mobilization call, I was actually going to Oklahoma and that morning, the day that I was supposed to leave, when I woke up, I had a ticket to Buffalo. It's a good thing both places were cold, so I was packed.

VB: My goodness, it's a really a testament to your flexibility and adaptability. When you arrived in Buffalo, what was it like and what did you learn about the assignment you were given, and what stage of developing the mass vacs site did you arrive in?

[01:20:53]

MN: All I had was my ticket, so I get to the airport and there was no other information about hotel website we were going to, I just knew that it was going to be a vaccination site.

VB: Commander Nguyen, I think we lost you for a second.

JS: She's off Vanessa.

VB: We lost her, perhaps Commander Pham could pick up.

QP: I also deployed to Buffalo, but after Commander Nguyen so in many ways we relieved her and her team. One of the things to make things a little bit – continuity of what she said and what I'm going to say, is that I also had similar experience where I was rostered and just waited around and then maybe four weeks later, I was told you can stand down now. So, I'm always ready, right now during this situation I'm perpetually ready, I have my suitcase right next to me actually. When Buffalo came around, I was rostered and a week passed and I asked what's happening, and it took a week to actually fly out and land in Buffalo.

When I landed in Buffalo, I learned even before then, that the PHS team in Buffalo, eight people were demobilizing. But we were only back filling with two people, they had planned three, but then one person didn't show up, or maybe four and two people didn't show up. So basically, only two people had shown up and I was really concerned because you can't backfill eight people with two people and still expect the same amount of work to be done. And we were assured all sorts of things, and as it turns out, there was a lot of miscommunication. Certain groups thought that the demobilized people were still at the site and working when they were actually told to demobilized by FEMA, but then they didn't get their tickets to go home until a couple days later. So, we jumped into a situation where immediately upon landing I had to go to

the site and get oriented. The next day I worked a 16- or 17-hour shift in order to get all the things that needed to be done. I see a Commander Nguyen is back.

MN: Sorry, I didn't know that I got kicked out. I don't know what I was saying when I got logged out.

VB: You had just started to talk about what the situation was like in Buffalo when you got there and how you learned what your assignment was going to be.

MN: When we got to site, FEMA didn't know that we were coming. So, the FEMA person in charge, I don't know what his exact title was, he quickly introduced us to the different agencies that were there and the Buffalo employees, and that's when we had to figure out what their needs were and where we would fit in.

VB: So how far along were they in setting up the mass vaccination site?

MN: FEMA had only gotten there maybe three days before we got there. We were in a community center, and they were, they'd moved things around to make, vaccination station. They made wait room, the pharmacy, they made the kitchen. I forget the title. I forget what you call it.

QM: Command Center.

MN: Yes. Command Center. And then at that point they were in the middle of the PowerPoint by talking about the needs of the community. And then once we found out what their needs were, that's when we got our assignments of what we were going to do. So, we were told at that point that we were not going to give any of the vaccinations. And I know for myself, because I'm a nurse, I really thought I was going to be giving vaccinations, but that's not what their needs were at that point. They had contractors through the National Forest Service, EMTs and Paramedics that were going to give the vaccinations. Our role was the patients pharmacists were going to be in pharmacy. They needed people to QA the medical record system. And then we had to figure out the flow of traffic. We needed people to [indiscernible 1:25:51] to answer the questions and in the vaccination area to answer any concerns that the residents had.

So, we all did a lot of everything, but that very first day, when we did open the next morning there was a lot of people, I think probably 1200 people came that day. And my initial role was to stand at the front door with the AmeriCorps kids to answer some questions, to make sure that residents weren't trying to come in that we're symptomatic and just talk to all the residents about what was happening, keep the flow running, keep them calm. They too were surprised with how many people were there, this line was wrapped around our block. Not even one block, you would look out the door and you couldn't even tell where the line ended.

VB: Was this a line full of people that had made appointments ahead of time? Or was this first come first serve on the first day that you opened?

MN: It was both, and I don't remember how they advertised that. I remember seeing it all over the news, but there were a lot of people that made appointments. The way FEMA had set up their

registration sessions, there was one area for people to go through for residents that had appointments. And there was another area for people that just showed up and we were going to try to fit them in. I would say for the first week and a half, I know it was well over a thousand every day. And then it decreased slightly, above 900 or 950, but then it went back up.

VB: That's quite a lot of people. I'm sorry if you said this already, but where did you set up the mass vaccination site?

MN: It was a community center in the neighborhood.

VB: Was it in a building or was it in a parking lot?

MN: It was in a building. It was like a rec center.

QP: It was a building and there was a basketball court that was used to do the vaccination and observation, and then the rest of the center was a weight room. There was a weight room and activities rooms and things like that. The weight room was used by logs and pharmacy to do pharmacy and logs work, and then the kitchen was the kind of Command Center.

VB: So, at this point, I'm guessing since this is one of the first mass vaccine sites available in Buffalo that it was Phase 1A, maybe Phase 1B people who were coming to get vaccinated. Do you recall?

QP: That's correct. I came in a little bit later, but the folks who originally were able to register was the, I don't remember what Phase 1A was, I think Phase 1A was over 65.

MN: No, I think we had some frontline workers.

QP: Yeah. Frontline workers.

MN: And over 60 and people with comorbidities.

VB: You mentioned that you had to do this screening of for people that may be symptomatic and yet coming for COVID vaccine. Did you find many people that you had to turn away or that didn't realize they shouldn't be trying to get vaccinated when they're expressing symptoms?

MN: There wasn't a lot. I think maybe that first day there was maybe five, but there wasn't a lot. They knew not to come I don't know if they had heard through the community that before being allowed to enter that door, you were asked a series of questions before you could walk in. There was a lot of heavy security and things were very calm, but everyone was very serious that no, we're not trying to start a spread. We want everyone to be safe. I want to mention this particular community, it was not a safe neighborhood. I was very glad when we first got there to find out that it wasn't a poor neighborhood. These were people that were coming on site to register, they were just popping in because they didn't have computers or cell phones. And these were extremely old people and one gentleman in line who wasn't old, but he was walking with a cane, and he had just retired from his job in Texas and came back home to Buffalo, to help care

for his ailing parents. And he said that he was born and raised in that neighborhood. And this neighborhood, in particular, had never seen anything like this happen, no one ever came into that neighborhood to do anything, to help the community. So, they were very thankful and you could just see it all over their faces. They were so happy that their city was being helped.

VB: Do you have any insight into why this site was chosen? Was it because the community was so severely impacted or was it just a matter of access to the rec center or something like that?

MN: I was told by FEMA that this particular community center was owned by a woman that grew up in the neighborhood and she offered it. She wasn't asking to rent out the space. She just wanted to help her community.

VB: That's really wonderful. I'd like to learn more about, the people you worked with at this site. And you mentioned AmeriCorps volunteers. I know there's a great diversity of different groups of people that were being deployed to, or volunteering at mass vaccination sites, but I didn't realize AmeriCorps was involved. Who else was involved and who from the local Buffalo community or State Officials or City Officials were involved in making this site function?

MN: It was FEMA, the State of Buffalo employees, National Forest Service. They had all these different contracts for EMTs and paramedics come in there, DMAT, AmeriCorps, that was the first time I ever heard of AmeriCorps. I didn't even know what they were until they explained

it to me. I think that was it. And then all the security guards, they were retired security guards. They came in through a contract.

QP: By the time I joined, there were volunteers from other agencies also USDA in particular we worked with three USDA volunteers who were civilian but deployed to Buffalo to help out. And they helped us tremendously actually. Also, at the time they it was of a fluid situation there were additional contracts to help clean the bathrooms and things like that.

VB: This is perhaps a bizarre question to ask since you were at a site where people go because they want to get vaccinated, but I wonder if you witnessed or heard about, or got the impression of any problems with vaccine hesitancy in Buffalo or a need to encourage residents to get vaccinated or spread information about vaccine safety.

QP: I think I saw more of that than Commander Nguyen because when she deployed, it was early on in the vaccination cycle. After the first cycle and second cycle, when I was there it became more of a challenge to get the same numbers as they did several weeks before. We were doing, 600 or 700, rather than 1200. When I started, we were still doing 1200 because it was the second dose, and the same 1200 people who got the first dose would come and get the second dose. But when we went back to the first dose of Pfizer, we were having a challenge getting the numbers as high as before. It wasn't until they decreased the age to 16 that we saw another bump of parents and their kids coming in to get their vaccines.

But it was still nothing like the initial surge of people that wanted to get the vaccine early. It wasn't necessarily all due to the population having a disinterest in getting vaccinated it's also

that multiple other vaccination sites had opened up and were available. My understanding was that there was another vaccination site that had opened up literally a block away and they didn't have to register, they could just walk in. And I think that was a pharmacy lead site. I know there was also one at the University of Buffalo, which was only like 10 minutes away, and they did a lot of vaccinations there also.

VB: I'm guessing since you mentioned that you had to administer the second dose that you were dealing with either the Pfizer or the Moderna shot was it one or the other exclusively or did you just get whatever was available?

QP: We had the Pfizer exclusively throughout and our site was optimized for administration for Pfizer everything was in multiples of six. There were 12 vaccinators, you can get six doses out of a vial. It was six hours to expiration time after reconstitution. So, everything was in multiples of six. When there was a suggestion that we might move to Moderna, it became a little bit of a challenge to try to redo the facility so that we would be able to administer Moderna the way it was meant to be handled and processed.

VB: Was this still when Pfizer needed the super cold storage?

QP: Yes.

VB: It was?

QP: I happened to be the Pharmacy Lead after Commander Nguyen demobilized. So, there was a super cold ultra-cold freezer on site and there was actually a thaw refrigerator and a what we call ready to use refrigerator, meaning a refrigerator that held the temperature of four degrees. A lot of our task was to thaw the vaccine, and not only thaw, but accept the vaccine from UPS, put it into the ultra-cold, take out a reasonable amount that we think will be used each day, thaw it, and then put it into the ready to use refrigerator and then reconstitute the vials.

VB: Did you also prepare the syringes and provide them to –

QP: Yeah, we prepared the syringes closer to the end of the day. So that we would have better control over the number of vaccines that are delivered to the vaccinators. We're always trying to match up the number of doses in vials that we reconstitute to the number of arms that are available, who actually showed up and are available to get vaccinated. We try to match that exactly so that there isn't any wastage where we opened up a vial and there was one person who will use that vial, so we would waste five doses. At the end of the day, we would draw out syringes for each of the vials for the vaccinators to use. During the day we would reconstitute the vials and then hand the vials to the vaccinators for them to draw out because it's a consistent flow. We know that there will be a thousand people going through and we're not even close to trying to figure out how many arms at the end of the day yet. So, at the end of the day, it becomes a little bit more controlled.

VB: You have this really amazing deployment experience to have been there at the beginning of one of the first sort of landings of COVID in the United States and then involved in one of the

end points, I feel like I should say, I hope the end points of the pandemic, and providing mass vaccinations. I wanted to ask if you have any impressions, comments, takeaways particularly like lessons learned that you could share with fellow officers or researchers about what this pandemic was like and what we did well and what we could do better in future emergency responses.

JS: I think maybe Commander Nguyen should go first since she has to take off in just a few minutes.

MN: I don't know what to say. For me, it was the camaraderie and everybody knowing that we had a job to do, and we needed to get it done for the sake of our country. And I'm very proud about that. Very proud that I was asked to be a part of it. It's something that I'm not going to forget, and my kids are old enough to understand why I had to go. So, I feel very fortunate for being involved.

VB: Commander Pham do you have any takeaways or final impressions you'd like to share?

QP: I have lots, but there's not enough time to tell them all. I guess the highlights of my takeaway is that I think, something like this pandemic really puts things into perspective, and that when something like this happens you have to take a little time to think about what's important, and how you affect other people, and how life will change maybe momentarily, maybe temporarily, maybe permanently and the thing that really gets me is that similar to Ebola this virus affected the very fabric of who we are as a society of interacting with each other, being close to one another, touching one another, even talking to one another and meeting one another

it totally changed everything. I think for better or for worse, I think we need to recognize that the virus is quite real and know that we'll get through this, and we'll come out stronger.

[01:41:08]

VB: Thank you for those reflections. Thank you for taking the time to speak with us today and thank you both so much for your service. I'm going to go ahead and close the recording.

[END OF INTERVIEW]



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