FDA U.S. FOOD & DRUG ADMINISTRATION

FCON COVID-19 Deployment
Oral History Interview
Federal and State Logistics I
LCDR Kelli Shaffer, R.N.
and
CAPT Daniel St. Laurent

FCON History Committee
FDA History Office
Collaborative Oral History Project
Edited Transcript
Date of Interview: May 17, 2021

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Oral History Abstract

In this interview, USPHS officers LCDR Kelli Shaffer and CAPT Daniel St. Laurent discuss their deployments in response to the COVID-19 public health emergency. CAPT St. Laurent and LCDR Shaffer were deployed as Public Health Service officers who are in the USPHS Commissioned Corps in support of COVID-19 efforts for multiple COVID-19 Response Assistance Field Team (CRAFT) missions. On these missions, USPHS officers led teams of government Subject Matter Experts from a variety of agencies (including ACL, ASPR, CDC, CMS, FEMA, HRSA, and OASH) as they interacted with local government and health officials related to their COVID-19 response efforts. These missions allowed federal government SMEs to interact directly with local jurisdiction officials to identify strengths and challenges related to COVID-19 community mitigation and policy issues. CRAFT missions provided technical assistance resources related to community mitigation and facilitated access to federal resources. They performed physical deployments to Illinois and Nebraska. Shaffer also deployed to Washington state in April 2020. St. Laurent deployed to virtual CRAFT encounters in Utah and Texas, while Shaffer deployed virtually to Texas and Charleston, WV. In Washington DC, Shaffer was the last CRAFT Team Cohort (COVID-19 Response Assistance Field Team).

Keywords

Centers for Disease Control and Prevention (CDC); Commissioned Corps; COVID-19; COVID-19 Response Assistance Field Team (CRAFT); deployment; Health Resources and Services Administration (HRSA); Office of the Assistant Secretary for Preparedness & Response (ASPR); subject matter experts (SMEs); testing; virtual deployment

Citation Instructions

This interview should be cited as follows:

"LCDR Kelli Shaffer and CAPT Daniel St. Laurent Oral History Interview", History Office and FCON History Committee, U.S. Food and Drug Administration, Department of Health and Human Services, May 17, 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

VB: This interview is a contribution to the FDA Commissioned Officer's Network and the FDA History Office's Collaborative Project to document experiences of officers who have deployed for the COVID-19 emergency response. Today is May 17th, 2021. My name is Vanessa Burrows from the FDA History Office.

JS: And this is John Swann, also from the FDA History Office.

LP: This is CAPT Lauren Pincock from the PharmPAC History Workgroup.

JE: This is LCDR Jen Eng from the Historical Committee of FCON.

DS: This is a CAPT St. Laurent. I am one of the personnel who deployed.

KS: This is LCDR Kelli Shaffer. I am also one of the officers that deployed and I'm currently with CDER.

VB: Thank you all. Today's interview is going to be focused on the theme of Federal and State logistics. CAPT St. Laurent if you could tell us a little bit about your professional background, your position at FDA, how long you've been at FDA and any other Federal positions you've held that are relevant.

SL: Thank you. Again, this is CAPT Dan St. Laurent. Currently I am at the FDA Center for Tobacco Products, Office of Science where I am the Branch Chief of the Knowledge Management Branch. I've been with Center of Tobacco Products for about six or seven years at this point. Prior to that, I was with FDA, as an ORA Field Investigator. Altogether, I've been with USPHS for about 14 years.

I was also active-duty Air Force for approximately five and a half years. I am in the nurse category and all of my experience in the Air Force was as a nurse. I had a short break in service, where I went back to school and got my master's degree in nursing, then came back to USPHS as a Field Investigator. I was performing inspections on clinical trials, blood banks and plasmapheresis centers at the Denver district office and then transitioned over to CTP around 2013. Was there anything else that I missed?

VB: Nope, that's great. Thank you so much. LCDR Shaffer, would you mind also sharing a little bit about your professional background and your position at FDA and any other federal positions you've held.

KS: Sure, thank you. I have been a registered dental hygienist for 26 years now. I joined after 17 years in the private sector. I joined in 2013. I started in the Bureau of Prisons in Oregon. I transferred to another Bureau of Prisons facility in California. I started with the FDA at the Center for Tobacco in 2017. And last year in April (of 2019), while I was on deployment, I started with the CTECs the Center for Terrorist and Emergency Management Staff in CDER, and that's where I am currently at.

VB: Excellent. Thank you so much. And now without going into any great detail at this point, CAPT St. Laurent if you could tell us very briefly about your deployment, the role you played, where you were sent and the approximate dates that you were on deployment.

DS: I was on deployment approximately August 29th, 2020, to October 2nd, 2020. That encompassed about five weeks, for the first two weeks we traveled physically to different locations in the United States, which included Peoria, Illinois and Lincoln, Nebraska. Then we spent a week doing some deployment work, but not traveling. The next couple of weeks we spent virtually traveling to a number of other locations. And again, including Texas and Utah. My first week of deployment I shadowed the team lead, as a team member, and then subsequently was team lead for my other encounters.

VB: Thank you so much. LCDR Shaffer, would you mind telling us very briefly about your deployments also?

KS: Do you want both deployments or just the one that I was on with CAPT St. Laurent?

VB: Both deployments, please.

KS: My first deployment was April 5th through the 25th, and it was actually supposed to be longer. It was supposed to be through May 19th, but the mission had changed, and I ended up in Bothell, Washington. We flew into Bothell, and we were supposed to open a field hospital in Yakima, Washington, which is a rural area over the pass, as they call it, in Eastern Washington

in a small rural area. When the mission changed, we were brought back to Bothell. When I deploy, I go as a logistics officer so after moving equipment back and forth over the pass, and then being in Bothell, we were going to start working with nursing homes and teaching them donning and doffing PPE, going to over testing protocols, doing some testing and the logistics just never worked out.

So, it ended up that several of our teams went to different places like Miami, Florida, and Detroit, [MI for other COVID missions]. They demobilized some of us that were not necessary, so at that point I was demobilized. The second one was with CAPT St. Laurent that was in Washington, DC. I deployed from August 28th through October 2nd. We were extended for five weeks [and we supported] Peoria, Illinois and Lincoln, Nebraska. We did one week of virtual and we did different online stuff [support research and development]. I then virtually deployed to Texas. And my last [city to support] was Charleston, West Virginia, and with that we were both part of what they call the CRAFT team, which is a COVID Response Assistance Field Team.

We had very similar roles while on deployment. The superior officer did most of the introductions and leading the meetings, I did more of the notetaking and a follow-up for further information. So that was my role.

VB: Thank you so much both of you. And now I'd like to get into greater detail about your deployments. I'd like to ask you each to think back to your first deployment. Think about when you were first contacted and about and how that contact was made, how much notice you were given anything along those lines you'd care to share. And if you had any insight into how your assignment was determined or input into what duties or assignments you would fill. Can we start with CAPT St. Laurent please?

DS: Sure. Shoot, I was hoping you would start with the LCDR Shaffer so I could rack my memory a little longer. How I recall it occurring was I was rostered for deployment, and honestly, I don't know what the lead time was. I do remember there were a number of days where I was requesting additional information and the only response I would get is we don't have any additional information for you. Just be prepared to leave when we tell you to leave.

I think it was only a matter of a few days before I was told you need to report on Saturday, downtown DC for the day, for an initial briefing and an overview of what's going on. Prior to that, I didn't really receive any sort of detailed information via phone or email as to what the deployment was or how long it was going to be. Saturday rolls around, and I show up downtown at HHS headquarters and we're in a conference room with about 20 or so other officers and introduced to the concept of this CRAFT mission. Again, that's the COVID-19 Response Assistance Field Team. At that point there had already been many cadres of CRAFT teams that had gone out [in the field all over the U.S.] and they were going to go out for one more week [after our team], I think.

It was during that first week that our deployment group would be trained on our roles and responsibilities. Then the previous CRAFT group would come off deployment and then we would continue the missions. That was Saturday. Sunday we went to Frederick, MD for a mask fitting, to get equipment, and get some further training. The tempo was pretty quick for the remainder of the deployment. Sunday night we would receive a briefing on what was going on [for the week] and Monday morning we would head to the airport, and by Monday afternoon to evening we were back online with briefings back to headquarters. Tuesday, Wednesday, Thursdays, we would have our engagements with the local jurisdictions. Fly out Friday, have a

report to do every night and we would teleconference every night with headquarters. Fridays we returned to get our documents aligned. I think our report for the week was due either Friday or Saturday, and then Sunday started all back up with another briefing for what to expect for the next week. That was the general tempo from one week to the next. Did I get to all your questions?

VB: Yes, that's great. Thank you so much. And in the future, you don't have to follow the order in responding that I recommend you can feel free to respond in whatever order you want. LCDR Shaffer could you tell us a little bit about when you were first contacted to deploy and how much notice you had, and how much input you had into what your assignment would be and how it was determined?

KS: For the first one I received notification that I had been rostered the end of March. On April 1st received official notification that I would be deployed, and I was rostered. On the 2nd I received flight information and by April 5th, I was on a flight to Washington. So that's basically about a four-day turnaround. We're not told a whole lot, but I was told that I would be a logistics officer on my Rapid Deployment Team. For the last five or six years I have been a logistics officer, and I actually knew one of the other officers that had been on a Rapid Deployment Team for quite some time.

So, we contacted each other and got a feel for the lay of the land. I also know one of the NDMS logistics officers who was in charge of the mission as well. I have deployed with him many times, so knowing that he was going to be there, I contacted him on the side to say, “I'm

coming out [and inform the NDMS staff that the other officer], who was also on my Rapid Deployment Team, will be there."

[The NDMS staff] didn't have a whole lot of details to give but basically just said that we were going to open a field hospital in Yakima. As we're going out there we have this mindset that that's what we're going to do. And as a logistics officer, again, I primarily move people, boxes, equipment, transportation, and provide housing and food.

I work with the NDMS teams [to provide support for] whatever they need. Part of the logistics operation of establishing the hospital is moving staff, moving boxes, and getting things established. I provided transportation if people had to go to different hotels, transportation to and from the airports. As our mission changed from the rural hospital to supporting the nursing homes as a logistics officer, my role is very much to support the officers. So, when an officer was injured, I ended up taking him to the hospital once, if not twice a day. Then it was once a day for a week, he wasn't able to drive or fly. I also took several officers to urgent care for dog bites. They were out jogging in a community and were actually nipped by dogs.

I make sure that people have transportation when they need it. I was in charge of the keys for all the vehicles. Every night we have to log in the vehicles, who's taking them, when are they taking them, why are they taking them. So, my role in Washington was strictly as a logistics officer.

The next deployment, the dates were the same as CAPT St. Laurent had mentioned. I had a few days' notice, we were told that it's going to be in DC, which is local for me, so we didn't have to have initial transportation or flight anywhere. That deployment ended up being August 28th through October 2nd. Our first day, like CAPT St. Laurent had mentioned, we went downtown [Washington DC] and we did some training there. We received debriefing as to what

they were doing, how things were going, [and listened to] their formal reports. The second day was here in Frederick, Maryland, which is local to where I live. I had already been fit tested in April, so I didn't have to fit test again. And at that point we were given more information as to the missions, what we were doing, what our roles would be, where we were going initially.

I want to say we got a flight the next day and we were on a plane. But like he had said, we were only there initially Monday through Friday. We traveled on Mondays and Fridays. And we were there Tuesday, Wednesday, Thursday for note taking, meetings [and support of the local communities]. The first one in Peoria we had an itinerary of, I want to say seven-ish meetings every day that we [participated in with different local entities. We collaborated with] everything from the local Health Department, local hospitals, to EMS transportation, a private company that they were working with all sorts of people that had their hands in the response. We would fly out Monday, come back Friday for Peoria and Lincoln.

The week of the deployment, we did everything virtually [sending back data to local jurisdictions that requested COVID support information related to testing, PPE, and regulations.] We then deployed virtually to Texas and Charleston, WV. Those [deployments] were a little different because we reached out virtually from our local station to try to set up some of those meetings [with local personnel. Communication was] a little more challenging not having that face-to-face interaction and showing up to say, here we are, we want to participate. Again, my role in that was primarily note-taking and sending updates so that the team was able to complete reports every night. I was not the senior officer, so my role was more of a supportive role. Is there anything else that you would like above and beyond?

VB: I wonder if now is a good time to ask you guys, if you could explain a little bit more about the concept of the CRAFT mission and any insight you have into how that model was developed and what was unique about it. Anything along those lines.

DS: You want me to take first stab at that, and then you can correct all my mistakes CDR Shaffer? Speaking specifically to the CRAFT missions, I'm going to provide to you what was provided to us. The purpose of the COVID 19 Response Assistance Field Team is to engage with local jurisdictions, specifically public health leadership and community-based organizations, to help them stop the spread of COVID-19 in their community.

And that does sum it up for the most part, very simplistically, but there's a lot to it. It's my understanding, and I may not be a hundred percent accurate on this because I really feel like this was just provided by word of mouth and not in writing, but it sounds like the idea for the CRAFT missions came out of the White House Task Force at the time, which included Ambassador Birx. The intent was for the Federal Government to have face-to-face direct conversations with local Public Health Officials and Community Representatives.

We don't normally take that route, normally the Federal Government interacts with the State, and the State Government officials interact with the local jurisdictions. This was intended to get everybody at the table together at the same time, because the state was informed prior to the actual visit. And in some cases, I believe the states were reluctant or refused to accept a visit.

And in other instances, it appeared as though the visits were very welcome. Again, the intent was so that Federal Representatives had an opportunity to speak with the local jurisdiction. But really the reverse [was also true], the local jurisdiction had access to Federal Representatives

from many different agencies, FEMA ASPR, CDC, folks with on the most up to date information available that could be shared.

As CDR Shaffer mentioned, we interacted in different areas with different people. But I would say across the board, we interacted with local Health Departments, school officials, whether that was the Health Officials for the school, or school nursing. Faith-based organization leaders, higher education university level officials and their tasks force associated with combating COVID-19. And what else? I think that's all I have for that.

[00:20:09]

JS: One quick question if I may. CAPT obviously this was set up for COVID, but was CRAFT based on, or inspired by similar efforts in other in previous public health emergencies?

DS: Not that I'm aware of, I can't say for sure. But I don't believe that was that was the case or I'm pretty sure that I didn't hear that message if it was.

VB: With the CRAFT missions did local areas request assistance? Would a state put in requests for officers to be deployed or was the need determined by PHS or by the White House Task Force? How did how did you identify what local communities and which local officials you needed to interact with?

DS: I believe generally that there was a group of folks with the White House Task Force that would identify emerging hotspots of COVID-19 based on the data that they had been receiving.

And upon reviewing and identifying those hotspots that would narrow down potential visits. All of that was before the CRAFT team or the PHS deployment team was involved. At some level there would be some decision to identify which places would be visited.

There might be an initial reach out to that area to say, CRAFT would like to come visit because I do believe there was an instance or two where CRAFT was trying to get to a space, but that space preferred to pass on that visit. To some degree, I guess it was a voluntary participation, but the deployment team led by a USPHS officer generally wouldn't know where they were going until the day before they were going there.

VB: It sounds like this is very much driven by data and the current information you had about where the most dangerous areas of the country were. Were either of you involved in monitoring data related to the case rates? I know there was a lot of work put into visualizing case rates and hotspots and that our field force is still really dependent on that information. We were either of you involved in monitoring datasets like this?

DS: I'll answer. And then I don't know if you want to repeat the questions for LCDR Shaffer or if she had a different understanding or experience of those parts. As far as data goes, I would agree it did seem to be that it was very much data driven. We had daily briefings, whether they morning, mid-afternoon or evenings depending on weekends or weekdays. We would constantly have briefings with individuals that represented the data collection folks. And for each of the weeks that there was a CRAFT mission we would receive a CRAFT pack, which contained a significant amount of information.

A lot of the information was data driven so that we would have that information available to us during our conversations with local folks. I didn't personally participate in collecting or monitoring data, but there were individuals doing that because they were feeding us that data on a daily basis in order to help us identify who we should be reaching out to during our interactions.

VB: LCDR Shaffer, did you have any firsthand interactions with this data analysis or was it more passed on to you in your decision-making?

KS: Just like CAPT St. Laurent said, there was a work group working behind the scenes, collecting this data and culminating it and organizing it into these CRAFT packs we received. I guess you could say we were the face of the CRAFT team. We were the ones that went out and made the connections. We were the ones who connected the subject matter experts from different organizations, and we actually had subject matter experts from ACL, ASPR, CDC, CMS, FEMA, HRSA, OASH on the phone with us. One showed up in person who was local, but for the most part, they were part of our virtual team, so we didn't culminate that data. We did not determine where we were going. It was based strictly on hotspots that were popping up. [The deployments] seemed to be related to, and CAPT St. Laurent can correct me if I'm wrong, but it was based on where they were at in different phases.

At one point we focused on the Health Department and schools, and then another part we were focusing on response and transportation and the Health Service. So, it really depended, as a lot of the students were going back to college, we dealt with more of the higher education. It seemed to be based on where they were in terms of their process of opening up or changing the

guidelines as to whether it was K through 12 guidelines, whether it was college kids coming back, whether it was testing, whether it was the Health Department. That was my understanding.

One of the things CAPT St. Laurent had mentioned is that we did a lot of culmination of data and information that we collected, that also went into a website on ASPR TRACIE. We developed resources, not only for our officers to use, but basically it was public knowledge that any college, any Health Department, any state had the ability to go out to this ASPR TRACIE website and look up these resources that we had culminated such as testing, how often to do it, what kind of testing, what the testing showed, how often that should be, how long they should quarantine.

We were the face of the CRAFT teams that went out and when we went out, we only went out for that specific period of time, we didn't have additional contact. We connected the subject matter experts from those other federal agencies, particularly the ones in their state, because they might say like a university might not have reached out to CMS in their state or their local CDC person or HRSA.

We made those connections sometimes, and they [the local jurisdictions] seemed very appreciative that now they had the [connections with] subject matter experts basically on their speed dial for lack of a better term. They could ask them technical questions. They [the local jurisdictions] felt they weren't getting unified messaging, and I think this really helped them develop that messaging not only across their community, but also across the state. We also collected some of the "best practices" and put them out there on that ASPR TRACIE site. So again, if a university was struggling with how often do they test, when do we quarantine, when do we send them home or keep them here? Just in that phase of opening up the schools, they

have the ability to go out and look at different best practices that other schools were doing that were being successful. We were the connector of the subject matter experts.

We actually deployed 234 interagency representatives from other Federal Agencies that I mentioned. We deployed to 83 communities in 32 states that were identified. Specifically, as CAPT St. Laurent said, hotspots that were popping up, that they were trying to gain data as to what they were doing, what they weren't doing. Collecting of information that was the other thing, how was the school putting data out on their website? What was that based on? We also created six technical resource pages on that ASPR TRACIE site that other people could access. Does that sound fairly accurate CAPT?

DS: Yes, that was a much better description than I gave. I do want to piggyback off of that because LCDR Shaffer brought up some really good points about making those connections. One more version of connections that was generated during these CRAFT missions was at the local level. It wouldn't be uncommon for us to be in a room with multiple places being represented, whether that was several different work groups of a university or maybe a Public Health official and EMS official and another official, and sometimes we were bridging a gap even locally.

We were putting people in the same room that maybe they were having one-on-one conversations with, but they weren't having potentially four or five different groups represented and having a conversation together. I did experience that a couple of times and I think it was a benefit of the mission to not only make the connections from the Federal and State to local level, but sometimes even at the local level, there were connections that were created.

KS: I would completely agree with that.

JS: This is a terrific overview of how this worked. I wonder if either, or both of you might be able to recall an example or two of this that you were involved in? What the local need was, without naming names of course, where the subject matter expert was located what the outcome of this of this connection was?

DS: Do you want to try that?

KS: Sure. I'll get started. I remember seeing it the most on the first two deployments where we were face-to-face, but there were several connections made with HRSA and the CDC. At the time there was a lot of questions about the testing. Which testing was best? Which one do you do when do you do it? What does it tell you? When does it tell you need to quarantine or not quarantine? What do you do with that information once you get it and how do you culminate it? On several occasions, more so I think in Peoria and Lincoln, Peoria the health department was the center of their COVID response locally.

They were a very strong Health Department and a lot of people really trusted the director there. They also had a slightly different framework in where the emergency management group was located. So instead of being this outside entity that got a lack of funding, so to speak, or the funding that was left over or was an afterthought, the Emergency Management Department was actually part of the Health Department. They understood the value of that emergency management on the local level, but it also filtered up because that emergency manager knew a lot more of the connections, but for the most part, those two, the Peoria and Lincoln, I think between the CMS and the CDC and HRSA, we made some connections on giving them information on

testing and answering those questions as to when and which one was better, and how long do you quarantine.

Again, not going into specifics of that as to who and how, I think we really made some connections. They took notes, they took down who they were talking to. They said, okay, we're going to follow up and we're going to connect with you after these meetings. And I think repeatedly we heard that on many levels all across the meetings that we had. Again, if you want to follow up CAPT St. Laurent?

DS: I agree. I don't know that I have any different or unique thing to add to it. I would echo LCDR Shaffer's points that I did see that we were brokering communication and opening up lines of communication that may be either weren’t open or were minimal prior to CRAFT. I will say as lead on a couple of the missions, part of that role, I was exposed to a lot more behind the scenes communications where maybe we visited a place during the day, we had some conversations and hooked up people back in DC, subject matter experts. But then the local folks would reach back out to me and say, Hey who is it that I should speak to regarding X, Y, and Z, or who was the HRSA representative again, I missed that person, or I have a question who should I speak to, and ferreting that out and triaging it to CMS or CDC.

LCDR Shaffer explained it very well, I think she said the USPHS was the face of the mission, and we were the boots on the ground. We were having the face-to-face dialogues. We were setting up those meetings going from place to place. But it was really with the intent of connecting the subject matter experts at the federal level, the state level, and the local level.

KS: Just to follow up with CAPT St. Laurent, one of the things I think was very helpful, and he had mentioned this prior, was the local people are used to doing things from the bottom up. The local would talk to the county and, or the state, and based on whoever they spoke to at the state level, their information was based on that state level person's experience or connections or the subject matter expert's connection and experience and the bubble that they brought to that situation.

When we came in, I don't want to say we sidestepped, because we didn't. We actually included the state, if they wanted to participate in discussions, but I think it also opened up that dialogue. It opened up that bridge to that bubble of information. I think we brought a much bigger bubble of information to the local level and gave them more possibilities of resource connections than say one or two people at the state level could have ever known, or connected them with. I think it opened up that bridge of information to different aspects that they may or may not have had experience with without our connections. That was just my feeling.

VB: Can either of you tell us a little bit more about the kinds of subject matter experts that you were able to put local officials in touch with. If you had to do research to identify who would be the correct person, or if you had rosters of all pre-identified SMEs that you could contact? If any of them were also Commissioned Officers or if they were almost more predominantly Federal Employees? Can you give us a sense of who these subject matter experts were?

KS: Vanessa, I don't mean to cut you off. This is LCDR Shaffer. I do have to get to my next meeting. I leave you in the best of hands with CAPT St. Laurent. He was the person that even after hours, he connected people with subject matter experts. So, I leave you in very good hands.

I greatly appreciate the opportunity of speaking with your group and if you need any additional information, feel free to reach out to me. I'm more than happy to help any way I can.

VB: Thank you so much. LCDR Shaffer, and we'll be in touch shortly.

KS: Thanks you guys.

VB: CAPT St. Laurent do you want me to repeat the question?

DS: Sure. Why not.

VB: Okay. I was wondering if you could give us a more of a sense of who the subject matter experts you were working with were and if you had to do digging to identify the right people, or if other people were helping to pre-identify SMEs? In general, a little bit more information about them.

DS: Sure. I think LCDR Shaffer identified many of the different agencies that were involved. I have a list in front of me ACL, ASPR, CDC, CMS, FEMA, HRSA, OASH, and USPHS. Generally speaking, when we received our CRAFT pack, which was the data for the next week's engagements, and we had a briefing prior to traveling to the next location. In that CRAFT pack there would already be identified SMEs for each of the teams. When I went to Peoria, there were three or four other CRAFT teams deploying at the same time to various locations. So, it wasn't like there was just my CRAFT mission one week, there were multiple CRAFT missions every

week during this timeframe. Each team had a defined list of subject matter experts or representatives from those Federal Agencies. So, when we set up meetings with the local jurisdiction those SMEs would be included in those meetings and they would virtually attend. They were there to participate in the conversation for the most part, occasionally they wouldn't be able to attend for one reason or another. But at least we had their name and their agency affiliation if we needed to reach back to them.

[00:39:58]

And then you asked were they mostly other Federal Representatives or PHS officers. Besides the folks on the ground leading the conversation, which were I believe a hundred percent were PHS officers, there were a few officers on that SME roster and it just depended because PHS officers exist in a lot of these different agencies. Occasionally the SME would be a PHS officer, I would say more often it would be not a PHS officer.

VB: Thank you. I also wanted to learn a little more about what the conversations were like. I anticipate that they vary quite a lot and there wasn't like a boilerplate conversation you had with every local representative that you interacted with. I'm curious about the breadth of response you got from local officials. I'm thinking that in hotspots in August and September of last year they had some pretty scary situations on their hands. I'd like to learn more about what the tone of the conversation was like. You already mentioned testing, certainly more information about testing was something high on their list of priorities. Were they struggling with promoting health literacy or common sense Public Health Practices like mask wearing and hand-washing? What

were the top priorities that they needed help with or anything else you care to share about the nature of those conversations?

DS: I'll take a stab at it, reign me back in or reroute me if I get off track. You're correct, the conversations were not pre scripted, though we went in with a number of questions and those questions would be on different topic areas such as testing or preventative measures or maybe specific to the higher education location challenges that they would experience.

We would go in with a pile of questions, but similar to how I'm presuming this interview's occurring you just go with the conversation and see where it leads you. I would say that some interactions were much more positive than others. There were interactions where it truly seemed like a collaborative effort, and then other interactions where maybe not so much. Maybe our presence was considered a burden or a hindrance. I would say for the most part interactions with Public Health Officials, Directors of Public Health Departments, EMS or other emergency systems were very open and collaborative.

I'm sure there's a significant political component associated with some of the interactions that we had. Again, some people were more receptive to the concept of this conversation than others. Generally speaking, because they were in identified hotspots, our focus was on mitigation strategies.

Specifically, what were different areas doing related to stopping the spread of the disease? Were there mask mandates? Were there curfews? Were there quarantine efforts in place? I think LCDR Shaffer spoke to it a bit when she talked about – I'm sorry, I lost my train of thought there. I will circle back, there were also conversations with local businesses, small

business associations, the local restaurant associations. You would get different points of view from different places on the appropriate measures that were in place for mitigation.

I will also say that one frustration that appeared to occur regularly throughout my experience in the CRAFT mission was local jurisdictions frustrated by the messaging that they felt was either inconsistent or confusing or not very clear coming from wherever, whether it was the White House [or elsewhere]. One of the biggest frustrations was messaging.

I think that also played into why these CRAFT missions were stood up in the first place was to get out there get those face-to-face interactions, make those direct connections, so that folks that had questions could get very specific answers. I will say, I received a lot of response from the local folks saying that they very much appreciated being able to interact with an SME at CDC, if you will, or CMS to get their questions answered directly.

VB: Thank you for sharing that's really interesting to learn about. I can imagine that there was a lot of tension and frustration imbued in a lot of those conversations. I also imagine that there was great relief to local officials by being able to have a direct line to experts, to clarify some of the confusion that they may have had.

You had mentioned earlier that one of the big issues, of course, this was September, right? So, one of the big issues was returning to campus or returning to the classroom for K-12 schools. And to the campus for colleges and universities. Could say a little bit more about some of the specific concerns surrounding that. Whether or not to have in-person classes or to mandate testing and how to go about doing that. Anything else along those lines that that the educational facilities were concerned about back in September 2020.

DS: Sure. I would say on each of the four geographical places I visited we covered elementary and high school education areas. And then a couple of instances, we covered institutes of higher learning, colleges and universities. It seemed from my interactions that everyone wanted to do the right thing. And had good intentions, but they just didn't always know what the right thing to do was. I don't know that anybody knew what the right thing was. What we would do is share experiences from other places. Places where they either were having declining rates, or places that were seeing some sort of relief. I know LCDR Shaffer mentioned this earlier sharing best practices or good practices from one place to another, whether that was at primary or secondary education levels.

I do recall a couple of the universities had a huge number of personnel devoted to responses, they would have these multiple work groups or task forces that were looking at communication strategies because on a campus you've got some unique scenarios with the shared housing, with the social life aspect of it.

Different universities at that time were approaching the return to school different ways either all virtual or mixed, or they would come in, but they would still be in their dorms for classes. So, in general, from my experiences, interacting with all of these different representatives, it really did seem people had the best intentions. I guess it just depends on what your underlying belief or acceptance of the science in the situation at hand was, which helps determine what you thought was the best approach.

VB: You also mentioned that you had a number of conversations with faith-based community leaders and I'm curious, on one hand, there's concern about the direct impact of the pandemic and how to keep people safe and how to hold religious services, especially regular services, but also a

funeral services in a pandemic context. But I also realize that a lot of religious organizations have stepped in to provide charitable services during the course of the pandemic to try to provide food or to offset the economic impact of the pandemic on their constituents. In regard to those kinds of conversations, what guidance were religious leaders looking for in terms of expertise that they could invoke in how they organized their routine and charitable activities.

DS: Yeah. I appreciate the question. Unfortunately, I'm probably not going to be able to speak to it in any great detail. I didn't have much experience with faith-based organizations. They were part of this effort and there were times where our deployment team might divide and conquer if you will, to reach as many people as possible. I personally did not have one-on-one conversations with faith-based leaders. But that said it was often they were represented through our conversations with other personnel that were present. For example, with the Public Health Director that LCDR Shaffer spoke of that had a very good reputation in her community. She had a number of people come in and out of those meetings from the community. I don't recall in that experience that any one of those we're a faith-based leaders, but that they had some insight into what was going on there. Either they worked alongside them regularly or more likely they went to that church and could speak to the experiences – how they were handling services and whatnot.

Additionally, at the university level, especially the larger universities where there's significant religious entities available for the students, I vaguely recall in that scenario, the largest university that I participated in a CRAFT visit that the faith-based community on campus didn't necessarily participate directly with the university in conversations about spread or mitigation.

They did what they thought was appropriate and the university did what they thought was appropriate. And I don't know that there was any sort of structured there whereby one group had the authority over another group to tell them what they did, what they should or should not be doing. All that is to say, I'm sorry, I can't speak any more specifically to faith-based organizations. Although I do believe some of the other CRAFT missions did have more specific interaction with those organizations.

VB: Thank you for that, I understand that you can only answer what you can answer. I'm curious, especially since this was such a new concept for PHS the role of the PHS in an emergency response. I was wondering if there were any past deployment experiences in particular that you drew on in helping you during this deployment.

DS: Sure. Just in general about experience and what to bring with them on deployment versus this specific experience I think is what the question is? I will tell you, at that point I had been with PHS for about 13 years, and though I often raised my hand I've I had never deployed with PHS before. I've always been on a tier three deployment roster so there's been instances where I was asked to deploy and I said, yes, and then for whatever reason didn't pan out. That said I think in general, my experience in the US Air Force being a nurse in particular, provided me a lot of resilience and ability to deploy successfully.

At the end of the day, and you'll hear this from anybody that deploys, the key is flexibility. If you are going to be rigid or inflexible, you might need to start looking for a different job. The role of a deployed officer can change from one day to the next, and it can be frustrating or aggravating. At the end of the day it is what you have to do, so you approach it as a

professional with best intentions. I don't have previous PHS deployment experience. I have had multiple training experiences, extended training experiences with both the Air Force and as a civilian nurse. And then in PHS which I think helped.

VB: From your career FDA, were there any particular experiences or skills that you drew on for this deployment?

DS: I told you I was a field investigator with ORA for about seven years in Denver. With that experience, you traveled frequently, and you interviewed and investigated from morning till night so you never knew exactly what you would find. And when you had these conversations, you followed where the conversation went, and I think that was very helpful. That experience provided me the ability to be flexible and have these conversations, be cordial and respectful. But at the same time seek to get information, seek to understand what it is the folks you're conversing with are experiencing and what resources they might be lacking that you could potentially put them in touch with.

VB: That's really interesting to hear, and I think important to get a sense of, what skills you need to marshal, and what qualities serve you best in an emergency response situation. I'd like to return to the point you made about always being willing to serve a deployment. This is the first one that you actually were sent on, and I imagine that in your 13 years with PHS regardless of not being actually sent on a deployment, you still have a perspective on how some deployments have impacted the corps. From that point of view, do you have any first blush perceptions of how the COVID response is beginning to impact the Corps or if it's too soon to tell.

DS: I think there's two sides to that coin. I would say that deployments are one of the main reasons that the Corps exists and as such every officer should be prepared and willing and able to deploy, and that those deployments highlight the value of the Corps to the general public most of which are still in the dark about who we are and what we do. I think the deployments are very important, not only in the role that they cover during the deployment, but also as far as showing value across the US and the world of this premier Public Health Agency.

The flip side of that coin is, and I just heard this tangentially occurring now in this COVID response time, is the impact on the individual officer, especially with multiple deployments with little respite. I think it can certainly cause some difficulty for an officer if you've got this large pool to select from. You've got some individuals raising their hand and willingly going back-to-back and then others maybe not so much in, of course everybody's got things going on in their life as far as families or work responsibilities or social, emotional welfare needs.

I guess the point there is I stress the importance of flexibility, and I think that being flexible allows you to roll with the punches and accept some of this. But then there's likely at some point a breaking point for some folks where it just becomes too difficult if there's not some respites in between lengthy deployment.

VB: It strikes me that that’s a really important point, that the magnitude of the emotional and physical impact of this emergency response on officers and that is a really significant factor in future response planning. I would love to hear from whatever you're willing to share about what sort of outlets you and your team had for relieving some of the stress of the mission or

opportunities for commiseration or just letting off steam. What sort of mental health supports were available to officers that you were aware of during your mission?

DS: Sure. The missions, when we were traveling, were pretty quick paced because you are either traveling or preparing for a meeting or consolidating your notes from the meeting constantly. And so the group you were with I would say you got pretty close to in that very short period of time because the teams would change from one week to the next and there wasn't much time during the course of the deployment for much downtime. There was no time for recreational activity. Your letting off steam was having dinner together and maybe having an opportunity to vent or commiserate during a meal.

Afterwards I know the PHS had Corps are available. I didn't I didn't reach out for any specific assistance, so I'm not honestly exactly sure about the breadth of their services. I think I was personally, and I would say for the teams I was on, I don't think during that period and none of us had been – you heard Kelli , she had been on a previous deployment in April, but then there were several months from that to the August deployment. Versus some of these quick turnaround back-to-back deployments. I don't think any of us were in instances where we were so overwhelmed that we weren't able to do our job and do it well. I would say that during deployment, there was very little time or opportunity to let off steam, and then after deployment, I did have a period of a few respite days. I forget exactly how many they gave us. But that was an opportunity to not have to jump directly back into the rigors of my day job, so that was helpful.

[01:01:09]

VB: I would imagine that one factor that really helps if not alleviate, at least offset some tension on a deployment, is having a really strong team people that you can count on. And the fact that PHS officers are drawn from across all these different agencies. On one hand you draw together all of these people with all these diverse skills that make the team stronger, but on the other hand maybe people you've never met before from a very different agency culture and work environment. I was wondering if you could tell us a little bit about how your team came together and jelled and a little bit about the composition who were your team members. You don't have to name names if you don't want to, but what agencies did they represent and what skills did they bring to the table?

DS: Each week was a different team which had its pros and cons. Like it if there's somebody that's difficult on a team and you're with that person for five weeks I can see that being challenging over time. Whereas if you go in and, you're only with a group for one week at the end of the week you'll be transitioning to a different group, your team composition will be different the next week that, but I don't think that's a significant risk. I think that it was difficult to be on a team of random members from one week to the next. During the course of one engagement, you would learn people's strengths where somebody was a better conversationalist or a better note taker, or based on their experience, you got to know they're a nurse or they're a pharmacist, or they'd be asking specific questions.

It was difficult in that you would work with this one team, get accustomed to everyone's strengths and idiosyncrasies, and then the very next week you have to start from scratch. I don't know honestly how the teams were generated because CDR Shaffer and I were on a couple of

weeks together. But there were other folks that transitioned, that weren't on our team that I would have on my team the following week. I think LCDR Shaffer and I worked together for two out of the five weeks, it may have been three but she was, I believe the only other person on the team, and the team would generally consists of four to five public health officers. I don't know if I addressed your question. I feel like I started rambling. Do you want me to focus back on something?

VB: No, that was, it was really informative to get a sense of what the team structure was like and that it changed so much in and of itself is really interesting to learn about. I'm wondering in a situation where your teams are changing weekly you really have to rely on predetermined reporting structures and policies and guidelines and so on and so forth. Did you find that the ICS was really rigidly adhered to during your deployment or did modifications have to be made given the nature that this craft mission was very unique and obviously you're interacting with people outside of government let alone PHS. Was the ICS a firm backbone of the mission of the CRAFT missions that you served on? Would that be a fair way to characterize it?

DS: Yeah I'll explain the scenario and then we can see if that addresses what you're asking. I do think there was a very good amount of structure related to the overall organization of the CRAFT mission. We would have daily communications with the group that was managing our teams on the ground. In that group I believe was out of ASPR, there were one or two individuals in particular that we would interact with. They would ensure that we were getting information as up-to-date as possible, and we were responsible for reporting directly back to them our experiences and addressing the questions that they had. That part was very clear. The CRAFT

mission itself, there was a lot left to the team lead to perform on the ground because you would show up and the day before you arrived, you would get a point of contact and that point of contact really could have been any sort of representative.

It could have been the Public Health Department Director. It could have been the chancellor of a university, it could have been a political representative for a county and you would reach out to them and say, Hey this is what CRAFT is, we're coming to your to your town tomorrow. Can you help start to set up meetings with different folks in that jurisdiction so we can have these conversations.

So in that space, there was a lot of uncertainty and flexibility and requirement of the team lead to create a rapport and some sort of structure. I would say from a team lead perspective going down there wasn't an organization that was set in stone. That was something that the team lead had to do. But from the team lead going up the chain there was plenty of organization and a reporting structure that was very clear.

VB: The fact that the White House Task Force was involved in the data analysis and determining where the CRAFT missions focus would end up. Did that impact the incident command structure at all, or the relationship with the task?

DS: From my perspective I did not have had any interaction with the White House Task Force. So the bubble, if you will, of how things were organized or mandated or decided or collaborated upon from ASPR up I was not privy to what was going on there. I would receive my marching orders from ASPR and then go from there.

VB: This is not specific to your deployment, but I'm curious, given your experience, if you have a larger perspective on the role of the CRAFT missions in this response. Are there any current CRAFT missions? Did they stop operating at a certain point? Do you have any visibility on that?

DS: A little, I can tell you there was a set of CRAFT missions that occurred prior to my involvement. I think though I'm not sure, there were about three to four weeks' worth of visits prior to my group coming in because we were affectionately known as a craft 2.0. So, there were missions prior to the CRAFT missions that I participated in. And then you heard during the course of my deployment, we went from two full weeks of physical CRAFT mission deployment visits. Then this week where there was some transition going on and we were working remotely from the DC area on CRAFT mission information. And then the following two weeks, all the CRAFT missions I believe had transitioned to virtual meetings. And then when we finally rolled off of that final virtual meeting, I am not aware of any additional CRAFT branded missions that continued to occur. I do think that it transitioned into a different concept. We went from this boots on the ground face-to-face interaction to virtual interaction. Then it was co-leading all the resources that we had generated and making them available, and that's the website that Lieutenant Shaffer was talking about. Making those resources available to the general populace to local health officials. I don't think there were continued interactions as involved as the CRAFT missions, after my deployment ended.

JS: CAPT, I wanted to revisit a point you had made about working on site with this CRAFT effort versus the virtual work. Can you compare what your role was virtually versus what it was

on site? Was there someone on site carrying out the role that you had previously when you switched to a virtual deployment in your last two sites?

DS: I would say the role of the CRAFT members, and the lead in particular was the same, the experience was much different. When you're speaking to someone face to face in a conference room, you get the body language and the personal connection there's a lot more openness, and willingness to share and willingness to hear suggestions or feedback or opportunities for improvement. The virtual situation was much more difficult.

I will say when we were deploying physically, the majority of the Federal force was still participating virtually. They were calling in from the DC area the SMEs and POC, but we were on the local jurisdictions turf, we were there, we were physically present and you're trying to create a relationship. When we went to a virtual visit now everybody's in different times zones because me as a team lead on the east coast, I'm trying to coordinate with Texas or Utah or anywhere else. And it was much more difficult to have open and candid conversations in the virtual environment.

And honestly, you didn't ask about this, but I will add this, and it goes back to the whole concept of being flexible. I'm sure that the virtual visits were probably easier for some PHS officers to fit into their life and probably more difficult for other officers. For me, in particular, it was more difficult to do a virtual deployment concept because I'm still at home with family and animals and they [may not understand] the demands of this 24/7 deployment tempo, which was an expectation of the deployment team during the virtual timeframe.

Whereas when I'm completely removed from the home environment, personally in my scenario, it's, I think it's much [more straightforward]. It was easier on the family and me to

focus on what we needed to accomplish during that time. But I do believe that it was probably just the opposite for many officers. It was probably easier maybe from a social, emotional welfare standpoint, for them to be virtually deployed versus physically deployed. [Definitively, each scenario has its pros and cons.]

VB: Before you shifted to virtual deployments, you had a unique experience where you got to visit Illinois and Nebraska, both of these places being hotspots. Could compare what it felt like, let alone what your more sophisticated reflections on the pandemic may be at that point in time. But from DC to Illinois to Nebraska what was the same and what was different about the pandemic last September?

DS: At that point, I had followed very strict guidelines for safety and mitigation. I was not traveling at all, so it was surreal to put on a mask and walk through the airport and then be on an airplane in that time. I will say there were instances where it felt very different from my local community because I had been out [very little, really only for essentials such as] the grocery store. But then going out to some other places where mask mandates, weren't it either they weren't in place, or they weren't strictly enforced, or the community didn't feel like they had the ability to enforce them.

I do recall going grocery shopping while on deployment and though there was a mask sign before you entered the grocery store, I would say probably 50 to 75% of the individuals in the store did not have a mask on, which was eye-opening to me because I just thought that we were all living in this experience and participating in the same mitigation techniques together.

But, getting out on deployment I was outside my bubble, and I did interact with many people that had different views of the experience than I had.

VB: I realize you were had shifted to virtual by the end of your deployment, but I was wondering if you could tell us a little bit about what it was like to transition out of your role as a responder and back into your normal tour of duty and your home and so on and so forth. I think you said you took a couple, a days of respite before you returned to duty. Did you quarantine? Did you get testing? Did you do anything particularly restorative or relaxing to help ease the transition back into your FDA role?

DS: Just putting a little bit of a spin on it in, we would travel back to our home on Friday. On the Fridays of the weeks where we were physically going places. And then we'd be doing work on Friday evening and Saturday, and Sunday, and then fly back out on Monday. So, I was coming home after being out at a hotspot for a week, and that was a difficult space to be in because like I said, my family and I were trying to adhere to all the recommendations at the time. Even during deployment, when I would come home, I was quarantined or isolated within my home, separated from the family as much as possible.

And then when I returned for good, after two traveling experiences, I remained isolated in a portion of the house as much as possible. I did not get tested, but during the final three weeks of that deployment I would have been isolated in my own home regardless. And we were doing daily temperature checks and I never experienced any symptoms of concern.

All that is to say, when the deployment ended, I had already been isolated for a few weeks. And I felt like I could safely transition back into the regular home environment. And then

in between the having the deployment end and getting back up to my FDA job I don't know that we did anything particularly restorative. It was just nice to be home and not isolated and be able to walk around the neighborhood and play with my family. And then the transition back to work itself was pretty difficult. From a workload perspective. We all have different roles in our, in the job in our day job and I wouldn't say that mine is any more or less stressful than anyone else's.

I think they all have their own unique stresses, but when I came back, I had a significant amount of work and it was difficult to get back into the swing of things and pick up some balls that had been dropped, figure out where some projects had progressed to or stalled, figure out what needed to be done in order to get things back on track. I would say, for a couple of weeks, it was difficult to get back into the swing of things at my FDA position.

VB: Were there other officers in your office or your immediate team that also deployed? I know that there's been a lot of challenges with shifting workloads for teams that have multiple commissioned officers that have gone on deployments.

DS: Yes, my office, The Office of Science, has deployed the majority of the PHS officers, and some of them multiple times. For me in particular, where I sit in the organizational structure, I'm the Branch Chief of a group of people and no one else in that group is a PHS officer. So, when I left, I left a leadership position vacant, and it was filled in by some of my staff. But there weren't multiple people from my staff that were deployed at the same time or otherwise deployed because there's nobody else in my branch that's a PHS officer. But again, there are multiple officers in the Office of Science CTP, and they've continued to deploy us. I think that if any one space had multiple officers deploying, it would be more of a significant burden on that business

entity. But with the officer spread out the way they are I'm not sure that's the case, I don't know for sure.

VB: I wanted to ask in closing, piggybacking off of the question I asked earlier about, how this response has impacted the Corps. Do you have any insights into key takeaways or lessons that we can take from this pandemic that would be useful to fellow officers or to the Corps in general, in responding to future emergencies?

[01:20:57]

DS: I'll take a stab at it. I'll go back to the concept of flexibility and flexibility does not mean that you can't get frustrated, or you can't be annoyed, but it does mean that you've got to be willing and able to roll with it, and to understand that things change and that you can only do the best that you can do, but you need to do the best that you can do. Additionally for the Corps in particular, I looked back at the dates of when I was notified, and I was rostered for deployment. I was notified on the 25th and I was deployed three days later and during that space I had very little information provided to me.

I think that regardless of the information people are more willing and accepting and understanding of a scenario if they're provided with as much information as they can get. And sometimes providing them with information, creates more questions, but I think that being left in the dark can generate much more anxiety than is beneficial when someone's preparing to deploy and has a lot of unknowns and unanswered questions.

VB: CAPT St. Laurent I want to thank you so much for taking the time to speak with us today and to give these memories to the historical record. Most of all, thank you for your service. If there's any final comments you'd like to make, I'd love to give you the opportunity to do that, if not, I'll go ahead and close out the recording.

DS: Okay. No, I don't have anything else. Thank you so much for the opportunity. I really appreciate it.

[END OF INTERVIEW]

Deed of Gift