Organized Chaos in Disaster

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EXECUTIVE SUMMARY:

A disaster, pandemic, or other crisis, by definition, exceeds the capabilities of local healthcare workers and first responders to provide necessary care. During the 2009 H1N1 pandemic, in some areas of the country, hospitals turned to field tents for patient care and activated volunteer medical responders, such as the Medical Reserve Corps. The Federal government's pandemic preparedness plan dictates that states must be able to provide for themselves at least during the initial wave. This means that state preparedness planners must build in surge capacity.

In many disasters or pandemics, the mental health footprint is significantly larger than the medical footprint. For example, following the September 11, 2001 terrorist attacks, an estimated 228,000 people required medical attention; 50 times as many persons required mental health support.[1] The so-called worried well and those with real mental health distress or disorders can easily over-run the existing mental health system.

The Kentucky public health system finds itself with the responsibility and obligation to provide for the community's needs through the establishment of shelters for the special medical needs population in the event of disaster or pandemics. In caring for those individuals and for responders, the arena of emotional wellness must be addressed and provided by the public health system and we find ourselves ill equipped in that regard.

The goal of the project/deliverable is to provide a framework to both state and local public health agencies to equip their staff and develop policies which will allow the system to attend to complex emotional first aid needs of the community and to the responders of disasters. While training and structure is early in its conception, it begins to provide a systematic approach for agencies to create competency in their staff. Through a special project of the University of Louisville, there are collaborative partnerships being formed for an evidenced-based training model of psychological first aid which Kentucky public health will be able to access and implement.

INTRODUCTION/BACKGROUND:

The Federal Emergency Management Agency (FEMA) mission is to support citizens and first responders to ensure that as a nation we work together to build, sustain, and improve our capability to prepare for, protect against, respond to, recover from, and mitigate all hazards. As part of that mission, FEMA developed the National Response Framework (NRF) which presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies – from the smallest incident to the largest catastrophe. As part of the NRF, Emergency Support Functions (ESFs) are primary mechanisms at the operational level used to organize and provide assistance. The purpose of ESF 6 is to coordinate the delivery of mass care, emergency assistance, housing, and human services when local, tribal, and state response and recovery needs exceed their capabilities.[2]

In 2009, Kentucky public health adopted and became charged with the operation and management of Special Needs Medical Shelters (SpNS) under EFS 6. Until this point in time, public health had never been taxed with the operation of any type of shelter in times of disaster or emergency and had only served in those capacities on a voluntary basis as a resource of support for shelters managed by other community partners. Per FEMA, Kentucky had four federally declared disasters in 2009, being one of the highest number of disasters on record for the state.[3] The first disaster of 2009 was the worst natural disaster in Kentucky with a winter ice storm that gripped the state leaving over a half million without power, 200,000 without water, at least 172 shelters open, and many deaths as a result. According to Governor Beashear's office, 90 of 120 counties declared emergencies and the crisis was compounded by the lack of communication as downed towers and lines made it very difficult to assess conditions to target relief.[4] Only in the midst of this disaster, did most local public health fully have the realization that the establishment of SpNS was the local public health responsibility; therefore, many agencies had no knowledge or experience to even begin to tackle the awesome responsibility of supporting individuals and communities facing disaster.

As a result of the ice storm of 2009 and being faced with the ESF 6 responsibilities, local public health began to aggressively pursue a path to improved understanding and ability to manage the ESF 6 tasks. During the past year, emergency preparedness planners, public health administrators, agency staff, and state emergency operations/preparedness staff have closely examined and worked towards defining how to best support the communities in a disaster through mass sheltering of the special medical needs population. Through this work, it has become clear that there is a multitude of needs in communities thus a large framework and support system must be in place to deal effectively with individuals and the community as a whole. One significant issue identified is providing resources and services for psychological first aid needs when disaster occurs.

Problem Statement:

Why haven't special medical needs been met in disaster shelters effectively?

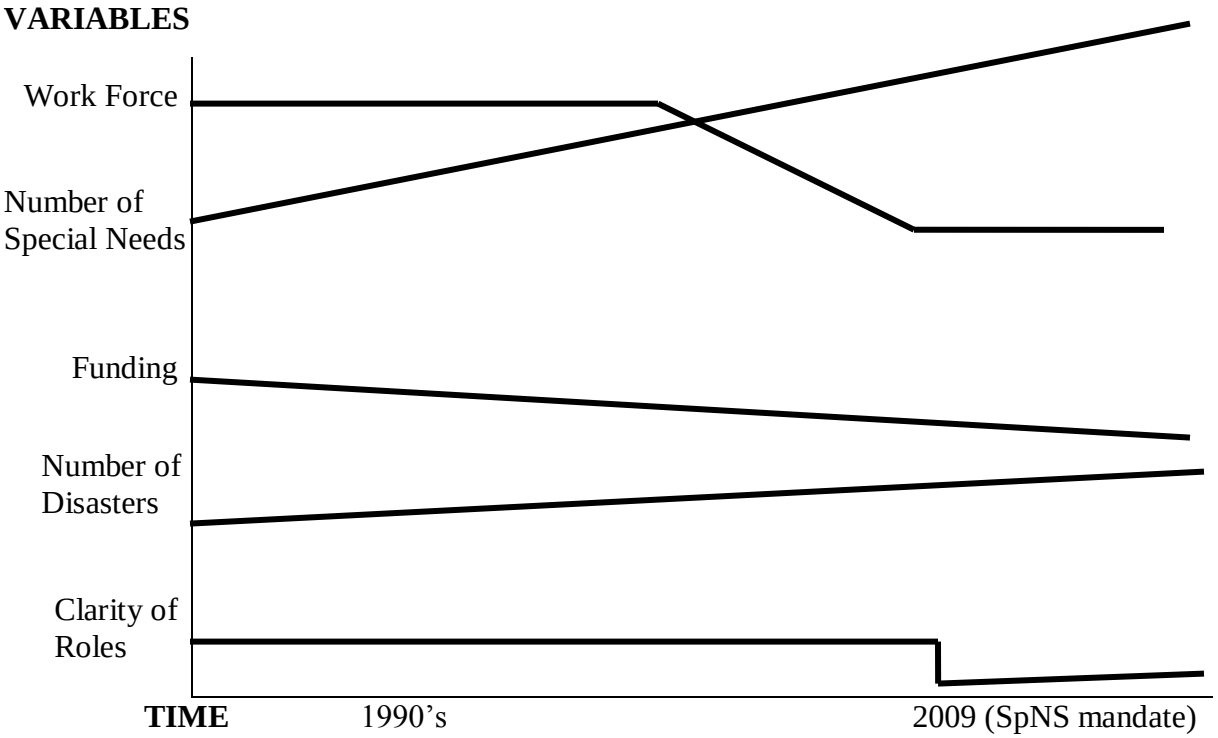
The problem statement elicited many different directions which a project could support thus upon survey of current work being done by other public health groups at this time, one area which did not appear to be addressed thus far was the psychological first aid needs of individuals and communities being sheltered. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.[5] Mental health needs are exacerbated by crisis and all individuals will have some type of emotional impact from a disaster, regardless of prior mental health history. Disasters unavoidably impact survivors both psychologically and socially.[6]

The following guiding principles, as defined by Center for Mental Health Services, form the basis for beginning to understand and develop disaster mental health intervention programs.[7]

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma-individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Disaster relief assistance may be confusing to disaster survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and non-profit agencies' disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.

Hence, the problem statement addresses the special medical needs of social/emotional well being which contributes to the overall health and wellness of individuals and communities.

Behavior Over Time Graph:

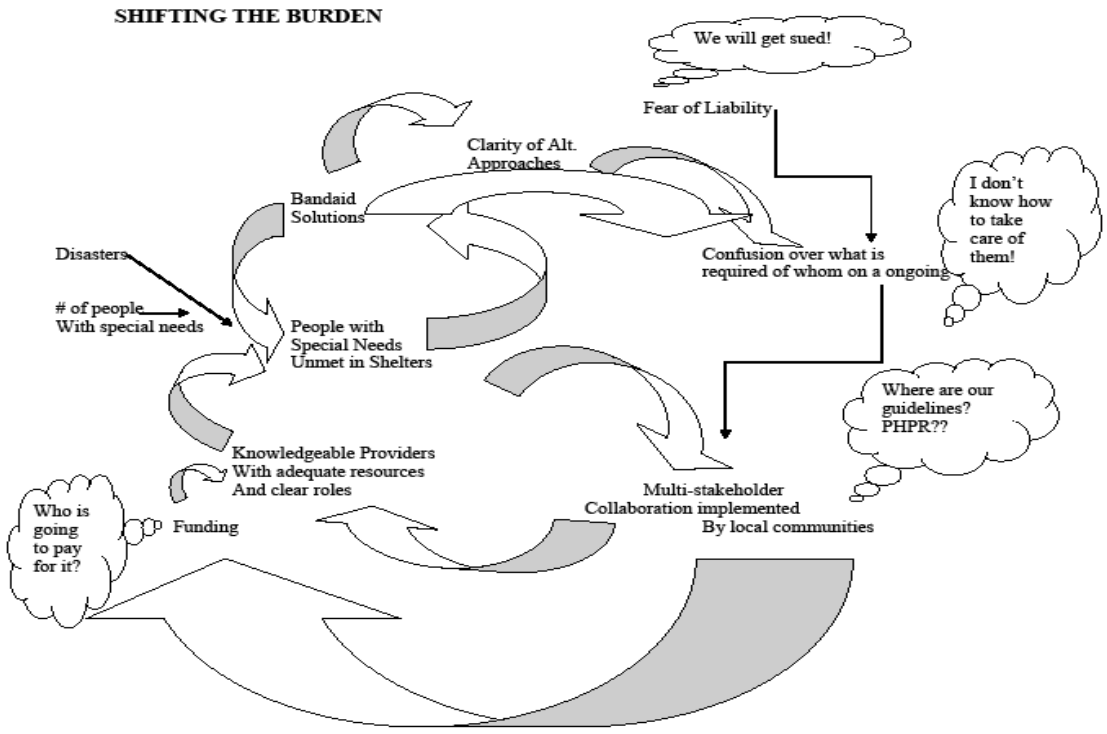


- Work Force – The public health work force has been strong at different points, but in the last three to five years, there have been a high number of retirements and a streamlining of programs. With the retirements, public health has lost a wide berth of knowledge and experience. Due to economic decline and

restructuring of staff, the number of individuals to support programs is not optimal.

- Number of Special Needs – This references the high number of individuals with special needs. This population has grown due to improvements in health care extending life, meaning more individuals living longer with more medical care requirements.
- Funding – Due to the economy and budget shortfalls, programs in public health have been cut across the board. The operation and management of a SpNS for public health does not have special funding or a general fund set aside to support the operation of shelters; therefore, funding would have to come from current revenue and reserves of local public health agencies already facing budget cuts for other programs.
- Number of Disasters – The number of disasters is up in Kentucky.
- Clarity of Roles – Public health role in SpNS has been unclear as roles, objectives, templates, guidelines, protocols have never been formally established.

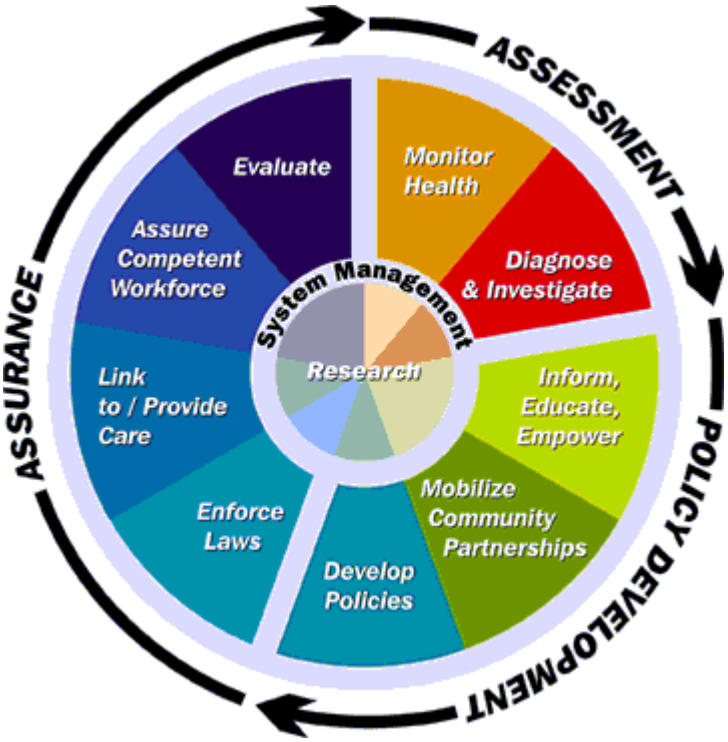
Causal Loop Diagram:



As disasters and the numbers of individuals with special needs have increased, public health has been unable to fully meet the needs of communities or the assigned special medical needs functions. In public health's early attempts at establishing SpNS, we have attempted Band-Aid solutions as a result of lack of knowledge on various fronts, including: poor clarity of public health roles and staffing, lack of knowledge about how

to operate and manage a SpNS, limited understanding of what truly defines or constitutes "special medical needs", and confusion over what is required by who. To exacerbate those issues, public health must address the social and emotional issues facing individuals in crisis and support individuals as we plan for discharge from shelters. Funding is another significant concern for public health due to budget constraints and no supplemental funding available to manage SpNS. Multi-stake holder collaborations, clear protocols, guidelines for the operation of SpNS, and ensured funding streams would allow public health to begin to provide for individual and community needs in these situations.

10 Essential Public Health Services/National Goals Supported:



Psychological First Aid (PFA) and the availability of effective mental health resources during a disaster are vital to comprehensive public health. While generally categorized under emergency preparedness and response, PFA can be linked to any of the 10 Essential Public Health Services (EPHS). For the purpose of the Change Master project, one can juxtapose EPHS to several with direct correlation to elements of the project.

- EPHS #1 (Monitor health) and overall assessment applies to not only populations at-risk or persons exposed to emergency situations, but also to the public health practitioners who respond. If the mental well-being of both the public and the responders is neglected, the initial problems will only be exacerbated and require more resources and time to fully address. By garnering mental health resources

into a single guide to be used and expounded upon by local health departments, we seek to improve assessment efforts during emergency response efforts.

- EPHS#3 (Inform, Educate, and Empower) can be observed in goal of the Change Master project as the awareness and knowledge of local health departments will be enhanced. Complimenting the preparedness training, our mental health resource guides will directly improve the health related outcomes of the public during often tumultuous response efforts while also decreasing stress levels of responders. By informing, educating, and empowering all; public health programs and policy development can improve. During the 2009 Kentucky Ice Storm, limited to no information complicated already complex response issues, the Reference Guide for Kentucky Public Health – SpNS: Meeting the Emotional and Social Needs will assist in easing that burden.
- EPHS#7 (Link to/ Provide Care) connects PFA to the 3 other EPHS (Enforce Laws, Assure Competent Workforce, and Evaluation) associated with the core function of Assurance. When responding to any public health situation, it is critically important to fully understand the situation, have the needed resources to amend the problem, effectively apply those resources to the situation, and then evaluate the outcome. Too often due to the compartmentalized nature of public health, the disconnection occurs when responders are not connected to valuable resources. In a disaster, the disconnection between the state and local health departments could significantly hinder a response. The Reference Guide for Kentucky Public Health – SpNS: Meeting the Emotional and Social Needs will assist in bridging that gap.

PROJECT OBJECTIVES/DESCRIPTION/DELIVERABLES:

The primary objective of this guidance document is to support local public health departments with beginning to understand and address mental health and emotional first aid needs in a disaster. In addressing this objective, a deliverable is offered to public health in the form of a Reference Guide for Kentucky Public Health – SpNS: Meeting the Emotional and Social Needs which will support public health with:

- broad general framework for identifying those who need general psychological first aid versus intense mental health support,
- listing of current training resources to support staff with disaster mental health needs prior to comprehensive training,
- resource list of publications available to public health regarding disaster management and mental health,
- a recommendation for a standard of care in providing psychological first aid and the training tools available to ensure competency of that standard,
- a protocol for public health to train staff to build surge capacity within their own agency/state for times when support beyond local resources is required,
- and a writing guide for Memorandum of Understanding and sample memorandums of understanding which can be used by local public health

agencies with community partners in developing relationships to plan for disasters.

METHODOLOGY:

Psychological First Aid (PFA) is a growing concern in the field of public health due to the rising number and increased severity of natural and man-made disasters. The body of scientific literature and resources is increasing as a result of more studies related to various components of preparedness and response activities and unique interventions that have been developed to address these emergency situations. Several methodologies were utilized in developing the report and the deliverable. Through the use of different methodologies, a more complete picture of current resources and quality standards became apparent.

Two different types of literature review were completed and a review of online training courses. Initially, a literature review was completed to allow best practices of psychological first aid to be identified for consideration in training guidelines and recommendations. An additional literature review allowed the building of a resource guide of publications to be developed of interest to public health addressing social/emotional issues in the event of a disaster.

In combination with the literature review recommendations, TRAIN (TrainingFinder Real-time Affiliate Integrated Network) modules regarding disaster mental and psychological first aid were accessed and completed. Guidance from an experienced practioner was solicited to identify noteworthy trainings from an evidence-based practice perspective. A content analysis was conducted of the existing trainings using the key words Psychological First Aid and/or Disaster Mental Health. The results were then used to develop a listing of recommended and supplemental trainings available.

Four different types of information gathering methods were used during the process. Initially, members met with a regional public health preparedness planners group for identification of their view of the most pressing issues facing the SpNS. As a result of that discussion, a team member joined a state work group of administrators and leaders who had tasked themselves with addressing the various concerns of the operation of SpNS. The three other methods to identify current surge building capacity within local public health, included:

- HANDS (Health Access Nurturing Development Services) coordinators shared their staff educational demographics
- a survey via SurveyMonkey with Kentucky Public Health Directors to request insight regarding staff demographics and current level of training of staff in psychological first aid
- information request with the local health personnel branch to identify staff who could be recruited for an initial wave of psychological first aid training based on the staff person's educational background, i.e. human service professional area.

The final layer of research involved members contacting state level human service professional organizations. The purpose was to ascertain the level of support with psychological first aid which could be offered to local public health agencies in the event of a disaster. To determine what professional associations may be beneficial to public health during disaster, the first step was to examine the licensing boards that are operating in Kentucky. Nine professional associations were located in the state and are as follows:

- Kentucky Psychological Association [KPA]
- Kentucky Chapter of the National Association of Social Workers
- Kentucky Play Therapy Association
- Kentucky Music Therapy Association
- Kentucky Art Therapy Association
- Kentucky Association for Marriage/Family Therapy
- Kentucky Mental Health Counseling Association
- Kentucky Counseling Association
- American Association of Pastoral Counselors

After locating the applicable licensing boards throughout the state, an Internet search was completed of the pertinent associations. The Executive Directors of the associations were then contacted either via email or telephone. A questionnaire was developed to guide conversations assessing what services their association's members could or have offered to public health during times of disaster.

RESULTS:

Literature Review:

A literature review was completed from the following sources: Pub MED, the Centers for Disease Control & Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Pub MED Literature Review Findings:

The Johns Hopkins University School of Medicine and Center for Public Health Preparedness are conducting several projects to address certain elements of psychological first aid (PFA). Three papers present direct support for the use of PFA with personnel outside of the mental health arena, specifically public health professionals. The first literature review suggests that PFA is one aspect of the psychological continuum of care and strongly recommends the training of public health, public safety, and other disaster response personnel who have not received formal clinical mental health education to assist with response efforts.[8] The second paper discusses the importance of addressing physical and mental health needs during a full-scale public health response to disasters. It describes psychological first aid as the provision of basic psychological care in the short-term aftermath of a traumatic event and a skill set that public health professionals can

acquire via proper training. The recommended application of PFA could ameliorate front-line community-based mental health responses during a crisis event. To ensure credibility and effectiveness, the training would be based on competencies from best practice models and consensus statements from leading mental health organizations.[9] The third paper suggests that during a disaster psychologically-related complaints can outnumber physical symptoms stemming from injury-causing agents or events. Based on this idea, the synergy of mental health training and the experience of client/patient services would allow public health professionals to serve as gatekeepers. This is highly beneficial to the process of early mental health intervention and more efficient appropriate referrals to mental health specialists.[10]

A Walter Reed Army Medical Center, Department of Psychiatry publication describes the psychosocial or medical consequences (i.e. anxiety, fear, chaos, and disorder) that first responders to emergency situations become susceptible to. This paper recommends proper training and preparation, as opposed to psychotropic medications to reduce symptoms and enhance the delivery of care during a response effort. Comprehensive prevention strategies could benefit both high-risk groups: first responders and healthcare providers.[11]

The University of Southern California's Keck School of Medicine published a paper discussing the benefits of integrating mental health into disaster preparedness to other vulnerable populations- children, adolescents, and their families. The article summarizes that the inclusion of mental health concerns prevents further and unnecessary psychological harm to children and adolescent survivors following a disaster.[12]

In the review of the literature, it is important to know that research regarding Critical Incident Stress Management (CISM) was examined as well. Due to mixed findings regarding the effectiveness and benefit of CISM, it is not being suggested as a training component at this time. In general there was no change in symptoms of distress or protective effect for individuals who received CISM.[13]

CDC Literature Review Findings:

The Centers of Disease Control and Prevention (CDC) have taken great interest in the effects of participation in emergency response efforts. While the agency has been integrally involved in many international disasters in the past, the attacks of September 11, 2001 stimulated a deeper and stronger dedication to emergency preparedness and response. Psychological health and well-being for health professionals and the at-risk communities is one element of that comprehensive approach which is being researched in detail.

A search of the CDC's resources produced three findings through news article and resource guides. The CDC news article describes the growing concern of CDC's Office of Health and Safety (OHS) and the National Institute of Occupations Safety and Health (NIOSH) in regards to protecting deployed staff. A pilot training, Deployment Safety and Resiliency Team (DSRT), was developed by CDC behavioral scientists to equipment

response team members with training on resiliency (psychological first aid, stress management, coping peer support, and assessment and proper referral protocols) and safety (customized versions of disaster site worker training and collateral duty for federal workers). With the support of the Center for Traumatic Stress at the Uniformed Services University of the Health Sciences (USUHS) and Virtually Better, Inc., this training material was infused with virtual reality equipment and is currently being piloted through CDC Emergency Operations Center (EOC).[14]

The first resource guide, Disaster Mental Health for States, provides basic information on psychological conditions and rationale during a disaster like the ABC's of PFA (Arousal, Behavior, and Cognition), community demographic characteristics, cultural groups, socioeconomic factors, mental health resources, government roles and responsibilities, nongovernmental organizations roles and responsibilities, and community partnerships. A detailed example of a state's mental health association response to a bioterrorism event is also provided describing the pre-event, response, and recovery phrases.[15]

The Coping with a Traumatic Event resource guide has versions created for both the general public and public health professionals. This resource provides helpful information to assist in the response to disasters such as common responses to a traumatic event (behavioral, cognitive, emotional, and physical), tips on how to interact with patients, guidance on what you can do to help patients cope, information on populations at risk for severe and long-term reactions to trauma, recommendations on what you can do to treat patients in response to a traumatic event and general information to increase awareness of what those involved in those disaster maybe experiencing mentally.[16,17]

SAMHSA Literature Review Findings:

The Substance Abuse and Mental Health Services Administration (SAMHSA) search produced findings for multiple documents. Several informational documents provide tips for emergency and disaster response workers and a linkage to the Psychological First Aid: Field Operations Guide - 2nd edition produced by the National Child Traumatic Stress Network of the National Center for Post-Traumatic Stress Disorder were the prominent findings. This very detailed document provides information on Preparing to Deliver Psychological First Aid and Core Actions. The Core Actions section includes: contact and engagement, safety and comfort, stabilization, information gathering: needs and current concerns, practical assistance, connection with social supports, information on coping, and linkage with collaborative services. Additional appendices are provided that highlight supportive information such as overview of: psychological first aid, service delivery sites and settings, PFA worksheets, handouts for survivors, and other duplicate handouts to copy and distribute.

SAMHSA provides access to many resources that directly or indirectly influence mental health during and after disaster responses. Many of these resources were created to be used as field guides or quick references. The topics of these resources include: A Guide to Managing Stress in Crisis Response Professions, Communicating in a Crisis: Risk Communications Guidelines for Public Officials, Developing Cultural Competence in

Disaster Mental Health Programs, Disaster Counseling, Disaster Mental Health: Crisis Counseling Programs for the Rural Community, Field Manual for Mental Health and Human Service Workers in Major Disasters, Managing Stress: Tips for Emergency and Disaster Response Workers, Mental Health All-Hazards Disaster Planning Guidance, Psychological First Aid: A Guide for Emergency and Disaster Response Workers, Psychosocial Issues for Children and Adolescents in Disasters, Tips for Emergency and Disaster Response Workers: Managing and Preventing Stress, and Tips for First Responders: Possible Alcohol and Substance Abuse Indicators.

Publication Literature Review:

A literature review was completed to identify publications available to public health agencies which they could download or order to use for staff training, community outreach, and/or to support the emotional first aid needs of individuals. There are significant resources available for agencies and a complete listing from reputable organizations was gathered and is available via the Reference Guide.

Online Training Modules Review:

Of the TRAIN modules, a list of preferred modules has been prescribed to give guidance to public health to train staff while moving towards a more comprehensive and complete training component. After the content analysis was conducted, there were 34 trainings identified on TRAIN in relation to Psychological First Aid and/or Disaster Mental Health. With guidance from mental health professionals, it was determined that 3 trainings were significant to the overall deliverable. The other 21 trainings provided vast knowledge; however, they were not specific to Psychological First Aid and/or Disaster Mental Health. These additional trainings could be used as supplemental information. During the Change Master process, more information was gathered about the specifications of professionals responding to crises. Crucial to the training piece of responding to a disaster is the fact that FEMA has required courses for responders. At a minimum, these three courses are:

- FEMA IS-100.a: An Introduction to Incident Command System (ICS)
- FEMA IS-200.a: Single Resources and Initial Action Incidents
- FEMA IS-700.a: National Incident Management System (NIMS), An Introduction

As public health employees, further trainings are required through FEMA periodically and the aforementioned are applicable to those requirements.

Information Request Results:

The regional group of public health preparedness planners shared many thoughts and concerns in regard to the broad area of SpNS. One of the concerns identified more than once included how to best address the mental health needs of individuals in a disaster.

The other information requests all sought to identify what the capacity of staff and agencies were to either address the emotional first aid needs of individuals currently or to begin to train staff towards that component. The requests sought to identify "hidden" resources or pools of individuals with a human service background within local health departments who could be targeted for the initial waves of a comprehensive training program. Those results while not accurate in entirety due to overlapping nature of different people providing the responses did reveal an underestimated group of staff.

The reports from HANDS coordinators identified approximately 50 individuals serving in HANDS roles that have a human service degree. The information provided from the local health personnel branch found 49 individuals indentified as having social work or social science degrees. The similarities between the results of the HANDS administrators and personnel could indicate some overlap between those identified depending on how the HANDS staff were classified, i.e. HANDS staff might be classified as program specialist in the personnel program while holding a social work degree.

Public health directors responded to a survey that identified several interesting pieces including:

- The majority of responders' agencies did not have experience in opening a SpNS.
- Most of the agencies would depend on providers outside of the agency staff to provide for mental health support during a disaster or in the post-emergency care of the disasters.
- Only 8% of responders reported LHD staff trained in disaster mental health.
- In the responding agencies, directors identified 67 staff with human service background degrees.

Professional Organization Findings:

Although all nine of the associations were contacted, some representatives were not available for discussion. Three of the associations referred back to the Kentucky Community Crisis Response Board (KCCRB) as the primary association to contact in times of disaster. In Kentucky, the KCCRB has the official designation to respond. Also, KPA employs a Disaster Response Network that has been called upon to assist in other states during times of disaster. Looking towards the future, in a related project by Scott LaJoie, PhD, MSPH, of the Health Promotion and Behavioral Sciences School of Public Health and Information Sciences at the University of Louisville, work is being done to expand the pool of training recipients to include licensed mental health professionals throughout the Commonwealth, representing each professional association. Thus, further exploration of these untapped resources could prove beneficial in the upcoming years as another alliance to turn to in the event of a disaster.

CONCLUSIONS:

The overall conclusion of addressing the problem statement of "why haven't special medical needs been met in disaster shelters effectively" can certainly be defined in a

variety of ways. The emotional needs of the population will be one of the more significant concerns. Mental health intervention has become a valued dimension of immediate and long-term disaster response. Psychological recovery is recognized as a focus for relief efforts, along with repairing homes and rebuilding bridges.[18] As noted, all individuals are impacted by disaster and thus public health as a whole must be prepared to address those concerns. With research demonstrating that this is a new arena for Kentucky public health, it necessitates that public health become equipped to manage the emotional needs of the community to effectively provide for the care required under ESF 6. An approach that trains staff to understand and address the psychological first aid needs of individuals is essential. Due to limited resources available for the entire state and the scope of need, a reference guide for Kentucky public health was developed in effort to provide administrators and direct staff with the essential tools for skill development. The reference guide provides a format for beginning to understand the complex emotional first aid needs of individuals and the community as well as provided resources and publications for additional support and review. Specific tools for training have also been defined per the reference document.

A project led by Dr. LaJoie is focused on working with colleagues and community partners to develop a comprehensive approach to assuring a quality driven response to the delivery of psychological first aid. To meet these objectives, LaJoie and his team will perform several, often overlapping steps:

- Identify and establish collaboration with Kentucky mental health provider networks or associations, such as the Kentucky Psychological Association and the National Association of Social Workers – Kentucky.
- Establish collaboration with the KCCRB, the developers of TRAIN, and the gatekeepers of K-HELPS. (See below).
- Survey Kentucky mental health providers to assess disaster mental health training, facilitators and barriers to volunteerism, and willingness to commit to respond during a disaster or pandemic.
- Develop new or refine existing education modules (hosted online at https:www.ky-TRAIN.org and elsewhere) so that volunteers are taught best practice approaches to providing psychological support to victims.
- Recruit and train mental health volunteers from across the state. Register the volunteers with KCCRB and credential them through K-Helps.
- Develop a Geographic Information System (GIS) database that maps the location of all mental health volunteers. Layers of information will be made available for each volunteer.
- Incorporate into this GIS database the current list of all KCCRB mental health volunteers.
- Link this GIS database to the real-time decision support system being developed in other phases of the grant project.
- Create a mechanism that maintains the currency of this database and motivates volunteers to stay involved.

This process will assure a standard of training for all public health agencies which will provide the desired quality of care and ensure Kentuckians' emotional first aid needs are fully and adequately addressed.

LEADERSHIP DEVELOPMENT OPPORTUNITIES:

Amber Azbill

For the past year, KPHLI has challenged my already busy life as a full-time HANDS employee at the Clark County Health Department and while working on my Masters in Social Work from UK. The experience has led me to a new set of knowledge and insight, a new group of friends, strengthened relationships with old friends, and an opportunity to give back to public health. Being able to work on such a needed cause as mental health issues in times of disaster allowed me to grow both personally and professionally. Although I have some mental health background, I now see the great responsibility that public health has been tasked with in providing special medical needs shelters during times of disaster. I fully believe that Team OCD's project will be an instrumental tool for health departments across the state and am proud to have had a hand in the workings of it. Thanks to each of my teammates, our mentor (Scott LaJoie), Scott Lockard, and to Cynthia, Erin, and Lisa for allowing me this opportunity!

Shelly Greenwell

My experience as a scholar in the Kentucky Public Health Leadership Institute Program this past year has brought an understanding and realization for the pride of my predecessors. The concept of team learning was realized when our conversations and synergy was created with our KPHLI workgroup. This group taught me the importance of shared vision and creating mental models for success. The 360~ Emotional Intelligence and other tools assisted me in examining my personal strengths and weaknesses to move me toward personal mastery. The varied components of the program continue to strengthen and grow my leadership skills both professionally and personally. I am thankful for the opportunity to gain knowledge and insight of effective leadership through this program.

Christopher Smith

This past year as a KPHLI scholar has proven to be a true growing experience. As a newly assigned CDC Prevention Specialist to Kentucky, I hoped that a year invested in this program would provide networking to some of the Commonwealth's greatest public health practitioners and novel approaches to enhance my knowledge and skills to become a comprehensive public health leader. I have been enlightened by the concepts presented, impressed by the various learning style activities used to infuse these complex principles into the simplicity of our everyday routines, and motivated by the phenomenal persons fighting disease and health disparities within the state. Our Change Master Project team experienced the challenges of being the vectors of change-oriented leadership. We felt a myriad of emotions during the course of the year as we focused our efforts on one area

that needed much change and eventually had to redirect to another more strategic and unique topic. Our selection of a public health topic that none of us focus on as a primary work responsibility, posed a steep learning curve that was eventually our groups "tipping point" of redirection. Despite the pains of growing, we have all expanded the depths of our potential and better equipped ourselves to produce effective change within our agencies. I am especially grateful to Team O.C.D. (Organized Chaos in Disasters), Scott LaJoie, and Scott Lockard for remaining patient and steadfast as we sought to produce a useful tool for the Commonwealth and a valuable learning experience for ourselves as ever-evolving public health practitioners. Also, I want to thank the Division for Public Health Protection & Safety (Kentucky Department for Public Health) for unwavering support. Finally, I want to extend my sincerest thanks to the KPHLI Staff (Cynthia Lamberth, Erin Louis, & Lisa "Liza" Peterson) for their encouragement, constructive feedback, and support over this past year.

Melissa Sparks

I had often heard KPHLI mentioned in the public health field during my tenure, but I was unsure of what to expect. I can say that KPHLI has definitely been a challenge; however my team's collaboration and work ethic outweighed the challenges faced. Relationships are very important to me, not only with my clients, but those on my team, thus I try to find what the teams values and work to foster an environment of inclusion and belonging. It is incredibly important to me that all members of the team are treated with great dignity just as our client systems are cared for. All members need to feel respected. The hope or goal of individuals feeling empowered is that it will elicit motivated responses from them to give their best performance. To that point, engendering trust among a team and at different levels of management and service delivery, is essential, in order to find staff willing. I will always want to be a visible team leader as well by not giving up some functions of direct service. Keeping this piece of the puzzle will keep my skills refreshed and allow fellow staff to see that I will do the tasks that I ask them to do and that I do understand life in the trenches as I still live there with them. I believe in the parallel process and what I reflect to others will be mirrored to the multiple systems we work in. In reviewing my approach and my behavior dimensions, I am able to see my strengths as a leader as well as opportunities for professional and personal growth. My personal leadership attributes which are the strongest are self awareness and self regulation. I believe that I am keenly aware of my strengths, my weakness and my desires. The experience of KPHLI has allowed me the opportunity to truly look at leadership style and begin to formulate an approach/action plan to enhance my overall leadership performance. Thanks to Team OCD, our mentor Dr. Scott LaJoie, Scott Lockard, and to Cynthia, Erin and Lisa for believing in me.

Shawna Thomerson

I have been more than richly blessed through my work in public health over the past 14 years. Opportunities and experiences have been given to me through my many roles that have enriched not only my professional growth but just as importantly, my personal growth. It is incredibly humbling to know that people have allowed me to enter their

lives and become part of who they are as individuals, families and as a community. I know that my professional life is about being a "public servant" and the public health arena allows me to fulfill that passion. Being a part of the Kentucky Public Health Leadership Institute allowed me to expand my view of public service into a more global thinking. My new found understanding of how "systems" work or don't work together has given me a deeper appreciation for administrators and policy makers. I have also reaffirmed my belief in the possibilities of grass root works. I truly appreciate how closely weaved macro and micro level practice are as a result of my KPHLI experience. All systems are interdependent on one another and for great success, there must be a common joining of thought processes and goals. Team OCD found itself eager to work towards a goal yet the goal remained undefined for quite some time which was a struggle for our group of motivated and talented individuals who like being overachievers. The simple experience of learning patience as a group as we allowed the goal to become defined over time and with discovery, taught us all invaluable lessons in cooperation, support, and teamwork. I will always feel interconnected to my team members and have found new friends among them and strengthened bonds with new respect for my team members I already had relationships with. I owe deep gratitude to my director, A. Scott Lockard, for committing his time, energy and support to our team and leadership in the process. Our mentor, A. Scott Lajoie, became our biggest cheerleader and his faith and pride in our work motivated us further. Lastly many thanks to the KPHLI leadership team of Cynthia, Erin and Lisa for guiding and leading us down uncertain paths of change and growth for which we are forever changed.

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