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Examining the CDCynergy Event Assessment Tool: An Investigation of the Anthrax Crisis in  
Boca Raton, Florida

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Abstract

This study examines the dependability of the Event Assessment tool over time. The tool is part of a CD-ROM, *CDCynergy*, distributed primarily to public information officers in the United States by the Centers for Disease Control and Prevention. The Event Assessment tool is designed to aid emergency professionals in identifying the magnitude of a crisis event and provide suggested actions appropriate to confronting an event. Applied two times during the emergence of the anthrax bioterrorism crisis in Boca Raton, Florida, the tool operated in a binary manner by first indicating a moderate crisis level and then four days later indicating a highly intense crisis, suggesting that the Event Assessment tool is time sensitive. Additional limitations and implications of the tool are discussed.

## Examining the CDCynergy Event Assessment Tool: An Investigation of the Anthrax Crisis in Boca Raton, Florida

Less than one month after the tragedy of September 11, 2001, a Florida man was diagnosed with inhalation anthrax. The diagnosis came from a Boca Raton doctor and was later confirmed by the Center for Disease Control and Prevention. At this time, health authorities at all levels were reluctant to speculate that the source of the anthrax was anything but natural; however, in the next two weeks the attitude in Florida and the rest of the United States would change dramatically.

The public sought information they could trust as “the 2001 *anthrax* attacks brought public health into the media spotlight in a way unmatched since the AIDS epidemic of the 1980s,” (Winett & Lawrence, 2005: p. 3). The agencies involved in the crisis were walking a fine line between informing the public about a natural, albeit rare, strain of anthrax and avoiding an overreaction by a terror sensitive public. The national media was very interested in the uncommon disease contracted by the Florida native and questioned government health agencies about the possibility of bioterrorism. Officials were steadfast in their responses and stated that the anthrax case was unlikely an act of bioterrorism (Global News Wire, 2001). During the unfolding of the anthrax crisis, authorities were shown to be incorrect in their public statements on the facts of this case on a far too regular basis. As Blendon, Benson, Desroches and Weldon (2003) warned, “To be effective in their communications, health officials need to know as the crisis is unfolding what Americans believe, what they know and understand, whom they trust, and what actions they are taking in response to the crisis (pp. 7-8). The communication errors impugned the credibility of the agencies involved and kept a portion of the public at risk for contracting anthrax.

The message errors started immediately with the first case of anthrax, which was initially reported to be from natural sources and was unlikely an act of bioterrorism. Secretary of Health and Human Services, Tommy Thompson went so far as stating, “There is no terrorism” (Kolata, 2001: p. 3). Then four days later, based on information from “patients, their families, the county health director, the state epidemiologist, the CDC, the Miami medical care facility, and law enforcement agencies”, the “event was characterized as a plausible bioterrorism event” (CDC, 2003). Eventually, the anthrax case surfaced as the CDC’s first bioterrorism crisis in the United States (McClam, 2001).

Another illustration of poor communication with the public appeared when the anthrax investigation moved into the local, south Florida post offices. The public’s concerns were initially met with a variety of quotes from varying government agencies. A spokesperson for the Postal Inspection Service in South Florida expressed skepticism that a letter sent to American Media Incorporated was the carrier of anthrax. Concurrently, the FBI and the CDC were at the Boca Raton post office briefing employees about anthrax and emphasizing to the press that the briefing was extremely precautionary because the mail was not the confirmed carrier of the anthrax (Canedy & Yardley, 2001). The CDC’s lead investigator Dr. Bradley Perkins was quoted as saying “this is the stuff of extraordinary precaution to ensure the public’s safety” (Firestone, 2001: para. 7). The next day the post office was shut down as the previously mentioned letter tested positive for anthrax. Five days later, the presence of anthrax was found and confirmed at the Boca Raton post office (Firestone, 2001). Further communication miscues diminished public trust in the authorities involved. Shore (2003) perhaps best captured this decline by noting,

The very public airing of medical errors has eroded the perception of health care’s competence. During the anthrax crisis in fall 2001, changes in or poor communication

about treatment recommendations and methods of testing for exposure had a similar detrimental effect on the perception of the competence of public health agencies. The trust cue of conscience, particularly critical to building trust, has been subjected to near-daily doses of accounts of fraud and abuse, conflicts of interest, disruptive behavior, and other trust-busters . . . An additional challenge for establishing trust is the public's craving for consistency and consensus, particularly in times of crisis. Satisfying this craving is always hard, given the ephemeral nature of some health recommendations. Variability in health care recommendations during the anthrax attacks led to a caveat emptor mentality perhaps most famously proclaimed in the quote, "In Cipro We Trust." (pp. 13-14)

#### *The Crisis Assessment Tool*

The CDC developed CD-ROM *Emergency Risk Communication CDCynergy* offers public information officers throughout the country a wide range of experience to draw from in a public health crisis situation. The information presented in the CD-ROM provides a review of crisis literature, standardizes crisis levels, presents the necessary terms to effectively communicate between organizations, and indicates response actions based on expert experiences and research. In essence, this CD-ROM works to raise the overall effectiveness of risk and crisis communication for health and emergency professionals in the United States.

This study examines the CDC's Event Assessment tool and its use in the Boca Raton anthrax crisis. This tool, as a whole, is an extremely useful resource for health and other emergency response organizations in all stages of risk and crisis communication and will serve as a good foundation for developing specialized crisis plans and training programs for organizations (Overland, personal communication, 2004). Unfortunately, during the Florida

anthrax case, the tool was ineffective in helping the CDC determine the crisis intensity level and resulted in a lack of preparation for the looming crisis.

The Event Assessment tool was developed to aid public health and other emergency officials judge the seriousness of a crisis situation, detail the personnel and resources needed to effectively confront a situation, and propose the frequency of public information statements. The anthrax case and apparent failure of the Event Assessment tool provide an opportunity to improve this particular crisis classification system. Specifically, this study concentrates on the crisis levels that the Event Assessment tool arrives at during the unfolding of a crisis event.

There are four levels of crisis explained on the CD-ROM that are used to recommend appropriate actions to confront a crisis event. The crisis levels range from A to D in descending intensity (see Table 1). The instrument is composed of 24 criteria statements that may or may not

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Insert Table 1 about here

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describe the event being assessed. Officials using the tool read the event criteria and check those that apply to the case. After users indicate whether the statement is applicable to their current context, and based on the selections, the electronic wizard used predetermined intensity points to calculate the crisis level. Based on the intensity level the assessed event achieves, the tool recommends actions appropriate to the intensity of the situation (see Appendix 1 for complete listing of values of each criteria statement).

The value of this study lies in determining if the Event Assessment tool functions dependably over time. As a crisis situation evolves, the different statements in the tool may

become applicable to the situation and in turn affect the crisis intensity rating. Thus, the response recommendations would change as intensity grows.

### *The Context*

Accurately determining intensity levels was imperative during the events that would unfold in early October of 2001. After the terrorist attacks of September 11, 2001, the United States of America was dealing with the loss of thousands of innocent lives, a national symbol, and the assumed security of being geographically distant from terrorist organizations. When the Twin Towers crashed to the ground in New York, many Americans were in a daze, not knowing what to feel, but soon feelings of anger, blame, sorrow, and fear became common emotional reactions (Greenberg, 2002). Citizens were concerned about further terrorist activities and were sensitive to the emergence of exotic disease that may indicate a biological attack. Then the first case of inhalation anthrax in 25 years appeared in the news (Global News Wire, 2001).

Health officials involved in the Boca Raton discovery of anthrax displayed caution in the careful language they used when speaking to the press. The secretary of health and human services said that the case appeared to be “isolated” and that there were no indications of a “bioterrorist” attack (Global News Wire, 2001: para. 2). Authorities became involved in a waiting game. If no other cases appeared soon, then the supposition of contraction by natural causes would be supported. Unfortunately, a second case of anthrax was soon discovered and America was once again faced with a horrendous act of terrorism. The FBI and CDC took over the investigation and another media frenzy ensued.

### *Testing the Crisis Assessment Tool*

The Event Assessment tool’s classification of the crisis intensity level and associated response recommendations would have changed between the morning of October 4 (first case

confirmed by the CDC) and October 8 (the second confirmed case). To understand these differences, a timeline was constructed listing the events that unfolded around the discovery of anthrax in Boca Raton, Florida (found in Table 2). The events preceding each of these dates were used to complete the Event Assessment tool thus allowing a comparison of the recommendations made at those times.

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Insert Table 2 about here

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This study applied the Event Assessment tool for the dates of October, 4 and October, 8 2001. The tool's criteria statements were selected based on what was known about the situation determined by an analysis of media reports in the Associated Press, The Boston Globe, and The New York Times (see Table 2).

The interpretation of events by different users may lead to small variations in selecting or not selecting some of the event criteria; however, these variations do not effect the overall crisis level arrived at by the Event Assessment tool. To increase the crisis level, criteria statement one, two or four must be selected (see Table 3).

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Insert Table 3 here

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Looking at the initial anthrax events, officials in Boca Raton had sufficient information to legitimately complete the Event Assessment tool (see Appendix 1). Because only criteria statement three applied, the intensity of the crisis could not be defined as highly intense. Because items one, two or four were not selected, the CDC would argue that the event "is not a public

health emergency requiring aggressive public communication” (CDC, 2003). Therefore, a less intense response was warranted (see Appendix 2). An official or public information officer using the tool at this time would likely not mobilize resources nor set up a 24 hour information center.

On October 8 officials again had sufficient information to use the Event Assessment tool; however, at this time the tool would yield a very different response (see Appendix 3). As additional statements became applicable to this case, the crisis level would have moved to level A - a highly intense crisis (see Table 1). Once a crisis achieves the A level, the recommendations do not change no matter how many intensity points are added. This crisis is already determined to be at the most intense level. Below are the results given by the Event Assessment tool to describe the event and offer appropriate actions.

#### *Conclusions and Implications*

The results arrived at for the October 4 instrument application would appear reasonable with what was going on in the initial context of the anthrax crisis. The public and media attention to the situation could be accounted for by the novelty of the first case of inhalation anthrax in 25 years. After all, the public was still reeling from the terrorist attacks of September 11, and without any scientific connection to terrorism, the first case of inhalation anthrax could be reasonably attributed to natural causes. However, the reasonability of the moderate crisis level indication actually points to a flaw in the use of the tool. The result reflected the current understanding of the situation, but did not allow for new understanding or interpretation of the context.

Applying the instrument on October 8 yielded a much different response. The Event Assessment tool pointed toward a serious situation that would require an immense amount of

resources. Once again, the results were reasonable, but now health and other emergency agencies were placed in a position of catching up.

The CDC faced harsh criticisms for their handling of the anthrax crisis by the media, lawmakers, and the American public. The anthrax case was the first act of bioterrorism that the CDC had to confront on the United States homeland. Dr. Alfred Sommer, dean of public health at Johns Hopkins University stated, “The only people who can bring order to this is [sic] the people like CDC . . . This is a national crisis. This should be their day” (McClam, 2001).

Based on the two completely different results given by the Event Assessment tool, a reasonable conclusion would be that the crisis level is time sensitive. Public information officers must reapply the tool as a situation matures to maintain an accurate perception of the situation. The descriptive statements used to determine crisis level may become relevant or irrelevant over time, which in turn, could result in the raising or lowering of a crisis level. During the first stages of the anthrax outbreak, officials were trying desperately to move away from the idea that the disease was caused by bioterrorism. The tool recommended a moderate response; however, “the agency [CDC] was slow to alert doctors to the threat of other bioterror agents and didn’t do enough to calm a jittery nation ill-informed on the particulars of anthrax” (McClam, 2001). People were kept in harms way and officials communicated erroneous information to the public.

If a crisis level A was reached on October 4, when anthrax was confirmed, then a joint information center would have been formed. This action could have prevented the post office, CDC, and health officials from making erroneous statements that undermined the credibility of the agencies involved. “From the beginning of the crisis, a lack of co-located spaces for the different teams and a lack of technology were barriers to supporting the coordination of medical and communication responses” (Robinson & Newstetter, 2003: p. 21). Spokespersons would not

have been caught playing catch up with the media and public opinion. The public thought the worst, and officials tried to calm the worries only to have these concerns become real. More importantly, the crisis level would have shown investigators that this event required immediate attention.

Instead of waiting, officials could have maintained focus on the event and started the investigation days earlier. Subsequently, six people may have avoided exposure to inhalation anthrax. Boca Raton had four days of warning between the first confirmed case and the second. When the tool should have indicated the need for heightened awareness after the first case; unfortunately, it did not, and the potential warning period was squandered by inaction.

The CDC uses the anthrax case in the CD-ROM to illustrate how the assessment tool works; however, the case is assessed after the four days between the initial case and the secondary case. Mirroring the testing done in this study, the crisis emerges as highly intense, but the tool does not account for the four days with which this study has become concerned.

The CDC appears to have learned from the anthrax case that started in Boca Raton. A document on the CD-ROM illustrates a portion of this learning.

The public must feel empowered in the event of a crisis to reduce the likelihood of victimization and fear. How people absorb and act on information they receive during an emergency may be vastly different from non-emergency situations. Studies have shown however, that during an emergency, having more information leads to decreased anxiety.

(CDC, 2003: Step 3: Assess level of crisis)

Scholarly work in both emergency management and crisis communication repeat what the CDC learned through trial and error (e.g., Seeger, Venette, Ulmer and Sellnow, 2002). When considering the Florida anthrax case, “the CDC’s Dr. Rima Khabbaz, an infectious disease

specialist, said the agency was ‘on a steep curve of learning’ and was re-evaluating its response” (McClam, 2001). Unfortunately, learning resulted from tragic events, but future tragedies may be averted due to the CDC’s expanded frame of reference. Julie Gerberding, the Director of the CDC stated that CDCynergy “provides expert commentary by professionals who experienced the anthrax crisis from a public health perspective” and offers “tools and templates to help you respond quickly when every second counts” (CDC, 2003: Welcome).

The Event Assessment tool in this case operated in a binary manner. After the first diagnosis, the tool indicated that the crisis was not highly intense, perhaps leading to reduced vigilance on the part of the involved agencies. After the second case emerged, the tool designated the event as being of the highest crisis intensity. Thus, the tool was ineffective in allowing the organization to adequately prepare for intensification of events. Seeking improved effectiveness after the anthrax crisis, CDC communication officers “advocated for improved channels of communication among the different communication teams that produce information and for educating the public to expect information to evolve as facts are uncovered” (Robinson & Newstetter, 2003).

Also, to prevent this lack of preparation from reoccurring, the CDC needs to educate officials about the use of the tool and its limitations. Education of officials should begin with discussion of how the user’s perception of events has a significant impact on the tool’s result. Officials, while likely never entirely objective, must be cautious when selecting criteria. Officials should be willing to err on the side of being overly protective rather than erring on the side underestimating a potentially serious event. Even though sometimes precautionary decision making can cause more problems than it prevents, “the precautionary principle can serve as a useful tool to stimulate discussions on ways to improve risk science and decisionmaking [sic]

under uncertainty in order to proactively reduce risks while stimulating innovation in safer processes and products” (Tickner and Gouveia-Vigeant, 2005).

In this study of the anthrax case, officials appeared to focus efforts on avoiding over-reaction and public panic. However, their actions resulted in what they were trying to prevent. The public, faced with conflicting and inaccurate information, abandoned its trust in public health authorities and may have taken unwarranted precautions (Firestone, 2001a; Gray and Ropeik, 2002; Shore, 2003). Coppola (2005) reminds readers that “in many cases of terrorism, fear is the greatest emergency that must be managed, and irresponsible or inadequate attempts to do so can actually increase public risk” (p. 32). Specifically addressing the anthrax case, Dr. Gregg Wilkinson, chair of epidemiology at the University of North Texas’ school of public health argued, “I think that there’s a bit of an overreaction on the part of many members of the public. People are not using their heads . . . That’s where CDC and public health agencies need to calm people’s fears” (McClam, 2001).

Second, the tool must point to *potential* crises and not just indicate the current crisis level. The anthrax situation did intensify rapidly. Four days of lead time for this particular crisis could have, at the very least, yielded a much more competent public image. Through a joint information center, a spokesperson could have communicated a single message that other authorities could refer to, increasing message consistency. Also, agencies speaking about matters beyond their scope of expertise likely would have been reduced or eliminated with the creation of a joint information center.

The extra lead time could have also been used to investigate American Media’s employees and building. Testing employees for exposure while checking the building for contamination would have assured the public that the matter was taken seriously, even as a

precautionary measure. Findings could have indicated that the intensity of the situation was escalating at this point, and the investigation could conceivably have been three full days ahead of where it was.

To make *what could have been done* a reality, the Event Assessment tool must be able to warn officials of potential crises and give appropriate recommendations. The tool should be completed again as new information emerges. Users would first react to changes by selecting those statements that apply given the new available information. Second, the user would select appropriate statements based on a worst case scenario. In Boca Raton, one death from exposure to anthrax may not have required a strong reaction, as the tool suggested. However, officials should have determined their response based not only on the current situation, but also on the probability of future events. They could have predicted the discovery of more cases and the public's reaction to learning that anthrax was possibly being spread through the mail.

The CDC's efforts on this CD-ROM are astounding and this study should not be perceived as an attempt to discredit any portion of the CD. This study has shown that the Event Assessment tool is time sensitive, and should be used accordingly. This study also discusses some possible solutions to this problem, in addition to, other issues concerning the Event Assessment tool. The CDC's *Emergency Risk Communication CDCynergy* CD-ROM is a valuable tool that should be continually refined as more is learned about crisis.

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**Table 1** Descriptions of the crisis levels

<i>Crisis level</i>	Crisis description
<b>A</b> Highly intense in the initial phase	Need to <b>disseminate information rapidly</b> to the public and media is crucial. <b>Life and limb will be at risk</b> if the public is not notified about the risk and public health recommendations. Need to <b>directly provide public health recommendations</b> to the public and media to save life or limb is not immediate.
<b>B</b> Intense	The public and media, however, believe their health and safety are or could soon be at risk. There is high and <b>growing demand for more information</b> .
<b>C</b> Moderately intense	Media frenzy develops. Interest is generated because of the <b>event novelty versus a legitimate and widespread or immediate public health concern</b> . Interest could die suddenly if a “real” crisis occurred.
<b>D</b> Minimally intense	Builds <b>slowly and may continue for weeks</b> , depending on the outcome of further investigation. Requires monitoring reassessments.

Taken from: *Emergency Risk Communication CDCynergy*, 2003

**Table 2** Timeline of the anthrax crisis

<i>Date</i>	<i>Information</i>
September 19	A powder arrived in the Sun's mailroom. The powder was in a letter addressed to Jennifer Lopez and a Star of David was written on the letter. Several people were said to have handled the letter.
October 1	Robert Stevens came home from his vacation in North Carolina. Stevens had been feeling ill for a couple of days.
October 2	Stevens was admitted to the emergency room in Atlantis, Florida. Dr. Larry Bush believed that Stevens contracted anthrax and notified Palm Beach County Health Center.
October 3	Twelve members of the CDC started to investigate Steven's movements of the past few days. Spinal fluid samples are sent to the CDC for analysis.
October 4	CDC confirmed that Stevens contracted anthrax. Stevens was admitted to a hospital with non-contagious pulmonary anthrax. Tommy Thompson, secretary of health and human services, told reporters that the case is believed to be an isolated case, and there is no evidence of terrorism.
October 5	Robert Stevens, 63 year-old, photo editor for The Sun, died at 4 p.m. EDT.
October 8	FBI with CDC representatives took over the investigation after Ernesto Blanco was found to have anthrax spores in his nasal cavity after being hospitalized with flu-like symptoms. Traces of Anthrax were found on Steven's keyboard.
October 10	County Health Officials and FBI Investigators saw employees of American Media. Employees were questioned, their nasal cavities were swabbed for testing, and they were given Ciproflaxocin (antibiotic). State and local health officials in New York sent an advisory on bioterrorism disease information to all licensed doctors in New York City. CDC: <ul style="list-style-type: none"> <li>▪ Sent antibiotics for bacterial bioterrorist agents to New York city.</li> <li>▪ Stationed two epidemiologists at 12 hospitals in the area.</li> <li>▪ Discovered that Stephanie Dailey was exposed to anthrax.</li> </ul> Dailey's exposure was found through the nasal cavity swab test done two days prior. Preliminary test results were received on 700 out of the 1,000 people tested, and only 1 has shown anthrax exposure. Federal Officials announce they are now conducting a criminal investigation. Many of the already tested members of American Media took an additional, optional blood test.

**Table 2 continued**


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	CDC briefed Boca Raton postal employees about anthrax, and stressed that the mail was not the confirmed carrier.
October 11	The New York Times confirmed the report of the letter addressed to Jennifer Lopez with a bluish powdery substance. Del Alvarez, a spokesman for the Postal Inspection Service in South Florida, expressed skepticism that the letter was connected to the anthrax outbreak and said that officials had not been able to locate it. CDC tested 20 Boca Raton postal workers, and one mail distribution center was shut down, and three area post offices were tested.
October 12	78 samples were sent to the CDC for testing. FBI reported that 965 of the 1,000 American Media employee tests were completed, and no more were found. Five more American Media employees were shown to have exposure to anthrax through the latter blood tests.
October 13	Investigators disclose that Erin O’Conner, an NBC employee in New York City, was infected by a letter, and also confirmed a letter at a Microsoft affiliate in Carson City, Nevada also tested positive for anthrax.
October 15	Anthrax found in the main post office of Boca Raton. Letter containing highly refined anthrax was opened in Senator Daschle’s office.

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(Canedy and Altman, 2001; Canedy and Kuczynski, 2001a; Canedy and Kuczynski, 2001b; Canedy and Yardley, 2001; Daley and Kaplan, 2001; Firestone, 2001a; Firestone, 2001b; Firestone, 2001c; Global News Wire, 2001; Kolata, 2001; Ojito, 2001; Powers, 2001; Wade, 2001; Yardley and Canedy, 2001)

**Table 3** The first four questions of the event assessment tool

<i>Criteria number</i>	<i>Criteria</i>
1	The timing of the initial event is an unexpected, legitimate, public health emergency requiring swift and widespread public education to prevent further morbidity and mortality and empower the public (e.g., multistate e-coli outbreak or a bioterrorism event).
2	Deaths are expected within a short window of time (catastrophic event). Diagnosis and/or treatment are uncertain.
3	The media and public perceive the event as the “first,” “worst,” or “biggest,” etc.
4	Deaths are expected well above normal levels.

Taken from: *Emergency Risk Communication CDCynergy*, 2003

### Appendix 1 The Event Assessment Matrix

Event Assessment Worksheet		
Description of Event: <i>(Write a brief description.)</i>		
(Col A) Check If Applicable	(Col B) Intensity Points (0-8)	(Col C) Event Criteria
1. <input type="checkbox"/>	+++++++	The timing of the initial event is an unexpected, legitimate, public health emergency requiring swift and widespread public education to prevent further morbidity and mortality and inform the public (e.g., multistate e-coli outbreak or a bioterrorism event).
2. <input type="checkbox"/>	++++	Deaths are expected within a short window of time (catastrophic event). Diagnosis and/or treatment are uncertain.
3. <input type="checkbox"/>	+++	The media and public perceive the event as the "first," "worst," or "biggest," etc.
4. <input type="checkbox"/>	++++	Deaths are expected well above normal levels.
5. <input type="checkbox"/>	++	The event is occurring in a metropolitan area (with dense media outlets) versus a sparsely populated area (with fewer media outlets).
6. <input type="checkbox"/>	++	The event is sudden, is national in scope, or has the potential to have a national health impact.
7. <input type="checkbox"/>	++	The government is perceived as a cause of or responsible for the event.
8. <input type="checkbox"/>	++	The event predominantly impacts children or previously healthy adults.
9. <input type="checkbox"/>	++	The event is possibly "man-made" and/or deliberate.
10. <input type="checkbox"/>	++	Controlling the event will require a suspension of civil rights for a significant portion of the population.
11. <input type="checkbox"/>	++	Persons involved in the event must take active steps to protect their personal health and safety.
12. <input type="checkbox"/>	++	Responsibility for mitigating the event falls within the scope of your organization.
13. <input type="checkbox"/>	++	The event has some "exotic" aspect.
14. <input type="checkbox"/>	++	A well-known product, service, or industry is involved.
15. <input type="checkbox"/>	++	Sensitive international trade or political relations are involved.
16. <input type="checkbox"/>	++	A well-known "celebrity" is involved.
17. <input type="checkbox"/>	++	An ongoing criminal investigation is involved.
18. <input type="checkbox"/>	++	The disease or public health emergency, disaster, or crisis is not well understood by the general population, or the general population is misinformed about the situation.
19. <input type="checkbox"/>	++	The event is "acute." The event occurred and your organization is faced with explaining the event and the aftermath (e.g., an accident in the laboratory or a chemical release).
20. <input type="checkbox"/>	+	The long-term health effects for humans involved in the event are uncertain.
21. <input type="checkbox"/>	+	The event is evolving. Its progression is uncertain and may become more or less serious (e.g., identification of a novel influenza virus).
22. <input type="checkbox"/>	+	The event site does not have a well-equipped and resourced public information response capability.
23. <input type="checkbox"/>	0	The event occurred internationally with little chance of affecting the U.S. population.
24. <input type="checkbox"/>	0	Treatment or control of exposure is generally understood and within the person's control.
 [            ] ← Total Intensity Points		
Crisis Level: <input type="checkbox"/> (A) - Highly Intense <input type="checkbox"/> (B) - Intense <input type="checkbox"/> (C) - Moderately Intense <input type="checkbox"/> (D) - Minimally Intense		

Taken from: *Emergency Risk Communication CDCynergy, 2003*

**Appendix 2** Event Assessment for October 4, 2001  
**October 4, 2001**

Crisis Level	Crisis Level Description	Recommended Communication Response	Intensity Points
C	<b>Moderately intense.</b> Media frenzy develops. Interest is generated because of the event novelty versus a legitimate and widespread or immediate public health concern. Interest could die suddenly if a "real" crisis occurred.	<ul style="list-style-type: none"> <li>• Operate 10-12 hours a day, 5-6 days a week and assign a single team member for after-hour purposes during the initial phase.</li> <li>• Operate on weekend if event occurs on a weekend; otherwise use on-call staff only on weekends, not during full operation.</li> <li>• Attempt to move the media and public to maintenance phases with prescribed times and outlets for updates.</li> <li>• No need to form a joint information center.</li> </ul>	32

**Selected Criteria**

**Event Criteria**

✓	1.	The timing of the initial event is an unexpected, legitimate, public health emergency requiring swift and widespread public education to prevent further morbidity and mortality and empower the public (e.g., multistate e-coli outbreak or a bioterrorism event).
	2.	Deaths are expected within a short window of time (catastrophic event). Diagnosis and/or treatment are uncertain.
✓	3.	The media and public perceive the event as the "first," "worst," or "biggest," etc.
	4.	Deaths are expected well above normal levels.
✓	5.	The event is occurring in a metropolitan area (with dense media outlets) versus a sparsely populated area (with fewer media outlets).
✓	6.	The event is sudden, is national in scope, or has the potential to have a national health impact.
	7.	The government is perceived as a cause of or responsible for

		the event.
✓	8.	The event predominantly impacts children or previously healthy adults.
✓	9.	The event is possibly “man-made” and/or deliberate.
	10.	Controlling the event will require a suspension of civil rights for a significant portion of the population.
✓	11.	Persons involved in the event must take active steps to protect their personal health and safety.
✓	12.	Responsibility for mitigating the event falls within the scope of your organization.
<hr/>		
✓	13.	The event has some “exotic” aspect.
✓	14.	A well-known product, service, or industry is involved.
	15.	Sensitive international trade or political relations are involved.
	16.	A well-known “celebrity” is involved.
	17.	An ongoing criminal investigation is involved.
✓	18.	The disease or public health emergency, disaster, or crisis is not well understood by the general population, or the general population is misinformed about the situation.
✓	19.	The event is “acute.” The event occurred and your organization is faced with explaining the event and the aftermath (e.g., an accident in the laboratory or a chemical release).
<hr/>		
✓	20.	The long-term health effects for humans involved in the event are uncertain.
✓	21.	The event is evolving. Its progression is uncertain and may become more or less serious (e.g., identification of a novel influenza virus).
	22.	The event site does not have a well-equipped and resourced public information response capability.
<hr/>		
	23.	The event occurred internationally with little chance of affecting the U.S. population.
	24.	Treatment or control of exposure is generally understood and within the person’s control.

Taken from: *Emergency Risk Communication CDCynergy, 2003*

**Appendix 3** Event Assessment for October 8, 2001  
**October 8, 2001**

<b>Crisis Level</b>	<b>Crisis Level Description</b>	<b>Recommended Communication Response</b>	<b>Intensity Points</b>
<b>A</b>	<b>Highly intense in the initial phase.</b> Need to disseminate information rapidly to the public and media is critical. Life and limb will be at risk if the public is not notified about the risk and public health recommendations.	<ul style="list-style-type: none"> <li>Operate 24 hours a day, 7 days a week for media and public response, with an expectation that relief and replacement staff will be needed.</li> <li>Per your plan, form or join a joint information center (JIC).</li> </ul>	48

**Selected Criteria****Event Criteria**

1. The timing of the initial event is an unexpected, legitimate, public health emergency requiring swift and widespread public education to prevent further morbidity and mortality and empower the public (e.g., multistate e-coli outbreak or a bioterrorism event).



2. Deaths are expected within a short window of time (catastrophic event). Diagnosis and/or treatment are uncertain.



3. The media and public perceive the event as the "first," "worst," or "biggest," etc.

4. Deaths are expected well above normal levels.



5. The event is occurring in a metropolitan area (with dense media outlets) versus a sparsely populated area (with fewer media outlets).



6. The event is sudden, is national in scope, or has the potential to have a national health impact.

7. The government is perceived as a cause of or responsible for the event.



8. The event predominantly impacts children or previously healthy adults.



9. The event is possibly "man-made" and/or deliberate.

10. Controlling the event will require a suspension of civil rights for a significant portion of the population.



11. Persons involved in the event must take active steps to

✓	12.	protect their personal health and safety. Responsibility for mitigating the event falls within the scope of your organization.
✓	13.	The event has some "exotic" aspect.
✓	14.	A well-known product, service, or industry is involved.
	15.	Sensitive international trade or political relations are involved.
✓	16.	A well-known "celebrity" is involved.
✓	17.	An ongoing criminal investigation is involved.
✓	18.	The disease or public health emergency, disaster, or crisis is not well understood by the general population, or the general population is misinformed about the situation.
✓	19.	The event is "acute." The event occurred and your organization is faced with explaining the event and the aftermath (e.g., an accident in the laboratory or a chemical release).
✓	20.	The long-term health effects for humans involved in the event are uncertain.
✓	21.	The event is evolving. Its progression is uncertain and may become more or less serious (e.g., identification of a novel influenza virus).
	22.	The event site does not have a well-equipped and resourced public information response capability.
	23.	The event occurred internationally with little chance of affecting the U.S. population.
✓	24.	Treatment or control of exposure is generally understood and within the person's control.

Taken from: *Emergency Risk Communication CDCynergy*, 2003