Innovative Infrastructure in New Jersey: Using Health Education Professionals to Inform and Educate During a Crisis

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Federal funding supports the growth and development of public health infrastructure and preparedness. The New Jersey Department of Health and Senior Services used federal funds to increase local public health infrastructure that included the hiring of health educators or risk communicators (HERCs). The HERCs are a diverse group of health and communications professionals trained in emergency communication. They provide crisis information regarding public health threats. Over the years, the role and duties of HERCs have expanded from bioterrorism to all-hazards approach and emerging infections public health preparedness, including pandemic influenza. This article describes how HERCs are used in the New Jersey public health infrastructure.

Keywords: health educator; risk communicator; crisis and emergency communication; public health infrastructure

BACKGROUND

Public health infrastructure received a much-needed boost after the September 11, 2001 attacks. In 2002, the Centers for Disease Control and Prevention (CDC) provided funding to state health departments through the Public Health Preparedness and Response Bioterrorism Cooperative Agreement (BTCA) that aimed to strengthen state and local governmental ability to prepare for and respond to public health emergencies, including communicating risk and disseminating health information (Katz, Staiti, & McKenzie, 2006; Wray, Kreuter, Jacobsen, Clements, & Evans, 2004). Thanks to heightened emergency preparedness efforts, public health workers are now considered valuable assets (Barnett et al., 2005; Butler, Panzer, & Goldfrank, 2003; Gebbie & Turnock, 2006), are better prepared to respond to large-scale incidents, and have increased the capacity to respond to daily public health concerns (Gebbie & Turnock, 2006; Katz et al., 2006).

As per U.S. Census Bureau (2000) data, New Jersey has a population of over 8.4 million, distributed among 21 counties and 566 municipalities. The local public health structure in New Jersey is complex and consists of 114 local health departments, including 22 Local Information Network and Communication System (LINCS) agencies. The LINCS agencies are heterogeneous, where some LINCS agencies are county health departments, some are health departments that serve multiple municipalities or large urban areas, whereas others coordinate emergency planning but are not a local health department. The LINCS agencies are the lead public health emergency planning agency in the jurisdiction or county and are expected to work in collaboration local health departments. Local health departments are not required to employ a full-time health educator. The New Jersey Department of Health and Senior Services (NJDHSS) serves as the overall Federal funding supports the growth and development of public health infrastructure and preparedness. The New Jersey Department of Health and Senior Services used federal funds to increase local public health infrastructure that included the hiring of health educators or risk communicators (HERCs). The HERCs are a diverse group of health and communications professionals trained in emergency communication. They provide crisis information regarding public health threats. Over the years, the role and duties of HERCs have expanded from bioterrorism to all-hazards approach and emerging infections public health preparedness, including pandemic influenza. This article describes how HERCs are used in the New Jersey public health infrastructure.

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lead public health agency in New Jersey, providing additional support and guidance to local agencies as needed.

The NJDHSS designated LINCS agencies to receive funding to coordinate bioterrorism and public health preparedness on a regional level. Each LINCS agency was assigned an NJDHSS-employed planner and was provided funding to hire individuals for their bioterrorism or preparedness team, which included an epidemiologist, a public health nurse, an LINCS coordinator, a computer or information technology specialist, and a health educator or risk communicator (HERC). This decision to fund the bioterrorism or preparedness team mirrored the various priorities found in the 2002 CDC BTCA: preparedness planning and readiness assessment, surveillance and epidemiology, Health Alert Network and communication information technology, laboratory capacity, public information and communication, and education and training. The BTCA format used focus areas to address the aforementioned priorities. At the LINCS agencies, each bioterrorism or preparedness team member addressed the activities in the various focus areas. New Jersey combined focus areas F (public information and risk communication) and G (education and training), and were assigned to the HERC.

**DEMOGRAPHICS**

Some LINCS agencies split the HERC position and hired an individual to function solely as the health educator and another as the risk communicator. Because the position was created in 2002, 11 of the original 25 HERCs remain in the role. Currently, there are 24 individuals functioning in the HERC capacity: 13 have been in the position for 2 years or more, and 11 have been in the position less than 1 year, underscoring relatively frequent turnover of these individuals. The LINCS agencies are obligated to designate a staff person to fulfill HERC job responsibilities if the HERC position is vacant. All 24 HERCs (permanent or designee) have bachelor degrees: 10 have degrees in health science, health education, community health, or public health; 14 in other areas, such as nursing, psychology, microbiology, speech communication, economics, or education. Over half have graduate degrees: 9 with graduate degrees in health education, health administration, or public health and 5 have graduate degrees in other areas, such as nursing, organizational design and development, or public administration. Ten are certified health education specialists (CHES) and five others are CHES eligible. Table 1 provides a description of New Jersey HERC characteristics, including education background and years in the HERC position.

Many of the HERCs who left their positions accepted jobs at the state health department in various public health or emergency management roles (i.e., exercise team, communicable disease nurse, and emergency preparedness hospital liaison). A few were promoted at their LINCS agency and delegated the HERC duties to another employee.

Others took positions unrelated to emergency preparedness, pursued higher education, or left the state altogether.

**ROLE OF THE HERC**

The job of the HERC was developed to support bioterrorism preparedness at the local level. Over the years, HERC responsibilities have evolved from primarily bioterrorism preparedness activities to activities supporting existing public health services and new initiatives, including pandemic influenza. With the shift from a bioterrorism focus to an all-hazards approach to public health incidents, the HERC has adapted by becoming an integral member of the public health team. The shift to all-hazards preparedness allowed the HERC to expand their outreach opportunities. All-hazards preparedness includes man-made disasters, such as floods, which occur regularly in New Jersey.

The NJDHSS-facilitated monthly HERC meetings provide the opportunity for peer-to-peer idea sharing, training, and other important information dissemination. Since 2003, HERCs have participated in an array of training, exercises, and preparedness activities.
Activities are completed during the BTCA grant cycle, which is from August 31 to August 30. Table 2 provides a summary of HERC activities from 2003 to 2008. Listed below are highlights of the various tasks that HERCs have participated in throughout the years:

- **2003-2004**: Planning and participating in smallpox vaccination clinics; providing community bioterrorism education program—Taking the Terror out of Bioterrorism; developing LINCS agency risk communication plans.
- **2004-2005**: Participation in the Strategic National Stockpile (SNS) training, education, and demonstration (TED) package exercise; planning and evaluating mass prophylaxis clinics and point of dispensing (POD) exercises; participating in a statewide media and spokesperson training; developing a public information and communication shelf kit.
- **2005-2006**: Participation in the first annual statewide Crisis and Emergency Risk Communication Conference; hosting regional advanced media and spokesperson trainings; participating in the TOPOFF 3 exercise.
- **2006-2007**: Participation in pandemic influenza planning, education, and exercises; identifying and recruiting health education surge capacity volunteers; participating in the CDC’s Mass Antibiotic Dispensing: Public Information and Communication training, a daylong interactive seminar.
- **2007-2008**: Peer-to-peer training on the Pandemic Influenza Crisis and Emergency Risk Communication (CERC) training; recruiting for and implementing regional pandemic flu CERC trainings; participation and implementation of local media and spokesperson training; promotion and participation in regional rapid response avian influenza training.

The HERCs are also involved in the workforce development of the public health and health care professionals in their jurisdictions. Many times, NJDHSS sponsors preparedness and disease-specific trainings that carry various continuing education credits. The HERCs are tapped as advocates and training recruiters. In addition, HERCs offer local and regional trainings, and public health and health care professionals have come to rely on the HERC as a credible and reliable informant regarding education and training opportunities.

The NJDHSS promotes utilizing HERCs as local information providers. The HERCs receive communication messages from NJDHSS and distribute these messages locally to stakeholders and public health partners. The communication algorithm is pictured in Figure 1. This protocol ensures One Voice, One Message. Monthly face-to-face meetings between NJDHSS and HERCs have strengthened the ability to relay messages from the top down. The NJDHSS crafts the message and disseminates the message and talking points to the HERCs. The HERCs either relay the message locally or prepare a local spokesperson to present the message.

When the HERC position was first established, HERC duties included conducting needs assessments, creating linkages with community partners, coordinating and/or providing trainings for constituents, developing educational plans and materials to support various training initiatives, and overseeing workforce development. Because bioterrorism education was a relatively new concept for public health professionals, HERCs spent a considerable amount of time educating themselves about incident command systems and emergency operations, epidemiology of disease agents and risk communication concepts or theory. They were also challenged with fostering relationships with first responders, such as emergency management, emergency medical services, firefighters, and law enforcement.

The HERCs assisted with planning and coordinating local mass prophylaxis clinics, including recruiting volunteers, conducting just-in-time-training of staff and volunteers, preparing spokespeople for media interviews and tailoring education and clinic materials. The role also consisted of developing relationships and networks with public information officers in their counties or jurisdictions, delivering CERC workshops, and identifying spokespeople and promoting or attending media trainings. Plans are underway to offer spokesperson and

### TABLE 1

**New Jersey HERC Characteristics, September 2007 (N = 24)**

<table>
<thead>
<tr>
<th>Education</th>
<th>10 (42%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate degree in health science, health education, community health, or public health</td>
<td>14 (58%)</td>
</tr>
<tr>
<td>Other undergraduate degree</td>
<td>14 (58%)</td>
</tr>
<tr>
<td>Graduate degree in health education, health administration, or public health</td>
<td>5 (21%)</td>
</tr>
<tr>
<td>CHES</td>
<td>15 (63%)</td>
</tr>
<tr>
<td>CHES certified or CHES eligible</td>
<td>13 (55%)</td>
</tr>
<tr>
<td>CHES years in HERC position</td>
<td>11 (45%)</td>
</tr>
<tr>
<td>3 years or more</td>
<td>11 (45%)</td>
</tr>
</tbody>
</table>

**NOTE:** HERC = health educator or risk communicator; CHES = certified health education specialists.
media training in each county, with hopes to expand the spokesperson network. The HERCs are responsible for reaching out to public health, health care, government and community leaders (nonprofit, faith-based, etc.) to provide this important training that emphasizes risk communication techniques and strategies.

Within the past year, HERCs have been tapped to provide community influenza education developed by the NJDHSS. They were also tasked with planning and participating in pandemic influenza drills and exercises, disseminating general preparedness and influenza education materials, and recruiting individuals to serve as surge capacity health educators during a public health emergency. With their varied skill sets, HERCs have been involved in responding to everyday public health events, such as communicable disease

### TABLE 2
HERC Activity Timeline, 2003-2008

<table>
<thead>
<tr>
<th>2003-2004</th>
<th>Recruit smallpox response teams, provide smallpox pre-event education, hold smallpox vaccination clinics. Provide bioterrorism preparedness education program to community residents: Taking the Terror out of Terrorism. Conduct public health, health care, and first responder training needs assessment. Develop LINCS agency risk communication plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2006</td>
<td>Prepare for and participate in TOPOFF 3. Attend 1st Annual Crisis and Emergency Communication Conference. Participate and recruit for Advanced Media and Spokesperson training. Develop and provide influenza public education program. Provide regional CERC trainings to public health and health care professionals. Update and exercise LINCS agency risk communication plan. Update shelf kit to include chemical and radiological fact sheets</td>
</tr>
<tr>
<td>2007-2008</td>
<td>Participate in pandemic influenza planning and exercises; continue with public education program. (Proposed) Attend Pan Flu CERC training; provide training locally. Revise public health, health care and first responder training needs assessment. Contact and create linkages with special population leaders. Attend the 3rd Annual Crisis and Emergency Risk Communication Conference. Plan and coordinate local media and spokesperson training. Assist in creation of and attend new HERC orientation. Update and exercise LINCS agency risk communication plan. Update and maintain shelf kit.</td>
</tr>
</tbody>
</table>

NOTE: HERC = health educator or risk communicator; CERC = crisis and emergency risk communication; LINCS = Local Information Network and Communication System; SNS = Strategic National Stockpile; TED = training, education and demonstration; TOPOFF = top officials exercise.
events (e.g., meningococcal case investigations and food borne outbreaks) and chemical incidents.

**INNOVATION THEORY**

The Diffusion of Innovation theory describes how and why new ideas (i.e., innovations) are adopted. This theory has roots in sociology but can be used by various disciplines to explain the acceptance of new ideas by individuals and groups. Although health education practice in local and state health departments is certainly not new, how health educators are used and their involvement with risk communication in New Jersey is definitely an innovation for the state’s public health system.

The theory posits that an innovation is an “idea, practice or object that is perceived as new by an individual or other unit of adoption” (Rogers, 2003, p. 12). What makes the HERC innovative is that it incorporates two distinct disciplines into a hybrid of both: the dynamic framework of health education and blossoming structure of risk communication. The decision to merge the health education and risk communication into one position grew out of the necessity to address multiple preparedness initiatives with limited staffing resources. The NJDHSS team leaders from focus area F and focus area G worked together to collaboratively address tasks and activities with the HERCs. “Once an organization has made the decision to adopt, implementation does not always follow directly” (Rogers, 2003, p. 402). With appropriate funding and NJDHSS support and leadership, LINCS agencies embraced the HERC position. The HERCs have established themselves as integral members in the realm of preparedness. Because of the program planning, implementation, and behavior modification background acquired in their health education training, they offer unique insights during planning for mass prophylaxis clinics, just-in-time training, and general preparedness efforts. Risk communication becomes important when dealing with media, addressing community residents, and recruiting volunteers to participate in emergency public health preparedness exercises.

A literature search on Academic Search Premier for health department, health educator, and preparedness did not provide insight into how other states used their BTCA funding in regard to health education and/or risk communication. Granted, other states might have innovative health education structures in place, the literature does not support this assumption. The New Jersey experience might be the first documented account of how health educators are used in the realm of preparedness and how risk communication is incorporated into the fold of their duties.

**PREPAREDNESS INTO PRACTICE—TOPOFF 3**

In 2005, New Jersey participated in a Congressionally mandated full-scale exercise for top officials called TOPOFF 3 (T3). The exercise was coordinated and overseen by the U.S. Department of Homeland Security’s Office of State and Local Government Coordination and Preparedness. The T3 included players from Connecticut, Canada, and the United Kingdom. The purpose of the exercise was to test intraagency preparedness and response plans, conduct epidemiologic and criminal investigations, deploy assets, and supply medication to the affected public (U.S. Department of Homeland Security, 2007).

The NJDHSS and LINCS agencies prepared for T3 for nearly 1 year prior to the exercise. The HERC preparedness took place at monthly meetings, regional and local tabletop exercises and drills, and scheduled seminars.
designed to address specific biological agents, media training, and message map development. In the months leading up to T3, HERCs refined their risk communication plans, developed and tested emergency communication protocols, and participated in off-hours communication drills.

The NJDHSS developed a public information and communication shelf kit for use during public health emergencies. The shelf kit information contained fact sheets, frequently asked questions (FAQs) related to bioterrorism, message maps, and press release templates for the Category A biological agents and various chemical agents. The NJDHSS provided the shelf kit on CD-ROM to HERCs 2 months prior to the exercise.

The T3 scenario was an intentional release of *Yersinia pestis* (plague). The NJDHSS, along with other state, local government, and LINCS agencies, participated in the week-long exercise. Minimally, LINCS agencies were asked to receive, stage, and store assets from the Strategic National Stockpile and initiate the opening of an antibiotic point of dispensing (POD) in their jurisdictions. Some agencies opted to notionally open a POD, whereas others treated the exercise as a real event and opened a POD complete with volunteers, simulated victims, and real-world media.

It was anticipated that HERC duties during the exercise would vary depending on the LINCS agency’s level of participation. However, in most cases, job duties consisted of educating staff, volunteers, and the public about the disease agent, providing just-in-time training for staff and volunteers to function in a mass prophylaxis clinic, working with, or acting as, the public information officer, staffing and monitoring a hotline or communications center, preparing spokespeople for media interviews, posting press releases to the secure T3 mock-media Web site (VNN.com) and credentialing and monitoring local media.

An HERC meeting after the exercise to determine strengths and weaknesses (hot wash) provided valuable insight regarding the ability of one person being tasked with two roles during a public health emergency. The HERCs reported that they found it difficult to function in two highly visible roles, as both a health educator and risk communicator, during a 1-day simulated public health emergency. They noted that with all of the pre-event preparation, they were still overwhelmed with their expected tasks and responsibilities. Regardless, the T3 experience underscored the importance of risk communication during a public health emergency, because HERCs used this experience to test their risk communication plans and strengthen relationships with the media and local public information officers.

### PANDEMIC INFLUENZA

Since the T3 exercise, HERCs have had the opportunity to incorporate risk communication strategies into other preparedness and response initiatives, including severe weather events (floods and extreme heat), relationships with hard-to-reach populations and pandemic influenza planning.

In 2006, the CDC BTCA included additional funding for pandemic influenza preparedness. In an effort to inform the public about the different types of influenza and New Jersey’s preparedness efforts, the NJDHSS created a community education influenza program. The goal of Influenza: Facing New Global Challenges was to have a standardized presentation that synthesized potentially confusing information about influenza and pandemics and provided consistent messages for use statewide. The development of the community program incorporated various risk communication concepts and principles with the goals to alleviate confusion about the various types of influenza, debunk the many myths surrounding the disease, and inform the public what they could do to stay healthy and reduce their risk of contracting the flu. The presentation explained the differences between avian, seasonal, and pandemic influenza and stressed the importance of hand hygiene and staying home when feeling sick.

To reduce confusion, NJDHSS recognized the importance of providing the community with accurate and timely information with One Voice, One Message and enlisted HERCs to provide the community education program in their county or jurisdiction. The HERCs were trained at a monthly HERC meeting and received materials, including a CD-ROM, which had the community education program (complete with a PowerPoint presentation, presenter notes, pre- and posttests and sample promotional letter), planning checklists and pre-event message maps from the U.S. Department of Health and Human Services. The HERCs were asked to use the pre- and posttests each time they presented the program.

Between August 2006 and September 2007, 73 presentations have been provided to community groups, and 900 pre- and posttests have been collected. These tests identify participants’ recall of key points from the presentation and assess their level of concern for a future influenza pandemic and their level of confidence in New Jersey’s public health care system to prepare for and respond to an influenza pandemic. Data analysis of the pre- and posttests is in progress.

In addition to NJDHSS-approved influenza education programs, three HERCs attended the CDC’s pandemic influenza CERC training in fall 2006. This training...
focused on communication issues during a pandemic and how they differ from other emergencies.

Those who attended the training trained their HERC peers in fall 2007. All trained HERCs will reach out to local public health and health care professionals and other partners throughout the state to increase the understanding of crisis communication and the communication challenges during a pandemic.

**RISK COMMUNICATION CHALLENGES AND FUTURE INITIATIVES**

**One Voice, One Message**

The NJDHSS views HERCs as primary public health workers to disseminate messages and to provide feedback regarding local public health situations. The NJDHSS Office of Communications’ Risk Communication Plan specifies providing messages to HERCs via e-mail and/or phone. The same messages are sent via the Health Alert Network, which serves as a backup and redundant mechanism to ensure that the messages reach all HERCs.

Because they are so visible in their communities, HERCs are seen as a resource by residents, various partners, and local health agencies. The HERCs are viewed as sources for public health information and are invaluable to the efforts of relaying One Voice, One Message in their communities, which fosters less confusion, panic, and fear during an incident. Local health departments in New Jersey depend on the HERC to educate their staff, inform them of public health situations, and provide media talking points.

The HERCs are tasked with identifying and fostering relationships with various stakeholders and partners. Many have reached out to county and local governmental agencies, hospital, academic institutions, businesses, and community-based organizations to provide assistance with pandemic planning and exercising plans. Two communication challenges involve maintaining these relationships over time given personnel turnover and keeping pandemic influenza planning a priority.

In regard to the innovative approach to relaying risk communication messages, via HERCs, it is necessary to realize the significant change in the infrastructure. Before HERCs, there was no formal structure for relaying and disseminating messages at the local level or for ensuring consistent messages. Local health departments are not required to employ a full-time health educator. Often, a representative from the local health department would speak to local media, and the state health department was unaware. With the advent of the HERC, message coordination and collaboration exists at the local and county levels. The NJDHSS works with HERCs and their partners to ensure consistent One Voice, One Message. This infrastructure, along with the strong relationship between NJDHSS and HERCs, is a model that should be looked at by other states. Health educators are an untapped resource that can strengthen and expand communication efforts in the public health arena. Preparedness funding supplies a mechanism to incorporate the discipline into health departments and recognize the benefits of the state–local public health partnership.

**Public Apathy**

Pandemic influenza preparedness efforts bear striking similarities to activities related to organizing the 2003 smallpox planning and vaccination clinics. The public may not perceive pandemic influenza as a threat and dismiss communication and education efforts. Public health educators and planners must consider community apathy when preparing risk communication and prevention campaigns. The HERCs are appropriate messengers to relay prevention and personal preparedness communication, as they can add include influenza preparedness messages on to existing prevention and public health programs. Again, in their role as health educators, they have developed partnerships with grassroots leaders and are constantly looking for innovative ways to get their message to their constituents. Since 2002, the LINCS agency team has made great efforts to include the community and its leaders in drill and exercises to test various preparedness issues.

**Hard-to-Reach Populations**

The HERCs have begun a grassroots effort to identify groups within their communities that may not receive information or messages regarding preparedness via traditional media. This latest initiative aims to ensure that public health messages reach as many individuals as possible. For some communities, word of mouth and trusted community members are the best ways to relay messages. However, in a pandemic, this method of providing messages may be unavailable. Alternate channels of communication are being explored.

**Funding and Sustainability**

There has been turnover in the HERC position since 2003. As preparedness funding has decreased over the last few years, the HERC position is not always filled. Instead, the duties are often delegated to other team members, who may or may not have health education or communication backgrounds and important tasks...
are absorbed into other duties. As described earlier, HERCs found it difficult to function as both the health educator and the risk communicator during a public health emergency. If the HERO role is delegated to already overburdened public health staff, what important tasks will go undone during an emergency?

Retaining qualified and trained individuals is a challenge in any arena. However, previous HERCs cited low pay, little to no room for advancement within their agency, family obligations or a desire to pursue other interests as to why they left the job. In response to training new HERCs, NJDHSS, with the assistance of current HERCs, developed a daylong orientation. This orientation includes an introduction to public health in New Jersey, discussion of prior initiatives and current activities, and a clarification of the role and of expectations for the HERO. A regional mentoring program pairing new HERCs with veteran HERCs is also being formalized.

CONCLUSION

The HERO, a position solely dedicated to bioterrorism preparedness and risk communication, was an innovation in the New Jersey public health infrastructure. Bioterrorism preparedness and risk communication were new subject areas and, in some cases, HERO positions were difficult to fill. The individuals who filled the positions, more often than not, had a public health background; however, not many had prior experience with biological agents or risk communication. Fortunately, there were multiple outlets and opportunities for training and HERCs quickly became proficient in preparedness and response issues and biological agent epidemiology and mastered risk communication theory and concepts. In addition, they were integral members of mass prophylaxis clinic planning committees and Medical Reserve Corps recruitment efforts. Today, 6 years after the 9/11 attack, the HERO role is still relevant, but now HERCs face challenges in keeping the public engaged and interested in public health preparedness efforts.

With the potential threat of pandemic influenza, HERCs are again in an innovative position. Yet with the absence of a credible threat and a decline in media attention, public interest in a flu pandemic is waning. The HERCs are uniquely posed to empower communities and partners about influenza and pandemics. Although influenza is a familiar disease, special issues and circumstances surrounding a pandemic contribute to planning for uncertainties.

Having dedicated staff to attend to health education and risk communication issues has been beneficial to preparedness and response efforts in New Jersey. These individuals are knowledgeable about their communities and connected to local organizations, resources, and government services. Risk communication is a vital component of any public health event. Having competent and dedicated professionals with advanced risk communication training increases New Jersey’s capacity to mount and execute an effective public information response to a public health emergency.

REFERENCES