

tain the level of collaboration between their departments and local hospitals in regard to WMD preparedness and a coordinated medical and public health response. Forty-four (90%) of 49 CHDs completed the interview. One of the 49 responding CHDs is responsible for a six-county area, thus accounting for the state's 55 counties.

Fewer than half (20 of 44) of the respondents have provided contact information to local hospitals, and barely 20% have reciprocal information. Twenty-one percent were either unaware of a policy for WMD preparedness or reported that it was being handled by another agency. Although 72% of CHDs had attended WMD training, only 14% of the training was in conjunction with hospitals. While nearly two thirds rated their communication with hospitals as moderate to strong, a similar proportion stated they had no protocol for communicating with hospitals about a WMD event. Eighty-six percent of CHDs reported that no new collaborative efforts were directed towards the early identification of new or emerging infectious diseases possibly related to bioterrorism. However, approximately one third of the CHDs thought they should take initiative in this matter. Over 60% indicated that primary responsibility for identifying biological agents rested in another agency or was not the sole responsibility of the CHD. Further, 20% indicated they were weak or untrained in this area and thought that development and implementation of policies, procedures, and training were needed. While 93% of CHDs felt joint

training with hospitals would be beneficial, particularly in defining their respective roles in a WMD scenario, many cited manpower and scheduling constraints for such joint training sessions. Overall, CHDs reported weak relationships with area hospitals, but thought that development or improvement of policies and procedures through regular meetings and training would help prepare and plan for a WMD event.

The results of this survey suggest that before September 11, West Virginia CHDs and local hospitals had little collaboration in preparing to respond to a WMD event. Despite the recent terrorist activities, local health departments and hospitals may still be reluctant to spend resources in preparation for events with a low probability of occurring, such as WMD incidents. The local health departments and hospitals think that other pressing programs will be jeopardized (6–8). Many federal and state initiatives are under way to enhance the public health infrastructure and its preparation and response to bioterrorism. Improving on programs to meet daily operational challenges, as well as those presented by a WMD event, must include the expertise of local health departments and hospitals and encourage the creation of innovative, cost-effective preparedness programs at the local level (9,10). Future research should be conducted in areas of resource education and training, allocation and sharing, personnel, and policy. This research will indicate if existing programs should be improved

and if new programs should be instituted.

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Correction, Vol. 8, No. 5

In “Phylogenetic Analysis of a Human Isolate from the 2000 Israel *West Nile virus* Epidemic” by Thomas Briese et al., errors occurred in the text and figure legend. On page 529, right column, line 25, and in the figure legend on page 530, the host species for ISR-00PigC is pigeon. Additionally, in the figure legend, the GenBank accession no. for ISR-00PigC is AF380671, and the GenBank accession no. for WNV-ROM96(0334)-1996 is AF205879.

The online article at <http://www.cdc.gov/ncidod/EID/vol8no5/01-0324.htm> has been corrected.

We regret any confusion these errors may have caused.

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