

Emerging Public Health Threats: Tracking Infectious Disease Across Borders

Summary Report

August 10-11, 2004
Bellingham, Washington

Alaska
Alberta
British Columbia
Idaho
Montana
North Dakota
Oregon
Washington
Yukon



Washington State Department of
Health

Emerging Public Health Threats: Tracking Infectious Disease Across Borders

Summary Report

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Secretary of Health

Acknowledgements

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Acknowledgements (Continued)

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Acknowledgements (Continued)

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and Milne and Associates, LLC

Executive Summary

On August 10-11, 2004, the Washington State Department of Health held a workshop in Bellingham, Washington entitled *Emerging Public Health Threats: Tracking Infectious Disease Across Borders*. Time will tell whether what is now known as the “Bellingham meeting” will fulfill its historic expectations. Participants felt history was in the making as they left the conference with a renewed commitment to collaborative partnership.

The workshop’s purpose was to begin establishing a seamless cross-jurisdictional public health infectious disease surveillance system that can quickly and efficiently track acts of bioterrorism and emerging pathogen threats across local, state, provincial and the United States/Canada international borders. More than 200 invited professionals in the fields of epidemiology, public health laboratories, emergency management, and law came from Canada (Alberta, British Columbia, Canada Federal Government and Yukon Territories), Native American Tribes and the United States (Alaska, Idaho, Montana, North Dakota, Oregon, the United States Federal Government and Washington). Session speakers (plenary, lunch, dinner and breakout) provided insights into the multidisciplinary challenges of preparedness and the compatibilities of systems of detection and response within the local, provincial, state, and national jurisdictions in the region. On the day preceding the workshop, about 90 public health professionals from many of these jurisdictions also attended a 3-hour pre-workshop epidemiology session sponsored by the Washington State Department of Health to share information about their programs and experiences through a series of presentations and discussions (See [Appendix A](#)).

Emerging Public Health Threats: Tracking Infectious Disease Across Borders was truly a working conference. Participants were challenged to meet the following charge:

1. To build and strengthen strong professional relationships across our borders.
2. To develop a framework for formal agreements which define the major policy areas and guides our work together in tracking infectious disease across borders.
3. To develop a work plan which describes next steps in assuring that the protocols and procedures are in place to execute the agreements.

Using two separate tabletop exercises, all participants helped identify policy issues critical for successful development of cross-border tracking of infectious disease. These policy issues guided the subsequent development of detailed descriptions of the issues by breakout groups from the perspective of the individual disciplines. The leading five priority issues the breakout groups identified were communication (initial and on-going), jurisdictional issues, surveillance system compatibility, resources (human and material), and legal issues.

The meeting recorded substantive language useful in future memoranda of understanding which will guide this work among the partners. In addition, the final multi-disciplinary plenary sessions elicited commitments for immediate initiatives in five areas:

1. Formalizing Workgroups and Timelines for Development of Agreements
2. Developing a 24/7 Contact List/Directory
3. Planning and Executing Cross-Border Exercises, Joint Training and Systems of Continuous Improvement
4. Advocating for Public Health Preparedness at Appropriate Policy Levels
5. Planning the Next Workshop

Attendees signed on to actively participate in these initiatives and conveners volunteered to assure follow-through. Local, state, provincial and national leaders have stepped forward: this bodes well for realizing the historic aspirations of the group.

Table of Contents

Page

v	Executive Summary
1	Introduction
1	Speaker Presentations
1	Tabletop Exercises
2	Breakout Group Work Sessions
3	Building Networks and Agreements

APPENDICES

8	Appendix A -	Epidemiology Pre-Workshop Agenda
9	Appendix B -	Workshop Agenda
12	Appendix C -	Workshop Announcement
13	Appendix D -	Workshop Charge to Participants
14	Appendix E -	Tabletop Scenario Issues Report
21	Appendix F -	Breakout Session Approach
22	Appendix G -	Reports from the Breakout Workgroup Sessions
43	Appendix H -	Speaker Biographies
48	Appendix I -	List of Registered Participants

Electronic Copies of Workshop Materials

Electronic copies of workshop materials, including this report, the available speaker presentations in Acrobat Reader format, tabletop exercises, agreement examples and an updated participant list in Microsoft Excel may be obtained on compact disk (CD) by contacting Wayne Turnberg, Washington State Department of Health at (206) 522-0132 or by email at Wayne.Turnberg@doh.wa.gov.

Introduction

“Emerging Public Health Threats: Tracking Infectious Disease Across Borders” was designed to be a working conference. The planning committee held the view that breadth and depth of expertise among the invitees to the workshop was such that three goals could be achieved:

1. Build and strengthen strong professional relationships across our borders.
2. Develop a framework for a formal agreement which defines the major policy areas and guides our work together in tracking infectious disease across borders.
3. Develop a work plan which describes next steps in assuring that the protocols and procedures are in place to execute the agreement.

The agenda ([Appendix B](#)) structured the work to accomplish the goals intermingling formal presentations, informal opportunities for dialogue and facilitated sessions leading to specific and concrete outcomes. More than 200 invited professionals in the fields of epidemiology, public health laboratories, emergency management, and law came from Canada (Alberta, British Columbia, Canada Federal Government and Yukon), Native American Tribes and the United States (Alaska, Idaho, Montana, North Dakota, Oregon, the United States Federal Government and Washington) ([Appendix C](#)). Participants were charged with working towards meeting the workshop’s goals ([Appendix D](#)). The sessions were facilitated by the team of professionals from the University of Washington’s Northwest Center for Public Health Practice, Milne and Associates, LLC, and the Department of Health (See [Acknowledgements](#)). The unedited raw output from specific sessions is provided in the appendices to honor the onsite work of the participants. Each session is summarized in the following sections.

Speaker Presentations

Speakers and their presentation titles are identified in the workshop agenda ([Appendix B](#)). Speaker biographical sketches are presented in [Appendix H](#). Electronic copies of the available speaker presentations are available on [CD-ROM](#) from the Department of Health (see contact information at the bottom of page vii).

Tabletop Exercises

Two concurrent tabletop exercises were conducted to raise questions needing further discussion and clarification during the breakout work sessions that followed later in the afternoon. One tabletop exercise, developed by Dennis Anderson and Sabine Guenther of the Washington State Department of Health, involved a fictional account of a large-scale flu-like communicable disease outbreak aboard a cruise-ship. The scenario, which was facilitated by Dennis Anderson, primarily affected Alaska, British

Columbia and Washington. The other tabletop exercise, developed and facilitated by Carl Osaki of the University of Washington's Northwest Center for Public Health Practice, involved a fictional account of a food-borne communicable disease outbreak affecting US states and Canadian provinces.

Issues and questions raised for further discussion during the breakout sessions were recorded during each session under the following headings:

1. Initial and on-going communication (what sets it off, who talks to whom)?.
2. Surveillance system compatibility between Canada/US
3. Distribution of antimicrobials
4. Human and material resources
5. Media relationships
6. Legal issues
7. Economic impacts associated with outbreaks
8. Jurisdictional issues (who does what?)
9. Cultural competencies (multi-cultural groups)
10. Other issues
11. Additional issues identified at the end of the outbreak

The unedited report of the recorded issues identified by the participants in each tabletop exercise group is presented in [Appendix E](#) (Tabletop Scenario Issues Report). Electronic copies of the tabletop exercises are available on [CD-ROM](#) from the Department of Health (see contact information at the bottom of page vii).

Breakout Group Work Sessions

Following the tabletop exercises, participants broke out into five breakout work groups under the discipline areas of epidemiology (broken into two groups), public health laboratories, emergency managers, and law with objectives of: 1) developing an understanding of the system of response on each side of the border; 2) identifying the connections between both systems in relation to the issues identified in the tabletop exercises; and 3) identifying essential key policies that need to be developed for the framework of an agreement. The goal, objectives, and methods to conducting the breakout group work sessions are presented in [Appendix F](#) (Breakout Session Approach).

During the sessions, each breakout group prepared a report that attempted to summarize discussions of key issues under the following headings:

- Key issue
- Definition of issue
- Desired outcome/goals
- Objectives
- Key people
- Due date for accomplishment of objectives
- Measures of effectiveness and evaluation plan
- Sustainability

Unedited summary reports from each of the breakout workgroup sessions are presented in [Appendix G](#). Priority issues identified by each breakout work group are presented in Table 1.

Table 1. Priority issues identified by each breakout work group

Issues	Epidemiology Group A	Epidemiology Group B	Public Health Lab	Emergency Managers	Law
Communication (Initial and Ongoing)	X	X	X	X	X
Jurisdictional Issues	X	X		X	X
Surveillance System Compatibility	X	X	X		
Resources (Human and Material)		X	X	X	X
Legal Issues					X

Building Networks and Agreements

The meeting recorded substantive language useful in future memoranda of understanding which will guide this work among the partners. In addition, the final multi-disciplinary plenary sessions elicited commitments for immediate initiatives in five areas:

1. Formalizing workgroups and timelines.
2. Developing a 24/7 contact list directory.
3. Planning and executing cross-border exercises, joint training and systems of continuous improvement.

4. Advocating for public health preparedness at appropriate policy levels.
5. Planning the next annual conference on cross-border public health preparedness.

Workgroups, leads, and work plans for each of these initiatives are described as follows:

Initiative 1: Formalizing Workgroups and Timelines for Development of Agreements

Five discipline-specific workgroups will be formed to develop formal agreements relating to cross-border infectious disease tracking and response. These groups and the leads who volunteered to coordinate each group’s timelines, schedules and agendas are presented in Table 2.

Workplan: Workgroup leads will identify committee members and establish an agenda working toward developing a formal cross-border infectious disease tracking and response agreement.

Timeline: Plans for the first conference call for each group will be arranged before the end of September 2004.

Table 2. Field-Specific Workgroups and Leads

Workgroup	Lead
Epidemiology/Surveillance	Jo Hofmann, Washington State Department of Health David Patrick, BC Centre for Disease Control
Communications	Laura Blaske, Washington State Department of Health
Legal	Joyce Roper, Washington State Attorney General’s Office
Public Health Laboratory	Mike Davison, Washington State Department of Health Muhammad Morshed, BC Centre for Disease Control
Emergency Response	Wayne Dauphinee, British Columbia Ministry of Health Services TJ Harmon, Snohomish Health District, PHEPR Region 1

Initiative 2: Developing a 24/7 Contact List Directory

At the plenary session, it was agreed that a 24/7 contacts list directory will be developed and periodically updated. Those who volunteered to take on a lead role for this project are:

- Wayne Dauphinee, BC Ministry of Health Services
- Jo Hofmann, MD, Washington State Department of Health

The leads will establish and set a meeting date for the 24/7 Directory working group. Action dates will be established during the working group's first meeting.

Those who volunteered to assist on this project are as follows:

1. Cheryl Anderson, Vancouver Coastal Health Authority
2. Laura Blaske, Washington State Department of Health
3. Betsy Bower, US Food and Drug Administration
4. Jack Bunn, Washington State Department of Health
5. Harvey Crowder, Benton-Franklin Health District, PHEPR Region 8
6. Wayne Dauphinee, BC Ministry of Health Services
7. Judy Dumont, Fraser Health Authority
8. Glen Embree, Fraser Health Authority
9. Joe Finkbonner, Northwest Portland Area Indian Health Board
10. Cindy Gleason, Washington State Department of Health
11. TJ Harmon, Snohomish Health District, PHEPR Region 1
12. Maxine Hayes, Washington State Department of Health
13. Jo Hofmann, Washington State Department of Health
14. Joshua Jones, Northwest Portland Area Indian Health Board
15. Steve Kutz, Mason County Health Department
16. Jay Lewis, Washington Department of Health
17. David Patrick, BC Centre for Disease Control
18. Sara Podczervinski, Washington State Department of Health
19. Stacy Reisneauer, Spokane Regional Health District
20. Sheila Service, Vancouver Island Health Authority
21. Paul Stepak, Spokane Regional Health District
22. Greg Stern, Whatcom County Health Department
23. Nigel Turner, Tacoma-Pierce County Health Department
24. Paul Watersrat, Okanogan County Public Health Department

Initiative 3: Planning and Executing Cross-Border Exercises, Joint Training and Systems of Continuous Improvement

A workgroup will be formed to 1) Identify type of exercises and training needed (assessment), 2) Identify improvements to achieve (results); 3) Use existing training and expand (inclusive); and 4) Identify what works and what doesn't work.

Those who volunteered to take on a lead role for this project are:

- Paul Cox, BC Ministry of Health
- Karen Crouse, Spokane Regional Health District

The following action dates were established during the plenary session:

- Goals and objectives – Planning to begin before the end of September 2004
- Washington state exercise – May 24-25, 2005
- An Action Report will be presented at the next cross-border conference

Those who volunteered to assist on this project are as follows:

1. Karie Brouillard, Spokane Regional Health District
2. Dave Burgess, Fraser Health Authority
3. Bill Douglas, Health Canada, BC Yukon Health Region
4. Bill Edstrom, Spokane Regional Health District
5. Cindy Gleason, Washington State Department of Health
6. TJ Harmon, Snohomish Health District, PHEPR Region 1
7. Dale Kloes, Whatcom County Sheriff, Division of Emergency Management
8. Alvin Lee, Federal Emergency Management Agency
9. Eric Sergienko, Washington State Department of Health
10. Captain Andy Stevermer, Centers for Disease Control and Prevention
11. Paul Swenson, Public Health: Seattle and King County
12. Bud Taylor, Washington State Department of Health
13. Colonel Norman J. Toney, National Disaster Medical System

Initiative 4: Advocating for Public Health Preparedness at Appropriate Policy Levels

A workgroup will be formed to communicate the value and importance of public health preparedness to elected and senior public health policy makers at all levels.

Those who volunteered to take on a lead role for this project are:

- Wayne Dauphinee, BC Ministry of Health Services
- John Erickson, Washington State Department of Health

The leads will establish and set a meeting date for the advocacy working group. Action dates will be established during the working group's first meeting.

Those who volunteered to assist on this project are as follows:

1. Cheryl Anderson, Vancouver Coastal Health Authority
2. Sarah Baker, Tacoma-Pierce County Health Department
3. Peter Browning, Skagit County Health Department
4. Dave Cundiff, Clark County Health Department
5. Marcia Johnson, Capital Health Authority
6. Perry Kendall, BC Ministry of Health Services
7. Sue Olsen, Health Canada
8. Dave Peterson, Snohomish Health District
9. Paul Waterstrat, Okanogan County Public Health
10. Diana Yu, Thurston County Public Health

Initiative 5: Planning the Next Workshop

A workgroup will be formed to plan the next “Tracking Infectious Disease Across Borders” workshop which is tentatively scheduled to take place in British Columbia about February 2005.

Those who volunteered to take on a lead role for this project are:

- Wayne Dauphinee, BC Ministry of Health Services
- John Erickson, Washington State Department of Health

Those who volunteered to assist on this project are as follows:

1. Eric Bone, Capital Health Authority
2. Kevin Elwood, BC Centre for Disease Control
3. Jennifer Foster, Washington State Department of Health
4. TJ Harmon, Snohomish Health District, PHEPR Region 1
5. Valerie Munn, Washington State Department of Health
6. Pat Nault, Alaska Division of Public Health
7. Sheila Service, Vancouver Island Health Authority
8. Michael Smith, Washington State Department of Health
9. Jude Van Buren, Washington State Department of Health

Appendices

- [Appendix A](#) - Epidemiology Pre-Workshop Agenda
- [Appendix B](#) - Workshop Agenda
- [Appendix C](#) - Workshop Announcement
- [Appendix D](#) - Workshop Charge to Participants
- [Appendix E](#) - Coast and Land Tabletop Exercise Issues Report
- [Appendix F](#) - Breakout Session Approach
- [Appendix G](#) - Reports from the Breakout Workgroup Sessions
- [Appendix H](#) - Speaker Biographies
- [Appendix I](#) - List of Registered Participants

Appendix A

Emerging Public Health Threats: Tracking Infectious Diseases Across Borders

Pre-Conference Epidemiology Meeting 8/9/04

Agenda

1300 – Sign in and introductions

1320 – 1340 -Bio “What?” –

Jo Hofmann, MD, WA State Epidemiologist for
Communicable Disease

1340-1400 - Syndromic Surveillance –

Laurie Stewart, MS, Public Health: Seattle and King
County, Communicable Disease,
Epidemiologist

Nigel Turner, BS, MPH, RS, Tacoma-Pierce
County Health Department,
Epidemiology Manager

Hilary Metcalf, MPH, Region 2, Kitsap County
Health District,
Epidemiologist

1400-1420 -"Are We There Yet? Challenges in Rural Public Health Preparedness"–

Kammy Johnson, DVM, PhD, Montana
Department of Public Health and Human
Services

1420-1440 - Border Infectious Disease Surveillance, US & Mexico –

Steve Waterman, MD, MPH, CDC Division of
Global Migration and Quarantine

1440-1500 -Break

1500-1520 - Idaho PH Reporting and Surveillance in a Nutshell -

Christine Hahn, MD, Idaho Department of
Health and Welfare

1520-1540 - Canada Surveillance –

Lisa Zetes-Zanatta, MPH, BC Center for Disease
Control

1540-1600 - EWIDS –

Donna Duffy, MPH, RN, WA State Department
of Health

Appendix B

Workshop Agenda

Emerging Public Health Threats:
Tracking Infectious Disease Across Borders
(Attendance by Invitation Only)
August 9 – 11, 2004

Pre-Workshop Activities: August 9, 2004

1:00-4:00 **Epidemiology Pre-Workshop Work Session**
4:00-7:00 **Early Workshop Registration**
6:30-8:30 **Meet and Greet Mixer**

Day 1: August 10, 2004:

7:30-8:30 **Registration / Continental Breakfast**

Morning Session

8:30-9:00 **Welcome and Introduction.** Mary Selecky, Secretary, Washington State Department of Health, Presiding

- Regina Delahunt, Director, Whatcom County Health Department
- Joe Finkbonner, EpiCenter Director, Northwest Portland Indian Health Board
- Dr. Patrick O'Carroll, MD, Regional Health Administrator, US Department of Health and Human Services, Region X, Office of Public Health and Science

9:00-9:45 **How Does Emergency Response Work North of the 49th?** Dr. David Patrick, MD, Associate Professor, University of British Columbia/Director, Epidemiology Services, British Columbia Centre for Disease Control

9:45-10:00 **Break**

10:00-12:00 **Tabletop Exercises** (Concurrent Sessions)

- **Tabletop Land Scenario Exercise.** Presenter: Carl Osaki, Clinical Associate Professor, Northwest Center for Public Health Practice, University of Washington
- **Tabletop Coast Scenario Exercise.** Presenter: Dennis Anderson, Emergency Manager, Washington State Department of Health

12:00-1:30 **Lunch**

Moderator: Joyce Roper, Senior Assistant Attorney General, Washington State Office of the Attorney General

- **Legal Perspectives.** Jason Sapsin, JD, MPH, Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management

Afternoon Session

1:30-5:00

Breakout Workgroup Sessions

- **Track 1A: Epidemiology Surveillance and Investigation**
 - US Presenter: Dr. Jo Hofmann, MD, State Epidemiologist, Communicable Disease, Washington State Department of Health
 - Canada Presenter: Dr. Lisa Zetes-Zanatta, Surveillance Epidemiologist, British Columbia Centre for Disease Control
 - Facilitator: Tom Milne, Principal, Milne & Associates and Carl Osaki, Northwest Center for Public Health Practice, University of Washington

- **Track 1B: Epidemiology Surveillance and Investigation**
 - Canada Presenter: Dr. David Patrick, MD, British Columbia Centre for Disease Control
 - US Presenter: Dr. Marcia Goldoft, MD, MPH, Medical Epidemiologist, Washington State Department of Health
 - Facilitator: John Kobayashi, MD, Northwest Center for Public Health Practice, University of Washington and Casey Milne, Principal, Milne & Associates

- **Track 2: Public Health Laboratories**
 - US Presenter: Dr. Romesh Gautam, PhD, Director, W. R. Geidt Public Health Laboratories, Washington State Department of Health
 - Canada Presenter: Dr. Judith Isaac-Renton, MD, Director, Laboratory Services, British Columbia Centre for Disease Control
 - Facilitator: Paul Wiesner, MD, Milne & Associates

- **Track 3: Emergency Managers**
 - Canada Presenter: Paul Cox, Public Health Emergency Management Consultant, British Columbia
 - US Presenter: Dennis Anderson, Washington State Department of Health
 - Facilitator: Rick Buell, Washington State Department of Health

- **Track 4: Legal issues**
 - US Presenter: Joyce Roper, JD, Senior Assistant Attorney General, Washington State Office of the Attorney General
 - Canada Presenter:
 - Facilitator: Jack Thompson, Director, Northwest Center for Public Health Practice, University of Washington

5:30-7:00

Dinner

Moderator: Jude VanBuren, Assistant Secretary, Epidemiology, Health Statistics and Public Health Laboratories, Washington State Department of Health

- **Public Health Without Borders: Connected Leaders. Protected People.** Dr. Maxine Hayes, MD, State Health Officer, Washington State Department of Health.

Day 2: August 11, 2004

8:00-8:30 **Gathering / Continental Breakfast**

Morning Session

8:30-8:45 **Morning Greeting.** Mary Selecky, Secretary, Washington State Dept of Health

Welcome and Introductions. Dr. Patrick O'Carroll, MD, Regional Health Administrator, Department of Health and Human Services, Region X, Office of Public Health & Science, Presiding

Yesterday's Recap / Today's Charge. Dr. Jo Hofmann, MD, State Epidemiologist, Communicable Disease Epidemiology, Washington State Department of Health

8:45-9:45 **Anthrax in New York City, 2001: Lessons Learned for Regional Coordination.** Dr. Marcelle Layton, MD, Assistant Commissioner, New York City Department of Mental Health & Hygiene.

9:45-10:00 **Break**

10:00-12:00 **Plenary Work Session.** Facilitators: Paul Wiesner, MD, Tom Milne, Casey Milne, Milne & Associates

- Report from the Tabletop Exercises
- Reports from the Five Breakout Workgroups

12:00-1:30 **Lunch**

Moderator: Dr. Romesh Gautam, PhD, Director, W. R. Geidt Public Health Laboratories, Washington State Department of Health

- **Binational Bioterrorism Preparedness: Our Experience with Mexico.** Dr. Harvey Holmes, Deputy, Laboratory Response Branch/Bioterrorism Preparedness, National Centers for Infectious Diseases, Centers for Disease Control and Prevention

Afternoon Sessions

1:30-3:30 **Building Networks and Agreements.** Facilitators: Paul Wiesner, MD and Tom Milne, Principal, Milne & Associates

- Topical Cross-Disciplinary Breakout Group Work Session

3:30-3:45 **Break**

3:45-4:30 **Symposium Wrap Up / Next Steps / Workshop Evaluation.** Facilitators: Paul Wiesner, MD and Casey Milne, Principal, Milne & Associates

Final Remarks / Commitment to the Future. Mary Selecky, Secretary, Washington State Department of Health

4:30 **Workshop Adjournment**

Appendix C

Workshop Announcement

Emerging Public Health Threats:
Tracking Infectious Disease Across Borders
(Attendance by Invitation Only)

Dates	August 9, 2004 (Pre-Meeting Activities) August 10-11, 2004
Location	Best Western Lakeway Inn 714 Lakeway Drive Bellingham, WA 98226 Tel: (360) 671-1011 or (888) 671-1011
Target Audiences	Communicable disease epidemiologists and investigators, surveillance information technologists, hospitals, health authorities, public health laboratory representatives, public health lawyers, and emergency managers.
Participating Jurisdictions	United States: Federal, tribal, state and local representation. Participants include representatives from United States federal government, Washington (state, local and tribal), Idaho, Alaska, Oregon, Montana, and North Dakota. Canada: Federal, provincial, territorial and regional representation. Participants include representatives from Canadian federal government, British Columbia, Alberta, and Yukon.
Workshop Goal	To work toward establishing a seamless cross-jurisdictional public health infectious disease surveillance system that can quickly and efficiently track acts of bioterrorism and emerging pathogen threats across the US/Canada international border.
Workshop Charge	<ol style="list-style-type: none">1. To build and strengthen strong professional relationships across our borders.2. To develop a framework for formal agreements which define the major policy areas and guides our work together in tracking infectious disease across borders.3. To develop a work plan which describes next steps in assuring that the protocols and procedures are in place to execute the agreements.

Appendix D

Workshop Charge to Participants

- Build and strengthen strong professional relationships across our borders.
- Develop a framework for a formal agreement which defines the major policy areas and guides our work together in tracking infectious disease across borders.
- Develop a work plan which describes next steps in assuring that the protocols and procedures are in place to execute the agreement.

Appendix E

Coast and Land Tabletop Exercise Issues Report

Following is a listing of issues raised during each of the two tabletop exercises:

(1) INITIAL AND ON-GOING COMMUNICATION (WHAT SETS IT OFF, WHO TALKS TO WHOM)?

COAST

- CDC has cruise ship inspection stations- cruise ships required to report sick before arrival 24 hours out; required to report to quarantine office prior to porting-3% trigger for Health ; Health Canada and CDC would be in communication
- CDC health alert may be issued

LAND

- **Storyboard 1A** – do we have a problem? How is this different than any other day?
 - How would Alberta know what was going on in the US?
 - What would an operating case definition be? How is this defined a significant problem?
 - What is communication process between LHJs?
 - How do we communicate with people on verge of weekend?
- **Storyboard 1B**
 - Threshold protocols consistent?
 - Communication with EDs/frontline providers in community – over the weekend? What to anticipate?
 - Who has authority to determine outbreak status?
 - How/when are other states notified?
 - How do we assure awareness increased and capacity is lined up?
 - Who's on call? Is there a system in place to call back?
 - Who do front line providers call on the weekend? 24/7 notification protocols
 - Who will PH communicate outbreak info to?
 - Who should be on the call/on-call for decision making for notification
 - Who does CDC contact upon receiving report from WA DOH – local health? Province?
 - Who determines scale of event in re: to upcoming economic conference – at what point does epi investigation consider the broader context?
- **Storyboard 1B**
 - How do we get a case definition?
 - What is the communication plan/protocol?
- **Storyboard 1C**
 - At what point do notifications from BC/Canada to National Health take place?
 - Do hospitals/ems/local labs know what's being done? What are lines of communication with these agencies/disciplines?
 - Who makes the call on identifying the organism?

- **Storyboard 1D**
 - What other agencies involved with food need to be notified?
 - Talk to Canadian inspectors – interagency coordination
 - Coordinate with disease investigators cross-border, state/local/province
- **Storyboard 2A**
 - Who else needs to know – who needs to respond?
 - How do we assure the response agencies are notified?
 - Who's in charge/who is the spokesperson?
- **Storyboard 2B**
 - Information obtained by public health experts needs to be conveyed to law enforcement
- **Storyboard 2C**
 - What is health's role vs school's role in communicating the event information?
 - Who is responsible for working with the schools?
 - After patient death, need for communication
- **Storyboard 2D**
 - Who will collected information be released to?

(2) SURVEILLANCE SYSTEM COMPATIBILITY BETWEEN US/CANADA

COAST

- Outside of business hours, there may not be notification
- Sampling done? Rapid test kits on board

LAND

- **Storyboard 1D**
 - Identification of surge capacity
 - Guidance on who to sample and how many samples
 - Can non-epi responders be trained?
 - Who is collecting information about cases and how is it being transmitted?
 - Basic information collected similar – used for early calls across jurisdictions re: case finding, other communication
 - How do we share hypotheses re: organism
- **Storyboard 2B**
 - Coordinated epi response – what are we learning as the outbreak proceeds?
Coordinating information

(3) DISTRIBUTION OF ANTIMICROBIALS

None noted in either scenario

(4) HUMAN AND MATERIAL RESOURCES

COAST

- Local jurisdictions (LHJs) are likely overwhelmed with worried well and relative calls and self reporting; presenting at local hospitals and clinics

- CD Investigation triggered in Washington by chicken farm; Dept of Ag involved
- Surge capacity requested- how are interagency and international investigations managed
- Local EOCs opened
- JIC opened

LAND

- **Storyboard 1B**
 - What is lab capacity? Where are samples being taken? Where are they going?
 - When does the state lab weigh in to assure protocols are followed?
- **Storyboard 1D**
 - What is the process for sampling and making sure they are transported to lab?
 - Protocols for triaging lab samples
- **Storyboard 2B**
 - Accuracy of data and testing procedures questioned
- **Storyboard 2D**
 - Protocols for sharing lab information?
 - Who makes the call across the border?

(5) MEDIA RELATIONSHIPS

COAST

- Possible media leak prior to reporting
- Local PH notification will likely come via media
- Identify PIOs for each agency
- Necessary for damage control of worried well- regular updates must be made regardless of identification of agent

LAND

- **Storyboard 1B**
 - How/when does the media get involved? (DOH preps communication office involvement)
 - What is the message to the public – what is public notification process?
 - Lab capacity for media? Pressure on lab to release results information
 - How assure parts of system respond appropriately to media?
- **Storyboard 1C**
 - Who is the spokesperson to the public? I.e. Hospital spokesperson, public health spokesperson, etc
 - How do we manage the national news media i.e CNN, NBC, FOX News
 - How do we define messages/Consistent messaging from all information officers/ communication offices
 - How do we coordinate cross border media communications? (Regions/ states/ province/ locals/ etc)
 - What's our message to the public – what to do, what not to do?
 - Preventative messaging – public health education
 - Accuracy of information going to public?
- **Storyboard 2A**
 - Who's in charge? Who is the spokesperson?
 - Who responds to breaking news on national TV?

- **Storyboard 2B**
 - How do we insure proactive public messaging?
 - Who is the designated spokesperson?
- **Storyboard 2C**
 - Issues of training and risk communication as hospitals are overwhelmed
 - Is State EOC activated?
 - How do we get the message out to patients who need care?

(6) LEGAL ISSUES

COAST

- The quarantine Officer would decide whether or not to allow passengers to disembark.
- Both federal and State government have jurisdiction
- CDC has financial liability
- Multiple legal layers of confidentiality jurisdiction

LAND

- **Storyboard 1C**
 - WA law liberal with public information/ public disclosure – media pressure to release information re: emerging event
 - When do we activate mutual aid? Who has authority to activate?
- **Storyboard 2A**
 - LE role vs public health role? Who's in charge of investigation?
- **Storyboard 2B**
 - Issues between food growers and distributors – background checks on employees?
 - Chain of custody maintained on samples to lab? LE will want to interview company employees
- **Storyboard 2C**
 - How will we deal with individuals who are not treated or refusing treatment?
 - Are there legal recourse for individuals turned away from overwhelmed hospitals/care centers
 - Issues of patient confidentiality – HIPAA?
- **Storyboard 2D**
 - What is FBI's authority to get patient information, legal basis?
 - When FBI makes request, time for major legal involvement
 - LE wants information re: employees and what happened at the Salmonella genetic Stock Centre leading up to incident
 - How is information collected from stock center?

(7) ECONOMIC IMPACTS ASSOCIATED WITH OUTBREAKS

COAST

- Bad press if the info is released
- Exposures in Alaska and Washington (prior to departure)

LAND

- Shutting down restaurants
- What is threshold for closing?
- Who do we contact for protocols for closing restaurants
- Issues relating to incident back to economic summit
- **Storyboard 2E**
 - Chamber of commerce, tourism, new economic factors –
 - What is risk that may impact summit? How accurate is information re: risk?
 - Who decides to cancel economic summit? LE vs PH
 - What protocols might be developed for a different venue?

(8) JURISDICTIONAL ISSUES (WHO DOES WHAT?)

COAST

- Who has jurisdiction when their plan is implemented
- Locals would plan with or without jurisdiction
- Who decides if the ship ports
- International collaboration would be by invitation
- How does that change one criminal activity is determined
- RCMP and FBI would collaborate while CA has jurisdiction

LAND

- What is threshold for determining problem?
- **Storyboard 1B**
 - What's going on with LHJs?
 - LHJs – how are you going to notify on Saturday morning?
 - How do we communicate across jurisdictions?
 - When do we activate EOCs? Which ones are activated? What are they asked to do?
- **Storyboard 1C**
 - How do LHJs manage the worried well?
 - Who's in charge regionally? Is there a regional command center?
- **Storyboard 2A**
 - Role of PH...
 - How do we assure, with LE involved, this is terrorist related and not naturally occurring?
- **Storyboard 2B**
 - How is the message getting out to all local providers?
- **Storyboard 2E**
 - Who decides to cancel economic summit? LE vs PH
 - Relative risk assessment – economics, jobs vs effects of outbreak

(9) CULTURAL COMPETENCIES (MULTI-CULTURAL GROUPS)

COAST

- None

LAND

- **Storyboard 1B**
 - How do we communicate/message to special populations or ESL community
- **Storyboard 2C**
 - Who will manage the worried well?
- **Storyboard 2E**
 - How do we communicate info to special populations?
 - What other partners need cross-cultural education?

(10) OTHER

COAST

- What is the ship's plan?
- What is available on board
- Plan to protect investigators who board the ship
- Outbreak investigation team—while jurisdictional issues are sorted out, the agent needs to be contained and identified by someone
- Interagency and interdisciplinary communications and contact info in place?
- Participation of Cruise Ship company in EOC? Geographical limitations
- PPE for first responders
- Recovery operations
- Security of Ship prior to entry of first responders
- Political and economic impact
- Quarantine not answered
- US Military? (involved via Coast Guard)
- Border Patrol?
- WHO statements?
- WHO working on international reporting/ notification system

LAND

- **Storyboard 1A**
 - Lab protocols, specimen collection/sampling?
- **Storyboard 1B**
 - At this point who else becomes involved/mobilized? Preparedness staff?
 - How do we involve hospitals/local providers/ when do we involved local providers/hospitals
 - How do we mobilize local public health
- **Storyboard 1C**
 - Do we know what resources are available?
 - What's the backup plan? When do you activate the EOC plan?
 - Have we given a head's up to the emergency managers?
 - When do we brief elected officials?
 - When do we muster supplies and equipment – from where?
 - Are hospitals labs communicating with state labs?
 - How does government find out about pharmacy stocks?
 - What is the trigger for requesting pharmaceuticals?
 - What is the system for dealing with community panic/chaos?

- What is the federal role – when/how will they insert themselves and with what resources?
- Physician response need for guidance - consistent messaging from LHJs
- Are there provisions to keep pharmacies in the loop?
- When is it determined need to know what's been ruled out – local providers/responders
- **Storyboard 1D**
 - When do we consider sequencing and other more expensive but faster lab testing?
- **Storyboard 2A**
 - Have LE officials been notified? What triggers this notification?
 - Are we prepared to coordinate investigation with LE?
- **Storyboard 2B**
 - Do you have personnel?
 - Do you have an effective call back system?
 - Can you supplement responders/supplement back up leadership? And are they trained?
 - Are there sufficient resources 24/7
- **Storyboard 2C**
 - How wide spread is the problem? Identify distribution of food
 - As summit continues rules re: food preparation need to be implemented
 - Is there sufficient information to determine credible threat?

ADDITIONAL ISSUES: END OF OUTBREAK

LAND

- Surveillance/informatics: When should we start active surveillance in non-affected provinces/states. Lab samples and epi needs to be linked especially due to # of cases
- Infection Control: protect healthcare workers – promote handwashing and preventive measures, etc
- Local Health Jurisdictions must recognize an outbreak in order to get investigation started. LHJs needs to use ICS/IMS – especially to keep LE and PH investigations separate. At what point would epi folks have political summit on radar screen?
- Epi Investigation: Are these all the same illnesses? Are questions consistent for data collection? How do we decide on a common questionnaire/how long does that take to decide? Case control study – done locally, would locals be willing to give those up? Methodology determined early on?
- Epi Investigation Data Systems: identify interoperability early on – how do systems talk to each other/can they talk to each other?
- WA public Disclosure: make sure all participants are aware of legal issues
- Terrorism: What affect does that have on border – what will change given the new information? How will travel between US/Canada be affected? What are implications on international travel?
- Monitoring: Are we monitoring? Can we monitor?
- Tribal jurisdictions must be accounted for in planning and response

Appendix F

Breakout Session Approach

GOAL: TO DEFINE AND REFINE THE ISSUES IDENTIFIED IN THE TABLETOP EXERCISES FROM THE PERSPECTIVE OF EACH DISCIPLINE.

Objective #1) To develop an understanding of the system of response on each side of the border.

Objective #2) To identify the connections between both systems in relation to the issues identified in the tabletop exercises.

Objective #3) To Identify essential key policies that need to be developed for the framework of the agreement.

METHOD:

First Hour: Within each breakout group an expert from each side of the border will describe the typical system of response using the general framework of issues from the tabletop. These 15 minute presentations will be expanded upon by the participants in order to achieve a solid understanding of the similarities and differences between the “systems”

Second Hour: Each small group will be facilitated to reach consensus on a clear articulation of each policy issue including a working definition, a list of practical procedures and protocols linked to the issue, and a general sense of priority for the issue.

Third Hour: Through Facilitated discussion, each small group will jointly draft the potential language in an agreement for the top two-three issues. The draft should include at a minimum the following: the desired outcome, goals of the activity, expected participants in the response, reasonable timeframes, measures of effectiveness, evaluation and plans for improvement.

Remaining Time: Prepare report to be given in the Plenary session.

Appendix G

Reports from the Breakout Workgroup Sessions

- [Track 1A\(1\)](#): Epidemiology Surveillance and Investigation
- Facilitator: Carl Osaki
 - Plenary Presenter: Eric Sergienko, MD
- [Track 1A\(2\)](#): Epidemiology Surveillance and Investigation
- Facilitator: Tom Milne
 - Plenary Presenter: Eric Sergienko, MD
- [Track 1B](#): Epidemiology Surveillance and Investigation
- Facilitators: Casey Milne, John Kobayashi, MD
 - Plenary Presenter: Frank James, MD
- [Track 2](#): Public Health Laboratories
- Facilitator: Paul Wiesner, MD
 - Plenary Presenter: Richard Hudson
- [Track 3](#): Emergency Managers
- Facilitator: Rick Buell
 - Plenary Presenter: Wayne Dauphinee
- [Track 4](#): Legal Issues
- Facilitator: Jack Thompson
 - Plenary Presenter: Jude Van Buren, DrPH, MPH

Track 1A(1): Epidemiology Surveillance and Investigation

(Facilitator: Carl Osaki)

Issue: Initial & Ongoing Communication During Large Scale Outbreaks

Definition of Issue:

- When and how to communicate horizontally and vertically?
- Who initiates communication to responsible health agencies?
- How is “over communication” minimized?
- When does information need to be communicated?
- Lack of structure for formal or-going communication?

Desired Outcome/Goals:

- Put a plan in place for people who need to know get the right information at the right time. The plan needs to ensure that it allows for two-way input and feedback. It needs to be up to date with 24/7 contacts and independent of informal or personal relationships.

Objectives:

- Identify who are the “right” people that should receive/disseminate information
- Determine what is the “right” information
- Identify what is the “right” time to communicate information/data
- Test and drill the plan

Key People:

- LHJ
- Regional emergency planners
- State Health Officials
- CDC (US)
- All people who would use the plan (determined by meeting the objectives above)

Due date for Accomplishment of Objectives:

- Draft plan due December 31, 2004

Measures of Effectiveness and Evaluation Plan:

- Conduct a communications tabletop 2 times/year
- Get feedback of users of the plan about relevance and use

Sustainability:

- Conduct international tabletops to determine effectiveness of communication across borders
- Ensure that contact lists are current and up to date at 6 month intervals
- Develop a baseline level of communication to foster and maintain relationships

Issue: Surveillance System Compatibility

Definition of Issue:

- Lack of clarity of what the “system” is
- What are the important public health conditions about which we will be (should be) sharing surveillance data
- Locals need to have feedback loop on data that may be significant
- Need clarity about what surveillance data that departments are willing to share and need
- Surveillance data is not always shared in a timely manner

Desired Outcome:

- Detect outbreaks and individual cases of public health significance as early as possible

Goals/Objectives:

1. Develop an agreement or understanding (across borders) on what information or scenarios compel notification
 - Foster “cultural” shift between users of the system
 - Develop informal relationships across borders (eg., this conference)
 - Get feedback from local health justifications about
 - Incorporate issue into cross borders communications plan discussions
2. Develop a public use mechanism (i.e., website) with routine surveillance data which can be queried by geographical area and updated every 24 hours (GA/FL model)
 - Get feedback from locals about needed information
 - Identify successful examples of mechanisms or models which provide easily accessible data for immediate decision making

Key People:

- LHJ
- Regional emergency planners
- State and Provincial epidemiologists
- CDC (US Quarantine)
- Health Canada Quarantine

Due Date for Accomplishment of Objectives: Draft plan due December 31, 2004

Measures of Effectiveness and Evaluation Plan: (not completed)

Track 1A(2): Epidemiology Surveillance and Investigation

(Facilitator: Tom Milne)

Issue: Jurisdiction

Definition of Issue: There is a need to clarify jurisdictional responsibilities within the states, in the U.S., and Canada.

Desired Outcomes:

1. Public health workers at the local, regional, state, and provincial levels have a clearer understanding of jurisdictions and responsibilities among and across public health, law enforcement, EOCs, etc.
2. Regularly updated “nominal” contact information
3. Responsibilities for notification are clarified
4. Relationships with law enforcement, etc., are improved

Objectives:

1. Develop a chart of jurisdictional agencies and their respective responsibilities by November 2004
2. Establish an annual meeting between jurisdictional agencies by July 2004
3. Establish a NW “urgent” list serve by July 2004

Key Participants:

- State Health Departments
- Local Health Jurisdictions
- BC Centers for Disease Control
- Regional Health Authorities
- Coast Guard
- Homeland Security
- Law Enforcement
- RCMP
- Feds including CDC
- Food Inspector Agencies

Measures of Success:

1. Stakeholders all receive a copy of the chart of jurisdictional agencies (could be web-based)
2. Annual meetings between cross-border jurisdictional agencies take place
3. The List serve is established and serving core jurisdictions

Evaluation:

1. Exercise use of the list

Improvement: Yearly updates based on reviews/evaluation

Issue: Human and Material Resources

Definition of Issue: (a) Barriers exist in sharing human and material resources; (b) public health receives too few resources to fulfill their responsibilities

Desired Outcomes:

1. Improved ability to share resources across barriers, especially at the beginning of significant emergency events
2. Increased understanding of lawmakers regarding the importance of removing barriers in sharing resources across borders

Objectives:

1. Advocate for political solutions for the procurement and sharing of resources across all borders by December 2005
2. Standardize emergency credentialing of public health and health credentialing by December 2005
3. Create strategies for sharing resources with the first 24 hours of an emergency event by December 2005
4. Define and develop resources to address funding for the objectives for this issue
5. Explore and identify alternatives to regionally-based solutions to resource-sharing barriers, including identification of federal agencies' capacities
6. Develop multinational solutions to resourcing emergency response
7. Design public health worker exchange programs across borders

Key Partners:

- Governors
- Provincial Government
- Homeland Security
- Congressional delegations
- State/provincial budget staff
- Licensing Agencies
- Joint Commission

Measures of Success: (not completed)

Evaluation:

1. Exercise the sharing of resources using a field exercise

Improvement:

1. Debrief work on each objective annually
2. Annual reviews
3. Revisions based on annual reviews

Track 1B: Epidemiology Surveillance and Investigation

(Facilitators: Casey Milne and John Kobayashi)

Issue: Reporting out for Communication

Definition of Issue:

- Development of a 24/7 contact list of available officers.
- Development of protocols for cross border communications
 - What are the communication channels
- Clear listing of the contacts for health alerts and advisories
- Definition of nature/ mode of communication (verbal, electronic, paper)
- Consideration for routine vs. emergency communication
- Ad hoc vs. formalized communication, both are desirable

Desired Outcome Related to Issue (Vision):

- Timely appropriate systematic simple and accurate communication

Goals:

- Development of a communication plan to achieve facilitate disease prevention and control

Objectives:

1. Develop and share communication algorithm/tree
2. Define parameters (i.e. thresholds)

Key Participants:

- State level (epi, hos)
- Provincial (PHO epi)
- Federal CDC, health Canada
- Local health authority reps
- Regional HIS/FNIHB/tribal reps
- Military

Timeframes:

Short term

- 24/7 contacts (BC, Alberta, Yukon, AK, WA, OR, ID, MT, ND)
- And regional IHS , FNIHB by Sept 1st 2004

Long term

- Communication plan (finished by Aug 2005 with grant deadline)

Measures of Effectiveness:

- Periodic testing of emergency contacts
- Existence of directories

Evaluation Plan/ methods of continuous improvement: (Not completed)

Issue: Reporting out for Jurisdictional Issues

Definition of Issue: Full understanding of SOP for players. Roles of different organizations roles and responsibilities. For example duplication of communication. Because we don't understand the roles and responsibilities we are duplicating efforts.

Desired Outcome Related to Issue (Vision):

- Jurisdictional issues should not be a barrier to decreasing morbidity and mortality.

Goals:

- Identified parties should understand roles and responsibilities to decrease jurisdictional issues. They should also foster trust by having a clear idea of who should have authority and responsibility in which circumstances.
- Increasing and improving interactions between and among jurisdictions, for example in doing TB training do training together!

Objectives:

- Parties to identify resources to clarify roles and develop descriptions of roles and responsibilities in relation to specific events: Multi-jurisdictional events where one person travels between jurisdictions or when an outbreak involves more than one jurisdiction factors that effect these situation will be analyzed prospectively with respect to international shipping, air travel, trains, etc.

Key Participants:

- Local health, regional, federal, first-nations/tribal, military, FBI/RCMP
- WA DOH to use EWIDS to put in place early warning infectious disease surveillance system.

Timeframes:

1. Template: assessment of NIMS model (National Incident Management System) as a tool to respond to risks. Indicate roles and responsibilities in these areas. EWIDS to pull together and review list over next (two months)
2. Distribution to identified partners for review (six months)
3. Synthesis (two months)
4. Review, clarify and distribute final product to participants (two months)

Measures of Effectiveness:

1. Improve response times and completeness of investigations
2. Reduce duplication and omissions in case investigations
3. Product to be used in Emergency Response Plans

Evaluation Plan/ methods of continuous improvement:

- Pre and post surveys on knowledge of roles and responsibilities

Issue: Reporting out for Surveillance Systems

Definition of Issue: Lack of standardization of surveillance systems and their components

Desired Outcome Related to Issue (Vision):

1. Establish a cross border working group
2. Begin a basis of sharing information to build upon information sharing base to be built upon
 - 2a. Establish a communication mechanism
 - 2b. Establish a list serve on the BC CDC secure website
 - 2c. Share weekly reports

Goals/Objectives:

1. Establish cross border work group
2. Examine local, state, provincial and tribal surveillance systems
3. Establish routine communications (i.e. list serve)

Key Participants:

- BC CDC
- WA DOH
- Other
- Local health authorities
- LHJ
- Regional epidemiologists
- Tribes

Timeframes:

1. Cross Border Work Group formation 3mo
2. Share weekly reports 1 month after establishment of work group
3. Establish working list serve 1mo after establishment work group

Measures of Effectiveness:

- Creation of list serve
- Effective receipt of weekly CD reports
- Report that outlines surveillance systems for each system

Evaluation Plan/ methods of continuous improvement:

- Ongoing Meeting Schedule

Track 2: Public Health Laboratories

(Facilitator: Paul Wiesner, MD)

Issue: Internal and Ongoing Communications Between Laboratories

Definition of Issue:

- Sentinel Laboratory to Sentinel Laboratory
- Tier 1 Laboratory to Local Health Jurisdiction
- Sentinel Laboratory to Prov/State Lab
- State/Prov Lab to Local Health Jurisdiction or to CDC/BCCDC
- Laboratory to RCMP/FBI
- State/Provincial Labs to Tier 1 or Sentinel Labs
- Physicians to Local Health Departments
 - Epidemiologists to State/Provincial Labs
- Receipt of Samples is also Communication

Desired Outcome:

- Communication through Proper Channels, with a Rapid Response
- Communication is Documented
- Continuous Quality Assessment and Improvement
- Threat Threshold (State and Province)
 - At what point in any situation is communication needed

Goals and Objectives:

- Cross Border MOU
- Formalized and Delineated Lines of Communication
 - Laboratory and Epidemiology
 - Emergency Response
 - “On Call” Capabilities

Key Participants:

- Laboratories: Provincial, State, & Local
- Epidemiology: CDC, BCCDC, Prov/State, Local Health Jurisdiction
- Border Officials
- RCMP, FBI
- HazMat
- Military Support
- EOC: Canada and US
- Primary Care Providers
- Legal Authorities: Federal, State, Local

Time Frame for MOU:

- Cross Border MOU
- Share Information RE to MOU
- Communicate Framework for MOU
- Draft Document in 6 Months (Feb., '05)
- 6 Month Legal and Administrative Review
- Final August, '05

Indicators of Success:

- MOU Tested via Table Top or Similar Exercise
-

Issue: Surveillance Systems Across Borders**Definition of Issue:**

- Ongoing Collection of Data for Analysis
 - Passive and Active Surveillance
 - How are data collected
 - Who analyses data
- Standardization of Case Definition Which Includes: Lab Testing Protocols & Lab Results Reporting
- Equal Level of Communication Technology Available in all regions
- Comparable Training
- Privacy & Confidentiality Issues Addressed

Desired Outcomes:

- Timeliness
- Expanding LRN into all North America, other Countries

Goals and Objectives:

- Seamless Interactions
- Harmonization- working together toward the same end
- Best Use of Resources/Funding
 - Avoid Duplication

Key Participants:

- Local: Hospitals, Vets, Env. Sanitarians, Laboratories (public & private), Pharmacies, Health Departments
- State/Provincial: Reference Labs, State Health Dep't (Epi/Lab)/Health Service Delivery Area
- National: USDA, FDA, CDC, EPA, HC/CFIA, HRSA, CHEC, APHL/CPHLN

Timeframe:

- Expanding LRN: 6 Months
- APHL/CPHLN: 6 Months
- FERN(food emerg. response net)/ELEXNET to LRN: 2 years
- Standardizing Reportable Communicable Diseases: Resource Dependent
 - CDC/Health Canada create national lists

Indicators of Success:

- LRN expansion into Canada
- Ongoing Working Groups
- Resource Commitment (CPHA)
 - Canadian Public Health Agency
- MOUs

Evaluation/Improvement:

- Timely and Accurate Data
- Universal/Standardized Communication, Laboratory Technology, & Capability (Training)
- Annual Evaluation of Progress and Goals
- Participation in Common Proficiency Testing

Issue: Human Materials/Resources:

- Surge Capacity-Personnel
- Dependent Upon: When result is needed
- Who and What is Available to Address Analytical Needs (send work out/bring extra staff in)

Comparison Across Borders:

US

- LRN
- State Limitations on use of CDC funds for hiring and lab space

Canada

- No LRN
 - Hospitals, National, and Provincial Labs more available for surge support
-

Issues:

- Training and Impact on Routine Workload
- Liability, Reimbursement, and Union Issues
- Security Clearance for Private Lab Staff (e.g. biotech firms)

Desired Outcome:

- Across Border Lab Response Network (LRN)
- Rapid Response
- Accurate Information of Each Labs Capability (e.g. Level of Technology, PCR vs. Culture Confirmation)
- Training (comparable across border)
- Adequate Test Sensitivity (not necessarily using same test protocols)
- Rapid Access to Results
- Expedited Border Crossing
- Uniform Security Clearance

Goals and Objectives:

- MOUs
- Address cross border shipping
- Credentialing?
- Protocols for Exchange of Lab Information
- Secure access, web based
- Training (Comparable Across Border)
- Compare US Level B&C with Canadian counterpart
- Proficiency Testing Comparison
- Address Liability Issues and Security requirements
- Standardized Chain of Custody Forms/Procedures

- Survey of Capabilities (updated frequently and secure)
- BSL-3 Space, Storage, # of Staff & experience/education
- Testing Capacity and Capability (Select agents)
- Needs Assessment
- Communication Strategy
- Secure Adequate Funding

Key Participants:

- | | |
|------------------------------|--------------------------|
| • BCCDC | • CDC |
| • Nat'l Lab (Win.) | • APHL |
| • Other Prov. Labs(Alb) | • State PHL |
| • Animal Health | • Local PHL |
| • Canadian Food Insp | • FDA |
| • Universities | • Ag Labs |
| • Private Labs Sentinel Labs | • Vet Labs |
| | • Universities |
| | • Private (biotech) Labs |
| | • Military Labs |

Timeframes:

- Identify key people in each State/Province: 1 month once authority established
- Establish Task Force to Implement Goals and Objectives and Set Priorities
- Survey Capabilities
- Assess LRN and Develop survey: 2 Months
- Conduct Survey: 6 Months
- Work with Canada to Expand PT Program within LRN.
- See if EU has similar organization
- Survey/Build on Cross-Organization Training/Observation
- Understanding of each others procedures, techniques, capabilities
- Phased MOUs as Issues Arise and are Addressed

Indicators of Success/Evaluation/Improvement:

- Top Off Type Exercise
- Activation/Preservation of Taskforce
- Funding
- PR Results and Testing Participation by Labs
- MOUs Established
- On-going Cross Training
- Security Clearances in Place
- Secure, Web-Based Capability Database

Track 3: Emergency Managers

(Facilitator: Rick Buell)

Issue: Initial And Ongoing Communications - #1 Priority

Definition of the Issue: During a public health crisis who will be contacted, how and when?

Desired Outcome Related to the Issue:

- Establish pre-planned clear lines of communication: who, how, when and what-24/7.

Goals and Objectives (Mission):

- Establish Standard operating procedures for communications.

Objectives:

- Position Based
- Voice Contact---Supposedly Data
- Timely
- Minimum data to transmit
- 24/7
- Recognizable alert symbol

Key Participants:

- Federal, Provincial, State, Local public health and specialize agencies required

Timeframes:

- By October 31, 2004 International Multi-state Steering Group Established
- By December 31, 2004 Draft of Protocol
- By March 31,2005 Finalized Protocol
- By June 30, 2005 Protocols Tested
- By August 10, 2005 Protocol Accepted

Measures of Effectiveness (Indicators of Success):

- 100% of agencies contacted within “x” hours as determined by the plan.

Evaluation Plan/Methods of Continuous Improvement:

- Task force formed
- Draft of Protocols Written
- Protocol tested or,
- Real World Test
- Sharing with all agencies
- Blue Pages of Public Health Agencies

Issue: Initial and Ongoing Communications-#1 Priority

Definition of the Issue: Response Partners must be able to convey and share emergency information between jurisdictions (via telephone).

Desired Outcome Related to the Issue:

- Response personnel will have the knowledge and resources needed to share information before and during an emergency.

Goals and Objectives (Mission):

Goal 1: Identify common pathways and mechanisms for cross border communication between response partners.

- **Objective 1:** A tool for easy back-channel communications among people, across agencies, and geo-political boundaries.

Goal 2: Personnel can effectively and accurately share information in a timely manner.

- **Objective 1:** A telephone list that contains numbers for relevant emergency response duty officers, and also numbers of individual people working in health organization.
- **Objective 2:** A contact list that would contain office telephone numbers for individuals on a voluntary basis. ERDO's would be relied upon for after-hours or official contact.
- **Objective 3:** A sponsor agency or professional organization would need to adopt the list to maintain it, test numbers on a regular schedule and to acquire updated contact information.

Key Participants:

- State public health agencies
- Emergency Response Duty Officers (ERDO & Individuals)
- Provincial, Territorial, Federal

Timeframes:

- Now!!
- Develop Process over 3 months → Ongoing Maintenance

Measures of Effectiveness (Indicators of Success):

1. Continuous maintenance of contact lists
2. 24/7 call down lists published and distributed to partners (standard)
3. Expansion of formal process to other jurisdictions
4. Identification of maintenance organization

Evaluation Plan/Methods of Continuous Improvement:

1. Tests-Monthly call downs
2. Regular inclusion in scheduled exercises
3. Written report on lessons learned and improvements

Issue: Human & Material Resources #2 Priority

Definition of the Issue: Identify and address critical resources

Desired Outcome Related to the Issue:

- Develop inventory of critical resources throughout geographic area. Where to find it, who is contact, and how to get it. Everyone knows what's available.

Goals and Objectives (Mission):

- Develop surveys → Database of available resources, identify "players".

Key Participants:

- Emergency Management
- Law Enforcement
- Transport, Hospital
- Public health
- Fire/EMS
- Community Leadership

Timeframes:

- | | |
|--------------------------------------|-------------|
| 1. Develop task force (players) | 3-6 months |
| 2. Develop plan agreements | 3-6 months |
| 3. Identify goals/objectives/mission | 3-6 months |
| 4. Implementation | 6-12 months |

Measures of Effectiveness (Indicators of Success):

- Formalized agreements
- Cross-Border Cooperation/Planning/Implementation of plan

Evaluation Plan/Methods of Continuous Improvement:

- Exercise Plan
- Plan Revisions

Issue: Jurisdictional Issues- #3 Priority

Definition of the Issue: A process using public health and healthcare resources across local, state/provinces and international boundaries to respond to an emergency with multi-disciplinary resources.

Desired Outcome Related to the Issue:

- Operational guidelines for implementation of a Pacific Northwest Emergency Medical Assistance Compact.

Goals and Objectives (Mission)

Goal 1: Identify jurisdictions

- **Objective 1:** Consistent definition

Goal 2: Identify Type of Resources

- **Objective 1:** Identify Current linkages that work
- **Objective 2:** Identify gaps and barriers

Goal 3: Develop and approve guidelines for sharing and coordination of resources

Key Participants:

- Emergency management
- Public health
- Hospitals
- Healthcare systems
- EMS
- Federals
- Tribes

Timeframes:

- 1st Month Establish a public health subcommittee of WEMAC
- 1 Year Operational Guidelines done
- 18 Months Exercise operational guidelines

Measures of Effectiveness (Indicators of Success):

- Survey to measure progress
- Operational guidelines with ongoing relationship that are exercised regularly

Evaluation Plan/Methods of Continuous Improvement:

- Identify performance measures
- Establish benchmarks

Track 4: Legal Issues

(Facilitator: Jack Thompson)

Issue: Legal Issues

Definition of Issue:

- Lack of authority about ability to increase level of collaboration vs. need for further authority

Outcome:

- Clarification, enhance capacity

Goal:

- Improve authority to collaboration gathering and sharing information in emergencies

Objectives:

1. Define terms to assume consistency of language (e.g., “quarantine” and “jurisdiction”)
2. Clarify current authority to share information (what can be shared?)
3. Identify, resolve legal barriers to sharing information
4. Identify and resolve obstacles to securing information and authority to gather information
5. Identify and resolve issues involved in information sharing with law enforcement and first responders

Issue: Jurisdictional

Definition of Issue:

- Relative responsibilities both of levels of government and between public and private sector

Outcome:

- Improved system's approaches

Goal 1:

- Clarify the Compact/Protocol process

Objectives (Goal 1):

1. Agree on legal status of any documents produced and the process for decision making vs. decisions themselves
2. Explore feasibility of expanding existing agreements vs. developing new agreements

Goal 2:

- Reach agreement on protocol to facilitate shipping samples relative to emergency events across borders

Objective (Goal 2):

- Agree on the threshold that will trigger exemption from current law to facilitate sharing of data

Key Players:

- Public Health
- Attorneys General
- Departments

Goal 3:

- Improve surge capacity in joint cross-border population cities

Objectives (Goal 3):

1. Assess ability to use existing models, such as fire fighter protocols, for developing cross-border surge capacity in joint population centers (Vancouver/Bellingham)
2. Secure agreement on government role in licensure issues across borders
3. Secure agreement on private sector role in extending hospital privileges across borders

Issue: Communication

Definition of Issue:

- Need to clarify how and when authorities across borders and across jurisdictions share secured, intelligence information

Desired Outcome:

- (1) Information to providers
- (2) Personal health information
- (2) Timing thresholds on communication

Goals:

- Sharing relevant and secured information while protecting privacy in a timely manner (health care, privacy, operational)

Objectives:

1. Be aware of current laws/rules and whether exceptions are noted
2. Identify protocol, mechanism for sharing – can we give and receive information across borders?
 - Canada has ability to withhold information during an investigation
 - Responsibility of public body to disclose information to public
 - Can share protocols – can we protect it if we get it to you
 - Public physician issue

Issue: Human and Material Resource Sharing

Definition of Issue:

- Need to clarify issues relating to human and material sharing (staff, equipment, supplies, funding)

Outcome: (not completed)

Goal: (not completed)

Objectives:

1. Clarify issues around staff illness, compensation across jurisdictions
2. Clarify collective bargaining issues
3. Clarify credentialing/calibration issues
4. Identify coverage/capacity at “home port”
5. Clarify issues relating to the recalling of resources
6. Clarify liability coverage across borders
 - NOTE: Look at Fire Department agreements

7. Understand protocols outside of IEMAC

- Who requests
- Who responds
- Duration of response
- Level of response
- Backfilling of positions

Supplemental agreement to Emergency Management Assistance Compact (EMAC) would include these issues. Look at EMAC as a model.

8. Look at “immunity”(Good Samaritan approach)
 - Everyone takes care of their own approach

Other:

- Look at academic institutions
- Look at national disasters as a model – Federal Emergency Management Agency (FEMA) – Stafford Act

Appendix H

Speaker Biographies

(In Order of Appearance on the Agenda)

Mary C. Selecky

Mary Selecky was appointed Secretary of the Washington State Department of Health by Governor Gary Locke in March 1999. Before her appointment, Mary served for 20 years as administrator of the Northeast Tri-County Health District in Colville, Washington.

Throughout her career, Mary has been a leader in developing local, state and national public health policies that recognize the unique health care challenges facing both urban and rural communities. As Secretary of Health, Mary has made reducing tobacco use a top priority. She also leads the state's public health emergency preparedness efforts. Mary has worked in local government for 25 years and is known for bringing people and organizations together to improve the public health system and the health of people in Washington State.

Mary has served on numerous boards and commissions; she is President of the Association of State and Territorial Health Officials and is past president of the Washington State Association of Local Public Health Officials. A graduate of the University of Pennsylvania, she's been a Washington State resident for 30 years.

Regina Delahunt

Regina Delahunt is currently the Public Health Director for the Whatcom County Health Department in Bellingham, Washington. She has over 25 years of experience in the public health field primarily in the area of environmental health. Regina began her career with the State of New Mexico in the plague and vector control programs and was a member of their emergency response unit. She also worked for private industry for several years overseeing hazardous waste site remediation. Regina has been with Whatcom County for 15 years. She supervised and managed the county's environmental health programs before becoming Public Health Director in 2000. She has a BS in Biology from State University of New York and an MS in Biology from New Mexico State University.

Joe Finkbonner

Joe Finkbonner, RPh, MHA, is the Director of the Northwest Tribal Epidemiology Center (the EpiCenter) of the Northwest Portland Indian Health Board. The mission of the EpiCenter is to collaborate with Northwest American Indian Tribes to provide health-

related research, surveillance, and training to improve the quality of life of American Indians and Alaskan Natives

Dr. Patrick O'Carroll

Patrick O'Carroll, MD, MPH, FACPM is the Regional Health Administrator for Region X (AL, ID, OR, and WA) of the U.S. Public Health Service (USPHS). Dr. O'Carroll received his medical degree and his Masters in Public Health from Johns Hopkins University in 1983. After training in family practice and preventive medicine, he joined CDC as an Epidemic Intelligence Service (EIS) Officer. Initially assigned to work the area of violence epidemiology, Dr. O'Carroll later led the epidemiology research unit for the prevention of suicide and violence at CDC's National Center for Injury Prevention Control. In 1992, Dr. O'Carroll began working in the nascent field of public health informatics. He co-lead the development of CDC WONDER, was lead scientist on the CDC Prevention Guidelines Database project, and developed the nation's first training course and textbook in public health informatics. As Associate Director for Health Informatics at CDC's Public Health Practice Program Office, he developed and directed CDC's Health Alert Network program. In 2001, Dr. O'Carroll was assigned to the University of Washington's Northwest Center for Public Health Preparedness on public health informatics issues related to workforce development. In this assignment, he led the development of an explicit set of informatics competencies to guide training for public health professionals. In January 2003, he began his current assignment as Regional Health Administrator.

In his 17 years with CDC and USPHS, Dr. O'Carroll has received numerous awards and recognition for his work including two Outstanding Service Medals. He holds Affiliate Associate Professor appointments in the Departments of Epidemiology and Health Services at the University of Washington School of Public Health and Community Medicine, and is also Affiliate Associate Professor in the Division of Biomedical and Health Informatics, University of Washington School of Medicine.

Dr. David Patrick

Dr. David Patrick is Associate Professor of Medicine and Director of Communicable Diseases Epidemiology Services at the University of British Columbia Centre for Disease Control. His work in infectious diseases research has ranged from bench to clinic and through to population dynamics where it has been recognized by the International Society for Infectious Disease North American epidemiology award. His interest is in fostering interdisciplinary approaches to the control of infectious diseases in populations. Current expressions of this focus are found in the application of network theory to understanding epidemics and the establishment of interdisciplinary efforts to understand the emergence of new infectious diseases. Dr. Patrick's Communicable Disease Epidemiology team played a leading role in identifying the international scope of the SARS outbreak, defining a public health response and containing the first cases

to arrive in British Columbia. His challenge for the delegates is to find better ways of integrating emergency management to natural and man-made events with scientific discovery.

Dennis Anderson

Dennis Anderson has served as the Director of the Office of Risk and Emergency Management at the Washington State Department of Health since April 1999. His office is responsible for safety, security, and emergency management planning for the department. Prior to coming to DOH, Dennis worked for state's emergency management agency where he developed plans, training, and disaster exercises.

Carl S. Osaki

Carl S. Osaki, RS, MSPH is a Clinical Associate Professor and Research Project Manager in the Department of Environmental & Occupational Health Sciences, School of Public Health and Community Medicine, University of Washington. He retired as the Director of Environmental Health, Seattle-King County Department of Public Health in 1999 and was appointed to the Washington State Board of Health by Governor Gary Locke in 1997. He was one of the authors of PACE-EH (a nationally recognized community environmental health assessment tool), and is a consultant to environmental health programs nationwide. His consultant activities have been primarily in the areas of environmental health practice, policy development and training. He is currently managing an Association of Schools of Public Health training grant aimed at helping local and state agencies integrate the Essential Services of Public Health into environmental health practice. Carl is the past chair of the Washington State Association of Local Health Officials and is a member of numerous state and national public health organizations. He received his BS (1966) and MSPH (1973) degrees in Environmental Health from the University of Washington. Carl started his environmental health career in 1966 as a military sanitarian (1LT) with the US Army Medical Services Corps in Munich, Germany.

Jason Sapsin

Jason Sapsin, JD, MPH, is an attorney with the Johns Hopkins Bloomberg School of Public Health, Health and Policy Management. His principal research focus has been the use of law and legal interventions to promote infectious disease control. He has concentrated on domestic and international public health preparedness especially with respect to bioterrorism, including public health strategies for epidemic control. Most recently, his work has been expanding in the fields of administrative regulation and health, international trade and health and vaccine law and policy. He works also in the areas of environmental public health tracking and environmental public health practice.

Dr. Maxine Hayes

Dr. Maxine Hayes MD, is the State Health Officer for the Washington State Department of Health. She advises the Governor and the Department of Health Secretary on issues ranging from emergency response to outbreaks (such as E. coli outbreaks) to preventing childhood illness. She works closely with the medical community, local health departments, and community groups to give the public the latest scientific information on how to become and stay healthy, to prevent the spread of infectious diseases, and to protect the public's health.

Prior to her appointment as Health Officer, Dr. Hayes was the Assistant Secretary of Community and Family Health. As Assistant Secretary, she had responsibility for the statewide coordination of the following programs: WIC Nutrition, Maternal and Child Health, Family Planning, Children with Special Health Care Needs, Health Promotion, Heart Disease and Cancer Prevention, Immunization, TB Control, HIV/AIDS and STD, and Chronic Conditions and Injury Prevention.

Dr. Hayes is clinical professor of pediatrics at the University of Washington School of Medicine, and on the MCH faculty of the School of Public Health. She is a past president of the Association of Maternal and Child Health Programs, and is a past chair of the Maternal and Child Health Section of the American Public Health Association.

Dr. Hayes was the 1999 Distinguished Alumna of the Year for the State University of New York School of Medicine at Buffalo and the Year 2000 recipient of the Stockton Kimball Award. In 2000 she was presented an honorary Doctorate of Science by former Acting Surgeon General and President of Spelman College, Dr. Audrey Manley. She is the recipient of many awards and honors for her work in maternal and child health, including the American Medical Association's 2002 Dr. Nathan Davis Award and the 2003 Heroes in Health Care Lifetime Achievement Award through the Washington Health Foundation. Dr. Hayes is also a fellow of the American Academy of Pediatrics.

Dr. Jo Hofmann

Dr. Jo Hofmann, MD, received her medical degree in 1988 from the University of Pennsylvania and is board certified in internal medicine and infectious disease, served as a Epidemic Intelligence Service Officer from 1993 to 1995 at the CDC. She has worked for local and state health departments in New Jersey, Philadelphia, and Snohomish County, Washington. Dr. Hofmann has served as state epidemiologist for Washington since 2001, just before 9/11.

Dr. Marci Layton

Dr. Marci C. Layton, MD, is the Assistant Commissioner for the Communicable Disease Program at the New York City Department of Health. She received her medical degree

at Duke University and completed residency training in internal medicine at State University of New York Health Sciences Center in Syracuse, NY. She has also completed fellowship training in infectious disease at Yale University School of Medicine and was an Epidemic Intelligence Service officer with the Centers for Disease Control and Prevention.

Dr. Layton has participated as a member in the Institute of Medicine's Forum on Emerging Infections, the Center for Civilian Biodefense (which was formerly at Johns Hopkins School of Hygiene and Public Health) and the Executive Session on Domestic Preparedness of John F. Kennedy School of Government, Harvard University.

Dr. Layton is a frequent lecturer at local, national and international conferences on topics related to bioterrorism preparedness and emerging infectious disease issues. She played a key role in New York City's public health response to the appearance of West Nile virus in 1999 and following the attacks on the World Trade Center and intentional anthrax release in 2001. Dr. Layton has been recognized for her outstanding contributions to public health and has been the recipient of the 1999 Public Health Association of New York City Special Merit Award and the 2000 Sloan Public Service Award.

Dr. Harvey T. Holmes

Dr. Holmes, Deputy, Laboratory Response Branch, Bioterrorism Preparedness and Response Branch, National Centers for Infectious Diseases is a clinical microbiologist that provides clinical expertise to CDC's bioterrorism program, including agency representation in bioterrorism preparedness issues with USDA, FBI, APHL, ASM, and Food/Water/Veterinary Labs. As the former Chief, Diagnostic Microbiology Section at CDC he directed several reference microbiology laboratories for Staphylococci, most Enterobacteriaceae, Anaerobes, a Molecular Reference Laboratory and the Staphylococcus Toxin Testing (bioterrorism) laboratory. He directed the Clinical Bioterrorism Surge Capacity Laboratory that processed many of the environmental samples during the fall 2001, anthrax event. He's been instrumental in developing the revised protocols for detecting agents of bioterrorism and has traveled throughout the U.S. speaking on bioterrorism-preparedness for the laboratory and developed both web-based and video-based training modules. Dr. Holmes served as the Medical Director of Microbiology in a 550-bed community-based hospital in Michigan, after earning a doctorate in microbiology from Oregon State University and completing a residency program in Public Health and Medical Laboratory Medicine at CDC.

Appendix I

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(Updated on September 10, 2004)

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