

# *2007 Summary Report*

## **Cross Border Public Health Collaboration: Opportunities and Challenges**

May 14-16, 2007

Victoria, British Columbia

Alaska  
Alberta  
British Columbia  
Idaho  
Montana  
North Dakota  
Oregon  
Washington  
Yukon



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# **Cross Border Public Health Collaboration: Opportunities and Challenges**

May 14-16, 2007  
Victoria, British Columbia



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### ***Electronic Copies of Workshop Materials***

*Electronic copies of workshop materials, including this report, the available speaker presentations, agreement examples and an updated participant list in Microsoft Excel may be obtained by contacting Wayne Turnberg, Washington State Department of Health at (206) 418-5559 or by email at [Wayne.Turnberg@doh.wa.gov](mailto:Wayne.Turnberg@doh.wa.gov).*

# Pacific Northwest Cross Border Workshop

## May 14-16, 2007

### Executive Summary

**Background** – The fourth annual Pacific Northwest Cross Border Workshop was held in Victoria, British Columbia on May 14-16, 2007. Over 200 invited professionals in the fields of epidemiology, public health laboratories, emergency management, communications, and law attended from Canada (including Alberta, British Columbia, Yukon Territory and the Canadian Federal Government), Native American Tribes and the United States (including Alaska, Idaho, Montana, North Dakota, Oregon, Washington, and the United States Federal Government). The workshop was structured around plenary presentations to reinforce work conducted during six field-specific workgroup breakout sessions.

### Status of Cross Border Agreements

- **PNEMA, Annex B** – Governor Christine Gregoire and Premier Gordon Campbell signed the Annex B implementing procedures for the Pacific NW Emergency Management Arrangement on June 20, 2006.
- **WA/BC Public Health MOU** – Secretary Mary Selecky and Prime Minister George Abbott signed a “first of its kind” binational public health preparedness and response memorandum of understanding on June 20, 2006.
- **Pacific NW Cross Border Alliance** – A draft conceptual framework establishing *The Pacific NW Regional Alliance* was proposed during the Victoria workshop to formalize relationships between Pacific Northwest public health partners to continue efforts leading towards seamless public health preparedness and response capabilities across our binational borders.
- **Cross Border Operational Plans and MOUs** – Operational plans and MOUs are being developed between U.S. and Canadian jurisdictions using authorities of the Pacific Northwest Emergency Management Arrangement, addressing:
  - Confidential data sharing for epidemiology investigations.
  - Movement of medical personnel across the WA/BC border.
  - Public health laboratory surge capacity MOU between labs in WA and BC (a public health laboratory surge capacity MOU currently exists between WA, ID, OR, and AK).

### Next Steps

#### Epidemiology Workgroup

- Continue establishing electronic connectivity through CDC’s Epi-X and the Canadian Integrated Outbreak Surveillance Centre (CIOSC) for sharing health alerts and other outbreak information.

### **Epidemiology Workgroup (continued)**

- Continue to explore secure health information exchange with personal health information.
- Continue to test data exchanged via CDC's Epi-X confidential list serve.
- As part of PNEMA activities, continue to compile a table comparing disease reporting requirements across PNEMA jurisdictions.
- Continue work on a cross border data sharing agreement between PNEMA jurisdictions.

### **Public Health Laboratory Workgroup**

- Sign the Memorandum of Understanding (MOU) between the British Columbia Centre for Disease Control (BC CDC) Laboratory and the Washington State Public Health Laboratory (WA PHL). It is currently going through draft review steps.
- Include the Montana Public Health Laboratory in the existing Region 10 Laboratory MOU. This is also going through the draft review process.
- Complete full access for BC CDC to the U.S. Centers for Disease Control and Prevention (U.S. CDC) Laboratory Response Network (LRN).
- Research and evaluate using a web-based coordinating resource to improve communication for the working group. Propose that other working groups network through similar systems.
- Discuss the recently proposed Pacific Northwest Health Alliance as it applies to the Cross-Border Laboratory Work Group.
- Explore funding opportunities for cross-border laboratory collaboration. Determine types of high profile, high public health impact laboratory testing needed related to the 2010 Olympic Games to develop and ensure common laboratory procedures.

### **Surge Capacity/EMS Workgroup**

- Continue to use PNEMA, and educate politicians and other partners about PNEMA, develop written materials and presentations.
- Create agreements that fill in the details of how personnel will be shared.
- Exercise, drill and practice the operational plan.
- Involve health care providers, hospital CEOs, medical and nurses' associations, non-government organizations (NGOs), emergency management leads, Emergency Medical Services (EMS), and border/customs agencies.

### **Emergency Medical Services (EMS) Workgroup**

The EMS workgroup will continue developing operational plan solutions and language centered on the four objectives that were identified and addressed during the workshop:

- Patient transport and inter-facility transfers.
- EMS resources sharing, e.g. providers, equipment, protocols, vehicles, etc.
- Acceptance of cross border health care credentials and patient care protocols.
- Accepted essential elements of a Mutual Aid Agreement to meet patient care and patient movement needs.

### **Communications Workgroup**

- Continue collaboration through ongoing Cross-Border Communications Workgroup sessions
  - Schedule series of regular calls on key issues with communications team members from Alberta, British Columbia, Yukon, Washington, Oregon, Idaho, Montana and North Dakota; invite other partners, federal representatives (Canada and US) as appropriate.
  - Establish electronic system for ongoing communication resource-sharing.
  - Continue work on developing protocols for assistance and coordination on critical public health issues.
  - Develop communication strategies on key issues including pan flu and antivirals.
  - Continue to fold emergency issues into all-hazards public awareness approach; share best practices.
  - Discuss staff or training exchange program between states and provinces to help build understanding of different systems, emergency plans and risk communication strategies.
  - Share information from workgroup with other public health and emergency partners.

### **Public Health Law Workgroup**

- Complete legal review of the draft *Conceptual framework for the Pacific Northwest Border Health Alliance* proposal.
- With regard to the draft agreement for moving personnel across BC/WA border during an emergency, develop and review a list of the differences in liability, licensing and worker's compensation/death benefits among the PNEMA states/provinces will be compiled.

## Acknowledgements

We of the British Columbia Ministry of Health and the Washington State Department of Health wish to extend our sincerest appreciation to the binational planning committee, facilitators, speakers, and cross-border public health partners for their support and commitment to the success of this workshop. Working together we can fulfill the goal of establishing a seamless cross-jurisdictional public health system that can quickly and efficiently track and respond to natural or intentional public health threats across domestic and international borders.

We also wish to thank the Public Health Agency of Canada and the U.S. Centers for Disease Control and Prevention for providing financial assistance to conduct our fourth annual cross-border workshop in the Pacific Northwest.





## Acknowledgements (Continued)

### Cross Border Workshop Planning Committee

#### Epidemiology

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BC Centre for Disease Control

**Jo Hofmann, MD**  
State Epi for Communicable Disease  
WA State Department of Health

**Bonnie Henry, MD, MPH**  
Epidemiology Services  
BC Centre for Disease Control

**Judy May, RN, MPH**  
Bioterrorism Surv and Epi Program Mgr  
WA State Department of Health

**Barbara Smith**  
Nurse Epidemiologist  
Alaska Dept of Health & Social Services

**Kris Carter, DVM, MPVM**  
Career Epidemiology Field Officer  
Idaho Department of Health and  
Welfare/CDC/USPHS

#### Public Health Lab

**Muhammad Morshed, PhD MSc**  
Clinical Microbiologist, Laboratory Services  
BC Centre for Disease Control

**Yolanda Houze**  
Bioterrorism/Pub Hlth Threats Lab Manager  
WA State Department of Health

#### Surge Capacity/EMS

**Wayne Dauphinee, BPE, MHA**  
Executive Director, Emergency Mngmt Branch  
Ministry of Health Services

**John Erickson, MS**  
Special Assistant  
WA State Department of Health

**Mike Harryman**  
Program Manager  
Oregon State Public Health Services

#### Communications

**Peter Dalton**  
Communications Officer  
BC Ministry of Health Services

**Laura Blaske**  
Communications Systems Manager  
WA State Department of Health

#### Exercise Planning

**Chris Smith**  
Director Emergency Management Branch  
BC Ministry of Health

**Daniel Banks, MA**  
Emergency Response Exercise Coordinator  
WA State Department of Health

#### Public Health Law

**Kathy Stout, JD**  
Senior Policy Advisor--Office of The Secretary  
WA State Department of Health

#### Additional Members

**Regina Delahunt**  
Director  
Whatcom County Health Department

**RADM Patrick O'Carroll, MD, MPH**  
Regional Health Administrator - Region X  
DHHS / U.S. Public Health Service

**Jack Thompson, MSW**  
Director, University of Washington Northwest  
Center for Public Health Practice

**Jim Matsuyama**  
Environmental Health Director  
Northeast Tri-County Health District

**Wayne Turnberg, PhD, MSPH**  
Cross Border Workshop Coordinator  
Washington State Department of Health

**Gail Zimmerman**  
Cross Border Workshop Organizer  
Washington State Department of Health

## Acknowledgements (Continued)

### Workshop Facilitators and Recorders

**Laura Blaske**

Communications Systems Manager  
WA State Department of Health

**Larry Champine**

WA State Department of Health

**Cathy Cochrane**

Regional Risk Communications Specialist  
Spokane Regional Health District

**Shari Mattson-Cooper**

Regional Risk Communications Specialist  
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**Greg Nordlund**

WA State Department of Health

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### Workshop Organizers

**Gail Zimmerman**

WA State Department of Health

**Carrie McGee**

WA State Department of Health

**Susan Chamberland**

WA State Department of Health

**Amy Sheridan**

BC Ministry of Health

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*This report was prepared by Wayne Turnberg, Washington State Department of Health*

## Introduction

The fourth annual Pacific Northwest Cross Border Workshop was held in Victoria, British Columbia on May 14-16, 2007. Over 200 invited professionals in the fields of epidemiology, public health laboratories, emergency management, communications, and law attended from Canada (including Alberta, British Columbia, Yukon Territory and the Canadian Federal Government), Native American Tribes and the United States (including Alaska, Idaho, Montana, North Dakota, Oregon, Washington, and the United States Federal Government). The workshop was structured around plenary presentations to reinforce work conducted during seven field-specific workgroup breakout sessions.

## Plenary Session Summary – May 15, 2007

**Opening Remarks** - The workshop began with opening remarks from the Honourable George Abbott, Minister of Health, British Columbia Ministry of Health, and Mary Selecky, Secretary, Washington State Department of Health.

**Keynote Addresses** - Keynote addresses were presented by Dr. James Young, MD, Special Advisor to the Minister, Public Safety and Emergency Preparedness Canada, and RADM Craig Vanderwagen, MD, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services. The following questions were addressed during the question and answer session following each keynote address:

**QUESTION:** What does “taking it to the next level” mean?

**RADM Vanderwagen:** We need to share best practices with other groups and hone those best practices—build on them to make them more effective. We need to institutionalize our efforts. We need to continue research and share findings widely through publication.

**Dr. Young:** Cross border sharing between preparedness partners is strongest in the Pacific Northwest. We should challenge other regions to do the same. From our perspective in BC, often a north/south solution is more feasible than an east/west solution—that is, it is more effective to seek resources from Washington State than it is to bring them from Ottawa.

**QUESTION:** What kind of messages might the federal government give to help with the Olympics and what help will Washington State get from the federal government?

**Dr. Young:** Again, we need to work north/south in planning and to provide surge capacity.

**RADM Vanderwagen:** Regionally we would be happy to plan with you and identify gaps and policy implications associated with the Olympics.

**QUESTION:** At a local working level we are doing effective things, but what are the implications of formalizing working together, what are legal implications and how might they constrain us?

*Dr. Young:* Problems are managed at a local level. There are lots of local groups, relationships and collaborations we don't know about. We need to continue to identify them and bring them into the process. The attorneys' job is to watch our actions and protect us, not constrain us. They are there to help us, not prevent us from doing what needs to be done.

*QUESTION:* Some planning is done in excruciating detail. Are we over-planning?

*Dr. Young:* You can become plan-bound. Some people are most comfortable with plans that spell out everything. It makes them feel more secure to address every detail. But, you plan to build relationships and you need to be able to improvise. You start with the assumption the plan won't work completely.

*QUESTION:* Will we ever reach a point where Canada and the U.S. forget their common border in an outbreak and concentrate on other national borders?

*Dr. Young:* Possibly for a time. Closing the border in a pandemic won't help. The concept of "perimeter enforcement" developed after 9/11 - don't let terrorists in. You can't shut disease out, but it's a political issue as well as a public health issue.

*RADM Vanderwagen:* From a health perspective, borders don't make sense, but how do we put others at ease in other parts of government. Additionally, the public and media may demand border closure.

*QUESTION:* What is the function and status of the National Disaster Medical System?

*RADM Vanderwagen:* The NDMS is a system created to move patients and coordinate efforts in the U.S. during a disaster. NDMS is the linchpin for the Medical Reserve Corps program. We are trying to develop similar local capacity and assets.

*Dr. Young:* Similar work is being done in Canada. There is no shortage of volunteers during many emergencies but not much interest in volunteering to fight emerging diseases like SARS.

*QUESTION:* What is the role of universities in disseminating information?

*Dr. Young:* Universities can do basic research and make ideas commercially viable. They can partner with others for production and distribution. For example, government, universities and business could collaborate on antiviral and mask research.

*RADM Vanderwagen:* Universities can document exercises, analyze the information we gain and turn it into training capabilities.

*QUESTION:* How do we get analysis of unintended consequences and include it in planning?

*Dr. Young:* In trying to plan we do ignore unintended consequences. We need to reexamine our approach because there are so many significant consequences that we don't look at.

*RADM Vanderwagen:* At the federal level we are trying to model and quantify results of possible policy actions. We push our modelers very hard. We tend to want to see the positive effects but we need to look at our actions up and down.

*Dr. Young:* School closures are a big issue. We need to really look at the effects school closures can have on the economy. If we are going to close schools, we should only close them up to grade six because older students are too mobile. Once they're out of the classroom, they're all off to crowd the mall.

**2010 Olympic and Paralympic Winter Games** – A panel of experts was convened to provide presentations and discuss the upcoming 2010 Olympic and Paralympic Winter Games in British Columbia. The panel was comprised of Dr. Jack Taunton, Chief Medical Officer, Vancouver 2010 Olympic Games; Mr. Robert Bryan, Regional Director, Emergency Management, Vancouver Coastal Health Authority; and Ronald Weaver, Joint Chief of Staff, Washington State Military Department.

The panel identified the following issues and logistical considerations:

- Many of medical incidents will originate with the large number of staff needed to put on the events
- About 3400 athletes and coaches will attend
- There will be 60 days of games if you include Paralympic that follow
- During the Olympic Games in Turino, the medical response system ended at the fence (perimeter). It was unknown of how many medical encounters occurred outside the event perimeter. In BC, efforts are focusing on ways to get feedback between the Vancouver and BC medical systems and the Olympic health system.
- A coordinating committee of local and provincial health and sports organizations has been established.
- This has provided a chance to upgrade physiotherapy equipment for local hospitals and clinics.
- An electronic medical encounter tracking program is being developed.
- An anti-doping lab is being developed which will need over 100 phlebotomists plus analysts and chaperones for the anti-doping lab.
- Many test events are scheduled for the Olympic health systems next year.
- In BC, St. Paul's Hospital is the hospital for spectators; other hospitals near the event centers have been included in plans and many are upgrading to handle increased Olympic demand and services specific to types of injuries they may encounter.
- Disaster planning is ongoing for terrorism, mass casualty, chemical/biological, avalanche, rock slide, bus accident, flooding--carried out by Emergency and Disaster Planning Group.

**U.S. National Biosurveillance Integration System** – Dr. William Lyerly, Director of International Affairs, Special Assistant for Global Health Security, U.S. Department of Homeland Security provided an overview of the Department of Homeland Security's National Biosurveillance Integration System (NBIS). Key points from Dr. Lyerly's presentation are as follows:

- NBIS is an integrator of data from other agency surveillance systems--a system that leads to supporting decision making
- NBIS does not confirm a terrorist event
- NBIS does not include information on individuals
- NBIS will be come fully operation in Sept 2008
- The chief product of the NBIS is tailored surveillance products
- Products include annual assessments that can be used to establish baselines and also "hotlists"
- The report can be used to determine what is normal as well as what is abnormal
- International, state, intergovernmental and interagency partners participate in development of NBIS
- Focus on 4 areas: Avian influenza and zoonotic diseases, food safety, contagious foreign animal diseases, environmental monitoring (Biowatch)
- Early response is important to reduce intensity and duration of events. NBIS provides the big picture to accomplish this.

**Pacific Northwest Cross Border Alliance** – Wayne Dauphinee recognized that public health has interests that are different than other emergency preparedness players with special needs—"we need to be partners with PNEMA at the same time—now is the time to move on." Wayne and John Erickson presented a draft document (Appendix D) for discussion that formalizes work done by this group in past four years. This effort provides a basis for forming an organization and carrying on work year round. Mr. Dauphinee and Mr. Erickson urged that we institutionalize this work so that it will carry on beyond the current event organizers' involvement.

- Next Steps – The draft document will be reviewed by the public health attorney workgroup.

**Framework for Assessing Regional Public Health Preparedness** – During the luncheon session, RADM Patrick O'Carroll, MD, MPH, Regional Health Administrator, Office of Public health and Science, U.S. Department of health & Human Services, Region X, presented a conclusions from a project to assess regional public health preparedness. The purpose of the project was to "develop a coherent conceptual framework as well as a discrete checklist to assess regional public health emergency preparedness. The framework and checklist is to be used by Regional Health Administrators (RHAs) to:

1. Identify cross-border issues related to public health preparedness;
2. Assist the U.S. DHHS Regional Emergency Coordinators in assessing the cross-border preparedness needs of their region; and,
3. Work collaboratively with state public health officials to identify and address cross-border preparedness issues."

Details about the project are available at <http://www.nwcp.org/centers-projects/assessing-regional-public-health-preparedness>.

## Plenary Session Summary – May 16, 2007

**Opportunities and Challenges** – The morning plenary session began with a presentation by Dr. Richard Besser, Centers for Disease Control and Prevention entitled *Preparedness in the 21st Century: New Systems to Protect the Public's Health*.

The Opportunities and Challenges session concluded with a presentation by Dr. Bonnie Henry, British Columbia Centre for Disease Control, entitled *Lessons Learned from SARS in Toronto*. Dr. Henry's discussion points included:

- In Toronto, a telephone hotline staffed by public health nurses was established, which received a tremendous amount of calls.
- Animal services specialists were placed at hospitals to care for animals of patients. Pet care is an area of great concern to those who need to be evaluated or treated.
- It was difficult to get volunteers from outside of the country and there were unforeseen difficulties. For instance, volunteers from out of country had to be quarantined when they returned home. Licensing was a big problem for cross border volunteers. Many non-government organizations won't allow volunteers to come if disease is infectious.
- Public health and health care spent a lot of time trying to find the right people to talk to cross border and a lot of time going through channels and were often chastised for not going through proper channels.
- Media often got it wrong. Most reporters were from out of the areas and were not familiar Toronto, public health or the principle players.
- A medical conference was cancelled because of participants were international health care providers who could potentially transport the disease back to hospitals around the world.
- Many entities refused to do business across the border. There were mixed messages about the safety of traveling or transporting goods, especially due to WHO travel advisory which came as SARS was winding down.

**Tribes and First Nations: Cross Border Collaboration** – This session addressed Tribal and First Nations issues relating to cross border collaboration. Presentations were from Byron Loucks, Emergency Management Consultant / Dr. David Martin, Program Medical Officer, Health Canada, British Columbia Region, First Nations and Inuit Health – First Nations Preparedness in British Columbia; and from Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board – Tribal Preparedness in the Pacific Northwest

**Pandemic Influenza Planning in Canada and the United States: Similarities and Differences** – A panel of national experts was convened to address similarities and differences between national pandemic influenza planning efforts in Canada and the United States. The panel was comprised of Jill Sciberras, Senior Epidemiologist, Public Health Agency of Canada; Dr. Marty Cetron, Director, CDC, Division of Global Migration and Quarantine; Dr. Benjamin Schwartz, Senior Science Advisor, HHS, National Vaccine Program Office; and Dennis Brodie and Thomas Kind of the Public Health Agency of Canada.

### ***Community (Non-Pharmaceutical) Measures to Mitigate Spread –***

*QUESTION:* What kind of information do we have about costs of community interventions?

*PANELIST RESPONSE:* The costs of implementing community interventions are less than costs of not implementing them. Acting early is important to limit severity and not everyone has to comply for methods to be effective. It is more challenging to sell these interventions when dealing with moderate pandemic as in the Canadian plan.

*QUESTION:* How do you assess when to implement measures?

*PANELIST RESPONSE:* We have sophisticated data collection and modeling but it is not exact and we would prefer to err on the side of implementing early.

*QUESTION:* How about school closure? Would you use absenteeism to decide when to close schools?

*PANELIST RESPONSE:* You can't use absenteeism as a trigger. The decision needs to be tied to community attack rate. Individual school closure is often a business decision about teachers being available. Parents often keep well kids home without being asked to do so.

### ***Use of Antiviral Medicines***

*QUESTION:* Are our systems adequate to diagnose and treat people within 48 hours of exposure regardless of stockpile availability?

*PANELIST RESPONSE:* We probably can't do it today, but we need to look at ways to accomplish it and there are creative strategies available for getting antivirals into people's hands including pre-distribution. Washington is looking at distribution through pharmacies. We don't know how much antiviral medication is in private hands through doctor purchase and people buying over internet.

*QUESTION:* There is a real problem with getting people to the doctor within 48 hours especially in the U.S. where you can't get an appointment quickly and where the health care system emphasizes keeping people away.

*PANELIST RESPONSE:* We need to provide home diagnostics and rapid assessment sites.

*QUESTION:* How about defraying costs by rotating stock so that those doses about to expire are used for seasonal flu?

*PANELIST RESPONSE:* It would not help much because so much less vaccine is needed for seasonal flu. A lot of work is being done on shelf-life extension.



***Travel and Border Issues –***

*QUESTION:* With volume of travelers what good is it to stop a few cases?

*PANELIST RESPONSE:* The net is not a flu-specific response. It can be very valuable for stopping other diseases at the airport.

*QUESTION:* How effective is pre-flight screening?

*PANELIST RESPONSE:* Flu and SARS are different and you can't apply all lessons learned from SARS to fighting a flu pandemic. For instance pre-flight screening didn't work in SARS because of when it was implemented. Monitoring fevers may work for flu because people are most infectious early. In SARS it was in second week.

*QUESTION:* How does funneling flights through 20 ports affect small ports of entry?

*PANELIST RESPONSE:* They would probably be closed depending on severity of the event.

## **Breakout Workgroup Sessions**

### **Epidemiology Workgroup**

#### ***Epidemiology Cross Border Accomplishments 2007***

- Epidemiology activities fostered joint collaborations to address a Public Health Data Sharing Agreement. A draft agreement was submitted to the Public Health attorneys from WA State DOH and British Columbia CDC. The attorneys will review and discuss the agreement during their breakout session at the Cross Border Workshop. Feedback and recommendations for signatories will be provided to Drs Hofmann and Patrick. It is anticipated that the agreement will be revised and implemented by December 2007.
- The WA State epidemiologists attempted to share secure confidential information, that contained person health identifies (PHI), with British Columbia epidemiologists. The test data was exchanged via the CDC's Epi-X confidential list serve and included an attachment with factious names of individuals that were exposed to a highly infectious disease. The attachment to the message was able to be viewed by additional editorial and development staff at the CDC. This method of confidential information exchange that included PHI was determined to be unsatisfactory due to the access to it by persons who did not have a "need to know" the information. Further discuss with Dr Rossanne Philen, Medical Director for Epi-X, assured WA State that Epi-X is a level 3 security system and PHIN Certified to process data that includes personal health identifiers (PHI). Staff at Epi-X has signed confidentiality agreements and the system can track all persons who have accessed the system. DOH and other cross border partners will need to discuss and agree if this system meets their needs for secure electronic file transfer of information that includes PHI.
- The Pacific Northwest border regions shared and tested updated 24/7 emergency contact lists.
- As part of PNEMA activities, WA DOH compiled a table comparing disease reporting requirements across PNEMA jurisdictions. The commonalities and differences for immediately notifiable conditions were compared. The jurisdictions each have a list of immediately reportable conditions in all jurisdictions. This multi-jurisdiction list of notifiable conditions will assist in alerting neighboring jurisdictions and facilitate timely reporting and response activities.
- Pacific NW epidemiologists conducted an exercise to test epidemiology preparedness and response capabilities across national and international Pacific NW borders. This exercise was conducted during the annual cross border workshop in Victoria, BC on May 15, 2007.
- Washington State and cross border partners in British Columbia have taken steps towards establishing electronic connectivity through Epi-X and CIOSC for sharing health alerts and other outbreak information. A list of interested partners in the Pacific NW States has submitted their names to BC CDC who is facilitating connectivity for the U.S. to the Canadian system. Currently interested Canadian partners can request access to Epi-X.

- Presentations and discussions took place during the Victoria workshop to strengthen cross border relationships and enhance cross public health surveillance and response capabilities in preparation for the 2010 Olympic and Paralympic Games in British Columbia. Next steps include establishing cross border (real time) surveillance systems, and surge agreements

### ***Presentations***

- Cross-Border Collaboration: Interior Health Authority, BC; Panhandle Health District, Idaho, North East Tri-County, WA: Dr. Rob Parker, Medical Health Officer, Interior Health, BC / Jim Matsuyama, RS, NE Tri-County, WA
- Measles as a Model for Public Health Disaster Response – Dr. Jo Hoffman, WA DOH
- Measles Exercise International Ports; British Columbia, Anchorage, Seattle- Dan Banks, Eric Sergienko
- Quarantine Station Operations in Response to Measles: Peter Houck, MD US, DGMQ, CDC Quarantine Station; Thomas Kind, RN, Vancouver International Airport; Shah Roohi, RN MPH DGMQ, CDC, Anchorage International Airport

### ***Next Steps***

1. Continue efforts to establish electronic connectivity through CDC's Epi-X and the Canadian Integrated Outbreak Surveillance Centre (CIOSC) for sharing health alerts and other outbreak information.
2. Continue to explore secure public health information exchange with personal health information.
3. Continue to test data exchanged via CDC's Epi-X confidential list serve.
4. As part of PNEMA activities, continue to compile a table comparing disease reporting requirements across PNEMA jurisdictions.
5. Continue to test epidemiology preparedness and response capabilities.
6. Continue to address land border issues in Alaska.
7. Research information: Vancouver needs more information from the cargo industry.
8. Continue to fold emergency issues into all-hazards public awareness approach; share best practices.
9. Continue work on a cross border data sharing agreement between PNEMA jurisdictions.

## **Web Resources**

Epi X Homepage: <http://www.cdc.gov/epix/>

### Canadian Network for Public Health Intelligence (CNPHI)

- A secure internet-based suite of applications and resources, primarily directed towards strategic public health information and intelligence sharing. Applications include:
  - Canadian Integrated Outbreak Surveillance Centre (CIOSC)
    - CIOSC Goal: To enhance public health's capacity to anticipate and detect health risks associated with communicable disease threats.
  - CNPHI Summary Sheet: <http://mala.ca/cch/aded/documents/CNPHIFeb2005.pdf>

### Canadian Integrated Public Health Surveillance (CIPHS)

- Homepage: [http://www.phac-aspc.gc.ca/surveillance\\_e.html](http://www.phac-aspc.gc.ca/surveillance_e.html)
-

## **Public Health Laboratory Workgroup**

The Public Health Laboratory Work Group reviewed progress made on goals identified in past meetings and found that significant movement forward has been made toward formalizing laboratory relationships and working on finalizing several Memoranda of Understanding. A plan to conduct an exercise to test the sharing of resources was replaced by the success of a real-life situation last year, and the upcoming Olympic Games inspired a goal to assess options for funding cross-border laboratory collaboration.

### ***Presentation***

- *The Canadian Public Health Laboratory Network*, Theodore Kuschak, Ph.D., Manager, Canadian Public Health Laboratory Network, Public Health Agency of Canada

### ***Progress on Identified Key Issues:***

- *Resource Sharing* – Conducted real-life request of sharing of laboratory resources and found that the system worked as expected in time of need. Our familiarity with one another made it easy to call for help when the Washington State Public Health Laboratory needed supplies during a disease investigation. We received assistance from other labs in the states as well as from British Columbia. In light of the success of this situation, we decided not to hold the exercise of a similar event. We discussed the need to continue to update one another on individual and group laboratory issues.
- *Contact List* – Developed comprehensive contact list of key laboratory contacts. Group members have been in communication over the past year as needs arose. The list will be redistributed on a regular basis to maintain accuracy.
- *Terms of Reference* – Finalizing Cross Border Public Health Laboratories Team Terms of Reference. The workgroup looked at the Draft Terms of Reference and suggested that it be worded as a more informal agreement. Morshed and Yolanda will work on this and provide copies to the rest of the workgroup.

### ***Next Steps and Goals:***

- To sign the Memorandum of Understanding (MOU) between the British Columbia Centre for Disease Control (BC CDC) Laboratory and the Washington State Public Health Laboratory (WA PHL). It is currently going through draft review steps.
- Include the Montana Public Health Laboratory in the existing Region 10 Laboratory MOU. This is also going through the draft review process.
- Complete full access for BC CDC to the U.S. Centers for Disease Control and Prevention (U.S. CDC) Laboratory Response Network (LRN). British Columbia CDC currently has

“read” access to the LRN and is working with their federal partners in Winnipeg to gain complete access rights. Washington Public Health Laboratory (WA PHL) Director will continue to assist their efforts.

- Research and evaluate using a web-based coordinating resource to improve communication for the working group. Propose that other working groups network through similar systems.
  - Discuss the recently proposed Pacific Northwest Health Alliance as it applies to the Cross-Border Laboratory Work Group.
  - Explore funding opportunities for cross-border laboratory collaboration. Determine types of high profile, high public health impact laboratory testing needed related to the 2010 Olympic Games to develop and ensure common laboratory procedures.
-

## **Surge Capacity Workgroup**

The workgroup discussed the procedural issues involved in sharing healthcare personnel across borders during an emergency, with emphasis on how this would be done under PNEMA. The group's goal was to identify the existing procedures and agreements governing these transfers as well as the gaps that need to be filled to make the process work effectively.

### ***Presentations***

*State of Alaska Pediatric Respiratory Illness Outbreak* – Sally Abbott, ANP, Alaska Division of Public Health Preparedness Program

- An outbreak of RSV earlier this year, overwhelmed hospitals but was eventually brought under control through resource sharing, information sharing and a public information campaign
- Many resources were identified, including State Emergency Operations Center.
- Recommendations
  - Institutionalize convener in Public Health to coordinate partners and share information in a timely manner
  - Define what constitutes a public health emergency and what the triggers are to activate response.
  - Engage hospitals in EOC.
  - Encourage hospitals to sign mutual aid agreements to facilitate privileging of medical providers in emergencies.
  - Clarify when PNEMA takes effect. No protocols have been identified for PNEMA.
  - Staff EOC to include someone who understands health resources

*PNEMA and the Operations Plan* – Joyce Roper, Washington Office of the Attorney General

- Suggested that the plan be made more bilateral and provide for the movement of health professionals across borders
- PNEMA does not address a number of legal issues. (Annex B does address legal issues, however, that are related to PNEMA.)
- Liability and emergency worker issues are under discussion.

### ***Washington's Draft Operational Plan for Sharing Healthcare Personnel Across Borders During an Emergency***

— The draft agreement is intended for use as a template that any jurisdiction could apply when drafting agreements for requesting, sending and receiving emergency surge personnel.

- If adopted, the draft plan will become part of Washington's Comprehensive Emergency Management Plan.
- EMAC-like procedures and paperwork for implementing the process described in the plan will be developed by June.
- It hoped that agreements based on this template will be useful for a variety of situations from large scale disasters to smaller medical emergencies.

***Movement of Emergency Service Personnel Across Borders*** – There is an existing Cross-Border Ambulance Reciprocity Policy Statement between British Columbia and Washington covering emergency medical services. The Policy Statement is dated November 30, 2003 and is currently the basis for cross-border EMS service between Washington, BC, Oregon and Idaho.

***Online Portal*** – The Joint Regional Medical Planner from Ft. Lewis discussed an online portal that planners and emergency manager can use to get emergency contact information and more. Access can easily be arranged. The information is unclassified. The portal is in the early stages of development

***Facilitated Scenario Based Discussions*** – The group divided into two. Each group was asked to describe how it would go about requesting 50-60 medical professionals from a neighboring government under PNEMA and how they would get those people across the border and in place within 48 hours after an earthquake.

The groups discussed the chain of command that requests would follow, the process for contacting volunteers, issues of credentialing and licensing, liability, workers compensation, border crossing, transportation and deployment. The requesting process seemed clear to most but it seemed unlikely that governments could provide volunteers within 48 hours of receiving a request largely due to the lack of databases of pre-registered volunteers and licensing and credentialing issues. Many believed that if an emergency request was made at this time, governments would work from one official to another to smooth the way for effective action.

#### ***Gaps and issues that need to be resolved***

1. We need additional detailed agreements
2. There is not enough knowledge about PNEMA among users
3. Liability insurance coverage needs to be addressed
4. Credentialing and licensing need to be standardized and made more workable
5. Databases of pre-registered volunteer personnel must be developed
6. We may not have enough surplus professionals to provide adequate surge capacity
7. During a communicable disease outbreak it is difficult to get volunteers

#### ***Next Steps***

- 1 Continue to use PNEMA, and educate politicians and other partners about PNEMA, develop written materials and presentations
- 2 Create agreements that fill in the details of how personnel will be shared
- 3 Exercise, drill practice
- 4 Involve health care providers, hospital CEOs, medical and nurses' associations, non-government organizations (NGOs), emergency management leads, Emergency Medical Services (EMS), and border/customs agencies.

“Most people overestimate what can be accomplished in 1 year, but underestimate what can be accomplished in 5 years.”



## Emergency Medical Services Workgroup

**Goal:** Optimal Preparedness, response activities and patient movement across borders occur through the expeditious movement of health care personnel, resources and the transport of injured/ill patients to established health care facilities. (GOAL IS ON-GOING)

### **Objective #1 – Patient transport and inter-facility transfers. (Objective met)**

- Reviewed existing agreements/policies: Pacific Northwest Emergency Management Arrangement (PNEMA), MOU for Public Health Emergencies between WA/BC, Washington State EMS, Cross Border Ambulance Reciprocity Policy, BC Agreements, pending policies, and the Washington State EMS Scope of Practice Matrix.
- Discussed the existing procedures used by BC and Whatcom County EMS and USCBP to move patients from Point Roberts, WA, through BC to Washington. Discussed the use of the PNEMA between Washington, Alaska and British Columbia, along with Alaska's process and procedures to cross the borders.
- Sample procedures. Reviewed a sample Process Checklist for medical personnel notification and border crossing. Developed a draft Process Checklist for medical personnel notification and border crossing.

#### Recommendations:

- 1) The workgroup will continue discussions and develop a process checklist via email and teleconference.  
Action: Debbie Engels, Mike Smith and Bruce Harford will set up meetings and distribute updated documents.
- 2) The Washington State EMS, Cross Border Ambulance Reciprocity Policy should be added as an appendix to the Washington State Plan for Sharing Physician and Nursing Personnel Across the Border with British Columbia.  
Point of Contact: Dennis Anderson and Rick Buell
- 3) The Washington State Plan for Sharing Physician and Nursing Personnel Across the Border with British Columbia workgroup should include EMS and other health professions partners into the plan development.  
Point of Contact: Dennis Anderson and Rick Buell
- 4) Select a planning committee that includes EMS for the next Cross Border Workshop.  
Point of Contact: Wayne Turnberg, Wayne Dauphinee, Mike Smith and Bruce Harford.

### **Objective #2 – EMS resources sharing, e.g. providers, equipment, protocols, vehicles, etc. (Objective met)**

- Discussed capabilities both in Canada and Washington per above notes.
- Discussed capacities both in Canada and Washington per above notes.
- A barrier during disasters and Mass Casualty Incidents (MCI) was discovered in subparagraph #3 of the Washington State EMS, Cross Border Ambulance Reciprocity Policy. This paragraph states "3. While Transporting patients to medical, residential, convalescent, and nursing facilities in Washington State, but not from point to point, was identified as a barrier during a declared MCI or disaster.

Recommendation: Add to the end of #3 May be superseded when a state of emergency is declared in the case of a disaster or MCI as determined by the local incident commander.  
Point of Contact: Mike Smith

***Objective #3 – Acceptance of cross border health care credentials and patient care protocols. (Objective met)***

- Existing credentials are adequately addressed in the Washington State EMS, Cross Border Ambulance Reciprocity Policy. BC is finalizing a similar policy.  
Point of Contact: Bruce Harford
- Existing patient care protocols are adequately addressed in the Washington State EMS, Cross Border Ambulance Reciprocity Policy. BC is finalizing a similar policy.  
Point of Contact: Bruce Harford
- Patient care procedures are adequately addressed in the Washington State EMS, Cross Border Ambulance Reciprocity Policy. BC is finalizing a similar policy.  
Point of Contact: Bruce Harford

***Objective #4 – Accepted essential elements of a Mutual Aid Agreement to meet patient care and patient movement needs. (Objective met)***

- Both WA. and BC follows similar Incident Command Systems that included Mutual Aid Agreements (MAA) elements. However, an attempt to communicate to all EMS agencies the importance of local MAAs or MOUs cross border are important for improved communication lines and a seamless transfer of patients, equipment and supplies across borders.  
Point of Contact: Mike Smith, Debbie Engels and Bruce Harford.
  - Communicating and educating all EMS agencies and Border Protection Staff may become a time barrier.  
Recommendation: After BC has a formal Cross Border Policy, Mike Smith and Bruce Harford facilitate meetings between cross border EMS agencies and the border authorities.
-

## **Communications Workgroup**

The Cross-Border Communications Workgroup held two sessions this year, focusing on resource-sharing and key public awareness issues. Attendees represented local, state, provincial, federal and tribal governments and organizations. Discussions focused on developing methods to quickly share information across territorial and organizational borders to help assure effective public outreach and communications coordination on critical issues.

Because public health messages may vary between states and provinces, attendees agreed to create new channels for quickly sharing information and discussing potential differences in messaging. Attendees also agreed to develop ways to share information on organizational and emergency planning issues which may impact key messages.

The Cross-Border Communications Workgroup will address these issues on conference calls in the coming year (see Next Steps section below).

### ***Presentations***

- Pandemic Influenza – Public Outreach (Washington State)
- West Nile Virus (British Columbia and Washington State)
- Antiviral Deliberative Dialogue Project (Public Health Agency of Canada)
- Virtual Joint Information Center (Oregon State)
- Emergency Communications Toolkit (Washington State)
- Collaborative software (Public Health Agency of Canada)
  
- (For more information, see Web Resources section below.)

### ***Group Discussions***

- Pan flu outreach materials and need for collaboration –
  - Antiviral messaging on US/Canada differences; state/province differences
  - Using personal video Web sites for outreach (YouTube, MySpace, etc.)
  - Strategies to combat possible waning public interest.
  
- West Nile virus –
  - Using an all-hazards approach.
  - Potential for point-of-sale outreach.
  - Need for discussion on disclosure differences.
  
- Special Needs Communities –
  - Collaboration on outreach materials (including translations).
  - Best practices; how to engage community groups, partnering with existing programs as communication channels.
  - Testing materials in the community.
  
- Information-sharing across borders –
  - One-stop shop for people to see how issues are being addressed in provinces/states.

- Identify differences in our region and possible public awareness issues.
- Call Center Capacity –
  - Possible surge capacity issues.
  - Public will call numbers from other states/provinces; how can we share messages?
- Tribes/First Nations –
  - How can we better engage in developing collaborative communications strategies?
- Emerging Issues/Special Events –
  - Possible communication issues regarding upcoming Olympics.

### **Next Steps**

- Continue collaboration through ongoing Cross-Border Communications Workgroup sessions
  - Schedule series of regular calls on key issues with communications team members from Alberta, British Columbia, Yukon, Washington, Oregon, Idaho, Montana and North Dakota; invite other partners, federal representatives (Canada and US) as appropriate.
  - Establish electronic system for ongoing communication resource-sharing.
  - Continue work on developing protocols for assistance and coordination on critical public health issues.
  - Develop communication strategies on key issues including pan flu and antivirals.
  - Continue to fold emergency issues into all-hazards public awareness approach; share best practices.
  - Discuss staff or training exchange program between states and provinces to help build understanding of different systems, emergency plans and risk communication strategies.
  - Share information from workgroup with other public health and emergency partners.

### **Web Resources**

Public Health Agency of Canada –

- Information on Antiviral Deliberative Dialogue Project – [www.phac/aspc.gc.ca](http://www.phac/aspc.gc.ca)
- Public awareness materials – [www.healthycanadians.ca](http://www.healthycanadians.ca)

Washington State Department of Health –

- Communications Toolkit – [www.doh.wa.gov/phepr/toolkit](http://www.doh.wa.gov/phepr/toolkit)
- Medication Center resources – [www.doh.wa.gov/phepr/signs](http://www.doh.wa.gov/phepr/signs)
- Pandemic Flu resources – [www.doh.wa.gov/panflu](http://www.doh.wa.gov/panflu)

## **Public Health Law Workgroup**

The public health law workgroup discussed these three documents:

- Conceptual framework for the Pacific Northwest Border Health Alliance
- Washington State guide for local health
- Draft agreement for moving personnel across BC/WA border during an emergency

### ***Conceptual framework for the Pacific Northwest Border Health Alliance***

Although the intention was to clarify the structure of PNEMA, Annex B and the workgroups, the public health law workgroup agreed that in some portions of the draft, the proposal was unclear and that work needs to be done to clarify the informal nature of the alliance.

The Alliance deals with structure, not managing individual issues. However some issues were discussed that might or might now be incorporated in to this proposal. Those issues included data sharing, privacy protection, joint disease investigations. It was also suggested that the Alliance expand its language beyond infectious disease to other public health hazards including environmental health and public health hazards surveillance.

It was discussed whether the document was necessary at all. The group agreed that although it adds nothing new and does not expand or limit authority, it would be beneficial to clarify the structure and roles of both the administrative and workgroup roles and would provide a formal statement to support participation, commitment and funding.

Next Steps: Before being ratified or approved, the workgroup recommended a complete legal review of the proposal. Also, Joyce Roper will submit a list of suggested changes and considerations for the next draft.

### ***Washington state guide for local health***

Susan Ferguson of the Washington State Department of Health presented the outline of a guide she is writing for local health jurisdictions and local health officers that addresses the legal issues that they encounter on a daily basis. The guide is a guide in the strictest sense and will not serve as legal advice.

Among the issues in the outline are:

- the authority, roles and responsibilities of local health officers and other public health entities;
- the limitations of due process;
- disease surveillance, investigation and reporting;
- continuity during emergencies;
- isolation and quarantine;
- altered standards of care/alternate care facilities

The group discussed the use of administrative warrants in each state or province. The laws regarding them were vastly different from jurisdiction to jurisdiction especially when pertaining to commercial property.

Next Steps: Susan asked for input and suggestions from the workgroup, who was generally enthusiastic about the project.

***Draft agreement for moving personnel across BC/WA border during an emergency.***

There was a great deal of discussion about the complexities concerning the issues of liability, credentialing, and licensing of public health workers who volunteer in another state or province during an emergency.

Although some issues are discussed in PNEMA, many questions require interpretation, clarification and legal review.

These issues also include workers comp/death benefits for emergency workers.

Next Steps: Shannon O'Fallon from Oregon will compile list of the differences in liability, licensing and worker's compensation/death benefits among the PNEMA states/provinces. The final list will be distributed to the workgroups participants.

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## **Appendices**

Appendix A - Workshop Agenda

Appendix B - Draft Surge Capacity Operational Plan

Appendix C - Draft Epidemiology Data Sharing Agreement

Appendix D - Draft Pacific Northwest Border Health Alliance – Conceptual Framework

Appendix E - Speaker Biographies

Appendix F - Workshop Evaluation

Appendix G - Cross Border Workgroup Membership

Appendix H - List of Registered Participants

## Appendix A

# Cross Border Public Health Collaboration: Opportunities and Challenges

**Harbour Towers Hotel & Suites**  
345 Quebec Street, Victoria, British Columbia

May 14 – 16, 2007

## Agenda

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### **Pre-Workshop Workgroup Meetings** Monday, May 14, 2007

1:30-4:30 **Pre-Workshop Workgroup Meetings**

- ❖ Epidemiology Workgroup
- ❖ Public Health Laboratories Workgroup
- ❖ Emergency Management Surge Capacity Workgroup
- ❖ Emergency Medical Services Workgroup
- ❖ Communications Workgroup
- ❖ Exercise Planning Workgroup
- ❖ Public Health Law Workgroup

Noon-7:00 **Registration**

**Pre-Workshop Workgroup Meetings Purpose:** To update participants on discipline-specific cross border activities as a precursor to the workshop's May 15<sup>th</sup> breakout sessions. All workshop participants are invited to attend the pre-workshop meetings. Participants are encouraged to attend a workgroup meeting in their field of expertise.



**Workshop Day 1**  
**Tuesday, May 15, 2007**  
(Morning Plenary Session)

- 7:00-8:00     **Registration / Continental Breakfast**
- 8:00-8:40     **Welcome and Introduction** – Dr. Eric Young, Deputy Provincial Health Officer, British Columbia Ministry of Health
- Hon. George Abbott, Minister of Health, British Columbia Ministry of Health
  - Mary Selecky, Secretary, Washington State Department of Health
- 8:40-10:00    **Keynote Addresses** –
- Dr. James Young, MD, Special Advisor to the Minister, Public Safety and Emergency Preparedness Canada
  - RADM Craig Vanderwagen, MD, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
- 10:00-10:30   **Break**
- 10:30-11:30   **2010 Olympic and Paralympic Winter Games** (Wayne Dauphinee, Presiding)
- Dr. Jack Taunton, Chief Medical Officer, Vancouver 2010 Olympic Games
  - Robert Bryan, Emergency Management Director, Vancouver Coastal Health
  - Ron Weaver, Joint Chief of Staff, Washington State Military Department
- 11:30-11:45   **Overview of the National Biosurveillance Integration System** – Dr. William Lyerly, Director of International Affairs, Special Assistant for Global Health Security, U.S. Department of Homeland Security
- 11:45-Noon   **Pacific NW Cross Border Alliance**
- Wayne Dauphinee, Emergency Management Consultant, BC Ministry of Health
  - John Erickson, Special Assistant, Washington State Department of Health
- Noon-1:30     **Lunch** – Dr. Jude Van Buren, Assistant Secretary, Washington State Department of Health, Presiding)
- **A Framework for Assessing Regional Public Health Preparedness** – RADM Patrick O’Carroll, MD, MPH, Regional Health Administrator, Office of Public Health and Science, U.S. Department of Health & Human Services, Region X

# Workshop Day 1 (continued)

Tuesday, May 15, 2007

(Afternoon Breakout Sessions)

## 1:30-5:00 Facilitated Workgroup Sessions\*

### ❖ Epidemiology

- Canadian Lead: Dr. David Patrick, British Columbia Centre for Disease Control
- U.S. Lead: Dr. Jo Hofmann, Washington State Department of Health

### ❖ Public Health Laboratories

- U.S. Lead: Dr. Romesh Gautam, Washington State Department of Health
- Canadian Lead: Dr. Judith Isaac-Renton, British Columbia Centre for Disease Control

### ❖ Emergency Management Surge Capacity/Emergency Medical Services

- Canadian Leads: Wayne Dauphinee, British Columbia Ministry of Health; Bruce Harford, British Columbia Ambulance Service
- U.S. Leads: John Erickson, Washington State Department of Health; Michael Smith, Washington State Department of Health

### ❖ Communications

- U.S. Lead: Laura Blaske, Washington State Department of Health
- Canadian Lead: Peter Dalton, British Columbia Public Affairs Bureau

### ❖ Public Health Law

- Canadian Lead: Paul Bailey, British Columbia Ministry of Health
- U.S. Lead: Joyce Roper, Washington State Office of the Attorney General

*\*Workgroup Breaks - Afternoon beverages and snacks will be available at 3:00 PM*

## 5:30-7:30 Meet and greet mixer (cash bar) followed by dinner on your own

**Workshop Day 2**  
**Wednesday, May 16, 2007**  
(Morning Plenary Session)

- 7:00-8:00    **Continental Breakfast**
- 8:00-8:50    **Opportunities and Challenges** (John Erickson, WA Dept of Health, Presiding)
- Dr. Richard Besser, Centers for Disease Control and Prevention – Opportunities and Challenges in Cross Border Public Health Preparedness and Response
  - Dr. Bonnie Henry, British Columbia Centre for Disease Control – Lessons Learned from SARS in Toronto
- 8:50-9:30    **Tribes and First Nations: Cross Border Collaboration** (Dr. Mark Oberle, NW Center for Public Health Practice, Presiding)
- Byron Loucks, Emergency Management Consultant / Dr. David Martin, Program Medical Officer, Health Canada, British Columbia Region, First Nations and Inuit Health – First Nations Preparedness in British Columbia
  - Joe Finkbonner, Executive Director, NW Portland Area Indian Health Board – Tribal Preparedness in the Pacific Northwest
- 9:30-10:00    **Break**
- 10:00-Noon    **Panel Discussion: Pandemic Influenza Planning in Canada and the United States: Similarities and Differences** (Moderator: RADM Patrick O'Carroll, MD)
- 10:00-10:40    **Community (Non-Pharmaceutical) Measures to Mitigate Spread**
- Jill Sciberras, Senior Epidemiologist, Public Health Agency of Canada
  - Dr. Marty Cetron, Director, CDC, Division of Global Migration and Quarantine
- 10:40-11:20    **Use of Antiviral Medicines**
- Jill Sciberras, Senior Epidemiologist, Public Health Agency of Canada
  - Dr. Benjamin Schwartz, Senior Science Advisor, HHS, National Vaccine Program Office
- 11:20-Noon    **Travel and Border Issues**
- Dennis Brodie / Thomas Kind – Public Health Agency of Canada
  - Dr. Marty Cetron, Director, CDC, Div. of Global Migration and Quarantine
- Noon-12:30 **Workshop Accomplishments and Closing Remarks**
- Mary Selecky, Secretary, Washington State Department of Health
  - Wayne Dauphinee, Emergency Management, BC Ministry of Health
- 12:30    **Farewell Break** - Afternoon beverages and snacks will be available at 12:30 PM

## Appendix B

### Draft Surge Capacity Operational Plan

#### Draft Washington State Plan for Sharing Physician and Nursing Personnel Across the Border with British Columbia

- I. **Authority:** This operational plan is developed in accordance with the Pacific Northwest Emergency Management Arrangement (PNEMA) and ANNEX B of PNEMA.
- II. **Purpose:** The purpose of this plan is to operationalize timely and efficient movement and utilization of health professionals across the Washington border with British Columbia.
- III. **Activation:** This operational plan will be activated on the authority or direction of the Governor or designee.
- IV. **Concept of Operations:**
  - A. General: When a party to PNEMA (state, province, or territory) suffers a disaster that exhausts or threatens to exhaust physician and/or nursing resources, the Governor or Premier may request assistance from across the international border. Requests for such assistance will be presented formally from the requesting state/provincial Emergency Operations Center (EOC) directly to other state/provincial EOC. Requests for assistance from local jurisdictions in the state must be routed from the local EOC through the state/provincial EOC.
  - B. Format: Requests can be verbal or written. Verbal requests will be followed up in writing. State request forms will be used as the written request form. (See PNEMA Administrative Procedures). Requests should include the following information:
    1. Description of services need (mission)
    2. Number and type of professionals (using pre-identified resource typing designations whenever practical)
    3. Estimated length of time needed
    4. Specific time and place for mobilization center (staging location) and contact person
    5. Location of service delivery
    6. Specific information must be provided in written form (see Licensure and Credentialing issues sections of this plan)

C. Staging and Deployment:

1. State and/or BC EOC will provide information on staging locations to the jurisdiction providing personnel resources. Requested personnel will report to the identified staging location(s) of the requesting state/province for deployment to operational commands.
2. Expedited Processing:
  - a. Mobilization centers will be hosted by the state or province to provide a centralized processing facility from which administrative matters can be executed expeditiously. Personnel will not be deployed from the mobilization center until they have been briefed on administrative requirements (travel, communications, and length of deployment) and have necessary protective equipment and vaccinations (as appropriate). Operation of the mobilization center is the joint responsibility of DOH and EMD.
  - b. When Canadians are deployed to Washington, EMD will provide staff at the mobilization center to assure that personnel are registered as emergency workers as provided for in WAC 118-04 *prior* to allowing them to deploy from the mobilization center.
  - c. When Washingtonians are deployed to Canada, EMD will provide staff at the provincial mobilization center to verify that deployed personnel are registered in Washington as emergency workers. Those that are not registered may then be registered on the spot.

D. Field Support: The sending state/province recruits appropriate personnel and will arrange and provide for travel to staging locations. The state and/or BC EOC will provide management support (e.g., food, lodging, transportation, etc.) and provide for return travel and travel arrangements for responders. Once deployed to a duty station, day-to-day support will be provided by the duty station operation command.

E. Demobilization: Demobilization will be defined in deployment information provided to responders by the sending jurisdiction. The State or BC EOC will provide the deployment packet to the responder. Return travel will be arranged by the receiving jurisdiction.

V. **Legal and Administrative**

A. Liability Protection: In order to receive personal and professional liability protections of PNEMA and state law, personnel deployed to Washington must be

registered as emergency workers by the receiving local emergency management agency as specified under chapter 118-04 Washington Administrative Code.

B. Workforce Identification and Training:

1. DOH is responsible to maintain an inventory of physician and nurse assets deployable under this plan. DOH will create and maintain a database of volunteer providers known as Washington Health Volunteers in Emergencies (WAHVE), which initially will be limited to physicians, nurses, and mental health professionals.
2. Assets identified under an approved resource typing scheme must meet all the training and credentialing requirements of that type of asset.
3. Except as might otherwise be determined to be necessary, Washington will not form pre-designated teams. Rather, teams will be formed ad hoc at the time a need for a specific team type is identified or thought to be imminent. As such, pre-event collective team training will not be possible.

C. Personal Protective Equipment: The receiving jurisdiction and institutions or agencies will ensure that personnel deployed from the mobilization center will have adequate personal protective equipment prior to commencing their duties. If vaccination particular to the immediate threat (e.g., smallpox) is required, that vaccination will be provided by the receiving jurisdiction or institution and must be administered prior to commencing duties.

D. Licensure: During a declared emergency, whenever a person of the sending jurisdiction holds an active and unencumbered license, certification or other permit to practice as a physician or nurse, and such assistance is requested by the receiving jurisdiction; such person is deemed to be licensed, certified or permitted to practice by the jurisdiction requesting assistance, to the extent allowed by law. The practitioner is subject to limitations and conditions as the requesting signatory under PNEMA prescribes by executive order or otherwise.

D. Credentialing: The requesting jurisdiction is responsible for providing a descriptive request through the EOC as required by <insert title of PNEMA admin procedures here> managed by the state EOC. This request must clearly define medical scope of practice, any particular skills needed (e.g., licensed and practicing orthopedic surgeon specializing in knee reconstruction) and any licensure or credentialing documentation needed by the medical volunteer, in order to fulfill the request. This portion of the request may not be modified in any fashion by the EOC. The ultimate responsibility for credential verification resides with the requesting facility/end user institution.

E. Reimbursement: Reimbursement will be according to PNEMA and individual agency policies.

F. Border Crossing:

1. As part of the Western Hemisphere Travel Initiative (WHTI), beginning January 23, 2007, all persons, including U.S. citizens, traveling by air between the United States and Canada will be required to present a valid passport, Air NEXUS card, or U.S. Coast Guard Merchant Mariner Document.
2. As early as January 1, 2008, all persons including U.S. citizens, traveling between the U.S. and Canada by land or sea (including ferries), will be required to present a valid passport or other acceptable documents that denote identity and citizenship as determined by the Department of Homeland Security. While recent legislative changes permit a later deadline, the Departments of State and Homeland Security are working to meet all requirements as soon as possible.
3. The Department of Homeland Security has granted the state of Washington permission to develop, as a pilot project, an enhanced drivers license (or personal identification card) that will denote identity and citizenship and that will allow the holder to cross the land border between Washington and British Columbia under WHTI requirements. This document would be based on the standard Washington State driver license or identification card, but would be enhanced to meet the requirements of the WHTI.

This enhanced driver license would:

- be a voluntary program;
- be slightly more expensive than a standard license;
- require proof of citizenship, identity, and residence; and
- be more secure than a standard license, and similar in security features to a U.S. passport.

## Appendix C

### Draft Epidemiology Data Sharing Agreement

#### U.S. Pacific Northwest, British Columbia and Yukon, Canada; Draft Voluntary Public Health Data Sharing Arrangement\*

##### **Purpose of the Arrangement**

The purpose of this Arrangement is to facilitate data (individually identified and aggregate) sharing between the signatories for the purposes of prevention and control of communicable diseases and other urgent regional public health events.

##### **Definitions**

When used in this Arrangement, the following terms have the meanings ascribed below:

**Individually identifiable data** are specific to an individual (e.g., demographic data). **Identifiable** data directly identify an individual, could reasonably be used to identify an individual or they meet the definition in an applicable law. These data are defined by applicable federal, provincial and state laws and the definitions may vary from jurisdiction to jurisdiction.

An **infectious disease agent** is an organism that causes a disease for which the governing law or regulations of any of the signatories' jurisdictions (or of the Governments of the United States or Canada) have a requirement for mandatory reporting and/or other interventions needed to protect the public health;

**Health data** are written, electronic or visual information, identifiable or aggregate, that relates to an individual's or population's past, present or future physical or mental health status, condition, treatment, service or products purchased and includes, but is not limited to, laboratory test data or samples;

A **public health event** is an occurrence or imminent threat of a disease or condition that could result in the implementation of emergency public health interventions, reporting requirements or requests under the governing law or regulations of any of the signatories' jurisdictions (or of the Governments of the United States or Canada);

A **receiving signatory** is a signatory to this Arrangement that collects, uses or discloses health data from another signatory, within the receiving signatory's jurisdiction.

A **sending signatory** is a signatory to this Arrangement that sends or delivers information to the jurisdiction of another signatory with its permission and/or at its request;



## **Regional cross-border communication and coordination**

The signatories will establish a joint working group to meet and confer at least annually to develop and maintain procedures for data sharing that will facilitate an effective response to a public health event, including establishing a process and/or location for joint communication and coordination of data before, during and after a public health event.

## **Document repository**

As designated by the joint working group, each signatory should provide copies of their respective statutes or regulations related to public health events, infectious disease agents and other relevant material as needed to every other signatory. Each signatory should ensure that the copies so provided are accurate and current. The signatories should jointly identify and maintain in common a set of materials which they accept reflect the applicable laws and regulations of the Governments of the United States and Canada.

## **Dissemination of health data**

The signatories recognize that, in order to safeguard the health of their populations and facilitate emergency preparedness and response, their respective agencies or ministries charged with the protection of public health should exchange individual and/or aggregate health data, consistent with all applicable laws of their respective jurisdictions.

### Purpose of disseminating health data

Health data may be exchanged pursuant to the provisions of this Arrangement only for the purpose of preventing, detecting, responding to, or evaluating the response to, a public health event.

### When health data are disseminated

Each signatory endeavors to provide to every other signatory all health data relevant to an infectious disease agent or public health event. Health data should be transmitted in the form employed or maintained by the sending signatory or in such other form as accepted by the receiving signatory.

### Protection of health data

The signatories recognize the importance of safeguarding confidentiality and individual privacy in the exchange and use of health data. At the same time, recognize a compelling interest on the part of the state and provincial signatories to share these data to prevent, detect, respond to, and evaluate the response to, public health events to protect public health and safety.

The signatories understand that it would be impractical to attempt to adopt uniform standards for the protection of health data at this time or to attempt to impose law related to the privacy of health data of any of the signatories. The signatories therefore intend to transmit health data subject to the understanding that it is to be received and maintained by receiving signatories according to the laws or regulations by which the receiving signatories are bound, subject to any restrictions of applicable privacy laws within the sending jurisdiction. Signatories will

furthermore endeavor to protect data received from another signatory to the fullest extent permissible under law. Signatories will endeavor to notify a sending signatory, at the earliest possible time, if a request for health data provided by that jurisdiction is made under the receiving signatory's Freedom of Information Act or the equivalent of such an act under that jurisdiction's laws and regulations. Nothing in this Arrangement is to be construed so as requiring any signatory to transmit health data in contravention of the laws or regulations under which the sending signatory is bound.

**Effective date**

This Arrangement is effective upon signing by any two or more signatories. This Arrangement is subject to the laws of the United States of America and the Government of Canada and the several signatories. This Arrangement is not to be applied in derogation of any superseding law of the United States or Canada.

**Signatures**

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Signatory  
Washington State

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Signatory  
British Columbia

*\* Edited by Jo Hofmann, MD*

## Appendix D

### Draft Pacific Northwest Border Health Alliance – Conceptual Framework

#### I. Name

The name of this group will be the Pacific North West Border Health Alliance (*The Alliance*) and will be composed of the States of Alaska, Washington, Oregon and Idaho and the Province of British Columbia, and the Yukon Territory.

#### II. Purpose

The purpose of *The Alliance* will be a regional, multi-jurisdiction collaborative program that:

- Plans and provides inter-jurisdictional mutual aid and support for multi-jurisdictional response to public health crises not warranting a declared emergency.
- Provides regional, all-hazards public health response system with mechanisms and processes for escalating capability.
- Establishes a jurisdiction-based pilot program for testing public health readiness / performance indicators.

#### III. Steering Committee

##### Committee Mandate and Key Tasks

*The Alliance* Steering Committee's mandate and key tasks are:

- To identify opportunities to improve collaborative early warning infectious disease surveillance *and* surveillance information sharing between the above mentioned jurisdictions.
- To reach agreement regarding the type of early warning infectious disease information to be shared, and the manner in which it will be shared, including developing and agreeing upon a 24/7 response protocol between our jurisdictions that would include appropriate contacts, and their roles for all jurisdictions.
- To explore the development of a Memorandum of Understanding (MOU) for resource sharing, as appropriate, in an emergency between the above mentioned jurisdictions and to identify opportunities for additional collaboration.<sup>1</sup>

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<sup>1</sup> The MOU should be general enough to provide a framework which will be applicable to the circumstances and needs of all jurisdictions. Specific considerations can be included in appendixes [or schedules] if required.

## **Membership**

### **Core**

- Steering Committee Co-Chair – a U.S. State and British Columbia co-chair
- Representative (s) from the State of Alaska
- Representative (s) from the State of Idaho
- Representative (s) from the State of Oregon
- Representative (s) from the State of Washington
- Representative (s) from the Province of British Columbia
- Representative (s) from the Yukon Territory
  
- Public Health Communications Sub-Committee Co-chairs
- Laboratory Sub-Committee Co-chairs
- Legal Sub-Committee Co-chairs
- Emergency Response/Surge Sub-Committee Co- chairs
- Surveillance/Epidemiology Subcommittee Co-chair
- Emergency Medical Services Sub-Committee Co-chairs

### **Liaison**

- Representative from the Public Health Agency of Canada (BC & YK Region)
- Representative from United States Public Health Service Region X

## **Structure**

In addition to the Steering Committee, there will be standing or special committees (program or focus area committees) to assist in the operation and mission of *The Alliance*. The Steering Committee will authorize such committees, and confirm the membership of each committee.

Sub-committees will report, through their Co-chairs, to the Steering Committee.

Steering Committee Co-chairs will report to their respective sponsoring on activity updates.

Development of membership for Sub-committees and their respective Terms of Reference will be proposed by the Sub-Committee Co-Chairs and approved by the Steering Committee [to include plans for accomplishment of key tasks identified under mandate, by the appropriate Sub-committee].

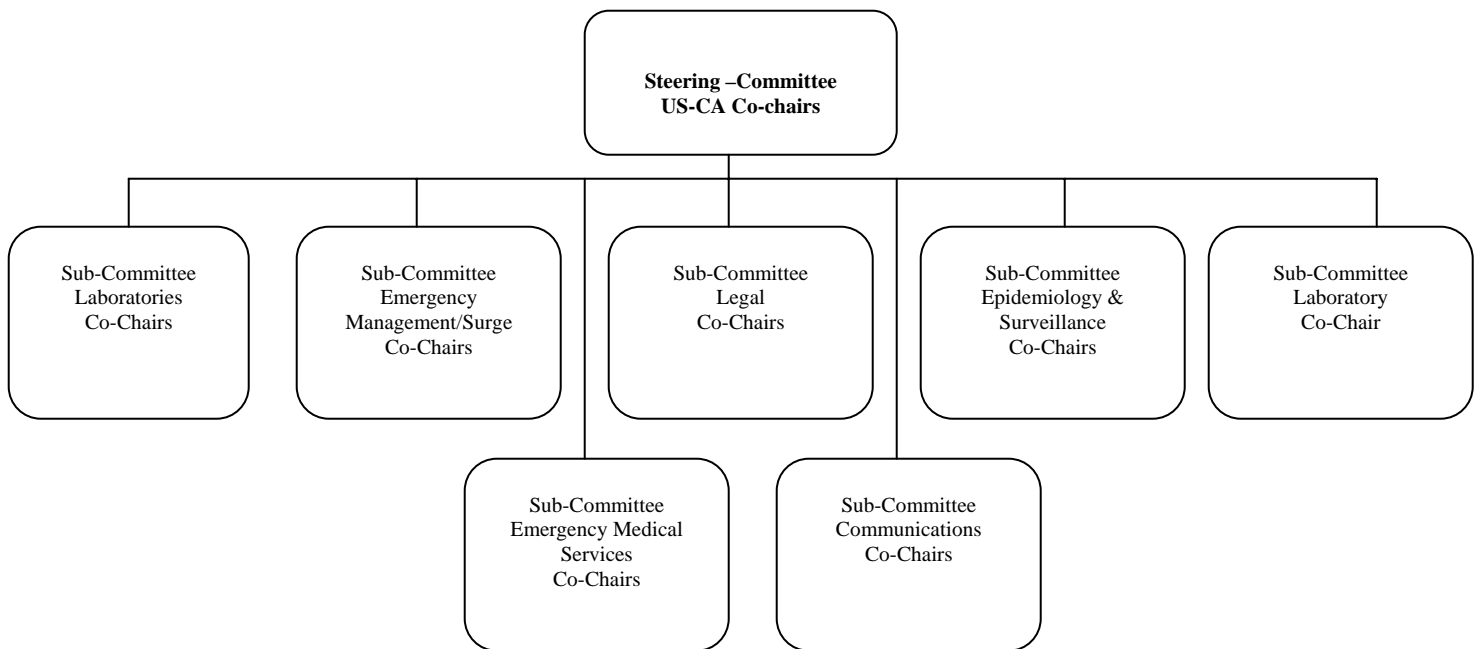
**Administration**

Primary administrative and logistical support will be provided by the State Health Department of the U.S. Co-Chair of the Steering Committee.

Work plans for key tasks will be developed jointly by the State Health Departments and the British Columbia Ministry of Health (BC MOH) with agreed upon deliverables and associated timelines.

Meetings will be in-person or by teleconference with frequency to be determined jointly by the respective co-chairs.

**Organizational Structure**



## Appendix E

### Speaker Biographies

(In order of appearance)

#### **Dr. Eric Young, Deputy Provincial Health Officer British Columbia Ministry of Health**

After graduating with a Bachelor of Science (BSc. – cum laude) at the University of Ottawa in 1970, Dr. Eric Young completed his medical school training (MD) at the same university in 1974. He did an internship at the Toronto East General Hospital, then followed up with a year as a Senior House Officer in Chirstchurch, New Zealand and a year as a resident in Internal Medicine at St. Paul's Hospital in Vancouver, BC.

He subsequently worked as a general practitioner in Surrey, BC until 1992. During that time, he was active in both Surrey Memorial Hospital and the BC Medical Association committees.

In 1992, Dr. Young began his specialty training in Community Medicine at the University of Toronto. During those four years he also obtained a Master's Degree in Community Health and Epidemiology (MHSc) and became a Certificant of the College of Family Physicians (CCFP). He became a fellow of the Royal College of Physicians of Surgeons of Canada (FRCP) in 1996.

After completing his community medicine specialization, he served as Associate Medical Officer of Health and Director of Communicable Disease Control at the Scarborough Health Department until 1997, when he moved to Regina, Saskatchewan to become Deputy Chief Medical Health Officer and Director of the Communicable Disease Control Unit, Population Health Branch, Saskatchewan Health. In that capacity, he served on many provincial and national committees dealing with issues such as pandemic influenza, AIDS, blood borne pathogens and injection drug use, diabetes, West Nile virus and public health information systems.

In May 2004, Dr. Young became the Deputy Provincial Health Officer (DPHO) for the Province of British Columbia. In this role, he supports the work of the Provincial Health Officer (PHO), acting in place of the PHO when required and participating in a wide range of committees at both the provincial and national level.

#### **Honourable George Abbott, Minister of Health British Columbia Ministry of Health**

George Abbott was appointed Minister of Health on June 16, 2005. He previously served as Minister of Community, Aboriginal and Women's Services and Minister of Sustainable Resource Management. Mr. Abbott also served as deputy house leader for the Official Opposition and was critic for municipal affairs and for forests.

He was Deputy Chair of the Select Standing Committees on Forests, Energy, Mines and Petroleum Resources, and was a member of the Select Standing Committee on Aboriginal Affairs. He also sat on the Official Opposition Caucus Committee on Crime.

He was first elected in 1996 to represent the riding of Shuswap and was re-elected in 2001 and 2005. Before his election to the Legislative Assembly, Mr. Abbott was a political science

instructor at Okanagan University College. He also owned the oldest and largest berry farm in the Interior.

He received his bachelor of arts from the University of British Columbia and his master of arts in political science from the University of Victoria.

**Mary C. Selecky, Secretary  
Washington State Department of Health**

Mary C. Selecky has been Secretary of the Washington State Department of Health since March 1999. In February 2005 she was reappointed to the position by Governor Christine Gregoire. Prior to working for the state, 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 tobacco prevention and control, nutrition and physical activity and emergency preparedness her top priorities. Mary 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 a past president of the Association of State and Territorial Health Officials, receiving the 2004 McCormack Award for excellence in public health, and a 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 33 years.

**Dr. James Young, Special Advisor to the Deputy Minister  
Public Safety and Emergency Preparedness  
Government of Canada**

In January 2005, Dr. James G. Young became Special Advisor to the Deputy Minister, Public Safety and Emergency Preparedness for the Government of Canada. He had previously been Commissioner of Emergency Management for Ontario.

At one point during his tenure with the Province of Ontario, Dr. James Young held three concurrent positions. He was appointed Chief Coroner and General Inspector of Anatomy for the province of Ontario on March 31, 1990. On June 1, 1994, he was assigned the position of Assistant Deputy Minister, Public Safety Division, Ministry of the Solicitor General and Correctional Services (as of April 15, 2002, the ministry's name was changed to the Ministry of Public Safety and Security).

Most recently on June 26, 2002, Dr. Young was appointed Ontario's first Commissioner of Public Security. Dr. Young is responsible for maintaining and enhancing physical and economic security in Ontario by working with a number of diverse partners and stakeholders located both within and outside the province. The Assistant Deputy Minister oversees: Emergency Measures Ontario; the Centre of Forensic Sciences; the Office of the Fire Marshal; and the Office of the Chief Coroner. This position is also responsible for administering the Ontario Society for the Prevention of Cruelty to Animals Act.

From April 1994 to June 1997, he was appointed an Associate Professor in the Department of Laboratory Medicine and Pathobiology at the University of Toronto. Since July 1997, he has held the position of Associate Professor, Department of Laboratory Medicine and Pathobiology at the University of Toronto. In April 2001, he became an Associate Professor in Forensic Sciences, University of Toronto at Mississauga.

**RADM Craig Vanderwagen, MD**  
**Deputy Assistant Secretary for Preparedness and Response and**  
**Chief Preparedness Officer**  
**Department of Health and Human Services**

RADM W. Craig Vanderwagen, M.D., was appointed the Department of Health and Human Services (HHS) Assistant Secretary for Public Health Emergency Preparedness and promoted to the rank of Rear Admiral, Upper Half, U.S. Public Health Service (USPHS) in July 2006.

He now serves as the Deputy Assistant Secretary for Preparedness and Response and Chief Preparedness Officer. In this position, he is the Secretary's principal advisor on matters related to bioterrorism and other public health emergencies. The mission of his office is to lead the nation in preventing, responding to and reducing the adverse health effects of public health emergencies and disasters.

RADM Vanderwagen has significant public health emergency and disaster response experience. Most recently, he was the Deputy Secretary's Special Assistant for Preparedness and led the teams who implemented changes at HHS recommended in the White House Report, Katrina Lessons Learned. In addition RADM Vanderwagen was the senior federal health official in the response to Hurricanes Katrina and Rita in Louisiana; led the public health team deployed on USNS Mercy to Indonesia to assist in the 2005 tsunami recovery; served as the Chief of Public Health for the Coalition Provisional Authority and the Ministry of Health in Iraq; and directed a portion of health care provided to Kosovar refugees during the 1999 Balkans conflict.

His federal career began with the Indian Health Service Albuquerque Area Office as a USPHS General Medical Officer at the Zuni Indian Hospital. RADM Vanderwagen also served as the IHS Office of Clinical and Preventive Services Director. He was responsible for the full scope of clinical health care programs, including quality assurance and preventive programs for 49 IHS hospitals, hundreds of clinics and health stations.

In support of the Surgeon General, RADM Vanderwagen served as the USPHS Chief Professional Officer for the Medical Category of the Commissioned Officers Corps. He provided guidance and advice on matters such as recruitment, assignment, deployment, retention and career development for more than 1,300 USPHS physicians.

RADM Vanderwagen is a board-certified family physician. He is published in several medical journals covering family practice, including, Medical Education, Children Today, and Hospital and Community Psychiatry.



**Wayne E. Dauphinee**  
**Emergency Management Consultant**  
**British Columbia Ministry of Health**

Wayne Dauphinee presently serves as an Emergency Management Consultant for the British Columbia Ministry of Health. He recently retired from the Emergency Management Branch, Ministry of Health, where he served as Executive Director since April 2003.

Mr. Dauphinee is a qualified health services administrator, strategic planner and educator with 40 years experience in the field of health emergency management.

As Executive Director, Wayne was responsible for the ministries corporate emergency management process, including: disaster preparedness planning; and guiding the development, implementation and management of disaster management policies and practices. During an emergency or disaster his responsibilities included providing function direction, coordination and support to regional Health Authorities.

He served as the Co-chair of the Federal/Provincial/Territorial (F/P/T ) Emergency Preparedness and Response Expert Group and as Chair of the FPT Council of Health Emergency Management Directors.

**Dr. Jack Taunton**  
**Chief Medical Officer**  
**Vancouver Organizing Committee for the 2010 Olympic and Paralympic Winter Games**

Dr. Taunton, MSc, MD, Dipl Sport Medicine (CASM) serves as the Chief Medical Officer for the Vancouver Organizing Committee for the 2010 Olympic and Paralympic Winter Games (VANOC)

**Robert Bryan, Regional Director**  
**Vancouver Coastal Health Authority**

Mr. Bryan serves as the Regional Director for British Columbia's Vancouver Coastal Health Authority.

**Ronald L. Weaver**  
**Colonel (Ret), Washington Army National Guard**

COL (Ret) Weaver currently serves as the Joint Chief of Staff for the Washington Military Department at Camp Murray, Washington. In this role he advises the State Adjutant General, who serves as the Governor's Senior Advisor for Homeland Security on matter relating to Homeland Security and Emergency Preparedness.

Mr. Weaver also functions as the Emergency Liaison and Coordinator between the Military Department and local, state and federal organizations.

COL (Ret) Weaver military service spans 37 years and includes an active duty tour in the Republic of Viet Nam and leadership positions within the Washington Army National Guard

ranging from platoon leader, Company and Battalion command, culminating with the position of Commander, 205th Leadership Regiment. This Regimental headquarters is responsible for the training and leadership development of future Army leaders covering the entire western region for the reserve component. Colonel Weaver retired from military service in 2006.

In addition to his military service, Mr. Weaver served for over 36 years in Washington State government, retiring in 2005 from the Washington State Department of Health where he served as Assistant Secretary, Health Systems Quality Assurance.

During his tenure in state government, Mr. Weaver also served as a Governor appointed member of the State Emergency Management Council (EMC) and Co-Chairperson of the nationally recognized state Homeland Security Committee.

**William L. Lyerly**  
**Director of International Affairs**  
**Special Assistant for Global Health Security to the**  
**Assistant Secretary for Health Affairs**  
**U.S. Department of Homeland Security**

Mr. "Bill" Lyerly, a career Senior Executive / Scientific-Professional (ST), has served in the U.S. Department of Homeland Security (DHS) since its creation in 2003. He serves currently as Director of International Affairs and Special Assistant for Global Health Security to the Assistant Secretary for Health Affairs.

From Mar 2003 to Mar 2006, he served as Director of the Office of WMD Operations and Incident Management, and Science Advisor to the DHS Under Secretary for Science & Technology; and from Mar to Sep 2003, he served also as Director of the Office of Bio-Countermeasures Coordination. Previously, Mr. Lyerly served in the Executive Office of the President as the Biodefense Lead in the White House's Homeland Security Transition Planning Office; and prior to that, as Senior Advisor for National Security and International Affairs to the Assistant Secretary for Public Health Emergency Preparedness, HHS (lead federal agency for responding to bioterrorism / public health emergencies), and Member of the BTEP (Biotechnology Engagement Program, for former Soviet Bioweapon Scientists) Advisory Group.

He has significant operational and policy-level experience in emergency management (for natural and man-made disasters), bio-security, interagency / civil-military coordination, and in teaching. Mr. Lyerly served also in the U.S. military for 28 years, in both active duty and reserve status. From 1975 until 1987, he served on active duty in Air Force, Army, and Joint assignments, initially as an Avionics Officer with the 354th Tactical Fighter Wing, and then in various health, research, and medical intelligence positions at Ft. Myer, the Walter Reed Army Medical Center, the U.S. Army Medical Research Unit - Kenya (WRAIR), the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID), and the Armed Forces Medical Intelligence Center (AFMIC from the U.S. Army Reserve as a Lieutenant Colonel, he served as the Epidemiology and Environmental Health Division Chief (IMA) at AFMIC, and Advisor to the 352nd Civil Affairs Command.

Mr. Lyerly is a registered Medical Technologist, MT(ASCP); a graduate of the USAF Academy (BS), Central Michigan University (MA), and Johns Hopkins University (MPH) where he has completed all course and residence requirements for 3 Doctorates; and recipient of the International Diploma in Humanitarian Assistance (IDHA).

**John Erickson, Special Assistant  
Washington State Department of Health  
Director of the Public Health Emergency Preparedness and Response Program**

Mr. Erickson is a Special Assistant with the Washington State Department of Health and Director of the Public Health Emergency Preparedness and Response Program. In this role he coordinates the overall agency work on emergency preparedness.

He also administers the bioterrorism cooperative agreements with the Centers for Disease control and Prevention and the Health Resources and Services Administration. As such he is involved in all aspects of biological, chemical and radiological emergency planning with Washington State's hospitals, local public health agencies, and other federal, state and local partners.

Prior to this he was the Director of the Department's Division of Radiation Protection. John joined the Washington program in 1982 as an environmental health physicist. He moved up through the ranks within the Division becoming the Director in 1996.

John received his training at the University of California at Los Angeles and the University of Washington. He holds an MS degree in nuclear chemistry.

**Dr. Jude VanBuren, Assistant Secretary  
Epidemiology, Health Statistics and Public Health Laboratories Division  
Washington State Department of Health**

Dr. Jude Van Buren is the Assistant Secretary for the Epidemiology, Health Statistics and the Public Health Laboratories (EHSPHL) Division at the Washington State Department of Health (DOH).

She is a member of the Governor's Health Outcome Advisory Committee which is addressing health information exchanges of state databases to better understand health outcomes and target state interventions. She has served as Chair of a national committee under the Federal Advisory Committee Act (FACA) - the Hanford Health Assessment Subcommittee (HHES) that studied human health effects from exposure to the Hanford Nuclear Reservation. She has served on several science advisory panels for the state legislature, and currently is a member and co-chair respectively of two statewide committees of the public health system that provides recommendations for public health technology and epidemiology and health assessment practices.

For the past four years she has served as an Senior Executive for a technical state health Division that supports over 190 employees in two locations and provides technical and analytical services to local public health, state public health programs, tribal organizations, and consultation services to academic institutions and clinical laboratories. This Division is composed of public health practitioners, including epidemiologists, physicians, researchers, laboratorians, the State Registrar and informatics and health assessment staff. They address infectious and non-infectious epidemiology, vital statistics, health research and data informatics and provide clinical and environmental analytical laboratory services at the Public Health Laboratories located in Shoreline, north of Seattle.

Her Masters and Doctoral level degrees in public health are from The Johns Hopkins School of Public Health; her doctoral work being in the field of environmental epidemiology. Her BS degree is from the University of Washington with a focus in environmental health and her nursing degree is an Associate Degree from the Columbia Basin College located in Pasco, Washington.

**RADM Patrick O'Carroll, MD, MPH, FACPM, FACMI**  
**Regional Health Administrator, Region X**  
**U.S. Public Health Service**

RADM Patrick O'Carroll is a Rear Admiral in the U.S. Public Health Service (USPHS), serving as the Regional Health Administrator (RHA) for USPHS Region X (Alaska, Idaho, Oregon, and Washington).

As RHA, RADM O'Carroll serves as the region's principal federal public health physician and scientist representing the Assistant Secretary of Health and the U.S. Department of Health and Human Services (HHS). As RHA, RADM O'Carroll (a) serves as liaison to state public health directors and other senior health officials in the region; (b) seeks to maximize the effectiveness of federal population health investments in the region.; (c) manages regional programs and activities of the Office of Public Health and Science (OPHS) including those of the Offices of Minority Health, Populations Affairs, and Women's Health; and (d) promotes regional all-hazards preparedness. He began this assignment in January 2003.

RADM 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 Officer. Initially assigned to work in the area of violence epidemiology, RADM O'Carroll later led the epidemiology research unit for the prevention of suicide and violence at CDC's National Center for Injury Prevention and Control. He was elected as a Fellow of the American College of Preventive Medicine in 1988.

In 1992, RADM O'Carroll began working in the field of public health informatics. He co-led the development of CDC WONDER (an innovative computer system providing global access to CDC's epidemiologic data) and was lead scientist on the CDC Prevention Guidelines Database project. RADM O'Carroll developed the nation's first training course and first (and only) textbook on public health informatics. As Associate Director for Health Informatics at CDC's Public Health Practice Program Office, he defined, developed and directed CDC's national Health Alert Network program. Under RADM O'Carroll's leadership, the Health Alert Network grew from an idea into a \$50 million annual investment in national public health information and communications infrastructure, and became established as a critical component of the nation's defense against bioterrorism. He was elected as a Fellow of the American College of Medical Informatics in 2004. During his 22 years with CDC and USPHS, as an epidemiologist, informaticist, program director and leader, RADM O'Carroll has worked in many subject areas on a great variety of health and policy challenges. These include immunization; chronic disease; maternal and child health; environmental health; infectious disease epidemic control; behavioral health; global health and disease surveillance; and bioterrorism preparedness. He has received numerous awards and other recognition for his work, including two Outstanding Service Medals. RADM O'Carroll holds Affiliate 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 Professor in the Division of Biomedical and Health Informatics, University of Washington School of Medicine.

**Dr. Richard E. Besser, MD, Director  
Coordinating Office for Terrorism Preparedness and Emergency Response  
Centers for Disease Control and Prevention**

Richard Besser, MD, serves as Director of the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER). He is responsible for all of CDC's public health emergency preparedness and emergency response activities. COTPER is the primary CDC/ATSDR organization tasked with oversight of terrorism preparedness, response and protection for the nation from biological, chemical, radiological, and naturally occurring emergencies.

He began his career at CDC in the Epidemic Intelligence Service working on the epidemiology of foodborne diseases. He has served as the epidemiology section chief in the Respiratory Diseases Branch, acting chief of the Meningitis and Special Pathogens Branch in the National Center for Infectious Disease, and as the medical director of Get Smart: Know When Antibiotics Work, CDC's national campaign to promote appropriate antibiotic use in the community.

Doctor Besser received his bachelor of arts degree in economics from Williams College in Williamstown, Massachusetts, and his medical degree from the University of Pennsylvania. He completed a residency and chief residency in pediatrics at The Johns Hopkins University Hospital in Baltimore, Maryland.

He has authored and coauthored more than 100 presentations, abstracts, chapters, editorials, and publications and has received many awards for his work in public health and volunteer service.

**Dr. Bonnie Henry, MD  
Physician Epidemiologist  
Associate Dean for Public Health Practice  
British Columbia Centre for Disease Control**

Dr. Bonnie Henry MD, MPH, FRCCP serves as the Physician Epidemiologist and Associate Dean for Public Health Practice, British Columbia Centre for Disease Control. Dr. Henry obtained her medical degree from Dalhousie University in Halifax, then practiced as a general practitioner, Diving Medical Officer and Flight Surgeon with the Canadian Armed Forces and in general practice in Victoria, British Columbia. Dr. Henry completed a Preventive Medicine Residency and Masters of Public Health with the University of California, San Diego and obtained her Community Medicine (Public Health) training at the University of Toronto. Dr Henry is a Fellow of the Royal College of Physicians of Canada and of the American College of Preventive Medicine. Dr Henry is a public health physician and epidemiologist and Assistant Professor in the Division of Public, Environmental and Occupational Health in the Department of Health Care and Epidemiology at UBC and is located at the BCCDC. She worked for the World Health Organization on the Ebola outbreak in Uganda in 2000 and the STOP polio program in Pakistan. She also served as the Associate Medical Officer of Health for the City of Toronto and led the operational response to the SARS outbreak in the City in 2003. She led the development of public health emergency management protocols for Ontario and was an executive member of the Ontario SARS Scientific Advisory Committee. Her research interests are in establishment of effective surveillance systems for communicable disease, including new and emerging diseases, public health emergency response and the continuum of community and hospital infection control.

**Dr. Mark W. Oberle, MD, MPH**

**Associate Dean for Public Health Practice and a Professor in the Departments of Epidemiology and Health Services in the School of Public Health and Community Medicine and an Adjunct Professor of Medical Education and Biomedical Informatics, University of Washington.**

Dr. Oberle established the School of Public Health's Northwest Center for Public Health Practice ([nwcphp.org](http://nwcphp.org)) to promote public health training and practice collaborations with public health agencies, tribes and community groups in the six northwestern states and more recently the UW Center for Public Health Informatics ([cphi.washington.edu](http://cphi.washington.edu)) to promote the integration of computer science and information science in public health practice.

Prior to returning to UW in 1999, Dr. Oberle worked for the Centers for Disease Control and Prevention both in the USA and 14 other countries as a medical epidemiologist focusing on infectious diseases, public health informatics, reproductive health, and contraceptive safety and efficacy. He also directed state infectious disease control programs in two states, and has published extensively on medicine, public health, and zoology.

**Dr. David Martin, MD**

**Program Medical Officer  
Health Canada, British Columbia Region  
First Nations and Inuit Health  
First Nations Preparedness in British Columbia**

Dr. David Martin, MD is the Program Medical for Health Canada, British Columbia Region, First Nations Inuit Health, First Nations Preparedness in British Columbia, Canada

**Byron Loucks**

**JEL Protection Ltd.  
Emergency Management Consultant  
Emergency Services Consulting Company**

Born and raised in Victoria and proud father of two boys, Byron spent 8 ½ years as a member of the Royal Canadian Mounted Police living in Alberta, returning home to work as the Regional Coordinator of Protection Services for the Vancouver Island Health Authority.

In 2004 Byron began JEL Protection Ltd., an Emergency Services Consulting Company, which he owns and operates today. He provides Emergency Preparedness planning, Fire and Life Safety planning and education, Security Consulting, as well as Personal Safety training. Byron is considered an expert in First Nation community Pandemic Influenza preparedness and planning, and specializes in Healthcare Emergency Management.

In the past 2 years Byron has worked with over 65 First Nation communities in the development of Pandemic Influenza preparedness, and has conducted 2 major Tabletop exercises involving Pandemic Scenario's with a multidisciplinary approach. He has worked closely with the First Nations and Inuit Health Program in BC and Health Authorities during these projects.

**Joe Finkbonner, RPh, MHA, Executive Director  
Northwest Portland Area Indian Health Board**

Joe Finkbonner, RPh, MHA is the Executive Director, Northwest Portland Area Indian Health Board located in Portland, Oregon.

**Jill Sciberras, BNSc, MHSc  
Senior Epidemiologist in the Immunization and Respiratory Infections Division  
Centre for Infectious Disease Prevention and Control  
Public Health Agency of Canada**

Ms. Sciberras received her Bachelor of Nursing Science from Queen's University in 1991 and her Masters of Health Science in Community Health and Epidemiology from the University of Toronto in 1995.

Between January 1995 and March 2002, she worked at the Ontario Ministry of Health and Long-Term Care as the Nurse Epidemiologist in the Vaccine Preventable Diseases and Tuberculosis Control Unit.

Since March 2002, she has been working as a Senior Epidemiologist in the Immunization and Respiratory Infections Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada. She is a lead author of the Canadian Pandemic Influenza Plan for the Health Sector and serves as an agency lead on several of the national pandemic working groups.

Currently she is involved in supporting ongoing pandemic preparedness activities in Canada including the national antiviral strategy and co-chairing the Public Health Measures Working Group of the Pandemic Influenza Committee.

**CAPT Martin Cetron, MD, Director  
Division of Global Migration and Quarantine  
Centers for Disease Control and Prevention**

Dr. Cetron is the Director of the Division of Global Migration and Quarantine located in Atlanta, Georgia.

**Dr. Benjamin Schwartz, Senior Science Advisor  
National Vaccine Program Office  
U.S. Department of Health and Human Services**

Dr. Benjamin Schwartz is the Senior Science Advisor for the National Vaccine Program for the U.S. Department of Health and Human Services

**Dr. Dennis Brodie, Quarantine Office Supervisor  
Public Health Agency of Canada**

Dr. Dennis Brodie is the Quarantine Office Supervisor for the Public Health Agency of Canada.

## Appendix F

### Workshop Evaluation

(n=93 respondents; response rate=48%)

#### 1. Where is your work location?

	<b># of Responses</b>	<b>% of Participants</b>
1. Alberta	2	2%
2. British Columbia	24	26%
3. Yukon Territory	0	0%
4. Alaska	6	6%
5. Idaho	0	0%
6. Montana	2	2%
7. North Dakota	0	0%
8. Oregon	4	4%
9. Washington	47	51%
10. Canada First Nation	0	0%
11. U.S. Tribe	0	0%
12. Other:	8	9%
	93	

#### 2. What type of organization/agency do you work for?

	<b># of Responses</b>	<b>% of Participants</b>
1. Local/Regional Government	19	20%
2. State/Provincial/Territorial Government	45	48%
3. Federal/National Government	11	12%
4. Hospital or Community Clinic	2	2%
5. Military	2	2%
6. First Nation / Tribal Affiliation	0	0%
7. College or University	4	4%
8. Business	0	0%
9. Other:	10	11%
	93	

#### 3. What days of the workshop did you attend ? (Please mark all that apply)

	<b># of Responses</b>	<b>% of Participants</b>
1. Monday, May 14, 2007 (Pre-Workshop Workgroup Meetings)	65	70%
2. Tuesday, May 15, 2007 (Workshop Day 1)	89	96%
3. Wednesday, May 16, 2007 (Workshop Day 2)	83	89%
4. I did not attend the workshop	1	1%



**4. What pre-workshop workgroup meeting did you attend on Monday, May 14th?**

	<b># of Responses</b>	<b>% of Participants</b>
1. Epidemiology	13	15%
2. Public Health Laboratories	7	8%
3. Emergency Management Surge Capacity	19	22%
4. Emergency Medical Services	7	8%
5. Public Health Law	13	15%
6. Communications	3	4%
7. Exercise Planning	1	1%
8. Floated between different workgroup meetings	2	2%
9. Did not attend a pre-workshop workgroup meeting	20	24%
	<hr/> 85	

**5. The pre-workshop workgroup meeting that you attended on Monday, May 14th provided a valuable forum for exchange of ideas and information.**

	<b># of Responses</b>	<b>% of Participants</b>
1. Strongly Agree	36	43%
2. Agree	26	31%
3. Undecided	2	2%
4. Disagree	1	1%
5. Strongly Disagree	1	1%
6. Did not attend a pre-workshop workgroup meeting	18	21%
	<hr/> 84	

**6. What workgroup breakout session did you attend on Tuesday afternoon?**

	<b># of Responses</b>	<b>% of Participants</b>
1. Epidemiology	22	24%
2. Public Health Laboratories	9	10%
3. Joint Emergency Management Surge Capacity / EMS	24	26%
4. Communications	7	8%
5. Exercise Planning	0	0%
6. Public Health Law	14	15%
7. Floated between different breakout sessions	4	4%
8. Did not attend a breakout session on Tues. afternoon	13	14%
	<hr/> 93	

**7. The workgroup breakout session that you attended on Tuesday afternoon was useful in enhancing cross border partnerships and collaboration.**

	<b># of Responses</b>	<b>% of Participants</b>
1. Strongly Agree	36	40%
2. Agree	41	45%
3. Undecided	3	3%
4. Disagree	0	0%
5. Strongly Disagree	0	0%
6. Did not attend a breakout session on Tuesday afternoon	11	12%
	91	

**8. There was enough time during your workgroup breakout session on Tuesday afternoon to meet its objectives.**

	<b># of Responses</b>	<b>% of Participants</b>
1. Strongly Agree	9	10%
2. Agree	53	58%
3. Undecided	7	8%
4. Disagree	12	13%
5. Strongly Disagree	0	0%
6. Did not attend a workgroup session	11	12%
	92	

**9. There was enough unstructured time during the workshop to informally converse with colleagues.**

	<b># of Responses</b>	<b>% of Participants</b>
1. Strongly Agree	15	17%
2. Agree	54	60%
3. Undecided	12	13%
4. Disagree	6	7%
5. Strongly Disagree	3	3%
	90	

**10. In general, there was enough time for questions and discussion from the audience during the plenary speaker presentations of Tuesday and/or Wednesday morning**

	<b># of Responses</b>	<b>% of Participants</b>
Strongly Agree	9	10%
Agree	60	65%
Undecided	7	8%
Disagree	13	14%
Strongly Disagree	0	0%
Did not attend either of the morning plenary sessions	4	4%
	93	

**11. This workshop was useful in strengthening public health preparedness and response partnerships across borders**

	<b># of Responses</b>	<b>% of Participants</b>
Strongly Agree	58	63%
Agree	30	33%
Undecided	3	3%
Disagree	1	1%
Strongly Disagree	0	0%
	92	

**12. If a cross border workshop is held next year, I plan to attend.**

	<b># of Responses</b>	<b>% of Participants</b>
Strongly Agree	41	45%
Agree	32	35%
Undecided	18	20%
Disagree	1	1%
Strongly Disagree	0	0%
	92	

**13. Please indicate the format you would like to see for the next workshop.**

	<b># of Responses</b>	<b>% of Participants</b>
Three day workshop (pre-meeting day followed by two formal workshop days)	61	67%
Two day workshop (no pre-meeting activities)	20	22%
One day workshop	3	3%
No workshop	0	0%
Other:	7	8%
	91	

#### **14. What cross border issues would you like to see addressed at the next cross border workshop?**

1. Continued development and exercising of cross border operational plans.
2. More on local connections. Comparison with other cross border efforts (Great Lakes, etc).
3. Given a large scale MCI that exceeds the capabilities of the resources (clinics, etc.) available at the Olympic sites (or somehow limits their functional abilities), develop a plan for triage, transport and treatment destination decisions.
4. More 2010 Olympic planning info
5. Tribal & First Nations issues
6. West Nile Virus
7. I believe you are covering the most important and relevant areas
8. More examples of shared epidemiology investigations between jurisdictions.
9. New/evolving public health technologies, Health promotion as a mitigation strategy, Management of biohazardous events
10. Passport requirements for patients, their immediate family members, and the accompanying paramedics traveling to health care facilities in air ambulances.
11. HR Pandemic Flu Plans
12. Of most importance, continuance of specialized forums to enhance specific cross border communication between agencies...an excellent work group forum this time.
13. 2010 BC Olympics, Pandemic Influenza Preparedness
14. Although I know the pre-meeting subgroups meet, I am unclear what comes out of those meetings. I think a brief summary to all of the attendees about the scope, issues and next steps by each of the working groups to the larger assemble would be of value. Nothing laborious--no more than a 10 minute highlight.
15. Tabletop exercises for all participants.
16. Integration through tabletop competing interests (public health and economic) involved in social distancing interventions
17. More interaction between the jurisdictions health officers.
18. Recent real event report outs.
19. Lab Response Network but how it works between Federal/Provincial governments.
20. I would like to explore the mechanics of actually supplying goods, personnel and equipment based on different scenarios. What might be needed? What type of personnel might be needed? Are they actually available?, etc.
21. Disaster Psychosocial response must be addressed in planning
22. EMS Patient, personnel, equipment and supply seamless movement cross borders for all state and province attendees.  
Or better yet, movement of medical personnel all inclusive!
23. Specific pan flu readiness activities conducted on both sides of the border.

24. I would continue tracking on the two big issues - pan flu and the 2010 Olympics. Would it be worthwhile to tabletop a scenario involving the latter? In addition, would there be value in adding environmental health issues? Also, more on International Health Regulations and how they can help/hinder the current cross border relationship.
25. Same.
26. Rather than esoteric discussions of what we do or do not do, I would rather see a functional exercise where we actually convened staff and called across borders to actually obtain help.
27. How the disease reporting systems of both countries are meeting the new International Health Regulations.
28. I think "contracting" for preparedness has become a question in my mind. What works and what doesn't?
29. Continue work to formalize communication and processes among partnerships. e.g. create algorithms/flowsheets illustrating lines of communication across borders; triggers to initiate notification, etc.
30. Updates on planning for 2010 Olympics, on *C. gattii*, and on pandemic influenza. Also present examples of specific cross-border planning and/or response efforts, where the cross-border agreements have been implemented.
31. I think more emphasis on local issues is needed, as that is where response first occurs.
32. All Hazards Risk Communication
33. Updates from this year.
34. Follow up on the legal issues needing addressing to make PNEMA Annex B workable, such as licensing, liability, immunity or indemnification, workers comp and death benefits, law waiver.
35. cross border staff placements (1-3 month exchanges); information transfer platforms; environmental issues
36. Issues involving Native Americans & First Nations.
37. I think it would be good to work on what our exact interactions will be during the 2010 Olympics.
38. Finalization of legal response agreements and MOUs
39. Joint project development on common cross border issue,
40. Cross border job shadowing for EMS personnel.  
 Formal agreement for expediting cross border movement of patients, equipment and personnel.  
 Training & Education for EMS providers regarding expediting cross border movement.
41. Technical aspects of communication, internet, radios, phones etc.
42. professional competencies and standards
43. Maybe by the next meeting - The goal of having MOUs in place across all borders (countries, States/Providences, Indian nations. etc).  
 Progress/updates on 2010 Olympic Games cross border planning.

44. -Preparations for 2010 Olympics-Sharing Health Care Providers Across Borders
  - Conduct a table top exercise and emphasize the role of Federal government during a Pacific NW response
  - What areas of Annex B can be operationalized
  - Best practices from other border alliances
45. Moving patients across borders during disasters irrespective of patient nationality.
46. Discussion about national stockpiles
47. Scenarios such as the measles scenario covered in the Epidemiology breakout section. It was interesting and useful to understand how the port authorities operated and it sparked some interesting dialogue with local public health officials.
48. More emphasis on hospital and medical staff issues. I know the emphasis is on PH, but the rest of the medical world needs to have a stronger and more recognized place in the proceedings.
49. Medical Surge, resource typing, paper work involved in PNEMA, case studies of cross-border issues, hospital issues
50. Pandemic flu preparedness data sharing agreements 2010 Olympics planning - surveillance for disease
51. More focus on interaction between states and the cross state border problems.
52. Identification of legal barriers and what states/jurisdictions can do to overcome them.
53. Continuation of work on medical surge issues.
54. Progress reports on key issues....credentialing, international logistics, data sharing
55. Electronic access to medical records.
56. Speaker addressing any of the many legal issues
57. Monitor of surveillance data
58. Legal issues around the delivery of health services during a pandemic.

## 15. What did you like most about this workshop?

1. Breakout workgroup exercises.
2. Location was great (Victoria). Dr. Henry should have been a plenary speaker. Her presentation is what this is all about.
3. Information provided and multiple agencies represented.
  - Pre-workshop meeting
  - Dr. Young's presentation and messaging re: unintended effects of public health decisions.
4. Networking opportunities
5. The discussions during the break out sections and pre-meeting workshops. (Note comment above that there didn't seem to be a difference in the activities of pre-meeting vs. conference/workshop in the breakout sessions, other than the fact that not everyone attended the pre-meeting activities, so we lost out on valuable input).
6. Interactivity; Table Top; Contrasting responses by Alaska, Canada, Washington and other states represented
7. Collaborations among partners
8. Relationship building
9. Face to face with counterparts from BC
10. The opportunity to meet counterparts.
11. Well organized, good topics ,keep up the good work
12. SARS Lessons and 2010 Preparations
13. The ability to connect with colleagues who practice in the same area of the law.
14. The time and work groups...the ability to work together in specialized focus groups.
15. Quality of speakers
16. Mix of local, state and federal players. I also very much enjoyed the presentation by the CMO for the 2010 Olympics, and the presentation of the SARS outbreak. Making a link to the U.S. in their presentation was very useful and informative.
17. Meeting with counterparts from across the border.
18. The small group work and time to talk with colleagues
19. Meeting the people that I will need to work with should we have an international disease issue.
20. The break out sessions and the Olympics presentation.
21. SARS presentation by former Toronto health officer
22. Meeting USA colleagues again.
23. It was a relaxed atmosphere in which discussion was usually encouraged. Gave us a chance for lots of "What ifs"
24. Seeing the good work being done across borders; people knowing each other which always makes for better response ability
25. All of it! Everyone was engaged with each other.
26. Dr. Bonnie Henry's presentation. Lessons learned from SARS are directly related to our present Pan Flu discussions.
27. The afternoon sessions were most valuable.

28. As the years go by, participants are gaining momentum in building relationships. Each workshop seems to get better. This mirrors our state's hospital regional planning meetings, where folks from differing agencies are comfortable communicating off-line to resolve emerging issues. I assume as issues of international concern emerge, this same comfort and familiarity will benefit the situation.
29. Learning the details of activities occurring on both sides of the border and how they are managed.
30. Networking.
31. The opportunity to discuss our approach and compare it to other approaches.
32. Networking opportunities
33. Panel discussions and speakers who addressed how issues will be dealt with on the ground.
34. Meeting and making connections with other Lab groups.
35. the laboratory break out sessions were most valuable
36. Use of scenarios to identify responses in different geographical areas and to discuss cross border notification/assistance.
37. Opportunity to meet and talk to regional and national partners, and to address dilemmas and gaps in PH emergency planning and response.
38. Organization
39. Meeting with our Canadian counterparts, as well as attorneys from neighboring states who are grappling with the same issues.
40. Opportunity to get together with others from multiple states and provinces
41. Dr. Cetron's presentation; high level attendance; Victoria was great; easy to get to, nice venue and setting and weather
42. Good speakers.
43. It is always good to get to speak face-to-face with colleagues and to learn about the exciting things they are doing and the issues they have had over the past year. Having informal time together really does contribute to that ability to work with one another on sticky issues.
44. Opportunity to jointly plan with BC colleagues, and interact with federal representatives from both countries.
45. Meeting colleagues, share findings with each other, mock exercise on real issue etc.
46. The opportunity to learn what plans Canada had in place. Since it is a different premise than the US, I found this very useful
47. The collaborative atmosphere was very refreshing! Enjoyed getting to know my Canadian peers.
48. Breakout session
49. Very collaborative and participative; The Monday pre-workshop was very valuable, Tuesday afternoon exercise was very useful and Wednesday morning was very interesting
50. The workgroup work sessions; Wednesday morning topics & speakers; Tuesday Keynote Addresses
51. The opportunity to interact with people from all discipline.



52. Networking.
53. Visiting with colleagues
54. Speakers
55. The opportunity to meet and network with colleagues. You always learn a lot from those discussions.
56. The break out session was by far the most engaging and stimulating part of the conference. And the fact that the conference was in Victoria was an added bonus. Victoria and Vancouver are both more conducive to holding a conference than Bellingham. Bellingham is a great city, but it is not very accessible on foot from the Best Western (where it was held prior to Victoria).
57. The SARS experience continues to produce valuable lessons in retrospect. Thanks for providing the opportunity to reflect on that.
58. The location; the networking; the location; the ability to hear some issues played out in more detail; the location.
59. Location and length
60. Physician from SARS outbreak - Toronto was excellent  
Physician from preparedness - U.S. was excellent - he could really talk about on the ground work and his experience with SARS in US< Toronto and China
61. Chance to sit with Vanderwagen and Besser - wasn't really part of the workshop agenda but very helpful to Alaska.
62. It is always a wonderful opportunity to network. I learn a lot.
63. Getting to know counterparts in order states/countries
64. This was my first time attending and I found it very beneficial to talk to colleagues in different states. The networking was very valuable.
65. This was one of the most successful workshops I have attended in recent history.  
Congratulations and thanks to the Waynes!
66. Opportunity to meet colleagues from varied professions and geographic areas to discuss mutual issues.
67. Keynote addresses; Opportunities and Challenges speakers (Dr. Bonnie Henry and Dr. Richard Besser); Pandemic planning speakers
68. Networking opportunities that always exist during a conference at this level.
69. Excellent networking
70. The people!

## 16. What suggestions do you have for improving the next cross border workshop?

1. Additional opportunities for unstructured time to meet with colleagues.
2. Bellingham is nice but maybe something better like Seattle.
3. Would like to see projections re: participants, daily attendance, workers, anticipated border traffic, etc. available on the website or as section in program binder. More screens or better seating to view slides. Sitting in large circles works with conversations but not necessarily for listening to speakers. Less formal presentations at the pre-workshop meetings and more time for discussion.
4. The layout of the plenary room was awkward and detracted from the presentations and discussion; should ensure better set up next year.
5. More concise Powerpoint presentations...
6. More state and local level presentations / sharing of info. Less federal level stuff
7. Include all activities as part of the full workshop to encourage participation through the entire time. Work out the times to fit with transportation. The Clipper schedule for returning meant you either missed the last 2 hours of the workshop or had to wait around another 7 hours.
8. Continue with institutionalization of systems. Time for reports and issues of other break out sessions.
9. Bigger meeting rooms. Have it in Canada again.
10. Including provision for pre-workshop sessions from public and environmental health officers and health services (hospitals) sector
11. Keep the high level speakers in the program CDC Atlanta for example. BCCDC etc.
12. Select an attractive venue, such as this year's program
13. I would suggest that there be a panel discussion on a particular topic [which includes local, state and fed reps] and then dive deeper on the topic. Otherwise--excellent workshop. Well done again.
14. Need more representation from BC! In other than epidemiology, BC was poorly represented.
15. More time for plenary session, especially when there are so many good speakers.
16. Focus Groups: Health Officers; Emergency Management; State and Prov. (Not just DOH)
17. I've attended 3 of the 4 meetings and I'm struck by the fact that we are still rehashing SARS and 9/11. I realize that this is an attempt to get the newbies up to speed. But I think that if part of the first plenary session was report outs by the various subject workgroups, it would be just as beneficial and more interesting. I also recommend that events within the year are appropriate for the plenary. For example the fungus outbreak in shellfish would have been great.
18. Nothing - well done.
19. Have a few less speakers, SCHEDULED breaks and allowances for discussions, especially question and answer periods for the "experts". A more "round table" approach might be fun too, with discussion among the presenters, discussing and arguing various roadblocks and solutions.

20. Invite more people who have expertise in the area of disaster psychosocial response and as well as an understanding of emergency management. Education in this area is critical as emergency planners do not tend to have it on their 'radar', and yet disaster behavioural health has been shown to have significant impact on the overall disaster response.
21. Build an actual, full scale, exercise where medical personnel, patients, equipment and supplies cross the border from north and south. Practice our plans!
22. Start with a scientific presentation, like Dr. Henry's, rather than 1/2 day of political intros.
23. I like Bellingham, but can we try someplace else?
24. I enjoyed the presentation on SARS Wednesday morning. However, it seems that SARS is an annual discussion at these workshops. The presentation this year went way too far into the background and statistics of the event. Not only do we here this at the annual workshops, but we are getting or have gotten a lot of this detail at other national meetings. I think at this point the presentation would have better served the audience if the discussion had focused more on the international cross-border issues of SARS. The level of detail caused the speaker to go way too far into other speaker's time. I would suggest at these plenary sessions that there be a time monitor at the table nearest the speaker to keep things moving along so as to 1) not interfere with subsequent speakers and 2) allow more time for questions.
25. Do not sit participants at round tables - some had to sit backwards during talks, some didn't have room to write.
26. If the next one is in Washington, please do NOT go to Bellingham. How about Lake Chelan or some comparable place that would match the natural beauty of Victoria?
27. Continue your thoughtful design.
28. U.S. Federal level speakers (excluding CDC) have been extremely disappointing for the past two years. Maybe that is reflective of this administration but it is too bad, and more than a little embarrassing because the Canadian speakers are so much better by comparison. This does not include the CDC speakers who have been very good.
29. For the Lab group. No representation from Alberta.
30. Please don't conflict with the APHL meeting scheduled for May 18-21, 2008
31. Have handouts available during the conference, or immediately afterward (have staff ready to load presenters files directly onto web site).
32. More Tribal involvement
33. When the conference is in the home location of some participants, they tend to go home rather than stay and socialize. Better to locate where no one is at home to facilitate relationships outside the conference setting.
34. Consider brief presentations to the plenary of progress made in the work group's breakout sessions.
35. Dig a bit more in depth into some specific issues, to note the variation and similarities between Canadian and U.S. approaches
36. I really don't have any.

37. More unstructured time for discussion. Demonstrations and sharing of some of our best practices via lobby posters. A planned after-work activity, such as a tour or other recreational item.
38. The current format is excellent. Need to continue at its current speed
39. Hold the next cross border at Lake Chelan, Washington. (Campbell's Resort)
40. Less federal bureaucrats
41. Assure we address goals set this year (progress, achievements & stumbling blocks)
42. Consider a location other than Bellingham. Spokane? Port Townshend? Port Angeles? Tacoma?
43. Clear objectives.
44. An earlier-to-later social event to network more.
45. Have many opportunities for interactive sessions. Maybe a little shorter presentations that encourage or enable discussions.
46. I would say about half of the presentations during the plenary sessions were a complete waste of time. Some of the speakers were so general and bland that I felt as though I was sitting in the classroom of a Peanuts cartoon...Wha-wha-wha wha-wha wha. So, I understand it is difficult to screen who will be a good presenter, but maybe we could cut down on the number of speakers and allow more time for facilitated activities (such as the break out sessions).
47. I think having a dinner presentation would be an excellent way of keeping people engaged for the entire time. While I realize that "getting out and seeing where you are" is very nice, not everyone was invited to be a part of some group for dinner.
48. Bring someone for areas from my state where we are represented in all working groups.
49. Too many talking heads from U.S. Fed government - they really were not prepared and did not add to the discussion = except for Dr. \_\_\_\_\_ on SARS and preparedness
50. Let's have it in Sitka.
51. Fewer speeches, more structured workshop time.
52. While the breakout sessions were very helpful, there was no sharing of what was happening in each group. For example, if I wanted to know how the Epidemiology group was working, I could not find out if I attended another breakout. Is it possible to have a brief report from each group sometime during the meeting?
53. Some direct participation from Dept of Foreign Affairs and Dept of State. I understand that most of the senior federal officials backed out late in the planning this time. Maybe next year, commit them to presentations explaining how they are supporting local and regional cross-border initiatives.
54. Option for pre-arranged dinner in the 5:30 - 7:30 time slot
55. Better representation from all provinces and U.S. States; More time for questions and answers; Better enforcement on restrictions on length of presentations; Shorter presentations with better formatting (i.e. minimal text that is visible)
56. Keep it going as is. Great work.
57. Confusion with who should attend pre-workshops. Best to have all part of the scheduled workshop and if needed have special sessions/breakout groups to meet specific

objectives. Screen placements made it difficult to see, should have one placed closer to speakers as well.

## Appendix G

### Cross Border Workgroup Membership

#### Epidemiology Workgroup

##### Alaska

**Barbara Smith**  
Nurse Epidemiologist  
Alaska Dept of Health & Social Services

##### British Columbia

**David Patrick, MD (Workgroup Lead)**  
Director, Epidemiology Services  
BC Centre for Disease Control

**Bonnie Henry, MD, MPH**  
Epidemiology Services  
BC Centre for Disease Control

**Elaine Cramer, MD, MPH**  
Medical Officer  
Public Health Agency of Canada

##### Montana

**Kammy Johnson, DVM, PhD**  
Epidemiologist  
Montana DPHHS

##### Idaho

**Kris Carter, DVM, MPVM**  
Career Epidemiology Field Officer  
Idaho Department of Health and  
Welfare/CDC/USPHS

##### Oregon

**Katrina Hedberg, MD, MPH**  
Medical Epidemiologist and Manager,  
Communicable Disease Preparedness  
Program  
Oregon Public Health Services

##### Washington

**Jo Hofmann, MD (Workgroup Lead)**  
State Epidemiologist for Communicable  
Disease  
WA State Department of Health

**Judy May, RN, BSN, MPH**  
Bioterrorism Surveillance and  
Epidemiology Program Manager  
WA State Department of Health

**Donna Duffy, BSN, MPH**  
Epidemiologist  
WA State Department of Health

**Wayne Turnberg, PhD, MSPH**  
Epidemiologist  
Cross Border Workshop Coordinator  
WA State Department of Health

##### Yukon

**Bryce Larke, MD, DCISc**  
Chief Medical Health Officer  
Yukon Health and Social Services

## Public Health Laboratories Workgroup

### Alaska

**Dr. Bernd Jilly, Chief**  
AK Department of Health and Social  
Services  
State Public Health Laboratories

**Mary C Westcott, BS Med Tech,  
MTASCP**  
Public Health Microbiologist II  
AK State Virology Laboratory

### British Columbia

**Judith Isaac-Renton, MD, DPH, FRCP(C)  
(Workgroup Lead)**  
Director, Laboratory Services  
BC Centre for Disease Control

**Muhammad Morshed, PhD MSc**  
Clinical Microbiologist, Laboratory Services  
BC Centre for Disease Control

### Idaho

**Richard Hudson, PhD**  
Chief, Idaho Bureau of Laboratories  
Idaho Department of Health and Welfare,  
Division of Health

### Montana

**Anne Weber, MS**  
Laboratory Director  
MT Department of Public Health

### Oregon

**Michael R. Skeels, PhD, MPH**  
Laboratory Director/Administrator  
OR State Public Health Laboratory

### Washington

**Romesh Gautam, PhD, MS (Workgroup  
Lead)**  
Director, Public Health Laboratories  
WA State Department of Health

**Jinxin Hu, PhD**  
Director, Division of Microbiology  
WA State Department of Health

**Yolanda Houze**  
Bioterrorism/Pub Hlth Threats Lab  
Manager  
WA State Department of Health

**Wayne Turnberg, PhD, MSPH**  
Epidemiologist / Cross Border  
Workshop Coordinator  
WA State Department of Health

## Surge Capacity Workgroup

### Alaska

**Jim Mackin**  
AK Dept of Health

### British Columbia

**Jeanette Beattie**  
Coastal Health Authority

**Wayne Dauphinee (Workgroup Lead)**  
BC Ministry of Health

**John Lavery**  
BC Provincial Health Services Authority

**Chris Smith**  
BC Ministry of Health

### Idaho

**Angela Wickham**  
ID Dept of Health

### Oregon

**Mike Harryman**  
Oregon PHEPR Manager

### Washington

**Dennis Anderson**  
WA Dept of Health

**Cynthia Dold**  
WA Region VI, Regional Public Health

**John Erickson (Workgroup Lead)**  
WA Dept of Health

**Verne Gibbs**  
WA Dept of Health

**Ben Haworth**  
Providence Health Systems

**Marianne Klaas**  
Swedish Medical Center

**Judith May**  
WA Dept of Health

**Cindy Miron**  
WA Region V, Regional Public Health

**Valerie Munn**  
WA Dept of Health

**Anne Newcombe**  
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**Peggi Shapiro**  
Washington State Hospital Association

**Johnese Spisso**  
Harborview Medical Center

**Wayne Turnberg**  
WA Dept of Health

**Jon Vansant**  
WA Region IX, Regional Public Health

**Ron Weaver**  
WA Military Department

**Nathan Weed**  
WA Region IV, Regional Public Health

**Chris Williams**  
WA Dept of Health

### Canada Federal

**Betsy McKenzie**  
Public Health Agency of Canada

### U.S. Federal

**Debbie Engels**  
U.S. Customs and Border Protection

**Andy Stevermer**  
DHHS, Region 10

**Alvin Lee**  
DHHS, Region 10



## Emergency Medical Services (EMS) Workgroup

### British Columbia

#### **Lauren Boon**

Western Coordinator National Defense  
Canada

#### **Bruce Harford (Workgroup Lead)**

Superintendent  
BC Ambulance Services

#### **Chris Nickerson**

Executive Director  
BC Emergency Health Services  
Commission

### Washington

#### **Bill Beusan**

Stevens County Sheriff's Ambulance  
East Region EMS/Region #9

#### **Cindy Button**

North Central Region EMS &  
Trauma Care Council

#### **Garth Eimers**

Retired San Juan Fire Chief

#### **Tom Hardy**

Director, U.S. Customs and Border  
Protection

#### **Darrel Kirking**

North Central Region EMS & Trauma Care  
Council

#### **Jonathon Larsen**

Paramedic, Seattle Fire Dept

#### **Gayle Pollock**

Director of EMS  
Pend Oreille County Fire District #2

#### **Larry Pollock**

Chief, Pend Oreille County Fire District #2  
East Region EMS/Region #9

#### **Jim Ricks**

E911 Coordinator  
Paramedic, Region 1

#### **Bonnie Robinson**

North Region EMS

#### **Michael Smith (Workgroup Lead)**

EMS Terrorism and Disaster Response  
WA Dept of Health

#### **Wayne Turnberg**

Cross Border Workshop Coordinator  
WA Dept of Health

#### **Dr. Marvin Wayne**

Bellingham Medic One

### Canada Federal

#### **Tony Wong**

CBSA-ASFC, Canada

#### **Kirsten Carrier**

CBSA-ASFC, Canada

### U.S. Federal

#### **Debbie Engels**

U.S. Customs and Border Protection

## **Public Health Law Workgroup Leads**

### **Paul Bailey**

Executive Director, Health Protection  
BC Provincial Ministry of Health

### **Joyce Roper**

Sr. Assistant Attorney General  
WA State Office of the Attorney General

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## **Communications Workgroup Leads**

### **Peter Dalton**

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