2008 Summary Report

Cross Border Public Health Collaboration: Mass Gatherings and Major Events

May 14-16, 2008
Bellingham, Washington

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Pacific Northwest Cross Border Workshop

May 14-16, 2008

Executive Summary

Background – The fifth annual Pacific Northwest Cross Border Workshop was held in Bellingham, Washington on May 14-16, 2008. Building upon the work accomplished during the previous four workshops, this year's event focused on strengthening cross border public health collaborations to address mass gatherings and major events, with specific focus on the upcoming 2010 Olympic and Paralympic Games in British Columbia. Over 200 professionals attended from Canada (including Alberta, British Columbia, Yukon Territory and the Canadian Federal Government), Native American Tribes and the United States (including Alaska, Idaho, Minnesota, Montana, North Dakota, Oregon, Washington, and the United States Federal Government), representing fields of epidemiology, public health laboratories, emergency management, emergency medical services, communications, and law.

Agreements – Work continued on the following draft agreements, MOUs and operational plans:

- **Pacific NW Cross Border Alliance** – Formalizing 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** – Work continues on operational plans and MOUs between U.S. and Canadian jurisdictions using authorities of the Pacific Northwest Emergency Management Arrangement, addressing:
  - Confidential information sharing for epidemiology investigations.
  - Movement of healthcare providers and resources 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).

Keynote Address – Dr. Patrick O'Carroll, MD, MPH, Regional Health Administrator, Office of Public Health and Science, US Department of Health and Human Services, Region X gave the keynote address entitled *Binational Public Health Response and Preparedness: How Do We Continue Our Success*? The following key points were made in the address:

- We need to institutionalize this initiative, with clarity as to fundamental purpose, leadership and governance, geographic scope, funding/sustainability, and measures of progress/success. Our cross border work needs to outlast us.
- We need to balance the interests of current and potential supporters of this work, and consider alliances with existing structures (e.g., Pacific Northwest Economic Region).
- We need to challenge ourselves in a way that will powerfully remind of work to be done (expose inadequacies). We should have a real exercise in 2009 to focus on particulars—to test how well we're really set up.

Cross Border Workgroups: Next Steps – Cross border workgroups will continue to meet to address the following activities during 2008-09:

Epidemiology Workgroup

- Increase electronic connectivity capacity for health alerts and epidemic information exchange
- Continue working towards establishing a information sharing agreement and mechanism between British Columbia and Washington (in conjunction with the Public Health Law Workgroup)
- Continue review and implementation of the International Health Regulations to identify local requirements, identify indicators, develop and test an evaluation instrument for assessment of compliance.
- Continue the larger discussion about how well surveillance data is integrated in public health work from a broad perspective. and shared across borders.

Public Health Laboratory Workgroup

- Develop and implement a strategy for ensuring regional surge capacity. Circulate a resource information collection table to each laboratory to identify proficiencies.
- Resolve issues regarding the shipment of samples (including rates charged by different shipping companies) state to states, from BC to US, from US to BC. It was agreed that these challenges need to be resolved for routine shipping needs and prior to the 2010 Olympics
- Work on ideas to share data and other information without jeopardizing confidentiality regulations. Plan to develop an information sheet
- Develop and widely distribute alternative proficiency testing standards, helping each other with testing
- Hold periodic joint meetings with the Epi Workgroup to work on common issues together

Emergency Management Workgroup

- Work on coordinating messaging across the border, particularly common protocols and triggers
- Work towards making jurisdictions across the border have access to communications, beginning with discussions with local officials
- Develop a cross border exercise in conjunction with next year's workshop. Link the exercise to the 2010 exercises that BC is already involved in

Emergency Medical Services (EMS) Workgroup

- Continue working with the Public Health Law Workgroup leading towards approval and adoption of the draft operational plan for movement of healthcare workers and resources across the Washington/British Columbia border by government leaders
- Once approved, conduct train-the-trainer training at 17 border crossing sites to operationalizing the plan
- Exercise the plan in February 2009

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

- Finalize legal review on the Pacific Northwest Border Health Alliance MOU, developing foundation for this initiative
- In conjunction with the Epidemiology and Public Health Laboratories Workgroups, continue legal review of the Draft Public Health Information Sharing Agreement
- In conjunction with the Emergency Management and Emergency Medical Services Workgroups, continue legal review of the draft operational plan for movement of healthcare workers and resources across the Washington/British Columbia border

Tabletop Exercise – A tabletop exercise was conducted to promote discussion and highlight gaps in knowledge or understanding regarding response to a binational public health event. Recommendations identified during the exercises were highlighted as follows:

- Develop common protocols and triggers to ensure coordinated messaging and information exchange across the border.
- Explore the possibility of designated health liaisons to work in respective Emergency Operation Centers during the Olympics.
- Develop formal pathways for exchange of information between Canada and the US
- Determine what mass casualty resources need to be staged.
- Institute a cross-border exercise program.

Acknowledgements

We of the British Columbia Ministry of Health Services 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)

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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.

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Pacific Northwest Cross Border Workshop

May 14-16, 2008

Introduction

The fifth annual Pacific Northwest Cross Border Workshop was held in Bellingham, Washington on May 14-16, 2008. Building upon the work accomplished during the previous four workshops, this year's event focused on strengthening cross border public health collaborations to address mass gatherings and major events, with specific focus on the upcoming 2010 Olympic and Paralympic Games in British Columbia. Over 200 professionals attended from Canada (including Alberta, British Columbia, Yukon Territory and the Canadian Federal Government), Native American Tribes and the United States (including Alaska, Idaho, Minnesota, Montana, North Dakota, Oregon, Washington, and the United States Federal Government), representing fields of epidemiology, public health laboratories, emergency management, emergency medical services, communications, and law.

On the first day, the workshop began by convening each of four cross border workgroups to build upon accomplishments and establish work plans and next steps for activities to be conducted during the next year. On the second day, plenary session presentations reinforced the workshops theme and work conducted during the four field-specific workgroup breakout sessions from the previous day. Concepts and plans then were exercised during three concurrent tabletop exercises. On the workshop's final day, participants convened for after action summaries and discussions of work from the tabletop exercises, and reports from each of the cross border workgroups. A plenary session panel of key officials from British Columbia and Washington was held to discuss public health preparedness collaborations relating to the 2010 Olympic Games.

Workgroup Meetings – May 14, 2008 (Workshop Day 1)

John Erickson, Washington State Department of Health, and John Lavery, British Columbia Ministry of Health Services provided opening remarks and guidance to a plenary gathering of attendees prior to four-hour meetings of five cross border workgroups. Meetings were held in fields of: 1) epidemiology and surveillance, 2) public health laboratories, 3) emergency management, 4) emergency medical services, and 5) public health law. Workgroup session summaries are presented below. Workgroup reports are presented in Appendix B.

Plenary Session Summary – May 15, 2007 (Workshop Day 2)

Opening Remarks

The session began with opening remarks from Regina Delahunt, Director of Whatcom County Health Department, Mary Selecky, Secretary of the Washington State Department of Health, and Dr. David Patrick, MD, MHSc, Director of Epidemiology Services at the BC Centre for Disease Control (speaking on behalf of Perry Kendall, MD, Provincial Health Officer for British Columbia).

Keynote Address

Dr. Patrick O'Carroll, MD, MPH, Regional Health Administrator, Office of Public Health and Science, US Department of Health and Human Services, Region X gave the keynote address on Binational Public Health Response and Preparedness: How Do We Continue Our Success? The following key points were made in the address:

Dr. O'Carroll began on a positive note, identifying what has been accomplished as a result of the Cross borders conferences:

- Issues and obstacles have been identified
- Subgroups formed to work on these issues.
- Agreements have been developed and signed, such as PNEMA Annex B and others
- Various specific operational plans and MOUs have been developed
- Movement toward institutionalizing this collaboration, specifically the PNW Border Health Alliance
- Old relationships strengthened, new relationships established, new partnerships

However, he is concerned about possible threats to success.

Three potential threats:

1) Drift over time
2) Complacency
3) Routine: are we in our groove or in a rut?

As an example, Dr. O'Carroll pointed to differences in the statements of purpose for Cross borders conferences. The statement of purpose of meeting in 2004 was about surveillance, infectious disease (reflecting funding and key issues). The statement of purpose of the meeting in 2005 focused on pan flu. In 2006, it was more about formalizing and signing agreements. However, in 2007 the purpose was not explicitly stated; instead, the work of subgroups was listed. He expressed caution about the potential to fractionalize into subgroups and opening up the possibility of drift.

Other cautions and considerations

Drift –

- Should our efforts be about infectious disease control across the border, or all hazards emergency preparedness/response? All hazards is more inclusive but unwieldy. Infectious disease control is challenging alone, but doesn't capture all we need to do.
- Geographic scope: PNEMA v. PNW BHA versus collaborative across entire border (not just the NW).
- "Under the radar" tension: how visible do we want this to be? Do we risk getting slowed down if it's too big, too visible? We need to find the right balance.
- Success: what do we mean by this? We should be concrete about what this looks like and have clarity about what we're trying to achieve.

Complacency – There is a danger with feeling too pleased about what we've accomplished without awareness of potential dangers. We've had initial success that has been well recognized at a national level, but it can lead to complacency. Beware the low-hanging fruit trap: we need to address challenges.

Are we falling into a routine unconsciously, just because it's working? Is it possible some of the initial excitement at a new challenge, or the initial flush of early success, is wearing off?

Recommendations

Drift – We need to institutionalize this initiative, with clarity as to fundamental purpose, leadership and governance, geographic scope, funding/sustainability, and measures of progress/success. Our cross border work needs to outlast us.

We need to balance the interests of current and potential supporters of this work, and consider alliances with existing structures (e.g., PNW Economic Region).

Complacency/Routine – We need to challenge ourselves in a way that will powerfully remind of work to be done (expose inadequacies). We should have a real exercise in 2009 to focus on particulars—to test how well we're really set up.

Questions and Comments – After Dr. O'Carroll's presentation, there were a number of questions from attendees.

- What about federal governments stepping in once we've done the work as states and provinces?
- When you're under the radar, you may not have access to all information. Under the radar doesn't really work.
- Federal involvement is important. We can't be ignorant of each other's capacities and practices when the emergency arrives. Federal governments should play in the proposed exercises.
- Can we piggyback the cross border exercise on existing 2010 exercises? (There was general agreement that we could).
- A public health veterinarian reminded everyone to remember cross-border animal health issues.

Federal Preparedness and Response Partner Updates

Dr. Dave Hutton, Senior Advisor, Federal/Provincial/Territorial Coordination Centre for Emergency Preparedness and Response, Public Health Agency of Canada and Dr. Kevin Yeskey, MD, Deputy Assistant Secretary, Office of the Assistant Secretary for Preparedness and Response (ASPR), US Department of Health and Human Services provided the updates.

From Dr. Hutton:

- The federal governments can figure out how to make plans happen, can help identify red flags and address them. There is a commitment to look at cross border issues. The

federal government can be helpful. We need to look at what we need to do together: recognize jurisdictional boundaries, plan together for what role each play.

- Preparedness happens at the local level. But the federal government should be involved in listening, determining how they can be helpful for locals.
- What is good for you is often good for us. It makes sense to work together on cross border issues, which will also help the federal agencies move forward: there is a multiplication of benefits.
- More coordination between Ottawa and Washington has happened; a federal work group to work on cross border issues is under consideration.
- How do we start institutionalizing this work? The federal government will look to this group to figure it out. We are grateful to leadership in the of governments of BC and Washington state in getting this work started.

From Dr. Yeskey:

- US DHHS is fully supportive of cross border efforts. They are invested in this and want to continue the investment.
- Regarding whether it is better to be under of above the radar: a prepared and knowledgeable State Dept is better than an unprepared, uninformed one, so it is better to include them. They will probably back off if they understand good plans are in place.
- Tell us what your needs are so we can provide support that you want (rather than having to guess).

Aboriginal Health in British Columbia

Dr. Evan Adams, MD, Aboriginal Health Physician Advisor, BC Ministry of Health provided an overview of the *Tripartite First Nations Health Plan.* Key points from the presentation were as follows:

Tripartite First Nations Health Plan (TFNHA) is tripartitie because it involves the Aboriginal governments (First Nations Communities), Provincial Health Services, and Federal Health Services.

The TFNHA calls for a First Nations Health Council: Made up of BC First Nations and First Nations Leadership Council, representing 203 communities. The chiefs are without a lot of experience in health, but their staffs do have some health background.

Key messages from First Nations –

- Vision of wellness (not disease): embracing all aspects of wellness of the individual family and community
- Cultural, holistic approach to health: embracing indigenous knowledge and ways of being/doing
- Community-driven process: support what is already happening in communities; increases connections between communities and public health personnel

- Common challenges: lack of resources, personnel and funding
- Need for communication: transparent and easily accessible communication

Priority Areas of Action –

- Governance, relationships, and accountability: relationships were difficult; need to track whether we're doing what we need to do
- Health promotion, injury and disease prevention: need to communicate clearly about access to data to prevent blocking by community

Long term goals –

- New governance structure that leads to improved accountability and control of First Nations health services by First Nations
- Ongoing and direct community involvement in health services
- Support for communities to carry out planning through collaborative networks
- Improved relationships and enhanced opportunity to collaborate
- No One Gets Left Behind (stop disparities within First Nations)

Public Health Aspects of Mass Gatherings

Overview of Mass Gatherings and Public Health – Dr. Andy Stergachis presented a session about the issue of mass gatherings and their public health implications. Mass gatherings, including things like Olympic games, large music festivals, sporting events, or religious and political gatherings involve many people over the course of a defined period.

This many people in one place, at one time increases the potential to spread or introduces diseases and strain the existing infrastructure of medical and emergency response services.

Two main issues must be addressed. First, is the ability to be able to provide additional personnel to accommodate the surge in medical and response needs. Also important is relying on the cooperation of disease surveillance and investigation workers over county, state, provincial and national borders.

Planning for the events is crucial especially to identify the risks that may be involved and make sure that the proper safety measures are set in place.

Public Health for the 2010 Olympics – Dr. Patricia Daly shared the experience of planning for an upcoming mass gathering — the 2010 Winter Olympics and Paralympic Games. Although Vancouver is the largest city ever to host the Winter Games and has had experience with other large gatherings, it still has a big job ahead making sure the athletes and visitors have a safe and healthy Olympics.

The framework for cooperation has been put in place between the Olympic Committee, provincial public health, local public health and EMS.

Dr. Daly discussed the challenges of identifying the needs that the area will have not only during the 27 days of competition, but the two weeks between the events and for weeks before and after. For public health, the preparation primarily involved planning for disease and injury surveillance, communicable disease control and outbreak response, emergency management and health promotion.

Key issues relating to disease and injury surveillance included coordinating and enhancing existing surveillance methods, assuring solid communications between partners – physicians, hospitality industry, aboriginal communities, and engaging partners from the outside the immediate region. Public Health Reports will be published daily during the games (and bi-monthly prior) with information about disease surveillance, air and water quality, weather, inspections and health promotion. The long term goal is to establish health initiatives that last beyond the games, including tobacco-free sports, HIV/AIDS awareness, physical activity, healthy eating, tobacco-free, healthy schools, healthy workplaces, and healthy communities.

Creating a Pacific Northwest Health Alliance

Wayne Dauphinee, Emergency Management Consultant, British Columbia Ministry of Health Services presented an update on formalizing the cross relationships in the Pacific Northwest. The past five years of these workshops have established and strengthened one-on-one relationships and this has lead us to the point where it is time to formalize the group and make the connections sustainable. The Pacific Northwest Border Alliance will continue to fine-tune, and augment past agreements and MOUs and create new ones where the needs arise. The Alliance will institutionalize the process and provide a body to connect with other authorities. It will consist of the Northwest Pacific Economic Region (PNWER) states, provinces and territories — Alaska, Alberta, British Columbia, Idaho, Montana, Oregon and Washington and Yukon.

One of the first actions will be the creation of a Special Working Group, with representation from the participating jurisdictions, to oversee the ratification and implementation of the Pacific Northwest Border Alliance (PNWBHA) Memorandum of Understanding (MOU), including activation of the Joint Coordination Committee.

Tabletop Exercise (Workshop Day 2)

Three concurrent tabletop exercises were developed and facilitated by Dan Banks, Washington State Department of Health, Dave Burgess, BC Ministry of Health Services, and Eric Sergienko, U.S. Dept. of the Navy. The purpose of the tabletop exercises was to exercise the following scenario: “Threats not tied to any specific group. Widespread intestinal illness with fever, vomiting and diarrhea.” The After Action Report for the exercise is presented in Appendix F.

Plenary Session Summary – May 16, 2008 (Workshop Day 3)

Introductory Remarks

The plenary session on the third day began with opening remarks from Dr. Muhammad Morshed, BC Centre for Disease Control, Public Health Laboratory Branch, and Yolanda Houze, Washington State Department of Health, Public Health Laboratories.

Tabletop Exercises After Action Review

Three separate exercises, using the same scenario for each, were conducted to promote discussion and highlight gaps in knowledge or understanding. Common themes, recommendations and next steps identified during the exercises were highlighted as follows:

Common themes – Common themes focused on communications, with the following questions:

- What systems will be established for 24/7 communications during the Olympics?
    - A public health liaison needs to be formalized across the border.
- How can stove piping of outbreak information be minimized?
- Will daily reports be sent out through public health system?
- How can personal preparedness messages be developed and widely distributed?
- How can alternate care be conducted during a surge event, recognizing that there is limited surge capacity of hospitals on both sides of the border?
- What is the role of public health in the US Coordination Center in Whatcom County?

Recommendations –

- Develop common protocols and triggers to ensure coordinated messaging and information exchange across the border.
- Explore the possibility of designated health liaisons to work in respective Emergency Operation Centers during the Olympics.
- Develop formal pathways for exchange of information between Canada and the US
- Determine what mass casualty resources need to be staged.
- Institute a cross-border exercise program.

Comments –

- The exact role of a proposed public health liaison is unclear/undecided, and needs to have a proper linkage formalized both north and south of border.
- When an event is discussed, there are multi-agency or unified command structures. One should be developed that takes this into consideration (e.g., a liaison). Coordinated command structures should include partners from both sides of the border, whether or not a liaison is established.
- There is a plan to have unified command structure somewhere in Whatcom County that would be separate and distinct from the state EOC. This coordination center would be capable of situation awareness, assessing assets. Health will be represented in the coordination center.
- Pre-scripted messages need to be coordinated.

Workgroup Summary Reports

Epidemiology and Surveillance Workgroup

The Epidemiology group talked about how epidemiologists communicate across the border. Epi-X, WA Secures, Canadian CIOSC systems provide some electronic surveillance and alerting tools. But in addition to routine communications, they need communication for tracking purposes. The legal group put together an MOU that will assist with moving information for case contact follow-up.

The epidemiology workgroup discussed international health regulations, and recognize that they needed to look at whether requirements are being met at state and provincial levels. They will work together to develop an instrument

Dr. Jeff Duchin gave an update along with Dr. Bonnie Henry on the Mass Gatherings document developed by the WHO. The document will provide a framework for guidelines for communicable disease during mass gatherings.

Joint epidemiology and public health laboratory issues were addressed, including moving specimens and other capacity across borders; lab surge during mass events (BC uses two commercial labs); and the need for a common lab repository with electronic links and auto population.

Discussions continued on the need for a cross border information sharing agreement between British Columbia and Washington State.

Syndromic surveillance – Dr. Bryant Karras organized a symposium on real-time syndromic surveillance. There was a discussion of the existing surveillance plan coming together for 2010 Olympics. It will include elements of syndromic surveillance and environmental monitoring. They discussed communication between jurisdictions and looking at standards for any syndromic data. Among the issues raised about syndromic surveillance was the need to standardize definitions so that they can be compared across the border. They also talked about ESSENCE (software in the US to share syndromic info) and about developing a common repository. But the use of such software across borders may still be subject to the restrictions of the Patriot Act and desire of all parties to participate.

Next Steps – The epidemiology workgroup will continue to meet in 2008-09, addressing issues including:

- Increase electronic connectivity capacity for health alerts and epidemic information exchange
- Continue working towards establishing an information sharing agreement and mechanism between British Columbia and Washington (in conjunction with the Public Health Law Workgroup)
- Continue review and implementation of the International Health Regulations to identify local requirements, identify indicators, develop and test an evaluation instrument for assessment of compliance with the regulation.
- Continue sentinel influenza analysis, obtaining real-time seasonal data on regional ILI and recruit sentinel providers to report year round influenza surveillance.

- Continue the larger discussion about how well surveillance data are integrated in public health work from a broad perspective. and shared across borders.

Public Health Laboratories Workgroup

This small but cohesive group came up with subgroups to move forward with implementation of their initiatives.

Next Steps – These initiatives included:

- Develop and implement a strategy for ensuring regional surge capacity. Circulate a resource information collection table to each laboratory to identify proficiencies.
- Resolve issues regarding the shipment of samples (including rates charged by different shipping companies) state to states, from BC to US, from US to BC. It was agreed that these challenges need to be resolved for routine shipping needs and prior to the 2010 Olympics.
- Work on ideas to share data and other information without jeopardizing confidentiality regulations. Plan to develop an information sheet.
- Develop and widely distribute alternative proficiency testing standards, helping each other with testing. Yolanda Houze will take the lead.
- Hold periodic joint meetings with the Epidemiology Workgroup to work on common issues together.

Emergency Management Workgroup

The Emergency Management group listened to a proposal to formalize the NW Border Health Alliance. They support the project and want to get it formalized. The Emergency Management group would give authorization to get the work done.

There was a round robin discussion on successes and impediments on working together. As a result, they developed a long list (50 items) from broad concepts to minute items. They will try to synthesize them, identify common themes, and prioritize them.

Next Steps –

- Work on coordinating messaging across the border, particularly common protocols and triggers.
- Work towards making jurisdictions across the border have access to communications, beginning with discussions with local officials
- Develop a cross border exercise in conjunction with next year's workshop. Link the exercise to the 2010 exercises that BC is already involved in.

Emergency Medical Services Workgroup

During the past several months, the EMS group developed an operational plan for movement of healthcare workers and resources across border, to cover not just EMS, but also for healthcare providers. The purpose is to operationalize timely and efficiently the movement of healthcare workers across borders.

Next Steps –

- Continue working with the Public Health Law Workgroup leading towards approval and adoption of the draft operational plan for movement of healthcare providers and resources across the Washington/British Columbia border by government leaders.
- Once approved, conduct training at 17 border crossing sites to operationalizing the plan.
- Exercise the plan in February 2009

Communications Workgroup

Due to scheduling conflicts for many of our partners, Communications Workgroup members decided not to hold an in-person meeting at this year's Cross-Border Conference. The workgroup will meet via conference call later this summer to continue collaboration on a variety of health issues.

This year, the communications participants who were able to attend participated in other workgroups including discussions on the 2010 Olympics. This will help enrich our discussion, planning and resource sharing activities in the coming months. The workgroup intends to resume in-person meetings at next year's Cross-Border Conference.

Next Steps – Based on work conducted in 2007, next step activities include:

- 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

The Law group felt a shift from being treated as an obstruction to recognition of being colleagues and partners in the work.

In the next 30 days, they will meet to refine the Epi Health sharing agreement, EMS plan, and NW Health Alliance Agreements before they are signed.

The Attorney General from Oregon put together a side-by-side comparison of liability protection, immunity, etc. policies. They will be expanding this document to include other states and

partners. They expect this will be a repository that addresses laws that are important to the work of public health alliances.

At their workgroup, there was a vigorous discussion of public work disclosure. There is a tension for the need for privacy so that people will tell truth when gathering information, and the expectation for full and open disclosure (especially in Washington state). In Washington, information is disclosed, with some exceptions; BC is completely different in that information is not disclosed with exceptions. This was an "aha moment."

Public Health and law enforcement join investigations. Custodial interrogations, Miranda warnings, and other law enforcement work have an impact on Public Health work.

Next Steps –

- Finalize legal review on the Pacific Northwest Border Health Alliance MOU, developing foundation for this initiative
- In conjunction with the Epidemiology and Public Health Laboratories Workgroups, continue legal review of the epidemiology information sharing agreement
- In conjunction with the Emergency Management and Emergency Medical Services Workgroups, continue legal review of the draft operational plan for movement of healthcare workers and resources across the Washington/British Columbia border

Closing Remarks

Secretary Mary Selecky gave final remarks, stressing the importance of this work and how it is essential to do together, face-to-face. Secretary Selecky urged attendants to not miss the opportunity of the Olympics to build a legacy of cross border collaboration. She also asked all participants to provide feedback on three questions, presented on index cards to attendants during the workshop:

1) Should we have a meeting next year?
2) Should we have an exercise?
3) What suggestions do you have for the next meeting?

Responses to Secretary Selecky's questions will be examined by next year's workshop planning committee.

John Erickson, Special Assistant, PHEPR Program, Washington State Department of Health, John Lavery, Executive Director, Emergency Management Unit, BC Ministry of Health Services, Wayne Turnberg, Cross Border Workshop Coordinator, Washington State Department of Health, and Wayne Dauphinee, Consultant, Emergency Management Unit, Ministry of Health Services gave the closing remarks.

Comments on highpoints of the meeting:

- The Pacific Northwest Border Health Alliance not only represents an important multi-jurisdictional agreement, but provides a recognized vehicle to undertake technical and hands-on work. It will also provide for the cross-pollination of a wide-range of health sector groups. This needs to bring this work to the preparedness regional groups.
- Bringing forward the agreement for Border Health Alliance is an important accomplishment. Encouraged groups to look for interoperability, which can be enhanced by adopting standardization.
- Medical surge needs to be addressed. In the next 18 months, we need to build up US medical reserve corps. There is a wonderful opportunity to employ medical reserve corps on the US side during the Olympics.
- Next step – conduct an operational exercise for next year, based on feedback from workshop attendees.

Appendices

Appendix A - Workshop Agenda

Appendix B - Cross Border Workgroup Reports

Appendix C - Draft Public Health Information Sharing Agreement

Appendix D - Draft Operational Plan for Sharing Healthcare Providers and Resources Across the Washington and British Columbia Border

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

Appendix F - Tabletop Exercise After Action Report

Appendix G - Speaker Biographies

Appendix H - Workshop Evaluation

Appendix I - Workshop “Index Card” Direction from Participants

Appendix J - List of Registered Participants

Appendix A

Cross Border Public Health Collaboration: Mass Gatherings and Major Events

Best Western Lakeway Inn & Convention Center

714 Lakeway Drive, Bellingham, WA

May 14 – 16, 2008

Agenda

Workshop Day 1

Wednesday, May 14, 2008

9:00-5:00 **Registration**

1:00-1:30 **Plenary Gathering: Welcome and Introduction – Workshop Goals and Guidance for Workgroup Meetings**

- **John Erickson**, Special Assistant, Public Health Emergency Preparedness and Response Program, Washington State Department of Health
- **John Lavery**, Executive Director, Emergency Management Branch, British Columbia Ministry of Health Services

1:30-5:00 **Workgroup Breakout Sessions** (All participants are encouraged to attend a workshop session within their field of expertise)

- **Track 1: Epidemiology and Surveillance**
- **Track 2: Public Health Laboratories**
- **Track 3: Emergency Management**
- **Track 4: Emergency Medical Services**
- **Track 5: Communications**
- **Track 6: Public Health Law**

Note: Tracks 1 and 2, and Tracks 3 and 4 will combine at 3:30.

The purpose of the workgroup meetings is to recap the status of current workgroup activities, and to discuss public health surveillance and response issues relating to mass gatherings and major events. Readiness will be exercised during tabletop exercises scheduled for the afternoon of Thursday, May 15th.

5:30-7:30 **Meet and Greet Mixer**

Workshop Day 2
Thursday, May 15, 2008

7:00-8:00 **Registration / Continental Breakfast**

8:00-8:20 **Welcome and Introduction** – Regina Delahunt, Director, Whatcom County Health Department, presiding
- **Mary Selecky**, Secretary, Washington State Department of Health
- **Perry Kendall**, MD, Provincial Health Officer, British Columbia

8:20-9:00 **Keynote Address – Binational Public Health Preparedness and Response**
- **RADM Patrick O'Carroll**, MD, MPH, Regional Health Administrator, Office of Public Health and Science, US Department of Health and Human Services, Region X

9:00-9:20 **Updates from Our Federal Preparedness and Response Partners**
- **Dr. Dave Hutton**, Senior Advisor, Federal/Provincial/Territorial Coordination Centre for Emergency Preparedness and Response, Public Health Agency of Canada
- **Dr. Kevin Yeskey**, MD, Deputy Assistant Secretary, Office of the Assistant Secretary for Preparedness and Response (ASPR), US Dept of Health & Human Services

9:20-10:00 **Aboriginal Health in British Columbia**
- **Evan Adams**, MD, Aboriginal Health Physician Advisor, Office of the Provincial Health Officer, BC Ministry of Health

10:00-10:30 **Unstructured Networking (Break)**

10:30-11:30 **Mass Gatherings and Public Health** – David Patrick, MD, Director, Epidemiology Services, BC Centre for Disease Control, presiding
- **Andy Stergachis**, PhD, RPh, Professor of Epidemiology and Adjunct Professor of Pharmacy, Northwest Center for Public Health Practice, University of Washington; *An Overview of Mass Gatherings and Public Health Surveillance*
- **Patricia Daly**, MD, FRCPC Vice President, Public Health and Chief Medical Health Officer, Vancouver Coastal Health; *Public Health Plan for the 2010 Olympics*

11:30-11:50 **Creating a Pacific Northwest Border Health Alliance** – **Wayne Dauphinee**, Consultant, BC Ministry of Health Services

11:50-Noon **Afternoon Assignments** – **John Erickson**, Special Assistant, WA State Department of Health

Noon-1:30 **Hosted Lunch**

1:30-4:30 **Tabletop Exercises (Concurrent Sessions)**
- **Tabletop Exercise (Group 1) – Dan Banks**, MA, Exercise Coordinator, WA State Department of Health
- **Tabletop Exercise (Group 2) – Dave Burgess**, Director of Operational Readiness, Emergency Management Branch, BC Ministry of Health Services
- **Tabletop Exercise (Group 3) – Eric Sergienko**, MD, Head Public Health Emergency Planning, Navy Medicine

5:00 **Hosted Dinner**
- **Joe McLaughlin**, MD, MPH, Chief, Epidemiology Section, Alaska Division of Public Health, *Cross Border Public Health Collaboration – Perspectives from Alaska*

Workshop Day 3
Friday, May 16, 2008

7:00-8:00 **Continental Breakfast**

8:00-8:15 **Welcome** –
- **Muhammad Morshed**, PhD, Laboratory Services, BC Centre for Disease Control
- **Yolanda Houze**, Microbiology Supervisor, Public Health Laboratories, WA State Department of Health

8:15-9:00 **Tabletop Exercises Discussion of Findings** – Dan Banks, Exercise Coordinator, Washington State Department of Health, presiding
- Tabletop Exercise – Group 1
- Tabletop Exercise – Group 2
- Tabletop Exercise – Group 3

9:00-10:30 **The 2010 Olympics: Cross Border Public Health Collaboration Panel Discussion** – Jack Thompson, Director, Northwest Center for Public Health Practice, University of Washington, moderating
- **Regina Delahunt**, Director, Whatcom County Health Department
- **Réka Gustafson**, MD, FRCPC Medical Health Officer and Medical Director of Communicable Disease Control, Vancouver Coastal Health Authority
- **Paul Wiesner**, MD, Clinical Professor, Department of Health Services, Northwest Center for Public Health Practice, University of Washington
- **Marc Romney**, MD, FRCPC, DTM&H Medical Director, Infection Prevention and Control at Providence Health Care, St. Paul's Hospital

10:30-10:45 **Final Remarks**
- **Mary Selecky**, Secretary, Washington State Department of Health

10:45-11:00 **Break**

11:00-Noon **Reports from the Workgroups** – Wayne Dauphinee, Consultant, BC Ministry of Health Services, presiding
- Track 1 – Epidemiology
- Track 2 – Public Health Laboratories
- Track 3 – Emergency Management
- Track 4 – Emergency Medical Services
- Track 5 – Communications
- Track 6 – Public Health Law

Noon-12:30 **Next Steps/Wrap Up**
- **John Erickson**, Special Assistant, PHEPR Program, WA State Department of Health
- **John Lavery**, Executive Director, Emergency Management Branch, BC Ministry of Health Services
- **Perry Kendall**, MD, Provincial Health Officer, British Columbia

12:30 **Farewell Lunch –** (Boxed lunches will be available at 11:00)

Workshop Website - http://www.doh.wa.gov/Topics/cross border2008/

Appendix B
Cross Border Workgroup Reports

Epidemiology and Surveillance Workgroup

The Epidemiology and Surveillance Workgroup session was lead by Dr. David Patrick, British Columbia Centre for Disease Control, and Judy May, Washington State Department of Health. The following was discussed.

Electronic connectivity – The workgroup continued discussions on electronic connectivity for health alerts and epidemic information exchange with British Columbia by providing access to BC Centre for Disease Control epidemiologists on the Washington State Secure Electronic Communication, Urgent Response and Exchange System (SECURES) and the US CDC's Epi-X Epidemic Information Exchange System. Some Canadian readers have been granted posting rights to Epi-X. Epidemiologists with the Washington State Department of Health and other states have also been given access to the Canadian Integrated Outbreak Surveillance Centre (CIOSC).

Information sharing agreement – Fiona Gow, BA, LLB, Ministry of Health and Kathy Stout, JD, Washington State Department of Health provided an update on legal review of the draft epidemiology information sharing agreement, developed during the 2007 workshop. Of note, the legal approach to sharing information is undergoing change in British Columbia. A new Public Health Act has been introduced by the BC Ministry of Health that addresses the issue of sharing with public health officials in other jurisdictions. Although not in yet effect, legal staff are exploring ways to enter into an information sharing agreement with Washington State within the framework of the newly introduced Act.

- Assignment: Epidemiologists in the state and the provinces will continue to review this issue during the next year through periodic conference call meetings, with the goal of finalizing the agreement.

International health regulations (IHR) – The new IHR 2005 includes principles of local containment, and international collaboration. Defined are mandatory reporting, and nation states as IHR focal point.

- Assignment: Epidemiologists will continue to review the regulations, identify local requirements, identify indicators, and develop an evaluating instrument. Washington DOH and BCCDC will work together on conference calls to test the instrument for reporting public health events of international concern.

Mass gatherings WHO update – Jeff Duchin, MD, Public Health-Seattle & King County and Bonnie Henry, MD, BC Centre for Disease Control presented an update to the workgroup on the World Health Organization's (WHO) approach to mass gatherings. The document's objectives are to provide an overview of key topics when thinking of mass gathering from communicable disease perspective, and to establish a framework for WHO to provide technical assistance to countries hosting large events. The document is intended to help nations improve their public health capacity; sustainable "legacy" improvements that last after the mass gathering event.

The IHR is guiding the process of the mass gathering document by providing a framework for host governments to assess capacities by clarifying roles of the host government, WHO, and other key bodies. An international working group is working on guidelines for communicable

disease program response, which should be collaborative, coordinated and integrated into an overall multi-agency emergency response planning structure.

Joint epidemiology/laboratory issues – Yolanda Houze, Microbiology Manager, WA Public Health Laboratories, and Muhammad Morshed, PhD, Microbiologist, BCCDC attended the epidemiology meeting to discuss public health laboratory issues relating to mass gathering events. Issues to resolve include:

- Mechanism to determine how much testing needs to be done and when testing should cease.
- Mechanism to standardize electronic laboratory data exchange, recognizing that phoning or faxing results can quickly become overwhelmed during an emergency.

Real time surveillance/syndromic surveillance – A discussion was conducted to explore the value of syndromic surveillance in a mass gathering, identify perspectives from WA and BC for components of surveillance system, and define areas for collaboration and set priorities for future work together. Perspectives were presented by Dr. Jat Sandhu, Vancouver Coastal Health Authority, Dr. Atar Baer, Public Health: Seattle and King County, Dr. David Patrick, BC Centre for Disease Control, and Dr. Barry Rhodes, US CDC, Dr. Shari Lewis, US CDC, and . Marsha Taylor – Sentinel Physician Network for Influenza Surveillance, British Columbia.

Jat Sandhu, Vancouver Coastal Health Authority – Vancouver Coastal Health Authority is diverting public health resources to local level in anticipation of the 200,000 visitors projected during the 2010 Olympics. Surveillance components include communicable disease reports, emergency department visits, environmental health monitoring, and the Olympics medical encounters system. The intention is to generate daily extracts/internal surveillance reports during the Olympics through very clear lines of communication. On-going planning will continue via bi-monthly meetings.

Atar Baer, Public Health Seattle & King County – During the 2010 games, risks include foodborne illness, imported illness, flu and respiratory viral illnesses, sexually transmitted diseases, drug related events, and possible acts of bioterrorism. For syndromic surveillance, there is a need to standardize chief complaint classification and syndromic categories. One possible solution is through the use of the syndromic surveillance system, ESSENCE; a common system that would allow each jurisdiction to see their own data along with those of other jurisdictions. The comment was made that the Canadians will not be using ESSENCE. Therefore, there is a need to continue planning for sharing data electronically across systems.

David Patrick, Provincial Health Perspective – Many useful data sources are available through the Canadian MSP billing system that are currently being fed into the BC provincial data surveillance unit. The question was raised about whether or not MSP billing claims, which come on a daily basis and are accumulated over the year, could provide early warning for influenza illness. The next step is to evaluate and compare MSP claims with ILI data. The goal is to have a secondary use of data that's already been collected. BCCDC also looked at over-the-counter sales in British Columbia, and compared these with physician visits and lab confirmed diseases.

Barry Rhodes and Shari Lewis, CDC – Dr. Rhodes described the CDC's BioSense syndromic surveillance system. BioSense is national program intended to improve the United State's capabilities for conducting real time biosurveillance and enabling health situational awareness through access to existing data from healthcare organizations across the country. The BioSense model has evolved into working with state and local health departments directly to receive data. From a national perspective, this can also be done across borders. Future

activities involve continued linkages in existing state/regional biosurveillance systems to create a nationwide capability, as well as developing and testing "case recognition" technologies. ESSENCE is currently operating in a number of states, and the systems can cover multiple jurisdictions. CDC is updating software and adding new modules and inviting state and local health departments to host software in their jurisdictions.

Marsha Taylor – Sentinel Physician Network for Influenza Surveillance, BC Canada – The program goal is to monitor the big picture of flu activity. Data sources include lab reporting, hospital laboratory involvement, and MSP billing. Currently there are 45 sentinels in the system which is coordinated by BCCDC. Physicians represent the backbone of the system, which operates by phone and fax, with plans to automate. Data are analyzed on a weekly basis. All patients presenting to sentinel physicians receive a swab, and are given basic information about flu prevention. Those who were vaccinated and also tested negative for flu were designated as controls. This provides an opportunity to study an additional component of vaccine effectiveness through an existing surveillance system.

Other Issues – Questions were raised by the workgroup regarding how to obtain and analyze data, determine its usefulness, and what to do with it once collected. The group identified both the need for information sharing as well as what to do with that data once received. The need was expressed to explore an integrated surveillance. One risk involved getting too specialized and not looking at the big picture. For example, an adequate animal and human surveillance connection has largely been ignored.

- Assignment – These issues will continue to be discussed during regularly scheduled phone calls of the epidemiology workgroup during the 2008-09 year.

Public Health Laboratory Workgroup

The Public Health Laboratory Workgroup was lead by Dr. Muhammad Morshed, British Columbia Centre for Disease Control, and Yolanda Houze, Washington State Department of Health. The following issues were discussed.

Smallpox testing – Because the CDC's Laboratory Response Network (LRN) rules require laboratorians who perform smallpox testing to have been vaccinated within three years of performing such tests, Washington, Montana, Oregon, and Alaska cannot currently conduct testing. The 100 dose vials of vaccine are part of the challenge when labs consider vaccination of a small number of staff. There is a new vaccine for smallpox, although it carries the same contraindications as the previous vaccine. An idea was raised to test lab staff (serum sample) to assess immunity.

Surge capacity and sample testing – As a strategy for ensuring regional surge capacity, it was agreed that a table would be sent to the labs to identify their various proficiencies. Several challenges were identified in the shipping of samples. There are difficulties and inconsistencies when sending state to state, from BC to US, from US to BC and in the rates charged by different shipping companies. It was agreed that these challenges need to be resolved for routine shipping needs and prior to the 2010 Olympics.

Pan flu as a model for information exchange – MT, OR, WA applied for CDC Pan Flu grant funding; it has not been announced who the recipients will be. It is thought that because so many labs applied, that more will be funded at a lower amount.

Emergency Managers Workgroup

The Emergency Managers Workgroup was lead by Dave Burgess, British Columbia Ministry of Health Services, and Ken Back, Washington State Department of Health. The purpose of the meeting was to recap the status of current workgroup activities, and to discuss public health surveillance and response issues relating to mass gatherings and major events. Challenges, advantages and priorities identified during the session are listed below.

Challenges –
- Moving food products
- Building cross border relationships
- Working with the sharing of health care providers / regulators
- Addressing liability issues with regard to medical professionals and volunteers
- Bringing the right groups to the table
- Bringing in tribal and emergency management partners
- Identifying mechanisms to transport equipment and pharmaceuticals
- Establishing core competencies to identify strategic plan needs
- Identifying issues with Sovereign authorities
- Pandemic Influenza planning and business continuity
- Sharing of information at the local level
- Pre-registration of volunteers
- Working with the Alaskan/Yukon Border, from the emergency management side they have had some challenges due to geographical issues
- Standardizing codes and colors for medical staff. Consistent codes across Canada and the U.S. Question: Who is responsible for writing the codes? Response: EM is currently responsible
- Educating of staff regarding codes
- Mobilizing medical professionals from private organizations
- Committing resources we do not own
- Handling movement of equipment and supplies
- Addressing hospital fear of liability issues
- Establishing commitment of health care providers (Renew Commitment / Duty of Care)
- Operationalizing evacuation processes and resources
- Operationalizing ground transportation in the transport of causalities

Advantages – Advantages included the following.
- Canada and the U.S. have commonalities such as health care coalitions
- Credentialing via colleges
- Working with North West Tribal Emergency Management Council on a coordinated response plan with Canada
- Cross border collaboration has worked well in the past in cross border wildfire issues
- There is funding available for public health through emergency management

- BC has been putting training dollars way for EOC's and EM training
- Resource typing, standardization
- Our link with our partners, standardization
- Ongoing work of SNS joi8nt agreement between Canada and U.S. (sharing response and resources)
- Collaborative thinking

Emergency Medical Services Workgroup

The Emergency Medical Services Workgroup was lead by Michael Smith, Emergency Medical Services Terrorism and Disaster Response, Washington State Department of Health; and Bruce Harford, International Programmes, British Columbia.

Overview and goals – The main goal of the workgroup session was to complete the *Sharing Healthcare Providers and Resources across the Washington and British Columbia Border Summary Report and Operational Plan* (the "Plan"). Michael Smith framed the discussion with a summary of existing guidance documents including the *Pacific Northwest Emergency Management Agreement (PNEMA)*, and the *Cross-Border Ambulance Reciprocity Policy and Procedure*.

The Plan development process was also discussed. The draft, started at last year's conference in Victoria, B.C., has been through several iterations and reviews. Along with last year's in-person meeting in Victoria, the full workgroup has met four times via teleconference, and subgroups have had several phone meetings to work out details.

The Plan, once finalized, may serve as a template for other PNEMA-based agreements.

The Emergency Medical Services Workgroup met separately for half the allotted time, then joined up with the Emergency Management Workgroup to share information and participate in broader discussion.

About the plan – The Plan addresses cross-border (Washington State and British Columbia) emergency issues concerning:

- Licensed healthcare providers
- Resources such as equipment, supplies and anciallary support staff
- Patients and lab specimens

The purpose of the Plan is to "operationalize timely and efficient movement and utilization of health professionals across the Washington State and British Columbia border."
It consists of several sections, including a Summary Report giving background and recommendations, the actual Operational Plan, and several appendices with supporting documents.

Along with Emergency Medical Services professionals, other partners were involved in developing the Plan. As one conference participant noted, "When we started to think about ambulances crossing the border, we needed to make sure we engaged our key partners in the

process." Customs officials, public health and hospital staff, as well as federal partners from both sides of the border took part in the process.

The Workgroup reviewed the draft and filled in information, as appropriate, on activation, concept of operations, request format and process. This final draft will be submitted for legal review. Once approved, the plan will be submitted for signature by the Secretary of Health (Washington State Department of Health), and the Minister of Health (British Columbia).

Next Steps/Assignments – Once the Plan is signed, key members of the workgroup will set up trainings and train-the-trainer opportunities for border-crossing stations. Number of stations trained next year will depend on funding, but will be between 5 to 17. Sites that have been trained will participate in a tabletop exercise on the Plan in February, 2009. An after-action report will be available in April, 2009. Workgroup leads will also work with key partners on implementation issues for the Plan. It is expected that the Plan will continue to evolve as new situations and policies arise, and the core team will develop a process for ongoing review and updating.

Priorities – Several priorities were raised, to include:

- Follow EMS training plan
- Mobilize equipment we don't own
- Figure out how we can meet expectation of assistance requests
- Address highest priorities and assign work group
- Determine what resources are already available and stop re-inventing the wheel
- All hazard resource typing: Consistent and common language
- Educate all responders (Canada and U.S.) on: Public Health 101
- Determine what resources we all have
- Determine what staff we already have in place
- Determine what $$$ are available
- Address how to be prepared to ask for resources not usually asked for

Questions and Comments – Several questions came up during the breakout session, and workgroup leads will follow up on them in the coming months. Questions and comments included:

- Who else do we need to engage when the Plan is finalized?
- Make sure marine ambulances are included in any agreements.
- Develop a cross-border contact list for Emergency Medical Services.
- Note 24-hour ports on contact lists.
- Look into database or tool to track resource availability. Who would maintain?
- Fire districts, for example, should make sure all vehicle numbers, license and insurance info is already documented and available for border crossings.
- Cost-reimbursement issues?
- Share information with local and private operators too.
- Call border ahead of time prior to crossing.
- The key to all of this is communication.
- Are we ready for 2010? Repatriation issues will be huge when we have 20-30 patients crossing the border each day.
- Can we make sure all staff have enhanced drivers licenses?
- What about quarantine issues?
- We need standard case definitions.
- How do we mobilize resources we don't "own" in a mutual aid situation?

Communications Workgroup

Due to scheduling conflicts for many of our partners, Communications Workgroup members decided not to hold an in-person meeting at this year's Cross-Border Conference. The workgroup will meet via conference call later this summer to continue collaboration on a variety of health issues.

This year, the communications participants who were able to attend participated in other workgroups including discussions on the 2010 Olympics. This will help enrich our discussion, planning and resource sharing activities in the coming months.

The workgroup intends to resume in-person meetings at next year's Cross-Border Conference.

Next Steps – Based on work conducted in 2007, next step activities for the Communications Workgroup include the following:

- 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

The Public Health Law Workgroup was lead by Paul Bailey, British Columbia Ministry of Health, and Kathy Stout, Washington State Department of Health.

A roundtable discussion took place surrounding the issues of disclosable information, privacy concerns and the obstacles they create for the group when developing agreements about sharing information. The continued need to learn more about the intricacies of each other's health systems, and legislative and judicial processes was emphasized by the group.

The session began with a quick overview of several documents that had been completed in the past year that had significant legal review or legal implications. The documents were:

1. The Pacific Northwest Border Health Alliance Memorandum of Understanding;

2. The Public Health Information Sharing Agreement between Washington State and British Columbia;
3. Sharing Health Care Providers and Resources Across the Washington and British Columbia Border.

Issues discussed included the following –

Authority – Issues relating to the regional state/provincial agreements versus Canada/US agreements continues to be an issue that dictates much of what is done with the various agreements and compacts. International agreements are wieldy and these regional agreements are preferred, but the authority for entering into regional cross border agreements must always be considered. The more formalized agreements that can be made individually lessen the need for national/federal laws and agreements.

Information sharing – Because each state and province has its own laws regarding privacy issues and the release of public information, it is essential to understand those limitations of each party. A long discussion took place with several states, provinces, and agencies explaining the issues pertinent to their locale.

Warrants/judicial procedure – Also discussed were the issues surrounding the differences in the judicial procedures in different jurisdictions. Of particular concern were the ramifications if a warrant was issued for large amount of information – e.g., whole databases or large sets of files.

Allowing local-to-local information sharing – The group agreed that it in the next year they will need to start exploring what would be involved in establishing agreements to allow local health jurisdictions (US) and Regional Health Authorities (Canada) to share information directly without having to go through state and provincial entities.

Indirect identification – Finally the group touched on the issue of indirect identifications. If each agency has different rules for what is disclosable, it is possible for someone requesting information to receive enough bits of different agencies to be able to piece together the identity of the person involved. Should we look at standardizing what information is disclosable to protect people from this indirect identification?

Guests from Minnesota and Nebraska offered valuable lessons from their experience with similar work in the Great Lakes are and with the Mid-America Alliance.

Appendix C

DRAFT Public Health Information Sharing Agreement between British Columbia Ministry of Health and Washington State Department of Health

May 13, 2008 (DRAFT)

PURPOSE OF AGREEMENT
The purpose of this Agreement is to facilitate public health related information, both individually identified and population related, between signatories for the purpose of assuring prompt and effective identification of infectious disease and other agents that could lead to public health concerns in the region.

DEFINITIONS
For the purposes of this Agreement, the following definitions apply:

- **Identifiable information** is specific to an individual and may include elements such as demographic information, address, and date of birth. Information is "identifiable" if it directly identifies an individual or there is a reasonable basis to believe it could be used to identify an individual. Information may also be "identifiable" if it meets the definition as contained in an applicable law. This type of information is defined by applicable federal, provincial and state laws and the definitions in those laws may vary from jurisdiction to jurisdiction.

- **Infectious disease agent** is the causative agent of an illness or health condition that may trigger reporting requirements or requests under the governing law or regulations of the signatories' jurisdictions or of the Governments of the United States or Canada or implementation of public health protection measures and/or emergency response procedures.

- **Health information** is written, electronic or visual information, identifiable or population based, 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.

- **Public health event** is an occurrence or imminent threat of an illness, communicable disease or health condition with the potential for cross-border implications that could trigger implementation of emergency health response procedures, reporting requirements or requests under the governing law or regulations of the signatories' jurisdictions, or of the Governments of the United States or Canada.

- **Receiving signatory** is a signatory to this Agreement which collects, uses, or discloses health information within its jurisdiction that it receives from the other signatory.

- **Sending signatory** is a signatory to this Agreement which sends or delivers health information to the other signatory.

AUTHORITY

- **Pacific Northwest Emergency Management Arrangement**
  Authorizes the Signatories to enter into agreements establishing procedures to provide mutual aid necessary to protect public health.

- **Freedom of Information and Privacy Act, R.S.V.C. 1996, c._____**
  Permits disclosure of personal information outside Canada, with the permission of the Minister of Labor and Citizen's Services.

- **Revised Code of Washington 43.70**
  Authorizing the Washington State Department of Health to identify and resolve threats to the public health.

- **Revised Code of Washington 42.56**
  Addresses disclosure of information.

REGIONAL CROSS-BORDER COMMUNICATIONS AND COORDINATION
The signatories will establish a joint working group as described in Appendix A, Joint Coordinating Committee Terms of Reference. The purpose of the group is to develop and maintain procedures for sharing information necessary in effectively responding to a public health event. The group will meet and confer at least annually. The signatories will establish a process and/or location for their joint communication and coordination of information before and during a public health event.

DOCUMENT REPOSITORY
Each signatory will provide and maintain current copies of its respective statutes, administrating rules and regulations regarding public health events and infectious disease agents, and other relevant material. The signatories will jointly identify and maintain in common a set of materials which they accept as reflecting the applicable laws and regulations of the signatories and the Governments of the United States and Canada.

SHARING HEALTH INFORMATION
The signatories recognize that sharing individual, population-level or epidemiological health information safeguards the health of their populations, and facilitates emergency preparedness and response. To that end, each signatory will provide to the other signatory health information relevant to a public health threat.

Specific terms and conditions for sharing health information

- Signatories may exchange health information under this Agreement only for the purpose of preventing, detecting or responding to a public health event.

- Each signatory may use and maintain information under this Agreement only for the purpose of preventing, detecting or responding to a public health event.

- Each signatory will maintain and protect the information it receives from the other signatory according to the receiving signatory's laws.

- The receiving signatory will notify the sending signatory, at the earliest possible time, if:

    - it receives a public record disclosure or similarly named request for the sending signatory's health information and

    - it discloses health information it receives from the sending signatory.

- The sending signatory will transmit health information in the form it usually employs or in such other form as accepted by the receiving signatory.

EFFECTIVE DATE

This Agreement is effective upon signature by both signatories.

_____	_____
British Columbia Ministry of Health	WA State Department of Health
_____	_____
Date	Date

Appendix D

Operational Plan for Sharing Healthcare Providers and Resources Across the Washington and British Columbia Border

Table of Contents

Electronic Copies

Electronic copies of the report may be obtained by contacting Michael Smith, Washington State Department of Health at (509) 625-5172 or by email at Michael.Smith@doh.wa.gov.

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: Washington's Governor or designee will activate this operational plan for Washington. The Solicitor General will activate this plan for British Columbia.

IV. Concept of Operations:

A. General: When a party to this plan experiences an emergency, disaster or mass casualty incident (MCI) that exhausts, or threatens to exhaust, all resources, the Governor or Premier may initiate action under this operational plan. Requests for assistance will go from the requesting Emergency Operations Center (WA) or Provincial Emergency Program (BC).

Local jurisdictions in Washington must make requests for cross border assistance through their local EOC or its equivalent. Local government in British Columbia must make their requests through their Local Emergency Operations Center. (Refer to Appendix A: Checklist for Requesting Assistance in Emergencies/Disasters)

B. Format: Requests may be verbal or written. The requesting jurisdiction will confirm verbal requests in writing within 15 calendar days of the verbal request. Washington State will use the form prescribed by the Washington State Military Department, Emergency Management Division. British Columbia will use a formal request.

Consistent with PNEMA Administrative Procedures, requests should include the following information:

1. Description of services needed (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 staging area (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)
7. Any language requirements for labels and/or instructions
8. Any Strategic National Stock Pile needs

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. (Refer to Appendices A and B)
2. Staging areas will be hosted by the state or province. Personnel will not be deployed from the staging area until they have been briefed on administrative requirements (travel, communications, and length of deployment) and have necessary protective equipment and vaccinations (as appropriate).
3. Washington local emergency management agencies will assure that Canadian and Washington state healthcare providers who volunteer are registered as emergency workers consistent with WAC 118-04 *prior* to allowing them to deploy from the staging area.

D. Field Support: The responding state/province recruits appropriate personnel and will arrange and provide for travel to staging locations. The requesting jurisdiction will provide management support such as food, lodging and transportation, and 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 responding jurisdiction. The State or BC EOC will provide the deployment packet to the responder. Return travel will be arranged by the requesting 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 requesting local emergency management agency as specified under RCW 38.52 and WAC 118-04.

B. Workforce Identification and Training:

1. Department of Health (DOH) is responsible to maintain an inventory of medical staff assets deployable under this plan. DOH will create and maintain a database of volunteer providers known as Washington Health Volunteers in Emergencies (WAHVE).
2. Assets identified under an approved resource typing scheme must meet all the training and licensing requirements of that type of asset.
3. Except as might otherwise 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 (PPE) and Vaccination:

1. The requesting jurisdiction will assure that responders will have adequate personal protective equipment and vaccination(s) prior to leaving the staging area.
2. The requesting jurisdiction determines the minimum protection level in terms of PPE and vaccination.

D. Licensure: Whenever a person of the responding jurisdiction holds an active and unencumbered license to practice as a healthcare provider, and such assistance is requested by the requesting jurisdiction, the person is deemed to be licensed

to practice by the jurisdiction requesting assistance, to the extent allowed by the requesting jurisdiction's law. The practitioner is subject to limitations and conditions imposed by the requesting jurisdiction. Washington law waives licensing requirements in a declared emergency.

E. Credentialing: The requesting jurisdiction is responsible for providing a descriptive request through the EOC. This request must clearly define 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.

F. Reimbursement: Reimbursement will be according to PNEMA and individual agency policies. If there is a conflict, PNEMA provisions prevail.

G. Border Crossing: (Refer to Appendix C)

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), may be required to present a valid passport or other documents as determined by the Department of Homeland Security.
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 allow the holder to cross the border without the other documents specified above.

Signed in _____, this __ day of _____, 2008

_____	_____
Mary C. Selecky Secretary of Health State of Washington	George Abbott Minister of Health Services Province of British Columbia

Washington State Department of Health

BRITISH COLUMBIA The Best Place on Earth | Ministry of Health

Operational Plan - Appendix A
Request for Healthcare Providers and Resources
Cross Border
Emergency and Disaster Process Checklist
June 17, 2008

Emergency and Disaster Process **(Long term is more than 24hr action)**	**Comments/Date**	**Yes**	**No**
Disaster Happens			
Identified need for cross border assistance	Identify state, province, or territory resources are or will become overwhelmed		
Pre-notification to Authorized Point of Contact at Health Department	State, province, or territory gives advanced notice of situation, e.g. a pandemic influenza or man made or natural disaster and pending needs		
Authority to respond is received by state emergency operations center (EOC) or provincial emergency program (PEP) for disaster*.	Disaster declaration		
Request made to responding state, province, or territory recognized government authority Sent or received verbal request. Confirm in writing within 15 calendar days.	Critical information received • Description of services needed • Numbers of medical personnel requested • Type of medical personnel requested • Estimated duration • Staging locations • Location of service delivery • Incident Commander • Nature of disaster • Number of patients involved		

<table>
<tr><th colspan="2"><u>Emergency and Disaster Process</u>

(Long term is more than 24hr action)</th><th><u>Comments/Date</u></th><th><u>Yes</u></th><th><u>No</u></th></tr>
<tr><td colspan="2"></td><td>• Contact information
• Specimens, illness, Injuries, organs, etc.
• Any language requirements for labels and/or instructions
• Any Strategic National Stock Pile needs
• Other</td><td></td><td></td></tr>
<tr><td colspan="2">Disaster information transferred to all agencies per plans</td><td><u>Examples</u>

EOC/PEP alerted

Customs (U.S. and Canada) contact list is available.

The United States Food and Drug Administration (FDA) Office of Crisis Management, Emergency Operations 24/7 # 301-443-1240</td><td></td><td></td></tr>
<tr><td>Available <u>responding</u> healthcare providers identified and alerted. Examples include the following healthcare professions</td><td>Responding Numbers</td><td rowspan="8">Healthcare providers per request and availability.</td><td rowspan="8"></td><td rowspan="8"></td></tr>
<tr><td>Medical Doctors</td><td></td></tr>
<tr><td>Physician Assistants</td><td></td></tr>
<tr><td>Mental Health providers</td><td></td></tr>
<tr><td>Nurses</td><td></td></tr>
<tr><td>Respiratory Technicians</td><td></td></tr>
<tr><td>Emergency Medical Services</td><td></td></tr>
</table>

Emergency and Disaster Process **(Long term is more than 24hr action)**		**Comments/Date**	**Yes**	**No**
(EMS) Personnel				
Resource Definition Type		When appropriate, use Resource Type for definitions of medical personnel and equipment. Typing information available at: *http://www.fema.gov/pdf/emergency/nims/508-5_health_medical_resources.pdf* *http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf* *http://www.fema.gov/emergency/nims/faq/rm.shtm#0*		
Respond as directed by EOC, Public Health, and/or Hospital Response Plans		Per response local plans and agreements		
Recover/Demobilize		Scale down per the incident command system (ICS), emergency response plans, and/or agreements		
Mitigate		Per ICS, emergency response plans, and/or agreements		

* RCW 38.52.010(6)(a) "Emergency or disaster" as used in all sections of this chapter except RCW 38.52.430 shall mean an event or set of circumstances which: (i) Demands immediate action to preserve public health, protect life, protect public property, or to provide relief to any stricken community overtaken by such occurrences, or (ii) reaches such a dimension or degree of destructiveness as to warrant the governor declaring a state of emergency pursuant to RCW 43.06.010.

Operational Plan - Appendix B
Request for Healthcare Providers and Resources
Cross Border
Mass Casualty Incident (MCI) Process Checklist
June 17, 2008

- MCI definition in Glossary.

MCI Process **(Short duration is 24 hours or less)**	**Comments/Date**	**Yes**	**No**
MCI Happens			
Identified as MCI	Multi car, factory explosion, illness, etc. many injured or sick		
Identified need for cross border assistance	Regional/local resources are or will be overwhelmed or out-of reach to respond		
Pre-notification sent to Authorized Point of Contact	On-scene Incident Commander (IC) gives advanced notice of situation, e.g. a pandemic influenza or human caused or natural disaster and pending needs		
Authority to respond received from regional/local authority for MCI per plans and agreements. (each entity must identify positions or individuals that have authority to authorize a response)	Incident commander requests regional/local cross border assistance		
Request for assistance (each entity must identify positions or individuals that have authority to request a response) Sent or received verbal request. Written confirmation within 15 calendar days of verbal request.	Critical information received • Description of services needed • Numbers of medical personnel requested • Type of medical personnel requested • Estimated duration • Staging locations • Location of service delivery		

<table>
<tr><th colspan="2"><u>MCI Process</u>

(Short duration is 24 hours or less)</th><th><u>Comments/Date</u></th><th><u>Yes</u></th><th><u>No</u></th></tr>
<tr><td colspan="2"></td><td>• Incident Commander
• Nature of MCI
• Number of patients involved
• Contact information
• Specimens, illness, injuries, organs
• Other</td><td></td><td></td></tr>
<tr><td colspan="2">Information Transferred
• Cross border and local authorities alerted
• Local entities per plans and agreements alerted
• Customs (U.S. and Canada) provided information contact list is available.
• The FDA Office of Crisis Management, Emergency Operations 24/7 # 301-443-1240</td><td><u>Example</u>
• Multi-vehicle incident
• Illness, injuries, or specimens
• Numbers involved
• Numbers of and type of medical personnel requested
• Estimated duration</td><td></td><td></td></tr>
<tr><td>Available <u>responding</u> healthcare providers identified and alerted. Examples include the following healthcare professions</td><td>Responding Numbers</td><td rowspan="4">Healthcare providers per request and availability.</td><td rowspan="4"></td><td rowspan="4"></td></tr>
<tr><td>Medical Doctors</td><td></td></tr>
<tr><td>Physician Assistants</td><td></td></tr>
<tr><td>Mental Health providers</td><td></td></tr>
</table>

MCI Process **(Short duration is 24 hours or less)**		**Comments/Date**	**Yes**	**No**
Nurses				
Respiratory Technicians				
Emergency Medical Services (EMS) Personnel				
Resource Definition Type		When appropriate, use Resource Type for definitions of medical personnel and equipment. Typing information available at: *http://www.fema.gov/pdf/emergency/nims/508-5_health_medical_resources.pdf* *http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf* *http://www.fema.gov/emergency/nims/faq/rm.shtm#0*		
Recover /Demobilize		Scale down per emergency response plans and agreements		
Mitigate		Per emergency response plans and agreements		

Operational Plan - Appendix C
Healthcare Providers, Resources and Patients
Cross Border Movement
Process Checklist

NOTE: This checklist is designed with the understanding an approval to move was authorized. This process may be implemented if it was a declaration as with a disaster or on-scene incident commander with a MCI.

June 17, 2008

Process	Comments/Date	Yes	No
Request for assistance was received and approved.	Per designated authority and response plans.		
Responding entities give a preliminary notification to border security point of contact (POC). Via fax to border POCs. (Each entity must identify methods of contacting POCs that have responsibility and authority to meet this need)	Washington State EOC 24/7 #1-800-258-5990 United States Customs and Border Protection (USCBP) numbers are located on the Seattle Field Office (SFO) Port Information spread sheet. (attach 3) Canada Border Services Agency (CBSA) numbers are located on the CBSA spread sheet (attach 3) The FDA Office of Crisis Management, Emergency Operations 24/7 # 301-443-1240		
Account for all responding medical personnel.	Use Incident Command System (ICS) process and forms when available.		
Secure transportation for health care providers, equipment, and supplies movement (each entity must identify plans, agreements or individuals that have responsibility and authority to meet this need)	Per define transport needs. (Resource and Typing Definitions are found in the glossary and the attached web sites.) http://www.fema.gov/pdf/emergency/nims/508-5_health_medical_resources.pdf http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf		
Follow CBSA "Procedures for Processing Emergency Support Personnel CBSA - Pacific Region"	CBSA • If advanced notify CBSA using the Port level contact list attachment 3		

Process	Comments/Date	Yes	No

attached (Each entity must identify methods of contacting POCs that have responsibility and authority to meet this need)
 	
Following information should be provided:
 	
• Nature of emergency and priority of response
 	
• Starting point and destination of emergency vehicles and equipment
 	
• Nature of the transport process and information regarding the number of vehicles, equipment and personnel to be expected
 	
• Details regarding patients (if applicable) to be processed including name, date of birth, citizenship, and place of residence
 	
• Estimated time of arrival at the port of entry
	• CBSA representative will direct their call to the Port of Entry where clearance will take place
	• Follow CBSA instructions
	• On duty law enforcement and emergency medical vehicles may utilize the Nexus or emergency Lanes (if available) in order to cross through our Port of Entries (this makes the process much quicker considering there are extremely low volumes expected in these lanes).
	• Our policy states that personnel must stop at the Nexus or emergency lane booth, provide identification and be subject to normal inspection requirements. However, with emergency situations where the well being of a traveler may be negatively impacted by the delay, EMS vehicles will likely be waved through without any reporting requirements. In which case, documentation would not be required.
	• Drivers of vehicle transporting equipment and personnel should adhere to the following:
	  • Carry 2 copies of the equipment list including serial numbers or other uniquely identifiable markings;
	  • Present the list to CBS A for clearance approval upon entry;
	  • Report to a CBSA ot1ice prior to leaving Canada so that the temporary admission documents can be cancelled if completed on entry		

Follow USCBP instructions for best crossing locations and routes (Each entity must identify methods of contacting POCs that have responsibility and authority to meet this need) Following information should be provided: • Name	USCBP The processes are essentially the same. • Notify the port of entry closest to the emergency as soon as possible with information of persons who will be seeking entry into the U.S., patients, doctors, nurses, drivers etc, and nature of the emergency and final destination. • Port personnel will be awaiting arrival of the emergency vehicles and will conduct their inspections accordingly.		

Process	**Comments/Date**	**Yes**	**No**
• Date of Birth • Drivers license, Passport # if available • Arrest history if available Contact the FDA Office of Crisis Management, Emergency Operations 24/7 # 301-443-1240	• Proof of identity/citizenship is required as outlined in WHTI to seek entry into the U.S. (waivers of documents are available on a cases by case basis). • There is no blanket exemption for these occurrences for exempting the inspection of pilots, crew and passengers on board an air ambulance responding to or from an emergency in a foreign country, and seeking entry into the United Sates;		
Rendezvous with requesting officials at identified locations	Per Incident Commander (IC) request instructions and agreements		
Accounted for medical staff at the predetermined location or staging area.	Contact IC and use ICS forms when available.		
Provide patient care as needed and requested by medical control hospital and Public Health, etc.	Per patient care protocols, guidelines, emergency response plans and agreements		
Provide patient movement as needed and requested by medical control hospital and Public Health, etc.	Per procedures, emergency response plans and agreements		
Notify Incident command and responding agency or facility if a patient is returned to the original state or province. This is to assure patient accountability and potential infectious control issues.	Potential patients may not be accepted into a country. Unless paroled (USCBP), the patient may be returned to the original country.		
Recover /Demobilize	*Scale down* per emergency response plans and agreements		
Assemble all reports and documents	Per ICS, emergency response plans and agreements		
Mitigate	Per emergency response plans and agreements		

OPERATIONAL PLAN - ATTACHMENT 1
GLOSSARY OF KEY TERMS

For the purposes of the NIMS, http://www.fema.gov/nimscast/Glossary.do the following terms and definitions apply:

All Hazards: Any incident caused by terrorism, natural disasters, or any chemical, biological, radiological, nuclear, or explosive (CBRNE) accident. Such incidents require a multi-jurisdictional and multi-functional response and recovery effort.

Emergency or Disaster: "An event or set of circumstances which: (i) Demands immediate action to preserve public health, protect life, protect public property, or to provide relief to any stricken community overtaken by such occurrences, or (ii) reaches such a dimension or degree of destructiveness as to warrant… declaring a state of emergency…."RCW 38.52.010

Emergency Operations Centers (EOCs): The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, county, city, tribal), or some combination thereof.

Healthcare provider A person who is licensed to practice healthcare within a certain scope. In Washington people in the following professions are considered healthcare providers and the person in the profession will most likely be involved in this operational plan: http://www.doh.wa.gov/hsqa/licensing.htm.
Examples are:

- Advanced Registered Nurse Practitioners
- Airway Technician (and IV/Airway Technician)
- Audiologists
- Certified Nursing Assistants
- Chiropractors
- Chiropractic X-Ray Technician
- Dental Hygienists
- Dentists
- Denturists
- Dietitians/Nutritionists
- Dispensing Opticians

- Emergency Medical Technician
- First Responders
- Fitters/Dispensers - Hearing Aids
- Health Care Assistants
- Hearing and Speech
- Hygienists - Dental
- Intermediate Life Support (ILS) Technician
- IV/Airway Technician
- Licensed Practical Nurses
- Medical Doctors
- Mental Health Counselors
- Midwives
- Naturopathic Physicians
- Nursing (RN, LPN, ARNP)
- Nursing Assistants
- Nursing Technician Registered
- Nutritionists
- Occupational Therapists and Assistants
- Ocularists
- Operator Certification (Water System)
- Ophthalmologists
- Opticians
- Optometrists
- Orthopedics
- Orthotists/Prosthetists
- Osteopathic Physicians
- Osteopathic Physician Assistants

- Paramedics
- Pharmacists
- Pharmacist Assistants
- Pharmacy Technicians
- Physical Therapists
- Physicians
- Physician Assistants (Medical)
- Physician Assistants - Osteopathic
- Podiatric Physicians and Surgeons
- Radiologic Technologists
- Registered Counselors
- Registered Nurses
- Registered Nursing Assistants
- Respiratory Therapists
- Speech Language Pathologists
- Social Workers
- Surgical Technologists
- Veterinarians
- Veterinary Technician
- Water System Operators
- X-Ray Technician

Incident Commander (IC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Licensure Licensure includes all levels of credentialing by a regulatory authority. Levels include: registration, certification and licensure.

Mass A mass casualty incident is defined as an event which generates more patients

Casualty Incident	at one time than locally available resources can manage using routine procedures. It requires exceptional emergency arrangements and additional or extraordinary assistance. Found on (page 35) of http://www.who.int/hac/techguidance/tools/mcm_guidelines_en.pdf
Mitigation:	The activities designed to reduce or eliminate risks to persons or property or to lessen the actual or potential effects or consequences of an incident. Mitigation measures may be implemented prior to, during, or after an incident. Mitigation measures are often informed by lessons learned from prior incidents. Mitigation involves ongoing actions to reduce exposure to, probability of, or potential loss from hazards. Measures may include zoning and building codes, floodplain buyouts, and analysis of hazard-related data to determine where it is safe to build or locate temporary facilities. Mitigation can include efforts to educate governments, businesses, and the public on measures they can take to reduce loss and injury.
Mutual Aid Agreements	Written agreement between agencies and/or jurisdictions that they will assist one another on request, by furnishing personnel, equipment, and/or expertise in a specified manner. (2004 NIMS Guidance Glossary)
Processes:	Systems of operations that incorporate standardized procedures, methodologies, and functions necessary to provide resources effectively and efficiently. These include resource typing, resource ordering and tracking, and coordination.
Qualification and Certification:	This subsystem provides recommended qualification and certification standards for emergency responder and incident management personnel. It also allows the development of minimum standards for resources expected to have an interstate application. Standards typically include training, currency, experience, and physical and medical fitness.
Recovery:	The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.
Resources:	Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.
Resource Typing:	Resource typing is the categorization of resources that are commonly exchanged through mutual aid during disasters. Resource typing definitions help define resource capabilities for ease of ordering and mobilization during a disaster. For additional information please visit http://www.fema.gov/emergency/nims/rm/rt.shtm.
Resource Typing	Categorization and description of response resources that are commonly exchanged in disasters through mutual aid agreements. The FEMA/NIMS

Standard: Integration Center Resource typing definitions provide emergency responders with the information and terminology they need to request and receive the appropriate resources during an emergency or disaster.

Response: Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and incident mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. For additional information please see the NRP, page 72 or the NIMS document, page 136.

Canada Border Services Agency | Agence des services frontaliers du Canada

OPERATIONAL PLAN - Attachment 2

Procedures for Processing Emergency Support Personnel

CBSA - Pacific Region

Background

In the event of an emergency, Canada Border Services Agency (CBSA) has specific regulations governing the movement of persons and goods required for an effective response. It is recognized that emergencies can occur as a result of natural disasters such as floods, fire or earthquake, but may also result from an industrial accident or a medical emergency involving one or more patients.

The entry of equipment and personnel, into Canada is controlled by CBSA.

The following procedures have been developed to assist in efficiently processing emergency support personnel, goods and patients (where applicable), in the event of an emergency.

Advance Notification

In an effort to provide expedited processing of emergency vehicles, equipment, personnel, and patients (EMS scenario), it is requested, that advance notification be provided to CBSA, using the Port level contact list provided.

The representative of the appropriate agency, municipal, provincial, state organization or EMS (Emergency Medical Service) provider, will direct their call to the CBSA Port of Entry where clearance will take place, to obtain further advice and guidance.

Emergency Response Personnel and/or a representative, placing the call, should be prepared to provide the following information:

- Nature of the emergency and priority of response (routine, urgent)
- Starting point and destination of emergency vehicles and equipment
- Nature of the transport process and information regarding the number of vehicles, equipment and personnel to be expected
- Details regarding patients (if applicable) to be processed including name, date of birth, citizenship, and place of residence
- Estimated time of arrival at the port of entry

Canada

Program and Communications Division
Pacific Region
May 28, 2008

With advance notification, a CBSA representative will provide direction to the representative regarding the appropriate place of entry. In some cases, this may include the use of the NEXUS lanes at the Ports of Pacific Highway or Douglas. In the case of entry through a Port without a designated NEXUS lane, CBSA will provide instruction on the appropriate place to report to facilitate processing.

When time or circumstances do not permit an official notice of an emergency, Border Services Officers will have to assess the situation as it develops, by consulting with local response agencies or local or regional management representatives.

Documentation

Equipment to be utilized in an emergency response may be impol1ed 011 a temporary basis, duty free, under Tariff item 9993.00.00 and relieved of the requirement to pay GST under the "Goods for Emergency Use Remission Order".

When time pemits, a Temporary Admission Permit E29B will be issued covering all equipment and supplies, not consumed in Canada. This permit will be issued covering emergency supplies and equipment without collection of security (duty or Goods and Services Tax [GST]).

Border Services Officers will be given discretion to determine the documentation required at the time of importation or entry, based on the nature of the emergency

In the event that documentation is completed, the record will be cancelled whenever evidence that the goods have been consumed or exported from Canada is provided, preferably from an official or person involved in the emergency situation.

The driver of the vehicle transporting equipment and personnel to Canada should adhere to the following:

- Carry 2 copies of the equipment list including serial numbers or other uniquely identifiable markings;
- Present the list to CBS A for clearance approval upon entry;
- Report to a CBSA ot1ice prior to leaving Canada so that the temporary admission documents can be cancelled if completed on entry.

Canada

Program and Communications Division
Pacific Region
May 28, 2008

CBSA - Immigration Regulations when Entering Canada

Emergency response personnel may be granted entry to Canada as Visitors. The Immigration Program - Foreign Workers Manual section Rl86 (t), outlines how emergency service providers are exempt from obtaining a work permit when rendering services in times of emergency. These services should be aimed at preserving life and property. Under this provision they would not be required to obtain an employment authorization.

Coordinated or Sustained Non-Emergent Response Procedures

When the requested assistance is not of an immediate nature and involves a response that includes multiple vehicles, equipment movements and personnel, the municipality, province or agency is requested to contact the CHSA Regional 011ice. A determination of logistics will be made in consultation with Regional and District Management. Coordination of efforts involving personnel, vehicles and equipment may be undertaken to facilitate entry into Canada. Should a non-imminent request of this nature be made directly to ports of entry, the Regional Office must also be notified as soon as possible.

Special Procedures

EMS Response including Transportation of a Sick or Injured Passenger by Ambulance (Emergent Care)

Whenever possible, advance notification is requested to assist in ensuring the most efficient processing of personnel, equipment and patients. When the nature of the response makes that impossible or would result in a delay that would negatively impact the health and well-being of the individual being transported, EMS personnel are requested to approach the Port of Entry at a safe rate of speed and must be prepared to stop and report to a Border Services Officer and provide the following details:

- Nature of the emergency
- Details including the number of passengers, patients and personnel on board
- Details regarding patients to be processed including name, date of birth, citizenship, and place of residence

Canada

Program and Communications Division
Pacific Region
May 28, 2008

Border Services Officers will make every effort to expedite processing and may waive normal reporting requirements, documentation and examination of the vehicle, goods, patients or personnel, or defer them, until a more practical time.

EMS Response including Transportation of a Sick or Injured Passenger by Ambulance (Non-Emergent Care)

In the case of a non-emergent care response or transport of a patient, passengers, and personnel advance notification is required. Advance notification will assist the operation in anticipating the arrival of the patient and will provide an opportunity to identify a specific lane or location. EMS personnel are requested to approach the Port of and must be prepared to stop and report to a Border Services Officer.

Please note:

All personnel, including patients, should carry the required identification to establish their identity, citizenship and place of residence. It is recognized that in emergencies, patients may not carI1' readily accessible identification and normal reporting requirements may be waived. Border Services Officers will carry out a risk assessment and use their judgement and discretion in determining the need for identification and/or documentation in these instances.

Canada

Program and Communications Division
Pacific Region
May 28, 2008

Operational Plan - Attachment 3

Contact Information for Canada Border Services Agency

Land Border Ports of Entry – Pacific Region

Operational Plan - Attachment 4

Pacific Northwest Emergency Management Arrangement (PNEMA)

PNEMA Annex B

Operational Plan - Attachment 5

Department of Health

Notice of Adoption of a Policy Statement

Cross-Border Ambulance Reciprocity

November 30, 2003

Operational Plan - Attachment 6

Public Health Emergencies

Memorandum of Understanding between the

State of Washington Department of Health and the

British Columbia Ministry of Health

June 20, 2006

For copies of Attachments 3 – 6, contact Mike Smith, Washington State Department of Health by email at Mike.Smith@doh.wa.gov.

Appendix E

Draft Pacific Northwest Border Health Alliance – Conceptual Framework

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FINAL DRAFT
MAY 13, 2008
PACIFIC NORTH WEST
BORDER HEALTH ALLIANCE
MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING BETWEEN:

PROVINCE OF ALBERTA MINISTRY OF HEALTH AND WELLNESS
as represented by the Minister of Health and Wellness
(hereinafter called "Alberta")

and

BRITISH COLUMBIA MINISTRY OF HEALTH SERVICES
as represented by the Minister of Health
(hereinafter called "British Columbia")

and

YUKON TERRITORY MINISTRY OF HEALTH
as represented by the Minister of Health
(hereinafter called "Yukon")

and
STATE OF ALASKA DEPARTMENT OF HEALTH
as represented by the Secretary of Health
(hereinafter called "Alaska")

and

STATE OF IDAHO DEPARTMENT OF HEALTH
as represented by the Secretary of Health
(hereinafter called "Idaho")

and

STATE OF MONTANA DEPARTMENT OF HEALTH
as represented by the Secretary of Health
(hereinafter called "Montana")

and

STATE OF OREGON DEPARTMENT OF HEALTH
as represented by the Secretary of Health
(hereinafter called "Oregon")

and

STATE OF WASHINGTON DEPARTMENT OF HEALTH
as represented by the Secretary of Health
(hereinafter called "Washington")

THIS MEMORANDUM OF UNDERSTANDING IS NOT INTENDED TO BE AND WILL NOT BE INTERPRETED OR CONSTRUED AS A FORMAL OR LEGALLY ENFORCEABLE AGREEMENT BUT IS SOLELY AN EXPRESSION AND RECORD OF THE ARRANGEMENTS AND UNDERSTANDING CONCLUDED BETWEEN THE PARTIES.

THE PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING (MOU) AMONG THE PARTIES IS TO ENGAGE IN A COLLABORATIVE APPROACH TO USING AVAILABLE HEALTH SERVICE RESOURCES TO PREPARE FOR, RESPOND TO AND RECOVER FROM PUBLIC HEALTH EMERGENCIES[1].

WHEREAS the Parties entered into the Pacific Northwest Emergency Management Arrangement ("PNEMA") effective April 1, 1996, and Annex B to PNEMA which contemplate cooperative efforts between the Parties with respect to use of available health service resources to deal with public health emergencies.

A. GOALS:

1. The primary goals of the collaborative approach between the Parties are to:

    a. Prevent and/or mitigate an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic/pandemic disease outbreak, or a novel/highly fatal infectious agent or biological toxin through integrated surveillance and early notification;
    b. Respond to surge capacity demands on health systems and health resources efficiently and in a cost effective manner when public health emergencies arise in any jurisdiction party to this MOU; and
    c. Assess current and explore future areas of operational responsibility that could result in efficiencies when providing health services in the jurisdiction of any Party to this MOU.

2. The Parties wish to enhance their working relationship and explore ways and methods to realize those goals.

[1] In this MOU a "public health emergency" is an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic/pandemic disease outbreak, or a novel/highly fatal infectious agent or biological toxin, that poses a substantial risk to human health and requires action beyond normal procedures. A public health emergency may occur as the result of a natural, e.g., earthquake/flood, accident, e.g., chemical spill, or intentional, e.g., terrorism, event.

B. STRATEGY:

1. The Parties agree to research, analyze and work to determine how available emergency assistance capacity can be used to mitigate situations that may overwhelm the health care resources of one or more of the Parties using:

    a. A regional planning approach;
    b. Inter-jurisdictional and intra-jurisdiction mutual assistance; and
    c. Inter-agency and interdisciplinary collaboration.

2. The parties agree to enter into agreements which would provide for integrated surveillance and early notification.

3. Each Party, to the extent reasonably practical, to:

    a. Review, prioritize and determine most likely and most damaging potential emergencies the Parties might jointly experience, whether due to natural disaster, technological hazard, human-caused disaster, emergency aspects of resource shortages, civil disorder, insurgency, or enemy/terrorist attack.
    b. Review jurisdictional emergency plans and consider developing mutual assistance plans, relevant to:

        1. prioritized emergencies, for public health
        2. mass care and treatment
        3. patient transportation, and
        4. interoperable communications services

    c. Determine the mechanism for management and provision of assistance.
    d. Develop procedures, relevant to prioritized emergencies, to fill identified gaps and overlaps, and resolve inconsistencies in plans. This includes mobilizing existing community capacities within the Party's jurisdiction to assist in addressing vulnerable populations.
    e. Explore what would be necessary to minimize disruption to delivering services, medicines, critical lifeline equipment and other resources, both human and material.
    f. Investigate procedures for loaning and delivering human and material resources, including those for reimbursement or forgiveness. Explore related issues, such as licenses and permits, liability, compensation and reimbursement that may affect implementation of plans considered as a result of this MOU.
    g. Explore issues arising under any laws that may affect plans considered as a result of this MOU.
    h. Assess current areas of operational responsibility to identify how to achieve efficiencies in providing health services and explore future options.

C. GOVERNANCE

The Parties will establish a Joint Coordinating Committee (the "Committee") to provide direction and advice to any authorized working groups as may be determined, by the Committee, to be necessary.

D. REPORTS TO OFFICIALS:

The Committee will report progress, results, and recommendations (as available) to their respective leadership periodically. The Committee will provide an initial progress report to the Parties within one year of founding.

E. DISCRETION AND AUTHORITY NOT FETTERED:

Nothing in this MOU is intended to or shall be interpreted so as to fetter the discretion or the authority of the respective Legislatures of the Parties.

F. REVIEW:

While the goals expressed in this MOU may be met by each of the Parties developing separate processes and procedures, one result of the work conducted may be an agreement or agreements as may be necessary and agreed upon between the Parties that further the goals set out herein. It is the intent of the Parties to review the status and progress made under this MOU at the end of the first year of operation. Nothing in this paragraph prevents Parties from withdrawing its participation under this MOU with written notice to the other Parties.

Signed:

Minister of Health Province of Alberta	Secretary of Health State of Alaska
Minister of Health Province of British Columbia	Secretary of Health State of Idaho
Minister of Health Yukon Territory	Secretary of Health State of Montana
Director of Health Division Department of Human Services State of Oregon	Secretary of Health State of Washington

Annex A

Joint Coordination Committee
Terms of Reference

Purpose

The Joint Coordination Committee *(*hereinafter the "Committee") is the operational component of the Pacific North West Border Health Alliance. The purpose of the Alliance is to enhance the working relationship among member states and provinces/territory in responding to public health and health service emergencies.

Committee Goals

The goals of the Committee are to:

- Identify opportunities to improve collaborative early warning infectious disease surveillance and surveillance information sharing between the participating jurisdictions, including the type of information to be shared.

- Develop plans to address surge capacity demands on health systems and resources when public health emergencies arise, including a 24/7 response protocol between participating jurisdictions that would identify appropriate contacts and their roles.

- Assess current and explore future areas of collaboration that could result in efficiencies in the provision of health services

- Conduct an annual Cross Border Public Health Preparedness Workshop.

Membership

Core

- Co-Chair – a Canadian and United States representative
- Representative from the State of Alaska
- Representative from the State of Idaho
- Representative from the State of Montana
- Representative from the State of Oregon
- Representative from the State of Washington
- Representative from the Province of Alberta
- Representative from the Province of British Columbia
- Representative from the Yukon Territory

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 Committee, there may be standing or special sub-committees/working groups (program or focus area committees) to assist in the operation and mission of the Committee. The Committee will authorize such sub-committees/working groups

Sub-committees/working groups will report, through their respective co-chairs, to the Committee.

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

The development of membership for sub-committees/working groups and their respective Terms of Reference will be proposed by the sub-committee/working group co-chairs and be approved by the Committee. The sub-committee/working group will also develop plans for accomplishment of key tasks related to their mandate. These plans will be approved by the Committee.

Administration

Primary administrative and logistical support will be provided on a rotational basis by the Department or Ministry of one of the co-chairs.

Work plans for key tasks will be developed collaboratively, in conjunction with State Health Department's and Provincial/Territorial Ministries of Health, with agreed-upon deliverables and associated timelines.

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

Appendix F

Tabletop Exercise After Action Report

Exercise Overview

On May 15, 2008 The Washington State Department of Health (DOH) and British Columbia Ministry of Health conducted a Tabletop Exercise. The Tabletop Exercise tested the preparedness agencies that might be tasked to respond to a public health event requiring a response on both sides of the Western United States-Canadian Border. The upcoming Vancouver 2010 Olympic and Paralympic Winter Games were used as a focal point for discussion.

Exercise Goals and Objectives

- Identify major issues that might occur during a medical response that will affect U.S. and Canadian Healthcare resources.
- Identify any differences between U.S. and Canadian responses to a health related event that occurs during a mass gathering.
- Assess the ability of Canadian and U.S. Federal resources to support a mass outbreak.
- Assess how the Canadian and U.S. health systems interact with the provincial, state, Tribal/First Nations, and local public health jurisdictions during an emergency response.

Exercise Synopsis

The exercise occurred on May 15th from 1:00 p.m. to 4:00 p.m. at the Lakeway Best Western Conference Facility in Bellingham, Washington as part of the annual Bi-National Cross Border Workshop. To accommodate the over 200 people who signed up for the workshop, the exercise participants were divided up into three equal representation groups. For each group, the exercise was conducted in a separate room using the same scenario. Each group was assigned one facilitator and at least two recorders. The facilitators were:

Group One – Dan Banks, Washington State Department of Health

Group Two – Dave Burgess, British Columbia Ministry of Health Services

Group Three - Eric Sergienko, US Northern Command

The exercise scenario focused on a food borne event that centered on the hockey venue of the 2010 Winter Olympics in Vancouver, British Columbia. Initial reports had numerous patients presenting at Vancouver, British Columbia area hospitals with what appeared to be an intestinal illness.

The next update had the initial investigation indicating that most of those suffering from this malady were at or in the vicinity of the hockey semi-final match between Canada and the U.S. at Canada Hockey Place the previous evening.

The second update was followed by several updates that spread the illness further to include large number of patients moving south of the border to hospitals in Washington as well as overwhelming the health care system in the southwestern mainland of British Columbia.

Finally it was determined that the cause was most likely “Vancouver Gold,” an ice cream novelty created especially for the Olympics by a creamery in Whatcom County, Washington. The ice

cream novelty was served at Canada Hockey Place and by food vendors in the immediate vicinity.

As each scenario was presented, the facilitator engaged the participants in what their agencies' response would be in this event. The interaction generated lively discussion which uncovered the need for further work on both sides of the border.

(*A copy of the exercise PowerPoint used during the tabletop exercise is attached*.)

Each group was tasked to single out the issues that they viewed as most important. The issues are listed below:

Group 1 Outcomes

- What kind of contact will be established for 24/7 communications during the Olympics?
- How are we going to do alternate care/surge?
- Will daily reports be sent out through public health system?
- We need to map out healthcare facilities on the I-5/99 corridor.
- Communication between EOCs needs to be collaborated on (WebEOC and E-TEAM).

Group 2 Outcomes

- Whatcom County Health needs to be at the planning and coordination table.
- Canada has a healthcare system that is coordinated, and the US is privatized.
    - The private providers need to be on alert and in the information loop.
- A Public Health Liaison needs to be formalized across the border.
- Develop and widely distribute personal preparedness messages.
- Limited surge capacity of hospitals on both sides of the border.

Group 3 Outcomes

- Communications: stove piping of outbreak information.
- Unclear communication pathways through federal entities and border control.
- Coordination Center: what's health's role?
- Surge capacity: how are we going to deal with them; where can they be sent; and do we need to pre-stage?

The facilitators and recorders then grouped the responses to determine themes which were common across all three groups. The common themes (edited for the purpose of clarity in this report) were:

Communications

- What systems will be established for 24/7 communications during the Olympics?
    - A Public Health Liaison needs to be formalized across the border.
- Stove piping of outbreak information such that information is not disseminated widely across sectors, disciplines, boundaries and borders.
- Will daily status/situation reports be sent out through public health system?

- Develop and widely distribute personal preparedness messages for persons attending The Games.

Surge Capacity

- How are we going to manage alternate care/surge?
- Limited surge capacity of hospitals on both sides of the border.
- Coordination Center (Washington): what's health's role?

These findings were presented at the conference on Friday Morning. The presentation can be found in Attachment 2.

Analysis of Issues

1. Activity: Health Alerting Systems

Observation: Alert and warning systems are not linked across the US/Canada border.

Analysis: The present systems that exist on both sides of the border are isolated from one another. Public Health and Healthcare Agencies and personnel do not receive timely messages regarding health threats from the neighboring country.

Recommendation: Need to develop common protocols and triggers to ensure coordinated messaging and information exchange across the border. Ensure inclusion of local, regional, state/provincial, and national governments, agencies and authorities

2. Activity: Linking with Federal Border Protection Agencies.

Observation: Pathways for communication between health agencies and federal border protection agencies are not clearly defined.

Recommendation: Create formal pathways for the exchange of information between Canadian and US response agencies.

3. Activity: Identification of an Emerging Threat.

Observation: The ability to pick out an emerging public health threat from the "background noise" is critical to a quick and positive response.

Analysis: An enhanced ability to detect emerging public health threats is critical.

Recommendation: Ensure that enhanced surveillance and detection processes are designed and tested through exercises.

4. Activity: Health Care and personal preparedness messages for Foreign Visitors to Canada.

Observation: Foreign visitors maybe uncertain of how to access and pay for health care, while visiting Canada.

Analysis: Visitors from the US and other countries should be informed of the steps they can take to be prepared for unexpected events.

Recommendation: Develop informational products that would be widely distributed prior to and during the Olympics and other large scale events, outlining personal preparedness options.

5. Activity: Pre-Positioning of supplemental resources.

Observation: There is no clear plan or consensus of what resources might be pre-positioned in light of the incremental risk resulting from The Games.

Analysis: To fully integrate various aspect of planning for The Games, planners need to know what supplemental resources will be deployed into the region such that appropriate planning and support can be accomplished.

Recommendation: Coordinate with partner agencies to get a clear idea of what supplemental resources will be deployed for this event.

6. Activity: Coordination of EOC Efforts.

Observation: Washington State and the Province of British Columbia use different web based Emergency Management Coordination Systems (WebEOC-Washington, E-Team-British Columbia).

Analysis: The abililty to integrate these systems is unknown

Recommendation: Integration of these systems should be investigated by a working group before the Olympics. A recommendation on integration and exercises required prior to the games should be provided to respective state/provincial authorities.

7. Activity: Bed Capacity Tracking.

Observation: Western Washington's Harborview Bed Capacity Program is converting to a web based tracking program. British Columbia's HealthLines (bed tracking/telehealth agency) is also engaged in change.

Analysis: There is an opportunity to implement enhancements in bed-tracking capacity in both Washington State and British Columbia.

Recommendation: Develop state and provincial recommendations regarding incremental bed tracking capacity for use during a Health Emergency or Mass Casualty Incident and implement a test program for a new bed capacity tracking program.

8. Activity: Identification of health facilities on either side of the border?

Observation: Health Emergency Managers from Canada and the United States have little awareness of healthcare facilities and capacities across the international border.

Analysis: Information on the nature of health facilities should be made available and updated for Health Emergency Managers

Recommendation: Develop a plan for keeping planners on both sides of the border informed of what health care facilities exist and their capabilities.

9. Activity: Planning for 2010 Olympic response.

Observation: Health sector planning seems to be lagging behind the main thrust of the planning efforts.

Analysis: Health agencies have not always been directly involved in the planning discussion.

Recommendation: Ensure that the health sector is not just invited, but involved in all major planning discussion in preparation for the Olympics on both sides of the border.

10. Activity: Recovery Planning.

Observation: Recovery Planning is not well understood and there is limited awareness of the existence of such plans.

Analysis: Education regarding recovery planning and how it fits into the cycle of emergency management is required.

Recommendation: Washington State Department of Health and British Columbia Ministry of Health should ensure education/training is available regarding recovery planning, the cycle of emergency management, and sample recovery plan templates.

11. Activity: Communicating across the Border.

Observation: There is no plan for health sector communications across the US/Canada border during The Games.

Analysis: Some type of 24/7 communications capability should be in place during the The Games.

Recommendation: Identify and map and exercise 24/7 communications between British Columbia Ministry of Health and Washington State Department of Health for implementation during The Games. Similarly, identify, map, exercise and implement specific agency to agency links required.

12. Activity: Cross Border care of mass casualties/patients

Observation: There is no clear plan for management of mass casualties/patients where there is a requirement to cross the border to receive care.

Analysis: a plan for the movement of mass casualties across the border is required

Recommendation: Develop a plan to allow movement of mass casualties/patients across the international border when required.

13. Activity: Ensure planning and coordination involves local and regional/county agencies.

Observation: Health care agencies and providers in Whatcom County, and Fraser Health Authority in British Columbia, have not been heavily involved in planning for cross-border incidents.

Analysis: In the event of a cross-border event, local and regional/county agencies are likely to be engaged in the response.

Recommendation: Ensure that representatives from health agencies and providers in Whatcom County and Fraser Health are actively involved in the planning.

14. Activity: Daily Reporting of Health Issues for the Games.

Observation: There is no plan for daily reporting of Health Issues during The Games

Analysis: A daily situation/status report should be provided with distribution to all appropriate agencies in Canada and the United States.

Recommendation: Develop, exercise and implement a plan to distribute daily/situation status reports during The Games. Incorporate systems recommended in Activity #1 and #4 above in the plan.

15. Activity: Consistent Messaging to Public.

Observation: Health information sources for the public in Washington and British Columbia have not planned for joint or consistent messaging.

Analysis: In the event of a health emergency, it is important that messaging produced in British Columbia and Washington in consistent.

Recommendation: Health Information sources in Washington and British Columbia should develop joint public information plans.

16. Activity: Implementation of the Cross Border Emergency Medical Services Agreement.

Observation: This new agreement is untested

Analysis: Ambulances are liable to be inspected at Border Crossings. There is a need to expedite ambulance crossings.

Recommendation: EMS personnel from Washington State, and BC Ambulance Service personnel should expedite their work with border inspection agencies to ensure these issues do not occur. Monitoring should be established and corrective action taken as necessary.

17. Activity: U.S. Border Coordination Center (Washington State Only Issue)

Observation: The role of US Public Health (state, federal, and local) in the coordination center is being established in Whatcom County to support events in Vancouver, British Columbia during 2009 and 2010 event period.

Analysis: Most planning up until this point has been focused around security from a law enforcement perspective. Health care related issues have generally been overlooked.

Recommendation: Need to examine the role of public health in the coordination center. At a minimum, Emergency Support Function (ESF) 8 needs to have a presence in the coordination center.

Conclusion

In general, the exercise received significant positive feedback from participants. This was the first time in several years that a tabletop exercise of this type had been done at this conference. It was a chance to explore the different implications an event of this type would have in each county and also at the provincial/state and local levels.

Appendix G

Speaker Biographies

(in order of appearance)

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 Office of the Assistant Secretary for Preparedness and Response (ASPR). 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.

John Lavery, Executive Director
Emergency Management Unit
British Columbia Ministry of Health Services

John Lavery serves as the Executive Director of the Emergency Management Unit of the British Columbia Ministry of Health Services.

Regina Delahunt, Director
Whatcom County Health Department
Washington State

Regina Delahunt has almost 30 years of experience in the public health field primarily in the area of environmental health. Regina has served in a leadership capacity with the Whatcom County Health Department in Bellingham, Washington for almost 20 years and has been Public Health Director for Whatcom County since 2000.

In this capacity, she approaches public from a broad-based community perspective, playing an active in bringing community partners together to address public health needs. With a focus on creating solutions to complex public health problem, she serves on many local and regional boards tackling public health issues such as health care access, domestic violence, mental health and homelessness.

She is also active in community emergency planning efforts including Pandemic Flu planning and the establishment of the Whatcom County Medical Reserve Corps. Regina received her Bachelor of Science with honors from State University of New York, New Paltz and her Master Degree in Biology from New Mexico State University.

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 34 years.

Perry Kendall, MD
Provincial Health Officer
British Columbia

Since 1999, Dr. Kendall serves as Provincial Health Officer (PHO) for the province of British Columbia. In June 2005 Dr. Kendall was awarded the Order of British Columbia for his contributions to Public Health practice and to harm reduction policy and practice in British Columbia (BC).

The Health Act outlines the role of the Provincial Health Officer (PHO). As senior medical health officer for British Columbia (BC), the PHO's responsibilities include: advising the Minister and senior members of the ministry on health issues in BC and on the need for legislation, policies and practices concerning those issues; monitoring the health of the people of BC; providing information and analyses on health issues; and reporting to the public on health issues, the need for legislation, a change of policy, or practice respecting health in BC.

Dr. Kendall participates on a number of committees at the provincial and national level and co-chairs the Pan-Canadian Public Health Network Council.

Born in the United Kingdom, Dr. Kendall completed his undergraduate medical training at University College Hospital Medical School in 1968 and interned at the Seaman's Hospital in Greenwich, before spending a year as Senior House Officer at the University Hospital of the

West Indies in Kingston, Jamaica. In 1972 he moved to Toronto, Canada and spent two years working in general practice and at Toronto's Hassle Free Clinic. He is married with two children.

RADM Patrick O'Carroll, MD, MPH
Regional Health Administrator
Office of Public and Science
Us Department of Health and Human Services, Region X

Patrick O'Carroll is a Rear Admiral and Assistant Surgeon General 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). Specifically, 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 regions; (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. 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.

David Hutton, PhD, Senior Advisor
Federal/Provincial/Territorial Coordination Centre for
Emergency Preparedness and Response
Public Health Agency of Canada

David Hutton, PhD, serves as the Senior Advisor for the Federal/Provincial/Territorial Coordination Centre for Emergency Preparedness and Response for the Public Health Agency.

Kevin Yeskey, MD, Deputy Assistant Secretary
Office of the Assistant Secretary for Preparedness and Response (ASPR)
Director of the Office of Preparedness and Emergency Operations (OPEO)
US Department of Health and Human Services

Dr. Yeskey serves as the Director of the Office of Preparedness and Emergency Operations (OPEO).

OPEO is responsible for developing operational plans, analytical products, and developing and participating in training and exercises to ensure the preparedness of the Office, the Department, the Government and the public to respond to domestic and international public health and medical threats and emergencies.

OPEO is also responsible for ensuring that ASPR has the systems, logistical support, and procedures necessary to coordinate the Department's operational response to acts of terrorism and other public health and medical threats and emergencies.

Evan Adams, MD
Aboriginal Health Physical Advisory
Office of the Provincial Health Officer
British Columbia Ministry of Health

Evan Adams, MD, serves as the Aboriginal Health Officer for the Office of the Provincial Health Officer, British Columbia Ministry of Health.

David Patrick, MD, Director
Epidemiology Services
British Columbia Centre for Disease Control

David Patrick, MD, serves as the Director of Epidemiology Services for the British Columbia Centre for Disease Control.

Andy Stergachis, PhD, RPh
Professor of Epidemiology and Adjunct Professor of Pharmacy
Northwest Center for Public Health Practice
University of Washington

Andy Stergachis, Ph.D., R.Ph., is Professor of Epidemiology and Global Health and Adjunct Professor of Pharmacy and Health Services, and Associate Dean, School of Public Health and Community Medicine, University of Washington. Andy is Co-Director of the University of Washington's Graduate Certificate Program in Emergency Preparedness and Response. Andy has served as a Strategic National Stockpile Coordinator for Region 6, King County, Washington and is presently pharmacy advisor to PHSKC Preparedness Section.

He earned his pharmacy degree from Washington State University and his M.S. and Ph.D. in Social and Administrative Pharmacy from the University of Minnesota.
Based in the Northwest Center for Public Health Practice (www.nwcphp.org) he teaches and provides technical assistance on pharmaceutical preparedness, including mass dispensing, and actively participates in local trainings and drills pertaining to public health preparedness and response.

In 1999, American Druggist selected him as one of the most influential pharmacists in the U.S. He was awarded the American Pharmaceutical Association Foundation 2002 Pinnacle Award. In 2004, the U.S. sent him to Athens, Greece, to assist with public health preparations for Athens Olympic Games and participated in preparing "Mass Gatherings and Public Health: The Experience of the Athens 2004 Olympic Games."

In 2006 he spent a sabbatical with the Infectious Diseases Institute, Makerere University, Kampala, Uganda. International responsibilities include service as a Temporary Advisor, Communicable Disease Alert and Response for Mass Gatherings for the World Health Organization. Dr. Stergachis has served on several Institute of Medicine's Committees,

including: Poison Prevention and Control System; Interactions of Drugs, Biologics, & Chemicals in U.S. Military; and the Assessment of the U.S. Drug Safety System.

Patricia Daly, MD, FRCPC, Vice President
Public Health and Chief Medical Health Officer
British Columbia Vancouver Coastal Services
Public Health Plan for the 2010 Olympics

Patricia Daly, MD, FRCPC serves as the Vice President of Public Health and the Chief Medical Health Officer for the British Columbia Vancouver Coastal Services, Public Health Plan for the 2010 Olympics.

Wayne Dauphinee, Emergency Management Consultant
British Columbia Ministry of Health Services

Wayne Dauphinee presently serves as an Emergency Management Consultant for the British Columbia Ministry of Health Services.

He retired from the Emergency Management Branch, Ministry of Health in 2007, 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.

Dan Banks, Emergency Exercise Coordinator
Washington State Department of Health

Daniel (Dan) Banks is the Emergency Exercise Coordinator with the Washington State Department of Health. In his position, he coordinates exercise design and execution for the department's emergency response exercises.

In this capacity he was the state lead coordinator for the 2005 and 2007 WASABE exercises, and 2006 TAHOMA RESILIENCE Full-Scale exercises. Previously, while with Washington Emergency Management Division, he was an Exercise Coordinator for the 2003 TOPOFF 2 Exercise and has worked in disaster response and recovery.

Dan has over 25 years experience participating in, designing, and evaluating exercises at local, state and national level. He holds a BA in Political Science and Geography from the University of Washington, and a MA in International Relations from California State University Stanislaus.

Dave Burgess, Director of Operational Readiness
Emergency Management Unit
British Columbia Ministry of Health Services

Dave Burgess serves as the Director of Operational Readiness for the Emergency Management Unit, British Columbia Ministry of Health Services.

Eric Sergienko, MD
Head Public Health Emergency Planning
Navy Medicine

Dr. Eric Sergienko is an active duty US Navy physician in the Command Surgeon's Office at the North American Aerospace Defense Command and the United States Northern Command.

Previous assignments include Head of Public Health Emergency Preparedness, US Navy's Bureau of Medicine and Surgery; Emergency Physician, Naval Hospital Guam; and Diving Medical Officer, Naval Hospital Roosevelt Roads.

He served as a CDC Epidemic Intelligence Service Officer in Washington State where he worked extensively on pandemic influenza preparedness and bioterrorism response. He is board certified in emergency medicine, having completed a residency in emergency medicine at Naval Medical Center, Portsmouth. He completed a transitional internship at Naval Medical Center, San Diego and is a graduate of the Uniformed Services University of the Health Sciences and Oregon State University.

He has been involved in disaster planning and response at the local, state, national, and international levels.

Joe McLaughlin, MD, MPH, Chief
Epidemiology Section
Alaska Division of Public Health

Joe McLaughlin, MD, MPH, serves as the Chief of the Epidemiology Section, for the Alaska Division of Public Health, State of Alaska.

Muhammad Morshed, PhD, Program Head
Zoonotic and Emerging Pathogens
Laboratory Services
British Columbia Centre for Disease Control

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Appendix H

2008 Cross Border Workshop Evaluation

Response Rate: 83/198 = 42%

QUESTION 1: Where is your work location?

	Frequency	*Percentage*
Alberta	1	1%
British Columbia	13	16%
Yukon Territory	0	0%
Alaska	4	5%
Idaho	0	0%
Montana	1	1%
North Dakota	0	0%
Oregon	3	4%
Washington	55	66%
Canada First Nation	0	0%
US Tribe	0	0%
Other:	6	7%

QUESTION 2: What type of organization/agency do you work for?

	Frequency	*Percentage*
Local/Regional Government	18	22%
State/Provincial/Territorial Government	39	47%
Federal/National Government	16	19%
Hospital or Community Clinic	0	0%
Military	2	2%
First Nation / Tribal Affiliation	1	1%
College or University	2	2%
Business	0	0%
Other:	5	6%

QUESTION 3. What days of the workshop did you attend ?

	Frequency	*Percentage*
Wednesday, May 14, 2008 (Workshop Day 1 - Workgroup Meetings)	66	80%
Thursday, May 15, 2008 (Workshop Day 2)	76	93%
Friday, May 16, 2008 (Workshop Day 3)	64	78%
I did not attend the workshop	1	1%

QUESTION 4. What workshop workgroup meeting did you attend on Wednesday, May 14th?

	Frequency	*Percentage*
Epidemiology and Surveillance	17	21%
Public Health Laboratories	7	9%
Emergency Management	29	36%
Emergency Medical Services	5	6%
Public Health Law	7	9%
Floated between different workgroup meetings	3	4%
I did not attend a workshop workgroup meeting	13	16%

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

	Frequency	*Percentage*
Strongly Agree	29	36%
Agree	31	39%
Undecided	3	4%
Disagree	4	5%
Strongly Disagree	0	0%
I did not attend a workgroup meeting on Wednesday, May 14th	13	16%

QUESTION 6. The workgroup meeting that you attended on Wednesday, May 14th was useful in enhancing cross border partnerships and collaboration.

	Frequency	*Percentage*
Strongly Agree	23	29%
Agree	36	45%
Undecided	6	8%
Disagree	2	3%
Strongly Disagree	0	0%
Did not attend a workgroup meeting on Wednesday, May 14th	13	16%

QUESTION 7. There was enough time during your workgroup meeting on Wednesday, May 14th to meet its objectives.

	Frequency	*Percentage*
Strongly Agree	14	18%
Agree	30	38%
Undecided	15	19%
Disagree	7	9%
Strongly Disagree	1	1%
I did not attend a workgroup meeting on Wednesday, May 14th	13	16%

QUESTION 8. What tabletop exercise did you attend on Thursday, May 15th in the afternoon?

	Frequency	*Percentage*
Group 1 (Red, with Dan Banks)	23	28%
Group 2 (Green, with Dave Burgess)	22	27%
Group 3 (Black, with Eric Sergienko)	23	28%
I floated between different tabletop exercises	1	1%
I did not attend a tabletop exercise on Thursday, May 15th	14	17%

QUESTION 9. The tabletop exercise that you attended on Thursday, May 15th was useful in highlighting strengths and weaknesses in cross border communication.

	Frequency	*Percentage*
Strongly Agree	16	20%
Agree	37	46%
Undecided	9	11%
Disagree	4	5%
Strongly Disagree	1	1%
I did not attend a tabletop exercise on Thursday, May 15th	13	16%

QUESTION 10. There was enough unstructured time during the workshop to informally converse with colleagues.

	Frequency	*Percentage*
Strongly Agree	15	18%
Agree	56	68%
Undecided	6	7%
Disagree	5	6%
Strongly Disagree	0	0%

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

	Frequency	*Percentage*
Strongly Agree	31	38%
Agree	41	50%
Undecided	10	12%
Disagree	0	0%
Strongly Disagree	0	0%

QUESTION 12. It would be beneficial to conduct a binational cross border functional exercise in 2009.

	Frequency	*Percentage*
Strongly Agree	45	54%
Agree	32	39%
Undecided	4	5%
Disagree	1	1%
Strongly Disagree	1	1%

QUESTION 13. If a cross border workshop is held next year, I plan to attend.

	Frequency	*Percentage*
Strongly Agree	34	41
Agree	34	41
Undecided	14	17%
Disagree	1	1%
Strongly Disagree	0	0%

QUESTION 14. Please indicate the format you would like to see for the next cross border workshop.

	Frequency	*Percentage*
Three day workshop	33	40%
Two day workshop	37	45%
One day workshop	6	7%
No workshop	0	0%
Other:	6	7%

QUESTION 15. What cross border issues would you like to see addressed at the next cross border workshop?

Total responses (N): 56 Did not respond: 27

1. Medical surge
2. Ways for continued communication after the conference! Perhaps an annual one day meeting 6 months after the conference for specific issue-centered workgroups?
3. Epi/surveillance and Communication
4. Continued discussions regarding electronic laboratory reporting.
5. The pubic health law segments being worked out.
   Continued chipping away at the system set up for sharing of surveillance information between states and Canada
   How/ what Border systems would function in a major biological event
6. Specific plans and implementation
7. Planning for exercises.
8. Systems integration
9. Financial implications of cross-border evacuation and patient transfer.
10. Other issues besides the Olympics. Try to identify more technical and specific roadblocks that can be targeted. And find a few things that affect everyone on a daily basis(like patient movement and laboratory cooperation).
11. Separate discussion or at least the opportunity for LE officers/managers to discuss the topics
12. We should have a cross-border exercise about 4 weeks before the workshop. The workshop would be a good forum to discuss the findings of the exercise and chart a course for addressing the AAR issues.
13. concrete work for the emergency management group.
14. How the US and Canadian Federal emergency preparedness and response agencies would work cross border when neighboring State and Provincial governments are jointly addressing a cross border disaster or public health emergency.
15. Even though our partners in EMS feel that the border crossing issues are all solved by their new document it fails to account for the many logistical issues that will arise during a major public health event. We need to work logistical issues with boarder security and public health with large amounts (eight 53-foot trucks) crossing the boarder.
16. The one area that needs to be completely vetted is how the numerous disciplines will communicate cross border. EM to EM, Lab to Lab, EMS to EMS, etc.
17. The physical border cross, without too much red tape or waiting times. We have to ensure an seamless transition between countries.
18. moving emergency workers and supplies across borders. Keep in mind that moving from the US to Canada has different rules than moving from Canada to the US. Those two need to be addressed separately.
19. Continuation of the issues identified during 2008 - build on the issues identified - pull out two or three key issues from each group and coordinate a focus groups to actually identify some steps forward. Identifying issues is not enough - work is needed to move the issues forward. Develop a process which may take a few years, or not – depending on the complexities of the issues – also assign leads and working groups – prior to the end of the conference.
    1st – identify issues
    2nd priorities 2 to 3 main issues
    3rd focus group to strategies how to manage or over come issues
    4th develop agreements, mou's plan and standard operating procedures
    5th table top
    6th revise and do an exercise

20. Communications, cross border issues around Medical Reserve Corps and the border crossing, A real expanded exercise
    One day to lay out the basics of the two day exercise. Exercise to include enough causalities to necessitate utilizing staff from both nations, crossing ambulances back and forth with a criminal element to operationalize law enforcement and the feds. Something more than the immature exercise we had this year.
21. Non disaster assistance needed on a smaller scale - approved at the Federal Government level.
22. A non-tabletop, real time exercise
23. movement of material, specifically pharmaceuticals, that work require authorization and/or approval from federal agencies
24. As a member of the emergency medical services, this group is very familiar with ICS structure and language. It appears other groups are not comfortable with this system and is trying to recreate the wheel--using language that is comfortable for them--but not necessarily understandable or efficient during a time of emergency. Perhaps a stronger emphasis on ICS would help.
25. As far as disaster planning, how would patients specifically be moved to hospitals? How is it decided who goes where and in what order? How is this decided?
26. Functional exercise
27. Surge capacity
28. Focus on operations around cross-border and interagency communication, surveillance, and medical care.
29. First Nations/Tribal issues
30. No additions. I was impressed with the current organization and productiveness of the workshop agenda.
31. communication - data sharing, message sharing, etc
32. Quarantine
    Border crossing issues
33. Cross border communication. More with other states, not just Washington/BC
34. Environmental public health issues
    Infectious disease surveillance
35. Stronger integration of EM with public health operations
36. I think that an exercise for the Olympics, and hotwash for the vast majority of the conference time is the best way to see what works and what doesn't. It would be especially valuable if the exercise was conducted in a real venue. Such an extended exercise will identify better than any ideas now about what work we need to do.
37. I think a smaller--invited--group in each section with a clear agenda would be more effective. Some people were new to the process and it seemed like we started from scratch again on some issues.
38. Legal issues identified by non-lawyers as being helpful (or complicating) to their work.
39. Community Mitigation; Altered Standards of Care
40. Public transit (rail)
41. The Health Care Provider Operational Plan update and 2009 table top exercise review.
42. Activation of PNEMA (the how process with EM's leading the effort).
43. hard to say what the next issue d'jour will be-
    global emerging infections and antimicrobial resistance
44. After an independent epi and lab session, we should have some common time together
45. Coordination across entire US-Canada border
    Clarify interface between regional response and federal response in the event of an actual disaster

46. Medical surge capacity issues surrounding patient movement across borders.
47. -Preparation for the 2010 Olympics -Explanation of Canadian national health and medical resources -Explanation of U.S. federal health and medical resources
48. The current work is very infectious disease oriented, and we need to expand into other disaster/emergency areas to explore what communication issues can be identified and resolved.
49. Cross border medical and hospital issues
50. primarily a full tabletop, but if not presentation of projects/systems work.
51. Continue emergency response actions between Canada/US if/what/when and how. I feel this needs to be visited and re-visited as I for one think it is not if but when a major event whether nature and man induced takes place and we cannot be chickens with our heads cut off when it does.
52. I think EMS has taken the lead with agreements and planning. I would like to see more on joint hospital and healthcare planning.
53. Border patrol issues Standardization of radio communication and epi surveillance
54. I would like to see a binational exercise conducted prior to the meeting, and addressed during the meeting.
55. Surge preparedness for the Olympics
56. Hospital level surge and infection control management

QUESTION 16. What did you like most about this workshop?

Total responses (N): 62 Did not respond: 21

1. Tabletop and presentations on Olympics planning.
2. Very information, made a lot of great contacts in Canada. Overall it was very well organized.
3. The opportunity to build relationships
4. Ability to discuss details with workgroup.
5. The collaboration beginning to jell into operational pieces.
6. Broad spectrum of perspectives
7. Meeting my colleagues from the other government groups.
8. Update on issues and networking across borders
9. Three areas: - RADM O'Carroll's presentation. - Diversity of participation. - Providing conference materials on thumbdrive.
10. Overview and inter relation with public health
11. Presenters were good and the workshop seemed to move along on time with opportunity to network.
12. Networking
13. Working through the tabletop was very enlightening. It was also good to work through issues with our cross border partners.
14. I thought the most helpful part of the workshop was the after-knowledge of how much work is being done to make us all better prepared and safer. The workshop gives us valuable "face" time with others on both sides of the border, which helps us collaborate more easily throughout the year on various objectives.
15. I really like the networking towards a common goal (or goals)
16. networking

17. Networking and sharing of information between borders and programs
18. This was the first time there was real connection between the two sides of the border with functional abilities. Networking
19. Meeting colleagues from other US agencies and those from Canada
20. working group on the first day
21. Meeting up with group members from last year. Networking and sharing ideas.
22. It was pretty well organized and the presentation were interesting.
23. Evan Adams and Patrick O'Carroll
24. Ongoing relationships and hearing about progress over the past four years.
25. getting to know colleagues from other areas
26. (1) All of the sessions were well organized.
    (2) The attendees were committed to sustaining the productivity of this cross border effort by the participating members of PNEMA.
27. It is very valuable to exchange contact information and meet with colleagues from other states and Canada.
28. Chance to meet other PH emergency people.
29. Ability to develop relationships and collaborative projects with neighboring public health partners
30. networking
31. The opportunity to renew the connections I have made.
32. I appreciated the small group time.
33. The exercise
34. Networking
35. Well run.
36. The opportunity to work closely with legal colleagues and to have contact with those who make use of our services.
37. It was interesting to hear from individuals who are involved in different areas of public health, i.e., medical providers, policy makers, attorneys.
38. Meeting people face to face who are doing similar work... and folding them into a monthly telephone conference call that exists with other neighboring states.
39. tabletop exercise - excellent exchange
40. Chance to network and learn from other colleagues.
41. I loved the small workgroup sections. It was a great opportunity to meet people and have an open discussion.
42. ALL!
43. Networking and the after hour meeting with ASPR officials.
44. diversity of approaches to planning shows that there is no ONE way-- efforts are always imperfect but very necessary.
45. Networking
46. catching up with colleagues informally
47. The strong relationship between Washington State DOH and the BC Ministry of Health Services.
48. Seeing progress made on operationalizing cross border EMS protocols for sharing EMS personnel and resources.
    Federal presence from ASPR HQ.
49. The diversity of participants and learning about what Canada is doing on issues.
50. Multi-disciplinary

Learning how others are dealing with similar issues
51. right time of year. Having in Bellingham relatively convenient.
52. Networking opportunities
53. Stayed on time and to the task.
54. Networking is always beneficial.
55. The opportunity to meet people and network.
56. The interaction with cross border colleagues.
57. The epidemiology workgroup meeting provided a valuable opportunity to meet with colleagues and discuss issues.
58. Building relationships with the other attorneys
59. That participants are committed to sustainability and making it work
60. That federal-level representatives were better able to converse with participants at the state and local levels. So often they don't
61. I liked the opportunity to meet with my counterparts in other states and in BC. We had a good breakout session and set new goals for the future.
62. Able to learn more about what plans local government authorities in BC have for the winter Olympics

QUESTION 17. What suggestions do you have for improving the next cross border workshop?

Total responses (N): 56 Did not respond: 27

1. Would be good to have a moderator-led small group discussion that is focused on identifying what our goals are and strategizing how to accomplish those goals. Ideally, there should be structured meetings/workgroups in between workshops so that we can strengthen our partnerships and get some actual work done. I don't see much of a need for inviting CDC or JHU or any other big players until we've established what our needs are.
2. I suggest a second session for our breakout group, maybe during lunch?
3. Exercise with the top two or three leaders from all states participating in a Cross Borders exercise. A specific exercise to test the basic systems. Alert and notification, specimen collection, initial contacts to those who would activate the first elements of an emergency response (border screening, surveillance, Hsp. EMS. elements. continue to include and assist to ensure the all PNEMA states are represented.
4. Implementation, implementation, implementation! Make things happen! We are out of time for theorizing.
5. More focus on one or two most important specific issues, such as notification, data transfer, technical help, etc.
6. Keep up the good work!
7. There needs be more time for discussion and fewer presenters. Those that do present should be given more time to articulate there ideas. Consider brain storming about possible scenarios and how they might be addressed.
8. Three areas: - Improve selection of and objectives for invited speakers. - Involve a professional facilitators so forum outcomes are more definitive and disagreements are resolved. - Gather additional critical resources for thumbdrive.
9. Suggest less time spent on telling both sides how great they are and more time on issues other than

	the Olympics. Perhaps Whatcom County and BC can get together and talk about it, but it was not relevant to the rest of the folks to hear about it for three days. If this is any prelude, then next year's meeting will be even worse as the Olympics get closer. The refreshments were awful.
10.	Extend the LE category
11.	I prefer issue driven "workshops" vs. the conference format. Small group roundtable work sessions with reports to the larger group is appreciated. I think that this would work well with the exercises plan identified in question 15.
12.	Do actual work at the workshops and not just update or lecture.
13.	Clone myself so I can attend multiple workgroups. (Repeat concurrent workshops if anticipated attendance is high)
14.	Cease the Olympic planning in a vacuum and create both US and Canadian planning teams that have all the players at the table. It was not very comforting to have the US State Emergency Management planner stand up and state that health will be at the table for the Bellingham forward operating location when we have not been at the table. For most of us, this plan came as a complete surprise and it should not be.
15.	An idea would be to have the host province or state choose to highlight a "Day in the Life" of one of its disciplines. Showcasing how they operate, a look into their workday/worklife, etc.
16.	We need to see if what we have planned can work. A full-scale exercise is in order in the next couple of years.
17.	I was disappointed that the EM group did not identify at least one issue to work toward solution - my comments in Q 15 are reflective of my suggestions
18.	An exercise that is more complex than the poor example of an exercise used this year.
19.	None
20.	more should be done in between workshops in carrying out the findings of the workshop.
21.	cookies in the afternoon
22.	The large conference room set up this year was not as comfortable as last year. Last year had tables set up which made it easier to manage notebooks, lap tops etc. Also, flag etiquette needs to be reviewed. The flags were poorly and improperly displayed in the main conference room.
23.	Be careful to plan a more appropriate presentation during dinner...and I am sure this is not the first time you heard this.
24.	More interaction, less lecture
25.	Less single page papers in the binders.
26.	I like the idea of organizing the workshop around a more extensive exercise, with a focus on problem identification and solutions rather than status reports.
27.	Fewer talks by elected and appointed heads of programs and more from people that do the front line work
28.	No suggestions submitted beyond sustaining the current format.
29.	If we could conduct a functional exercise and implement some of the agreements that have been discussed. It all still feels a bit theoretical at this point.
30.	Try to get more local people. This one seemed very strong on state and federal. Local health needs to be more in touch with counterparts.
31.	Make sure that the workshop is broadly applicable to all participants
32.	Build on what has been done and recommendations provided by the delegates
33.	The table top was extremely weak. The idea is great, but his one was not well thought out; at least in my group.

Also, I think that specifics (whether in speakers or work sessions) are always more thought provoking than generalities.
34. I did not get much benefit from the other aspects of the workshop. It seems like a lot of the information could have just been handed out in a report and not set up as a topic.
35. The Emergency Management Working Group could benefit from a more structured discussions with clearly set goals and objectives. The conversations were good, but covered too many topics and tended to get off topic. Perhaps dividing the emergency management section into smaller working groups would help?
36. The dinner would have been a good opportunity for recognition and informal remarks. The speaker at dinner was good but totally inappropriate for a "dinner" speech. He should have appeared elsewhere on the program. I think there should be a best practices opportunity where partners can talk about new developments...not just in small groups.
37. No botulism -- or similar topics -- at dinner. (With all due respect to the dinner speaker, who was knowledgeable and enthusiastic about his presentation.)
38. The workshop could be reduced to two days and still accomplish its goals.
39. Drop the tabletop.
40. Have more concrete objectives/outcomes identified for each workgroup well ahead of the meeting.
41. I was only there for the workgroup meeting on Wednesday and I would say my one complaint was that there really wasn't enough time to have a really good discussion around the topics of the agenda. We decided to create breakout workgroups and have calls to discuss in further detail. I would love to see more time devoted to this as well as more IT resources/personnel attending the conference.
42. Keep it going!
43. Add communications; PIO and Health Alert Networking systems.
44. I like the current format
45. Incorporate an actual (more than tabletop) exercise into the workshop
46. -Increased focus on 2010 preparations. -An update on the credentialing process for receiving Canadian licensed health care providers in the U.S. -A discussion on the role the Canadian military might play in patient movement & evacuation. -A presentation on the status of operational plans or protocols between B.C. and the states. e.g., EMS protocols exist but what about other areas: data sharing? lab protocols? credentialing? etc. -What gaps exist in preparedness efforts between the two countries?
47. I think that the length and structure is well done. I believe it will be a challenge to incorporate a true exercise in the next meeting and keep it structured in a similar way.
48. A glossary of terms, acronyms, etc. Better organized emergency management workgroup session If exercise conducted again, ensure participants are discussing the issues not fighting the accuracy of the scenario. Ensure there is something for everyone in the scenario. Many were left out.
49. Lack of joint projects/programs participants can report on. One wonders if there is just not the inherent drive or need to coordinate work on a routine basis - participants will need to have some concrete work from among themselves reported on at future meetings, to continue to believe there is substance to the liaison.
50. The TTX addressed very specific issues related to the Olympics between Washington and BC. Although very interesting, there was little to engage Alaska in the exercise. I did not find it applicable to the entire group. If needed, develop breakouts for other states to discuss broader issues.
51. More tabletop exercises involving communication technology
52. The workshop needs more unstructured time to meet with colleagues. We lost an opportunity during the sit-down dinner with the long dinner presentation.

53. Better location would be nice
54. Provision for a Networking Café to provide an opportunity for participants to participate in an informal and interactive environment. Participants would have one hours circulate through various “stations” to network and learn about current activities relevant to seniors and emergencies. Presenters would have two options: 1) Stand-up Tables: A sign on the table will indicate the topic you are addressing and there will be limited space for handouts. Speakers will engage in informal discussions with participants on their initiative or network. 2) Display Area: Space will be provided for poster presentations such as research posters and demonstrations. Presenters would be available to discuss their work with participants who would circulate around the room
55. I think it would be helpful to have tables in the plenary sessions. It is difficult to take notes on your lap.
56. Better and more structured tabletop exercise.

Appendix I

Workshop "Index Card" Direction from Participants

During the closing of the workshop, Secretary Selecky presented each member of the audience with an index card to answer three questions:

1. Do we want to have a Cross Border Conference next year?
2. If a Cross Border do you want an exercise as part of conference?
3. What would you like to see change?

Following are comments from the audience expressed on the workshop "index cards."

1. Do we want to have a Cross Border Conference next year?

- **Yes**: 135 (94%)
- **No**: 8 (6%)

- **Comments**

1) Share key materials in advance so we come prepared
2) Phone and computer banks for each state federal level at host facility to each partner state or province
3) More focused agendas

2. If a Cross Border do you want an exercise as part of conference?

- **Yes**: 137 (97%)
- **No**: 4 (3%)

- **Comments**

Exercise – Yes

1) A functional exercise of communication and resources sharing across the border
2) Actual sending and receive communication info and specimens
3) An actual exercise at the front end of the meeting would be great
4) An exercise would be useful to clarify roles, responsibilities, gaps
5) Can we integrate with a BC exercise for 2010 already planned
6) Cross Border communication exercise at next years workshop
7) Exercise as part of the meeting
8) Exercise but maybe virtual
9) Exercise fist - meeting to debrief (extended hotwash)
10) Exercise would be most important
11) Exercise, but limited and in keeping with BC's 2010 initiatives
12) Full scale and table top
13) I think an exercise (not just a tabletop) together with a meeting would be valuable
14) If coordinated and worthwhile
15) If we can play in a realistic scenario, but an exercise preceding is important
16) Joint not just DOH
17) Lots of pre-planning and orientations sessions

18) Much more intense
19) Need to have a plan to exercise
20) Progressive exercises overtime - ID phase steps to end and articulate end product move forward on those scenario, But the exercise should be held 2-4 weeks before and the meeting should report out
21) Rural exercise, but not necessarily at or during the workshop
22) Similar to that at the IAFP conference in Florida July 2007, where a rep from each department was involved and a scenario played out for the conference attendees. In this case the US and Canadian partners should be represented
23) The value is in testing our plans and procedures and training our folks before the meeting functional communication exercise
24) With clear objectives participation and planning
25) Yes but not functional unless the resources are provide to do a good job
26) Yes but perhaps not at the conference. Have people at their workplaces

Exercise - No

1) BC is doing enough right now
2) NO exercise
3) No we should have an exercise before the meeting and use the conference as an After Action Report
4) This is not a group to do one

3. What would you like to see change?

Agenda

1) Add discussion of cross border notification - if 2010 attendees are with a common illness and are from us - how when will we be notified?
2) Begin to have real discussion about real issues not just "random" presentations about traditional public health sub committees
3) Change - winter olympics presenters focus- real time communications
4) Change- set the next years objectives at the annual meeting
5) Change; focus; bring new, i would appreciate optional sessions covering the health systems in us and can more background info; the em discussions could be more focused
6) Have mitigation workgroups and sessions
7) Have more on wa-doh preparedness for the olympics
8) More activity between meetings on key objectives
9) More law enforcement presentation - ems based - not everything is public health based- provide insight into le focus
10) More technical talks - have a plan and rear it apart - do the exercise then debrief it
11) Pre-conference identification of issues for consideration by professional groups
12) Skip the speeches that are general principles everyone already knows. It is specifics that grab attention and fosters problem solving . Generalness put people to sleep. Don't tell people to communicate. Discuss a specific area of communication on problems and attack it. That will foster creation of other problems

13) This is my first workshop. I particularly valued thursday morning where speakers could get into topics in depth- change - session drifted and were not consistent with eh identified objectives. I suggest tighten that up. Please share the presentations slides before hand-
14) Conference could be shortened- debrief of exercise

Communication

1) Develop web portals for information before we get here
2) How to make it work - create a website
3) Make sure communications workgroup has representation
4) Need to have communication of the action s/ status on quarterly basis to interested parties (it will keep us engaged throughout the year- help link to other activities, bring in other partners - multiple benefits) this can be done by the current sub groups

Exercise

1) Communication dialog collection exercise surge capacity drill
2) Conduct the exercise at ph and em and hospital works "typical" place of work and then meet to discuss and plan around the results
3) Continue inter-specific and intra specific exercise such as lab to lab and lab epi, communication liability
4) Coordination between hospital to test referral an transport of clients
5) For exercise do not just focus on olympics, could be earthquake, smart bomb, etc incorporated with an olympic theme
6) Full scale exercise prior do the meeting
7) Have plans for communication made per-conference and exercise them
8) If we do successful exercise can alternate between meetings and real exercise need to be certain that presentations reflect diverse audience - adult education in playing bigger role in ensuring everyone gets the most out of the event
9) Make the exercise be 3 days - with an scenario drafted by all disciplines including lawyer. Lawyers will help develop a scenario that is more challenging
10) Make the exercise real-time (not just a discussion) - activate the eoc, collect lab samples, test them, etc.
11) One group exercise (whole group) as well as smaller groups
12) Practical exercise that will test everything that has been worked on for the last 5 years. (theory into action)
13) Run an exercise prior to the next meeting - use the aar as a focal point for the next meetings in bc
14) The next conference should simply be a functional exercise with a hot wash the following day

Focus

1) Focus - i like the new theme each year
2) Focus - more specifics in 2010 - communications - make it work
3) Focus can be addressed by people knowing if they are or would be involved
4) Focus on 2010 olympics implement specific actions implement pnw border health alliance
5) Focus on collaboration (continued) protocols for communication cross border working groups that meet regularly - not just at this conference
6) Focus on collaboration between health professionals to include human medical, veterinary, and public health - more involvement with cbp
7) Focus on communication between agencies and integrated command structures
8) Focus on cross border alliances and mous - drill down into specific around exercises
9) Focus on establishing relationships and infrastructure that have legacy building
10) Focus on objectives for next year and ensure reporting in the year following
11) Focus on practical on the ground front line - relationships (formalizing) focus on products and processes
12) Focus on priorities, scale, procedural guide lines
13) Focus on routine surveillance communication collaboration - then apply those 2010 olympics
14) Focus still needs to be "all hazards" preparedness even though special olympics are looming
15) Great change - give the group the ability to put some in all the work done over the last 5 years into practice
16) It was better this year - the federal level options didn't rule - a ??? Is always local - and everyone seemed more receptive at all levels
17) It was better this year - the federal level options didn't rule a
18) It's time to re-swot (strengths, weaknesses, opportunities, and threats) sub groups should state strategically plan
19) Just seems like talk
20) Keep focus on infectious disease
21) Less speeches more interaction
22) Less talk about how we need to communicate and collaborate and more actual action - who exactly is to call who - who might serve as a liaison - not just whether or not we should have one lets make a formal list of names and contact information
23) Little less focus on epidemiology and more on "on the street" practical emergency response
24) Look for ways to expand the tools, agreements and processes beyond d infections disease planning to include chemical natural disaster (wind storm, flooding, etc) that is actually more likely to occur
25) More federal buy-in both canada and us
26) More focus of first day of discussions
27) More focus on small achievable pieces 1 st have the pieces identified
28) More plenary time focused on action items/ deliverables by sub-groups
29) Move from plans to operations - it is all logistics and communication plans are necessary but insufficient
30) Move to planning cooperatively

31) My first workshop so this workshop has not lost any luster for me. I am not prepared to suggest any improvements
32) Need to provide a list of acronyms for all involved
33) Need to put in place a brief actionable plan that is tied to strategic outcomes with accountabilities
34) New partners and focus have been brought up during conference (invite)
35) Seems like a lot of talk - how integrate into current systems
36) Set clear objectives and outcomes to work forwards - presentations are great - but needs to discussion of things to work towards - integration of public health and other responders - elms , law enforcements and security, etc..
37) Shake up - have goals for each year
38) Simple language when/if crisis.
39) Stay with infectious disease - not "all hazards"
40) The focus should be on developing a way ahead for the next year for each of the working groups. Determine what needs to be developed, what needs to be delivered and at least a royal approximation of how to the there
41) The focus should be on making arrangements concrete
42) The mass gathering/ olympics was a good discussion
43) We need to focus more on what are we going to do to fix these problems i.e. Deliverables
44) Widen the frame but improve focus. Leave the emphasis on infections disease while enhancing the expectations of working groups

Workgroups

1) Be sure to include a (public) communication track next year
2) Better structured workgroups with action items, speakers need to talk about specifics, not high level blah, blah, blah
3) Create active subcommittees to work on issues and produce results
4) Define region - elect leaders, convene ongoing work groups, conduct quarterly check ins by work groups - develop a structure that makes this regular work together than just an annual meeting
5) Develop specific goals and action plan of regroup and sub groups so there's cleared direction
6) Expand these work groups
7) Have more breakout sessions so that people could focus on areas of interest
8) More structure to workshop meetings - specifically emergency managements - a lot was discussed no priorities or deliverables established
9) Need more disciplines specific time
10) Quarterly conference call s to report on progress
11) Smaller decision- making groups…. Many new people who wanted to start from scratch
12) We need a time (maybe as part of the pre - conf exercise for the technical it informatics and communications folks to work together and do real detail work
13) We need very specific tasks for these workshops - soon is not a time and some in not a #
14) Work needs to continue between meetings

Participants

1) Bring people from vanco to participate
2) Broaden audience to include more partners (emergency management, healthcare and law enforcement etc.
3) Change add new partners like vets - focuses - exercise - hot wash shake up - make sure it works
4) Fewer people that administer and more threat practices public health on the front lines more focus on specifics - mrsa, etc.
5) Invite- for 1 year as special guests emergency preparedness and response people - how do we (ph) work with em. It's time to learn to play with others in the sandbox instead of sticking to own corners and not sharing out toys
6) Make sure that there is representation from all relevant organizations (nee to be decision makers) and have commitment from all players to move forward on issues and gaps identified
7) Need state emergency manager's who must operational pnema
8) Need to involve all partners
9) Seems to be a bunch of folks who have been here the whole 5 years - invite new people who are not invested in eh meeting but in the goals. To much of a "click" feeling
10) Shake this up - bring in representatives of "non traditional" partners in the ph system

Product

1) At the end of the meeting have each individual attendee turn in their personal list of action items with deadlines that they will carry back to their agencies to complete in order to be prepared for 2010 and beyond - cement the commitment to have a lasting legacy
2) Additional development of MOA's and other concrete work products that reflect actual procedures
3) Better focus on specific areas - to achieve specific deliverables
4) Change - each year have a themes or focus - goals to be achieved - focus - communication skills
5) Change - not just talk, but participate in - focus - exercise processes and define processes - shake up- buying in by all through exercise roles /collaborations
6) Continue with what's done in 2008
7) Coordinator designated to facilitate follow- up with federal officials to obtain buy-in for state / provincial initiatives
8) Cross border orientations - surge support volunteer staffing
9) Defined governance work plans - outcomes
10) Defined questions to be answered by each session (e.g.- what is the role of the federal gov in cross border mutual aid?)
11) Find governance develop action items and follow up with completion dates
12) Focus - change - more accounts of actual cross border cooperative efforts (success and failures) be it us - canada or anther border
13) Formalize this into the cross border alliance
14) Get specific about how we will communicate

15) In my break out discussed" code" but in real crisis i feel simple clear language needed possible
16) Keep hearing the same thing alliance etc. What progress has been made?
17) Less talk and more action - reports should be summarized
18) Less talk and more action. A focus on actual project or product development with the workgroups. "definition of a cross border strategic plan" would be a great start
19) More products - deliverables
20) Need concrete actions for emergency management planning
21) Need definite deadlines to ensure that any proposed solutions or actions items get accomplished prior to 2010
22) Need to narrowly focus on arriving at specific products such as a protocol etc. That answers one (or more) of our identified issues or questions - we highlight but don't resolve
23) Products must be tangible - solutions , not recommendations
24) So far so good - keep it up - maybe show evidence of electronic systems of data sharing
25) Start with updates form this meeting

Relationships

1) Continuing to manage relationships between meetings - formalize the relationships
2) I wish i knew - we should look past 2010 for durable agreements and institutional relationships
3) Interoperability - standardization focus - working better together
4) Keep up networking

Other Comments

1) Special thanks to the organizers the did a great job. It was smoothly run
2) Dynamic planning committee

Appendix J

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