

2010 Summary Report

Pacific Northwest Border Health Alliance Seventh Annual Bi-National Cross Border Workshop: *“Public Health Collaboration: Global Challenges, Regional Solutions”*

May 4 – 6, 2010
Seattle, Washington

Alaska
British Columbia
Idaho
Oregon
Washington
Saskatchewan
Yukon



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May 4 – 6, 2010
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Electronic copies of this report are available on the Pacific NorthWest Border Health Alliance webpage (<http://www.pnwbha.org>). For further information, please contact info@pnwbha.org

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Acknowledgments

We of the Washington State Department of Health and the Pacific NorthWest Border Health Alliance wish to extend our sincerest appreciation to the bi-national 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 establish a seamless cross-jurisdictional public health system to 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 seventh annual cross border workshop in the Pacific Northwest.



Acknowledgments (continued)

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Report preparation – Information presented during plenary and workgroup breakout sessions that appears in this report was collected and assembled by the Washington State Department of Health’s team of facilitators – Laura Blaske, Larry Champine, Greg Nordlund and Cindy Marjamaa.

Electronic Copies of Workshop Materials

Electronic copies of this report are available on the Pacific NorthWest Border Health Alliance webpage (<http://www.pnwbha.org/>).

Pacific Northwest Border Health Alliance Seventh Annual Cross Border Workshop “Public Health Collaboration: Global Challenges, Regional Solutions”

Introduction

The Pacific NorthWest Border Health Alliance held its seventh annual bi-national cross border workshop in Seattle, Washington, held May 4-6, 2010. This year’s theme, “Public Health Collaboration: Global Challenges, Regional Solutions,” focused on continuing public health relationships through early warning infectious disease surveillance and mutual assistance and collaboration across borders.

The 2010 workshop brought together over 200 professionals from Canada (including Alberta, British Columbia, Saskatchewan, Yukon, and the Canadian Federal Government), Canadian First Nations’ and Aboriginal Health, Native American Tribes, and the United States (including Alaska, Idaho, Minnesota, Montana, Oregon, Washington, and the United States Federal Government), representing fields of epidemiology, public health laboratories, emergency management, emergency medical services, emergency response, communications and law.

New Attendees/Refresher Orientation

“Forging Ahead – Pacific NorthWest Border Health Alliance”

Wayne Dauphinee, Executive Director, Pacific NorthWest Border Health Alliance
Wayne Turnberg, PhD, MSPH, Washington State Department of Health

This session provided an overview of the history of public health collaboration between Canada and the United States in the Pacific Northwest region. Participants also learned about current Pacific NorthWest Border Health Alliance activities, as well as some of the accomplishments of previous Cross Border Workshops.

Wayne Dauphinee: *Forging Ahead*

Chronology

- 1991 - Pacific NorthWest Economic Region (PNWER)
Objective – To increase the economic well-being and quality of life for all citizens of the region; coordinate provincial and state policies throughout the region; identify and promote “models of success”; and to serve as a conduit to exchange information.
- 1996 – Western Regional Emergency Management Advisory Committee.
- 1996 – Pacific Northwest Emergency Management Arrangement (PNEMA)

Objective – To establish regionally based emergency preparedness response and recovery measure that will benefit all jurisdictions within the Pacific Northwest, and best serve their respective national interests in cooperative and coordinated emergency preparedness.

- 2002 – Ad Hoc Cross Border Public Health Preparedness Working Group
Objective – To establish an interjurisdictional collaborative approach to mitigate and respond to the public health impact of both routine disease outbreaks and catastrophic health emergencies across the Canada-United States border.
- 2004 – British Columbia-Alberta Mutual Operating Understanding (MOU).
- 2006 – British Columbia-Washington MOU.
- 2007 – PNEMA Operational Plan.
- 2008 – Pacific NorthWest Border Health Alliance (PNWBHA)
Objectives – To prevent and/or mitigate communicable disease outbreaks; to respond to surge capacity demands on health resources; to assess current—and explore future—areas of operational responsibility that could result in efficiencies.

Joint Coordination Committee

Membership includes:

- Co-chairs (Canadian and U.S. representatives)
- Signatory representatives (9)
- Working group leads

Working groups include:

- Emergency Management
- Epidemiology and Surveillance
- Public Health Laboratories
- Health Services
- Emergency Medical Services
- Legal
- Communication

Liaisons:

- Public Health Agency of Canada representative
- U.S. Public Health Service representative

Funding:

- No dedicated funding stream
- States/provinces/territories volunteer to cover respective costs

Wayne Turnberg: *Public Health Preparedness and Response Across Borders*

PNWBHA Members

United States

- Alaska
- Idaho
- Montana
- Oregon
- Washington

Canada

- Alberta
- British Columbia
- Saskatchewan
- Yukon

Other Regional Alliances

- Great Lakes Border Health Initiative
- Mid America Alliance
- U.S./Mexico Border Regions
- Eastern Border Health Initiative

Workgroup Meetings

This year, six cross border workgroups convened on May 4, 2010, to discuss status of projects, new issues and next steps. Following are reports on each session:

Epidemiology and Surveillance Workgroup

The workgroup identified the following accomplishments for 2009-2010:

- BC developed a website for posting surveillance information and health alerts.
- BC developed a template for surveillance reporting across jurisdictions during the 2010 Olympics and Paralympics.
- BC and Vancouver Coastal Health, with DOH and Washington counties, conducted a daily short conference call before, during and after the Games for surveillance reporting across jurisdictions.
- Used Sharepoint for surveillance data during the Olympics.
- BC integrated health emergency group—developed framework—will continue use and expand it to a greater region.
- Shared common information and added BC-CDC staff to EpiX.
- Shared common definitions for Emergency Department data.
- Added Washington staff to the Canadian CNPHI Alerting System.
- Finalized the formal Memorandum to Share and Protect Health Information to Assure Prompt and Effective Identification of Infectious Disease and Other Public Health's Threats.

Next steps:

- Develop an Operational Plan to implement the information sharing agreement. The plan will be based on the existing MOU and will include jurisdictions that are not on the border.
- Develop a procedure to describe how the information will be shared to include:
 - Permission from the infected person to share personal health information for contacts across jurisdictions.
 - Identifying list of variables that jurisdictions will share (i.e., name, address, contact information, disease, onset, lab confirmed, immunization status, contact information, disposition of person, etc.).
- Identify the approval process for procedure (who will sign?).
- Delineate the key elements that all signatories agree to share (examples of frequently needed data) but be sure to say it is not limited to the list.
 - Clearly define “personal protected information.”
 - Specify who determines whether sharing the data is necessary for public health.
 - Create a procedure for determining if something is relevant.
 - Includes data that will have an action attached to it.
 - Include a timeline for sharing information.
 - Collect data with the idea of reciprocity (a jurisdiction may need data that another jurisdiction doesn’t typically collect—for true reciprocity all jurisdictions should collect the same data).
 - Determine how data will be transferred in a secure way.
 - Spell out criteria for determining proof of immunity.
- Triggers for sharing information, conference calls, etc.
- Develop communication protocols across jurisdictions, Health Authority to province to state to county. The goal is to get to a place where not just neighboring counties and states can share PHI information.
 - Information needs to be shared with states or other provinces. The health authority can directly share the information, but they are to let BC-CDC know so that BC-CDC doesn’t duplicate the information. BC-CDC will pass the information on to the state level.
 - Information needs to be fed in parallel at the state/provincial level and county/health authority.
 - Whatcom has set up local communications plans with Fraser Health so that communications are a lot faster.
- Develop guidance so that investigators know they are allowed to share data.
- Review existing framework of the MOU for additional partners (Alaska, Montana, Alberta, Saskatchewan).
 - Determine how this needs to be modified.
- Determine a trigger for being involved in conference calls—may extend beyond outbreaks...whatever events might affect other jurisdictions.
- Update protocols for quarantine and isolation.
- Alaska will review the existing MOU Data Sharing framework to get lawyers to agree on existing format.
- Would like to extend the agreement to Montana, Alberta and Saskatchewan.

Public Health Laboratories Workgroup

Dr. Muhammad Morshed gave a BC-CDC public health lab update.

- Preparation for the Olympics and Paralympics took much time and effort:

- Supported surveillance for flu, Norovirus, food, water, enteric illness, unusual events—provided daily and weekly reports
- Expanded networking capabilities
- Acquired Mobile Emergency Response Team (MERT)—a mobile lab in a converted RV
- Little activity during event—one gastrointestinal outbreak involving 84 people
- Measles outbreak in BC caused some concern.
- The lab is piloting the use of Interferon-g Release Assays (IGRA) testing for tuberculosis among selected populations including certain immune-compromised persons and certain foreign-born or Aboriginal persons. The IGRA tests are considered more reliable than traditional skin tests. BC-CDC has arranged for the rapid transport of IGRA samples from several test sites to their lab.

Blaine Rhodes reported on the Washington Public Health Laboratories' (WAPHL) role in an incident involving production of Ricin in a private home. Police and firefighters who responded to the incident were concerned about their exposure to the toxin. WAPHL tested the urine of those in the home, as well as the responders. One occupant tested positive. However, the contaminated home was declared an EPA site, and during the cleanup extremely large numbers of samples were sent to monitor progress. Testing and chain of command for samples required a major commitment of time and space at the WAPHL. Blaine suggested that public health laboratories should establish very clear agreements in advance with the Environmental Protection Agency (EPA) or similar agencies to clarify testing responsibilities during site cleanups. Perhaps testing should be an EPA responsibility. The WAPHL developed a quick and inexpensive Ricin test, described in a handout that Blaine shared.

Neil Chin discussed his work on export and import permits for sending samples. He said a new Canadian act lists pathogens that can be brought into Canada. He has worked to extend the list to cover most common samples that might be sent from the U.S. to Canada for analysis. It includes the transport of samples for all entities represented in the workgroup and will be extended to Alberta and Saskatchewan in the future. Neil expects work on the expedited permitting process will be completed within one month.

Mary Anne Thomason described WAPHL's experience with introducing a centralized data management system called STARLIMS. WAPHL focused on adapting the system to collect H1N1 data. It was difficult to determine suitable fields especially given that requirements changed frequently during H1N1. The lab is assessing how quickly partners are able to get information from the system and pass it on to their partners.

The WAPHL is undertaking a new biomonitoring project to test people for trace amounts of arsenic in their urine. They are trying to create a baseline for Washington's population.

Teresa McGivern showed the group a secure area of Oregon's public health website that can be used to share Pacific NorthWest Border Health Alliance (PNWBHA) lab work group information such as lists of contacts, reports, notes, PowerPoints and other information.

A discussion of Oregon's new courier system followed. The system was created because hospitals are closing their micro labs, and shipping samples to the Oregon public health lab was taking too long. Now samples are delivered from anywhere in the state to the lab within one day. It is an expensive service but worth it. Couriers make routine pickups at all county health departments daily. The service is funded by fees, general fund and CDC grant money.

Troy Leader described his experience evaluating Philippine lab services during the H1N1 response. He said getting samples went well but reporting results was problematic. Their viral culture area was very small and they lacked sophisticated equipment but they were able to get a lot of work done through excellent work flow. They did an enormous amount of cross training. They were also well-prepared to expand their hours to meet increased demand. They did a lot of team building. The health lab is trying to bring Polymerase Chain Reaction (PCR) to larger regional sentinel sites and supporting them with training and proficiency testing.

H1N1 response: group discussion

- BC-CDC had to be careful about logging overtime due to cost. They did a lot of cross training and used an assembly line process to speed work (devised through a Rapid Process Improvement initiative).
- WAPHL concentrated on workflow and tried to get people who were good at a particular task to do that most often while being careful not to burn them out.
- BC-CDC worked 24/7 shifts. Alaska, Washington and Oregon staggered shifts but not 24/7.
- In both Canada and Washington, the groups tested and the types of results reported changed several times over the course of the H1N1 event.
- In Washington, logging in samples and reporting results were the biggest challenges. Washington found it worked better to have separate staff log in and test samples.
- In Washington, handling phone calls from the public was unexpectedly time-consuming.
- The Alaska, the virology lab was overloaded until the workload was distributed between Anchorage and Fairbanks.
- BC-CDC was able to continue all routine testing in addition to testing for H1N1.
- Oregon had to prioritize the tests it did. Fortunately, Norovirus activity was low and required less time and effort than expected.
- Washington transferred its whooping cough testing to King County.
- Dr. Gautom said the good relationship with Oregon labs established at this meeting helped when Washington needed its H1N1 testing validated and Oregon was able to perform the validation.

Tony Barkey, from the Association of Public Health Laboratories (APHL), said that cross border groups from the different regions such as this one and the group from the Great Lakes region should share best practices and model agreements to save effort and avoid duplication. Tony reported that some state labs struggled during H1N1, and pointed to Texas as an example. Texas had trouble meeting CDC testing requirements and was overwhelmed, in part, because they tested every sample. They hired temporary workers to try to keep up with demand.

Yolanda Houze said that messaging from the CDC to labs and to epidemiologists conflicted so that when epidemiologists followed CDC procedures for submitting samples, the samples were sometimes rejected by labs based on the conflicting rules they received from the CDC. Yolanda asked if APHL could help facilitate consistent messaging.

Washington, Idaho and Oregon MOU will be meshed with nearly completed BC and WA MOU. The way was paved by the larger PNEMA agreement which gave states and provinces the ability under federal law to make agreements in the area of emergency preparedness.

2010-2011 goals:

- Hold quarterly meetings, webinars, teleconferences and perhaps an additional regional lab call.
- Attempt to connect with other regional groups such as Great Lakes Border Alliance by sending representatives to each other's meetings. (Find funding source.)
- Explore lab to lab data sharing through PulseNet or other.
- Encourage full participation in this group by Alberta, Saskatchewan and Idaho.
- Establish chem and radiation program connections between BC and Washington.

Accomplishments

- BC-CDC added to LRN
- BC-Washington MOU
- Expedited permitting process for sample shipment across the border

Emergency Medical Responders Workgroup

Facilitator: Mike Smith, Washington State Department of Health, EMS Terrorism and Disaster Response Consultant

Smith provided a brief history and review of the 2009 workshop and the agenda items for the 2010 workshop. He facilitated the workshop and introduced each attendee.

Roland Webb, Superintendent, Emergency Management Office (EMO), BC Ambulance Service

Webb discussed BC Ambulance's preparation for the 2010 Olympics. To be ready for the huge amounts of people the Olympics venues were bringing into the city, British Columbia Ambulance Service (BCAS) was equipped with:

- 3500 employees and 450 ambulances.
- Three command centers with day-to-day communication.
- Other 2010 site resources including a media center and one mass casualty incident (MCI) center.

The Olympics brought many new challenges, such as:

- Protestors who were not happy about the Olympics coming to Vancouver.
- Large crowds in general.
- Athletes who were not typical EMS patients (outside normal scope of EMS).

Specifically for the 2010 Games, BC Ambulance joined with new and different partners:

- Health Canada
- Public Safety Canada
- Department of Foreign Affairs
- Royal Canadian Mounted Police (RCMP) Integrated Safety Unit
- Canadian Forces (large medical presence)
- Vancouver Olympic Committee (VANOC)

Additional resources included:

- Units deployed before security sweep.
- Units deployed to Urban Domain areas (“Urban Domain” refers to anywhere outside the venues).
- IPP (internationally protected people) details.
- Bike units.
- ATV units deployed to venues and Urban Domain.
- Critical care helicopter to Whistler.
- BC Ambulance emergency operation center activated.
- Regional Logistics Center established (a place to stock ambulances with supplies and “sweep” with mirror devices; also where staff could assemble equipment).
- Special EMD placed in Vancouver Dispatch.
- CBRN units staged/deployed throughout the region.
- Medical support units (mass casualty vehicles) added to region.
- Mass casualty management units created.
- 100 extra “pre-bought” ambulances (purchased during the last fiscal year, now being re-deployed into service).
- Mandatory accreditation tags for anyone entering the venues.

Webb said it was an overall successful integrated response between Vancouver’s police and fire departments and BC Ambulance.

Mike Webb, Manager, Telecommunications & Systems Emergency Management, BC

Webb talked about communications interoperability, which focuses on:

- Managing shared channels and projects.
- Facilitating regular interoperability working groups with “fair and service-neutral” governance.
- Coordinating cross border interoperability planning.
- Developing long-term provincial strategy for emergency communication systems.

Regional interoperability planning goals include:

- Coordinating discussion between public health agencies in the region.
- Conducting trainings and exercises.
- Collaborating on infrastructure development.

Vision for the future:

- Identify, coordinate, develop and approve guidelines for emergency plans.
- Replace ad hoc groups with groups that have formal structure (both provincial and regional/local).

Challenges lie in planning and coordinating resources, especially with a high-population area (southwest British Columbia) bordering on a low-population area (northwest Washington). Webb also acknowledged that the Olympics derailed progress a bit.

The next steps:

- Support an EMS agreement.
- Draft a work plan defining goals, outcomes and players.
- Inventory existing capabilities.

Alan Komenski, State Interoperability Executive Committee (SIEC) Project Manager/State Interoperability Coordinator, Washington State Patrol

Komenski provided a Washington State interoperability update. “Technology nowadays is the easy piece,” he said. “Governance is the challenge.”

However, Washington is making progress, mostly at the local level in the form of projects and grants. Current state projects include:

- State SCIP rewrite.
- Regional governance development.
- Policies and procedures workgroup.
- Communication Assets Survey and Mapping (CASM) project.
- Technical assistance projects.

Three projects enhancing interoperability along the border have been submitted by Washington State agencies. The challenge to these projects is that limitations on cross border frequencies hamper efforts.

Marina Zuetell, N7LSL, Specializing in Radio Communications for Health Care

Zuetell gave a brief update, mentioning the issue of redundant communication between hospitals. To streamline communication, they are standardizing equipment and replacing old equipment.

Peggi Shapiro, Washington State Hospital Association

Shapiro talked about how Washington’s hospitals have regional response plans. Two years ago the plan approach was changed—it is now an all-hazards plan. Each year the plan is reviewed and revised within the region. Last year, a cross border component was included in the All Hazards Plan that covers bordering states or British Columbia.

Next steps:

2010/11 Action Plan - Phase II

- Cross border interoperable communications.
- Temporary and cross credentialing.
- Mutual aid definitions template.
- Crosswalk health care template.
- Air ambulance.
- Remove unfamiliar acronyms – National Incident Management System (NIMS).

Emergency Managers Workgroup

Council of Health Emergency Management Directors (CHEMD) overview

Both Gerry Delorme, Manitoba Health, and Mike Harryman, Oregon Health, gave an overview of the state of emergency management, how we got here, and the past successes and coming challenges.

One challenge is improving communications nationally (local to regional to state/provincial to federal), as well as between neighboring states and provinces. This is why fostering the relationships between emergency management officials is important—not only to be able to understand each other's processes and protocols, but also to share ideas and recognize obstacles and overcome them before an emergency.

Washington State Radiological Program

Leo Wainhouse, Washington State Department of Health, and Herbert Antill, Health Canada, gave an overview of their radiation programs and talked about the cross border efforts between states and provinces. Wainhouse discussed the lessons learned from the TOPOFF2 radiation exercise in 2004, and how they generated an outreach effort to the state's neighbors that has resulted in a greater understanding of each other's programs and more participation during exercises.

Antill discussed Canada's radiation surveillance and response plans for the 2010 Winter Olympic Games in British Columbia—their preparation, the deployment of both fixed and mobile surveillance and their experiences during the Games.

Roundtable discussion of the 2010 Winter Olympics

Participants from British Columbia and the state of Washington discussed the experiences of the 2010 Winter Olympics in British Columbia and its preparations. The discussions included what lessons were learned from the Games; what worked and what didn't; what successes will be used on an ongoing basis; and the value of the exercises held prior to the Games.

Border Health Alliance Job/Project Sharing Proposal

John Lavery from the BC Ministry of Health Services discussed this proposal that would encourage job sharing, project sharing or job shadowing between different states and provinces. The value of such exchanges—both long- and short-term—could be to forge and strengthen relationships between partners, allow for peer review and provide new perspectives. The proposal received an enthusiastic reception.

Border Health Alliance Regional Exercise Proposal

In keeping with the spirit of the project sharing proposal, it was also suggested that the states and provinces begin testing some of the Alliance agreements and processes by establishing a series of exercises. Although in-person exercises have not been ruled out, the proposal concentrates on the use of exercise software that would allow a larger group from a broader set of disciplines to participate in these tests.

The PNW Border Health Alliance Strategic Plan

Wayne Dauphinee from the NW Border Health Alliance discussed the need to establish a strategic plan for the Alliance. The Alliance needs to begin to set goals and timelines, establish projects and designate people and groups to head initiatives—not just year by year, but year to year. A new Alliance website (<http://www.pnwbha.org>) has been created to pull together ideas, proposals and goals.

Communications Workgroup

Communications Workgroup Leads

- **Laura Blaske** – Washington State Department of Health
- **Jeff Rud** – British Columbia Ministry of Healthy Living and Sport

Communications Workgroup Participants

- **James Apa** – Public Health Seattle & King County
- **Richard Buck** – New York State Department of Health
- **Candy Cates** – Oregon Department of Human Services
- **Tim Church** – Washington State Department of Health
- **Larry Flynn** – Health Canada
- **Peter Houck, MD** – CDC Seattle Quarantine Station
- **Mike Howard** – DHS-FEMA Region X
- **Meredith Li-Vollmer** – Public Health Seattle & King County
- **Tara Melinkovich** – Northwest Center For Public Health Practice, University of Washington
- **Donn Moyer** – Washington State Department of Health
- **Shelley Owens** – Alaska Division of Public Health
- **Suzanne Pate** – Snohomish Health District
- **Missie Thurston** – Northwest Center For Public Health Practice, University of Washington

The Cross Border Communications Workgroup held an extensive session this year with a busy agenda of presentations and discussions. The main discussion focused on recent H1N1 communication activities including best practices and lessons learned.

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

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

Presentations

- Cross Border Communications Overview – Laura Blaske & Jeff Rud
- H1N1 Communications Strategies – Tim Church
- Public Engagement Project – Meredith Li-Vollmer
- Call Centers – Candy Cates
- Communication: Research We Can Use – Tara Melinkovich & Missie Thurston
- U.S. Federal Government Response Coordination – Mike Howard
- Quarantine Station – Dr. Peter Houck
- Communications and the Olympics – Jeff Rud
- Next Steps – Laura Blaske and Jeff Rud

Group discussions

- Social Media –
 - Role of social media in public health.
 - Sharing strategies, policies and guidelines.
- Special Needs Communities and Public Engagement –
 - Share best practices, research findings.
- Call Center Capacity –
 - Possible surge capacity issues.
 - Public will call numbers from other states/provinces; how can we share messages?
- Tribes/First Nations –
 - How can we better engage in developing collaborative communications strategies?
- Information sharing across borders –
 - Need to start up regular conference calls and information-sharing opportunities.

Next steps:

- Continue collaboration through ongoing Cross-Border Communications Workgroup sessions
 - Schedule series of regular calls on key issues with communications team members from Alberta, British Columbia, Yukon, Washington, Oregon, Idaho, Montana and North Dakota; invite other partners, federal representatives (Canada and US) as appropriate.
 - Establish electronic system for ongoing communication resource-sharing.
 - Continue work on developing protocols for assistance and coordination on critical public health issues.
 - 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 workgroup included participants from British Columbia, Washington, Oregon, Michigan and Idaho. Several important topics were discussed, including:

- Presentation of Olympic Peninsula LHJ-Tribal Mutual Aid Agreement and draft operating agreement (three public health jurisdictions and 10 tribes).
- New legal issues arising with H1N1.
- Impact of federal legislation regarding emergency workers and immunization.
- Legal logistics of how to broaden health information sharing agreement to other jurisdictions under PNEMA.

Plenary Session Summaries

Opening Remarks

Tribal welcome: The Honorable Cecil Hansen, Chairwoman of the Duwamish Tribe

Tribal blessing: Glen Pinkham of the Yakama Nation

Mary Selecky, Secretary of Health, Washington State Department of Health

Secretary Selecky talked about the public health system's experience with H1N1 in the past year—not only how “it brought incredible challenges and lessons learned,” but also how it built and strengthened relationships across the border.

She listed notable events of the past seven years since the first Cross Border Conference, beginning with SARS in 2004 and ending with the successful 2010 Olympic Games.

The annual conference is an excellent opportunity to exchange more information and ideas, but it's also an opportunity to ask the question “How can we do this better?”

Selecky stressed the need for adaptability. “We never know what the next emergency is going to be or when it's going to happen,” she said. “We need to continue to cement plans and procedures.”

Major General Timothy Lowenberg, Washington State Adjutant General

Lowenberg referred to the Cross Border Conference as “the catalyst for a remarkable exchange of information.”

Back in 2004, the upcoming 2010 Olympic Games brought “the sobering reality of security dimensions” to the forefront, prompting Gov. Gary Locke to start a Winter Olympics Task Force. The Cross Border Conference was another opportunity for the U.S. and Canada's bordering states and provinces to prepare for adaptive threats during the Olympics.

Lowenberg mentioned other ongoing preparedness issues—for example, chemical, radiological and biological threats from vessels going through the San Juan Islands—but emphasized how “iconic events” such as the Olympics really get people focused on planning and synchronizing.

Plenary #1: H1N1 – Mexico’s Experience

Isabel Vieitez, MD, Assistant and Advisor for H1N1, Deputy Minister of Health, Mexico

Dr. Vieitez thanked the Canadian and U.S. governments for their assistance to Mexico during the H1N1 pandemic. “Our collaboration was very important,” she said.

Mexico is a federation of 32 states with a population of 107 million. Because of Mexico’s decentralized health services, it was difficult to evaluate what was happening with H1N1; disease surveillance capabilities varied from state to state. Most cases were seen in Mexico City.

Chronology of events:

- April 14: A patient in Oaxaca died as a result of atypical pneumonia (reported as probable SARS)
- April 16: Epi alert for influenza-like illness (not certain of the virus)
- April 17: Government alarm about extended seasonal flu in mostly young patients
- April 20: Confirmation that the Oaxaca death was due to H1N1, not SARS
- April 23: First H1N1 cases appeared in U.S. (California)

The pandemic moved from the central part of the country (Mexico City) outward. Most patients were very young with atypical pneumonia, and most deaths occurred in people with metabolic disorders like obesity. Health care personnel were overwhelmed and working around the clock.

Mitigation efforts included social distancing measures like closing schools and limiting public gatherings. The initial vaccine strategy was to target health care workers, pregnant women and children ages 6-24 months.

During the pandemic, 30-35 million people were infected with the H1N1 virus, with an estimated 3,500-5,200 deaths.

It was a challenging situation everywhere—but particularly so in Chiapas, one of Mexico’s poorest states. Between June and August, hospital admissions for pneumonia increased by 500%. Hospitals relied on the federal government for stockpiles of medicine and supplies. The government also deployed health care workers from Mexico City to intensive care units in Chiapas. In time, they were able to improve their surveillance system, strengthen ICUs and decrease fatality rates by nearly half.

Lessons learned:

- The impact of H1N1 on Mexico’s economy was profound—tourism dropped by 60%, and it took six months to begin recovering. It was only in late spring 2010 that tourism rates started returning to normal levels.

- Epidemiological surveillance improved a lot after H1N1—at the start of the pandemic, there was a two-month gap between deaths and reporting of deaths.
- Laboratory capacity increased—labs are now processing 3,000 samples a day. (The CDC helped for months in the beginning.)
- Each state had its own vaccination strategy—some states did well, but overall not enough vaccine was available. Mexico City provided vaccinations more quickly than other places.
- Communicating with Mexico’s indigenous people was difficult because they speak 80 different languages, and much of the indigenous population is illiterate.
- Vaccination for health care workers needed to be mandated in the beginning.
- There was no way to evaluate whether social distancing made a difference, but with 20 million people in Mexico City, it was deemed worth the effort.

Secretary Selecky added that Mexico’s H1N1 experience demonstrates “how health events and security events are also economic events.”

Plenary #2: H1N1 – The States’ and Provinces’ Experience

Tony Marfin, Washington State Department of Health

Jay Butler, Alaska Native Tribal Health Consortium

Perry Kendall, British Columbia Provincial Health

Brendan E. Hanley, MD, Chief Medical Officer of Health for Yukon

Joe McLaughlin, Alaska Section of Epidemiology

The five speakers talked about the experiences in their states, provinces or jurisdictions during the H1N1 (swine flu) outbreak of 2009. The areas were diverse in population and language access, and the experiences also varied and were affected by national, state/provincial, tribal and local circumstances.

Overall, there were obstacles, successes and improvements to concentrate on before another outbreak. Among them:

- Need better communications between state/provincial and local governments and tribal/First Nation leadership.
- Planning ahead paid off in many respects; its value must be recognized and planning must be continued.
- Differences between urban and rural or isolated communities must be factored into planning.
- The experiences of vaccine and antiviral delivery and access need to be adjusted based on lessons learned during H1N1.
- Some processes established for H1N1 might be improvements on how we respond to seasonal flu.
- Build on lessons learned in surveillance and laboratory testing.
- Monitoring critical care facilities and bed availability are crucial and will be more so during a more severe event.
- Continue planning and perfecting communications with health care facilities, doctors and pharmacies.
- Continue to build on relationships with local organizations, support agencies and, especially, schools.

Luncheon Speaker: Haiti's Disaster – Past, Present and Future

Moderator: Jack Thompson, MSW, Northwest Center for Public Health Practice, Senior Lecturer, Department of Health Service, University of Washington

Captain Andrew Stevermer, Health Emergency Preparedness Liaison Officer, Public Health Agency of Canada, Centre for Emergency Preparedness and Response

Capt. Stevermer discussed his experiences while serving as the commander of the incident response coordination team delivering medical support in Haiti following the devastating 2010 earthquake.

He talked about the monumental obstacles that Haitians and relief workers faced, including lack of food, lack of emergency planning, abject poverty of Haitians, increased security, lack of transportation, the tremendous loss of infrastructure—especially the hospitals and developing new processes and protocols to fit the situation. But he credited the resiliency of the Haitian people to overcome these and more challenges, in the months and years ahead.

Capt. Stevermer showed a short film detailing the great magnitude of the disaster and the efforts of the Department of Health and Human Services during the Haitian response.

Plenary #3: H1N1 Preparedness Activities with the First Nations in British Columbia

Moderator: Sally Abbott, ANP, Preparedness Program Director, Alaska Department of Social and Health Services

Evan Adams, MD, MPH, Aboriginal Health Physician Advisor, Office of the Provincial Health Officer, Ministry of Health Living & Support

There are 203 First Nation villages in Canada, most in remote areas. They are very diverse but are attempting to unify around certain issues including public health and health care. Each village is responsible for administering and paying for its own public health and health care programs. A 2005 accord between the first Nations Leadership Council, BC and Canada brought provincial and national access to First Nations through their chiefs.

Surveillance was already in place for H1N1 through Health Canada's First Nations and Inuit Health Branch. Early on, surveillance discovered clusters of H1N1 in Manitoba and some other first Nations villages. Among First Nations, the disease followed the epidemiological curve of the general population but was four times more prevalent.

H1N1 was countered with a program that vaccinated 80 percent of those living on reserves.

The First Nations formed an H1N1 Working Group that:

- Decided which communities got stockpiles of antivirals—based largely on their remoteness.
- Worked with the First Nations Health Council on communications to reassure the population.
- Improved diagnostic capabilities of remote nurses.
- Increased doctor and nurse coverage for villages.
- Determined vaccine distribution priorities.

Many in the First Nations found that the H1N1 response streamlined a complicated health system and would like to see that new efficiency carried forward.

Plenary #4: North Dakota and Manitoba – Cross Border Flood Response Experience

Moderator: Sally Abbott, ANP, Preparedness Program Director, Alaska Department of Social and Health Services

Juli Sickler, Division Director, Emergency Preparedness and Response, Public Health Preparedness Division, North Dakota Department of Health

In January 2009, heavy snowfall and ground saturation led to concern that the Red River would flood. Public health, hospitals and emergency management began planning. They began by using Survey Monkey to determine how many ambulances would be available for surge and where they were located, and created evacuation plans for nursing homes and other facilities located on the river.

The North Dakota Department of Health had a 24/7 EOC in operation throughout. During the event nursing homes were evacuated, and homes in several areas were evacuated as well—thousands of people. Most evacuees went to federal (HHS) medical shelters.

The response lasted about one month, from early March to early April.

During the response, North Dakota made an urgent call to Manitoba requesting assistance. They asked for “everything you’ve got.” There was no existing agreement between the state and the province, and North Dakota made it clear that they had no means to reimburse Manitoba for whatever help it might provide.

Gerry Delorme, Director, Office of Disaster Management, Manitoba Health

At the time North Dakota made its request, Manitoba’s EOC was already in operation, because the Red River flows north into Canada and Manitoba expected to experience flooding after North Dakota. They were already preparing. When the request came, Gerry made a few requests up the chain of command and was cleared to proceed. Overnight his group rounded up a number of ambulances, crews and medical supplies. At the same time they made decisions

about credentialing, liability, and border crossing. They agreed to take the chance that their efforts would be received in good faith, and that if there were legal consequences, they would deal with them as they occurred.

A day later with some crews and supplies already en route, the request was canceled, but Manitoba had managed to put together a rapid response.

Manitoba and North Dakota now plan to work out an MOU based on the Northwest EMS agreement that will facilitate any future response.

Plenary #5: The 2010 Olympics/Paralympics Health Perspective

Moderator: John Lavery, Executive Director, Emergency Management Branch, British Columbia Ministry of Health

Patricia Daly, MD, FRCPC, Chief Medical Health Officer, Vancouver Coastal Health, British Columbia

The public health duties for the events fell within one health jurisdiction, Vancouver Coastal Health (VCH). Action was guided by an agreement with VANOC that detailed responsibilities.

VCH monitored gastrointestinal illness, respiratory illness, imported communicable diseases and injuries.

Gastrointestinal: VCH worked with hotels and other facilities to promote handwashing and other preventive practices. The Norovirus season was milder than most years. There was one outbreak of gastrointestinal illness in a workers' temporary housing unit, possibly because the facility was given an exemption allowing less space between workers.

Respiratory: Flu was the big worry going into the Games but never developed. Workers were vaccinated against seasonal flu and H1N1 in advance, but very few athletes were vaccinated. BC has a good sentinel system and several types of data are collected, including ER data and claims from physicians (under Canada's single payer system, every service billed includes an illness or injury code).

Communicable diseases: None reported during the Games.

Injuries: There was an increase in alcohol-related injuries, assaults and automobile accidents, mostly due to crowds in downtown Vancouver. However, the impact on the public health system was not significant.

VCH also monitored air quality and water quality, inspected food facilities and conducted educational campaigns related to HIV/AIDS prevention and smoking reduction. Smoking was banned in city parks during the Games, and that will continue now that they have concluded.

VCH produced 17 regular "Health Watch" newsletters prior to the Games. They were released daily during the Games.

Rumor control was important as exemplified with constant misperceptions about a cruise ship used for game housing. Problems falsely reported by the media included an STI outbreak, bedbugs, rashes, scabies and a sewage spill.

Mike Sanderson, MHS, Executive Director, Lower Mainland, British Columbia Ambulance Service

The objectives of the British Columbia Ambulance Service were to provide service to the Games while maintaining the level of public service, develop new relationships (particularly with VANOC), and avoid negative publicity (an issue due to a protracted labor dispute prior to Games).

Historically, Olympic Games have not resulted in significantly increased demand for ambulance services and that was the case this time, but they were prepared. The Regional Emergency Operations Centre operated 24/7 and provided a point of contact as well as a decision-making body.

Crowds downtown made it almost impossible for ambulances to operate there at some times. However, response times for the Olympics were not much different than for any other time of year.

Marcus Deyerin, MA, Emergency Response Program Specialist, Whatcom County Health Department, Washington State

Marcus outlined the challenges and concerns for Whatcom County, located across the border from BC, related to the Olympics. Challenges included coordinating with others, marshalling resources and getting a seat at the planning table. Concerns included determining how many visitors would pass through and deciding how to cope with the many different possible public health threats from flu to terrorist attack.

Marcus discussed the importance of working hard to build relationships and to bring public health's perspective to partners. One distinguishing characteristic of public health emergencies is that they last longer.

Whatcom County was involved in numerous planning sessions and exercises between August 2008 and January 2010, concluding with a functional exercise that was put together in only three weeks in December 2009.

Flu was the wild card that was thrown into the deck at the end of 2009 and added a layer of planning and activity.

Marcus stated that public health emergency staff need to become more conversant with the Incident Command System. It is a standard for all other emergency planning partners. He also stressed the importance of exercising. "Amateurs do something until they get it right. Professionals do a thing until they can't get it wrong."

Innovation and Initiatives Panel

Welcome and Opening Remarks

Mary Selecky, Susan Johnson, Sylvie Bérubé

Moderator: Wayne Turnberg, PhD, MSPH, Washington State Department of Health

Mike Harryman, Preparedness Director, Public Health Emergency Preparedness, State of Oregon

The Lane County Oregon Preparedness Mentoring Demonstration Project was created to assist community-based organizations that serve the homeless. In March 2008, Lane County received a \$197,000 CDC grant to study their homeless population. On any given night, the county has about 2,000 homeless people on the street or in shelters. The goal of the project wasn't to get the homeless off the street—it was to help preparedness organizations reach this population.

The project focused on 100 community-based organizations that serve the most vulnerable citizens. Among other accomplishments, all the participating organizations developed:

- Plans to communicate with clientele.
- Plans to sustain essential functions during and after an emergency.
- A description of the organizational emergency operations structure.
- An identified single point of contact for public health emergency messages and alerts.

Those involved were excited about this project, Harryman said. The project showed the value of positive messaging and “starting where people are” to integrate emergency preparedness into regular planning and work practices. It also highlighted the importance of building relationships between local government and community-based organizations. The result was successful communication with the homeless population and increased resiliency of community-based organizations.

Sally Abbott, ANP, Preparedness Program Director, Alaska Department of Social and Health Services

Abbott's presentation focused on two H1N1-related situations in Alaska: (1) Little Diomed Island and (2) the cruise industry.

Little Diomed Island

Little Diomed Island (pop. 128) lies off the remote western coast of Alaska. Transporting passengers and patients from the island to the mainland during the H1N1 pandemic was a huge problem. On Nov. 14, 2009, a medevac request was made to the Alaska Air Guard to transport patients. It was carried out as a training mission; however, the Guard can't conduct continuous training missions, so an official medevac request was necessary.

Vaccine doses also had to be redirected to reach the residents of Little Diomed. “Clearly this was a real medical need,” Abbott said. All but four people on the island were vaccinated. Pan flu funds were used to pay for that need. “We looked at that as a very creative solution,” she added.

The cruise industry

Cruise ships bring one million visitors to Alaska each year, which can mean up to 10 times more people in a community on a given day. To illustrate how a port city's hospital(s) could be overwhelmed by a cruise ship filled with sick passengers, Abbott noted that:

- Juneau has one 71-bed hospital.
- Sitka has two hospitals with a total of 40 beds.
- Skagway has no hospital.

The state's preparedness program worked closely with the cruise industry to determine what to do in case of passengers with the flu. They learned the cruise lines had solid plans in place to care for sick people—ships had doctors and nurses aboard, access to Tamiflu and rapid test kits, and quarantine plans.

“The big cruise lines did an excellent job of taking care of their passengers,” Abbott said.

Communication with the port cities was vital. The main purpose of these conference calls was to decrease panic and rumors. “Clearly we were all partners—it was incredibly collaborative,” she said.

Marisa D'Angeli, MD, MPH, Washington State Department of Health

Using Sentinel Surveillance to Rapidly Assess Critical Care Capacity During Fall 2009 H1N1 Influenza Pandemic, Washington

Challenges

- Emergency was widespread so couldn't count on ability to “borrow” from unaffected regions.
- Decentralized U.S. and state system made getting information difficult on critical care resources such as ventilator and ICU bed usage.

Critical Care Capacity Project

- Project goal is to obtain real-time data on critical care resource utilization during pandemic.
- Our goal was to obtain daily information.
- No existing data source is timely; several organizations and agencies tried to obtain similar information and some local health jurisdictions are making plans for collecting timely hospital resource usage data.
- Partnership between the Washington State Hospital Association and the Washington State Department of Health.
- Recruited hospitals with intensive care units from all nine Public Health Emergency Preparedness and Response regions in Washington State.
- Daily entry of 6 data elements including:
 - Number of critical care beds and ventilators available.
 - Number in use.
 - Number used for severe acute respiratory infection.
 - Data compared to influenza-associated deaths and critical care hospitalizations reported in Public Health Information Management System (PHIMS).

Conclusions

- Sentinel critical care resource system was:
 - Rapidly implemented.
 - Required little training.
 - Provided real-time.
 - High correlation with PHIMS validated sentinel system.

Project acknowledgments

- Ken Rudberg, Washington State Hospital Association
- Carol Wagner, Washington State Hospital Association
- Anthony Marfin, Washington State Department of Health
- Wayne Turnberg, Washington State Department of Health
- Tracy Sandifer, Washington State Department of Health
- Natasha Close, Washington State Department of Health

More information

[Using Sentinel Surveillance to Rapidly Assess Critical Care Capacity During Fall 2009 H1N1 Influenza Pandemic](#)

Community Resiliency

Moderator: Wayne Dauphinee, Executive Director, Pacific NorthWest Border Health Alliance

Capt. Julie Sadovich, PhD, Community Resilience Program Manager, Office of Health Affairs, U.S. Department of Homeland Security

Community Resiliency at the Nexus of Health and Security

Sadovich's presentation focused on the gap between health and security and how it affects community resilience in times of emergency.

She defined "resilience" as a community's (or region's) ability to prepare for, respond to, and recover from disasters. "Recovery" in this context includes a community's ability to:

- Return citizens to work.
- Minimize disruption to life and economies.
- Reopen schools and businesses.
- Prevent and mitigate cascading failures.

A whole host of systems comes into play when businesses, health care organizations and local government start working together in this capacity. There are often conflicting desires that need to be ironed out, as well as legal issues that arise.

She discussed the link between national and community efforts in building community resilience, and how to promote seamless transitions between levels of government and the private sector.

As a fairly new entity, the Office of Health Affairs presents an opportunity to “do things in an open way, getting input and not creating barriers” between disparate groups working toward a common goal, she said.

Sadovich concluded with descriptions of two current community resilience initiatives, one in Seattle and the other in Memphis. The Office of Health Affairs is partnering with existing community initiatives to bridge the health and security gap, and the resulting products will be transferable to other communities.

Paula Scalingi, PhD, Director, Pacific Northwest Center for Regional Disaster Resilience

Developing a Holistic Strategy to Achieve Community Health Resilience

Dr. Scalingi talked about the Comprehensive Community Bio-Event Resilience (CCBER) Pilot Project in the Puget Sound region. The goal of the project is to help develop holistic health resilience guidelines to integrate the private sector, nonprofits and public institutions into preparedness planning for major public health hazards. The project will serve as a model for communities nationwide.

The pilot project takes an all-hazards approach looking at major events and their impact on health. At the project kick-off workshop in June 2009, stakeholders identified four top priority concerns:

1. Communications.
2. Public information, education and awareness.
3. Business continuity and workplace issues, including liability concerns.
4. Planning challenges and public health care issues.

During a workshop in October 2009, participants identified solutions to these concerns and developed a template or “roadmap” that considered the importance of gap analysis. A survey of stakeholders in the Puget Sound region showed there are huge issues around disaster recovery in several areas, including (but not limited to) vaccine distribution and business continuity.

Preliminary findings from the workshops, plus a tabletop exercise held in March 2010, showed that public health officials have made major strides in addressing both H1N1 challenges and preparedness planning associated with potential flooding from the Howard Hanson Dam. However, cultural and operational challenges arise when incorporating local and federal level responses. There needs to be a unified command structure for “whole recovery restoration” to create the decision-making process and to determine who needs to be involved.

Based on these findings, selected recommendations include:

- Developing best practices to address all-hazards.
- Local government conducting outreach to area businesses and other organizations.
- Holding a workshop that brings together private sector organizations with local, state and FEMA officials.
- Developing a Green River Valley flood recovery management structure for information sharing and decision making.

- Improving alerts/warnings, communication and two-way information sharing on health resilience that identifies what needs to be conveyed, and how it will be coordinated and disseminated, ideally from a central focal point.
- Researching and testing the impacts of increased bandwidth and possibly compromised IT infrastructure.
- Undertaking a Public Information and Training Gap Analysis that creates an inventory of current outreach and exercise activities and identifies how well these activities are addressing health resilience challenges.
- Assessing the health, safety and economic consequences of impacts to critical infrastructures and key resources in the Green River Valley.
- Exploring ways to expand FEMA and other governmental assistance programs.

World Café

The **World Café** is designed as an informal opportunity for agencies and organizations to highlight their public health/resiliency programs, as well as being a great networking opportunity for Cross Border participants. Exhibits are intended as an educational/awareness opportunity, rather than a vendor-based forum. Refreshments and appetizers are served.

This year's World Café poster presentation was intended to provide individual attendees an opportunity to showcase a particular project or program without having to tackle a formal presentation. Final selections were based on innovation, workshop theme, topic relevance, diversity and their visually appealing and educational nature.

Presenters included:

Susan Allen
Northwest Center for Public Health Practice, University of Washington

Poster title: *The Northwest Preparedness & Emergency Response Research Center (NWPERRC)*

Abstract: NWPERRC is gathering information that will assist public health departments and organizations in developing and improving emergency communication strategies. The H1N1 pilot studies also provided valuable research for public health, currently and in the future.

Neil Chin
BC Public Health Microbiology & Reference Laboratory

Poster title: *Public Health Laboratory Planning for the Vancouver 2010 Winter Games*

Abstract: Public health events were very minor in the context of the overall health impact of the Games however they resulted in enhanced networks and improved communication links with key clients and partners; improved lab capacity particularly for BT agent testing; and, promoted much collaboration among the laboratory team.

Wayne Dauphinee
BC Ministry of Health Service

Poster title: *Contingency Response Medical Material Initiative*

Abstract: To describe a joint federal-provincial initiative to meet IOC requirement for to maintain pre-positioned contingency medical materiel caches throughout the operational area during the 2010 Olympic and Paralympic Winter Games.

Tricia L. Franklin
Alaska State Public Health Laboratory

Poster title: *Universal Biological and Chemical Agent Environmental Sampling Kits for First Responders in Alaska*

Abstract: To describe a project to develop a field sampling protocol and universal collection kit for use by hazardous material (HAZMAT) first responders, when collecting samples for biological and chemical terrorism agent testing by the Alaska State Public Health Laboratory (ASPHL).

Mike Harryman
Oregon Public Health Division

Poster title: *CHEMPACK Cross-Border Agreement and Exercise*

Abstract: To describe a cross-border memorandum of understanding (Oregon, California and Nevada) to share Chempack assets if needed for emergency response. A cross-border exercise drill was conducted. The training Chempack container was dispatched from Brookings and arrived on scene in Crescent City, California within 30 minutes.

Teresa McGivern
Oregon State Public Health Laboratory

Poster title: *Response to the Need for Urgent Transport of Clinical Laboratory Biothreat and Pandemic Influenza Specimens to Oregon State Public Health Laboratory (OSPHL)*

Abstract: Issue - urgent transport of clinical specimens of potential public health significance needed statewide, but challenging to achieve.

Challenges - 35 local jurisdictions; 97,000 sq. miles; cost.

Results - Planning gaps involving roles and responsibilities for urgent transport were determined, and statewide courier service implemented 9-2010.

Susanne Mackinnon
BC Provincial Health Services Authority

Poster title: *Integration of health – Getting it right the first time!*

Abstract: To define an optimal working relationship between Emergency Social Services (ESS) and health providers to meet the needs of the public during emergencies.

Emily Nixon
BC Ministry of Health Services

Poster title: *Understanding Personal Preparedness and Risk Perception to Storm Surge Events at High Tide in the Community of Oak Bay, BC*

Abstract: With more than 255 waterfront properties in the community of Oak Bay, BC, storm surge at high tide is a hazard that many citizens may face. Through a better understanding of this hazard and awareness of personal preparedness, this research aims to enhance community preparedness activities and understand how risk is perceived.

Carey Palm
Oregon Public Health Preparedness

Poster title: *Public Health Emergency Preparedness and Geographic Information Systems (GIS)*

Abstract: Describes GIS tools designed for Tribal and Local Health Departments and Emergency Managers to aid in planning for natural and technological risks in the community.

Barbara Progulske
Oregon Public Health Division

Poster title: *New Tools for Epidemiology & Surveillance*

Abstract: To provide an overview of the surveillance tools developed and used by the Preparedness Surveillance & Epidemiology Team (PSET) and the Acute & Communicable Disease Program (ACDP) at the Oregon Public Health Division.

Therese Quinn
Snohomish Health District, Washington State

Poster title: *Diversity & Inclusion in Emergency Planning*

Abstract: This poster will illustrate the Language Cadre, which was developed between the Snohomish Health District and the Snohomish County Department of Emergency Management to ensure that all of Snohomish County is served in a disaster.

Barbara Smith
State of Alaska, Section of Epidemiology

Poster title: *Use of a Commercial Off-the-shelf Program for Enhanced Hospital Influenza Surveillance during the 2009 H1N1 Pandemic-Alaska, September 7, 2009-March 6, 2010*

Abstract: To describe the use of an off the shelf web-based tool to collect weekly influenza hospitalization and death data from 25 hospitals in Alaska.

Frank James
San Juan County, Washington State

Poster title: *School Based Disease Reporting in Influenza with public health nursing follow-up of reported cases*

Abstract: San Juan County required electronic, named, real time reporting of all students absent from school for ILI symptoms during the recent pandemic. Public Health Nurses then followed up with each family with information on at home care for the student, information on when to seek medical care and when the student would be able to return to school. San Juan had one hospitalization (in a 14 month old child with underlying pulmonary disease) and no deaths in the outbreak.

Laura Blaske
Washington State Department of Health

Poster title: *Lines of Communication: Planning vs. Reality During H1N1*

Abstract: The poster illustrates outreach capacity during the H1N1 event. It shows the complex network of internal and external partners and how emergency planning fared in the face of a real emergency.

Appendices

Appendix A - Workshop Agenda

Appendix B - Speaker Biographies

Appendix C - Workshop Evaluation

Appendix D - List of Registered Participants

Appendix A

Workshop Agenda

Pacific NorthWest Border Health Alliance
Seventh Annual Pacific NorthWest Cross Border Workshop
Public Health Collaboration: Global Challenges, Regional Solutions
Seattle, Washington
May 4-6, 2010

Day 1 Tuesday, May 4, 2010 Orientation/Workgroups

9:00-5:00 Registration

10:30-11:30 New Attendees/Refresher Orientation Session

A summary of previous years' workshops, our cross border collaboration work history, and refresher option.

- Wayne Turnberg, PhD, MSPH, Program Manager, Epidemiology Preparedness and Response, Washington State Department of Health
- Wayne Dauphinee, MHA, Executive Director, Pacific NorthWest Border Health Alliance

11:30-1:00 Lunch on Your Own

1:00-5:00 Workgroup Breakout Sessions

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

5:00 Dinner on Your Own

*5:00-7:00 Pacific NorthWest Border Health Alliance (PNWBHA)
Joint Coordination Committee (JCC) Business Meeting – by invitation only*

Day 2
Wednesday, May 5, 2010
Workshop Plenary Session

7:00-8:00 Registration/Continental Breakfast

8:00 – 9:15

Opening Remarks

- John Erickson, Special Assistant, Public Health Emergency Preparedness and Response, Washington State Department of Health

Tribal Welcome and Blessing

- Welcome: The Honorable Cecile Hansen, Chairwoman of the Duwamish Tribe
- Blessing: Glen Pinkham, Yakama Nation

Welcome

- Mary Selecky, Secretary, Washington State Department of Health
- Major General Timothy J. Lowenberg, Washington State Adjutant General

9:15-10:00

Keynote Speaker

H1N1 - Mexico's Experience

Moderator: Mary Selecky, Secretary, Washington State Department of Health

- Isabel Vieitez, MD, Assistant and Advisor for H1N1, Deputy Ministry of Health, Mexico

10:00 -10:15 Networking Break

10:15–12:00 H1N1 - The States' and Provinces' Experiences

Moderator: Patrick O'Carroll, MD, Regional Health Administrator, US Department of Health and Human Services, Region X

- Tony Marfin, MD, Communicable Disease Epidemiologist, WA State Department of Health
- Jay Butler, MD, Senior Director, Division of Community Health Services, Alaska Native Tribal Health Consortium, Anchorage, Alaska
- Perry Kendall, MD, OBC, FRCPC, Provincial Health Officer, British Columbia
- Brendan E. Hanley, MD, Chief Medical Officer of Health for Yukon
- Joe McLaughlin, MD, MPH, Alaska Department of Health, Epidemiologist

- Participants Experiences and Question & Answers

12:00-1:15

Luncheon Speaker

Haiti's Disaster: Past, Present and Future

Moderator: Jack Thompson, MSW, Northwest Center for Public Health Practice, Senior Lecturer, Department of Health Services, University of Washington

- Captain Andrew Stevermer, Health Emergency Preparedness Liaison Officer, Public Health Agency of Canada, Centre for Emergency Preparedness and Response

1:15-1:30 Networking Break

1:30-2:05

H1N1 Preparedness Activities with First Nations in British Columbia

Moderator: Sally Abbott, ANP, Preparedness Program Director, Alaska Department of Social and Health Services

- Evan Adams, MD, MPH, Aboriginal Health Physician Advisor, Office of the Provincial Health Officer, Ministry of Health Living & Support

2:05-3:00

North Dakota and Manitoba: Cross Border Flood Response Experience

Moderator: Sally Abbott, ANP, Preparedness Program Director, Alaska Department of Social and Health Services

- Juli Sickler, Division Director, Emergency Preparedness and Response, Public Health Preparedness Division, North Dakota Department of Health
- Gerry Delorme, Director, Office of Disaster Management, Manitoba Health

3:00-3:10 Networking Break

3:10-4:30

The 2010 Olympics/Para-Olympics Health Perspective

Moderator: John Lavery, Executive Director, Emergency Management Branch, British Columbia Ministry of Health

- Patricia Daly, MD, FRCPC, Chief Medical Health Officer, Vancouver Coastal Health, British Columbia
- Mike Sanderson, MHS, Executive Director, Lower Mainland, British Columbia Ambulance Service
- Marcus Deyerin, MA, Emergency Response Program Specialist, Whatcom County Health Department, Washington State

4:30 –6:30

World Café – Posters Presentations & Networking Opportunities

- *The **World Café** is designed as an informal opportunity for agencies and organizations to highlight their public health/resiliency programs as well as being a great networking opportunity for Cross Border participants. Exhibits are intended as an educational/awareness opportunity, rather than a vendor-based forum. Refreshments and appetizers served.*

6:30 Dinner on your own

6:00-7:00 – US Department of Health and Human Services, Region X, Meeting – by invitation only

Day 3
Thursday, May 6, 2010
Workshop Plenary Session

7:00-8:00 Registration/Continental Breakfast

8:00-8:15

Welcome and Opening Remarks

- Mary Selecky, Secretary, Washington State Department of Health
- Susan Johnson, Regional Director, US Department of Health and Human Services
- Sylvie Bérubé, EMBA, Regional Director, British Columbia/Yukon Region, Public Health Agency of Canada

8:15-9:15

Innovation and Initiatives Panel

Moderator: Wayne Turnberg, PhD, MSPH, Program Manager, Epidemiology Preparedness and Response, Washington State Department of Health

- Mike Harryman, Preparedness Director, Public Health Emergency Preparedness, Public Health Divisions State of Oregon
- Sally Abbott, Preparedness Program Director, Alaska Department of Social and Health Services
- Marisa D'Angeli, MD, MPH, Medical Epidemiologist, Washington State Department of Health, Communicable Disease Epidemiology

9: 15-10:00

Community Resiliency

Moderator: Wayne Dauphinee, MHA, Executive Director, Pacific NorthWest Border Health Alliance

- Juliana M. Sadovich, RN, PhD, Associate Director for Global Health Security, Office of International Affairs and Global Health Security, Office of Health Affairs, U.S. Department of Homeland Security
- Paula Scalingi, PhD, Director, Pacific Northwest Economic Region (PNWER) Center for Regional Disaster Resilience and lead for the Comprehensive Community Bio-Event Resiliency (CCBER) Project

10:00-10:15 Break

10:15-11:15

Reports from the Workgroups

*Moderator: Mike Harryman, Preparedness Director, Public Health Emergency Preparedness,
Public
Health Divisions State of Oregon*

- 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

11:15-12:15 pm

Next Steps: What Does the Future Hold?

- John Erickson, Special Assistant, Public Health Emergency Preparedness and Response
- John Lavery, Executive Director, Emergency Management Branch, BC Ministry of Health
- Wayne Dauphinee, MHP, Executive Director, Pacific NorthWest Border Health Alliance
- Mary Selecky, Secretary, Washington State Department of Health

12:15 Workshop Ends

- Boxed Lunch – (Boxed lunches will be available at 10:30)

Appendix B

Speaker Biographies

(in alphabetical order)

Sally Abbott
Public Health Preparedness Director
State of Alaska

Sally has been a nurse for over 25 years and has worked in hospitals, home care, hospice, schools and industry. She's worked in Alaska Department of Health and Social Services for 5 years on healthcare disaster and emergency preparedness.

She is now the Director of Public Health Preparedness for the State of Alaska and Section Chief for EMS and Trauma. She's worked with many agencies and partners on pandemic influenza planning and response. During the Spring of 2009 DHSS responded to severe flooding along the Yukon River in Interior and Western Alaska.

Evan Adams, MD, MPH
Aboriginal Health Physician Advisor
Ministry of Healthy Living & Sport
British Columbia

Evan Adams is a physician from the Sliammon Band near Powell River, BC Canada. Dr. Adams completed 3 years of pre-med studies at the University of British Columbia (UBC), a Medical Doctorate from the University of Calgary in 2002, and a Family Practice residency (as Chief Resident) in the Aboriginal Family Practice program at St. Paul's Hospital in Vancouver, BC.

Dr. Adams is the 2005 winner of the (provincial) Family Medicine Resident Leadership Award from the College of Family Physicians of Canada (CFPC), and the 2005 national winner of the Murray Stalker Award from the CFPC Research and Education Foundation. He is the past President of the Indigenous Physicians Association of Canada and is currently the Director of the Division of Aboriginal Peoples' Health, UBC Department of Family Practice.

Sylvie Bérubé, EMBA
Regional Director
British Columbia - Yukon Region
Public Health Agency of Canada

Sylvie Bérubé has over 20 years of public sector experience both in Ottawa and in Vancouver with most of her career within the health portfolio. She holds an MBA from Simon Fraser University (2002) and a BA with Distinction in Sociology from Carleton University (1996).

Ms. Bérubé held a series of positions in Health Canada from 1987 to 2004, where she played a variety of roles of increasing seniority addressing strategic planning, policy analysis, managing community-based programs, conducting evaluations and developing frameworks and agreements addressing

public health issues involving three levels of governments. In October 2006, she was appointed the Regional Director, BC/Yukon Region, for the Public Health Agency of Canada.

From April 2004 to October 2006, Ms. Bérubé was the Executive Director of the Pacific Federal Council. As of April 2007, Sylvie is serving as the Pacific Federal Council's Official Languages Champion.

Ms. Bérubé volunteers on the Vancouver chapter of the Institute of Public Administration of Canada which provides a way to influence broader public administration initiatives that transcend jurisdictions.

Jay Butler, MD
Senior Director
Division of Community Health Services
Alaska Native Tribal Health Consortium

Jay Butler, MD, FAAP, FACP is the Senior Director for the division of the Community Health Services. Dr. Butler joined the Centers for Disease Control and Prevention (CDC) National Center for Preparedness, Detection and Control of Infectious Diseases (NCPDCID) Division of Emerging Infections and Surveillance Services (DEISS) in June 2009 as a Program Director to assist with the nation's response to the H1N1 virus (swine flu) outbreak.

Before returning to the Centers for Disease Control and Prevention in Atlanta, Georgia, he served as Chief Medical Officer for the State of Alaska since 2007. Previously, Dr. Butler was the Director of the Alaska State Division of Public Health, and headed the division's Section of Epidemiology. From 1998 to 2005, he was Director of the Centers for Disease Control and Prevention NCPDCID/DEISS Arctic Investigations Program and also served as an infectious diseases physician at the Alaska Native Medical Center in Anchorage.

Prior to Alaskan assignments, Dr. Butler was a Centers for Disease Control and Prevention epidemic intelligence service officer for the Wisconsin Department of Health. He is board certified in general internal medicine, general pediatrics, and infectious diseases. Dr. Butler earned his medical degree from the University of North Carolina, and completed residencies in internal medicine and pediatrics at Vanderbilt University, residency in preventive medicine at the Center for Disease Control and Prevention and fellowship in infectious diseases at Emory University.

Patricia Daly, MD, FRCPC
Chief Medical Health Officer,
Vancouver Coastal Health
Vancouver, British Columbia, Canada

Patricia Daly, MD, is the Chief Medical Health Officer and the Vice President, Public Health for Vancouver Coastal Health. She is also a Clinical Professor in the School of Population and Public Health in the Faculty of Medicine at the University of British Columbia.

As Chief Medical Health Officer, her primary mandate is to improve the health of the population served by Vancouver Coastal Health through population health and prevention initiatives. She is also responsible for communicable disease control, environmental health, community care facilities licensing, public health surveillance, emergency management and Aboriginal health within the region. Dr. Daly obtained her medical degree and completed a residency in Family Medicine at the University

of Toronto, and obtained a fellowship in Community Medicine from the Royal College of Physicians and Surgeons of Canada in 1992.

Marisa D'Angeli, MD, MPH
Medical Epidemiologist, Washington State Department of Health,
Communicable Disease Epidemiology

Dr. D'Angeli received her medical degree from University of California, Davis School of Medicine in 1992. She completed a pediatric internship and residency at Oakland Children's Hospital in California and Madigan Army Medical Center in Washington.

Dr. D'Angeli worked in primary care pediatrics in the Seattle area for 9 years before obtaining her MPH in Epidemiology at University of Washington in 2008. She joined the Washington State Department of Health Communicable Disease Epidemiology Section in 2009.

Gerry Delorme, Director
The Office of Disaster Management
Manitoba Health

Gerry has an extensive background in emergency management and was educated at Brandon University where he was first exposed to world of emergency management. After university Gerry began working with the government of Manitoba with Water Stewardship, but spent much of his time in the fire service and municipal emergency management developing preparedness for rural municipalities, towns and villages throughout Manitoba.

Gerry Delorme joined The Office of Disaster Management with Manitoba Health in 2005 to assist in the development of the Health sector's comprehensive emergency management program including work on hazards like pandemic influenza, forest fires and floods.

In his spare time Mr. Delorme enjoys the outdoors where he likes to kayak and hike for extended periods of time especially in areas with no cellular or blackberry service.

Marcus Deyerin, MA
Emergency Response Program Specialist
Whatcom County Health Department
Washington State

Marcus Deyerin is the Emergency Response Program Specialist for the Whatcom County Health Department, where he is responsible for developing public health incident response plans and capabilities. Before joining Whatcom County, Mr. Deyerin worked as a technology analyst for Department of Defense, and as a Program Manager for the King County Office of Emergency Management.

Mr. Deyerin served in the U.S. Army, graduated with a BA from the George Washington University as a National Security Education Program scholar, and a MA in Technology and National Security Policy from Georgetown University.

Wayne Dauphinee, BPE, MHA
Executive Director
Pacific NorthWest Border Health Alliance

Wayne Dauphinee is the former Executive Director, Emergency Management Branch, Ministry of Health Services, Victoria, British Columbia. He is a qualified health services administrator with over 40 years experience in the field.

While with the Ministry of Health Services Mr. Dauphinee was responsible for providing leadership in the implementation of a strategic planning process for emergency management, including maintaining the momentum, which BC has displayed in leading numerous pan-Provincial and pan-Canadian public health preparedness initiatives. In this regard, he was a driving force in the creation and operationalization of the Pacific NorthWest Border Health Alliance fostering improved dialogue and collaboration on the management of bi-national cross-border public health preparedness. Most recently, as a Contract Service Provider, he assisted in guiding the British Columbia health sector planning for the 2010 Olympic and Paralympic Winter Games.

He is a former co-chair of the Federal/Provincial/Territorial (F/P/T) Emergency Preparedness and Response Expert Group and the F/P/T Pandemic Preparedness Health Operations Working Group and was a member of the National Pandemic Influenza Committee. He also served as chair of the F/P/T Council of Health Emergency Management Directors.

Mr. Dauphinee and wife Nancy (nee Trowell) have two grown children, Michelle and Jason, who together with their families all live in Victoria BC.

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

John Erickson is a Special Assistant to the Secretary of 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 and response. He also administers the cooperative Centers for Disease Control and Prevention and Assistant Secretary for Preparedness and Response agreements As such he is involved in all aspects of natural, biological, chemical and radiological emergency planning with Washington State's hospitals, local public health agencies, tribal 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.

Mike Harryman, BM, AA
Emergency Preparedness Manager
Oregon State Public Health Division
Oregon Health Authority & Department of Human Service

Mike Harryman has served as the Preparedness Manager of the Oregon Department of Human Services Public Health Division Emergency Preparedness Program since February 2006. Within the preparedness program for Oregon, both the CDC-PHEP and ASPR-HPP cooperative agreement grants are managed at the state level within Mike's program.

Prior to this assignment, he was the program support manager for the Office of Public Health Systems where he managed administrative operations for the Drinking Water, Emergency Medical Services & Trauma, Radiation Protection Services, Environmental Toxicology, Health Care Certification and the Food Safety programs.

Mike is a veteran of the '91 Gulf War and retired after a 22-year career at the rank of a Master Sergeant from the U.S. Army/Oregon Army National Guard in 1999. During his deployment to Saudi Arabia in support of Operation Desert Shield/Storm, he served as the Platoon Sergeant of the 97-member Ground Support Platoon in the 2186 Maintenance Company.

Some of his other military assignments included service at both the company and battalion levels as the Nuclear, Biological and Chemical Noncommissioned Officer in Charge (NCOIC) and a Tank Commander with the 1st Armored and 25th Infantry Divisions. In his last military assignment with the 41st Separate Infantry Brigade, he was assigned as the Senior Chief Supply Sergeant and assisted in the management of all logistical operations.

Mike is currently enrolled in the American Military University Master's program for Emergency and Disaster Management and is due to complete the program in November 2010. He holds a B.S. in Business Management from the University of Phoenix and an A.A. from Vincennes University in Indiana.

Mike was born and raised in Oregon, is married and he and his wife are raising two sons.

Brendan Hanley MD, MPH
Chief Medical Officer of Health
Yukon

As the sole Medical Officer of Health in the Territory, Dr. Hanley's responsibilities cover the full gamut of public health, whether it be overseeing outbreak investigation and management, developing public health policy and setting public health priorities, answering clinicians' questions, regular communication with the public, or participating on national committees. Dr. Hanley's focus has been on developing surveillance capacity in remote and under-structured regions, and in fostering community partnerships to strengthen Yukon's public health system.

Prior to working as Yukon's Medical Officer of Health, Dr. Hanley was the Chief of Emergency at the Whitehorse General Hospital, where he still practices on a part time basis, and also practiced Family Medicine. Dr. Hanley has practiced in a number of both rural and inner city locations around Canada as well as internationally. He spent many years in the Canadian arctic and regularly worked with Doctors without Borders and other relief organizations.

Dr. Hanley received his MD from the University of Alberta, a diploma in Tropical Medicine and Hygiene from the University of Liverpool, and a Masters in Public Health (MPH) from Johns Hopkins Bloomberg School of Public Health.

Brian K Johnson, MPH
Public Health Preparedness Coordinator
Lane County, Oregon State

Mr. Johnson has served as the Public Health Preparedness Coordinator for Lane County, Oregon since 2006. He coordinates both the Lane County Preparedness Program and the Preparedness Mentoring Project, a Centers for Disease Control and Prevention funded demonstration grant to enhance preparedness among local community based organizations.

Mr. Johnson serves as the chairperson for the Lane County Vulnerable Populations Emergency Preparedness Coalition and is local representative on the National Association of City and County Health Officials Advanced Practice Centers Workgroup. In addition to his work at Lane County Public Health, he has contributed his talents for more than 8 years as a Research Associate and Project Coordinator on 17 award winning interactive multimedia health education programs funded through multi-phase grants from the National Institutes of Health. The projects have received the APHA Public Health Education and Health Promotion award, Telly Award, Omni Award, the Communicator Crystal Award of Excellence, among many others.

Mr. Johnson received his Masters in Public Health in health promotion and education from Oregon State University.

Susan Johnson, Regional Director
US Department of Health and Human Services

Susan M.R. Johnson served as the Director of the King County Health Action Plan for the Public Health Department in Seattle and King County for two years, prior to her appointment as Health and Human Services Regional Director in 2009.

In that capacity, she developed and implemented innovative programs addressing health care needs for children, teenagers and persons with chronic diseases. She also served as liaison to elected leaders in King County and Seattle for H1N1 communications. In the 80's and 90's, Ms. Johnson was appointed to the Shoreline Community College Board of Trustees and the State Board for Community and Technical Colleges. She was also member on the steering committee for the State Public Health Improvement Plan and a member of the Long-Term Care Advisory Committee to the former Washington Health Services Commission.

Ms. Johnson was also appointed by Governor Lowry to the Washington State Health Care Policy Board, where she represented the concerns of consumers and workers in the development of health policy recommendations for state officials. From 1984-1995, she served as director of governmental relations for the Washington State Council of the Service Employees International Union. She received a B.A. from Middlebury College.

When not working on health policy, Ms. Johnson enjoys skiing, tennis and golf, as well as fly fishing, writing and paints water colors.

Perry Kendall MBBS, MHSC, FRCPC
Provincial Health Officer
Ministry of Health Living and Sport, British Columbia

Born in the United Kingdom in 1943, Dr. Perry 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.

In 1993 Dr. Kendall spent a year on secondment to the Deputy Minister of Health as Special Adviser on Long Term Care and Population Health.

In March 1995 he was appointed President and Chief Executive Officer of the Addiction Research Foundation of Ontario, one of six academic health science centres in Toronto and a World Health Organization Collaborating Centre, a position he held until the Foundation's amalgamation with three other hospitals to form the Addiction and Mental Health Services Corporation.

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 BC.

He is married with two children.

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

John Lavery is the Executive Director of the Emergency Management Unit at the Ministry of Health Services in British Columbia and was previously the Director of Emergency Management at the Provincial Health Services Authority in Vancouver.

Prior to moving to British Columbia, he spent 10 years in Manitoba in a variety of emergency management positions including as the Director of the Office of Disaster Management with Manitoba Health, and an Emergency Management Advisor with the Manitoba Emergency Measures Organization.

**Major General Timothy J. Lowenberg
Washington State Adjutant General**

Major General Timothy J. Lowenberg was appointed as Adjutant General of the State of Washington on 13 September 1999. As the Adjutant General, he is the commander of all Washington Army and Air National Guard forces and Director of the state's Emergency Management and Enhanced 911 programs. General Lowenberg also serves as Homeland Security Advisor to the Governor of Washington and as State Administrative Agent (SAA) for all U.S. Department of Homeland Security grants awarded to Washington State, local, tribal and non-profit agencies and organizations.

He serves as Chair of Homeland Defense and Homeland Security of the Adjutants General Association of the United States (AGAUS); Chair of the Governors Homeland Security Advisors [NGA] Council (National Governors Association Center for Best Practices); Co-Chair of the National Homeland Security Consortium - a coalition of more than two-dozen public and private sector national associations; and Chair of the Governor's 2010 Winter Olympics Task Force Security Committee.

General Lowenberg is a distinguished graduate of the Air Force Reserve Officer Training Corps (ROTC). He received his commission in 1968 concurrent with a Bachelor of Arts degree in Political Science from the University of Iowa. He earned a Doctor of Jurisprudence degree from the University Of Iowa College Of Law in 1971.

In his previous assignment as Air National Guard Assistant to The Judge Advocate General, General Lowenberg oversaw the formulation, development, and coordination of legal policies, plans and programs affecting more than 114,000 Air Guard members in more than 1,100 units throughout all 50 States, the District of Columbia, Puerto Rico, Guam and the Virgin Islands.

He coordinated the accession, training, and deployment of all Air Guard judge advocates and paralegals and was responsible for developing and executing the worldwide civil affairs (nation-building) mission of the U.S. Air Force.

Anthony (Tony) Marfin, MD, MPH
Washington State Epidemiologist for Communicable Diseases
Washington State Department of Health

Dr. Marfin is the Washington State Epidemiologist for Communicable Diseases and a Clinical Professor with an appointment in Epidemiology at the University of Washington. In addition to this academic and clinical training, he served as a Medical Epidemiologist for 13 years with the Centers for Disease Control and Prevention's Division of Vector-Borne Infectious Diseases, Division of Global Migration and Quarantine, and the Division of STD Prevention. Over the past 25 years, his primary epidemiology study interests have been the study of bacterial and viral pathogens causing encephalitis and meningitis and the use of non pharmaceutical interventions for the control of diseases with pandemic or epidemic potential.

Dr. Marfin served for two years with Centers for Disease Control and Prevention's Influenza Division and was assigned to the U.S. Naval Medical Research Unit in Cairo, Egypt as a regional influenza subject matter expert. Dr. Marfin has also served as the Program Director for the HIV/AIDS, STD, and TB Prevention Program at the Oregon Health Division and a Medical Officer for the Indian Health Service in southern Arizona.

Dr. Anthony Marfin earned a medical degree from the University of California Davis and a Master of Public Health degree from the University of California (Berkeley). He is specialty and sub-specialty trained in Internal Medicine, Infectious Diseases, and Pulmonary/Critical Care Medicine.

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

Dr. Joe McLaughlin is the State Epidemiologist for Alaska and the Chief of the Alaska Section of Epidemiology. He began his career in Alaska as an Epidemic Intelligence Service Officer with the U.S. Centers for Disease Control and Prevention in 2001. After completing his two-year fellowship with Centers for Disease Control and Prevention, he was hired on with the Alaska Section of Epidemiology in 2003. He completed his medical school training at the University of Minnesota, a Master's Degree in Public Health and Tropical Medicine at Tulane University, and residency training in Preventive Medicine at Emory University School of Medicine.

He is an Assistant Professor with the University of Alaska's Master's in Public Health Program and a member of the Alaska Area Institutional Review Board. He is also a member of the Delta Omega National Public Health Honorary Society and was the recipient of the "Rising Star Award" by the American College of Preventive Medicine.

As an epidemiologist in Alaska, he has led numerous outbreak investigations, published a number of peer reviewed journal articles on various medical topics, and has been an invited speaker at many national and international conferences.

Dr. McLaughlin's recreational interests include whitewater kayaking, rock climbing, mountain biking, hiking, and backcountry skiing.

Rear Admiral Patrick O'Carroll, MD, MPH
Regional Health Administrator
US Department of Health and Human Services, Region X

As Regional Health Administrator, 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). On behalf of the HHS Assistant Secretary for Preparedness and Response, he also serves as the Pandemic Influenza Senior Federal Official for Health, for Department of Homeland Security Region E (USPHS Regions IX and X). Since November 2008, he has also served as Acting Regional Director, HHS Region X, on behalf of the HHS Office of Intergovernmental Affairs.

RADM O'Carroll received his medical degree and his Masters in Public Health from Johns Hopkins University in 1983. As Associate Director for Health Informatics at Center for Disease Control and Prevention's Public Health Practice Program Office, he defined, developed and directed Center for Disease Control and Prevention's national *Health Alert Network*. During his 24 years with USPHS, as an epidemiologist, informaticist, program director and leader, RADM O'Carroll has worked in on a great variety of health and policy challenges, including immunization; chronic disease; maternal and child health; environmental health; infectious disease epidemic control; behavioral health; global health and disease surveillance; and bioterrorism and disaster preparedness.

Mike Sanderson, MHS
Executive Director
Lower Mainland, British Columbia Ambulance Service

Currently the Executive Director of the BCAS Lower Mainland Region Michael has moved through a range of paramedic, educational, supervisory, management, and executive roles since first starting as an ambulance attendant in Port Hope Ontario in 1974. With the Olympic and Paralympic Games operating entirely within the Lower Mainland Region his role included designation as the Provincial lead for EMS provision to the Games.

Educational experiences include his initial "Casualty Care Attendant" training at CFB Borden, the Humber College Ambulance and Emergency Care (Paramedic) program with Honours; Canadian Hospital Association Departmental Management; AAA Ambulance Service Management Program; Bachelor of Arts (Sociology) from Wilfrid Laurier; Master of Health Sciences (Health Administration) from University of Toronto, and the Physician and Clinical Management LEADS Program at Simon Fraser University.

In addition to representing BCAS on the Board of Directors for E-Comm where he also serves as Chair of their Human Resources Committee, Michael's current professional memberships include the EMS Chiefs of Canada where he serves as Board Secretary, and the Canadian College of Health Service Executives. Honours and awards include admission to the Order of St. John (2000), the Governor General's Emergency Medical Services Exemplary Service Medal (with bar), and appointment as Honorary Lt. Col. 12 Vancouver Field Ambulance in Her Majesty's Canadian Armed Forces.

Juliana M. Sadovich, PhD, MSN
Associate Director for Global Health Security
Office of International Affairs and Global Health Security
Office of Health Affairs, U.S. Department of Homeland Security

CAPT Sadovich is a Nurse Officer in the United States Public Health Service (USPHS) and is currently assigned to the Department of Homeland Security, where she is the Associate Director for Global Health Security, Office of International Affairs and Global Health Security in the Office of Health Affairs.

During her career she has had extensive experiences clinical nursing, health care regulations, and disaster management. While assigned to the Department of Homeland Security, CAPT Sadovich served as the Chief of Staff for the Office of WMD Operations and Incident Management in the Science and Technology Directorate and as the Director of Emergency Management and Medical Response Integration, Office of Medical Readiness in the Office of Health Affairs.

CAPT Sadovich holds a Doctorate in Human Services with a specialty in Health Care Administration from Capella University, a Masters degree in Nursing with an Education Certificate from George Mason University and a Bachelor Degree in Nursing from the University of Nevada Las Vegas.

Paula Scalingi, PhD,
Director, Pacific Northwest Economic Region (PNWER)
Center for Regional Disaster Resilience
Lead for the Comprehensive Community Bio-Event Resiliency (CCBER) Project

Paula Scalingi is Director of the Pacific Northwest Center for Regional Disaster Resilience (CRDR), which develops and manages homeland security and disaster resilience activities for the Pacific NorthWest Economic Region (PNWER), a public-private partnership chartered by the states of Alaska, Idaho, Montana, Oregon, and Washington; the western Canadian provinces of Alberta, British Columbia, Saskatchewan and Yukon; and Northwest Territories.

Since October 2001, Dr. Scalingi has helped private, public sector, and non-profit organizations to develop and implement regional initiatives and mitigation activities focused on infrastructure security and disaster resilience. As part of these efforts, Dr. Scalingi has helped stakeholders design and conduct numerous regional interdependencies exercises, among them the well-known *Blue Cascades Series*, workshops and seminars focused on all hazards threats and disruptions, including cyber security, pandemics/other bio-events and supply chain resilience, and develop and implement regional and sector-focused preparedness plans and mitigation strategies

Dr. Scalingi previously was founder and director of the U.S. Department of Energy's Office of Critical Infrastructure Protection. She also served in the U.S. Arms Control and Disarmament Agency, the Central Intelligence Agency, and on the staff of the House Permanent Select Committee on Intelligence. Dr. Scalingi has written extensively on infrastructure interdependencies and disaster

resilience issues and regularly speaks in stakeholder forums across the nation on how to improve regional preparedness, continuity of operations and business.

**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, serving under Governor Chris Gregoire and former Governor Gary Locke. 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, patient safety, 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.

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 is 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 35 years.

**Juli Sickler, Division Director
Emergency Preparedness and Response
Public Health Preparedness Division
North Dakota Department of Health**

Juli Sickler joined the North Dakota Department of Health in 2003 and was named director of the Division of Public Health Preparedness in 2009. She is a native of North Dakota and has a bachelor's degree in management from the University of Mary, Bismarck, North Dakota.

The North Dakota Division of Public Health Preparedness provides local and state public health guidance, planning, coordination, response and funding for large-scale emergencies. These activities include coordination and funding of incident command and control, coordination of the state medical supply cache, coordination of all-hazards preparedness planning with local and tribal public health, and coordination for receipt of federal medical assets with the Strategic National Stockpile program.

The Division of Public Health Preparedness integrates emergency preparedness with many other divisions and sections of the North Dakota Department of Health, including Disease Control, Laboratory Services, Public Information, Environmental Health and Education Technology.

**Captain Andrew Stevermer MSN, ARNP
Health Emergency Preparedness Liaison
Office of the Assistant Secretary for Preparedness and Response
United States Department of Health & Human Services**

Captain Andrew Stevermer is a Health Emergency Liaison Officer from the HHS Office of the Assistant Secretary for Preparedness and Response. He is currently assigned to the Public Health Agency of Canada in the Centre of Emergency Preparedness and Response.

Captain Stevermer has many years of experience as a field commander for federal health and medical responses. Most recently, he was the Incident Commander for the Incident Response Coordination Team that provided managed all US HHS health and medical response assets engaged in the response to the earthquake in Haiti in 2010.

Jack Thompson, MSW
Senior Lecturer
Department of Health Services
University of Washington
Washington State

Jack Thompson has been on the faculty of the Department of Health Services since 1994. From 2000 to 2008, he served as the Director of the Northwest Center for Public Health Practice. Prior to his appointment, Thompson was employed by the Seattle-King County Department of Public Health for ten years, and was the Director of the Seattle Health Services Division from 1986 to 1994.

Before coming to the Seattle-King County Department of Public Health, Thompson was Executive Director of Neighborhood Health Centers of Seattle, a consortium of community health centers, for six years. Prior to his Lecturer and Senior Lecturer appointments, he served as a Clinical Instructor in the Department of Health Services for six years.

Wayne Turnberg, PhD, MSPH
Epidemiology Preparedness and Response Program Manager
Washington State Department of Health's Office of Communicable Disease Epidemiology

Wayne Turnberg currently serves as the Epidemiology Preparedness and Response Program Manager with the Washington State Department of Health's Office of Communicable Disease Epidemiology. Since 2004, Wayne has worked closely on bi-national cross border infectious disease surveillance and response issues in the Pacific Northwest.

He received his Bachelor of Science degree from the University of Massachusetts, and his Master of Science in Public Health degree from the University of Washington. In 2006, he received his Doctor of Philosophy degree from the University of Washington, School of Public Health, focusing study on respiratory infection control practices among health care workers.

Isabel Vieitez, MD
Assistant and Advisor for H1N1
Deputy Minister of Health
Mexico

Isabel Vieitez was born in Mexico City. Since the epidemic alert on influenza A H1N1 she has served as H1N1 - International Liaison and as Assistant to the Undersecretary for Prevention and Health Promotion, Ministry of Health, Mexico. She participated as medical supervisor on Hospital Surge

Capacity Response for Influenza A H1N1 for the Ministry of Health of Mexico. She is actually serving as Mexico's Liaison Officer in the Public Health Agency of Canada.

She is completing her Master's Degree on Epidemiology and her specialty on Preventive Medicine and Public Health at the National Institute of Public Health in Mexico (2007-).

She worked as a family physician for the American British Cowdray Hospital in Mexico City (1999) and as a health sciences teacher for undergraduate students for 6 years.

She worked at the Departments of Pathology and Infectious Diseases as well as at the National Institute of Nutrition and Health Sciences "Salvador Zubirán" participating in different research projects that included pathology and molecular biology research (1995-98).

Appendix C

2010 Cross Border Workshop Evaluation

Response rate = 102/xxx = xx%

Question 1. Where is your work location?

	Frequency	Percentage
Alberta	1	1%
British Columbia	23	23%
Saskatchewan	0	0%
Yukon Territory	1	1%
Alaska	7	7%
Idaho	3	3%
Montana	0	0%
North Dakota	1	1%
Oregon	8	8%
Washington	49	48%
Canada First Nation	0	0%
US Tribe	0	0%
Other:	9	9%

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

	Frequency	Percentage
Local/Regional Government	15	15%
State/Provincial/Territorial Government	50	49%
Federal/National Government	14	14%
Hospital or Community Clinic	2	2%
Military	1	1%
First Nation / Tribal Affiliation	1	1%
College or University	8	8%
Business	1	1%
Other:	10	10%

Question 3. What days/sessions of the workshop did you attend (mark all that apply)?

	Frequency	Percentage
Tuesday AM, May 4, 2010 (Orientation Session)	37	36%
Tuesday PM, May 4, 2010 (Workshop Workgroup Meetings)	80	78%
Wednesday, May 5, 2010 (Workshop Day 1)	97	95%
Thursday AM, May 6, 2010 (Workshop Day 2)	91	89%
Thursday PM, May 6, 2010 (PNWER Community Resilience Meeting)	21	21%
Thursday PM, May 6, 2010 (HHS US/Canada Alliances Meeting)	24	24%
Friday, May 7, 2010 (HHS US/Canada Alliances Meeting)	19	19%
I did not attend the workshop	1	1%

Question 4. What workshop workgroup meeting did you attend on Tuesday, May 4th?

	Frequency	Percentage
Epidemiology and Surveillance	22	22%
Public Health Laboratories	7	7%
Emergency Management	26	26%
Emergency Medical Services	12	12%
Communications	8	8%
Public Health Law	10	10%
Floated between different workgroup meetings	2	2%
I did not attend a workgroup meeting	14	14%

Question 5. The workshop workgroup meeting that you attended provided a valuable forum for exchange of ideas and information.

	Frequency	Percentage
Strongly Agree	49	49%
Agree	32	32%
Undecided	5	5%
Disagree	1	1%
Strongly Disagree	0	0%
I did not attend a workgroup meeting	14	14%

Question 6. There was enough time during your workgroup meeting to meet its objectives.

	Frequency	Percentage
Strongly Agree	21	21%
Agree	47	47%
Undecided	11	11%
Disagree	9	9%
Strongly Disagree	0	0%
I did not attend a workgroup meeting	12	12%

Question 7. There was enough unrestricted time during the workshop to informally converse with colleagues.

	Frequency	Percentage
Strongly Agree	28	28%
Agree	58	58%
Undecided	7	7%
Disagree	7	7%
Strongly Disagree	0	0%

Question 8. The workshop was useful in strengthening public health preparedness and response partnerships across borders.

	Frequency	Percentage
Strongly Agree	51	51%
Agree	47	47%
Undecided	3	3%
Disagree	0	0%
Strongly Disagree	0	0%

Question 9. The World Café was a valuable forum for learning and exchanging ideas with colleagues.

	Frequency	Percentage
Strongly Agree	15	15%
Agree	42	41%
Undecided	12	12%
Disagree	1	1%
Strongly Disagree	0	0%
I did not attend the World Cafe Poster Session	32	31%

Question 10. If a cross border workshop was held next year, I plan to attend.

Q10

	Frequency	Percentage
Strongly Agree	51	51%
Agree	40	40%
Undecided	8	8%
Disagree	1	1%
Strongly Disagree	0	0%

Question 11. Please indicate the format you would like to see for the next cross border workshop.

	Frequency	Percentage
Full 3 day (3-night accommodation) workshop	16	16%
2.5 day workshop (same as this year's workshop)	57	56%
2 day workshop	23	23%
1 day workshop	2	2%
No workshop	0	0%
Other:	3	3%

Question 12. If offered, would you be interested in attending a ½ day CME accredited pre-conference workshop?

	Frequency	Percentage
Yes	35	35%
No	30	30%
Undecided	36	36%

Question 13. What cross border issues would you like to see addressed at the next cross border workshop?

1. Same as those covered this year; add an update on the Canada US Public Health Border Strategy Summit; possibly have a brief update by the Joint Coordination Committee of the PNWBHA.
2. 49th parallel agreement, tribal/public health MAAs
3. A presentation or panel that can give overview and context of how public health laws and regulations differ between states and provinces and how those differences affect cross-border concerns.
4. Although we have addresssed through the EMS breakout some cross border resource sharing, this issue is not fully addressed. A sub-group in the Emergency Management breakout of Logistics type folks is working to address cross border resource issues under the PNEMA umbrella. SNS/NESS post confrence meeting is a group that has decided to teleconference quarterly to help address the shortfalls and develop the SOP for medical supplies and pharmaceuticals.
5. An overview of the impact of and response to - a major seismic event along ther pacific plate.
6. Any legal issues which arise from proposed agreements.
7. Better coordination and communication between/among all the U.S./Canadian border health alliances/initiatives. More on early warning of infectious disease and infectious disease surveillance. How to include unaffiliated states and provinces.
8. Change Management,
9. Climate change and disasters and health, Virtual exercising, Medical tourism,

10. Communications, Risk Communication, Patient Transfer, Liability, Licensure and Credentialing
11. Connection to Canada-US Public Health Border Strategy Summit, Opportunity to connect with Alliance activities
12. Continue building on the outcomes of the workshops. Begin discussion on the tribal cross border issues - particularly with the Colville Tribe which has a number of members living in BC and Washington and traveling regularly between the two locations
13. Cross border exercises
14. Cross Border exercises, Update on Pacific Northwest Border Health Alliance progress, Update on efforts to create a coast to coast cross border health alliance, Role of state and provincial emergency management agencies in facilitating cross border health and medical response, Tutorial on Canadian (provincial and federal) health and medical organization structure vs how its done in the US.
15. Data use agreements across borders and jurisdictions
16. Drills and exercises cross borders. Focusing on the details of "How" and "When" cross borders resources and capabilities can be used not just in major emergencies (pandemics mass flooding, earthquakes) but daily. How to better use the capacities of our labs and medical facilities- who is closer? especially along the borders of Alaska, Yukon, B.C. and Washington. Marine hwy- issues of cross border jurisdictions. How is it being done now and what needs to be improved.
17. Enjoy the sharing of regional issues
18. Evaluation of Outbreak Response across borders.
19. Follow up on cross border exercise that was discussed at the Emergency Management workgroup.
20. Food protection and evolving pathogens
21. From an EMS perspective the issue related to single incident responses not associated with a Declaration of State of Emergency.
22. Greater interstate collaborative efforts
23. How do the Emergency Operations Centers (State, Provincial, and Federal) interact and coordinate on a common cross border event?
24. How do we help smaller agencies in forming mutual aid agreements where there may be only one patient or a situation somewhat short of an MCI.
25. How to expand cross-border coordination beyond the public health community to essential key stakeholders in the private sector and non-profit communities. How to facilitate improved cooperation, coordination and decision-making among public health and emergency management professionals in preparing and managing major events that significantly impact health and safety.
26. How workgroups could interact with other alliances across the country to learn what they are doing and perhaps avoid re-creating the wheel. Also, of concern in all of public health, is how we sustain this work as many of us are approaching retirement.
27. I would like to see more Information Technology issues if at all possible.
28. I would like to see our partners in Blood Operating business
29. I'd like to hear a report from DGMQ and their Canadian counterparts on issues they have faced over the last year. Are there other areas where communicable disease issues span the border that could benefit from coordination and establishment of relationships that can be used during emergencies? e.g TB or C. gattii.
30. Ideas for collaborating on EWIDS projects.
31. Improvements on cross border communication since H1N1. Any major issues/events that might occur (like H1N1)
32. Job shadowing across borders.

33. Keeping individual working group as it is, allow more time to integrate with other groups
34. Message development & coordination among agencies. Discussion of media pools & how to set up MOA with media in advance of need. Cross border media tools, such as shared central Web site, blog, coverage collection (clips), news archive, & 800# phone bank.
35. More problem solving on legal obstacles to and work-arounds for timely communication about outbreaks, both about cases and contacts.
36. Moving pharmaceuticals across the border from state and city stockpiles such as CRI.
37. On the U.S. side I would like to see the State's Emergency Managers present so that they can talk about making the PNEMA operational and how PH can use it. Its time for them to be invited and step up.
38. Operational manual for cross border communication. Communication protocols. Secure "chat room" or other mechanism to share information as situations unfold.
39. Passing on information to a new generation of PH Leaders. Preparations for when current ranks retire and take the knowledge and experience with them!
40. Possibly a breakout session to discuss/enhance cross border agreements such as between Alaska and BC, Yukon.
41. Presentations from local health depts and BC public health units on surveillance, epi and communication links.
42. Public engagement
43. Public health recovery
44. Special populations planning such as pediatric
45. Strategic National Stockpile
46. Thank you for hosting the conference in Seattle. Having the interaction with emergency management partners is very important and a great learning environment as well.
47. The actually border crossing procedures in writing as well as a table top exercise for same. One for patients / med staff, another for lab / chain of custody and another for identification procedures with advanced notification to border patrol.
48. The Alliance structure and support PanBorder.
49. Updates on cross-border response experiences similar to that provided by the State of North Dakota and Province of Manitoba. Try to extend geographic scope to include attendees and presenters from the Wisconsin border east.
50. Using lessons learned from "international" cross border work to improve "interstate" and "interprovince" efforts. Showing how lessons learned from international cross border work applies to states without (or with small) international borders.
51. Whatever is timely (e.g. the focus on measles in the epid session was excellent).
52. Would like a presentation from the Border Manager about their issues and how we are able to work with them in an emergency to get across the border with supplies or manpower.

Question 14. What did you like most about this workshop?

1. Ability to network
2. All!
3. As an academic it is extremely valuable for me to see what practitioners are dealing with and directly connect with them - otherwise we risk conducting research that is not relevant.
4. Collaboration and connections with others doing similar things.
5. Communications workgroup was a great forum for exchanging ideas and best practices.

6. Comparative reports of H1N1 response and learnings. Chance to interact with colleagues. Lunchtime presentation on Haiti response
7. Congenial, cooperative atmosphere to compare and contrast healthcare systems and approaches to medical emergencies
8. Discussion of practical application of cross border cooperation e.g discussion of how measles investigation was conducted
9. Diversity of people attending
10. Examples of cross border cooperative responses.
11. Good to hear what others have done to address problems facing us all. Sharing H1N1 experiences for example.
12. Got a good appreciation for what the Pacific NW area is doing, related to public health and infectious disease surveillance.
13. Great location, Succinct information/background from the "founders", Timed panels, Particular presentations
14. Great speakers throughout(especially liked Andy Stevermer's talk and the one with Manitoba and N.D. on cross border resource sharing). Greater Canadian participation than in the past. Wonderful location (both Seattle and the Red Lion Hotel). Very relevant post conference sessions. Commitment to do more work on issues between the annual meetings.
15. Hosts
16. I always learn from my colleagues and I enjoy being with such enthusiastic people.
17. I enjoyed hearing the real experiences from the Provinces and other states.
18. I really enjoyed meeting people from other states/countries. It's a great networking conference!
19. I really enjoyed the variety of presentation from different states, Canada, and Mexico. It's nice to get a chance to hear different perspectives.
20. I thought it was the best conference of the ones I have attended. The law group has made significant progress with PNEMA, and now the 49th parallel approach is very exciting and worthwhile.
21. Information sharing and networking. Opportunity for discussions about developing a new Mid-West Alliance
22. Interaction with US colleagues. Building networks and tools that could actually benefit alliance members.
23. It seems like speakers are more realistic - ie the comment that plans aren't important but planning is imperative.
24. It was a great forum for networking and collaboration.
25. It was well organized. Speakers topics were well chosen and the content was interesting.
26. It's informal and collegial atmosphere that encouraged participants to energetically contribute and share ideas in and outside the proceedings. Presentations were uniformly good. Several of the workgroups resulted in good recommendations for useful new activities.
27. Learning about areas of public health/emergency preparedness that are not in my normal scope of work; meeting people from other places.
28. Learning from other jurisdictions' experiences with H1N1. Meeting colleagues from other jurisdictions.
29. Location, participation level, topics - particularly about real life events such as the N. Dakota Red River flood coordination and response.
30. Many presenters shared recent experiences with cross-border cooperation, which provided a platform for evaluating what works, what doesn't work, and where ar the gaps.
31. Meeting and hearing from people who care about cross border public health

32. Meeting the attendees and networking with colleagues. The H1N1 presentation from the panel of experts was great.
33. Net working; see friends
34. Networking
35. networking and hearing info I can use
36. Networking opportunities
37. Networking with other providers and administrators
38. Networking. Case Studies. Sharing of promising practices
39. Networking, good presentations, opportunity to learn about other areas of the health business.
40. Networking, really like to see my peers and other professionals from the region.
41. Open discussion in epi workgroup about what worked and what didn't work in recent BC measles outbreak with contacts in US. Developing relationships and trust with colleagues in other agencies and levels of government.
42. Opportunity to connect with colleagues.
43. Opportunity to learn what different challenges and successes the Canadians experience.
44. Orientation session. Many of the plenary speakers. Poster session.
45. Presentation on the HHS responses in Haiti
46. Really enjoyed the general session speakers! It was good to have question and answer period at the end.
47. Sharing best practices and lesson learned.
48. The "can do" attitude of the management team
49. The ability to network and learn more about the emergency preparedness infrastructure and partnerships
50. The affirmation that no matter who we were or where we were we are seeing the same issues and for the most part are responding in a like manner.
51. The approach of having the working groups meet ahead of the workshop is an effective way to have the content experts from the US and Canada roll up their sleeves and then to be able to report back to the whole group.
52. the breakout session with colleagues
53. The chance to learn how other jurisdictions are facilitating agreements between the various groups responsible for public health governance, and re-connecting with the lawyers from other jurisdictions.
54. The dedicated colleagues who attend. The presenters were very good this year.
55. The energy of the workshop. Representatives coming together to make things happen and share ideas and methods. I liked the orientation presentations. I felt these were very helpful.
56. The epidemiology workgroup session provided a valuable opportunity to exchange ideas and work out issues with our cross border colleagues.
57. The fact that representatives from the federal level down to the local level all had an equal voice.
58. The Haiti lunch session and the lunch was delicious!
59. The information from the presenters was very good maybe a little bit much with all the graphs but very valuable information.
60. The networking and relationship building between groups.
61. The North Dakota/Province of Manitoba presentation of the 2009 flooding response. The luncheon presentation on Haiti relief
62. The presentation concerning the North Dakota flood response was excellent. Both presenters were engaging and did a nice job. A few of the presenters who discussed lessons learned from H1N1 were also good.

63. The sharing of information, to include accomplishments and goals for the future.
64. The variety of presentations and participants discussing a multitude of cross-border considerations when responding or preparing.
65. the workgroup was excellent and we could have used more time to talk through issues. The plenary speakers, for the most part, was as good as or better than before. The time to connect with colleagues and new folks was very important.
66. This conference brings together all types of professionals and allows them to be creative and address issues outside of the box. Our federal partners recognize this and often use us as an example.
67. This was an introduction for me. I really enjoyed learning the rich history of the group and its accomplishments across many avenues. I am eager to see how it continues to evolve.
68. This was my first cross border workshop and event (other than teleconferences), so found the exposure to other programs and contacts to be very valuable.
69. Valuable information, meeting colleagues in person
70. Very good range of discussion topics.
71. Wide range of organizations involved; 1. Expertise level of the presenters, 2. Opportunity for dialogue and collaboration, 3. Pace was effective - sufficient time for breaks/networking, 4. Printed materials were thorough, 5. the venue was convenient and comfortable
72. Work group meeting - good opportunity for dialogue.
73. Working Group Meetings.

Question 15. What suggestions do you have for improving the next cross border workshop?

1. There was much repetition in the presentations about planning and I would have liked the epidemiology panel to have more time.
2. It went very well.
3. Great job again this year!
4. A bit different layout for and more panel discussions with Q&A, maybe reduce presentations to 30-45 minutes and insert the Q&A. Lets also start addressing the NHSS.
5. Add a half day for the sub-groups of the breakout work groups to meet and discuss progress and pitfalls.
6. An effort should be made to include other states / provinces other than Washington, Alaska and BC in workgroup discussions. Although it is recognized that these two are the true border states, engaging other attending states would be beneficial.
7. Box lunches both days!
8. Continue in the same vein.
9. Continue with Poster and Innivation Sessions and add streamed breakout sessions, e.g. emergency management, public health, technology, etc.
10. Couldn't be improved on!
11. Create opportunities for the neighbours to be in specific workgroups to explore the issues that are either hindering or helping the resource sharing across the boundaries.
12. Cross-discipline workgroup sessions: Legal and epi to address privacy and information exchange. Emergency management and epi to address integration of public health/epi in ICS/NIMS, Unified Command structures. Less didactic/descriptive presentations and more dialog/discussion about common challenges and approaches to solutions.

13. Encourage presenters to use PowerPoint more effectively. Many presenters had the following problems: 1. too much information on slides, 2. too many slides - often flipped past them to get through in allotted time, 3. It may help to provide a one-page sheet providing suggestions for effective PowerPoint presentations, 4. The opening prayer was supposedly a Native American prayer. Though I am not Native American, I was troubled that this prayer was from a thinly disguised fundamental European Christian perspective. I have been present at several conferences where Native American elders have offered prayers and this was truly an exception. Though I am not necessarily opposed to rotating the prayer among various religious groups, we should take more care so as not to mischaracterize the nature of the prayer. While it is difficult to vet a prayer before hand, I do think it possible to request that the person offering the prayer provide some detail concerning their spiritual perspective and effort to be both inclusive of all faiths in the audience and accurate as to the perspective they are advertised as providing.
14. Field trip to FEMA facilities in Bothell.
15. Goal of having a usable product from a workgroup session. Having cross sectional small group meeting (meaning that the lawyers, lab and epi have a joint workgroup session)
16. Have it in Victoria
17. Hold the next meeting in Vancouver or near Vancouver. As much I would like to go to Vancouver Island or the BC interior, it cost more in terms of time and money to get those locations. Especially with the state of budgets, the location of next years conference will have an impact on my attendance...thus my suggestion of Vancouver.
18. I appreciate the addition of the orientation session, and if I attend next year, I will try to attend the orientation.
19. I can't think of any.
20. I didn't learn about the Thursday afternoon meetings until arriving at the conference. It would have been nice to know about these.
21. I like the current format
22. I think the history of the workgroup accomplishments could be part of the orientation. I would like to see "action items" for each participating state come out during the workgroups so progress on issues can be made and shown. I would like to see workgroups meet telephonically once or twice during the period between the annual meeting to assist members with their tasks and promote collaboration.
23. I would like to see less paper printed out. Make the presentations available on the web-site (before the conference if possible) so folks can print out the ones of greatest interest. The presenters didn't seem to provide their most updated copies for print-out anyway, and the binder was well organized, but wasteful because it seemed to be multiple reprintings of the agendas and speaker line-ups over and over. I really liked the contact lists! Please add all information and don't duplicate contact lists in the break-out sessions to make up for missing information. Otherwise, keep up the good work!
24. I would suggest a stronger emphasis on developing product among workgroups and less on plenary speakers.
25. I would suggest trying to break up the day and not have a full day of presentation - maybe work in some time for additional workgroup meetings.
26. Include more dynamic presenters. Several of the presenters at this year's workshop were very dry in their presentation. Simply reading from one's slides does not engage the audience.
27. Involve more communications professionals from other jurisdictions.
28. it was very well organized and implemented. no specific recommendations
29. It was well done.

30. It would be good to share this with a broader audience, yet maintain the networking assistance of the on-site meeting. Perhaps have one session that is available by i-link so more people can attend that would not come to the in-person meeting. Say around disease surveillance and labs with 20 minutes on systems in respective countries and 20 minutes on what has been going on and then questions and throw out the invitation to all jurisdictions.
31. Less of the bureaucratic jargon (largely US federal) and more of the on-the-ground reportage and comparisons.
32. Longer workgroup sessions or more interactive sessions. Is there an expectation of an end product after the workgroup/workshop? Engage those interested in assisting, throughout the year via conference calls or social media.
33. Make the workgroup meeting more interactive and action oriented. Save information sharing for the plenary sessions. Make the workshop more relevant for states/provinces other than WA and BC. Have the workgroup session after the plenary sessions so that ideas presented are captured in plans for next year.
34. Maybe allow a bit more time between sessions for conversation/networking.
35. Meet in Vancouver, BC
36. Might be impossible to DO...but would be great to have the presentations or synopses of same available for download in advance of the event. I may have chosen different sessions had I been able to preview the material. Please limit the number of org charts per presentation. One chap in my work group had about 20 of them, and read out all the titles and names in each box of his outfit--and never mentioned a neighboring country.
37. More breakout sessions. The large plenaries did not provide enough of an opportunity to dialogue. I found the work group meeting the most valuable part of the workshop. Also, I would have liked to attend more than one of the small work group work shops.
38. More diverse topics throughout the 2 days
39. More workshop time with better agendas for them.
40. Need more time for the workshop report outs.
41. Need to include some key private sector and emergency management representatives and add topics on specific issues of interest to workshop participants as noted in answer to question 13. Greater PNW state and provincial representation would also be useful.
42. Nicely done this year! Enjoyed the conference. Came home with some concrete ideas on continued support for cross border efforts.
43. None - already excellent.
44. None I can think of
45. None!
46. None, really. This was very good
47. Not sure....would of loved to have tables instead of chairs- only for the plenaries. The speakers were wonderful, but I became a bit overloaded after so many. Liked the poster session, wonder if they could be up on the first day for folks to look at while waiting between sessions? and then they would know what questions to ask during the time that the presenters were standing by their posters. Oral posters 10-15 min. or less could take the place of the longer presentations.
48. Perhaps at a different hotel
49. Please eliminate the prayer that was "disguised" as a cultural welcome. Religion has no place at a conference such as this and is offensive to me.
50. Possibly smaller working groups to aid in the ability to connect with those who are directly across the border with us to develop working relationships. This was my first year so getting to know who is directly across the border from me and making a connection is important.

51. Probably nothing you can do about this, but Wednesday presentations were all spectacular. Great speakers, great topics. Thursday morning was disappointing, partially because Wednesday set the bar so high and partially just because the presentations were not well executed. Lessons in how NOT to give a presentation.
52. Support staff seemed pretty overloaded at times. Maybe more worker bees would help. Give folks the big bulky notebooks at the end of the session to take home (if they want) so they don't have to lug them around during the meetings. At the beginning just give them a compact agenda and session summaries they can carry in their pocket. Sound system (microphones) at the Red Lion was a problem. Kept cutting in and out. Was distracting. Needs to work better next year. Give more than ten minutes per work group for the report outs on the last day. Should be at least 15 minutes and maybe more. These work groups do the real work of the Alliance and they had to short change their report out presentations due to time constraints. Consider having the meeting in Kelowna BC instead of Victoria. Horizon flies to Kelowna and its not too bad a drive from Seattle or Oly. Would be a nice change of pace from the big city. Also closer to other Canadian provinces and states like Montana. East side of the mountains considerations too just like we have in WA state. Lets move these meetings around more.
53. The breakout teams would be interesting if we were presented with a scenario that involved cross border collaboration and we were tasked as a group to try and operate together within the confines of the presented disaster. This would help us get to know each other better and create an environment where we had to collaborate and focus on business continuity.
54. The group size is getting to large to get much accomplish during a session. Many voices go unheard. Breaking the groups into even smaller sizes with a specified topic or issue to resolve would be more inclusive.
55. The large meeting room had large pillars down the middle. It would be nice to find a room without the obstructions.
56. The main meeting room was small and the pillar placement obstructed view of the presentors.
57. The Poster presentation format could be improved. Have the Posters on display as early as possible (1st day and duration of conference, "unmanned") so people have more time to read them during breaks or before and after meetings. So when the official Cafe poster session occurs people can ask questions to the poster presenters.
58. The registration table this year was pretty unorganized. I did not get a badge or binder or anything because the gal that was attending to the registration desk was really busy and kept getting called away from the table. I literally got up to front and she left. I was going to be late for my workgroup session so I left without getting any direction at all.
59. The workgroups need to be more structured and real work needs to occur during them - work sessions, not just presentations. A lot of really great work can happen during that time.
60. This is not very important, but better snacks. Replace prepackaged granola bars...
61. This year's Cross Border seemed to have too much squeezed into the time frames scheduled. Fewer presenter may resolve this issue.
62. Try to extend geographic scope to include attendees and presenters from the Wisconsin border east. Maximize the opportunity for "real-life" presentations and "best practices" based on "real-life" response.
63. Very good balance this year. Would not change anything! Loved having the poster sessions
64. Victoria next year?
65. We don't need to be rewarded with gifts (blanket, compact mirror, etc.) in order to be inticed to come. Next time you do, offer us the option of donating them to a shelter instead.
66. Wednesday's lunch presentation was interesting, but lunch is a valuable time to get into more in-depth conversations with new people (as opposed to the brief chats that stand-up networking breaks tend to encourage). I would strongly prefer not to combine presentations and lunch hour.

Appendix D

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