2014 Summary Report

Pacific Northwest Border Health Alliance
Eleventh Annual Cross Border Workshop
“Mutual Assistance: A Cross Border Perspective”

May 12 - 14, 2014
Portland, OR
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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The Pacific NorthWest Border Health Alliance (PNWBHA) extends its most sincere appreciation to the Oregon Health Authority for hosting the 11th Annual Cross Border Workshop. We would also like to thank the Washington State Department of Health for their financial support and assistance in program developing and management. Last but not least, we must thank the bi-national planning committee, facilitators, speakers and our cross border public health partners for their support and commitment to the success of this workshop. Working together, we are establishing a seamless cross-jurisdictional public health system to quickly and efficiently track and respond to natural and intentional public health threats across both domestic and international borders.

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Executive Director
Pacific NorthWest Border Health Alliance

Mike Harryman
Co-Chair (United States)
Pacific NorthWest Border Health Alliance

Garnet Matchett
Co-Chair (Canada)
Pacific NorthWest Border Health Alliance

Member Jurisdictions
Acknowledgments (continued)

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Acknowledgments (continued)

**Workshop Recorders**

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<tr>
<td>Larry Champine</td>
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<td>Cindy Marjamaa</td>
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<td>Greg Nordlund</td>
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**Workshop Organizers**

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<td>Gail Zimmerman</td>
<td>Washington State Department of Health</td>
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<td>Carrie McGee</td>
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**Electronic Copies of Workshop Materials**

Electronic copies of this report are available on the Pacific NorthWest Border Health Alliance webpage [http://www.pnwbha.org/](http://www.pnwbha.org/).
Pacific NorthWest Border Health Alliance
11th Annual Cross Border Workshop
“Mutual Assistance: A Cross Border Perspective”

Introduction

The Pacific NorthWest Border Health Alliance (PNWBHA) held its eleventh annual bi-national cross border workshop in Portland, Oregon, May 12-14, 2014. The workshop’s theme, “Mutual Assistance: A Cross Border Perspective,” focused on the PNWBHA’s continued collaborative approach to prepare for and respond to any natural, accidental and intentional events impacting the Pacific Northwest in a coordinated and effective manner. Over 200 professionals attended from Canada (including Alberta, British Columbia, Saskatchewan, Yukon Territory, Canadian First Nations and Federal Government Agencies) and the United States (including Alaska, Idaho, Montana, Oregon, Washington, Native American tribes and federal government agencies), representing the fields of healthcare, public health, epidemiology, public health laboratories, emergency management, emergency medical services, indigenous health, risk communications and public health law.

New Attendees/Refresher Orientation

P3 - PNWBHA, PNEMA, PNWER: Who We Are and What We Do

Wayne Dauphinee, Executive Director
Pacific NorthWest Border Health Alliance (PNWBHA)

Patrick Quealey, Chair
Western Regional Emergency Management Advisory Committee/Pacific Northwest Emergency Management Arrangement (PNEMA) and Assistant Deputy Minister Emergency Management BC

Eric Holdeman, Director
Pacific North West Economic Region (PNWER)
Center for Regional Disaster Resilience
Workgroup Meetings

Nine cross border workgroups convened on May 12, 2014, to discuss the status of projects, new issues and next steps. Following are reports on each session:

Epidemiology and Surveillance Workgroup

The group focused on discussing the epidemiological and surveillance aspects of an unlikely event: wildfires.

- Catherine Elliott of the British Columbia Center for Disease Control spoke to the group about their experiences monitoring and conducting surveillance over the past several wildfire seasons and incidents. The surveillance includes the physical measurements of particulate matter in the environment as well as surveillance of several human health issues including rates of asthma, bronchitis and pneumonia; doctor visits for respiratory ailments; and dispensing of medications to treat those ailments.

  This surveillance and monitoring enable them to better predict the health impacts, although the erratic nature of wind directions impedes more rapid response.

- Carla Britton of the Alaska Tribal Health Consortium spoke about her experiences working with wildfires in Idaho. She focused on the challenges faced by firefighters working on the line and in temporary camps.

  The firefighters face the physical challenges or long hours, rugged terrain, extreme heat and physical demands that can lead to injuries and ailments. The close quarters and transient nature of the camps can lead to communicable disease like foodborne illness and norovirus.

- Theresa Watts of Oregon Public Health spoke about how they have used surveillance in past wildfires to help develop and improve outreach to people in affected areas. Using demographics and interviews with residents of remote wildfire areas, they were able to ascertain that traditional media and the internet were not enough to keep the public warned; they have begun to coordinate more closely with other agencies and community groups to increase the effectiveness of information delivery.

  Judy Bardin of Washington State Department of Health discussed a case study that revealed a long list of current and potential measurements that can be used in the surveillance during wildfire and other smoke events. They include asthma, bronchitis, pneumonia, injuries, occupational hazards, low cardiovascular ailments, school absenteeism, low birth weight, veterinary (pets and livestock) and mental health.

- A wildlife subgroup was formed to explore outstanding issues and to explore ideas around pre- and post-wildfire season briefings.
• For next year’s work plan, it was decided to refocus on communicable disease. Using meetings/webinars, the group would convene during the year to share experiences with recent, real-world outbreaks like measles, MERS Co-V and Haj.

Public Health Laboratories Workgroup

Co-chairs: Dr. Muhammad Morshed, Dr. Romesh Gautom

Dr. Muhammad Morshed (British Columbia Public Health Microbiology and Reference Laboratory [BCPHMR]): He encouraged others at the meeting to promote the idea of studying ticks and Lyme disease in their states or provinces to obtain a more complete picture of the phenomena in the region as a whole. He would like to pool data from our respective agencies and publish the information. The Cross Border Workshop provides an opportunity to foster these efforts.

Dr. Emilio Debeess: Discussed trends in Lyme disease specifically from the veterinary point of view in Oregon State, with the overwhelming majority collected from the west side of the state. There has been an increase in the case reports from five in 1988 to more than 45 in 2012.

Blaine Rhodes: Discussed the December 2013 geoduck embargo issued by China on Pacific Northwest growing areas. The embargo was instituted based on the discovery of elevated levels of arsenic in exported geoduck. Subsequently the Washington State Public Health Laboratories were asked to test for arsenic in geoduck tissue. The lab rapidly validated a new method and tested numerous specimens and specimen types. It was found that the highest levels of arsenic were in the skin of the geoducks and exceeded Chinese standards.

Brian Hiatt: Discussed vibrio testing in Washington State. Described the increased incidence of vibriosis as the agent of foodborne illness. Discussed updated protocol focused on detecting additional pathogenicity markers. Discussed the observed rapid shift in Vibrio praehaemolyticus strain prevalence in clinical isolates received at the lab.

Dr. Muhammad Morshed: Discussed specimen transport between Canada and the US, specifically the blanket permit that Canada has in place allowing import of many pathogens for diagnostic testing purposes. There are also new regulations pending in Canada that may simplify the permitting process.

Dr. Muhammad Morshed, Rob Vega: Discussed the history and current testing and surveillance efforts regarding Carbapenem-Resistant-Enterobacteriaceae (CRE). Incidence has greatly increased from five reports in 2008 to 222 in 2013. Currently conducting provincial surveillance. Oregon has recently begun molecular testing to screen for several resistance mechanisms, as well as the Carba NP test which is a phenotypic assay designed to detect Carbapenemase activity.

Dr. Mike Skeels: Discussed the need for a regional menu of specialized and after-hours testing services within each member laboratory. This would be a valuable tool for all states in the region seeking assistance from partner labs. There are several other states in the country working on a
similar project specifically in New England. There may be some federal support through the ELC LEI project. This kind of system should be pursued even without federal support.

**Previous action items:** (Incomplete items will be pursued and followed up on in future meetings.)

- Develop permits to allow shipping of samples from laboratories in British Columbia to labs in Washington, Oregon, Montana and Idaho. **No progress made since last conference. Additional effort required from the US side to get permits in place to allow for reciprocal services.**
- Update contact list for this workgroup. **In progress.**
- Develop collaborative study of Lyme disease. **Needs further discussion between individuals performing this work.**
- Connect Blaine Rhodes with Tom Kelly. **No progress made.**
- Invite Canadian shellfish experts to attend future Cross Border Conference. **Will try to contact them for the next conference.**
- Conduct a communications exercise. **Will attempt to include member states in future exercises at the lab level.**
- Invite a biosafety expert from British Columbia. **Will try to contact them for the next conference.**

**New action items:**

- Continue to pursue Laboratory Efficiency Initiatives (LEI) opportunities. Funding will facilitate the process; however, the potential benefits may warrant a concerted effort even without federal support.

**Health Emergency Management Workgroup**

The workgroup discussed the possibility of creating a memorandum of understanding (MOU) that better clarifies what they need to do to actually enable movement of personnel and resources across borders (i.e., operationalize PNEMA). PNEMA is often used as an enabler, but many members in our alliance are not signatories on the agreement.

Other topics of discussion included:

**Mutual aid/sharing resources**

- BC has been working with college of physicians and surgeons on how to use physicians from other provinces/states to ensure our response capability (this is how the Emergency Management group connects to the Clinical Medical Surge group).
- Oregon has successfully exercised the transfer of volunteers to Washington and made them agents of the state.
• There is ongoing work in Washington concerning legislation around volunteers—prompted by a tabletop exercise three years ago.
• Need to further explore how to streamline the credentialing process.
• Might be able to use the Olympics as a starting point—states can do backwards planning.

Learning opportunities during incident response

• Emergency managers could be moving between borders to help in incidents as well.
• This topic is often neglected during an incident; we only think about inviting colleagues during exercises.
• Should be bringing in others early on in the response, not when resources are worn out.
• Early in an incident is a good time to observe, advise and be involved.
• Need a local champion in each jurisdiction to make that happen.
• Need to consider that the last thing you need in an emergency is more people to involve—be careful around the idea of involving others during tough times.
• Difficult to deal with logistics and payment issues when a jurisdiction is going through tragedy with a large loss of life.

Working with the military

• The Public Health Agency of Canada (PHAC) can work with Public Safety Canada to look into connecting more with the military.
• Usually Public Safety counterparts work with Department of Defense in Canada.
• On the Canadian side the regional responsibility for response from the military is housed in the joint taskforce concept (one point of contact has the authority over decisions for support).
• Regionally, Washington has strong relationships with their federal counterparts.
• Relationships with Washington DC and Ottawa is where things are more difficult—lack of understanding on both ends.
• Would be great to have DC/Ottawa personnel at these meetings.
• At WREMAC this year there will be representatives from Public Safety Canada and this might be a venue to bring up health issues.

After-action report highlights from jurisdictions

Washington: Discussion topics included the WASABE exercise (terrorist anthrax scenario) and issues after the Oso mudslide (casualty management; environmental health; communications with the public).
British Columbia: The group discussed the Lemon Creek incident, in which a tanker truck with 35,000 liters of jet fuel crashed, spilling all contents into a small creek. Other topics included a tabletop exercise in which BC and Washington State participated, and a radio communications exercise.
Oregon: The main topic was wildfires that were the worst seen in 10 years. Resulting issues included stagnant smoky air and determining who was responsible for monitoring air quality; and communities left without usable water for weeks.

Partnership with Clinical Medical Surge Workgroup
- Spent time last year identifying what the issues are for the surge group; discussed liability issues; and came back renewed to talk about planning, training and exercises that involve pediatric care.
- Discussed preparing a mission-ready package for providers.
- Emergency management world will provide health professionals with logistics so they can do their work.
- A lot of goals are aligned for the Emergency Management Workgroup and the Clinical Medical Surge Workgroup.
- Need to identify specific regional resources we have, different levels of pediatric care, and knowing where special equipment is and those who can operate it.
- BC Ambulance Service has infant transport teams—this can fall under the EMS agreement with cross border as long as patients aren’t moved.
- An agreement is in place between Washington and BC for movement of EMS resources across border.
- Need to look at credentialing, regulatory capacity and mission-ready packages.
- Important to be very specific in what is asked for and what the task is so the assisting jurisdiction can be clear in what to provide and how they align with priorities.
- Looking to establish MOU with PNWBHA membership to allow us to share resources back and forth—operationalizing PNEMA and including all alliance partners.
- Can have the baseline of how to do this in the MOU and then bring the “who” into it once we have it clarified.

Important to include the pediatric lens in your exercises; pregnant women and vulnerable populations also need to be considered (may need to draw on clinical experts).

**Health Emergency Medical Services Workgroup**

**Mike Smith (Washington State Department of Health)**
During 2013-14 there were 44,350 cross border transfers of patients either from one facility to another or in the form of an EMS response, and that prior to the agreement facilitated by this workgroup, these types of transfers were difficult or did not happen.

- Six of 10 jurisdictions reported cross border activity.
- Numbers represent air, ground and marine cross border EMS transports.
- Activity = response and interfacility transport were included in the numbers.

**Jim Cole (San Juan Island EMS and Med Evac)**
Jim discussed the state of communications technology for EMS. He said interoperability is the key concept for successful emergency communications and cited the two-week period during 2013 when the San Juan Islands were without 911 service due to a break in an underwater cable.

- Nationwide Public Safety Broadband Network (NPSBN) is coming nationwide in the US for all emergency responders. Will help facilitate the introduction of GPS pinpointing, 911 texting, and apps that automatically call responders or medical personnel.
• Many new technologies are now being adapted or will be soon including those that:
  o Help activate first responders (apps such as Active 911 and Voxel, digital radio, satellite paging, VOIP/ROIP, E dispatches, IAMResponding.com).
  o Aid response (Map Books, turn by turn GPS).
• Provide on-scene aid (interactive emergency response such as Lifenet, iPhone apps that provide information about treatment, texting medical personnel, phone cameras used to show pictures of medical condition to doctors, telemedicine with specialists).
• Facilitate hospital communications (use of tablet to record information such as EKG and temperature readings for electronic patient records).
• Personal Locator Beacons (PLB) used by ground EMS staff to locate an accident scene when normal communications are not available increase the connectivity with ground/air EMS units and decrease response times.
• Use of airborne helicopter communications to relay patient information from ground EMS in areas where ground communications in not available.
• Use of Air Ambulance to spot incident in remote areas.
• BCAS capabilities were explained.

Cole emphasized that good human communications is still the most critical factor—knowing how to get and give information when talking with patients, medical personnel and responders so that the needs of all are met. **One key point is connecting dots.** The work that has gone before has been built on relationships and the passing of knowledge. The ability to move resources across the border with very few hitches has been because of hard work. The use of locator beacons for landing zone locations is a great idea.

**Charles Cunningham (Agriculture Branch Chief U.S. Customs and Border Protection)**
Cunningham gave an overview of the duties and structure of US Customs and Border protection along the border between the US and Canada. He explained the way patient transfers are made at Blaine and other points of entry and pointed out ways that border crossings can be expedited when emergencies require the transfer of firefighters, electrical linesmen, or medical personnel and equipment. For example:

• Call ahead with as much information as possible—who will be crossing the border, with what equipment and supplies, and when they expect to return.
• Email documents ahead if possible—personnel list, equipment manifest, proof that our help has been requested.
• Bring a manifest for equipment and supplies. This will help you avoid taxation of items going into Canada.
• Remember that personnel with criminal records are not allowed to cross. For those entering Canada, this includes DUI.

**Mike Smith (Washington State Department of Health)**
Smith discussed the lists of Emergency Patient Transport Assets that have been developed for Washington State. A statewide matrix and a matrix for each of the nine preparedness regions identify a wide variety of vehicles including ambulances and school buses that have been identified to move those who need help during an emergency. You can see the matrices at: [http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/PatientTransport.aspx](http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/PatientTransport.aspx)

**EMS workgroup discussion of transporting “at-risk” people with disabilities**
• Use of Medicaid Transportation Brokerages to identify and communicate with populations would be a good idea.
• Privacy issues could be avoided when the communication comes from entities that already have information about the population. There wouldn’t be sharing of information in those cases.
• Because of HIPAA, it can be difficult to get information about the location of people with disabilities who may need transport during an evacuation.
• HCA works with brokers to provide transport for Medicaid patients on a daily basis. Add them to your plan to provide emergency transport to those they serve. Brokers also serve many non-Medicaid people.
• BC is piloting a voluntary registry of those who need transport in an emergency.
• Tapping into privately operated handi-bus operators may be able to assist at pre-identifying risk populations that may require medical support/transport during major emergencies or disaster events.
  o Currently being done in some US states.
  o Privacy must apply.
  o BCAS - BC working with an NGO called People with Disabilities Registry.
    ▪ Voluntary registration being used to manage the privacy issue.

Larry Torris (Oregon Health Authority)
Torris discussed the shortage in saline, medication and supplies that have occurred in recent years. These shortages are due largely to just-in-time ordering practices and single-vendor contracts. He and others suggested these actions to address shortages:

• Establish communications with other providers and MOUs to allow your agency to find out who may have supplies you need.
• Monitor potential demand more closely.
• Improve your vendor contracts to cover emergencies.
• Develop ways to alter practice in ways that conserve scarce medication and supplies during an emergency.

Merged with the Emergency Management workgroup
“Cross Border 14 Communications Exercise” (Marina Zuetell, Washington State Communications)
• Largest ever bi-national communications functional exercise was reviewed.

Communications Workgroup

Convening an in-person communication workgroup meeting is a challenge each year due to travel restrictions and limited budgets. This year, workgroup co-leads Laura Blaske (Washington State) and Trish Rorison (British Columbia) hosted a conference call with communication representatives from member states/provinces including Oregon, Montana, Alaska, Idaho and British Columbia, as well as federal partners from Health Canada.
The main purpose of the call was to find a way to keep workgroup communication and activities going despite budget issues.

Each workgroup member gave an overview of their health department/ministry and basic emergency communications procedures. The group discussed challenges of developing a cross-border emergency communication process, and brainstormed ways to:

- Regularly touch base and update each other.
- Collaborate on shared issues.
- Quickly coordinate messages in emergency situations.
- Share training materials and opportunities.

Next steps

The group agreed to several conference calls during the year, each “hosted” by a different agency. Responsibilities in hosting a call would include:

- Planning and distributing the agenda.
- Giving a main report on issues in your area.
- Facilitating discussion.
- Taking notes during the call.
- Sending out notes after the call.

Issues identified for upcoming calls include:

- Key communication contact list.
- Engaging other partners.
- Talking about roadblocks in planning and how to overcome them.
- Current health issues.
- Emerging topics/issues of concern.
- Best practices.
- Training needs and opportunities.

British Columbia agreed to reach out to other provinces and get participants/contact info. Washington and British Columbia will contact workgroup members and get a call scheduled for early fall.

Public Health Law Workgroup

British Columbia Update: Fiona Gow

The Emergency Health Services Act contains provisions about agreements with other jurisdictions, issues of licensed personnel crossing borders, and practicing. In BC, each licensed profession has its own “college” that licenses them. The emergency medical assistance licensing board acts under the Ministry of Health. It would be complicated if each of these
colleges had to enter into an agreement with Washington; for example, last year authorized ambulance service to enter into agreements with a foreign jurisdiction.

The minister and other governmental entities can request that health professionals provide services from another jurisdiction, up to 72 hours. There is no apparent extension. They can provide only those services authorized by their own jurisdiction; if they provided additional training, at their discretion, they could do that.

Gow talked about how it would be best for BC to contact the program in the states that administers the health professional volunteer registry.

There is an agreement in place across Canada (MOU) with operational framework, mutual aid and health resources.

**Washington Update: Joyce Roper**

After the Oso landslides, officials deployed vets and grief counselors. They dealt with issues of ESF8 and a tug-of-war over what kind of mental health professionals should be deployed. The coroner system worked fairly well.

In the last legislative session, a bill was passed that protects the employer of a healthcare professional who is deployed as a volunteer. There is also protection for the hospital credentialing process for employers. Hospitals are also asking for protection for decisions to withhold healthcare during an emergency. (HB 2492)

Doctors from out of state who are not licensed in Washington wanted to provide healthcare at a free clinic. A bill has been passed that allows you to be a volunteer healthcare provider at low-cost clinic.

**Oregon Update: Shannon O’Fallon**

O’Fallon talked about the relinquishment of the public health authority and the future of the Public Health Task Force.

**CDC Public Health Law Program: Matt Penn**

Penn said the CDC is looking at liability issues related to emergencies across the country. They are conducting a 50-state assessment of who has authority to declare emergencies, and what authorities flow from that. Maybe once this information is gathered, research can be done. They are trying to gather all emergency declarations. There is also an assessment coming out on radiation authorities in the US (maybe May 15).

**Indigenous Health Workgroup**

The Indigenous Health Workgroup renewed its commitment to examine the unique positions, vulnerabilities and protective factors of Indigenous populations, their linkages to current
emergency planning and services, the identified limits to current approaches and collaborations, and the building of relationships, policies and plans between our nations.

Much time was spent discussing health supports for large events like the yearly “Tribal Journeys” canoe gatherings, this year in the remote BC community of Bella Bella, which is expected to draw upwards of 20,000 participants in an area with little infrastructure. The workgroup recognizes that though, historically, trust between Indigenous groups and local/state/provincial/federal institutions can be a challenge, this particular event represents a unique opportunity for increasing the capacities of and cooperation between a number of entities.

The First Nations Health Council and the Pan American Health Organization will hold a Hemispheric Consultation on Engaging Indigenous Peoples in Disaster Risk Reduction in Vancouver, May 22-23. Thirteen countries will participate, including Canada and the US. Thank you to the PNWBHA for its contribution to the social and cultural event for the participants.

**Clinical Medical Surge Workgroup**

The goal of this year’s workgroup was to improve the ability to respond in a medical surge event. A review of minutes shows that many action items have not yet been accomplished.

**Briefing on pediatric training: Vicki Sakata, MD**

- Dr. Sakata would encourage use of these open source materials and has offered assistance for other regions wanting to develop similar programs.
- The Pediatric Readiness Project results are now available online: [http://www.pediatricreadiness.org/State_Results/](http://www.pediatricreadiness.org/State_Results/). Use this information to provide support for further training and education.
  - ACTION ITEMS:
    - Contact Sally Abbott and Dr. Sakata regarding interest in developing pediatric workshops.
    - Develop budget and plan for helping those communities interested.

**Regional cross border pediatric resource list**

- Provide a template which has been used in the King County Pediatric Evacuation Annex.
- Most agreed that contact information would be important (i.e. phone or email for emergency managers and a nurse manager).
  - ACTION ITEM: Dr. Sakata to provide template for distribution.

**Pediatric cache equipment**

- Discussed the location and types of pediatric caches.
• Recommend that caches of important lifesaving pediatric equipment need to be quickly accessible and a local and regional project. One cannot be waiting around for airway equipment or correct IV sizes. But you can wait for many of the other pediatric-specific equipment.

Review of regional exercises involving pediatrics

• Tabletop exercise between Seattle Children’s Hospital and Oregon Health & Science University (OHSU) regarding critical care resources. Scenario: pertussis
  o Lesson: Rather than try to surge internally, it’s best to identify those patients who may need extracorporeal membrane oxygenation (ECMO) and transport them quickly rather than waiting.
  o Lesson: Reach out to local agencies to keep them informed of the situation and how they can be of assistance (i.e. transport).
• Transport list: Washington State has a list of all transport assets, updated quarterly. Needs to be distributed so others can do the same.
  o ACTION ITEM: Sally to distribute sample of Washington State transport list.
  o ACTION ITEM: Encourage all exercise and drill planning to include a few pediatric cases.

Mission-ready packages

• The Federal Emergency Management Agency (FEMA) has a structure by which a pediatric mission-ready package (MRP) can be developed.
• A MRP can then be designated so that pediatric specialists can be called up and deployed quickly.
• Liability would not be an issue as long as providers are registered emergency workers.
• Downsides of EMAC: needs a governor declaration, doesn’t apply internationally.
• Need to explore the PNEMA option: potential problems regarding deployment to areas that are not PNEMA signatories.
• Reimbursement to come after the fact.
• Need to decide what a pediatric MRP would look like.
  o Recommendations made to consist primarily of personnel.
  o Logistics need to be involved so that the team does not need to be concerned about hotels, food, etc.

Environmental Health Initiative Workgroup (new 2014)

This year marked the workgroup’s first meeting. The breakout session covered four topics:

Fukushima Panel

Participants from coastal states and British Columbia provided information about their activities and response to tsunami debris and radioactive cesium in ocean water and fish. Highlights of the discussion between participants from Alaska, British Columbia, Washington and Oregon:
• Alaska has been testing water and soil samples from debris brought in by ocean currents. Depending on the sensitivity of instruments, some levels of radiation can be detected, but there has been no evidence of contamination on their coast.
• Small amounts of radiation were found in BC in March 2011, but they were determined to be far below levels of concern to public health. To address citizen concern, Health Canada made enhancements to monitoring and put regular advisories on their website.
• The Washington State Department of Health took hundreds of calls from people who believed inaccurate news stories and internet activists ("Deadly radiation cloud headed to US"). Talking to people in non-bureaucratic language and holding public meetings in coastal communities helped to prove there was no public health impact. Data collection ramped up, and it was determined radiation levels were never dangerous during the acute phase.
• In Oregon, lessons learned included establishing command and control with the media, and creating talking points with scientific facts as quickly as possible to avoid giving out inaccurate data. They are now doing quarterly environmental surveillance through the Oregon Parks Department.

(Panel: Al Conklin, Clyde Pearce, Lauren Bergman, Dr. Jean-Francois Mercier, Dr. Kurt Ungar)

Fish Advisories Panel

The panel discussed partner collaboration on the upper and lower Columbia River to identify contaminants of concern and develop appropriate fish advisories that recommend people limit or avoid eating certain species of fish caught in certain places.

Testing is mainly done for two fish advisory contaminants—polychlorinated biphenyls (PCBs) and methylmercury. What to consider when consuming fish:

• Size: there is more mercury (and more concentrated mercury) in larger fish.
• Species: different species eat different things (ex: carp are fatty bottom-feeders).
• Migration: should eat migrating or hatchery-raised fish; resident fish have more concentrated contaminant levels.
• Who is consuming the fish: children are most vulnerable because of their developing brains; people who eat a lot of fish are also at risk; fish preparation methods can also have an impact.

The fish advisory process in Washington State consists of six steps:

1. Determine contaminant concentration of fish.
2. Estimate fish consumption rates by the public.
3. Estimate dose to contaminants for each population based on contaminant concentration and consumption rates.
4. Determine if the exposed dose results in an unacceptable health risk.
5. If the estimated dose exceeds a “safe” dose, determine a “safe” consumption rate.
6. Incorporate risk management and risk communication decisions. Provide recommendations and revise fish advisory if needed.

(Panel: Dave McBride, David Farrer)

One Health
One Health is a concept defined as the collaboration of health professionals, veterinarians, environmental experts and other experts to attain optimal health for people, animals and the environment. It embraces a “three is one” notion that humans, animals and the environment each have an impact on the health of the others.

One Health addresses the changing health challenges of today and tomorrow. By expanding collaborations in all aspects of healthcare—and by removing barriers between agencies, specialties and sectors—a One Health approach will enhance public health efficacy.

It is critical for the future control of infectious diseases. Over the past 30 years new infectious diseases have arisen, and antibiotic resistance is increasing at an alarming rate. The One Health time is now to manage the risks of emerging and resurging infectious diseases.

To protect the people of Washington State from zoonotic diseases, the Department of Health proposes a One Health Initiative to support and foster the concepts of One Health. A technical support team and steering committee have been formed, moving beyond concept into practice.

(Presenter: Dr. Ron Wohrle)

China Geoduck Import Ban

In December 2013, China banned imports of geoduck clams from Washington State and most of the US west coast for exceeding China’s arsenic standard. The geoduck industry is worth tens of millions of dollars in exports, 90 percent of which goes to China.

In response to the ban, agencies in Washington and Alaska began an initial investigation. Meanwhile, the Washington State Department of Health and the National Oceanic and Atmospheric Administration (NOAA) stopped issuing export certificates to China.

However, test results from the Department of Health’s Public Health Laboratories showed arsenic test results from the edible parts of geoducks were well below China’s standard, confirming previous results showing the quality and safety of the state’s shellfish. The bottom line: unless people eat the [inedible] skin, or very frequent large meals, the health hazard of consuming geoducks is extremely low.

Next steps for the Department of Health include arsenic validation testing, and coordination with:

- NOAA and Department of Natural Resources on arsenic testing protocols.
- NOAA on the export certification process.
- NOAA on delegation visits.

(Presenters: Clara Hard, Dave McBride, Brehan Kohl)
Plenary Session Summaries

Opening Ceremonies

Post the Colors
Northwest Indian Veterans Association, Colorguard
Oregon Army National Guard, TAG Select Honor Guard

First Nations Welcome
Bud Lane III, Tribal Vice-Chairman
Confederated Tribes of Siletz Indians

Pacific NorthWest Border Health Alliance (PNWBHA)
Michael Harryman, PNWBHA Co-Chair
Director of Emergency Operations, Oregon Health Authority

Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health

Oregon State Government Welcome
Tom Eversole, DVM, MS
Administrator, Center for Public Health Practice
Oregon Health Authority, Public Health Division

Canadian Welcome James
M. Baumgartner Honorary
Consul of Canada

Opening Remarks from the Pacific NorthWest Border Health Alliance (PNWBHA)

Michael Harryman, PNWBHA Co-Chair
Director of Emergency Operations, Oregon Health Authority

Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health

Building Resilient Communities through Mutual Aid

Introductions:
Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health, CA

John Madden, Director
Madden talked about the need to translate mutual aid from a reaction to a discipline—that is, discussing what needs to be done before the chaos and confusion of a disaster, not in the midst of one. The most vital element of mutual aid is a partnership built between communities during peacetime.

By planning ahead, communities can start with a baseline and then look at what can go wrong, what the consequences are and what can be done about them. Of the capabilities we have—transportation, communication, finance, public safety, civil order—none is more important than the others, and all are needed by the others. What other capabilities do we need to develop? What investments need to be made in these areas and how will mutual aid play a role?

Building communities with limited resources in an already burdened system is one of the big challenges. One approach is to treat the cause, not just the symptom, by making healthcare ready in homes, in shelters, on the streets—not just in hospitals and other healthcare settings.

Another challenge is that mutual aid is not free and comes with a price; an asset deployed is an asset not available at home. An example was in 2009 when Alaska experienced several emergencies including flooding, wildfires, the H1N1 epidemic and mudslides (“flood, flames, flu, flow”). These events emphasized the need to plan for the reality that nature won’t be respectful of timing, and communities must be agile and adapt to emerging threats and increasing risks.

Hot Legal and Legislative Topics in Emergency Preparedness

Introductions:
Shannon O’Fallon, JD
Public Health Law Workgroup, Co-Chair (US)
Senior Assistant Attorney General
Oregon Department of Justice

Matthew Penn, JD, MLIS, Director
Public Health Law Program
Office for State, Tribal, Local and Territorial Support
Center for Disease Control and Prevention, US

Penn discussed the difficulties of balancing the reality of emergencies with the response structures that are tasked with responding to them.

Penn’s discussion focused on the relationship between an emergency and “the administrative state” that is responsible to help out during the response. There are huge disconnects when trying to apply something we control—the administrative state—onto something we can’t—the emergency—and trying to make it conform.
Disasters create new “states” that are comprised of the area inside the disaster. What are things we can do to prepare to make those areas operate as an entity?

- Appreciate the massive scope of the things we can’t control.
- Think more deeply about how we can improve the administrative state.
- Develop plans, compacts, laws, orders, agreements, etc. that help mitigate some of the disconnects.
- Getting people out of jurisdictions (workforces, healthcare systems, death systems, information management).
- Anticipate legal hurdles especially when straddling borders (workers, volunteers, deployment issues, liability; workers’ compensation, liability of hospitals when credentialing temporary help, standards of care, pharmaceutical tracking).

**Recent Mutual Assistance Experiences**

**Garnet Matchett**, PNWBHA Co-Chair, Canada  
*Director of Operations, Health Emergency Management Unit*  
*Saskatchewan Ministry of Health, CA*

**Shawn Carby**, Health Emergency Management Workshop Co-Chair  
*Executive Director, Emergency Management Unit*  
*British Columbia Ministry of Health, CA*

**Tina Maslyk**, A/Director  
*Emergency Management Unit*  
*Alberta Ministry of Health, CA*

In June 2013 heavy rainfall in southern Alberta led to full, fast-flowing rivers, resulting in flood waters covering the province from Calgary south to the Montana border. It was the largest natural disaster in Alberta’s recorded history. Statistics included the following:

- More than 80,000 people were evacuated.
- In two days, 28 states of local emergency were declared.
- Ten healthcare facilities, 80 schools and 14,000 homes were damaged.

The ripple effect of the disaster greatly impacted the mutual aid process. Local resources couldn’t be drawn on because many of those who could normally help were in a worse situation than those asking for assistance.

Mutual aid was especially needed in the recovery phase about five days in, mostly in deciding how to get people back home and where to house them in the meantime. Teams of experts from environmental health, building and fire code enforcement, and insurance companies went house by house doing inspections.

Counties north of Edmonton were called upon for help. Alberta also requested help from Public Health Canada. However, the MOUs already in place didn’t operationalize mutual aid, so an
MOU that would allow BC to assist Alberta had to be drafted. Twelve environmental health inspectors and 30 mental health professionals from BC went to Alberta.

Lessons learned included the need to work out agreements ahead of time; five days was short, but also long in terms of response. Public health inspectors and psychosocial experts were needed for three-weeks-on assignments, and it was difficult finding people who could work for more than one week at a time. There were also liability issues working with volunteers, and workers’ compensation issues as well.

**Volcano Hazards and Disasters in the Pacific Northwest: What Can We Learn from the Global Experience?**

**John Ewert**, Scientist–in-Charge  
*United States Geological Survey*  
*Cascades Volcano Observatory, US*

**Dan Banks**, MA, Plans and Operations Manager  
*Office of Emergency Preparedness and Response*  
*Washington State Department of Health, US*

According to the most recent USGS volcano threat assessment, 10 of the 17 United States volcanoes considered a very high threat to erupt are located in the Cascade mountain range. Mt. St. Helens has the highest threat level of any US volcano.

Volcanoes present the following dangers:

- **Blast**—extremely destructive but affecting a limited area.
- **Pyroclastic flow**—fast-moving, high-temperature gas, rock and ash that can travel hundreds of miles along the land surface or over water.
- ** Lahar**—mud flows that travel rapidly down drainages for many miles. Can stem from volcanic events but occur under other conditions as well. A lahar killed 23,000 people in Amaro, Colombia in 1985.
- ** Ash fall**—can range up to 500 kilometers, is highly abrasive and contains acid salts. Ash can disrupt aviation, cause crop damage, clog sewers, damage electrical equipment and cause difficulties for those with breathing issues.
- **Sediment in rivers and waterways**—can alter the course of rivers.

Volcanoes have become more of a threat over time because people build closer to them and because we take them for granted when they lie dormant for long periods. Volcanic eruptions can be predicted with instrumentation, although the exact timing and nature of the eruption cannot be predicted. The USGS provides a volcano notification service that can be accessed through a phone app and provides online prediction of ash distribution through its Ash3D modeling program.

**Dan Banks--Washington State Department of Health**
Banks discussed an exchange between the US and Colombia involving visits by representatives of each country to towns that have been affected or have the potential to be affected by lahars. These are the towns of Amaro, Colombia, where an estimated 23,000 people died in a lahar in 1985 and Orting, Washington, which is in an identified lahar zone at the foot of Mt. Rainier. Banks stated that the keys to avoiding the loss of life in future Amaro-like events are effective warning systems, a well-trained populace in potential lahar areas, and the engagement of local officials.

Crisis Standards of Care

Sally Abbott, RN, MSN, Clinical Medical Surge Workgroup Co-Chair, Medical Surge and Healthcare Coalition Coordinator  
*The Office of Emergency Preparedness and Response*  
*Washington State Department of Health, US*

Richard F. Leman, MD, Chief Medical Officer  
*Health Security, Preparedness, and Response*  
*Public Health Division, Oregon Health Authority, US*

A presentation and discussion was led by Sally Abbot of the Washington State Department of Health and Richard Lerman of the Oregon Health Authority on the issue of altered standards of care during an emergency.

The discussion included an overview of the basic issues that need to be considered when developing and implementing altered standards. The development of Oregon’s Standards of Care was also discussed.

The speakers discussed the myriad issues that need to be taken into consideration when developing guidelines for crisis care and altered standards of care, including: defining triggers; making sure care is ethically grounded and logistically sound; establishing legal authority; assessing risks and vulnerabilities; determining how to prioritize/triage patients.

Standards of care stakeholders include a long list of entities involved in response and preparation: legal, government, EMS, hospitals/acute care, clinics, alternate care facilities, public engagement, those involved in ethics, palliative care, mental health. This list grows when factoring the special needs of rural and cross border areas.

Emerging Mycotic Diseases in Washington State: Partnerships in the Investigation of Fungal Pathogens

Nicola Marsden-Haug, MPH
Marsden-Haug talked about two emerging diseases in Washington State: Coccidioidomycosis (Valley Fever) and Cryptococcus gattii.

Valley Fever is a soil-dwelling fungus transmitted through inhalation of spores. In 2010 and 2011 three cases were diagnosed in Washington State. This was unusual because the disease normally occurs in the southwestern US and other hot, dry regions. Washington cases typically have traveled to one of these regions, but none of the three reported recent travel.

Clinical tests showed acute infection in all three cases, and they were geographically clustered. The CDC tested soil samples from two suspected exposure sites in Benton County. DNA from one patient and from soil isolates matched, proving the infections were locally acquired—leading to unanswered questions about how widespread it might be.

It is important to generate awareness among doctors and veterinarians that there have been locally acquired cases. The biggest concern is that delay in medical care could lead to substantial complications. Clinicians and labs have been asked to report all positive cases.

Cryptococcus gattii is an environmental fungus also transmitted through inhalation of spores, typically presenting as meningitis. Previously seen only in tropical/subtropical climates, it first appeared in British Columbia in 1999 and then expanded into Washington and Oregon.

C. gattii surveillance in Washington began in 2004, reportable as a “rare disease.” Because of suspected underreporting, notifiable conditions were revised in 2011 requiring clinical and veterinary labs to report positive cases. Collaboration with neighbors in Oregon, California and elsewhere began to increase awareness.

A study evaluating epidemiological differences between Australia, British Columbia and the US led to a data use agreement being signed and moving forward. Initial investigation in Washington and Oregon determined that the majority of cases were among immunosuppressed patients and were mostly respiratory in nature. There is a long delay to diagnosis in such a rare disease, especially among pulmonary patients.

There are still many unanswered questions: Has C. gattii always been here or was it recently introduced? Has the organism adapted? Have environmental conditions become more favorable for it in the Pacific Northwest?
The Framework provides a consistent method Canadian provinces and territories can use to obtain or provide timely aid to one another during emergencies. Although it is non-binding, the Framework has been signed by all Canadian provinces and territories. Under the Framework, aid requests are arranged directly by jurisdictions without federal involvement. The agreement emphasizes single-window access, a single point of contact for each agency for coordinating requests. At this time the Framework primarily addresses requests for physicians and nurses although it has been used to acquire support from other disciplines as well.

The Framework is based on the following assumptions:

- Provinces and territories have varying degrees of capacity.
- Provinces and territories agree to share existing capacity.
- Jurisdictions should not provide support to others if it endangers their jurisdiction.
- The jurisdiction that requests aid will pay associated costs.

The Framework provides guidance for each of the three phases of response:

**Pre-mobilization**
- Early warning, request, offer of mutual aid, acceptance of aid, licensing and credentialing, logistics coordination, practitioner briefing

**Mobilization**
- Move healthcare providers, integrate healthcare providers locally, provide ongoing support, renew request or release requested personnel

**Demobilization**
- Demobilize, debrief, monitor health of providers, evaluate

The Framework was exercised in 2013 and was adapted by Alberta to request health inspectors and psycho-social assistance during flooding in 2013.

Canada is now working to expand the Framework to address more professions, physical assets and international mutual aid.

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**Enhancing Mutual Assistance through Canadian and US Federal Health Coordination**

*Introductions:*

**Michael Harryman**, PNWBHA Co-Chair  
*Director of Emergency Operations, Oregon Health Authority*

**Maria Julia Marinissen**, PhD, Director  
*Division of International Health Security, United States Health and Human Services, US*

**Tammy Delaney-Plugowsky**, IA-RN, BScN, Chief  
*Office of Health Emergency Responder Support and Coordination (HERSC), Alberta, CA*
Marinissenn described the following international and regional initiatives:

- Global Health Security Initiative—an international ministerial-level initiative to strengthen response to pandemic influenza, radiological and chemical events and other health threats.
- Global Health Security Agenda—an international partnership that works to prevent avoidable epidemics, detect disease threats early, and promote rapid and effective response.
- North American Plan for Animal and Pandemic Influenza (NAPAPI)—Presidential-level initiative among the US, Mexico and Canada to prepare for animal and pandemic influenza.
- Beyond the Border—A US-Canada initiative to promote trade, strengthen cross border law enforcement and protect critical infrastructure. It also addresses shared response to health security threats.
- 2014 Capstone Exercise: Alaska Shield—a US exercise with limited Canadian observation based on an earthquake and tsunami scenario occurring in Alaska during the winter. The scenario called for Canada to offer certain medical supplies and personnel.

Two white papers have been developed for discussion by the US and Canada. They are in the final stages of development and will be available for review by PNWBHA members:

- Identifying barriers to sharing health personnel in crisis situation and suggesting options for overcoming those barriers.
- Identifying countermeasure strategies and policy options to overcome identified barriers.

**Mutual Aid Challenges: SR 530 Flood and Mud Slide Response and Recovery**

*Introductions:*

**Michael Harryman,** PNWBHA Co-Chair  
*Director of Emergency Operations, Oregon Health Authority*

**Peter Mayer,** Deputy Director/Chief Operating Officer  
*Snohomish Health District*  
*Everett, Washington, US*

The mudslide and flooding disaster in Oso, Washington, on March 22, 2014 covered a square mile and caused more than 40 deaths. More than 100 emergency responders from Snohomish County and surrounding counties were dispatched to assist with emergency medical and search-and-rescue efforts. Details about public health’s role and the emergency response included:

- The Snohomish Health District played a large role in the response under its ESF 8 responsibilities to provide access to healthcare services for survivors and responders,
oversee worker safety, address environmental hazards, provide mental health services, and provide mortuary services.

- **Assistance came from many areas. A few key contributors:**
  - Health and Human Services DMORT team provided help with victim identification, forensics and processing remains.
  - Washington Air National Guard provided search and rescue.
  - Public information officers from several state agencies.
  - Medical examiners from Pierce and Snohomish counties.
  - Washington State Department of Health provided advice and technical assistance and helped coordinate federal aid offers.
  - Green Cross, American Red Cross and clergy provided mental health and counseling services.

- **Some issues that need to be addressed for future events:**
  - Snohomish County has no patient tracking system.
  - It is unclear who is responsible for providing mental health services.
  - Veterinary services need to be formalized.
  - Volunteer safety needs to be addressed more clearly.
  - A system for monitoring the health of workers should be developed, including a system for monitoring and addressing stress.
  - Roles of EOC and ICP need to be clearly defined.
  - JIC operations should be clarified—message approval was often difficult during this incident.

- **Some advice:**
  - Know and practice your plans.
  - Don't forget continuity of operations at your agency. Staff will want to do all they can for the emergency effort, but the day-to-day business has to be done.
  - Know your local resources.
  - Don't underestimate need for psychosocial services.

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**Mutual Aid Assistance Group Discussion**

**Joe Lynch,** Project Specialist  
*BCFS Health and Human Services  
Emergency Management Division*

**Dwight Graves,** Project Specialist  
*BCFS Health and Human Services  
Emergency Management Division*

**Richard Hooks,** Director of Program Management  
*BCFS Health and Human Services  
Emergency Management Division*
A tabletop discussion took place around the scenario of response to a large-scale earthquake. The participants were asked to discuss the needs for health and medical services, requesting mutual aid through PNEMA or EMAC agreements, and what the barriers are to those resources.

Also discussed were the issues of mutual aid pertaining specifically to the areas of volunteers, patient transport and alternate care facilities. The group talked about the issues of fatality management and mental health needs.

Among the hurdles and considerations participants mentioned were:

- PNEMA – Credentialing & privileges (REMAC meeting)
- Who will coordinate and adjudication of resources
- Patient tracking
- HIPAA impact
- How do we repatriate
- Ability to move patients by air
- Volunteers – training and credentialing
- Resources – knowing what to ask for
- Victim support and family communications
- Transport plan – military assistance and if so, how do we request it?
- Resource typing
- Religious leadership support
- NGO’s for shelter support
- Line of Duty Death
- Variations in fatality management – ME versus coroner

- Fatality identifications – human remains process
- Mental Health – to augment fatality management teams
- Faith based organization support
- Death certificates back to families – electronic
- Move to centralized fatality processing and storage
- Tribal liaison to assist with cultural differences
- Public notification/messaging of process to receive death certificate
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.

This year’s World Café poster presentation was intended to provide individual attendees an opportunity to showcase a particular project or program. Final selections were based on innovation, workshop theme, topic relevance, diversity and their visually appealing and educational nature.

Presenters included:

**Peter Hennecke**  
*British Columbia Mobile Medical Unit, PHSA*

**Jesse Veenstra**  
*British Columbia Mobile Medical Unit, PHSA*

Poster title: “British Columbia Mobile Medical Unit as a Catalyst for Healthcare Delivery in First Nations Communities: A Pilot Study”

**Dacey Storzbach**  
*Northwest Center for Public Health Practice, University of Washington*


**Laura Blaske**  
*Washington State Department of Health*

Poster title: “WashYourHandsingTon”

**Laura Blaske**  
*Washington State Department of Health*

Poster title: “Results of the Pacific Northwest Emergency Management Arrangement (PNEMA)”

**Maria Gardipee**  
*Washington State Department of Health*
Poster title: “Searching for Native Stories about Cascadia Subduction Zone Earthquakes”

Larry Torris  
_Oregon Emergency Medical Services_

Rod Salem  
_British Columbia Ambulance Services_

Mike Smith  
_Washington Emergency Medical Services_

Poster title: “Emergency Medical Services’ Cross Border ‘Mutual Assistance’ Saving Lives!”

Christopher Chadwick  
_Association of Public Health Laboratories_


Resham Patel  
_National Association of County and City Health Officials_

Poster title: “Project Public Health Ready (PPHR)”

Michael Kubler  
_Cascadia Region Earthquake Workgroup_

Poster title: “Cascadia Subduction Zone Scenario”
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
11th Annual Pacific NorthWest Cross Border Workshop
“Mutual Assistance: A Cross Border Perspective”

Portland, Oregon
May 12-14, 2014

Monday, May 12, 2014

Orientation Session/ Workgroup Breakout Sessions

8:00-5:00 Registration

10:30-12:00 Orientation Session
  Introductions: Wayne Dauphinee, Executive Director
  Pacific NorthWest Border Health Alliance (PNWBHA)

  P3 - PNWBHA, PNEMA, PNWER: Who We Are and What We Do

  Wayne Dauphinee Executive Director
  Pacific NorthWest Border Health Alliance (PNWBHA)

  Patrick Quealey Chair
  Western Regional Emergency Management Advisory Committee/Pacific Northwest Emergency Management Arrangement (PNEMA ) and Assistant Deputy Minister
  Emergency Management BC

  Eric Holdeman Director
  Pacific North West Economic Region (PNWER)
  Center for Regional Disaster Resilience

12:00-1:00 Lunch on Your Own
11th Annual Cross Border Public Health Preparedness Workshop

Monday, May 12, 2014

1:00-4:00  Workgroup Breakout Sessions

Track 1  Epidemiology and Surveillance
         Eleni Galanis, Co-Chair (CA)
         Mike Boysun, Co-Chair (US)

Track 2  Public Health Laboratories
         Muhammad Morshed, Co-Chair (CA)
         Romesh Gautom, Co-Chair (US)

Track 3  Health Emergency Management
         Shawn Carby, Co-Chair (CA)
         Nathan Weed, Co-Chair (US)
         Dan Banks, Lead (US)

Track 4  Health Emergency Medical Services
         Ralph Jones, Co-Chair (CA)
         Rod Salem, Lead (CA)
         Mike Smith, Co-Chair (US)

Track 5  Communications
         Trish Rorison, Co-Chair (CA)
         Laura Blaske, Co-Chair (US)

Track 6  Public Health Law
         Fiona Gow, Co-Chair (CA)
         Shannon O’Fallon, Co-Chair (US)

Track 7  Indigenous Health
         Evan Adams, MD, Co-Chair (CA)
         Elizabeth, Buckingham, Co-Chair (US)

Track 8  Clinical Medical Surge Workgroup (new 2013)
         Janice Penner, Co-Chair (CA)
         Sally Abbott, Co-Chair (US)

Track 9  Environmental Health Initiative (new 2014)
         Leo Wainhouse, (US)
         To be announced (CA)

4:30-6:00  PNWBHA Joint Coordination Committee (JCC) Annual Meeting
(by invitation only)
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 1

Tuesday, May 13, 2014

6:30 –4:00 Registrations
7:00 –8:00 Continental Breakfasts

8:00–8:45 Opening Ceremonies

Post the Colors
Northwest Indian Veterans Association, Colorguard
Oregon Army National Guard, TAG Select Honor Guard

First Nations Welcome
Bud Lane III
Tribal Vice-Chairman
Confederated Tribes of Siletz Indians

Pacific NorthWest Border Health Alliance (PNWBHA)
Michael Harryman, PNWBHA Co-Chair
Director of Emergency Operations, Oregon Health Authority

Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health

Oregon State Government Welcome
Tom Eversole, DVM, MS
Administrator, Center for Public Health Practice
Oregon Health Authority, Public Health Division

Canadian Welcome James
M. Baumgartner Honorary
Consul of Canada
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 1

Tuesday, May 13, 2014

8:45-9:00 Opening Remarks from the Pacific NorthWest Border Health Alliance (PNWBHA)

Michael Harryman, MA, PNWBHA Co-Chair
Director of Emergency Operations, Oregon Health Authority, US

Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health, CA

9:00-10:00 Building Resilient Communities through Mutual Aid
Introductions: Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health, CA

John Madden, Director
Alaska Division of Homeland Security & Emergency Services
State of Alaska

10:00-11:00 Hot Legal and Legislative Topics in Emergency Preparedness
Introductions: Shannon O’Fallon, JD,
Public Health Law Workgroup, Co-Chair (US)
Senior Assistant Attorney General
Oregon Department of Justice

Matthew Penn, JD, MLIS, Director
Public Health Law Program
Office for State, Tribal, Local and Territorial Support
Center for Disease Control and Prevention, US

11:00-11:15 Transition Break
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 1

Tuesday, May 13, 2014 – continued

11:15-12:15  2 Concurrent Breakout Session
Breakout 1- Recent Mutual Assistance Experiences

- **Garnet Matchett**, PNWBHA Co-Chair, Canada
  Director of Operations, Health Emergency Management Unit
  Saskatchewan Ministry of Health, CA

- **Shawn Carby**, Health Emergency Management Workshop Co-Chair
  Executive Director, Emergency Management Unit
  British Columbia Ministry of Health, CA

- **Tina Maslyk**, A/Director
  Emergency Management Unit
  Alberta Ministry of Health, CA

Breakout 3 - Volcano Hazards and Disasters in the Pacific

  Northwest: What can we learn from the global experience?

- **John Ewert**, Scientist –in-Charge
  United States Geological Survey
  Cascades Volcano Observatory, US

- **Dan Banks**, MA, Plans and Operations Manager
  Office of Emergency Preparedness and Response
  Washington State Department of Health, US

12:15-12:30  Transition Break

12:30-1:30  Networking Luncheon and Awards Presentation
**Wayne Dauphinee** Executive Director
Pacific NorthWest Border Health Alliance (PNWBHA)
Lunch to be provided

1:30-1:45  Transition Break
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 1

Tuesday, May 13, 2014 – continued

1:45-2:45  3 Concurrent Breakout Sessions

Breakout 4 - Crisis Standards of Care

- Sally Abbott, RN, MSN, Clinical Medical Surge Workgroup Co-Chair, Medical Surge and Healthcare Coalition Coordinator
  The Office of Emergency Preparedness and Response
  Washington State Department of Health, US

- Richard F. Leman, MD, Chief, Medical officer
  Health Security, Preparedness, and Response
  Public Health Division, Oregon Health Authority, US

Breakout 5 - Emerging Mycotic Diseases in Washington State: Partnerships in the Investigation of Fungal Pathogens

- Nicola Marsden-Haug, MPH Zoonotic Disease Epidemiologist
  Washington State Department of Health, US

Breakout 6 - Canada’s Operational Framework for Mutual Aid Requests

  – O Plan

- Tammy Delaney-Plugowsky, IA-RN, BScN, Chief
  Office of Health Emergency Responder Support and Coordination (HERSC), Alberta, CA

- Shawn Carby, Health Emergency Management Workshop Co-Chair
  Executive Director, Emergency Management Unit
  British Columbia Ministry of Health, CA
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 1

Tuesday, May 13, 2014 – continued

2:45-3:45 Enhancing Mutual Assistance through Canadian and US Federal Health Coordination
   Introductions: Michael Harryman, PNWBHA Co-Chair
   Director of Emergency Operations, Oregon Health Authority

   Maria Julia Marinissen, PhD, Director
   Division of International Health Security
   United States Health and Human Services, US

   Tammy Delaney-Plugowsky, IA-RN, BScN, Chief
   Office of Health Emergency Responder Support and Coordination (HERSC),
   Alberta, CA

3:45-4:00 Networking/Transition Break

4:00-5:00 International Mutual Aid Agreements: Foundations of Health Security in North America
   Introductions: Garnet Matchett, PNWBHA Co-Chair
   Director of Operations, Health Emergency Management Unit
   Saskatchewan Ministry of Health, CA

   Kenneth D. Murphy, Regional Administrator, Region X
   Department of Homeland Security
   Federal Emergency Management Agency

5:00-6:30 Poster Presentations and World Café Networking

6:00 Dinner on your own
11th Annual Cross Border Public Health Preparedness Workshop

*General Sessions – Day 2*

**Wednesday, May 14, 2014**

7:00  
Registration
7:00 –8:00  Continental Breakfasts

8:00–8:15  **Opening Remarks from the Pacific NorthWest Border Health Alliance (PNWBHA)**

*Michael Harryman, MA, PNWBHA Co-Chair*

*Director of Emergency Operations, Oregon Health Authority*

*Garnet Matchett, PNWBHA Co-Chair*

*Director of Operations, Health Emergency Management Unit*  
*Saskatchewan Ministry of Health*

8:15-9:45  **Mutual Aid Challenges: SR 530 Flood and Mud Slide Response and Recovery**

*Introductions: Michael Harryman, PNWBHA Co-Chair*

*Director of Emergency Operations, Oregon Health Authority*

*Peter Mayer, Deputy Director/Chief Operating Officer*

*Snohomish Health District*

*Everett, Washington, US*

9:45-10:00  **Break**
11th Annual Cross Border Public Health Preparedness Workshop

General Sessions – Day 2

Wednesday, May 14, 2014 continued

10:00-12:45 Mutual Aid Assistance Group Discussion
Joe Lynch, Project Specialist
BCFS Health and Human Services
Emergency Management Division

Dwight Graves, Project Specialist
BCFS Health and Human Services
Emergency Management Division

Richard Hooks, Director of Program Management
BCFS Health and Human Services
Emergency Management Division

10:00-10:15 - Scenario Introduction

10:15-12:15 Disaster Scenario Sessions

12:15-12:45 - After Action Discussion

12:45-1:00 Workshop Wrap Up and Next Steps
Wayne Dauphinee Executive Director
Pacific NorthWest Border Health Alliance (PNWBHA)

Michael Harryman, MA, PNWBHA Co-Chair
Director of Emergency Operations, Oregon Health Authority, US

Garnet Matchett, PNWBHA Co-Chair
Director of Operations, Health Emergency Management Unit
Saskatchewan Ministry of Health, CA

1:00 Workshop Ends
Brown Bag Lunch provided
Appendix B

Speaker Biographies
(in alphabetical order)

Sally Abbott, RN, MSN  
Medical Surge and Healthcare Coalition Coordinator  
Public Health Emergency Preparedness and Response  
Washington State Department of Health, US

Sally Abbott has been a nurse for over 30 years and has done state-level healthcare emergency preparedness for eight years. She serves as the Medical Surge Coordinator in Washington State, working with large and small hospitals, community health centers, tribal health corporations, and other partners on medical surge planning and did similar work in Alaska until 2010.

One of her current projects is state-coordinated patient movement. She has been a member of incident management teams for both exercises and real life responses. Her clinical practice experience includes general medical-surgical hospital units, home care and hospice, school nursing and occupational health.

Dan Banks, MA, Section Supervisor  
Emergency Response Planning, Operations & Exercise  
Office of Emergency Preparedness and Response  
Washington State Department of Health, US

Daniel (Dan) Banks is the Plans, Operations & Exercise Manager with the Washington State Department of Health, Public Health Emergency Preparedness and Response Program.

In his position at Department of Health, he manages the agency’s Comprehensive Emergency Management Plan, the Department’s Emergency Operations Center, the Emergency Support Function 8 (Public Health and Medical) for Washington State, and emergency response exercise program. Previously as the department’s Emergency Exercise Coordinator, he led the development of numerous state-level public health emergency response exercises. He has been integral in developing cross-border response planning in the Pacific Northwest. This includes lead planning for health and medical support to British Columbia, during the 2010 Olympics and the development of annual duty officer’s communications drill. Dan has over 30 years’ experience in emergency response operations and exercising at the federal and state level. He holds a BA in Political Science and Geography from the University of Washington, and a MA in International Relations from California State University Stanislaus.

Shawn Carby, CD, MAL, BHSc, EMT-P Executive Director  
Emergency Management Unit  
Population Public Health Division
Ministry of Health, British Columbia, Canada

Shawn has been involved in hospital and emergency healthcare, public health, and disaster health and preparedness service delivery for 30 years. Through his experience as an emergency services and healthcare executive, administrator, consultant, instructor and provider, he has acquired a wealth of experience in municipal, regional health authority, military and provincially operated emergency medical services, disaster, and healthcare systems.

Areas of responsibility have included urban, rural and remote demographics including international disaster relief and peacekeeping deployments.

Currently he is the Executive Director of the Emergency Management Unit, Population and Public Health within the British Columbia Ministry of Health, which oversees the coordination of health emergency response and planning for the province of British Columbia.

Wayne Dauphinee, MHA, Executive Director
Pacific NorthWest Border Health Alliance
British Columbia, Canada

Mr. Dauphinee is the former Executive Director for the Emergency Management Branch, Ministry of Health Services, Victoria, British Columbia. He is a qualified health services administrator with over 40 years of 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 British Columbia 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. He is a former co-chair of the Federal/Provincial/Territorial (F/P/T) Emergency Preparedness and Response Expert Group and Chair of the F/P/T Council of Health Emergency Management Directors.

Prior to joining the British Columbia Public Service, Wayne spent 35 years with the Canadian Forces (CF) as a Health Services Officer and currently serves as the Chair, Royal Canadian Medical Service Association.

Tammy Delaney-Plugowsky, Chief
Health Emergency Surge Capacity Unit
Public Health Agency of Canada

Tammy currently serves as Chief of the Health Emergency Surge Capacity Unit in the Public Health Agency of Canada. Previously, she was the Nurse Coordinator in the National Office of Health Emergency Response Team in the Public Health Agency of Canada.

She has worked closely with provincial and territorial counterparts in maintenance of a sustainable, flexible, efficient and effective means of coordinating inter-jurisdictional mutual aid in times of health emergencies. The Federal/Provincial/Territorial (FPT) Memorandum of Understanding (MOU) on the Provision of Mutual Aid in Relation to Health Resources during an
Emergency Affecting the Health of the Public was signed by all Canadian health ministers in 2009.

Her office successfully coordinated the development and recent pan-Canadian endorsement of the FPT Operational Framework for Mutual Aid Resources (OFMAR). This highly collaborative piece of work contains a series of protocols and templates meant to aid in mutual assistance requests for health professionals across jurisdictional boundaries in Canada.

John Ewert, Scientist-in-Charge
USGS Cascades Volcano Observatory
Portland, Oregon, US

Since 2010, John W. Ewert has been the Scientist-in-Charge of the USGS Cascades Volcano Observatory. His entire career has been spent working on matters pertaining to explosive volcanism, volcano monitoring and volcano hazards mitigation in the United States and around the Pacific Rim. From 1980 to 1986 he worked at Mount St. Helens on various research projects pertaining to volcanic gas emissions and ground deformation over the course of 15 eruptions, as well as working on projects at other Cascade Range volcanoes.

He was one of the founding members in 1986 of the ongoing USAID-USGS Volcano Disaster Assistance Program (VDAP) and worked in VDAP from 1986-2010 responding to volcanic eruption crises and developing volcano monitoring infrastructure in Latin America, the southwest Pacific and southeast Asia. In addition to responsibilities with VDAP, in 2005 Mr. Ewert developed the methodology to conduct a national volcanic threat assessment for US volcanoes. The results of the assessment are being used to guide long-term improvements to the nation’s volcano-monitoring infrastructure operated by the USGS and affiliated partners, and to improve USGS hazard- information products for the emergency managers, the aviation sector and the public.

Dwight Graves, Project Specialist
BCFS Health and Human Services (HHS)
Emergency Management Division, US

Mr. Graves is a project specialist and Incident Management Team (IMT) member for the BCFS Emergency Management Division. He serves as deputy incident commander for BCFS gold international IMT. Mr. Graves has extensive experience working in the private, public and government sectors with his 27 years of fire, healthcare and EMS service and 19 years in law enforcement. Appointed by the governor of Alabama, Mr. Graves served the last nine years as a Commissioner of the State of Alabama Fire College Personnel Standards and Education Commission. Additionally, he is adjunct faculty at the Texas A & M University and the Center for Domestic Preparedness (CDP). His experience includes key positions in numerous incidents of national significance, including the DHS HHS UAC Surge, TX 2012, Pipeline Rupture, IL 2012, BP Oil Spill, AL 2010, Hurricane Katrina, Gulfport, MS 2005 and, Alabama Tornado disasters 2012, 2011 and 1998. He also provides training and evaluation support for Department of Defense throughout the United States and internationally in Japan, Germany, Italy, Kuwait and England.

Michael Harryman, MS, Co-Chair, (US)
Joint Coordination Committee, Pacific Northwest Border Health Alliance  
Director of Emergency Operations  
Oregon Health Authority, US

Mike Harryman has served as the Director of Emergency Operations of the Oregon Health Authority’s, Public Health Division: Health Security, Preparedness and Response program since February 2006. The ASPR-HPP and CDC-PHEP cooperative agreement grants are managed at the state level within Mike’s program.

Mike also served as the Director of the EMS and Trauma Systems program from February 2012 until October 2013. Prior to his current 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 1991 Gulf War and retired after a 22-year career at the rank of a Master Sergeant from the US 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. Mike received his Master’s degree with honors in Emergency and Disaster Management from the American Military University. He holds a B.S. in Business Management from the University of Phoenix.

Bonnie Henry, MD, MPH  
Medical Director, Communicable Disease Prevention and Control Services and, Public Health Emergency Management  
British Columbia Centre for Disease Control  
Vancouver, British Columbia, Canada

Dr. Henry obtained her medical degree from Dalhousie University in Halifax, then practiced as a general practitioner, Diving Medical Officer and Flight Surgeon with the Canadian Armed Forces and in general practice in Victoria, British Columbia. Dr. Henry completed a Preventive Medicine Residency and Masters of Public Health with the University of California, San Diego and obtained her Community Medicine (Public Health) training at the University of Toronto. Dr. Henry is a Fellow of the Royal College of Physicians of Canada and of the American College of Preventive Medicine.

Dr. Henry is a public health physician and epidemiologist and Assistant Professor in the School of Population and Public Health at UBC and is located at the BCCDC. She worked for the World Health Organization on the ebola outbreak in Uganda in 2000 and the STOP polio program in Pakistan.

Most recently she was the Associate Medical Officer of Health for the City of Toronto and led the operational response to the SARS outbreak in the City in 2003. She led the development of public health emergency management protocols for Ontario and was an executive member of the Ontario SARS Scientific Advisory Committee. Her research interests are in establishment of effective surveillance systems for communicable disease, including new and emerging diseases, public health emergency response and the continuum of community and hospital infection control.
Eric Holdeman, Director
Pacific Northwest Economic Region (PNWER)
Center for Regional Disaster Resilience, US

Eric’s areas of expertise include building regional coalitions between agencies, governments, the private sector and nonprofits. Planning, regional planning, Emergency Operations Center (EOC) design and construction, multimedia public education programs, Joint Information Center (JIC) formation and operations, media relations, social media, meeting facilitation and integration of technology into emergency management and homeland security programs are just a few of the areas in which he has extensive experience.

Eric currently works professionally in the areas of port security, emergency management and risk management. He is a writer for Emergency Management Magazine where he contributes feature articles and also has a regular column, “Eric’s Corner.” An experienced and accomplished public speaker he is sought after to present at national and regional conferences. Eric blogs on emergency management and homeland security topics at [www.disaster-zone.com](http://www.disaster-zone.com).

Eric is a member and past president of the Washington State Emergency Management Association (WSEMA). He currently serves on the Board of Directors for the Emergency Information Infrastructure Partnership (EIIP). He is also on the Advisory Council for the Center for Regional Disaster Resilience and the Pacific Northwest- Advanced National Seismic Safety Region Advisory Committee.

Additionally, he serves on the Advisory Board for the University of Washington’s Masters in Strategic Planning for Critical Infrastructures.

Eric is married to Mary (Brower) Holdeman. Their home is in Puyallup, Washington. Eric is also an avid gardener with his home garden being featured in several Sunset Magazine publications.

Richard Hooks, Director of Program Management
BCFS Health and Human Services (HHS)
Emergency Management Division, US

Richard Hooks is the Director of Program Management for BCFS Health and Human Services Emergency Management Division and a member of the BCFS Incident Management Response Team. He is a Certified Public Manager and is the retired Fire Chief and Emergency Management Coordinator of the Corpus Christi Texas Fire Department.

He also served as the Chief of Staff for the Texas Division of Emergency Management, and is a founding member of the Texas Task Force One Urban Search and Rescue Team. Richard responded to numerous events including sheltering operation for Hurricane Katrina, citywide evacuations for Hurricanes Rita and Ike, Fort Worth tornado incident, south Texas floods, Corpus Christi tornado and flood incidents and numerous major refinery fires in the industrial complex of Corpus Christi.

Richard Leman, MD, Chief, Medical Officer Health Security, Preparedness, and Response Public Health Division, Oregon Health Authority, US
Dr. Lehman is a distinguished orthopedic surgeon in St. Louis, Missouri, who pioneered the procedure for articular cartilage reconstruction using two-phased cartilage grafts. He’s also been a central figure in sports injury treatment, presenting at over 30 conferences, as well as participating in multiple sports injury research projects. He currently serves as the founder and medical director of the US Center for Sports Medicine in Kirkwood, MO.

Throughout his career, Dr. Lehman has written over twenty-seven articles in science journals like Arthroscopy. He has also authored and co-authored clinics in sports medicine and guidelines on how to sports teams can avoid injuries. Because of his advancements in sports medicine, Dr. Lehman was inducted into both the St. Louis and Missouri Sports Halls of Fame.

Joseph Lynch, Project Specialist
BCFS Health and Human Services (HHS)
Emergency Management Division, US

Joseph Lynch is a Project Specialist and Incident Management Team (IMT) for BCFS Health and Human Services Emergency Management Division. Mr. Lynch retired as the Fire Chief of the City of Irondale, Alabama, Fire Department with 27 years of fire service experience. He is an Adjunct Faculty Member of the Alabama State Fire College, Jefferson State Junior College, Texas A & M University, the Center for Domestic Preparedness, and the Georgia Fire Academy, where he has developed and taught a number of courses.

Mr. Lynch is a Certified Emergency Manager and is Board Certified in Homeland Security Level V. Incidents of national significance he has responded to include the Eric Rudolph bombing of the New Woman All Women abortion clinic in Birmingham, Alabama (1998). Resulting in the death of a police officer, the April 27, 2011, F-5 Alabama tornado disaster, resulting in 32 deaths, 221 injured, and 1000 homes destroyed, and the Enbridge Pipeline Rupture (environmental disaster) occurring in Marshall, MI, on July 26, 2010. In September of 2005, Chief Lynch served as a liaison between the Alabama fire service and the federal Joint Field Office that was established in Montgomery, Alabama, as a result of Hurricane Katrina.

John Madden, Director
Division of Homeland Security & Emergency Management
State of Alaska, US

Mr. Madden has served his state and his country for more than 40 years. First appointed by Governor Sarah Palin in January 2007, Mr. Madden continues under Governor Sean Parnell as the Director of the Division of Homeland Security & Emergency Management for the State of Alaska.

This followed a year as the Deputy Director for Homeland Security within the division. His state service follows a distinguished career in seven federal agencies.

Maria Julia Marinissen, PhD
Director, Division of International Health Security
Division of International Health Security
Office of Assistant Secretary for Preparedness and Response
US Department of Health and Human Services, Washington, DC

Dr. Marinissen oversees and provides leadership in international programs to develop early-warning infectious-disease surveillance capacity in partner countries and coordinates the development of policies to provide international assistance during public health emergencies.

She also oversees several international partnerships and serves as the US liaison to the Global Health Security Initiative (GHSI) and as the chair for the Trilateral Health Security Working Group under the North American Leaders’ Summit Framework.


Nicola Marsden-Haug joined the Washington State Department of Health Office of Communicable Disease Epidemiology in 2008 as the Zoonotic Disease Epidemiologist. She works on investigation of zoonotic, mycotic and enteric diseases. Nicola has a Master of Public Health and a bachelor's degree in biology.

Prior to joining the state Department of Health, she worked as an epidemiologist at Tacoma-Pierce County Health Department and before that at the Walter Reed Army Institute of Research in Maryland. She has also worked in public health workforce training for the University of Washington’s Northwest Center for Public Health Practice.

Tina Maslyk, Acting Director Emergency Management Unit Alberta Ministry of Health, Canada

Tina Maslyk is the Acting Director for Alberta’s Ministry of Health - Emergency Management Unit. In this role she is responsible for Alberta’s Health’s emergency management program, public health emergency planning, business continuity and facility emergency response planning.

Tina was a registered nurse by trade and has dedicated over 18 years to the field of health and emergency services. Her experience includes frontline hospital care, emergency services dispatch, air ambulance coordination, and inter-jurisdictional emergency management coordination initiatives.

Tina was elected to the Disaster Recovery Institute of Canada Certification Commission in 2009 and has taught in the University of Alberta’s School of Public Health’s Emergency Preparedness, Planning and Response program. Tina has a passion for health emergency management and believes that every emergency should be explored for ways to do better. Tina has a husband and two children and they enjoy living in the rural Alberta prairies.

Garnet Matchett, Co-chair, Joint Coordinating Committee Pacific NorthWest Border Health Alliance Director of Operations, Chief Health and Safety Officer Health Emergency Management, Saskatchewan Health, Canada
Mr. Matchett is the Director of Operations and Chief Health and Safety Officer of Health
Emergency Management in Saskatchewan Health, and the Canadian Chair for the Pacific
Northwest Border Health Alliance.

He is a member of Expert Group on Emergency Preparedness and Response, Public Health
Agency of Canada, Provincial Emergency Management Committee, Provincial Emergency
Operations Advisory Council and Emergency Response Assistance Program (Transport
Canada/National Microbiology Laboratory-Public Health Agency of Canada) SCDL (Human Risk
Level 4 Pathogens).

Mr. Garnett was appointed Emergency Planning Officer for Saskatchewan Health, and has held
many other positions as the chair for National Emergency Stockpile Systems Strategic Review
and Council of Health Emergency Management Directors. He is also a guest lecturer for
multiple Universities throughout Canada.

Peter Mayer
Deputy Director, Chief Operating Officer
Snohomish Health District
Everett, Washington, US

Peter is responsible for the day-to-day operations of a municipal corporation with 162 FTEs and
an annual budget of $16 million dedicated to improving the health of individuals, families and
communities through disease prevention, health promotion and protection from environmental
threats. He also assists the Director/Health Officer in facilitating the work of a 15-member Board
of Health, representing communities throughout Snohomish County and over 713,000 citizens.

Peter currently supervises the support divisions including Human Resources, Information
Services, Finance and Communications as well as the operational divisions of the district that
includes Community Health, Environmental Health and Communicable Disease Control, as well
as serving as the Incident Commander to coordinate the district's response to emergencies
throughout Snohomish County.

Kenneth D. Murphy
Regional Administrator for Region X
Department of Homeland Security
Federal Emergency Management Agency (FEMA), US

Kenneth D. Murphy was appointed Regional Administrator for Region X for the Department of
Homeland Security's Federal Emergency Management. Mr. Murphy is responsible for
developing, administering and coordinating FEMA’s mitigation, preparedness, response and

Mr. Murphy served with Oregon Emergency Management from 1999 to 2010. As the agency's
director, Murphy was responsible for coordinating emergency management activities with state
and local emergency services agencies and all governmental agencies. He also served on the
Oregon Homeland Security Council, Oregon's State Interoperability Executive Council, the
Governor's Search and Rescue Policy Commission, and the Governor's Recovery Cabinet, as
well as being appointed to serve on FEMA’s National Advisory Council. Murphy oversaw the
response and recovery for seven Presidential and eight gubernatorial disaster declarations in Oregon.

Shannon O’Fallon, JD
Senior Assistant Attorney General
Oregon Department of Justice, US

Shannon graduated from the University of Oregon, School of Law in 1993. After law school Ms. O’Fallon moved to Alaska and worked for the Alaska Attorney General’s Office for over seven years, representing both human services and natural resources agencies.

She has been with the Oregon Department of Justice since April 2002, and has advised the Public Health Division since 2004. Ms. O'Fallon advises such programs as Health Security Preparedness and Response, Health Care Licensure, Emergency Medical Services and Trauma Systems, the Center for Health Statistics, Medical Marijuana, Death with Dignity, and Acute and Communicable Disease Prevention.

Matthew Penn, JD, MLIS, Director
Public Health Law Program, Center of Disease Control
Office for State, Tribal, Local and Territorial Support, US

Matthew Penn is the Director of CDC Office of State, Tribal, Local and Territorial Support’s Public Health Law Program (PHLP). PHLP works toward a public health community that understands how the law impacts the public health system and the public’s health. In his role as PHLP Director, he leads a team of legal analysts responsible for the agency’s efforts to support the use of law as a public health tool at the state, tribal, local and territorial levels. Prior to entering federal service he was a Staff Attorney serving South Carolina’s Department of Health and Environmental Control for nine years as an adviser in the areas of public health practice, emergency preparedness, and environmental health.

Mr. Penn developed expertise in legal preparedness issues as lead counsel for SCDHEC’s Office of Public Health Preparedness, the South Carolina Advisory Committee for the Emergency System for Advance Registration of Volunteer Health Professionals, and the South Carolina Pandemic Influenza Ethics Task Force. During the 2009 H1N1 Influenza Pandemic, he served as SCDHEC’s front line attorney coordinating all legal activities between the Office of General Counsel, SCDHEC’s Emergency Operations Center, and the Commissioner's office.

He received his law degree with honors from the University of South Carolina. He began his legal career with the South Carolina Supreme Court in the Staff Attorney’s Office and the University of South Carolina’s Office of General Counsel.

Patrick Quealey
Assistant Deputy Minister
Emergency Management BC
British Columbia, Canada
Mr. Quealey is the Chair of the Western Regional Emergency Management Advisory Committee for the Pacific Northwest Emergency Management Arrangement (PNEMA) and is the Assistant Deputy Minister for Emergency Management, British Columbia, Canada.

His clinical practice experience includes general medical-surgical hospital units, home care and hospice, school nursing and occupational health.
Appendix C

2014 Pacific Northwest Border Health Alliance Workshop Evaluation

Question 1. Where is your work location?
Total responses (N): 49 Did not respond: 0

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<th>Answer</th>
<th>Frequency</th>
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<tr>
<td>British Columbia</td>
<td>6</td>
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<tr>
<td>Saskatchewan</td>
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<td>2.04%</td>
</tr>
<tr>
<td>Yukon Territory</td>
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<td>0.00%</td>
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<td>North Dakota</td>
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<tr>
<td>Oregon</td>
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<td>30.61%</td>
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<tr>
<td>Washington</td>
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<td>38.78%</td>
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<tr>
<td>Canada First Nation</td>
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<td>2.04%</td>
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<tr>
<td>US Tribe</td>
<td>1</td>
<td>2.04%</td>
</tr>
<tr>
<td>Other:</td>
<td>2</td>
<td>4.08%</td>
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</table>

Question 2. What type of organization/agency do you work for?
Total responses (N): 49 Did not respond: 0

<table>
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<tr>
<th>Answer</th>
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<tr>
<td>Local/Regional Government</td>
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<tr>
<td>State/Provincial/Territorial Government</td>
<td>30</td>
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<tr>
<td>Federal Government</td>
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<tr>
<td>Hospital or Community Clinic</td>
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<td>2.04%</td>
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<td>Military</td>
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</tr>
<tr>
<td>First Nation / Tribal Affiliation</td>
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<td>4.08%</td>
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<tr>
<td>College or University</td>
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<tr>
<td>Business</td>
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<tr>
<td>Other:</td>
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<td>12.24%</td>
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</table>

Question 3. What days/sessions of the workshop did you attend? (Please mark all that apply)
Total responses (N): 49 Did not respond: 0

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<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Monday, May 12, 2014 (Orientation Session)</td>
<td>35</td>
<td>71.43%</td>
</tr>
<tr>
<td>Monday, May 12, 2014 (Workgroup Breakout Session)</td>
<td>43</td>
<td>87.76%</td>
</tr>
<tr>
<td>Tuesday, May 13, 2014 (General Session Day 1)</td>
<td>44</td>
<td>89.80%</td>
</tr>
<tr>
<td>Wednesday, May 14, 2014 (General Session Day 2)</td>
<td>33</td>
<td>67.35%</td>
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</table>
Question 4. What workgroup breakout session did you attend on Monday, May 12, 2014?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
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<tr>
<td>Epidemiology and Surveillance</td>
<td>5</td>
<td>10.42%</td>
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<tr>
<td>Public Health Laboratories</td>
<td>3</td>
<td>6.25%</td>
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<tr>
<td>Health Emergency Management</td>
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<tr>
<td>Emergency Medical Services</td>
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<td>Risk Communications</td>
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<tr>
<td>Public Health Law</td>
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<td>0.00%</td>
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<tr>
<td>Indigenous Health</td>
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<td>12.50%</td>
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<tr>
<td>Clinical Medical Surge</td>
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<td>6.25%</td>
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<tr>
<td>Environmental Public Health</td>
<td>7</td>
<td>14.58%</td>
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<tr>
<td>Floated between different workgroup meetings</td>
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<td>6.25%</td>
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<tr>
<td>I did not attend a workgroup breakout session</td>
<td>5</td>
<td>10.42%</td>
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Question 5. What new workgroups (if any) should be established? (e.g., Disaster Psychosocial Workgroup, Other?)

Total responses (N): 16 Did not respond: 33

1. Communicable Disease Emergencies/Pandemic
2. Community Involvement - community coordination
3. Disaster Psychosocial is a good suggestion. The importance of this topic is often referenced in other workgroups.
4. Disaster relief group
5. Food safety
6. I agree that the Disaster Psycho-social Workgroup needs to be added.
7. I think the bases are pretty well covered.
8. I think we need to build in time for cross sectorial work between the different work groups.
9. Mental health issues and serving people with special needs.
10. None.
11. None.
12. Psychosocial
13. Seems like the current options cover a broad range. Can't think of any essential additions.
14. Volunteer Management - Then Clinical Medical Surge could concentrate on other med surge issues besides volunteer credentialing or they could work together on this issue, also Consider calling the Health Emergency Management group, Health Preparedness and Emergency Management and invite non Health Emergency Managers to the conference as well as Preparedness (Health) Managers
15. Workforce Development, Change Management Strategies

Question 6. The workshop workgroup breakout session that you attended on Monday, May 12th provided a valuable forum for exchange of ideas and information.
Total responses (N): 48 Did not respond: 1

**Question 7. There was enough time during your workgroup breakout session to meet its objectives.**

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<th>Answer</th>
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<td>52.08%</td>
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<tr>
<td>Agree</td>
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<td>31.25%</td>
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<tr>
<td>Undecided</td>
<td>3</td>
<td>6.25%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
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<td>0.00%</td>
</tr>
<tr>
<td>I did not attend a workgroup breakout session</td>
<td>5</td>
<td>10.42%</td>
</tr>
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</table>

Total responses (N): 48 Did not respond: 1

**Question 8. There was enough unstructured time during the workshop to informally network with colleagues.**

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Strongly Agree</td>
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<td>22.92%</td>
</tr>
<tr>
<td>Agree</td>
<td>21</td>
<td>43.75%</td>
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<tr>
<td>Undecided</td>
<td>9</td>
<td>18.75%</td>
</tr>
<tr>
<td>Disagree</td>
<td>3</td>
<td>6.25%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>I did not attend a workgroup breakout session</td>
<td>4</td>
<td>8.33%</td>
</tr>
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</table>

Total responses (N): 47 Did not respond: 2

**Question 9. This workshop was useful in strengthening healthcare and public health preparedness and response partnerships across borders.**

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>25</td>
<td>52.08%</td>
</tr>
<tr>
<td>Agree</td>
<td>16</td>
<td>33.33%</td>
</tr>
<tr>
<td>Undecided</td>
<td>5</td>
<td>10.42%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
<td>2.08%</td>
</tr>
</tbody>
</table>

Total responses (N): 48 Did not respond: 1

**Question 10. The World Café Poster Session provided a valuable forum for learning and exchanging ideas with colleagues.**
### Question 11. If a cross border workshop is held next year with a registration fee of approximately $100-$150, I would still be likely to attend.

<table>
<thead>
<tr>
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<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>53.06%</td>
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<tr>
<td>No</td>
<td>9</td>
<td>18.37%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>14</td>
<td>28.57%</td>
</tr>
</tbody>
</table>

### Question 12. The elimination of hosted continental breakfasts and lunch (sit-down and take-away) is an acceptable solution in reducing workshop operating costs.

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
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<tr>
<td>Agree</td>
<td>20</td>
<td>40.82%</td>
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<tr>
<td>Undecided</td>
<td>8</td>
<td>16.33%</td>
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<tr>
<td>Disagree</td>
<td>10</td>
<td>20.41%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.00%</td>
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### Question 13. If a cross border workshop is held next year what would your venue preference be?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Victoria, BC</td>
<td>19</td>
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</tr>
<tr>
<td>Vancouver, BC</td>
<td>14</td>
<td>29.17%</td>
</tr>
<tr>
<td>Kelowna, BC</td>
<td>9</td>
<td>18.75%</td>
</tr>
<tr>
<td>Other:</td>
<td>6</td>
<td>12.50%</td>
</tr>
<tr>
<td>Other: Alaska or Seattle</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Other: Calgary</td>
<td>2</td>
<td>4.10%</td>
</tr>
<tr>
<td>Other: Penticton, BC</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>Other: Probably couldn't attend outside US</td>
<td>2</td>
<td>4.10%</td>
</tr>
<tr>
<td>Other: U.S.</td>
<td>1</td>
<td>2.08%</td>
</tr>
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</table>

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

Total responses (N): 21 Did not respond: 28
1. Communicable disease emergencies.
2. Data registries and how they can impact our collaboration through quantifiable objective outcome measurement
3. Development of an operational work plan covering all the members of the PNWBHA
4. Disaster preparedness for people with special needs
5. Environmental health, but emergency focused. The EH sessions this year were mostly non-emergency/routine EH.
6. Follow-up to address Licensing and verification of licenses across borders
7. Foodborne Illness issues - maybe cruises/trains that go into Canada and the US.
8. Have we talked about mass fatality management and repatriation of remains? I don't know that it is a public health issue, but this is one venue we could bring it up.
9. I think there should be a face to face meeting among groups find out common strings and issues
10. Incident command structure reworded to reflect health care language, e.g. - not military language/titles
11. It would be nice to have a speaker whose expertise is public health. Although the conference was supposed to address public health implications in a disaster, I didn't feel that that voice was adequately represented.
12. Maintaining a public health workforce in light of diminishing resources.
13. Mass gatherings
14. Maybe a focus on only 1-2 of the subject areas. Then increase the frequency of workshop meetings to focus on other areas.
15. Medical Surge detailed information, detailed EQ planning by states
16. Mission Ready Packages
17. More discussions on building a sustainable organization
18. More focus on epidemiology.
19. More lab-specific issues
20. Oil trains
21. Resource typing and matching
22. Super-bugs that are resistant to current antibiotics and a coordinated international response between Canada and the US.
23. Unsure
24. We need to game (tabletop?) the entire response for a public health emergency that requires the flow of resources across the border. I think we have a good concept of operations, but really need to have the principals or their deputies present to validate them.

**Question 15. Are there partners whose attendance is missing from the workshop?**

Total responses (N): 46 Did not respond: 3

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>19.57%</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>13.04%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>25</td>
<td>54.35%</td>
</tr>
<tr>
<td>If Yes, who?</td>
<td>15</td>
<td>32.61%</td>
</tr>
</tbody>
</table>

1. Air and sea control programs
2. BC MOH?
3. County (non-health) emergency managers
4. EMS agencies
5. Environmental health
6. Healthcare industry representation
7. Maybe more military
8. Montana, North Dakota, Yukon
9. More healthcare needed
10. More representation from communications group
11. More tribal invitations
12. NGOs
13. Public health partners
14. State department, dfait/dfatd
15. Tribal emergency management

**Question 16. What did you like most about this workshop?**

Total responses (N): 35 Did not respond: 14

1. Both horizontal and vertical integration -- we have people from all levels of government and from all sectors. First Nations and tribes -- great! I also like the increasing involvement of NGOs and the private sector.
2. Chance to network with new colleagues
3. Collaboration and exchange of ideas to solve problems. Creation of networking groups.
4. Connecting with partners form other disciplines. It is valuable to meet with your counterparts but there is also a lot of value in getting the broader perspective and seeing how things fit together.
5. Continued learning and networking
6. I appreciate the time that was given to explain the different P agreements and how they are distinct yet integrated.
7. Interacting with colleagues
8. Networking
9. Networking
10. Networking
11. Networking with counterparts from other states and Canada.
12. Networking. Session on earthquakes
13. opportunity for collaboration
14. Opportunity for greater exposure to emergency preparedness, also liked the session on Oso landslide as very informative
15. Partners from multiple jurisdictions
16. Some networking was good
17. Speakers, location, the smooth operation
18. Speakers, opportunity to share what each state/province does specifically
19. Table top exercise
20. The broad range of specialties that were represented.
21. The collegial and interactive atmosphere
22. The conference was well put together. I enjoyed being able to network with other groups and individuals to gain other perspectives.
23. The end table top exercise on the last day
24. The energy it creates for all jurisdictions and disciplines. This is a true collaborative environment. Processes and plans are accomplished! IT WORKS!
25. The epidemiology/surveillance breakout session surveillance discussions.
26. The Mass Fatality Presentation by Snohomish County Public Health Tabletop Exercise
27. The mutual aid assistance group discussion. It was interactive and a great learning opportunity from the small table top group work to the larger group discussions.
28. The networking with counterparts was absolutely invaluable!
29. The opportunity to hear about the responses to recent disasters and to learn from them and to re-engage with colleagues in my own field.
30. The presentation about Oso. I thought they were a good reminder of although ICS, planning and order are important, flexibility is just as important. Regimented thinking could be a problem in a disaster.
31. The speakers
32. The variety of preparedness topics
33. Variety of agencies involved, Variety of subjects, Good networking
34. Workgroups are very valuable. but there needs to be some follow-up and accountability for what is discussed so that plans can be put into action.
35. Workshop

Question 17. What suggestions do you have for improving the next cross border workshop?
Total responses (N): 29 Did not respond: 20

1. As mentioned above, more of specific area focus rather than a shotgun discussion. There are, within the Health Emergency area alone, several issues that need addressed. It would be good to cycle through each of those issues methodically to seek solutions.
2. Built in networking time, maybe a shared roster/attendance contact list
3. Development of an annual work plan for all to work toward accomplishing
4. Figure out what you want from an EH session.
5. Good question but can't think of an appropriate answer
6. Holding the workshop every other year rather than yearly.
7. Holding the Workshop in Penticton next year opens the door up to Vendor Booths and another avenue for revenue generation. The facility will also accommodate large static displays like the BC Mobile Medical Unit! Penticton has an Airport and is minutes from the US border crossing!
8. I enjoyed the choice of classes to attend on Tues. and Wed. It was interesting to be made aware of the most likely natural hazards facing the Portland and surrounding areas.
9. I felt like the second day was far too long. By the end of the day it seemed that a lot of people in the room were losing focus or left.
10. I think it would be better to include the poster sessions during the day instead of after the last session. Very few people showed up at the posters. Perhaps scheduling the poster presentations during lunch would encourage more people to stop by.
11. I thought that this year's workshop was well organized and topical.
12. I would suggest that a Blog or RSS feed be created to exchange ideas and share findings throughout the year.
13. If meals will not be provided which is totally fine, more time is needed for folks to access food.
14. JCC Meeting to be held at a different time, if possible. It's too long of a day to have that meeting following the 3 hour breakout session on Monday afternoon.
15. Keep up the great work!
17. More effort to incorporate tribal speakers. More emphasis on idea generation and less on info sharing in environmental health session.
18. More sessions on communicable disease emergencies/pandemic
19. More time spent on work group session but split it up over the course of conference. It would also be nice to have work group update (milestones reached and new goals set).
20. More virtual conferences with working groups -- this worked for EPI and with a solid work group schedule established beforehand, this could work for other groups were travel funds are limited. It does mean ongoing engagement of the leaders.
21. Need to make/take time in the breakout sessions for: a) participant self-introductions; and b) discussion of presentations/topics.
22. No handouts, I threw everything away.
23. Only one lifetime achievement award. No sit down lunch. Stronger and applicable general sessions.
24. Seems ok to eliminate the breakfast but dismissing people from lunch may disrupt the flow a bit with people arriving back at different times and it eliminates a networking opportunity.
25. Should dedicate time to have a face to face meeting among groups other than only reporting groups outcome.
26. The content provided was not interesting nor helpful to the work that I do. If such high level topics are going to be discussed for the main plenary sessions, then the workshop should be only for federal and tribal governments. The topics, like the epidemiology break out session, need to focus on tangible issues (i.e., lack of research on health effects and wildfire smoke; lack of resources to adequately monitor ER data during wildfires, etc.) and highlight the work US and Canada are doing. The topic of MOUs are so abstract it was hard to understand how a federal MOU would have any direct impact on the work that I do.
27. The working group on day 1 felt like more of an update on what some people are working on in the Health Emergency Management area. Wasn’t sure how the group was supposed to assist in planning efforts or if it was supposed to be more of an educational opportunity to learn of what others are doing.
28. This format is fine. Would not-change much. Have the feds explain how there is no funding to sustain this work, which benefits them (Both countrie